

Board of Directors held in Public - 02 April 2026

Thu 02 April 2026, 09:30 - 12:15

Meeting to be held at New Mill Meeting Room 4.03

We welcome stakeholders to submit questions to the Board of Directors. Questions can be submitted in advance of the meeting (contact details are at the end of the agenda).


This meeting will be held in person at New Mill (details of how to express your interest in joining this meeting can be found at the end of the agenda).

Agenda

09:30 - 09:35 1. Welcome and apologies for absence (verbal)

5 min


Information Sarah Jones

 Item 01.0 - Board of Directors Agenda - held in public - 2 April 2026 v4.pdf (3 pages)

09:35 - 09:35 2. Declaration of any conflicts of interest (enclosure)

0 min

Information Sarah Jones

 Item 02.0 - BDCFT Declaration of Interests for Members of the Board of Directors March 2026.pdf (1 pages)

09:35 - 09:35 3. Questions received (verbal)

0 min

Discussion Sarah Jones

09:35 - 09:35 4. Minutes of the previous meeting held on 5 February 2026 (enclosure)

0 min

Decision Sarah Jones

 Item 04.0 - Public Board minute 5 February 2026 CHAIR APPROVED v.2.pdf (15 pages)

09:35 - 09:35 5. Matters arising (verbal)


0 min

Information Sarah Jones

09:35 - 09:40 6. Action log (enclosure)

5 min

Sarah Jones

 Item 06.0 - Public Board of Directors - Action Log - for 2 April 26 v.2.pdf (3 pages)

09:40 - 10:00 7. Presentation IPS (presentation)


20 min

Discussion Phillippa Hubbard, Suzanne Hala and Jane Bridges

10:00 - 10:05 8. Chair's Report (enclosure)

5 min

Sarah Jones

 Item 08.0 - Chair's Report - 2 April 2026 (final).pdf (3 pages)

Close to
27/03/2026 15:42

10:05 - 10:15 9. Chief Executive's Report (enclosure)

10 min

Discussion *Therese Patten*


 Item 09.0 - CE Report Public April 26 Final.pdf (8 pages)

Quality and Safety

10:15 - 10:20 10. Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held 19 March 2026 (enclosure)

5 min

Discussion *Warren Brown*

 Item 10.0 - Mental Health Legislation Committee - Effective Oversight Escalation and Assurance - 19 March 2026 - Chair Approved.pdf (4 pages)

10:20 - 10:25 11. Alert, Advise, Assure and Decision Report: Quality and Safety Committee held 18 February 2026 (enclosure) and 18 March 2026 (verbal)

5 min

Discussion *Alyson McGregor*


 Item 11.0.0 - AAAD - Effective Oversight Escalation and Assurance - QSC Feb 2026 RATIFIED.pdf (3 pages)

People and Culture

10:25 - 10:30 12. Alert, Advise, Assure and Decision Report: People and Culture Committee held 19 March 2026 (enclosure)

5 min

Discussion *Mark Rawcliffe*

 Item 12.0 - AAAD - Effective Oversight Escalation and Assurance - PCC March 2026 EXEC AND CHAIR APP.pdf (3 pages)

Finance and Sustainability

10:30 - 10:35 13. Alert, Advise, Assure and Decision Report: Finance and Performance Committee held 25 March 2026 (verbal)

5 min

Discussion *Maz Ahmed*

10:35 - 10:50 14. Finance Report (enclosure)

15 min

Discussion *Mike Woodhead*

 Item 14.0 - Finance Report Trust Board (Month 11 - February 2026).pdf (9 pages)

10:50 - 10:55 15. Green plan update (enclosure)

5 min

Decision *Mike Woodhead*

 Item 15.0.0 - Board Green Plan update April 26.pdf (2 pages)

 Item 15.0.1 -Board Green Plan update April 26.pdf (2 pages)

10:55 - 11:00 Break (10.55 – 11.00)

5 min

Strategy and partnerships

11:00 - 11:15 16. Strategic Assurance and Performance Report (enclosure)

15 min

Case Policy
27/03/2026 15:42:07

Discussion Kelly Barker & Phillipa Hubbard

- Item 16.0.0 - Board Integrated Performance Report Cover Paper - April 2026.pdf (4 pages)
- Item 16.0.1 - Board Integrated Board Performance Report - April 2026.pdf (15 pages)

11:15 - 11:25 **17. Strategic Risk Summary (enclosure)**

10 min

Decision Fran Stead

- Item 17.0 - Strategic Risk Assurance Report 2026.03.pdf (10 pages)

11:25 - 11:35 **18. NHS Oversight Framework quarterly update (enclosure)**

10 min

Discussion Farhan Rafiq

- Item 18.0.0 - NOFv7 update.pdf (4 pages)
- Item 18.0.1 - NOF Dashboard Q3 2526 v7 BI Image Final.pdf (26 pages)

11:35 - 11:45 **19. Quality Management System update (enclosure)**

10 min

Information Farhan Rafiq & Chris Hunt

- Item 19.0 - CTW Quality Management System Update MAY CHANGE.pdf (7 pages)

Governance and well led

11:45 - 11:50 **20. Alert, Advise, Assure and Decision Report: Audit Committee held 29 January 2026 (enclosure) and 26 March 2026 (verbal)**

5 min

Discussion Christopher James Malish

- Item 20.0.0 - Effective Oversight Escalation and Assurance - Audit Committee 29.01.2026 - Chair Approved.pdf (3 pages)

11:50 - 12:00 **21. Well-led development plan update (enclosure)**

10 min

Discussion Fran Stead

- Item 21.0.0 -2026.03 - Well Led Development Plan.pdf (7 pages)
- Item 21.0.1 -2026.03 - Well Led DP - appendix 1.pdf (10 pages)

12:00 - 12:10 **22. Governance report (enclosure)**

10 min

Decision Fran Stead

- Item 22.0.0 - Governance Report - Board of Directors - 2 April 2026 v4.pdf (4 pages)
- Item 22.0.1- Audit Committee Annual Governance Report - 2025-26 v.1.pdf (10 pages)
- Item 22.0.2 - Terms of Reference - Audit Committee 2026 - Draft.pdf (11 pages)
- Item 22.0.3 - Finance and Performance Committee Governance Report - 25-26 - Committee Approved.pdf (13 pages)
- Item 22.0.4- Terms of Reference - Finance and Performance Committee - 03.2026 - Committee Approved.pdf (9 pages)
- Item 22.0.5 - Mental Health Legislation Committee Annual Governance Report 2025-26 - Committee Approved.pdf (12 pages)
- Item 22.0.6- Terms of Reference - Mental Health Legislation Committee 03.2026 - Committee Approved.pdf (8 pages)
- Item 22.0.7 - People and Culture Committee Annual Governance Report - 25-26 - Committee Approved.pdf (12 pages)
- Item 22.0.8 - Terms of Reference - People and Culture Committee 03.2026 - Committee Approved.pdf (9 pages)
- Item 22.0.9 - Quality & Safety Committee Annual Governance Report - 2025-26 Draft.pdf (14 pages)
- Item 22.0.10 - Terms of Reference - Quality Safety Committee - Draft - April 2026.pdf (9 pages)

12:10 - 12:10 **23. West Yorkshire ICS MHLDA Committee in Common AAAD held 28 January 2026 (enclosure)**

0 min

Information Information

- Item 23.0 - PRIVATE_WYMHSC Committees in Common_AAA Report_28.01.2026.pdf (1 pages)


Close History
27/03/2026 15:42:00

12:10 - 12:10 24. Board of Directors public meeting work plan 2026-27 (enclosure)

0 min

Information

Information

 Item 24.0 - Work Plan - Board 202627 DRAFT.pdf (1 pages)

12:10 - 12:10 25. Any other business (verbal)

0 min

Discussion

Sarah Jones

Close: Holly
27/03/2026 15:42:07

Board of Directors – held in public

Date: Thursday 2 April 2026

Time: 9.30 until 12.15

Venue: Meeting to be held at New Mill Meeting Room 4.03



We Care



We Listen



We Deliver

AGENDA

We welcome stakeholders to submit questions to the Board of Directors. Questions can be submitted in advance of the meeting (contact details are at the end of the agenda).

This meeting will be held in person at New Mill (details of how to express your interest in joining this meeting can be found at the end of the agenda).

Strategic Priority			Lead		Time
GG	1	Welcome and apologies for absence (verbal)	SJ	For information	9.30
	2	Declaration of any conflicts of interest (enclosure)	SJ	For information	
BUOR	3	Questions received (verbal)	SJ	For discussion	
GG	4	Minutes of the previous meeting held on 5 February 2026 (enclosure)	SJ	For decision	
	5	Matters arising (verbal)	SJ	For information	
	6	Action log (enclosure)	SJ	For decision	9.35
BQS	7	Presentation IPS (presentation)	PH/SH/ JB	For discussion	9.40
All	8	Chair's Report (enclosure)	SJ	For discussion	10.00
	9	Chief Executive's Report (enclosure)	TP	For discussion	10.05

Quality and Safety

BQS	10	Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held 19 March 2026 (enclosure)	WB	For discussion	10.15
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	11	Alert, Advise, Assure and Decision Report: Quality and Safety Committee held 18 February 2026 (enclosure) and 18 March 2026 (verbal)	AM	For discussion	10.20
<u>People and Culture</u>					
BPTW	12	Alert, Advise, Assure and Decision Report: People and Culture Committee held 19 March 2026 (enclosure)	MR	For discussion	10.25

Finance and Sustainability

BUOR	13	Alert, Advise, Assure and Decision Report: Finance and Performance Committee held 25 March 2026 (verbal)	MA	For discussion	10.30
	14	Finance Report (enclosure)	MW	For discussion	10.35
	15	Green plan update (enclosure)	MW	For decision	10.50

Break (10.55 – 11.00)

Strategy and partnerships

All	16	Strategic Assurance and Performance Report (enclosure)	PH/ KB	For discussion	11.00
	17	Strategic Risk Summary (enclosure)	FS	For decision	11.15
	18	NHS Oversight Framework quarterly update (enclosure)	FR	For discussion	11.25
	19	Quality Management System update (enclosure)	FR/ CH	For information	11.35

Governance and well led

GG	20	Alert, Advise, Assure and Decision Report: Audit Committee held 29 January 2026 (enclosure) and 26 March 2026 (verbal)	CM	For discussion	11.45
	21	Well-led development plan update (enclosure)	FS	For discussion	11.50
	22	Governance report (enclosure)	FS	For decision	12.00
	23	West Yorkshire ICS MHLDA Committee in Common AAAD held 28 January 2026 (enclosure)	For info	For information-	
	24	Board of Directors public meeting work plan 2026-27 (enclosure)	For info	For information	
	25	Any other business (verbal)	SJ	For discussion	12.10

	26	Comments from public observers (verbal)	SJ	For information	-
	27	Meeting evaluation (verbal) Was the meeting conducted in line with the Trust values? (verbal)	SJ	For discussion	-

Date of the Next Meeting: 7 May 2026– final details to be confirmed by Corporate Governance Team

Questions for the Board of Directors can be submitted to:

Name: Fran Stead (Trust Secretary)

Email: fran.stead@bdct.nhs.uk

Name: Sarah Jones (Chair in Common and Chair of the Trust)

Email: sarah.jones@bdct.nhs.uk

Expressions of interest to observe the meeting using Microsoft Teams:

Email: corporate.governance@bdct.nhs.uk

Strategic Priorities (Key)

Best Place to Work	Theme 1 – Looking after our people	BP2W:T1
	Theme 2 – Belonging in our organisation	BP2W:T2
	Theme 3 – New ways of working and delivering care	BP2W:T3
	Theme 4 – Growing for the future	BP2W:T4
Best Use of Resources	Theme 1: Financial sustainability	BUoR:T1
	Theme 2: Our environment and workspaces	BUoR:T2
	Theme 3: Giving back to our communities	BUoR:T3
Best Quality Services	Theme 1 – Access and Flow	BQS:T1
	Theme 2 – Learning for improvement	BQS:T2
	Theme 3 – Improving the experience of people using our services	BQS:T3
Best Partner	Co-production, working together, presence, insight	BP
Good Governance	Governance, accountability and effective oversight	GG

Close: Holly
27/03/2026 15:42:07

ID	Start time	Completion time	Email	Name	Last modified time	Name2	Directorships, including Ownership or part own	Majority or controlling	Position of authority in	Any connection with a	Any substantial or influ	Any other commercial	Declarations made in re
1	1/29/26 14:00:51	1/29/26 14:02:23	bob.champion@bdct.ni	Bob Champion		Robert (Bob) champion	None	None	None	None	None	None	None
2	1/29/26 15:14:11	1/29/26 15:16:45	Therese.Patten@bdct.ni	Therese Patten		Therese Patten	None	None	None	Trustee NHS Providers due to cease imminently	None	None	None
3	1/30/26 9:57:04	1/30/26 9:59:20	Phillipa.Hubbard@bdct	Phillipa Hubbard		Phillipa Hubbard	Director of Nursing and Quality within WY ICB working into Bradford District and Craven Architects	Langtry-Langton	None	None	None	None	None
4	2/2/26 5:38:49	2/2/26 5:39:44	farhan.rafiq@bdct.nhs	Farhan Rafiq		Farhan Rafiq	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
5	2/2/26 20:53:53	2/2/26 20:54:59	tim.rycroft@bdct.nhs.u	Tim Rycroft		Tim Rycroft	NA	NA	NA	NA	NA	NA	NA
6	2/5/26 12:30:40	2/5/26 12:32:06	sal.uka@bdct.nhs.uk	Sal Uka		Sal Uka	Nil	Nil	Nil	Trustee Overgate Hospice in Halifax	Nil	Nil	Nil
7	2/5/26 17:23:31	2/5/26 17:26:17	warren.brown@bdct.ni	Warren Brown		Warren Brown	Nil	Nil	Nil	Nil	Nil	Nil	Spouse is a member of Ilkley Town Council
8	2/6/26 11:42:51	2/6/26 11:45:31	Mike.Woodhead@bdct	Mike Woodhead		Mike Woodhead	none	none	none	none	none	none	none
9	2/18/26 11:30:30	2/18/26 11:31:42	sally.napper@bdct.nhs	Sally Napper		Sally Napper	None	None	None	None	None	None	None
10	3/9/26 10:14:05	3/9/26 10:15:31	anonymous			Christopher Malish	Bradford College	N/A	N/A	Outside my Non-exec r	No	No	None
11	3/9/26 12:44:38	3/9/26 12:47:56	anonymous			Mark Rawcliffe	Horse and Jockey Harbury Bridge Limited Park Tavern Ossett Limited	Dark Industries Limited As above 50% holding	N/a	N/a	N/a	N/a	N/a
12	3/10/26 15:02:50	3/10/26 15:06:11	anonymous			sarah jones	Trust Chair at Airedale F	None	None	None	None	None	None
13	3/15/26 19:49:55	3/15/26 19:56:15	anonymous			Cleveland Henry	None	None	None	None	None	None	Employed at EMIS Health/Optom UK (Software supplying to NHS) Director of Leeds Digital Ball CIC
						Alyson McGregor	None	None	None	None	None	None	Wife, Lead Cancer Nurse, Leeds Teaching Hospital Trust NHS
										Altogether Better (NHS hosted organisation): Director (declared 06/03/24) Health Foundation Common Ambition Programme Advisory Group: Expert Advisor (declared 06/03/24)			

**Board of Directors Meeting in Public
On Thursday 5 February 2026 at 09:00
Hybrid meeting held on Microsoft Teams and in Room 4.03 at
New Mill**

Members present in person:	<p>Simon Lewis Kelly Barker Warren Brown Phil Hubbard</p> <p>Chris Malish Alyson McGregor Sally Napper Therese Patten Tim Rycroft Sal Uka Mike Woodhead</p>	<p>Interim Chair of the Trust Chief Operating Officer Non-Executive Director Director of Nursing, Professions and Care Standards, Deputy Chief Executive Non-Executive Director Non-Executive Director (Until item 11) Non-Executive Director and SID Chief Executive Chief Information Officer Chief Medical Officer Chief Finance Officer</p>
Members present via teams:	<p>Bob Champion Farhan Rafiq</p> <p>Mark Rawcliffe</p>	<p>Chief People Officer Executive Director Transformation, Improvement and Productivity (Joined 9.10am) Non-Executive Director and Deputy Chair</p>
In attendance in person:	<p>M Cook H Kerr JO</p> <p>Fran Stead Rachel Trawally</p> <p>Sarah Jones</p>	<p>Care Coordinator, Board story (agenda item 3) Clinical Manager, Board story (Until item 11) Service User, Board story (Until item 11) Trust Secretary Corporate Governance Manager and Deputy Trust Secretary Chair of Airedale NHS Foundation Trust (Observer)</p>
In attendance via teams:	<p>Mike Lodge</p>	<p>Lead Governor</p>
Apologies:	<p>Maz Ahmed</p>	<p>Non-Executive Director</p>

Close: Holly
27/03/2026 15:42:07

MINUTES

Item	Discussion	Action
<p>1</p>	<p>Welcome and Apologies for Absence (agenda item 1)</p> <p>The Chair opened the meeting at 9.00am.</p> <p>The Chair welcomed the observers and representatives, and noted the apologies received.</p> <p>Warren Brown was welcomed to his first meeting as Non-Executive Director and provided a brief professional overview, outlining his career as a senior civil servant and NHS improvement leader before retiring following the COVID-19 period.</p> <p>The Board of Directors meeting was quorate.</p>	
<p>2</p>	<p>Declarations of interest (agenda item 2)</p> <p>No declarations of interest were made.</p>	
<p>3</p>	<p>Board story: Allied Health Professions (agenda item 3)</p> <p>The Board received a presentation from JO, Involvement Partner, M Cook and H Kerr on the “potato principle” and the impact of small acts of compassionate, trauma-informed care.</p> <p>The presenters described how professional stereotypes and “clinical tribalism” had sometimes limited understanding between professional groups. They emphasised the value of recognising AHP roles and working collaboratively to improve patient experience.</p> <p>JO shared lived experience of a traumatic 2015 admission, where, from her perspective, distress had been met with restraint, sedation and stigma. She contrasted this with a significantly more compassionate 2021 admission, characterised by tailored communication, sensory support and regular engagement through groups, OT and psychology. These changes helped rebuild trust, reduce restrictive interventions and support recovery.</p> <p>H Kerr outlined how Occupational Therapy had provided structure, safety and connection through meaningful activities such as cooking, gardening and crafts. Small gestures—such as sensory items, supportive conversations, and personalised interactions—were described as having a lasting positive impact.</p> <p>The “potato principle” was used to highlight how even small, imperfect beginnings can lead to growth when nurtured, illustrating the power of consistent, human-centred care. The presenters also emphasised the role of</p>	

Close: Holly
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Item	Discussion	Action
	<p>co-production and ongoing collaboration in shaping safer, more trauma-informed practice.</p> <p>The Board thanked the presenters for their openness and the powerful insight provided.</p> <p>A McGregor, Non-Executive Director asked whether the improvements described were being seen by other service users. It was confirmed that care had improved more broadly, particularly in communication support and trauma-informed practice. It was discussed how AHPs were integrated within ward teams and noted that joint working across nursing, medical, psychology and AHP roles was strengthening, with recent work focused on shared leadership and reducing restrictive interventions.</p> <p>It was discussed how relational and compassionate approaches such as spending time with patients could be embedded across all areas. Presenters reported that improvement work, including SafeWards and rapid improvement initiatives, had encouraged staff to prioritise meaningful engagement.</p> <p>The Board recognised the significant contribution of the lived experience of the presenter to training, policy development and restraint-reduction work. Members expressed their thanks for the powerful insights provided.</p> <p>M Cook left the meeting.</p>	
<p>4</p>	<p>Questions received (agenda item 4)</p> <p>S Uka, Chief Medical Officer presented a Freedom of Information request from the public raising a question concerning a historic allegation of electric shock aversion therapy used as part of conversion therapy at Lynfield Mount Hospital in the 1970s.</p> <p>S Uka confirmed that the Trust held no records from that period, as the events pre-dated the current organisation, but acknowledged the distress described in the published survivor account. S Uka confirmed a response would be developed through the rainbow alliance. Action: response to be circulated to Board once developed.</p> <p>P Hubbard noted a national public statement from NHS England had also been made in acknowledgement.</p> <p>Action: It was agreed to send a letter of apology, acknowledging that the Trust does not support electric shock aversion therapy and noting that the current Trust had not been part of the organisation during the time of the allegation.</p>	<p>SU</p> <p>SU</p>

Close: Holly
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Item	Discussion	Action
5	<p>Minutes of the previous meeting held on 4 December 2025 (agenda item 5)</p> <p>The minutes of the Public Board of Directors held on 4 December 2025 were approved as an accurate record.</p>	
6	<p>Matters arising (agenda item 6)</p> <p>No matters arising had been received.</p>	
7	<p>Action log (agenda item 7)</p> <p>The following action was closed:</p> <ul style="list-style-type: none"> M Woodhead confirmed £15m non-recurrent capital support secured towards the Lynfield Mount development from the wider system. It was noted that the Trust had met the condition to improve its financial plan by £2M as requested, however not all West Yorkshire partners had fully delivered against their plans. <p>The Board of Directors:</p> <ul style="list-style-type: none"> noted the contents of the action log; agreed to close the actions listed as complete; and noted that no further actions were required on any actions listed. 	
8	<p>Chair's Report (agenda item 8)</p> <p>S Lewis, Chair noted his report to the Board and highlighted the engagement work undertaken with the Trust and external partners.</p> <p>S Lewis noted an event he attended on 7 January 2026 relating to AI relating to mental health Trusts and the Board environment and indicated that he would see if he could get access to and share the recording. Action: to request access to and if available to circulate the recording.</p> <p>No questions or comments were raised.</p> <p>The Board of Directors noted the report.</p>	SL
9	<p>Chief Executive's Report (agenda item 9)</p> <p>T Patten, Chief Executive highlighted key items and handed over to the Executive Leads to provide updates to the Board.</p> <p>T Patten noted significant organisational change within the West Yorkshire ICB. A voluntary redundancy scheme was underway which would lead to substantial workforce reductions, and the new ICB structure was not expected</p>	

Item	Discussion	Action
	<p>to be in place until July. This created a period of transition risk, with potential impact on local commissioning capacity. The Trust continued to support colleagues affected by the changes.</p> <p>M Woodhead provided an update on the £65 million redevelopment at Lynfield Mount Hospital, which had received final approval. The scheme would provide ten additional beds and fully ensuite wards, alongside major improvements to therapeutic spaces. Construction was expected to begin in April, with completion planned for 2028.</p> <p>P Hubbard, Director of Nursing, Professions and Care Standards, and Deputy Chief Executive provided an update on a recent CQC Mental Health Act visit, highlighting that inspectors reviewed seclusion and segregation areas at Clover, Thornton and Najurally, and confirmed that improvements previously requested had now been implemented. Acknowledged thanks to M Cook and team for their work. A further query had been raised regarding the use of Section 136 suites, and they were waiting further details so that the Trust could prepare a written response.</p> <p>S Uka provided an update on a matter being treated as a “Never Event”, originating from a procedure undertaken at Leeds Teaching Hospitals with involvement with Dental Nurses from Leeds Community Healthcare was being investigated and would be considered in detail by the Quality and Safety Committee. In relation to the 10-point plan working conditions of resident doctors it was noted that assessment in December was at 69%, a more detailed update report was presented to People and Culture Committee.</p> <p>No further questions or comments were raised.</p> <p>The Board of Directors noted the Chief Executive’s report.</p>	
<p>10</p>	<p>Strategic Assurance and Performance Report (agenda item 10)</p> <p>P Hubbard presented the Strategic Assurance and Performance Report, noting it uses committee-aligned metrics and triangulated data. P Hubbard outlined movements across key performance metrics linked to the Trust’s strategic priorities. The Board noted significant assurance for “Best Place to Work” and financial governance, and limited assurance for “Best Quality Services” due to ongoing waiting-time pressures.</p> <p>F Rafiq, Director of Transformation, Improvement and Productivity reported improvements within the National Oversight Framework metrics, including data quality and response-time indicators. An update on the results of the latest NOF scores was due in March and an update would be brought to the next meeting. A revised strategic performance report, aligned to the six national domains, was being developed for April.</p>	

Close: Holly
27/03/2026 14:42:07

Item	Discussion	Action
	<p>T Patten noted an update on work being undertaken to progress neurodiversity waiting times. P Hubbard explained that as part of the task and finish group, three workstreams had been set up to address neurodiversity waits, prevention and education. K Barker noted significant delays for children starting treatment after diagnosis, caused by national medication supply issues and resulting backlogs. Work was under way to prioritise the most vulnerable children, introduce an expedited waiting list, and increase capacity in partnership with West Yorkshire.</p> <p>A system-wide review was being undertaken, including an options appraisal (with support from the Neurodiversity Programme Lead), to consider increased in-house capacity versus use of external providers. The preferred option would clear the expedited list within nine months through additional capacity, while slightly slowing new assessments. This would be offset by increased commissioned capacity at West Yorkshire level to avoid creating new bottlenecks.</p> <p>The proposals would significantly improve access to treatment, including medication, for the most vulnerable children, but they carry a financial requirement. While waiting times would not be eliminated entirely, they would become far more manageable. Ongoing oversight is required through the Quality and Safety Committee due to the level of risk. A joint business case across West Yorkshire would need to be developed with partners and local authorities to present to commissioners.</p> <p>The wider risk to children was also being addressed through linked education workstreams, including school attendance and exclusion, led in collaboration with education partners across Bradford District and Craven. Currently, without intervention, waits could extend to seven years for priority cases and far longer for others. The proposed model would stabilise the system over 48 months, creating a sustainable internal pathway and preventing future backlog growth.</p> <p>No further questions or comments were raised.</p> <p>The Board of Directors noted the report and the updates provided.</p>	
<p>11</p>	<p>Strategic Risk Summary (agenda item 10.1)</p> <p>F Stead, Trust Secretary presented the Strategic Risk Assurance Report, which provided an update on the development of the Trust’s strategic risks.</p> <p>It was reported that a Board development session held in December had reviewed the existing risks, identified gaps, and produced proposed revisions for the year ahead. Further work was scheduled at the Executive Management Team the following week to finalise the wording, confirm</p>	

Close: Holly
27/03/2026 14:42:07

Item	Discussion	Action
	<p>ownership, and prepare the updated risks for Board committee review in March.</p> <p>M Woodhead advised that completing this work on time was essential, as the strategic risk process formed a core element of the year-end internal audit opinion. It was noted that several internal audit reports during the year had received limited assurance, and failure to complete the risk work could negatively affect the Trust's overall assurance rating.</p> <p>T Patten raised a question was raised regarding the new Mental Health Act legislation and how its implications would be reflected within the strategic risk framework. It was confirmed that the legislation would require significant changes to models of care, staffing, thresholds, and community support, and that this would be captured in a dedicated strategic risk. Members agreed that a Board development session should be held to examine the impact of legislative change in more detail, supported by external legal expertise where required.</p> <p>Action: to add the board development session to the schedule.</p> <p>The importance of distinguishing risks from issues and ensuring that risks remained forward-looking was discussed. It was noted that once the revised risks were agreed, the risk management team would support a session on risk appetite and tolerance, after which the completed framework would be incorporated into future reports.</p> <p>No further comments or feedback were raised.</p> <p>The Board of Directors noted the update and the planned next steps.</p> <p>A McGregor, H Kerr and JO left the meeting.</p>	<p>CGT</p>
<p>12</p>	<p>Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held 22 January 2026 (agenda item 12)</p> <p>In the absence of the A McGregor, Non-Executive Director who chaired the Mental Health Legislation Committee in January, S Uka the Chief Medical Officer presented the update.</p> <p>S Uka explained that the committee had agreed to defer the planned Mental Capacity Act Audit to Quarter 1 in 2026/27. It was noted that the Mental Health Act team had been operating under business continuity arrangements but had now returned to normal functioning. Ongoing work continued to improve the timeliness and structure of reports presented to the committee.</p> <p>An update was requested on the recent recruitment to the panel of Hospital Managers, and it was confirmed that six candidates had been involved in an</p>	

Close: Holly
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Item	Discussion	Action
	<p>interview process and three had been appointed. The Board discussed the need for regular recruitment cycles to maintain capacity, due to natural turnover. In response to a question about broadening the applicant pool, it was noted that the recruitment process had recently moved beyond traditional NHS channels, which had improved diversity of interest.</p> <p>A further question was raised regarding whether Hospital Managers were required to have a local connection. It was clarified that this was not essential and that remote participation was increasingly common, mirroring the tribunal system. The Board agreed that widening the pool of applicants would likely strengthen resilience.</p> <p>There were no matters requiring alert or further escalation.</p> <p>The Board of Directors noted the update on the AAAD.</p>	
<p>13</p>	<p>Alert, Advise, Assure and Decision Report: Quality and Safety Committee held 21 January 2026 (agenda item 13)</p> <p>S Napper, Non-Executive Director provided an update from the Quality and Safety Committee, highlighting ongoing pressures within district nursing, including high demand, rising sickness absence, capacity challenges and reports of cancelled visits. The Committee advised that a deeper review of these pressures may be required and that this may need to be undertaken jointly with the Young People’s Committee, given similar concerns raised there.</p> <p>The Committee also noted the challenge of sustaining service improvements at a time when some teams were managing significant operational pressures. The Board was informed that this could have consequences for delivery of improvement plans and related cost-improvement programmes.</p> <p>A question was raised regarding duplication in committee reporting and how risks were being allocated across committees. It was confirmed that work was underway to improve visibility and alignment of performance and risk across committees, including clearer ownership of strategic risks.</p> <p>Members also asked about the district nursing pressures referenced in the report. It was noted that a recent “go-see” visit had confirmed the high complexity of patients and the strain on capacity. The Board was advised that a system-wide piece of work was underway to consider neighbourhood-level community models, including integration with virtual wards and other system services.</p> <p>The Board of Directors noted the update.</p>	

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Item	Discussion	Action
<p>14</p>	<p>Alert, Advise, Assure and Decision Report: People and Culture Committee held 18 December 2025 and 22 January 2026 (agenda item 14)</p> <p>M Rawcliffe, Non-Executive Director provided an update on the People and Culture Committee that met on 18 December 2025 and 22 January 2026.</p> <p>The Board received the summary reports from the People and Culture Committee meetings held in December and January. Two strategic assurance domains were rated as significant assurance and two as high assurance. “Looking After Our People” had reduced from high to significant assurance due to continued sickness absence pressures. Sickness and absence remained an alert, with improvement plans in place.</p> <p>An alert was also noted regarding the number of active grievances and employment tribunal cases, several of which related to disability. Updates would be brought back to the Committee once cases concluded to identify learning.</p> <p>From an advice perspective, the Committee reported that first-year turnover had stabilised at 20%, although the Committee agreed this remained too high. Progress was also reviewed on rostering, workforce modelling and implementation of the model roster.</p> <p>Assurance was received on positive feedback from the preceptorship programme and the ongoing expansion of the apprenticeship offer. Recruitment continued to improve, with the vacancy and fill rate now at 4.6%.</p> <p>The Chair questioned whether the disability-related tribunal cases suggested any systemic issues. B Champion, Chief People Officer confirmed that a detailed review was underway. Early themes related to uncertainty around disability disclosure and processes for reasonable adjustments. Findings would be reported to the Committee and Board.</p> <p>The Board also noted planned engagement with the University of Bradford to support workforce planning and curriculum development.</p> <p>The Board of Directors noted the update on the AAAD.</p>	
<p>15</p>	<p>Finance Report (agenda item 15)</p> <p>M Woodhead, Chief Finance Officer presented the Month 9 Finance Report. The Board was reminded that the Trust continued to forecast delivery of its £2 million year-end surplus, despite a significant shortfall in the Cost Improvement Programme (CIP). The Chief Finance Officer reported that the CIP under-delivery was increasing, particularly due to higher-than-planned</p>	

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Item	Discussion	Action
	<p>out-of-area placement costs and delays within the purposeful and productive workforce programme.</p> <p>To mitigate the shortfall, the Trust had drawn on £3 million of contingency and a further £2.5 million of non-recurrent technical and one-off benefits. On this basis, the Trust expected to meet its control total for the current financial year. The Board noted, however, that the underlying financial position remained concerning, with further risks anticipated in planning for the next financial year.</p> <p>A question was raised regarding pressures within the Continence Service contract and whether this posed an additional financial risk. P Hubbard confirmed that the service remained under review as part of wider ICB discussions, and T Patten noted that the Trust had received an MP enquiry on the matter, to which a response was being prepared. The Board was assured that contract negotiations would continue with transparency.</p> <p>The Board of Directors noted the content of the report.</p>	
<p>16</p>	<p>Quarterly submission to NHS England (agenda item 15.1)</p> <p>The Board formally approved the quarterly submission to NHSE financial return noting that it summarised the same position presented within the main Finance Report.</p> <p>The Board of Directors approved the report.</p>	
<p>17</p>	<p>Standing Financial Instructions and Scheme of Delegation (agenda item 16)</p> <p>M Woodhead presented the annual review of the Standing Financial Instructions (SFIs) and Scheme of Delegation. It was noted that the last full review had been completed in January 2025. The Audit Committee had considered the documents at its most recent meeting and confirmed that no updates were required for the current year, as the arrangements remained fit for purpose.</p> <p>A member asked whether any areas of accountability had been identified for further scrutiny. It was confirmed that no concerns had been raised, and that the comprehensive changes made the previous year particularly those relating to procurement remained current and compliant.</p> <p>No amendments were proposed by the Board. The Board therefore approved the Standing Financial Instructions and Scheme of Delegation without change.</p> <p>The Board of Directors approved the Standing Financial Instructions and Scheme of Delegation.</p>	

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Item	Discussion	Action
18	<p>Alert, Advise, Assure and Decision Report: Finance and Performance Committee held on 26 November 2025 and 28 January 2026 (agenda item 17)</p> <p>M Rawcliffe, Non-Executive Director presented the report in the absence of M Ahmed, Non-Executive Director.</p> <p>The Board received the summary of two meetings held on 26 November and 28 January. The Committee reported significant pressure on adult mental health beds, driven largely by delays in discharging patients. While out-of-area placements had been a longstanding focus, the Committee noted that the current pressures represented a new and more acute challenge.</p> <p>The Committee also highlighted the increasing financial pressure expected in the next financial year. It was noted that while non-recurrent funding had mitigated the position this year, this would not be available going forward, reinforcing the need to progress the Trust's sustainability programme. The Committee acknowledged the work led by the Director of Transformation to accelerate this programme, including increased focus on digital transformation.</p> <p>A Board member asked whether the emerging pressures on discharges were being fully reflected in planning. It was confirmed that the Executive Team was monitoring the issue closely and would incorporate the impact into financial and operational planning assumptions.</p> <p>The Chair noted that Non-Executive Directors S Napper and M Rawcliffe had been carrying a significant amount of additional work over a sustained period, and thanks were formally recorded for their contribution. It was noted that with two new Non-Executive Directors joining, this was an appropriate point to review NED allocations, committee memberships and workload distribution. R Trawally confirmed that this review was already being incorporated into upcoming governance work and would be covered under item 20.</p> <p>The Board of Directors noted the update on the AAAD.</p>	
19	<p>Alert, Advise, Assure and Decision Report: Audit Committee held on 29 January 2026 (agenda item 18)</p> <p>C Malish, Non-Executive Director presented a verbal update from the Audit Committee held on 29 January 2026. The Committee had reviewed internal audit activity, noting that while some reports had received limited assurance earlier in the year, most outstanding actions were now being closed. A small number of legacy actions required updated completion dates, and management had been asked to address inconsistencies identified through triangulation exercises, including issues highlighted during the right-to-work audit.</p>	

Item	Discussion	Action
	<p>The Committee also considered the external audit plan and noted that no material changes to risk assessments had been identified. The timetable for production of the annual report and accounts was reviewed, and the Committee was satisfied that the Trust remained on track to meet all required deadlines.</p> <p>A Board member asked whether any emerging issues might affect the year-end opinion. It was confirmed that, based on current progress, no significant risks had been identified beyond those already reflected within the Strategic Performance Report.</p> <p>The Board of Directors noted the update on the AAAD.</p>	
<p>20</p>	<p>Well-led action plan update (agenda item 19)</p> <p>F Stead, Trust Secretary presented an update on the governance action plan, which had already been considered by the Board committees. The Board was informed that this was the first full iteration of the consolidated plan, bringing together actions arising from last year’s three effectiveness reviews. Thanks were recorded to the corporate governance team, overseeing the process.</p> <p>It was explained that the update aimed to socialise the current format, gather feedback, and prepare a second iteration for committee consideration in March. A significant recent development included the Board development session in December, which had helped refine strategic risks and align actions across committees. The Board noted that several actions cut across multiple committees, and work was underway to ensure that cross-committee items were reported through the Audit Committee for assurance.</p> <p>F Stead advised that the action plan would not be “stood down” once items were completed; instead, it would become a live tool to capture future governance improvements, including the forthcoming annual effectiveness reviews. Work was also underway to automate the process using a Microsoft Teams channel to allow real-time updates.</p> <p>A point was made about how evidence of action completion would be captured, noting the importance of central storage and triangulation. In response, it was confirmed that evidence collection processes would be strengthened and aligned across committees, ensuring that completed actions were verifiable and traceable. The importance of what needed highlighting to Board going forward was raised.</p> <p>A further question was raised about prioritisation, given the number of actions in the plan. The Board was advised that part of the next iteration would include clearer indicators of priority and risk, ensuring that the most critical improvements were visible.</p>	

Close: Holly
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Item	Discussion	Action
	<p>Another member queried how the plan aligned with the wider strategic agenda, including the Care Trust Way and the well-led review recommendations. It was confirmed that several themes overlapped and would be integrated into the updated report.</p> <p>The Board noted the update and agreed that a further iteration would be presented through the Board committee cycle in March and presented to Board on 2 April, with refinements informed by the discussion.</p> <p>The Board of Directors noted the content of the report, which was provided for information.</p>	
<p>21</p>	<p>Governance report (agenda item 20)</p> <p>R Trawally presented the Governance Report, which provided an update on governance activity over the last two months. The report included information on the recently launched Advanced Foundation Trust framework, outlining the criteria and anticipated benefits. Further national updates were expected later in the year following consultation.</p> <p>The Board was reminded to complete the annual Fit and Proper Persons declaration required by NHS England, with submissions due by 11 February. Members were asked to notify the governance team if they had not received the request.</p> <p>An update was provided on Council of Governors' membership. Terry Henry had been appointed Deputy Governor on 10 December and had begun working with the Lead Governor. Several governors had resigned due to personal commitments, and their contributions had been formally acknowledged. Trevor Ramsey, the next eligible candidate from a previous election, had been reappointed to fill a vacancy.</p> <p>The Board noted that the 2026/27 meeting schedule had been approved and invites circulated. Annual effectiveness reviews for all governance committees were due to commence shortly, with outcomes to be reported to the Board. Chairs and lead officers would also be contacted regarding updates to committee work plans.</p> <p>In relation to Board membership, the report confirmed that two new Non-Executive Directors had joined, Warren who started on 19 January and a further appointment, Cleveland, beginning in April. His induction was underway and he was expected to observe meetings in March. Mark had formally taken up the role of Deputy Chair. Work was in progress to refresh the Board skills matrix and consider any changes to committee chairing arrangements to ensure balanced workloads.</p>	

Close: Holly
27/03/2026 14:42:07

Item	Discussion	Action
	<p>The Board noted the report and significant governance activity underway.</p> <p>The Board of Directors noted the content of the report, which was provided for information.</p>	
22	<p>West Yorkshire Community Health Services Provider Collaborative AAAD held on 6 January 2026 (agenda item 21)</p> <p>The Board of Directors noted the content of the report, which was provided for information.</p>	
23	<p>Board of Directors public meeting work plan 2025-26 (agenda item 22)</p> <p>The Board of Directors noted the content of the report, which was provided for information.</p>	
24	<p>Any Other Business (agenda item 23)</p> <p>T Patten thanked S Lewis as Interim Chair noting this would likely be his last Board of Directors meeting held in Public. Noting his significant contribution, particularly in chairing the Mental Health Legislation Committee. Members expressed appreciation for his commitment, advocacy and support over many years and wished him well for the future.</p> <p>In response, S Lewis thanked the Board, stating that it had been a pleasure and a privilege to serve over a long period and to work alongside many different colleagues as the Board evolved.</p>	
25	<p>Comments from public observers (agenda item 24)</p> <p>M Lodge, Lead Governor responded that he had no comments.</p> <p>The observers were thanked for their attendance and comments.</p>	
26	<p>Meeting evaluation (agenda item 25)</p> <p>The Chair thanked all colleagues for their contributions to the meeting. The Board discussed the meeting and reviewed its effectiveness as part of the Trust's commitment to good governance and continuous improvement.</p> <p>The Board reviewed the new format used for the Learning from Experience item, which included circulating the video in advance as well as playing it during the meeting. It was noted that technical issues had delayed the video upload, and the Board agreed to explore better methods for sharing materials in future.</p>	

Item	Discussion	Action
	<p>It was commented that advance access to the video may have encouraged more questions and agreed to continue trialling the approach. A question was raised regarding support for contributors sharing personal experiences, and P Hubbard confirmed that wrap-around support was provided before and after the session.</p> <p>A further point was made regarding audio quality in the video. The Board agreed that improved equipment to ensure clearer recording should be provided for future sessions. Action: to be taken forward consideration on equipment to support recording sound quality.</p> <p>The meeting was confirmed to have been conducted in line with trust values.</p> <p>The meeting was closed at 11.38.</p>	<p>PH</p>

These minutes were prepared with the assistance of AI tools and reviewed by the Deputy Trust Secretary and the Chair for accuracy and completeness

Close: Holly
27/03/2026 15:42:07

Action Log for the Public Board of Directors' Meeting – 2 April 2026

Action Key	Green: Completed	Amber: In progress, not due		Red: Not completed, action due
Action Log Reference	Action (including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / Date to be completed by	Update report - comments
1. 05/02/2026	<u>Questions received</u> Response from Rainbow alliance to be circulated to Board once developed.	S Uka	April	Ongoing: Update to be provided at meeting
2. 05/02/2026	<u>Questions received</u> It was agreed to send a letter of apology, acknowledging that the Trust does not support electric shock aversion therapy and noting that the current Trust had not been part of the organisation during the time of the allegation	S Uka	April	Ongoing: Update to be provided at meeting
3. 05/02/2026	<u>Chairs report</u> To request access to and if available to circulate the recording.	S Lewis	April	Closed: SL confirmed he was unable to access the copy of the recording.

Action Key	Green: Completed	Amber: In progress, not due		Red: Not completed, action due
Action Log Reference	Action (including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / Date to be completed by	Update report - comments
4. 05/02/2026	<u>Strategic risk report</u> Members agreed that a Board development session should be held to examine the impact of mental health legislative change in more detail, supported by external legal expertise where required.	CG team	April	Non returning: this has been added to board schedule for suggested topics – need to identify a date once further details on legislative changes are confirmed
5. 05/02/2026	<u>Meeting evaluation</u> to be taken forward consideration on equipment to support recording sound quality of board stories.	P Hubbard	May	Non returning: to investigate options with S Hala
Actions closed at the last meeting				
24/07/2025 <i>Close Holly 27/03/2026 15:42:03</i>	NHS England Quarterly declaration A question was raised about the additional £2 million and the caveats under which it was accepted. It was asked whether a summary of the outcomes and deadlines related to this amount had been provided and if the issues raised had been addressed. It was suggested	CR	October December February	Complete: Update provided at the February meeting

Action Key	Green: Completed	Amber: In progress, not due		Red: Not completed, action due
Action Log Reference	Action (including the title of the paper that generated the action)	Person who will complete the action	Meeting to be brought back to / Date to be completed by	Update report - comments
	to take this discussion offline and to follow up with M Woodhead.			

Close Holly
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Board of Directors – meeting held in public

2 April 2026

Paper title:	Chair of the Trust’s Report	Agenda Item 08.0
Presented by:	Sarah Jones Chair in Common	
Prepared by:	Corporate Governance team	
Committees where content has been discussed previously	People & Culture Committee	
Purpose of the paper Please check ONE box only:	<input type="checkbox"/> For approval <input type="checkbox"/> For information <input checked="" type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	
	Belonging to our organisation	
	New ways of working and delivering care	
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	
	Improving the experience of people who use our services	
Making Best Use of Resources	Financial sustainability	
	Our environment and workplace	
	Giving back to our communities	
Being the Best Partner	Partnership	
Good governance	Governance, accountability & oversight	X

Purpose of the report
Chair’s Report to inform Board members on activities over the last two months.

Executive Summary	
Chair’s Report to inform Board members on relevant strategic developments, system and Well-Led governance developments, Integrated Care partnership Working, external stakeholder engagement, activities with the Trust’s Council of Governors, and internal staff engagement and Board visibility, including service visits.	
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	<input type="checkbox"/> Yes (please set out in your paper what action has been taken to address this) <input checked="" type="checkbox"/> No

Recommendation(s)
<p>The Board is asked to:</p> <ul style="list-style-type: none"> note the continuing engagement that has taken place with external partners, internally at the Trust, and with the Council of Governors.

Links to the Strategic Organisational Risk register (SORR)	N/A
Care Quality Commission domains Please check <u>ALL</u> that apply	<input type="checkbox"/> Safe <input type="checkbox"/> Caring <input type="checkbox"/> Effective <input checked="" type="checkbox"/> Well-Led <input type="checkbox"/> Responsive
Compliance & regulatory implications	<p>The following compliance and regulatory implications have been identified as a result of the work outlined in this report:</p> <ul style="list-style-type: none"> Well-Led Compliance NHS Code of Governance NHS Act Health and Social Care Act Health and Care Act Nolan Principles Provider Licence

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Board of Directors – Meeting held in Public

2 April 2026

Chair of the Trust Report

Partnerships and strategy

Over the last two months Simon Lewis as Acting Chair and Sarah Jones as Chair in Common in their respective roles, have met with various stakeholders to continue discussions on key issues. They include the following:

<u>DATE</u>	<u>Meeting</u>
13 February	Bradford District and Craven – Formal Board Meeting in Private
19 February	Bradford District and Craven – Committee in Common
24 February	Leading Better Lives Together
19 March	Bradford District and Craven – Committee in Common
20 March	Bradford District and Craven – Formal Board Meeting (Public and Private)

Acting Chair and Chair in Common

Simon Lewis - Acting Chair from 1 January to 28 February 2026 and Non-Executive Director since 2018 has ended his term of office with the Trust. At the Private Board meeting of the Trust on Thursday 5 February 2026, the Board thanked Simon for his contributions to the Trust over his many years of service and wished him well.

With effect from the 2nd March, Sarah Jones was appointed as Chair in Common in conjunction with Airedale NHS FT. This will be for an initial pilot period of 12 months.

Council of Governors

Recent Council of Governors Meetings

Sarah's appointment was ratified as the Chair in Common at the Private Governors meeting on Thursday 17 February 2026.

Further Updates

The Bradford District & Craven Health and Care Partnership Board meet for the last time in its current configuration on Friday 20th March. This provided an opportunity for the partners of BD&C to thank those ICB colleagues who will be shortly leaving and to thank the Independent Chair, Elaine Appelbee for her skill and dedication in leading the work of the Board since its inception.

Sarah Jones March 2026

Board of Directors – Meeting held in Public

2 April 2026

Paper title:	Chief Executive's Report	Agenda Item 09.0
Presented by:	Therese Patten, Chief Executive	
Prepared by:	Therese Patten, Chief Executive	
Committees where content has been discussed previously	N/A	
Purpose of the paper Please check ONE box only:	<input type="checkbox"/> For approval <input checked="" type="checkbox"/> For information <input checked="" type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	Yes
	Belonging to our organisation	Yes
	New ways of working and delivering care	Yes
	Growing for the future	Yes
Delivering Best Quality Services	Improving Access and Flow	Yes
	Learning for Improvement	Yes
	Improving the experience of people who use our services	Yes
Making Best Use of Resources	Financial sustainability	Yes
	Our environment and workplace	Yes
	Giving back to our communities	Yes
Being the Best Partner	Partnership	Yes
Good governance	Governance, accountability & oversight	Yes

Purpose of the report
The purpose of the report is to provide commentary on strategic, operational and systems issues

Executive Summary	
<p>The areas covered in this report include:</p> <ul style="list-style-type: none"> ▪ NHS Staff Survey 2025 – Results ▪ Awards and Recognition ▪ Supporting our People ▪ CQC Notifiable Incidents, Regulatory Matters and Visits ▪ Media Coverage ▪ West Yorkshire Integrated Care Board 	
<p>Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?</p>	<p><input type="checkbox"/> Yes (please set out in your paper what action has been taken to address this)</p> <p><input checked="" type="checkbox"/> No</p>

Recommendation(s)
<p>The Board of Directors is asked to note the contents of the paper and seek any further clarification as appropriate.</p>

Links to the Strategic Organisational Risk register (SORR)	N/A
Care Quality Commission domains Please check <u>ALL</u> that apply	<input checked="" type="checkbox"/> Safe <input checked="" type="checkbox"/> Caring <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Well-Led <input checked="" type="checkbox"/> Responsive
Compliance & regulatory implications	N/A

Close: Holly
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Board of Directors – Meeting held in Public
2 April 2026

Chief Executive's Report

1 Purpose

The Chief Executive report provides an overview of news, events and significant issues that have occurred during the month that require Trust Board to be aware of and/or to discuss.

2 Trust News

NHS Staff Survey 2025 – Results

The annual NHS staff survey results provide organisations with a set of comprehensive national statistics that can impact change national and locally, and from this year contribute to the NHS Oversight Framework. This year's embargo was lifted on the 12th March so our Trust and Service results from 2025 are now live.

The survey has over 100 questions and the results are mostly grouped into themes and sub-themes, that align with the NHS People Promise. A summary of Trust-wide results is:

- All People Promise/ theme scores are very similar to our 2024 scores with We work flexibly, Morale, and We are compassionate and inclusive slightly improved, and We are always learning slightly declined.
- All People Promise/ theme scores are slightly higher than the rest of our benchmark group (48 Mental Health/Learning Disability/Community Trusts); most significantly so are We work flexibly, Morale and We are recognised and rewarded

Published Bank-only results will follow in April 2026, as will individual 'free text' comments, with a new framework provided for analysing these comments.

This year we are placing even more emphasis on local team results, so staff can help shape responses from the ground upwards, through a series of World Café Events during March and April. A summary of all results and the feedback from the local World Café events will be prepared for the May People and Culture Committee.

3 Awards and Recognition

Living our Values Awards

Each month, colleagues and teams are recognised in our Living our Values awards, for actively demonstrating one of our Trust values in their work. The most recent winners are mentioned below, congratulations to each of you.

<p>Jan 26</p> <p>We care – Kayley Gregory, Bracken Ward Manager For navigating low morale, significant staffing shortages and demanding KPIs as a new ward manager, with compassion and a consistently non-judgemental attitude. She has also demonstrated exceptional resilience and organisational skills and has managed complex challenges with considerable ease whilst completely turning the ward around.</p> <p>We listen – Maria Zaheer, Knowledge and Information Resource Officer For leading the organisation of Health Information Week 2026 for the Trust, a vital initiative aimed at boosting high-quality patient information to empower patients to manager their well-being. This included promotion and bookings and brought together colleagues from across our partnership to present interactive online webinars.</p> <p>We deliver – Jackie Knott, Tissue Viability Team Lead For going above and beyond her role to rally teams across district nursing services to address all outstanding pressure ulcer incidents. She organised a focussed improvement week and brought teams together to ensure incidents were managed, reviewed, learning was captured and actions implemented.</p>
<p>Feb - 26</p> <p>We care – Hilary Johnson, Marsha Buckingham and Larua Horton, Children’s Admin Hub For exceptional dedication, teamwork and unwavering commitment during a period of increased pressure. They consistently stepped up for one another and covered additional workloads to ensure the smooth running of the service – continuing to demonstrate compassion, professionalism and kindness.</p> <p>We listen – Gillian Marsden, Self-management Facilitators Team Leader For working hard to demonstrate the value and importance of patients accepting responsibility for elements of their care, reducing reliance on community nursing services and educating others about the opportunities to deliver a self-care approach. Gill has led her new team with enthusiasm and vision.</p> <p>We deliver – Peter Callaghan, Digital Network Manager For rebuilding a central ‘mother’ PC when the ward doors electronic access control system failed at Airedale Centre for Mental Health. His work on the 20 year old machinery was compared to ‘building a 1000 piece Lego set without instructions’.</p>

Thanks a Bunch Nominations

Month	Total nominations received	Total awards given	Breakdown of nominations			Breakdown of awards		
			Single nominations	Team nominations	Grouped nominations	Single awards	Team awards	Group awards
Jan 26	8	8	7	1	0	7	1	0
Feb 26	21	6	19	1	1	6	0	1

4 Supporting our People

With labour turnover now down to target at 10% and Trust-wide vacancies at an all-time low of 4%, People and Culture Committee at its March meeting, noted with thanks the outstanding performance of the Resourcing Team. Time to fill, the period between job advert

being published and a successful candidate at interview being made a conditional offer, is an impressive 23 days on average, with pre-employment screening before unconditional offer is made, averages at just 25 days. This has enabled the swift onboarding of 80 new starters in February and 46 in March (at the time of writing).

Our novel approach to holding assessment centres for aspiring new In-Patient Healthcare Support Workers provides an opportunity for candidates to experience the work environment and requirements of the roles in person, to establish mutual compatibility. This enables candidates and recruiting managers to make the right choices and decisions and avoid early attrition of new starters.

We were delighted to welcome new starters to the Trust, notable joiners in March include:

- Sarah Jones, Trust Chair in Common
- Maulbrey Mugani, Head of Operations - Adult Mental Health Pathway
- Catherine Sunter, Deputy Director of Performance, Planning and Insights

5 CQC Notifiable Incidents, Regulatory Matters and Visits (1 Jan – 12 Mar 26)

Regulatory matters and visits

Quarterly reporting on these matters continues to the Quality and Safety Committee with intermittent briefings being made where incidences of significant concern have been raised, or where these might be of interest to the Committee and/or Trust Board.

Mental Health Act (MHA) visits

There have been five Mental Health Act visit during this time period:

- Step Forward Centre unannounced MHA monitoring visit 21st January
- Oakburn unannounced MHA monitoring visit 11th February
- Clover unannounced MHA monitoring visit 4th February (**also seclusion and long-term segregation (LTS) on the same day along with Thornton and Najurally)

Unannounced inspections

As above – all MHA and LTS visits during this time period were unannounced.

CQC Notifiable incidents

There were no notifiable incidents during this reporting period.

CQC Engagement and Enquiries

The team continue to respond to these according to requests via the Director of Nursing, Professions and Care Standards, DIPC. A quarterly report detailing all engagement and enquiry activity is prepared for the Quality and Safety Committee.

Inquests

18 inquests were concluded during this period in which BDCFT provided some level of evidence to the Coroner - of these, staff were called by the coroner in three of these cases. There was no criticism made of the Trust by the Coroner in any of the cases. Further assurance was required in relation to one case, but no further concerns were then raised by the Coroner. The coroner's conclusions for all cases were:

- Drug related x 3
- Accident x 2
- Suicide x 5
- Self-neglect x 1
- Alcohol related x 1
- Natural causes x 2
- Narrative x 3
- Misadventure x 1

Patient Safety Incidents and Never Events

Since the last report 0 Never Events were reported. There were three new Patient Safety Incident Investigations (PSIIs) reported since the last report relating to three suspected suicides (community).

There are twelve open PSIIs, currently and there are three SJRs and six LLRs on-going currently. Several other response approaches are being utilised regularly as per the PSIRP: Thematic analysis, Structured Judgement Review, and Local Learning Reviews. During the reporting period the following were completed:

- 3 PSIIs
- 2 Thematic Analysis
- 2 Local Learning Reviews
- 2 Structured Judgement Reviews

The learning from these reviews will inform the next quarterly Patient Safety, Incidents, Experience, Feedback report to QSC. No significant learning or immediate safety actions were identified for this reporting period.


6 Media Coverage

Media and news highlights since the last Board meeting.

Area / dates	Details
£8,000 boost for patient care as Sovereign Health Care backs Care Trust - 26 January 2026	Sovereign Health Care has demonstrated its continued commitment to improving health and wellbeing across the region by donating £8,000 to Bradford District Care Trust and its charity, Better Lives.

Care Trust gets people talking on Time to Talk Day at Bradford City Library – 28 January 2026	Bradford District and Craven Talking Therapies, part of Bradford District Care Trust, is supporting this years' Time to Talk Day, by encouraging people to start conversations about mental health at an awareness event held at Bradford City Library.
Lynfield Mount Hospital given green light for redevelopment – 3 February 2026	Bradford District Care Trust has been given final approval by the Department of Health and Social Care to redevelop Lynfield Mount Hospital. The formal approval of the Full Business Case (FBC) released the funding needed for the redevelopment work to begin. A further £15 million has also been allocated to the redevelopment from the West Yorkshire Integrated Care System.
Care Trust goes above and beyond in patient assessments – 2 March 2026	Bradford District Care Trust has once again exceeded the national average across all areas in the 2025 Patient-Led Assessments of the Care Environment (PLACE) results. The PLACE assessments review a range of environmental and patient experience factors and are carried out by teams including service users, relatives, carers and patient advocates.

Awards

Award	Details
	The Pharmacy team has been awarded bronze in the Royal Pharmaceutical Society's Greener Pharmacy scheme. The award highlights the team's commitment to a reduction in environmental impact, ensuring patients are provided with holistic advice, careful prescribing, waste reduction and sustainable ways of working.

7 National, Place and System

West Yorkshire Integrated Care Board Chair

NHS England North East and Yorkshire region have confirmed the appointment of a new Chair for NHS West Yorkshire Integrated Care Board (ICB). Mark Chamberlain will Chair the ICB, starting his new role on 1 April 2026. Mark joins from NHS Humber and North Yorkshire ICB and has been a Non-Executive Director since 2022. During his time in this role, he was Vice Chair, Chair of the Remuneration Committee and Chair of the Quality Committee. Mark has more than 25 years' experience in a variety of senior leadership and non-executive roles, including 15 years in health and care organisations, and has worked and lived in West Yorkshire since his late teens.

West Yorkshire Integrated Care Board Organisational Change

The organisational change consultation closed for feedback on Friday 27 February. 717 responses to the consultation were received from staff with additional considered feedback from a number of partner organisations. The ICB Executive Management Team are now working through all the feedback to ensure that it informs and improves the final structures and operating model for the future ICB.

One of the key areas of feedback received was the appointments to posts process. Following a detailed review of this the ICB has confirmed to staff that it will be moving away from a wider access model to one that is based on slotting-in, ring-fencing and pooling. To seek further views from staff on the criteria for this, a further two-week consultation period, focused on a ring-fencing, slotting and pooling approach and the definitions and processes around these was launched on the 23rd March. This consultation will last for two weeks, ending on 6 April. Given this the final consultation outcome and structures will not now be shared until Monday 20 April.

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Effective Oversight: Escalation and Assurance

Report to:	Board	Meeting date:	02/04/2026
Report from:	Mental Health Legislation Committee	Meeting date:	19/03/2026
Quorate?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Members present	Warren Brown, Non-Executive Director (Chair of Committee), Kelly Barker, Chief Operating Officer, Phillipa Hubbard, Director of Nursing, Professions and Care Standards, DIPC, Deputy Chief Executive Director of Nursing and Quality for Bradford District and Craven Health and Care Partnership (from agenda items 01 – 07 & 11.0 – 22.0), Simon Lewis, Non-Executive Director, Alyson McGregor, MBE Non-Executive Director		
In attendance	Holly Close Corporate Governance Officer (Secretariat), Chris Dixon Deputy Director of Nursing and Professions, Simon Binns Mental Health Legislation Lead, Marilyn Bryan Associate Hospital Manager, Richard Cliff Head of Legal Services, Keith Double Involvement Partner, Karan Essien Involvement Partner, Tricia George Head of Patient Safety, Teresa O’Keefe Mental Health Act Advisor, Fran Stead Trust Sectary (for agenda items 8.2 & 15), Jo Tiler Mental Capacity Act Clinical Lead, Rachel Trawally Corporate Governance Manager and Deputy Trust Secretary and Dr Phalaksh Walishetty Deputy Chief Medical Officer for Quality and Patient Safety, Mental Health Legislation, Inpatients/Intensive Home Treatment Team/Liaison Psychiatry/Forensic Psychiatry and Intellectual Disability, Performance		
Observers	None.		
Apologies	Apologies from (members and attendees): Dr Anita Brewin Consultant Clinical Psychologist, Deputy Director of Professions (CPPO; Chief Psychological Professions Officer), Baljit Kaur Nota LA Team Manager, Thabani Songo Head of Nursing – Mental Health, Masira Hans, Appointed Governor: Hope and Light and Dr Sal Uka, Chief Medical Officer		
Best Quality Services	Theme 1 – Access and Flow		BQS:T1
	Theme 2 – Learning for improvement		BQS:T2
	Theme 3 – Improving the experience of people using our services		BQS:T3
Agenda items	<ul style="list-style-type: none"> • Minutes/AAAD of the Committee held on 22 January 2026 • Action Log • Patient Carer Race Equality Framework (PCREF) Discussion and Update • Feedback from Involvement Partners • Strategic Performance Report • Strategic Risk Report 		

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	<ul style="list-style-type: none"> • Alert, Advise, Assure + Decision Report: Positive & Proactive Group • Mental Health Act Reform update • Associate Hospital Managers Report • Care Quality Commission Update: Mental Health Act Monitoring Review Visits • Mental Capacity Act update (including Liberty Protection Safeguarding; Action Plan updates) • Alert, Advise, Assure + Decision Report: Clinical Board • Well Led Development Plan • Mental Health Legislation Committee Annual Governance Report • Mental Health Legislation Committee Terms of Reference • Notification of future meeting dates • Confirmation of Escalation Reporting including Confirming strategic priority assurance levels • Mental Health Legislation Committee: Annual Work Plan • Any Other Business • Meeting Evaluation
Alert items agreed by Committee	<ul style="list-style-type: none"> • No alerts to report.
Advise items agreed by Committee	<ul style="list-style-type: none"> • Associate Hospital Managers Report - The Committee was advised that further recruitment would be needed for associate hospital managers as overall numbers remained insufficient due to existing managers' wider work commitments and in preparation for an expected future increase in hearings due to the new legislation changes.
Assure items agreed by Committee	<ul style="list-style-type: none"> • Patient Carer Race Equality Framework (PCREF) Discussion and Update - The Committee received assurance that PCREF implementation was progressing beyond compliance, with a developing structure that includes governance, leadership, data insight, training and strengthened lived-experience involvement. Assurance was also received that over-representation was being examined more deeply, including through provider collaborative pathways. • Alert, Advise, Assure + Decision Report: Positive & Proactive Group - The Committee was assured that overall use of holds were continuing to fall, with long-term segregation and seclusion changes positively received by CQC. Trauma-informed approaches were being embedded, aligned with NICE guidance, and policy changes (blanket restrictions, long-term segregation) were now in place with monitoring underway to check impact. • Mental Health Act Reform update - The Committee was assured that early readiness work was underway, including multi professional training forums, improvements to Section 117 processes, and strengthened quality of tribunal and managers' reports.

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	<ul style="list-style-type: none"> • Associate Hospital Managers Report - The Committee received assurance that recruitment has progressed and mandatory training requirements have been streamlined. • Care Quality Commission Update: Mental Health Act Monitoring Review Visits - The Committee received assurance that recent inspections demonstrated improvement, with seclusion practice appropriately justified and documented, previous concerns resolved, and several services progressing from “requires improvement” to “good”. • Mental Capacity Act update (including Liberty Protection Safeguarding; Action Plan updates) - The Committee received assurance that the Mental Capacity function was stabilising following reduced capacity earlier in the year, with strengthened oversight, improved engagement with clinical areas, commencement of external audit planning, and recruitment of a band six role to support sustainability. • Well-Led Implementation Plan – Assurance was received that the new governance monitoring system was operating effectively, with clear operational leads, executive sponsors, monthly updates and evidence-tracking processes in place to support delivery. • Committee Annual Terms of Reference Review – The Committee received assurance that the annual review of the terms of reference had been completed, with updates reflecting current governance arrangements, including clarified executive and deputy roles. • Committee Annual Effectiveness Report & Annual Governance Report – The Committee was assured that the annual effectiveness review confirmed the Committee was operating in line with its terms of reference and supporting the Trust’s strategic objectives, with identified improvement actions incorporated into the Well-Led Development Plan to ensure continual strengthening of governance.
Decisions made by Committee	<ul style="list-style-type: none"> • Item 03.0 – Minutes from the Mental Health Legislation Committee & AAAD held 22 January 2026 • Item 11.0 – Associate Hospital Managers’ Group Report • Item 15.0 – Well Led Development Plan • Item 17.0 – Committee Annual Effectiveness Report & Annual Governance Report • Item 18.0 – Committee Annual Terms of Reference
New risks identified by Committee	<ul style="list-style-type: none"> • No significant new risks identified.
Items to be considered by other Committees/Groups	<ul style="list-style-type: none"> • N/A
Feedback following discussion at ‘parent’ meeting	

Report completed by	Corporate Governance Officer	Date	19/03/2026
On Behalf of Chair	Warren Brown		

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AAAD: Effective Oversight: Escalation and Assurance

Report to:	Public Board	Meeting date:	XXX
Report from:	Quality and Safety Committee (QSC)	Meeting date:	18.02.2026
Quorate?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Members present	Alyson McGregor, Sally Napper, Philippa Hubbard, Dr Sal Uka		
In attendance	Christopher Dixon Catherine Schofield, Tricia George, Bob Champion, Anita Brewin, Rebecca Jowett, Debbie Winder (ICB), Holly Close (secretary) Presenters for items; Dawn Lee, Helen Rush and Marnie Crew		
Observers			
Apologies	Kelly Barker, Carla Smith, Fran Stead, Thabani Songo, Rachel Trawally, Nazmeen Khan		
Best Quality Services	Theme 1 – Access and Flow		BQS:T1
	Theme 2 – Learning for improvement		BQS:T2
	Theme 3 – Improving the experience of people using our services		BQS:T3
Agenda items	<ul style="list-style-type: none"> • Deep Dive 0-19 Service • Talking Bradford Pathway for 0-5s and the developments • Community Nursing – Feedback from QAF • Waiting List: Bi-Annual Update • AWOL Update • Never Dental Event • Sexual Safety Update • Clinical Supervision Annual Update • CQC Quarter 3 report • Alert, Advise, Assure + Decision Reports .1 AAAD report: System Quality Committee. 2 AAAD report: Clinical Board .3 AAAD Report - Patient Safety and Learning Group .4 AAAD report: Senior Leadership Team Quality, Safety, Governance .5 AAAD Report: • Strategic Risk Summary • Confirmation of Escalation Reporting including: .1 Confirming strategic priority assurance levels (decision based on outcome of entire meeting, details of level in item 8) .2 Confirming top 3 strategic risk to include in AAA report (decision based on outcome of entire meeting) .3 Confirmation of Alert; Advise; Assure + Decision Reporting • Workplan 2025/26 • Any Other Business • Meeting Evaluation-Was the meeting conducted in line with the Trust values 		

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Alert items agreed by Committee	Issues that require urgent attention or escalation due to risk, concern, or significant change. Alert: <ul style="list-style-type: none"> • Speech and Language Therapy / Early Years Language Development: <ul style="list-style-type: none"> – System-wide risk relating to capacity, sustainability, and reliance on short-term funding. – Particular concern regarding the potential loss of momentum and impact should Talking Bradford not be sustained. • Community Nursing - <ul style="list-style-type: none"> – Ongoing workforce capacity pressures. – Evidence of deferred visits and emerging quality and safety risks highlighted through quality assurance and QOF activity. – emerging quality and safety risks highlighted through quality assurance and QOF findings. 		
Advise items agreed by Committee	Advise: <ul style="list-style-type: none"> • Bid for Children’s 0-19 service procurement: <ul style="list-style-type: none"> – The potential quality and safety impact of service pressures during procurement activity. – The capacity of teams to maintain safe service delivery while contributing to bid development. 		
Assure items agreed by Committee	Items providing evidence of good practice, compliance, or positive progress. Assure: <ul style="list-style-type: none"> • AWOL Update • Clinical Supervision Annual Update • Sexual Safety Update • CQC Quarter 3 report 		
Decisions made by Committee	The following items were approved by the Committee, <ul style="list-style-type: none"> • Item 3 - Minutes of the previous meeting and AAAD November 2025 • Item 5 - Action Log • Waiting List: Bi-Annual Update 		
New risks identified by Committee	<ul style="list-style-type: none"> • There were no new risks identified. 		
Items to be considered by other Committees/Groups			
Feedback following discussion at ‘parent’ meeting			
Report completed by	Nazmeen Khan	Date	23.02.2026

	Corporate Governance Officer		
On Behalf of Chair	Ayson McGergor (NED/Chair)		

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AAAD: Effective Oversight: Escalation and Assurance

Report to:	Board of Directors (Public)	Meeting date:	02/04/2026
Report from:	People and Culture Committee	Meeting date:	19/03/2026
Quorate?	Yes <input checked="" type="checkbox"/> Part of meeting quorate No <input checked="" type="checkbox"/>		
Members present	Mark Rawcliffe (Chair/NED), Sally Napper (NED) (part meeting), Bob Champion.		
In attendance	Rachel Trawally, Jess Greenwood-Owens (Secretary), Dr. Anitha Mukundan, Michelle Holland. Timed business: Claire Wiseman, Claire Ingle, Danielle Stephenson, Lisa Wright, Fran Stead.		
Observers	Robert James (Governor).		
Apologies	Sally Napper (NED) (part meeting), Dr Sal Uka, Kelly Barker, Phil Hubbard, Tim Rycroft, Farhan Rafiq, Mike Woodhead, Fay Davies, Jeanette Homer, Paula Hanson.		
Best Place to Work	Theme 1 – Looking after our people		BP2W:T1
	Theme 2 – Belonging in our organisation		BP2W:T2
	Theme 3 – New ways of working and delivering care		BP2W:T3
	Theme 4 – Growing for the future		BP2W:T4
Agenda items	<ul style="list-style-type: none"> • Learning from your experience • Strategic Narrative Report • Integrated Strategic Performance Report • Medical Staffing Update (10-point plan / exceptions) • Recruitment Activity Update • Employee Relations Activity (incl. Disciplinary Audit) • Rostering Activity (incl. 3-year Workforce Plans) • Gender Pay Gap Annual Report • Subject Focus – Sexual Harassment in the Workplace • Alert, Advise, Assure + Decision (AAA+D) Reports • Well-Led Implementation Plan Update • Strategic Risks • Annual Governance Report (incl. effectiveness review) • Committee Annual Terms of Reference Review • Notification of future meeting dates • Confirmation of Escalation Reporting • Draft Committee Workplan 2026–27 • Any Other Business • Meeting Evaluation 		
Alert items agreed by Committee	<ul style="list-style-type: none"> • National Pay Award: Although the 3.3% national uplift has been implemented, national unions have indicated dissatisfaction and are considering industrial action. This presents potential operational and financial risk. 		

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	<ul style="list-style-type: none"> • Sickness Absence Pressures: Sickness absence remains above 7%, particularly affecting 24/7 services. The Working Well / sickness programme is being escalated to strengthen organisational response.
<p>Advise items agreed by Committee</p>	<ul style="list-style-type: none"> • Employment Tribunal cases are being actively managed, with controls in place to mitigate financial and reputational risk. • Model Roster Review: A formal review is under way to assess value for money, staffing pressures and operational effectiveness. Findings may influence future workforce and financial planning. • 10-Point Medical Workforce Plan: Delivery continues at pace. Board visibility remains important given national pressures and upcoming guidance on rotations and leave. • Rostering & Workforce Data Quality: Unfilled shifts have increased, and data accuracy issues have been identified. Corrective work on data feeds and dashboards is in progress to improve confidence in future reporting. • Sexual Safety / Harassment: Implementation of the Worker Protection Act increases organisational responsibilities. Inpatient services continue to report incidents, and ongoing work to strengthen policies, reporting and staff support remains essential. • Pay Gap Reporting: Gender pay gap remains low and stable. Ethnicity and disability gaps have widened, partly due to improved data completeness. Work continues on recruitment, progression and differential attainment.
<p>Assure items agreed by Committee</p>	<ul style="list-style-type: none"> • Recruitment & Vacancies: Vacancy levels are below 4%, the lowest in several years. Processes are stable and performing well. • Employee Relations Caseload: Caseloads are at a four-year low, with faster resolution times and strong progress against audit recommendations. • Medical Workforce Governance: High levels of compliance continue in appraisal, revalidation and job planning.
<p>Decisions made by Committee</p>	<p>The following items was approved whilst the meeting was quorate:</p> <ul style="list-style-type: none"> • Minutes and AAAD • Action Log <p>The following items were circulated via email for approval following the meeting due to lack of quoracy:</p> <ul style="list-style-type: none"> • Gender Pay Gap Annual Report • Well Led Implementation Plan Update • Strategic Risks • Annual Governance Report (incl. Committee annual effectiveness review) • Committee Annual Terms of Reference Review

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New risks identified by Committee	<ul style="list-style-type: none"> • A new process for monitoring risks was currently in development. 		
Items to be considered by other Committees/Groups	<ul style="list-style-type: none"> • N/A 		
Feedback following discussion at 'parent' meeting			
Report completed by	Jess Greenwood-Owens Corporate Governance Officer	Date	20/03/2026
On Behalf of Chair	Mark Rawcliffe (NED/Chair)		

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Trust Board

2nd April 2026

*Close Holly
27/03/2026 15:42:07* **Item xx Finance Report – Month 11 (February 2026)**

Financial Performance – Key Messages & Risks

Key Messages

We are reporting slightly better than **plan at Month 11** and continue to forecast meeting our planned **surplus of £2m**.

Significant risks:

- During January and February there is a sustained increase in the number of out of area placements (OAPs), which has been trending at around **c34** (compared to a plan of c14). The forecast has been adjusted to reflect the current level resulting in a overspend on the out of area budget is £2.7m.
- March has seen a further increase in OAPs, at the time of writing **40** service users were placed out of area (3 of which were PICU). These levels pose a significant risk as we enter 2026/27, which the planned trajectory for April being 32.

The main risk to achieving the financial plan continues to be the under-delivery of the efficiency programme.

- The efficiency programme is **offtrack at Month 11 by £4.5m** and is **forecast to underdeliver by £5.6m** for the year. **Further risks** to delivery of the efficiency programme could worsen performance by **between £2k and £275k** – mainly in the Purposeful and Productive and Difficult Decisions workstreams.

The Trusts contingency and other non recurrent measures have been deployed to mitigate under-delivery of the efficiency programme and to support the bottom-line financial position.

Reporting breaches:

At Month 11, the Agency cap has been breached by **£1.1m YTD** and forecast to breach by **£1.1m for the year** – this is mainly due to an exceptional package of care for a service user on the Najurally Centre. As lead provider gross costs are reported in BDCFT books, contributions are received from PC partners however these do not net off against the agency spend. NHS England measure the agency cap at West Yorkshire level, at Month 8 the ICB was forecast to breach its ceiling by £0.9m.

Trust Financial Overview

Statement of Comprehensive Income

Financial Position by Care Group/Directorate						
£000's	YTD Budget	YTD Actual	Revised YTD Variance	Annual Budget	FOT Actual	Revised FOT Variance
Mental Health Care Group	88,623	90,685	2,062	96,452	99,167	2,715
Adults and Children's Comm. Care Group	60,860	61,320	460	66,325	66,963	638
Medical Directorate	15,973	16,108	135	17,416	17,495	79
Central Reserves & Developments	7,339	4,186	(3,153)	7,908	3,859	(4,049)
Contract Income	(208,814)	(207,893)	921	(227,792)	(226,763)	1,029
Estates & Facilities	11,206	10,976	(230)	12,231	11,988	(243)
Finance	2,418	2,396	(22)	2,694	2,682	(12)
Trust General Management	2,984	2,817	(167)	3,255	3,107	(148)
Nursing, Quality and Gov	5,938	5,888	(50)	6,488	6,429	(59)
People Matters	4,770	4,609	(161)	5,192	5,047	(145)
Digital Services	4,658	5,228	570	5,035	5,704	669
Transformation	2,559	2,066	(493)	2,796	2,296	(500)
(Surplus)/Deficit	(1,486)	(1,614)	(128)	(2,000)	(2,026)	(26)
Technical Adjustment - Horton Park		26	26		26	26
Reported (Surplus)/Deficit	(1,486)	(1,588)	(102)	(2,000)	(2,000)	0

Statement of Financial Position

Statement of Financial Position £000's	Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
Non-Current Assets	80,542	57,741	(22,801)	80,797	62,360	(18,437)
Current Assets	22,420	26,769	4,349	21,729	26,401	4,672
Current Liabilities	(16,191)	(25,274)	(9,083)	(13,253)	(17,271)	(4,018)
Non-Current Liabilities	(7,667)	(6,733)	934	(7,301)	(7,301)	0
Total Assets Employed	79,104	52,503	(26,601)	81,972	64,189	(17,783)
Public dividend capital	63,490	42,374	(21,116)	68,179	49,396	(18,783)
Income and expenditure reserve	(582)	(2,726)	(2,144)	(403)	(403)	0
Revaluation Reserve	6,000	2,659	(3,341)	4,000	5,000	1,000
Miscellaneous Other Reserves	10,196	10,196	0	10,196	10,196	0
Total Taxpayers' and Others' Equity	79,104	52,503	(26,601)	81,972	64,189	(17,783)

Managing the in year position

Headlines:

The current forecast includes pressures that have been non recurrently mitigated of £4.5m year to date and £5.6m for the full year. These are due to the efficiency plans being offtrack.

The mitigations include deployment of the Trust contingency and a range of one-off benefits/ underspends. Whilst this allows for the Trust to report a position in line with plan, there are risks to efficiency delivery that are highlighted later in the report.

Recurrent delivery of the efficiency programme continues to be the solution, with the focus on the Strategic Programmes overseen by the Organisational Sustainability Board.

Financial Position (Excluding risk assessment)	Year to date	Forecast
Efficiency Programme Position	4,511,034	5,591,060
Mitigations		
Contingency Deployment	(2,601,336)	(3,000,000)
Non recurrent measures	(1,909,698)	(2,591,060)
Sub total: mitigations released in the position	(4,511,034)	(5,591,060)
Revised Forecast	0	0

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Efficiency Programme

The Month 11 position includes under delivery on the efficiency programme of £4.5m YTD and £5.6m forecast. To manage the delivery shortfall, the Trust has fully deployed its risk contingency and needed to source one-off non recurrent measures to continue to report a position in line with plan.

The main pressures remain the achievement of the Purposeful and Productive Pathway; both the Workforce Productivity Programme and Continence are reporting fully off track; there have been delays in the delivery of the CYP leadership restructure, however these are now largely resolved and will begin to deliver in Q4; No further benefits are forecast for the Digital Optimisation programme.

The risk assessed delivery ranges from £2k to £275k, with a **likely case additional risk of £103k** (equates to a 5.2% delivery risk of the target for the remaining months). Mitigation plans to address the risk are outlined further in the paper.

Efficiency Plan	Director Lead	YTD Planned Savings	YTD Savings achieved Positive = actual savings delivered Negative = Savings not delivered and costs are increasing	Variance from Plan Positive = offtrack Negative = better than plan	Full Year Planned Savings	Full Year Savings achieved Positive = actual savings delivered Negative = Savings not delivered and costs are increasing	Variance from Plan Positive = offtrack Negative = better than plan	Delivery Risk Rating	Best Case Risk Assessment	Likely Case Risk Assessment	Worst case Risk Assessment
1. Purposeful and Productive Adult & Community Pathway (LOS/OAPs)	Kelly Barker	2,711,780	610,780	2,101,000	3,192,718	536,892	2,655,826	High	-	62,249	124,498
1. Purposeful and Productive Adult & Community Pathway (Staffing)	Kelly Barker	1,228,581	339,351	889,230	1,365,740	412,118	953,622	High	1,964	40,935	150,149
1. Purposeful and Productive Adult & Community Pathway Total		3,940,361	950,131	2,990,230	4,558,458	949,010	3,609,448				
2. Medical Staffing	David Sims	203,710	203,710	0	233,281	233,281	0	Low			
3. Continence service review	Kelly Barker	290,835	0	290,835	349,000	0	349,000	High			
4. Enteral Feeding consumables	Kelly Barker	70,835	70,835	0	85,000	85,000	0	Low			
5. CYP Leadership restructure	Kelly Barker	222,224	52,128	170,096	250,000	71,070	178,930	Low			
6. Adults Non Pay budget	Kelly Barker	458,337	392,530	65,807	500,000	428,746	71,254	Low			
7. Estates Rationalisation	Mike Woodhead	354,024	354,024	0	385,681	385,681	0	Low			
7. Estates Rationalisation	Mike Woodhead	130,339	130,339	0	142,180	142,180	0	Low			
8. Corporate Services review	EMT	927,151	1,861,565	(934,414)	958,094	1,889,174	(931,080)	Low			
9. Workforce Productivity	Bob Champion	1,777,776	0	1,777,776	2,000,000	0	2,000,000	High			
10. Digital Optimisation (PKB)	Tim Rycroft	115,830	115,830	0	126,353	126,353	0	Low			
10. Digital Optimisation	Tim Rycroft	416,665	137,500	279,165	500,000	150,000	350,000	High			
11. Difficult decisions	Mike Woodhead	3,231,606	3,231,606	0	3,645,906	3,556,398	89,508	Low			
12. LMH Development	Mike Woodhead	6,838	6,838	0	10,257	10,257	0	Low			
SUB TOTAL: Strategic Programmes		12,146,531	7,507,036	4,639,495	13,744,210	8,027,150	5,717,060				
13. Technical: Income Opportunities	Claire Risdon	200,001	200,001	0	200,000	200,000	0	Low			
14. Technical: Lively up Yourself	Bob Champion	43,538	43,538	0	47,500	47,500	0	Low			
14. Technical: Procurement	Mike Woodhead	183,337	183,337	0	200,000	200,000	0	Low			
14. Technical: CNST	Phil Hubbard	24,400	24,400	0	24,395	24,395	0	Low			
14. Technical: Telephony	Tim Rycroft	27,071	0	27,071	29,533	0	29,533	Low			
15. Vacancy Factor	Kelly Barker/Mike	3,666,681	3,822,214	(155,532)	4,000,000	4,155,532	(155,532)	Low			
16. SpA	Kelly Barker	66,667	66,667	0	100,000	100,000	0	Low			
Efficiency Programme Performance		16,358,226	11,847,192	4,511,034	18,345,638	12,754,578	5,591,060		1,964	103,184	274,647
Contingency Deployed		0	2,601,336	(2,601,336)	0	3,000,000	(3,000,000)				
Non Recurrent Mitigations		0	1,909,698	(1,909,698)	0	2,591,060	(2,591,060)				
Reported Position		16,358,226	16,358,226	0	18,345,638	18,345,638	0				

Headlines:

After taking account of known risks noted below:

- The main risks continue to be out of area placements and temporary staffing costs
- To deliver the planned surplus, the likely case risk assessment requires **gross** mitigations amounting to **£0.3m**, mainly driven by the risk of delivering the efficiency programme
- After taking account of further non recurrent mitigations a balanced position should be achieved

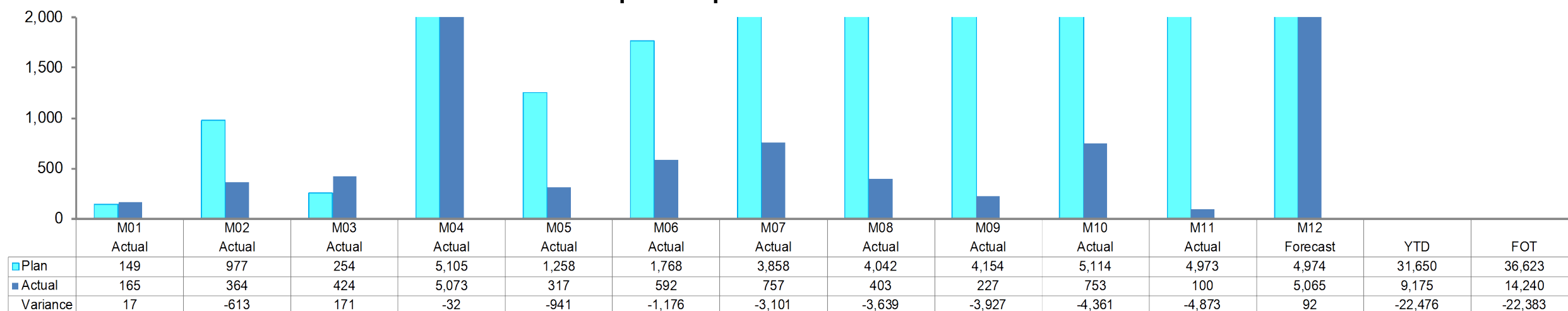
The risk assessment reflects all known risks. Risks are likely to change on a monthly basis and we will continue to remain dynamic in responding to changing pressures/ opportunities.

Detail	Assumption	Best	Likely	Worse
		£'000	£'000	£'000
Variance from plan in reported position		£0	£0	£0
Downside				
Efficiency delivery risk	See efficiency modelling	(£2)	(£103)	(£275)
Note: Within in the financial position and the downside risk the number of daily OAPs includes:				
* Best case - 34 for Mar				
* Likely case - 36 for Mar				
* Worse case -38 for Mar				
Depreciation	Dispute over baseline funding	(£204)	(£204)	(£204)
Total Downside Risks		(£206)	(£307)	(£479)
Upside				
Remaining Contingency		£0	£0	£0
Non recurrent mitigations		£263	£307	£307
Total Upside Mitigations		£263	£307	£307
Risk assessed plan - Surplus/ (Deficit)		£57	£0	(£171)

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Capital Expenditure

Capital Expenditure Plan vs Actual/Forecast



The capital position in February is underspent by £22.5m with a YTD spend of £9.2m. The changes on the phasing of spend for the Lynfield Mount re-development, were reflected in the capital forecast at M06 and again at M10 and M11. This has changed the initial PDC funded allocation of £25.04m 2026/26 to approximately £4.0m, resulting in a movement in the capital forecast against plan of £20.4m from M10 onwards. The remaining movement relates to £1.2m of in year PDC received on other capital schemes and £3m WYICS support on Lynfield Mount, now prioritised into a future financial year.

The initial Trust capital plan is allocated as follows:

- Operational Capital - £3.67m
- IFRS16 Lease Renewals, Additions and Remeasurements - £5.33m
- Initial PDC Plan Funding
 - £25.04m - Lynfield Mount Redevelopment
 - £2.57m – Estates Safety Fund (funding now increased to £3.21m, offset by a reduction in operational capital)
 - £0.532m – Digital Wayfinder funding to support PEP NHS App procurement/integration

In February, the Trust were successful in a bid for additional capital for £1m (cash backed), for digital and estates equipment.

The Trust is confident that it will spend their full capital allocation for Operational Capital and additional PDC.

Self-Certification

Self certification		00ACTYTD																						
		<p>Self-cert declarations</p> <p>Actual 28/02/2026 YTD DROP-DOWN</p>																						
<p>1. Declaration of review of submitted data The board is satisfied that adequate governance measures are in place to ensure the accuracy of data entered in this submission.</p> <p>The board is satisfied that there is sufficient oversight and scrutiny to ensure the delivery of the financial plans including reducing the risks associated with the delivery of the efficiency programme.</p> <p>We would expect that the template's validation checks are reviewed by senior management to ensure that there are no errors arising prior to submission and that any relevant flags within the template are adequately explained.</p>		<p>Confirmed</p>																						
<p>Approved on behalf of the board of directors (normally by CFO and CEO): The PFR must be signed off by the Provider CFO and CEO or Chair in their absence. In signing off the PFR the Provider CFO and CEO are providing assurance that the key information contained within the return is a true and accurate reflection of the Provider financial position.</p> <p>Name Email address Job title Date</p> <p>Name Email address Job title Date</p>		<p>CFO</p> <p>Name: Mike Woodhead Email address: Mike.Woodhead@bdct.nhs.uk Job title: Chief Finance Officer Date: 13/03/2026</p> <p>CEO or Chair</p> <p>Name: Therese Patten Email address: Therese.Patten@bdct.nhs.uk Job title: Chief Executive Officer Date: 13/03/2026</p>																						
<p>2. Is the return consistent with the system Integrated Finance Return? Please confirm the PFR figures have been agreed by the system and are consistent with the system Integrated Finance Return (IFR) submission. If a provider submits tab 99 Key Data reconciliation point figures that are different to the system IFR return, they will be asked to resubmit. In exceptional circumstances where the key data values submitted in the IFR are incorrect, authorisation from the ICB and region should be obtained and sent to england.financial.reporting@nhs.net prior to submission of the PFR.</p> <p>The reconciliation point values included in this return are:</p> <table border="1"> <tr><td>FOT - Bank</td><td>(14,126)</td></tr> <tr><td>FOT - Agency</td><td>(4,511)</td></tr> <tr><td>YTD - TOTAL Provider Surplus/(Deficit) - System performance measure</td><td>1,588</td></tr> <tr><td>FOT - TOTAL Provider Surplus/(Deficit) - System performance measure</td><td>2,000</td></tr> <tr><td>YTD - Less Non-Recurrent Deficit Funding</td><td>0</td></tr> <tr><td>FOT - Less Non-Recurrent Deficit Funding</td><td>0</td></tr> <tr><td>YTD - TOTAL Provider Surplus/(Deficit) Excluding Non-Recurrent Deficit Funding</td><td>1,588</td></tr> <tr><td>FOT - TOTAL Provider Surplus/(Deficit) Excluding Non-Recurrent Deficit Funding</td><td>2,000</td></tr> <tr><td>FOT - Total Charge against Capital Allocation (including impact of IFRS 16)</td><td>6,481</td></tr> <tr><td>YTD - Total Efficiencies</td><td>16,449</td></tr> <tr><td>FOT - Total Efficiencies</td><td>18,346</td></tr> </table>		FOT - Bank	(14,126)	FOT - Agency	(4,511)	YTD - TOTAL Provider Surplus/(Deficit) - System performance measure	1,588	FOT - TOTAL Provider Surplus/(Deficit) - System performance measure	2,000	YTD - Less Non-Recurrent Deficit Funding	0	FOT - Less Non-Recurrent Deficit Funding	0	YTD - TOTAL Provider Surplus/(Deficit) Excluding Non-Recurrent Deficit Funding	1,588	FOT - TOTAL Provider Surplus/(Deficit) Excluding Non-Recurrent Deficit Funding	2,000	FOT - Total Charge against Capital Allocation (including impact of IFRS 16)	6,481	YTD - Total Efficiencies	16,449	FOT - Total Efficiencies	18,346	<p>Confirmed</p>
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<p>3. Is the return consistent with the board report? Please confirm that the financial data reported in this monthly monitoring return is/will be consistent with the information reported to and published in the board report</p> <p>Date of board report (please note that this can be a future date)</p> <p>In the exceptional event that the forms are not consistent with the board report, please itemise the reasons why it is different</p>		<p>Yes</p> <p>02/04/2026</p>																						
<p>4. 2025-26 Dissolution Has the trust dissolved in the financial year? Number of months as a trust</p>		<p>No</p> <p>12</p>																						
<p>5. 2025-26 Capital ICS Envelope Allocations The capital plan included in this template has been agreed with ICS organisations, any additional funding requirements assumed are in line with ICS priorities, and the Trust's 25/26 capital plan is affordable within the overall 25/26 ICS Capital envelope allocation</p>		<p>Yes</p>																						
<p>6. 2025-26 Capital Delegated Limit All NHS trusts and Foundation trusts have a capital delegated limit. Foundation trusts not in financial distress benefit from greater autonomy with higher capital delegated limits. Foundation trusts that meet the definition of financial distress as set out in rows 62-64 will have the same delegated limits as NHS trusts.</p> <p>NHS trusts and Foundation trusts should refer to 'Capital investment and property business case approval guidance for NHS trusts and Foundation trusts' for details on capital delegated limits and the capital investment business case approval process.</p> <p>Are you or the ICB you belong to in the NHS England Recovery Support Programme, and therefore in segment 4 of the NHS Oversight Framework?</p> <p>If you are an FT, are you in breach of your provider licence? Or are you an NHS Trust? Have you been in receipt of DHSC revenue support from 1 April 2022 (received or planned)?</p> <p>The Board agrees to the delegated limit for capital expenditure and business case approvals in line with the Capital investment and property business case approval guidance for NHS Trusts and Foundation Trusts.</p>		<p>No</p> <p>Not in breach of Foundation Trust licence</p> <p>No</p> <p>Yes</p>																						
<p>7. Capital departmental expenditure limits (CDEL) forecast Is the trust forecasting a CDEL position with greater than 50% of the YTD value to be spent in the remaining months? If Yes: The Trust has reviewed its capital programme in detail and are satisfied that the forecast remains reasonable when compared against the level of YTD spend.</p>		<p>No</p> <p>Confirmed</p>																						

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Recommendations

Trust Board are asked to:

- Note the challenging financial position, and the actions being taken to deliver the agreed financial position;
- Note the level of risks and actions being taken to mitigate and
- Highlight any further assurances required.

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BDCFT Public Board Meeting

2 April 2026

Paper title:	Green Plan – Annual Review	Agenda Item 15.0
Presented by:	Mike Woodhead	
Prepared by:	Emma Clarke, Energy, Waste and Sustainability Manager	
Committees where content has been discussed previously	March Finance & Performance Committee	
Purpose of the paper Please check ONE box only:	<input checked="" type="checkbox"/> For approval <input type="checkbox"/> For information <input type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	x
	Belonging to our organisation	
	New ways of working and delivering care	x
	Growing for the future	x
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	x
	Improving the experience of people who use our services	x
Making Best Use of Resources	Financial sustainability	x
	Our environment and workplace	x
	Giving back to our communities	x
Being the Best Partner	Partnership	x
Good governance	Governance, accountability & oversight	x

Close: Holly
27/03/2026 15:42:07

Purpose of the report

All NHS Trusts are required to have a Board approved Green Plan that is reviewed annually. The Board are asked to approve the tracked changes in the Green Plan attached to meet this NHS England requirement.

Executive Summary

The March Finance and Performance Committee were sighted on the revised Green Plan and also progress against targets during 2025/26. The full FPC paper detailing progress and achievements, risks and next steps, can be made available to Board members if required.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? **Yes** (please set out in your paper what action has been taken to address this) **No**

Recommendation(s)

The Board is asked to approve the revisions to the Green Plan

<p>Links to the Strategic Organisational Risk register (SORR)</p>	<p>The work contained with this report links to the following corporate risks as identified in the SORR:</p> <ul style="list-style-type: none"> Financial sustainability and cost pressures (energy, travel) Regulatory and reputational risk associated with NHS net zero commitments Estates resilience and climate adaptation
<p>Care Quality Commission domains Please check ALL that apply</p>	<p><input checked="" type="checkbox"/> Safe <input checked="" type="checkbox"/> Caring <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Well-Led <input checked="" type="checkbox"/> Responsive</p>
<p>Compliance & regulatory implications</p>	<p>The following compliance and regulatory implications have been identified:</p> <ul style="list-style-type: none"> NHS Net Zero commitments (2040 / 2045) NHS Standard Contract sustainability requirements NHS Estates Net Zero Carbon Delivery Plan Greener NHS programme guidance <p>Failure to maintain progress may result in increased energy costs, regulatory risk, and missed opportunities for efficiency savings.</p>

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BDCFT Public Board Meeting

2 April 2026

Paper title:	Green Plan – Annual Review	Agenda Item 15.0.1
Presented by:	Mike Woodhead	
Prepared by:	Emma Clarke, Energy, Waste and Sustainability Manager	
Committees where content has been discussed previously	March Finance & Performance Committee	
Purpose of the paper Please check ONE box only:	<input checked="" type="checkbox"/> For approval <input type="checkbox"/> For information <input type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	x
	Belonging to our organisation	
	New ways of working and delivering care	x
	Growing for the future	x
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	x
	Improving the experience of people who use our services	x
Making Best Use of Resources	Financial sustainability	x
	Our environment and workplace	x
	Giving back to our communities	x
Being the Best Partner	Partnership	x
Good governance	Governance, accountability & oversight	x

Close: Holly
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Purpose of the report

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Board of Directors – Meeting Held in Public

2 April 2026

Paper title:	Board Integrated Performance Report	Agenda Item 16.0.0
Presented by:	Phillipa Hubbard, Director of Nursing, Professions and Care Standards, DIPC, Deputy Chief Executive, Director of Nursing and Quality for Bradford District and Craven Health and Care Partnership Fran Stead, Trust Secretary	
Prepared by:	Kelly Barker, Chief Operating Officer Cliff Springthorpe, Head of Business Support	
Committees where content has been discussed previously	Quality and Safety Committee Mental Health Legislation Committee People and Culture Committee Finance and Performance Committee Audit Committee	
Purpose of the paper Please check ONE box only:	<input checked="" type="checkbox"/> For approval <input type="checkbox"/> For information <input type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	x
	Belonging to our organisation	x
	New ways of working and delivering care	x
	Growing for the future	x
Delivering Best Quality Services	Improving Access and Flow	x
	Learning for Improvement	x
	Improving the experience of people who use our services	x
Making Best Use of Resources	Financial sustainability	x
	Our environment and workplace	x
	Giving back to our communities	x
Being the Best Partner	Partnership	x

Good governance	Governance, accountability & oversight	x
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Purpose of the report

Bradford District Care NHS Foundation Trust’s Integrated Strategic Performance Report is aimed at providing a monthly update on the performance of the Trust against its strategic priorities based on the latest information available and reporting on actions being taken to address any issues and concerns with progress to date.

Executive Summary

The contents of the report are aligned to the Trust’s strategic priorities which are informed by nationally defined objectives for providers - the NHS Constitution, the NHS Long Term Plan, the Oversight Framework for Mental Health, Adult Social Care Outcomes Framework and Integrated Care Systems (ICS), as well as local contracting and partnership arrangements.

Quarter 2 2025/26 data from the NHS Performance National Oversight Framework (NOF) was published in December 2025. The Trust showed an improved score and position but remained in Sector 4 (1 being the best) with an average indicator score of 2.74 (2.84 for Q1). A data quality improvement plan has been put in place which should see improvement across a number of indicators. The Q3 position is expected to be published in the second half of March 2026.

A range of additional NOF metrics for Mental Health, broadly based around planning indicators, have been out to consultation and if approved will come into effect during 2026.

This report presents two types of information:

1. Performance data against a range of metrics (integrated performance report)

Performance is aligned to the strategic priorities, key themes and the strategic metrics which are defined in the trust’s strategy, better lives, together.

Where performance is identified as within target ranges for a period of greater than 6 months, these indicators are not escalated for the attention of the Board/ committee.

A performance overview of key points is included in the beginning of each section.

2. Assurance levels (the Board Assurance Framework)

The performance overview also contains a section which uses a wide range of sources, including the performance data in this report, to describe how assured the Trust is that it is meeting the priorities and objectives described within the trust strategy, better lives, together and is operating safety and with good governance.

By combining the Board Assurance Framework and the performance report into one document, Committees and Board are better able to understand the breadth of evidence supporting the Trust’s level of confidence in being able to achieve its objectives.

February 2026 data has been presented for all operational performance and workforce sections, and the most recent published January 2026 data for the quality and safety sections.

The summary position as confirmed across the delegated committees is noted below.

Being the Best Place to Work

- Theme 1 – Looking after our People
 - Confirmed assurance level by delegated Committee – **High**
- Theme 2 – Belonging to our Organisation
 - Confirmed assurance level by delegated Committee – **High**
- Theme 3 – New Ways of Working and Delivering Care
 - Confirmed assurance level by delegated Committee – **Significant**
- Theme 4 – Growing for the Futures
 - Confirmed assurance level by delegated Committee – **High**

Delivering Best Quality Services

- Theme 1 – Access & Flow
 - Confirmed assurance level by QSC – **Limited**
 - Confirmed assurance level by FPC – **Low**
- Theme 2 – Learning for Improvement
 - Confirmed assurance level by delegated Committee – **Significant**
- Theme 3 – Improving the experience of people who use our services
 - Confirmed assurance level by QSC – **Limited**
 - Confirmed assurance level by MHLC - **Significant**

Making Best use of resources

- Theme 1 – Financial Sustainability
 - Confirmed assurance level by delegated Committee – **Low**
- Theme 2 – Our Environment & Workspaces
 - Confirmed assurance level by delegated Committee – **Low**
- Theme 3 – Giving back to our communities
 - Confirmed assurance level by delegated Committee – **Limited**

Best Partner – measures & metrics to be agreed

Good Governance - Confirmed assurance level - **Significant**

The detail and decision regarding each committees confirmed assurance level is included in each committee AAA+D reports.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	<input type="checkbox"/> Yes (please set out in your paper what action has been taken to address this) <input checked="" type="checkbox"/> No
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Recommendation(s)

The Board of Directors is asked to:

- Note the data and associated narrative and triangulation as discussed within each delegated committee, detailed within the AAA+D
- Accept the BAF Assurance levels as confirmed within each delegated committee, detailed within the report and in the AAA+D

Links to the Strategic Organisational Risk register (SORR)	<p>The work contained with this report links to the following corporate risks as identified in the SORR:</p> <ul style="list-style-type: none"> • 2609: Organisational risks associated with out of area bed use (finance, performance and quality) • 2672: Lynfield Mount Hospital – Estate condition, associated impacts & redevelopment requirements 						
<p>Care Quality Commission domains Please check <u>ALL</u> that apply</p>	<table> <tr> <td><input checked="" type="checkbox"/> Safe</td> <td><input checked="" type="checkbox"/> Caring</td> </tr> <tr> <td><input checked="" type="checkbox"/> Effective</td> <td><input checked="" type="checkbox"/> Well-Led</td> </tr> <tr> <td><input checked="" type="checkbox"/> Responsive</td> <td></td> </tr> </table>	<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Caring	<input checked="" type="checkbox"/> Effective	<input checked="" type="checkbox"/> Well-Led	<input checked="" type="checkbox"/> Responsive	
<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Caring						
<input checked="" type="checkbox"/> Effective	<input checked="" type="checkbox"/> Well-Led						
<input checked="" type="checkbox"/> Responsive							
Compliance & regulatory implications	<p>The following compliance and regulatory implications have been identified as a result of the work outlined in this report:</p> <ul style="list-style-type: none"> • The NHS oversight framework describes how NHS England’s oversight of NHS trusts, foundation trusts and integrated care boards operates. Oversight metrics are used to indicate potential issues and prompt further investigation of support needs and align with the five national themes of the NHS oversight framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability. 						

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Board of Directors Integrated Strategic Performance Report and Board Assurance Framework

2nd April 2026



Good Governance; Accountability; Effective Oversight

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Introduction

Bradford District Care NHS Foundation Trust's Integrated Strategic Performance Report is aimed at providing a monthly update on the performance of the Trust against its strategic priorities based on the latest information available and reporting on actions being taken to address any issues and concerns with progress to date.

The contents of the report are aligned to the Trust's strategic priorities which are informed by nationally defined objectives for providers - the NHS Constitution, the NHS Long Term Plan, the Oversight Framework for Mental Health, Adult Social Care Outcomes Framework and Integrated Care Systems (ICS), as well as local contracting and partnership arrangements.

This report presents two types of information:

1. Performance data against a range of metrics (integrated performance report)

Performance is aligned to the strategic priorities, key themes and the strategic metrics which are defined in the trust's strategy, better lives, together.

Where performance is identified as within target ranges for a period of greater than 6 months, these indicators are not escalated for the attention of the Board/ committee.

A performance overview of key points is included in the beginning of each section.

2. Assurance levels (the Board Assurance Framework)

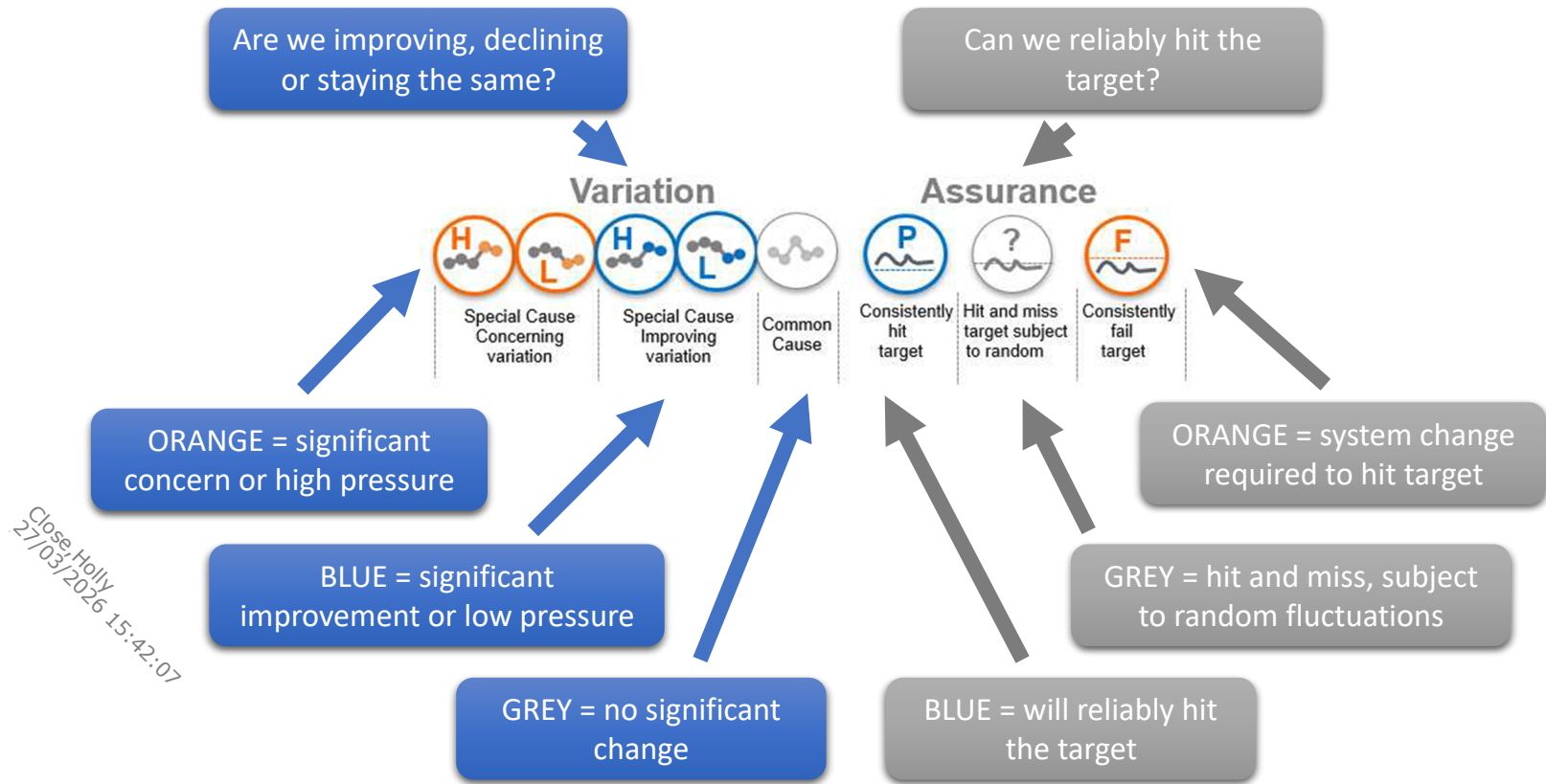
The performance overview also contains a section which uses a wide range of sources, including the performance data in this report, to describe how assured the Trust is that it is meeting the priorities and objectives described within the trust strategy, better lives, together and is operating safety and with good governance.

By combining the Board Assurance Framework and the performance report into one document, Committees and Board are better able to understand the breadth of evidence supporting the Trust's level of confidence in being able to achieve its objectives.

A note on SPC charts

Within this data pack there has been a concerted move to using Statistical Process Control (SPC) charts where this is the most appropriate way of visualising data. Where SPC charts are not deemed the most appropriate use of data, alternative charts and display mechanisms have been included. It is important to note that whilst the variation and assurance symbols are predominantly associated with SPC charts, we have taken the approach of standardising their use within this document across all data types to ensure consistency of language and approach.

The description of the meaning of the symbols (assurance icons) used throughout this document is explained below.



Delegated Strategic Priorities – Assurance Level

Being the Best Place to Work: We will continue to strive to be a Smarter Working organisation where we work together so that everyone is proud to work here, feels they belong and are valued.

<p>Theme 1: Looking after our people – we will</p> <ul style="list-style-type: none"> • Ensure our people have a voice that counts. • Strengthen the recognition and reward offers for our people. • Support our people to be active in improvement and innovation efforts inside and outside the organisation. • Embrace the principles of trauma informed practice across all of our services. 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • We have increased engagement with the NHS staff survey, with a focus on teams we hear less from. The NSS 2024 attracted an increased response of 53%, with a huge increase in Bank worker engagement to 35%. • All survey themes show a slightly higher score than the previous year, indicating improved engagement, morale and satisfaction. • Our labour turnover continues to improve month on month and in particular, the retention of new starters is improving.. • Our management of Employee Relations (ER) casework has improved dramatically, with the lowest number of open cases in three years and the speediest resolution evident. • Whilst sickness absence rises in line with seasonal trends, the provision of health and wellbeing support and resources. The newly re-launched Primary Care Wellbeing Service supplements the existing range with a comprehensive offer of holistic and person centred wellbeing services. 	<p>PROPOSED Current Assurance Level:</p> <p>4. High</p>
<p>Theme 2: Belonging in our organisation – we will</p> <ul style="list-style-type: none"> • Continue to nurture compassionate, supportive and inclusive teams in our Trust. • Build on our collective learning to shape an increasingly diverse, culturally competent, flexible and inclusive workforce that represents our communities. • Continue to empower our staff networks, ensuring people can engage and act as a voice for the unheard voices. • Continue to measure and improve the experiences and progression of our staff from protected equality groups. • Encourage greater use of our comprehensive wellbeing offer so people are safe, healthy, thrive in their place of work and have a good work/life balance. • Organise all our leaders to lead by example and demonstrate values, behaviours and accountability in action 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • We can demonstrate that our workforce, including our senior leadership, is representative of the community it serves. • Our WDES and WRES compliance continues to show improvements across all standards. • Our staff networks are thriving and ensuring their communities have a voice and are assured of our actions to support the Trust being the best place to work for people with protected characteristics. • The impact of the management skills training roll out is that fewer ER cases emerge and when they do, they are resolved more speedily at local level. • Roll out of NHS People Promise activities is supporting retention, including stay letters and career conversations. 	<p>PROPOSED Current Assurance Level:</p> <p>4. High</p>

Delegated Strategic Priorities – Assurance Level

Being the Best Place to Work: We will continue to strive to be a Smarter Working organisation where we work together so that everyone is proud to work here, feels they belong and are valued.

Theme 3: New Ways of Working and Delivering Care - we will

- Make sure that our physical places of work are accessible, well-resourced, high quality and maximise opportunities for new and integrated ways of working with our partner organisations.
- Create a digitally enabled workforce through training, education and support, and embedding digital clinical leadership across the organisation.

We will know we have been successful when:

- Our people are digitally confident, have consistently positive experiences using devices, applications and workspaces, that enable them to do their job effectively, supported by clinical digital leaders.
- We are exploring opportunities for “dual qualification” for nurses and AHPs across acute and MHLDA career pathways to introduce higher levels of competence and cross-sector integrated working.
- We have developed and implemented transformation programmes that change the way we deliver services and take a more creative approach to skill mix and developing the workforce.

PROPOSED Current assurance level:
3. Significant

Theme 4: Growing for the future – we will

- Deliver sustainable recruitment and development initiatives to improve retention, support progression opportunities and build organisational resilience and capabilities.

We will know we have been successful when:

- We have on-boarded a total of 30 newly qualified RMNs to ward based roles.
- We have contributed to the MHLDA Provider Collaborative Staff Bank and now have access to over 500 Bank Nurses from two other organisations to fulfil our temporary staffing needs.
- Our temporary staffing fulfilment is sustainably at a ratio of 90% Bank and 10% Agency.
- Continue ‘earn while you learn’ with student nurses from local Higher Education Institutes, by joining the Trust Bank alongside their academic training, with the first cohort by May 2024 as a feasibility pilot, with the potential to widen to a Bradford District and Craven offer from 2024 onwards.
- We are actively engaged in a BD&C Place scheme to collaborate around recruitment to entry level roles in all health and social care specialties, not only in respect of job opportunities that reach out into our communities, but also a cohesive approach to developing career pathways through vocational and academic programmes open to all.

PROPOSED Current Assurance Level:
4. High

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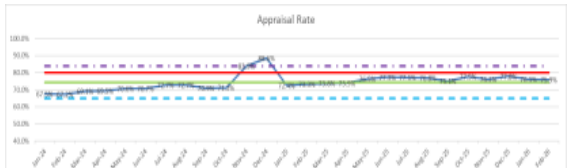
Key Performance Indicators

Best Place to Work: Theme 1: Looking After our People

Metric	Type	Year End Position 2023/24	Reporting month	Performance	Target	SPC / trend																																				
Staff survey – engagement levels	Strategic	7.08	2024	7.08	7.4 (best)	Staff engagement score remains stable/increased slightly at 7.08 (0.03);																																				
Staff survey - % would recommend the Trust as a place to work	Strategic	64.28%	2024	64.28%	63% (sector)	<table border="1"> <thead> <tr> <th></th> <th>2020</th> <th>2021</th> <th>2022</th> <th>2023</th> <th>2024</th> </tr> </thead> <tbody> <tr> <td>YOUR org</td> <td>66.33%</td> <td>63.10%</td> <td>63.89%</td> <td>62.26%</td> <td>64.28%</td> </tr> <tr> <td>Best result</td> <td>77.76%</td> <td>73.57%</td> <td>73.02%</td> <td>73.47%</td> <td>78.15%</td> </tr> <tr> <td>Average result</td> <td>67.83%</td> <td>63.10%</td> <td>62.73%</td> <td>65.57%</td> <td>65.21%</td> </tr> <tr> <td>Worst result</td> <td>49.05%</td> <td>43.47%</td> <td>49.54%</td> <td>49.56%</td> <td>42.78%</td> </tr> <tr> <td>Responses</td> <td>1269</td> <td>1412</td> <td>1329</td> <td>1671</td> <td>1755</td> </tr> </tbody> </table>		2020	2021	2022	2023	2024	YOUR org	66.33%	63.10%	63.89%	62.26%	64.28%	Best result	77.76%	73.57%	73.02%	73.47%	78.15%	Average result	67.83%	63.10%	62.73%	65.57%	65.21%	Worst result	49.05%	43.47%	49.54%	49.56%	42.78%	Responses	1269	1412	1329	1671	1755
	2020	2021	2022	2023	2024																																					
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Average result	67.83%	63.10%	62.73%	65.57%	65.21%																																					
Worst result	49.05%	43.47%	49.54%	49.56%	42.78%																																					
Responses	1269	1412	1329	1671	1755																																					
Labour turnover	Strategic	13.68%	Feb 26	10.4%	10%																																					
Number of leavers in 1st 12 months of employment	Supporting	93 (19.3%)	Feb 26	75 / 384 (19.5%)	N/a	<p>The top 3 reasons for leaving (excluding resignation – other/not known) are retirement, VR – Relocation and VR – promotion. 11.20% left due to the end of a FTC, 20.05% through retirement and 4.17% through dismissal.</p>																																				
Sickness absence related to stress / anxiety	Strategic	2.6% of the 6.6% (39.04% of all absence)	Feb 26	3.0% of the 7.61% (39.76% of all absence)	N/a																																					
Sickness absence (Overall)	Supporting	6.6%	Feb 26	7.61%	4.0%																																					
Return to Work Interviews –% (based on RTW's being recorded in a timely manner)	Supporting	N/a	Feb 26	49.38% (based on all absences in the last 12 months)	95%																																					

Key Performance Indicators

Best Place to Work: Theme 2: Belonging in our organisation

Metric	Type	Year End Position 2023/24	Reporting month	Performance	Target	SPC / trend
WRES data (number areas improved out of 8)	Strategic	5/8 improved	2024/25	5/8 improved	8/8	The WRES/WDES figures are reported Nationally on an annual basis. The figures are closely monitored alongside the Trust's EDI programme.
WDES data (number areas improved out of 12)	Strategic	8/12 improved	2024/25	6/12 improved	12/12	
Gender pay gap (number areas improved out of 2)	Strategic	1/2 improved	2024/25	1/2 improved	2/2	The average (Mean) GPG in favour of males increased from 2024. The median GPG reduced however is still in favour of females.
Number of grievances involving discrimination & Proportion disciplinaries involving BAME staff	Strategic	1 Grievance 12 Disciplinaries (15.38% of all ER Casework)	Feb 26	1 Grievances 5 Disciplinaries (19.35% of all ER Casework-excluding sickness)	N/a	
Annual Appraisal Rates	Strategic	69.08%	Feb 26	75.9%	80%	

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Key Performance Indicators

Best Place to Work: Theme 3: New Ways of Working and Delivering Care

Metric	Type	Year End Position 2023/24	Reporting month	Performance	Target	SPC / trend
Bank and Agency Fill rates	Strategic	91.4% 6.63% Agency 84.81% Bank 8.56% Unfilled	Feb 26	83.6% 2.64% Agency 80.94% Bank 16.42% Unfilled	100%	A reduction in agency and in bank and also a reduction in unfilled duties. Top 3 reasons for bookings are Increased Observations, Vacancy and High Patient Acuity
Bank and Agency Shifts	Strategic	5956 requested 395 Agency 5051 Bank 510 Unfilled	Feb 26	4843 requested 128 Agency 3920 Bank 795 Unfilled	N/a	
Bank & Agency Usage (WTE)	Strategic	30.01 Agency 313.70 Bank Ratio: 8.73% Agency 91.27% Bank	Feb 26	24.6 Agency 234.45 Bank Ratio: 9.49% Agency 90.51% Bank	N/a	
Vacancy rates	Strategic	7.4%	Feb 26	3.8%	10%	Reduction

Best Place to Work: Theme 4: Growing for the future

Metric	Type	Year End Position 2023/24	Reporting month	Performance	Target	SPC / trend
Number of apprenticeships	Strategic	116	Feb 26	154	63	Reduction
Number 'new' roles recruited to (inc NAs and ANPs)	Strategic	1	Feb 26	-4	N/a	Reduction

Strategic Priorities – Assurance Level

Delivering Best Quality Services: We will consistently deliver good quality, safe and effective mental health and physical health services, making every contact count and meeting the needs of our communities, with a focus on reducing health inequalities.

<p>Theme 1: Access & Flow – we will</p> <ul style="list-style-type: none"> • Implement ‘right care, right place, right time’ service delivery models to improve choice, access, reduce waiting times and enhance continuity in care, including working with our partners and those in our services, to identify where digitally enabled services will improve accessibility and experience. • Enhance collaboration between mental, physical community health services, and social care and system partners for all services to ‘make every contact count’ and to bring new and innovative ways of working to our communities. • Work collaboratively with partners in a locality-based model to reduce health inequalities by using data and evidence-based practices to maximise the impact and outcomes 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • We will have a coherent set of metrics to track performance and safety, highlight inequalities experienced by protected equality groups, identify improvements and consistently benchmark with others. • We can demonstrate equitable access to all of our services. • Use high quality information and analysis to drive predictive health interventions, clinical decision making and service planning to reduce health inequalities. • Service users have the choice to access our services using safe and secure digital tools where appropriate, to stay as healthy as possible. 	<p>Confirmed Current Assurance Level (QSC – quality perspective):</p> <p>2. Limited</p> <hr/> <p>Confirmed Current Assurance Level (Finance and Performance perspective):</p> <p>1. Low</p>
<p>Theme 2: Learning for improvement – we will</p> <ul style="list-style-type: none"> • Share best practice and learning across integrated multi-disciplinary teams, to improve clinical effectiveness and social impact for service users, carers and families. • Continue to embed the Care Trust Way training and support in service delivery to support continuous quality improvement, adopt innovation and reduce waste. 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • We consistently adopt a continuous improvement approach, share learning and creating opportunities for our people to develop their improvement and innovation skills. • We have a vibrant portfolio of research that guides clinical and service decisions 	<p>Confirmed Current Assurance Level:</p> <p>3. Significant</p>

Strategic Priorities – Assurance Level

Delivering Best Quality Services: We will consistently deliver good quality, safe and effective mental health and physical health services, making every contact count and meeting the needs of our communities, with a focus on reducing health inequalities.

Theme 3: Improving the experience of people who use our services – we will

- Embrace and apply the principles of trauma informed care in the way we offer services to people and their families consistently, underpinned by training and development for staff.
- Ensure the voices of people in our services help shape our continuous improvement journey.
- Enable better decision-making and choice on care provision and clinical practice through more active involvement of our service users, in particular those disproportionately represented in our services whose voices we don't hear

We will know we have been successful when:

- People who use our services are telling us that they have had a positive experience, including those who are waiting for treatment.
- We have embedded service user involvement throughout the organisation, including developing patient leadership roles.
- We have a coordinated approach to supporting children, young people, carers and their families that improves outcomes and experience.
- We have reduced the reliance on temporary staffing across services.
- We have implemented the Patient and Carer Race Equality Framework requirements.

Confirmed Current Assurance Level (QSC):

2. Limited

Confirmed Current Assurance Level (MHLC – restrictive practices):

3. Significant

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Key Performance Indicators

Best Quality Services: Theme 1: Access & Flow

Metric	Type	Reporting month	Performance	Target	Variation	Assurance	Mean	SPC / trend chart
Reportable Out of Area Placements Monthly Bed Days – Inappropriate	Strategic	Feb 26 Dec-Feb (3m)	248 668				477	
Average Length of Stay (Acute wards)	Supporting	Feb 26	40.6	NA			58.9	
Number of people with inpatient length of stay <=3 days (Acute wards)	Strategic	Feb 26	2	TBC			3	
Consultant led waiting times (incomplete) referral to treatment	Strategic	Feb 26	66.8%	92%			68.7%	

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Key Performance Indicators

Best Quality Services: Theme 2: Learning for Improvement

Metric	Type	Reporting month	Performance	Target	Summary
Number of staff speaking up through Freedom to Speak Up Guardian Route	Supporting	(YTD) Jan 26	12	N/A	
% of staff trained as a CTW Champion	Strategic	Jan 26	42.8%	50%	
% of staff trained as a CTW Leader	Strategic	Jan 26	23.4%	20%	
% of staff trained as a CTW Practitioner	Strategic	Jan 26	33.5%	3%	
% of staff trained as a CTW Sensei	Strategic	Jan 26	72.1%	0.5%	
No of participants in research studies (YTD)	Strategic	Nov 25	20	400	DATA UNAVAILABLE FOR JAN

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Key Performance Indicators

Best Quality Services: Theme 3: Improving the experience of people who use our services

Metric	Type	Reporting month	Performance	Target	Variation	Assurance	Mean	SPC / trend chart
Number of patient safety incidents relating to treatment or procedure delay/failure, delays in referral, cancellation of clinic/appointments, cancelled therapeutic activity, admission bed shortages and admission failure/delay to access services (Primary sub-cat)	Strategic	Jan 26	41	0	N/A	N/A	N/A	
No of complaints relating to people whilst waiting for services**	Strategic	Jan 26	12	0	N/A	N/A	N/A	
FFT / local patient survey – patient experience score	Strategic	Jan 26	96.1%	90%	N/A	N/A	N/A	

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Delegated Strategic Priorities – Assurance Levels

Making Best Use of Resources: We will deliver effective and sustainable services, considering the environmental impact and social value of everything we do

<p>Theme 1: Financial Sustainability – we will</p> <ul style="list-style-type: none"> • Ensure that all operational services and corporate functions optimise the use of resources, deliver best value and reduce waste within agreed budgets and with regard to environmental and social impacts 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • We are consistently delivering a financially balanced position at Trust and care group level. • We can demonstrate the return on investment and value for money of investments in our physical and digital infrastructure 	<p>Confirmed Current Assurance Level:</p> <p>1. Low</p>
<p>Theme 2: Our environment and workspaces – we will</p> <ul style="list-style-type: none"> • Ensure that our people have opportunities to shape, test and implement digital solutions to stimulate innovation and creativity in service delivery. • Co-design a revised green plan to embed sustainable healthcare models and to continually drive environmental improvements and innovation. • Co-design spaces that meet the needs of our people and service users, are energy efficient and decarbonising and, where possible, use existing facilities in our neighbourhoods to reduce duplication and deliver care closer to home. • Provide a robust, resilient and secure digital infrastructure that enables our people to do their job from anywhere, anytime 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • Services are co-located in shared health and care delivery spaces across Bradford and Craven, reducing our overall footprint. • Sustainability and efficiency are embedded into all refurbishment and new build projects, using sustainability principles, completing sustainability impact assessments and taking account of NHS England’s targets and guidance. • We will have achieved the targets set out in our Trust’s green plan by focusing on reducing waste, increasing recycling and reducing our carbon emissions. • We have assessed our organisation as being digitally mature, including meeting/ exceeding all 10 standards within the data security protection toolkit 	<p>Confirmed Current Assurance Level:</p> <p>1. Low</p>
<p>Theme 3: Giving back to our communities – we will</p> <ul style="list-style-type: none"> • Contribute to the social, economic and cultural development of our place through social value led approaches, programmes and procurement 	<p>We will know we have been successful when:</p> <ul style="list-style-type: none"> • We can demonstrate that social value is built into all material investment and procurements. • We have delivered the ambitions in our joint climate change adaptation plan, shared with Bradford Teaching Hospitals NHS Trust and Airedale NHS Foundation Trust. 	<p>Confirmed Current Assurance Level:</p> <p>2. Limited</p>

Strategic Priorities – Assurance Summary

Good governance: Good governance, accountability and effective oversight

We will Have in place good governance arrangements that ensure we make the best decisions	We will know we have been successful when: We have well embedded governance processes that are clear and effective	CONFIRMED Current assurance level: 3. Significant
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Board of Directors

2 April 2026

Paper title:	Strategic Risk Assurance Report	Agenda Item 17.0
Presented by:	Fran Stead – Trust Secretary	
Prepared by:	Fran Stead – Trust Secretary	
Committees where content has been discussed previously	Mental Health Legislation Committee; Quality & Safety Committee; Finance & Performance Committee, Audit Committee, People & Culture Committee; Board of Directors	
Purpose of the paper Please check ONE box only:	<input type="checkbox"/> For approval <input type="checkbox"/> For information <input checked="" type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	
	Belonging to our organisation	
	New ways of working and delivering care	
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	
	Improving the experience of people who use our services	
Making Best Use of Resources	Financial sustainability	
	Our environment and workplace	
	Giving back to our communities	
Being the Best Partner	Partnership	
Good governance	Governance, accountability & oversight	X

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Purpose of the report

The purpose of this report is to provide an update on the developments of the Strategic Risk Assurance Report as part of the Board Assurance Framework. The update includes the annual agreement of the strategic risks for 2026.

Executive Summary

In 2022 the Board agreed to develop the Board Assurance Framework to move from a risk-based approach to an assurance-based approach. The work included benchmarking and opportunity to reflect and utilise external independent review.

As an improvement organisation, it was agreed with the Board that an effectiveness review would be undertaken during 2024/25 to identify any success and areas of further development. This report confirms the work that has just taken place as agreed improvement activity, & the next steps.

Board members will be familiar with the planned updates that have taken place over the last year as part of the Trust's effectiveness reviews of existing governance arrangements.

This report outlines the proposed 2026 Strategic Risks for 2026/27 & the meeting which is the assurance receiver.

All Strategic Risks will also be presented to the Board and the Audit Committee, which will include a discussion on anything that has been identified as a new Strategic Risk, or area for further work. This is in support of creating a process that is responsive. Further discussion on how the Audit Committee can receive further assurance on the Committee's processes for the monitoring of strategic risk will take place as planned. This is outlined in the Well Led Development Plan, & the Audit Committee Strategic Narrative Report.

Once the new Trust strategy has been developed, a review will take place to ensure that they align to the new strategy.

The Board is asked to be re-assured that this is an iterative process, with all improvements being tracked over the coming months within this report.

A planned Board Development Session will take place in the coming months, where the Board will receive training on Risk, & agree the risk appetite levels for 2026. The Strategic Risk Report will be updated following this.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?

Yes (please set out in your paper what action has been taken to address this)

No

Recommendation(s)

Board of Directors – 2 April 2026

Strategic Risk Assurance Report

Introduction

As an improvement organisation there is a strong commitment and culture to undertake regular review to Trust practices. An example of that occurred 2022 when the Board agreed to change the model of the 'Board Assurance Framework' delivered at that point. The reason for the change was to create a new process that relied on assurance of progress with accountability for mitigating deviation from plan, rather than a risk-based approach to oversight and assurance. This has created a new process & report for strategic risk.

2 Better Lives Together (BLT)

The Trust strategy describes our role to connect people to the best quality care, where & when they need it, & be a national role model as an employer.

We will do this by supporting people to feel as healthy as they can be at every point in their lives & connecting people to the best quality care when & where they need it to make every contact count.

Everything the Trust does during this period will be focused upon making better lives, together.

During the refresh of the Trust's strategy 2022/23, a commitment was made to ensure 'governance, effective oversight & accountability' underpins the 4 strategic objectives as a golden thread & enabler. This was further supported 2024 through a Board Development Session, where the Board agreed the Trust's Well Led ambition to support this work, it is:



Better lives, together



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We have an inclusive & positive culture of continuous learning & improvement. This is based on meeting the needs of people who use our services, wider communities & ensuring health equity.

All our leaders & colleagues share this. Leaders proactively support colleagues to collaborate with partners to delivery care that is safe, collaborative, person-centred & sustainable.

3 Strategic Risk

As agreed by the Board, a planned discussed has taken place to identify the current strategic risks for 2026. This was building on past reviews where the Board agreed to remove any irrelevant strategic risks that had been being reported on as previously reported. In support of this, a number of Board Development Sessions on strategic risk have taken place, & a Board discussion to confirm the overarching strategic risks to the Trust. Which were agreed 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.

At the Board Development Session on 17 December, group work took place to consider the remaining strategic risks & propose any new strategic risks, both of which are outlined below. The group work focused on the different assurance Committees (Audit; Finance & Performance; Mental Health Legislation; Quality & Safety; People & Culture) & their role in receiving assurance on the Better Lives, Together strategy being delivered. A suggested strategic risk on 'partnership working' & 'health equity' is included for consideration.

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3.1 Strategic Risks 2026/27

SR no.	Description	Strategic objective	Oversight meeting	Lead Executive
SR01	If pressure on workforce increases, then it could impact on the quality of care to patients resulting in poorer patient experience and outcomes.	Best Quality Services	Quality & Safety Committee	Director of Nursing
SR02	If the Trust does not effectively contribute to delivering health equity across the population it serves, then unwarranted variation in access, experience and outcomes for protected and inclusion health groups will persist or worsen, resulting in negative impacts on people's lives, failure to meet national expectations (including Core20PLUS5 and EDS), misalignment with Trust strategy, reputational damage, and failure to meet the Trust's moral and statutory obligations as an NHS provider to its communities.	Best Quality Services	Quality & Safety Committee	Chief Operating Officer
SR03	If the Trust fails to fully implement the requirements of the Mental Health Act (MHA) and Mental Capacity Act (MCA), then it could result in breaches of statutory and regulatory obligations, potential enforcement action resulting in non-compliance, operational disruption, adverse impacts on quality, safety, reputation, and financial sustainability.	Best Quality Services	Mental Health Legislation Committee	Chief Medical Officer
SR04	If the Trust continues to focus on productivity and financial performance measures, then there may be a threat to organisational culture, resulting in poorer levels of colleague engagement, morale and inclusion.	Best Place to Work	People & Culture Committee	Chief People Officer

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SR05	If services do not optimally deploy and utilise their people using effective rostering, including recruiting to vacant posts, then there will be a continued increase in temporary staffing costs or gaps, resulting in a negative impact on wellbeing, reducing consistency, financial sustainability and quality of care delivery.	Best Place to Work	People & Culture Committee	Chief People Officer
SR06	In the context of current and impending financial challenges, if management capability, capacity and competence is not maintained at optimal level, then there may be a failure to deliver to expectations in terms of productivity, as well as maintenance of basic people management practices.	Best Place to Work	People & Culture Committee	Chief People Officer
SR07	If the Trust's data quality is not sufficiently accurate, timely and consistent, then decision making, performance reporting and benchmarking (including NOF, productivity indicators and reference costs) will be compromised, resulting in mis segmentation, reputational risk, inappropriate funding assumptions and reduced ability for the Trust to adapt to changing funding models.	Best Use of Resources	Finance & Performance Committee	Director of Transformation, Improvement & Productivity
SR08	There is a risk that a significant cyber security incident or major digital system failure, either within the Trust, across system partners, or affecting national NHS infrastructure, results in loss of access to critical clinical and corporate systems. This could prevent access to patient records, disrupt care coordination and workforce deployment, delay statutory reporting and financial processes, and compromise data sharing. Consequences may include patient harm, regulatory breach, financial loss, operational disruption, and reputational damage.	Best Use of Resources	Finance & Performance Committee	Chief Information Officer

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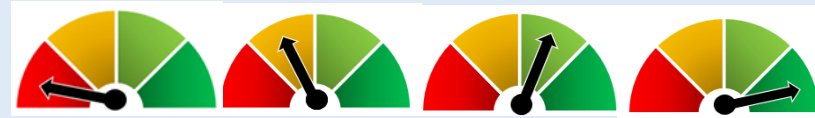
SR09	If the Trust fails to deliver its savings target and to control financial pressures during 2026/27, then it will fail to deliver its financial plan. Resulting in: reputational damage, regulatory intervention, financial loss, curbs on financial freedoms and flexibilities, and ultimately a detrimental impact to service delivery, service users and staff.	Best Use of Resources	Finance & Performance Committee	Chief Finance Officer
SR10	If the Trust fails to deliver on a credible, robust, compliant medium/long-term plan, then its financial performance will continue to deteriorate. Resulting in: reputational damage, regulatory intervention, financial loss, curbs on financial freedoms and flexibilities, and ultimately a detrimental impact to service delivery, service users and staff.	Best Use of Resources	Finance & Performance Committee	Chief Finance Officer
SR11	If the Trust does not have robust & effective governance, risk & compliance processes in place, then it will not comply with NHS licensing conditions, CQC, NHSE regulatory & Code of Governance requirements. Resulting in the Trust breaching license conditions.	Good Governance, Effective Oversight & Accountability	Audit Committee	Director of Nursing
SR12	Partnership Strategic Risk (to be agreed at Board held in Private on 2 April 2026).	Being the Best Partner	Board of Directors	Chief Executive

3.2 Assurance rating

The Strategic Risks will be monitored monthly. They will be scored using the 4 assuring ratings, which will be tracked throughout the year & included within future iterations of the report.

As planned, discussion will take place at Board, to agree how the Audit Committee can be assurance receiver on the systems within the other Committees, for good governance & risk management.

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4 Risk appetite & associate tolerance

The Board uses the Good Governance Institute matrix for risk appetite. A Board Development Session took place Autumn 2024 to facilitate the Board agreeing the appetite for the five domains (financial; regulatory; quality; reputation; people). This will be reviewed annually, with the next review being scheduled to take place over the next few months.

Once the appetite across the five domains has been agreed, work will take place to incorporate this within the Strategic Risk Assurance Report to ensure integrated governance in support of good decision making.

5 Next steps

This report acts as an update on the latest progress made by the Board. Discussion took place in the Committee meetings held March. Each strategic risk has been assigned to an Executive Director, the Executive Director is currently populating the Strategic Risk Assurance Report, which will be presented to the Committee's & Board.

Following development of the Integrated Strategic Performance Report (commencing November), the Board will agree whether the 'assurance' & associated strategic narrative, will remain in the ISPR. If not, consideration will be given to whether it should be a standalone report or be part of the Strategic Risk Assurance Report. Noting the comments on this from the external Well Led review.

The programme for development for the Audit Committee will continue. The next focus of this will be on the inclusion of the Strategic Risk Assurance Report; & 'assurance' report as a standing item for meetings, it will be added to the workplan.

Discussion will take place with Audit Committee, and other Committee Chairs to agree the new process for how the Audit Committee receives assurance on how effective the other Committees risk monitoring and supporting governance is. This will be scheduled as a Board Development Session. Subsequent actions will be tracked as part of the Well Led Development Plan.

The Board is asked to:

- note the update provided and the next steps as part of the agreed development work for this area

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- note the Strategic Risks for 2026 have been discussed by each Committee, and will be finalised by the Executive Management Team
- note that each strategic risk will be assigned to a lead Executive, who is finalising the wording for the risk & populating the assurance report
- approve the strategic risks, noting that a discussion will take place in Board held in Private on a proposed partnership strategic risk that is emerging
- agree any further actions in support of delivering this work.

Fran Stead
Trust Secretary
March 2026

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Board of Directors – held in Public

2 April 2026

Paper title:	NHS Oversight Framework Quarterly Update	Agenda Item 18.0.0
Presented by:	Farhan Rafiq	
Prepared by:	Raj Gohri	
Committees where content has been discussed previously	Finance & Performance Committee	
Purpose of the paper Please check ONE box only:	<input type="checkbox"/> For approval	<input type="checkbox"/> For information
	<input checked="" type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work set out in this report contributes to delivery of the following Board Assurance Framework (BAF) themes.		
Being the Best Place to Work	Looking after our people	X
	Belonging to our organisation	
	New ways of working and delivering care	X
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	X
	Learning for Improvement	X
	Improving the experience of people who use our services	X
Making Best Use of Resources	Financial sustainability	X
	Our environment and workplace	
	Giving back to our communities	
Being the Best Partner	Partnership	X
Good governance	Governance, accountability & oversight	X

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Purpose of the report

As part of a planned series of quarterly updates to the Board, this report provides an update on the Quarter 3 results from the National Oversight Framework, published in March 2026. It also summarises changes in performance across a range of indicators since the previous publication.

Executive Summary

The National Oversight Framework (NOF) league tables published in March 2026 confirm that the Trust has moved from Segment Four to Segment Three. Both the overall score and national ranking have improved, reflecting the early impact of actions to strengthen performance and data quality. Our position among non-acute NHS providers has improved to 43 of 61, from 50 in Quarter 2. While further improvement is required, this upward trajectory indicates that sustained focus on the priority areas will support continued progress.

The accompanying papers include the NOF dashboard, which summarises Quarter 2 and Quarter 3 performance, estimated Quarter 4 positions, emerging trends, key risks, and associated improvement actions. The dashboard also includes indicative metrics for 2026/27, enabling earlier tracking and supporting a proactive approach, rather than waiting for formal publication.

The summary below draws on published Quarter 3 data and Quarter 4 estimates.

Headline position

- Overall segmentation has improved from 4 to 3. Quarter 3 indicators show improvement across several measures, alongside a small number of emerging risks.
- At domain level, three domains have improved and two remain unchanged.

Key improvements

- Performance against the 52-week wait standard for community services has improved significantly. December performance shows waits reduced to 0.07%, with two Speech and Language Therapy patients waiting over 52 weeks. This is below the NHS England average and improved the Quarter 3 NOF metric score from 2.66 to 2.15.
- Crisis Care 24-hour face-to-face contacts performance continues to improve, reaching 57.73% in Quarter 3 compared with 35.27% in Quarter 2. The NOF metric score improved from 3.88 to 3.25, supported by improved data quality and resolution of data flow issues. Benchmarking indicates performance is now approaching the NHS England average. Local forecasts for Quarter 4 (January–February 2026) suggest further improvement to 85–90%, subject to March performance.

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Areas requiring continued focus

- Children and Young People (CYP) access shows further deterioration in the rolling 12-month position. Although this metric may be removed from future NOF iterations, it remains in scope for 2025/26.
- Workforce sickness absence for the published July–September period shows further deterioration compared with Quarter 2; however, despite the deterioration, the Trust’s position remains unchanged relative to other Trusts. This downward trend is expected to continue due to the seasonal nature of the measure.

Overall assessment

Published Quarter 3 performance data indicates that targeted operational and data quality actions—particularly in relation to 52-week waits and Crisis Care face-to-face contacts—are supporting an improvement in the Trust’s NOF position.

The following annual metrics are due to be refreshed in Quarter 4 (subject to national publication timelines):

- National CQC community mental health survey: overall experience rating.
- NHS Staff Survey (MHPRV): engagement sub-score and raising concerns sub-score.

At this time, it is not possible to accurately predict how these updates will affect metric scores or overall segmentation performance for Quarter 4.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?

- Yes** (please set out in your paper what action has been taken to address this)
- No**

Recommendation(s)

The Board of Directors is asked to:

- Note the progress to date.
- Provide feedback on the reporting format and the information presented.
- Advise on any further assurance required.

Links to the Strategic Organisational Risk register (SORR)

- The work set out in this report links to the following corporate risks as identified in the SORR: Pressure on workforce impacting on quality of care to patients, patient experience & outcomes – QSC
- Threat to culture change in light of additional performance/financial pressures - PCC

	<ul style="list-style-type: none"> Maintained risk of the Trust being unable to maintain financial sustainability in medium to long term – FPC Data Quality - FPC 						
<p>Care Quality Commission domains Please check <u>ALL</u> that apply</p>	<table border="0"> <tr> <td><input checked="" type="checkbox"/> Safe</td> <td><input checked="" type="checkbox"/> Caring</td> </tr> <tr> <td><input checked="" type="checkbox"/> Effective</td> <td><input checked="" type="checkbox"/> Well-Led</td> </tr> <tr> <td><input checked="" type="checkbox"/> Responsive</td> <td></td> </tr> </table>	<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Caring	<input checked="" type="checkbox"/> Effective	<input checked="" type="checkbox"/> Well-Led	<input checked="" type="checkbox"/> Responsive	
<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Caring						
<input checked="" type="checkbox"/> Effective	<input checked="" type="checkbox"/> Well-Led						
<input checked="" type="checkbox"/> Responsive							
<p>Compliance & regulatory implications</p>	<ul style="list-style-type: none"> The following compliance and regulatory implications have been identified in relation to the work outlined in this report: If sustained improvement is not achieved, there is a potential risk of formal provider intervention from NHS England (NHSE) in the future. 						

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National Oversight Framework Report

**Quarter 3 2025/26 &
Quarter 4 2025/26
Indicative Data & Trends**

**2026/27 Proposed
Metrics Indicative Data**

Version 7

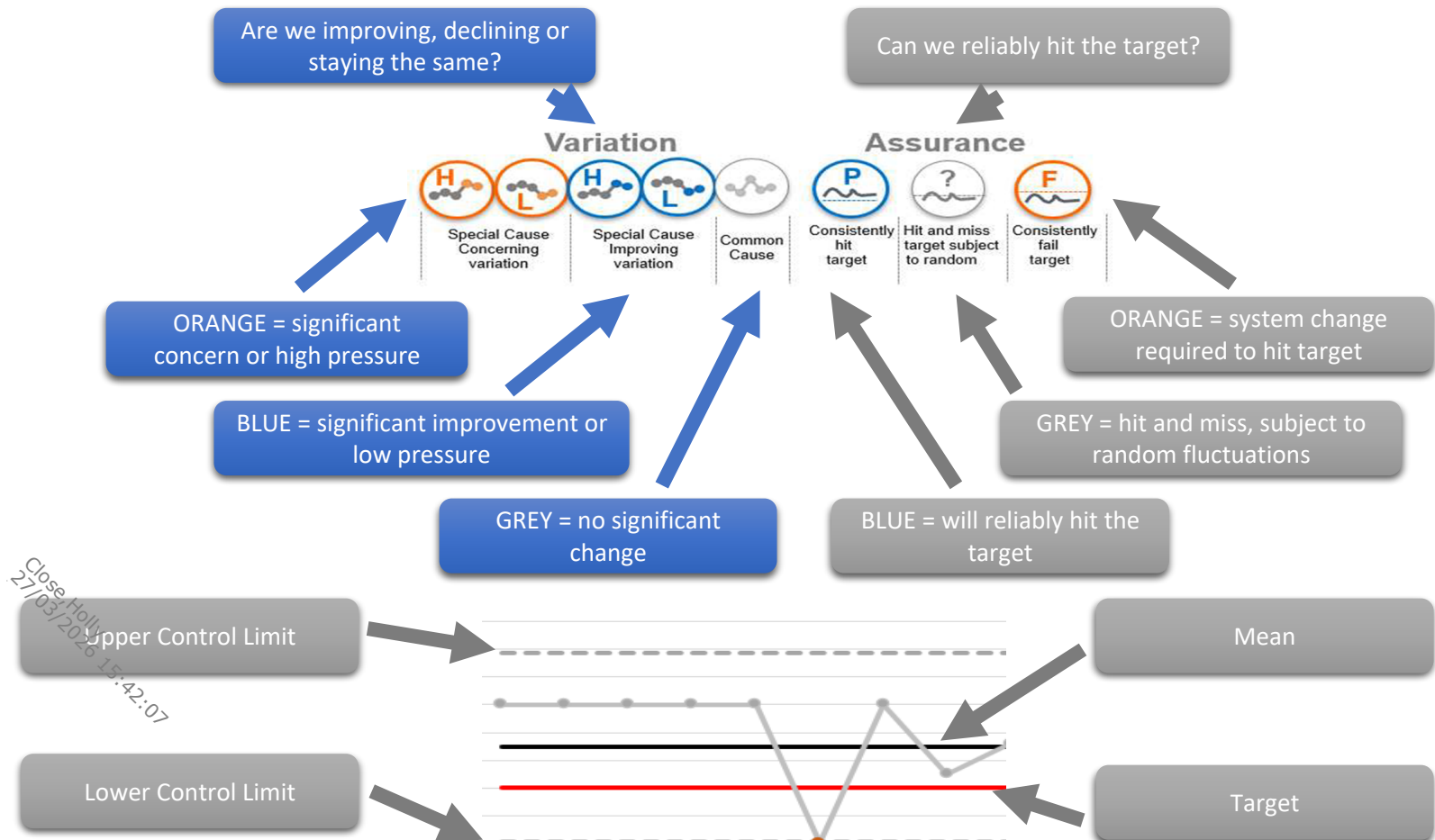
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Good Governance; Accountability; Effective Oversight

A note on SPC charts

Within this data pack there has been a concerted move to using Statistical Process Control (SPC) charts where this is the most appropriate way of visualising data. Where SPC charts are not deemed the most appropriate use of data, alternative charts and display mechanisms have been included. It is important to note that whilst the variation and assurance symbols are predominantly associated with SPC charts, we have taken the approach of standardising their use within this document across all data types to ensure consistency of language and approach. The description of the meaning of the symbols (assurance icons) used throughout this document is explained below.



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This report gives an indication relating to how published performance has changed overall and for each domain and metric since the last NOF publication.

The report also provides an indication on how performance has changed for a number of indicators since the last published quarter, however it does not forecast segmentation or individual metric scores due to the lack of clarity relating to the cohorts used for the national rankings.

As an impact of NHSE's implementation of the NHS Oversight Framework (NOF) a local Data Quality Improvement Working Group has been established with executive level membership. The aim of this group is to improve Trust average scoring and thereby a lower overall segmentation score. This is to be achieved through identifying and addressing metrics where data quality may be impacting on reported performance in particular where DQ improvements are most likely to improve those metric's scores. Of the 12 NOF metrics, 2 have been identified where data quality issues may impact reported performance.

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NHS Oversight Framework (NOF) Quarter 3 data, scores and segmentation officially published 18/03/26.

Quarter 3 updates

Based on the NOF publications for Q2 and Q3 performance changes are as follows:

- Overall segmentation has improved from 4 to 3.
- Ranking - Our organisation's position in the national league table for non-acute NHS providers has improved to 43/61, compared to Quarter 2 ranking position of 50/61.
- Metric scores - 4 metrics improved and 1 deteriorated, significant changes are:
 - “% of patients waiting over 52 weeks for community services” score improved from 2.66 to 2.15
 - “% of adult discharges with a length of stay above 60 days” score improved from 3.04 to 2.47
 - “% of urgent referrals to Crisis Care with 1st F2F contact within 24hrs” score improved from 3.88 to 3.25
- Domain scores – 3 domains improved and 2 are unchanged.
 - “Access to services” improved from 4 to 3,
 - “Effectiveness and experience” improved from 4 to 3,
 - “Patient safety” improved from 4 to 3,
 - “People and workforce” unchanged at 4
 - “Finance and productivity” unchanged at 2

Quarter 4 potential updates include:

The next formal release of the NOF is expected by mid-June 2026.

- “Percentage of patients waiting over 52 weeks for community services” - March snapshot will be used for NOF quarter 4 scoring – the only applicable community service with over 52 week waiters is CYP Speech & Language Therapy (SLT). The end of Feb. snapshot submission showed 2 waiters over 52 weeks, which is anticipated will maintain the metric score in the region of 2.15. Reducing these waiters to 0 by the end of March will potentially lower the metric score to between 1.00 and 2.00 from 2.15 (Q3).
- “Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours (3m rolling)”. Performance continues to improve month on month for this measure indicating an improvement in recording levels. January's figure is 93%, Q4 is forecasted to be in the region of 85-90%, Q3 was 57.73%.

The following annual metrics will be updated in Quarter 4:

- “National CQC community mental health survey overall experience rating”
- “NHS Staff Survey: engagement sub-score (MHPRV) & raising concerns sub-score (MHPRV)”

The impact of these cannot be forecasted either from a metric or segmentation perspective.

NHS Oversight Framework (NOF) Quarter 2 data, scores and segmentation officially published 11/12/25.

Quarter 2 updates

Based on the NOF publications for Q1 and Q2 performance changes are as follows:

- Overall segmentation is unchanged.
- Metric values - 6 metrics improved and 3 deteriorated
- Domain scores:
 - “Access to services” deteriorated from 3 to 4,
 - “Finance Productivity” improved from 3 to 2.
 - The remaining 3 domain scores are unchanged.
- The metric “Relative difference in costs” – this is an annual measure and Q2 has been updated with 24/25 NCC data submission, Q1 utilised 23/24 NCC data.
- There are 6 Contextual measures (a number of which are new in Q2) and 1 new non-scoring domain which are now included. These appear to relate to areas which include; ICB measures (ICBs are currently not being segmented), planning measures, national priority measures where underlying data quality would impact scoring, Improving health and reducing inequality. Ambiguity exists as to how these are going to be used in the future, are they solely contextual non-scoring or are they experimental and will become scoring measures.

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Other NOF updates

- There was an Indication that the new implied productivity measure would be introduced in 2025/26. Further clarity indicates that the new Implied productivity measure will be introduced for Acute Trusts only and will not be included in 25/26 for non-acute Trusts and is also unlikely to be included in 2026/27 for non-acute Trusts.
- There are some indications that the CYP access metric may be removed from future NOF publications following feedback from providers regarding the metric methodology and issues relating to service delivery models impacting Trust's performance.

NOF Proposed Measures 26/27

- A revised set of proposed NOF metrics for 2026/27 has been released for consultation to regional Mental Health Colleagues. This update was presented by the NOF Team on 4 December; feedback mainly noted the continued absence of outcome focused measures for trusts. Final decisions regarding scoring versus contextual use are still pending, and the distinction between ICB level and trust level metrics has not yet been confirmed. System testing and consultation on the 2026/27 proposals are expected to begin in the new year, alongside further development of technical specifications and scoring methodologies. This external work will likely include testing the draft metrics to understand the impact on trusts and ICBs before the final framework is agreed.
- Discussion about the proposed metrics are taking place within the Trusts Data Quality Working Group and will form part of the Trust DQIP where required. To provide early insight of new measures, where data is available, these will be added to enable monitoring and highlighting potential DQ issues which may impact performance. An additional element has been added to MH service management meeting to discuss and commence assessment of 26/27 measures.

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Draft Additional Metrics MH (as of 08/12/25)	Level (TBC)
Percentage of NHS talking therapies patients completing a course of treatment and achieving reliable recovery	ICB
CQC community mental health survey satisfaction rate	MH Trust
All adult inappropriate OAP bed days as a proportion of all bed days (PICU, adult and older adult acute, rehabilitation inpatient care, Acute Mental Health Unit for Adults with a Learning Disability and/or Autism and Adult Neuro-Psychiatry / Acquired Brain Injury)	ICB
The percentage of people on the General Practice (GP) SMI register receiving a full physical health check in the preceding 12 months	ICB
Mean length of stay for adult acute and PICU discharges	MH Trust
Mean length of stay for older adult acute discharges	MH Trust
Proportion of urgent referrals to Crisis Services with first face to face contact within 24 hours	MH Trust
Percentage of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages)	MH Trust
Proportion of total open CYP MH related waits that are over 104 weeks (help-based clock stop and referral spells methodology)	MH Trust
Proportion of adult acute discharges followed up within 72 hours	MH Trust
Adult acute admissions with no contact with mental health services in the prior year	ICB
Crude rate of MHLDA restrictive interventions per 1,000 occupied bed days (all ages)	MH Trust
TBC Proportion of discharges with rapid readmission (within 14 days) to adult acute beds	MH Trust

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Overview NOF Q3 2025/26 – Latest Publication

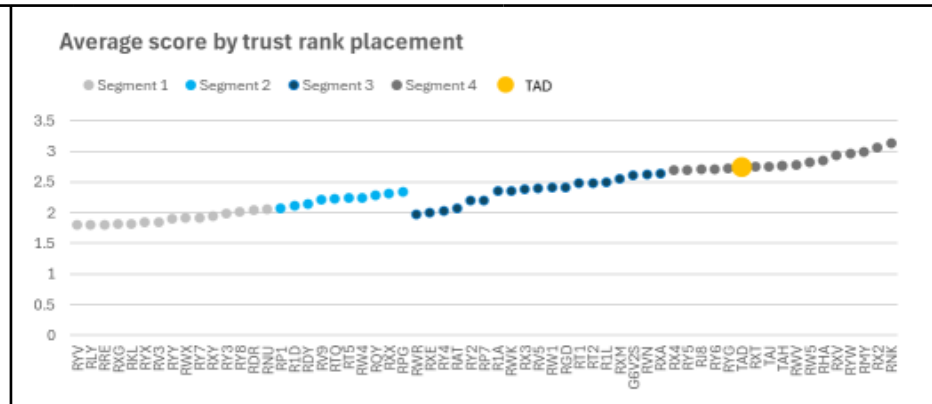
<p>Average score</p> <p style="text-align: center;">2.58</p> <p style="color: green;">Lower by 0.16 from previous quarter</p> <p>Trusts are scored on up to 30 measures of performance (metrics). Scores range from 1.00 (high performing) to 4.00 (low performing).</p>	<p>Trust in financial deficit?</p> <p style="text-align: center;">No</p> <p style="text-align: center;">No change from previous quarter</p> <p>If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.</p>	<p>Segment</p> <p style="text-align: center;">3 - Below average and/or financial deficit</p> <p style="text-align: center;">Previous quarter's segment: 4</p> <p>Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.</p>	<p>Trust rank</p> <p style="text-align: center;">43 out of 61</p> <p style="text-align: center;">Previous quarter's rank: 50 out of 61</p> <p>Trusts are ranked first on their segment and then their average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 61 (segment four trust with the highest average score).</p>
<p>Performance domains</p> <ul style="list-style-type: none"> Access to services 3 - Below average Finance and productivity 2 - Above average Effectiveness and experience 3 - Below average Patient safety 3 - Below average People and workforce 4 - Low performing 	<p>Average score by trust rank placement</p> <p>Segment ● 1 ● 2 ● 3 ● 4 Selected trust ●</p> <p>Average score</p> <p>Trust rank</p> <p>1 out of 61 (highest ranked) 10 20 30 40 50 60 61 out of 61 (lowest ranked)</p>		

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Overview NOF Q2 2025/26 – Published

Average Score	Trust in Financial Deficit?	Segment	Trust Rank
<p>2.74</p> <p>Lower by 0.10 from previous quarter</p> <p>Scores range from 1.00 (high performing) to 4.00 (low performing)</p>	<p>No</p> <p>No change from previous quarter</p> <p>If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.</p>	<p>4 – Low performing</p> <p>Previous quarter's segment: 4</p> <p>Each trust is assigned to a segment ranging from 1 to 4 based on average metric score and taking into consideration the financial deficit override.</p>	<p>50 out of 61</p> <p>Previous quarter's rank: 53/61</p> <p>Each trust receives a rank based first on their segment and then their average score within that segment. Ranks range from 1 (The segment one trust with the lowest average score) to 61 (the segment 4 trust with the highest average score)</p>

Focused performance areas	
Access to services	4 – Low performing
Finance and productivity	2 – Above average
Effectiveness and experience of care	4 – Low performing
Patient safety	4 – Low performing
People and workforce	4 – Low performing



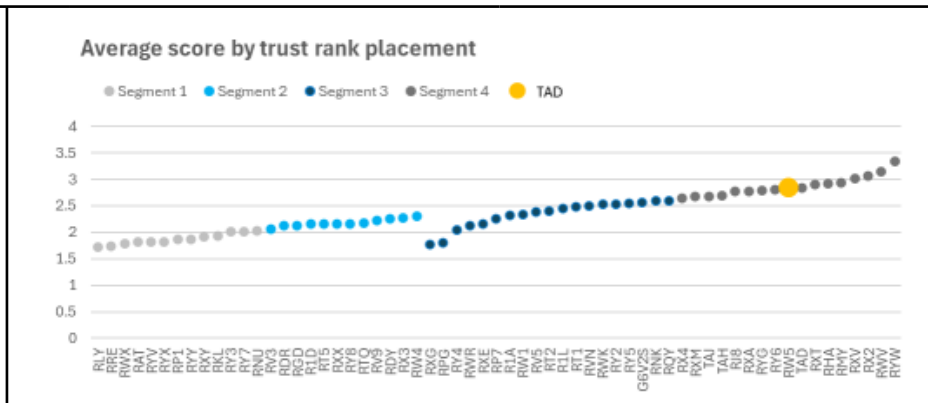
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Overview NOF Q1 2025/26 – Published

<p>Average Score</p> <div style="border: 1px solid black; padding: 10px; text-align: center; margin: 10px auto; width: 150px;">2.84</div> <p>Scores range from 1.00 (high performing) to 4.00 (low performing)</p>	<p>Trust in Financial Deficit?</p> <div style="border: 1px solid black; padding: 10px; text-align: center; margin: 10px auto; width: 150px;">No</div> <p>If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.</p>	<p>Segment</p> <div style="border: 1px solid black; padding: 10px; text-align: center; margin: 10px auto; width: 150px; background-color: #f8d7da;">4 – Low performing</div> <p>Each trust is assigned to a segment ranging from 1 to 4 based on average metric score and taking into consideration the financial deficit override.</p>	<p>Trust Rank</p> <div style="border: 1px solid black; padding: 10px; text-align: center; margin: 10px auto; width: 150px; background-color: #f8d7da;">53 out of 61</div> <p>Each trust receives a rank based first on their segment and then their average score within that segment. Ranks range from 1 (The segment one trust with the lowest average score) to 61 (the segment 4 trust with the highest average score)</p>
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Focused performance areas

Access to services	3 – Below average
Finance and productivity	3 – Below average
Effectiveness and experience of care	4 – Low performing
Patient safety	4 – Low performing
People and workforce	4 – Low performing



National Oversight Framework - Summary

Metric Description	2025/26							
	Q1		Q2		Q3		Q4	
	Raw measure	Score Derived	Raw measure	Score Derived	Raw measure	Score Derived	Raw measure	Score Derived
ACCESS TO SERVICES								
Percentage of patients waiting over 52 weeks for community services (end of quarter snapshot)	0.25%	2.15	1.12% ↑	2.66 ↑	0.07% ↓	2.15 ↓		
% change in no. of under 18s supported through NHS funded MH with at least 1 contact in a rolling 12m period	-0.43%	3.55	-2.96% ↓	3.43 ↓	-4.86% ↓	3.51 ↑		
DOMAIN SCORE		2.85 (3)		3.05 (4) ↑		2.83 (3) ↓		
EFFECTIVENESS AND EXPERIENCE								
National CQC community mental health survey overall experience rating	As expected	2.00	As expected	2.00 ↔	As expected	2.00 ↔		
Urgent Community Response % achieving 2hr standard	79.04%	2.62	77.12% ↓	2.71 ↑	79.54% ↑	2.59 ↓		
Percentage of adult discharges with a length of stay above 60 days (3m rolling)	33.33%	3.87	26.32% ↓	3.04 ↓	23.24% ↓	2.47 ↓		
DOMAIN SCORE		2.83 (4)		2.58 (4) ↓		2.35 (3) ↓		
PATIENT SAFETY								
NHS Staff Survey raising concerns sub-score (MHPRV)	6.83	2.35	6.83 ↔	2.35 ↔	6.83 ↔	2.35 ↔		
Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours (3m rolling)	28.08%	3.93	35.27% ↑	3.88 ↓	57.73% ↑	3.25 ↓		
DOMAIN SCORE		3.14 (4)		3.11 (4) ↓		2.80 (3) ↓		



National Oversight Framework - Summary

Metric Description	2025/26							
	Q1		Q2		Q3		Q4	
	Raw measure	Score Derived	Raw measure	Score Derived	Raw measure	Score Derived	Raw measure	Score Derived
PEOPLE AND WORKFORCE								
Sickness absence rate (3m rolling)	6.95%	3.85	6.30 ↓	3.78 ↓	6.84% ↑	3.78 ↔		
NHS Staff Survey engagement sub-score (MHPRV)	7.08	2.50	7.08 ↔	2.50 ↔	7.08 ↔	2.50 ↔		
DOMAIN SCORE		3.18 (4)		3.14 (4) ↓		3.14 (4) ↔		
FINANCE AND PRODUCTIVITY								
Planned surplus / deficit	0.0% (not published)	1.00	0.86% ↑	1.00 ↔	0.86% ↔	1.00 ↔		
Variance YTD to financial plan	0.0% (not published)	1.00	0.12 ↑	1.00 ↔	0.03 ↓	1.00 ↔		
Combined finance score		1.00		1.00 ↔		1.00 ↔		
Relative difference in costs	113.4	3.43	106.45 ↓	2.8 ↓	106.45 ↔	2.8 ↔		
DOMAIN SCORE		2.22 (3)		1.90 (2) ↓		1.90 (2) ↔		
Overall Average Score/Final Segmentation								
	2.84	4	2.74 ↓	4 ↔	2.58 ↓	3 ↓		

National Oversight Framework - Estimates

Metric Description	NOF Q3 Published			Q4 Estimates – Published data		
	Data Period	Raw measure	Score Derived	Raw measure	Benchmark	
ACCESS TO SERVICES						
Percentage of patients waiting over 52 weeks for community services (end of quarter snapshot)	Dec 2025	0.07%	2.15	0.00% Jan 26	England - 7.87% (Jan26) NE&Y – 8.25% (Jan26)	
% change in no. of under 18s supported through NHS funded MH with at least 1 contact in a rolling 12m period	01/25-12/25 v 01/24-12/24	-4.86%	3.51	-5.25% 02/25-01/26 v 02/24-01/25	England - +5.20% (Jan 26) NE&Y - +4.16% (Jan 26)	
DOMAIN SCORE			2.83 (3)			
EFFECTIVENESS AND EXPERIENCE						
National CQC community mental health survey overall experience rating	2024 Annual	As expected	2.00	Annual Refresh – TBC Q4 2025/26		
Urgent Community Response % achieving 2hr standard	Q3 2025	79.54%	2.59	77.4% Nov-Jan26 74.0% Jan26	England – 84.2% Nov-Jan NE&Y – 81.1% Nov-Jan	
Percentage of adult discharges with a length of stay above 60 days (3m rolling)	Q3 2025	23.24%	2.47	19% Nov-Jan 26	England – 24.16 (Nov-Jan)	
DOMAIN SCORE			2.35 (3)			
PATIENT SAFETY						
NHS Staff Survey raising concerns sub-score (MHPRV)	2024	6.83	2.35	Annual Refresh – TBC Q4 2025/26		
Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours (3m rolling)	Q3 2025	57.73%	3.25	68.4% Nov-Jan26 93% Jan26	England 65.22% (Nov-Jan) England 67.36% (Jan 26)	
DOMAIN SCORE			2.80 (3)			

National Oversight Framework - Estimates

Metric Description	NOF Q3 Published			Q4 Estimates – Published data		
	Data Period	Raw measure	Score Derived	Raw measure	Benchmark	
PEOPLE AND WORKFORCE						
Sickness absence rate (TBC 3m rolling/or previous complete published quarter)	Q2 2025/26	6.84%	3.78	7.11% Sep-Nov25 7.31% Nov 25	England – 5.61% (Nov 25) NE&Y – 6.17% (Nov 25)	 
NHS Staff Survey engagement sub-score (MHPRV)	2024	7.08	2.50	Annual Refresh – TBC Q4 2025/26		
DOMAIN SCORE			3.14 (4)			
FINANCE AND PRODUCTIVITY						
Planned surplus / deficit	Apr 25	0.86%	1.00			
Variance YTD to financial plan	Month 6 2025	0.12	1.00			
Combined finance score	Q1 2025/26		1.00			
Relative difference in costs	Mar 25	106.45	2.80	Annual Refresh		
DOMAIN SCORE			1.90 (2)			
Overall Average Score/Final Segmentation		2.58	3			

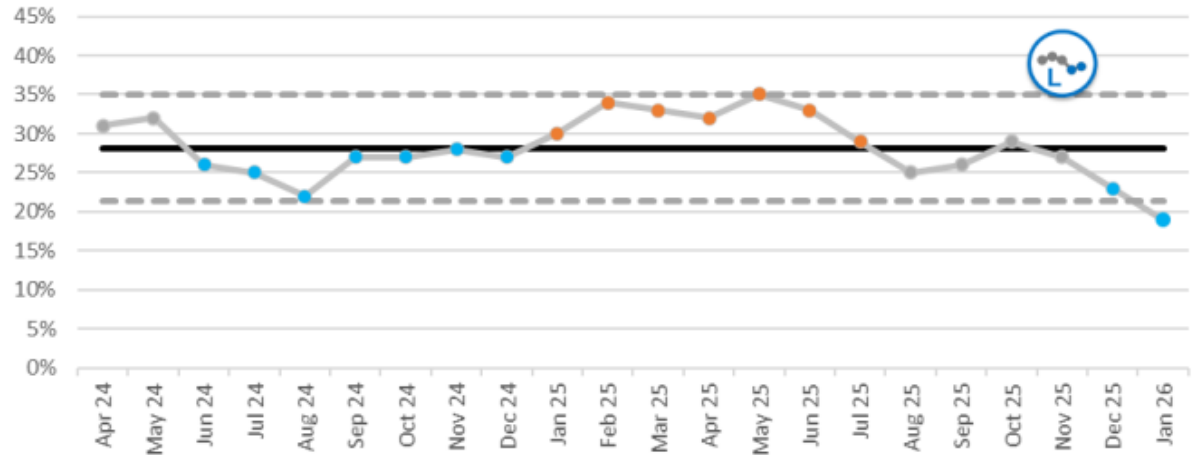
<p>Metric</p>	<p>BDCFT (published performance)</p>	
<p>Percentage of patients waiting over 52 weeks for community services – month-end snapshot</p>		
<p>Period / reporting period</p>		
<p>January 2026 (Published)</p>		
<p>Commentary</p>	<p>Benchmarking</p>	<p>NOF Q3 Ranking – 18/41</p> <p>Q3 2025/26 2.15 NOF Score Provider value 0</p> <p>Percentage of patients waiting over 52 weeks for community services score, National Distribution</p>
<p>NOF Publication showed an improvement from Q2 to Q3.</p> <p>Dec snapshot was used for NOF Q3 scoring. The only applicable community service with over 52 weeks waiters is SLT. The end of Dec snapshot submission showed a reduction to 2, which lowered the metric score from 2.66 to 2.15 (Q3).</p>		

<p>Metric</p>	<p>BDCFT (published performance)</p>	
<p>% change in number of under 18s supported through NHS funded mental health with at least one contact in a rolling 12-month period</p>	<p>Benchmarking</p> <p>NOF Q3 Ranking – 43/49</p> <p>Q3 2025/26 3.51 NOF Score Provider value </p>	
<p>Period / reporting period</p>	<p>January 2026 (Published)</p>	
<p>Commentary</p>	<p>NOF Publication showed a deterioration from Q2 to Q3. Jan. forecast indicates a potential further decrease for Q4.</p> <p>There are some indications that CYP access metric may be removed from 2026/27 NOF publications following feedback from providers regarding the metric methodology and issues relating to service delivery models impacting Trust performance</p>	

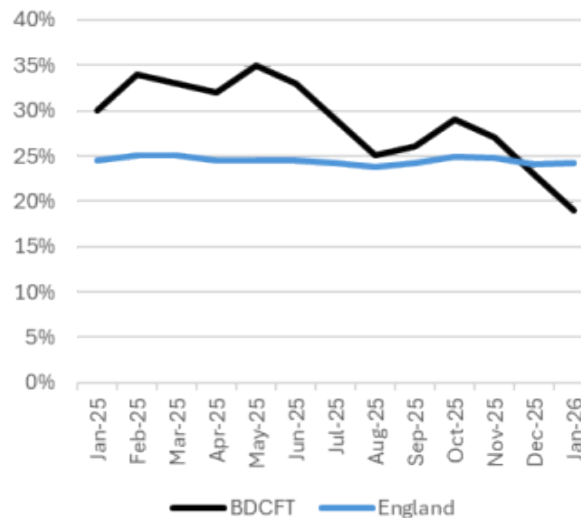
<p>Metric</p>	<p>BDCFT (derived from 3 month average)</p>	
<p>Urgent Community Response (UCR) Percent achieving 2hr standard</p>	<p>Benchmarking</p> <p>NOF Q3 Ranking – 30/38</p> <p>Q3 2025/26 2.59 NOF Score Provider value </p>	
<p>Period / reporting period</p>	<p>January 2026 (Provisional, Published)</p>	
<p>Commentary</p>	<p>NOF Publication showed an improvement from Q2 to Q3. Jan. forecast indicates no significant change for Q4.</p> <p>Note. Published data is insufficient to calculate a 3-month rolling percentage, an average of the previous 3 months has been used which is similar to the NOF published performance.</p>	

Metric
Percentage of adult discharges with a length of stay above 60 days (3m Rolling)
Period / reporting period
January 2026 (Published)
Commentary
<p>NOF Publication showed an improvement from Q2 to Q3.</p> <p>Jan. forecast indicates a further improvement for Q4.</p> <p>Note. Performance of this metric may fluctuate as efforts are made to discharge clients with long lengths of stay.</p>

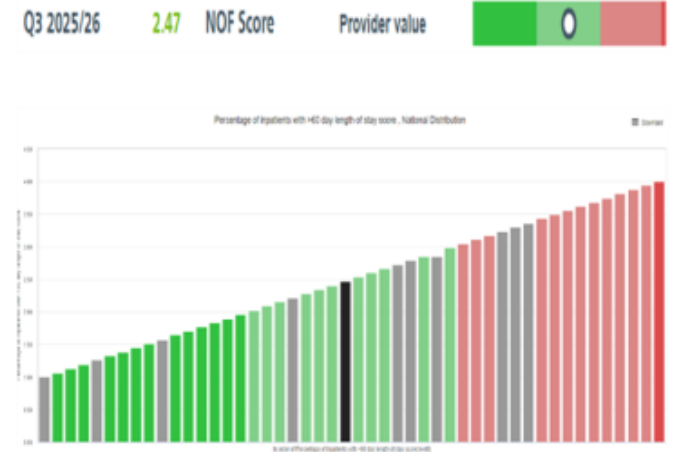
BDCFT (published 3 month rolling)



Benchmarking (3m rolling)



NOF Q3 Ranking – 24/47



<p>Metric</p>	<p>BDCFT (derived from published 3 month rolling average)</p>	
<p>Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours (3m Rolling)</p>	<div data-bbox="568 739 1188 1366"> <p>Benchmarking (Derived 3m rolling)</p> </div> <div data-bbox="1188 739 1864 1366"> <p>NOF Q3 Ranking – 36/48</p> <p>Q3 2025/26 3.25 NOF Score Provider value </p> <p>Percentage of patients in mental health crisis to receive face-to-face contact within 24 hours score, National Distributor</p> </div>	
<p>Period / reporting period</p>	<p>January 2026 (Published)</p>	
<p>Commentary</p> <p>NOF Publication showed an improvement from Q2 to Q3.</p> <p>Improvement in recording levels continues with Jan = 93%. Q4 overall is forecasted to be in the region of 85-90%, Q3 was 57.73%.</p> <p>Improvement actions underway include:</p> <ul style="list-style-type: none"> • Transfer FRS F2F activity to a MHSDS compliant S1 MH unit. • Address data recording issues relating to Clinical Response Priority Type within IHTT services (Adult & CAMHS). 		

<p>Metric</p>	<p>BDCFT (3 month rolling derived from published)</p>	
<p>Sickness absence rate (3m rolling)</p>	<p>November 2026 (Published)</p>	
<p>Period / reporting period</p>	<div style="display: flex; justify-content: space-between;"> <div data-bbox="568 796 1188 1398"> <p>Benchmarking</p> </div> <div data-bbox="1188 796 1856 1398"> <p>NOF Q3 Ranking – 52/61</p> <p>Q3 2025/26 3.78 NOF Score Provider value</p> </div> </div>	
<p>Commentary</p>	<p>NOF Publication showed no change in score between Q2 to Q3, however sickness rate has deteriorated from 6.30% to 6.84%</p> <p>National sickness publication timetable has been brought forward in January which may impact the data periods used for future NOF publications.</p> <p>Data periods used for NOF Publications:</p> <ul style="list-style-type: none"> • Q1 = Jan-Mar 25 • Q2 = Apr-Jun 25 • Q3 = July-Sep 25 • Q4 = TBC Oct-Dec 25 	

National Oversight Framework – Contextual Measures (non-scoring)

Additional contextual measures – non scoring Metric Description	NOF Q1 Published		NOF Q2 Published		NOF Q3 Published		NOF Q4 Published	
	Provider value	National value	Provider value	National value	Provider value	National value	Provider value	National value
Contextual measures - Access to Services								
Percentage increase in Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses			7.31% (Jun 25)	5.72% (not updated)	14.19% (Sep 25)	4.26%		
Proportion of patients with an open suspected autism referral in the month that has been open for at least 13 weeks that have not had a care contact appointment recorded			57.63% (Mar 24)	77.39%	80.00% (Sep 25)	98.00%		
Contextual measures - Effectiveness and Experience								
None								
Contextual measures - Patient Safety								
Rate of restrictive interventions use			21.00 (Jun 25)	22.00	22.00 (Sep 25)	21.00		
Contextual Measures – People and workforce								
National Education and Training Survey “Overall experience” survey score			81.87% (2024)	77.03%	81.87% (2024)	77.03%		
Contextual measures – Finance and productivity								
None								
Contextual Measures – Improving Health & reducing inequality (non scoring) (New in Q2)								
NHS Talking Therapies reliable recovery rate			49.00% (Jun 25)	47.00%	50.00% (Sep 25)	48.00%		
Percentage of inpatients aged 65 years and over with a length of stay at discharge exceeding 90 days			32.00% (Jun 25)	41.86%	35.48% (Sep 25)	40.88%		

<p>Metric</p>	<p>BDCFT Performance (published monthly)</p>	
<p>Percentage of NHS talking therapies patients completing a course of treatment and achieving reliable recovery</p>	<p>Benchmarking (3 month rolling average)</p>	
<p>Period / reporting period</p>	<p>This metric is included in the draft of metrics for 2026/27, ranking information is not available yet.</p>	
<p>January 26 (published)</p>		
<p>Commentary</p>	<p>This metric is included in the draft of metrics for 2026/27, ranking information is not available yet.</p>	
<p>The Medium-Term Planning document indicates that the target will increase from 50% to 51% in 2026/27 with a further 1% year on year increase for 2027/28 and 2028/29.</p>		

<p>Metric</p>	<p>BDCFT (published 3 month rolling average)</p>	
<p>Mean length of stay for adult acute and PICU discharges (3m rolling)</p>	<p>Benchmarking (published 3m rolling average)</p>	
<p>Period / reporting period</p>	<p>This metric is included in the draft of metrics for 2026/27, ranking information is not available yet.</p>	
<p>January 26 (published)</p>		
<p>Commentary</p>	<p>This metric is included in the draft of metrics for 2026/27, ranking information is not available yet.</p>	
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<p>Metric</p>	<p>BDCFT (published rolling 3 month average)</p>	
<p>Mean length of stay for older adult acute discharges (3m rolling)</p>	<p>Benchmarking (published 3m rolling average)</p>	
<p>Period / reporting period</p>	<p>This metric is included in the draft of metrics for 2026/27, ranking information is not available yet</p>	
<p>January 26 (published)</p>		
<p>Commentary</p>		
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<p>Metric</p>	<p>BDCFT (published monthly)</p>	
<p>Proportion of discharges from adult acute beds followed up within 72 hours in the reporting period</p>	<p>120% 100% 80% 60% 40% 20% 0%</p>	
<p>Period / reporting period</p>	<p>Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25 Feb 25 Mar 25 Apr 25 May 25 Jun 25 Jul 25 Aug 25 Sep 25 Oct 25 Nov 25 Dec 25 Jan 26</p>	
<p>January 26 (published)</p>	<p>0%</p>	
<p>Commentary</p>	<p>Benchmarking</p>	<p>This metric is included in the draft of metrics for 2026/27, ranking information is not available yet</p>
<p>Close Holly 27/03/2026 15:42:07</p>	<p>100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%</p> <p>Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26</p> <p>— BDCFT — England</p>	

<p>Metric</p>	<p>BDCFT (published 3 month rolling average)</p>	
<p>Adult acute admissions with no contact with mental health services in the prior year.</p>		
<p>Period / reporting period</p>		
<p>January 26 (published)</p>		
<p>Commentary</p>	<p>Benchmarking (published 3m rolling average)</p>	<p>This metric is included in the draft of metrics for 2026/27, ranking information is not available yet</p>
<p>Metric is based on 3m rolling admissions for clients with no contact in the previous 12 months.</p> <p>This metric may be impacted by appointments being recorded in the Out of Hours unit, similar to the issues experienced in the Crisis 24 hours measure.</p>		

CTW Quality Management System Update

Executive Summary

This paper provides an update on the development and implementation of the Trust's Quality Management System as part of the Care Trust Way improvement programme. It reflects learning from recent Board development and learning sessions and sets out how the QMS is being positioned as the Trust's core operating model for quality governance, improvement and assurance.

The Quality Management System is designed to bring together how the Trust plans for quality, manages day-to-day performance, improves services and assures itself that standards are being met. While these activities already take place across the organisation, they have not always been connected in a single, coherent system. The QMS addresses this by strengthening alignment between strategy, operational delivery, improvement activity and Board assurance, creating clearer line of sight from Board to frontline.

Board engagement has been central to shaping the QMS. Through dedicated sessions the most recent of which was held in March 2026, Board members reflected on their assurance needs, organisational culture and past experiences of risk and escalation. These discussions highlighted the importance of psychological safety, earlier visibility of emerging risks, and greater confidence that reported information reflects frontline reality. The proposed QMS framework has been designed in direct response to these insights.

The QMS is structured around four interconnected components: **quality planning**, **quality control**, **quality improvement** and **quality assurance**. Together, these describe how priorities are set, how services are monitored and managed in real time, how improvement is delivered and sustained, and how the Board gains evidence-based assurance. The Board recognised these as familiar concepts, but welcomed the clarity and discipline provided by bringing them together within a single system.

The next phase of work focuses on embedding the QMS into routine governance and management arrangements. This includes consolidating Board expectations, implementing an integrated quality dashboard, aligning committee reporting to the QMS framework, and establishing a regular governance cadence to maintain oversight. Priority improvement programmes will be aligned to the QMS, and training and communication will be updated to support consistent understanding and application across the organisation.

The Board is asked to note progress in developing the Quality Management System and the proposed next steps for implementation. Continued Board engagement will be critical to ensuring that the QMS becomes embedded as the standard way the Trust manages quality, supports continuous improvement and provides reliable assurance, ultimately contributing to better outcomes for patients, staff and communities.

Background and Strategic Context

The Quality Management System is the Trust's approach to ensuring high-quality care and robust governance through a single, integrated management system. It brings together how the organisation plans for quality, controls day-to-day performance, improves services and assures itself that standards are being met. Developed under the Care Trust Way methodology, the QMS aligns with national improvement expectations, including NHS Impact, and reflects established principles used in high-performing healthcare organisations.

At its core, the QMS provides a coherent management framework that connects strategy, performance management, risk and control systems, quality improvement activity and assurance processes. Rather than these elements operating in isolation, the QMS creates a shared line of sight from Board to frontline, supporting a single, reliable view of organisational performance. This integration is intended to strengthen decision-making, reduce duplication and ensure that data, operational reality and outcomes are consistently aligned with the Trust's strategic priorities.

The development of the QMS takes place against a backdrop of increasing external expectations and internal complexity. Regulators and system partners are placing greater emphasis on continuous quality improvement, effective oversight and provider capability. At the same time, the Trust faces ongoing pressures relating to demand, workforce, quality and financial sustainability. The QMS is designed to provide a structured and proactive way of responding to these challenges by supporting earlier identification of risk, clearer prioritisation of improvement activity and stronger assurance at Board level.

Board and Leadership Engagement

The Board and senior leadership have been actively involved in shaping the refreshed Quality Management System through a series of dedicated development and learning sessions. On 5 March 2026, the Board participated in a private development workshop followed by a public learning session, both facilitated by the Organisational Development team. These sessions were designed to re-engage the Board with the QMS from a strategic perspective, beginning with a clear focus on Board assurance needs and organisational culture.

The development session created space for reflective discussion about the Board's experience of quality governance, including consideration of key risks, areas of concern and occasions where issues had emerged unexpectedly. This ensured that the QMS is being designed around the Board's real information needs, rather than as a theoretical framework. Board members emphasised the importance of having confidence that reported information accurately reflects frontline reality and supports timely, informed decision-making.

The learning session built on this discussion by exploring how the proposed QMS framework responds to the issues raised. It considered the wider regulatory and system context and tested the QMS design against practical scenarios to assess whether it would provide effective early warning and assurance. Collectively, these sessions reinforced Board ownership of the QMS and established clear expectations for how it should support oversight, risk management and continuous improvement.

Key Themes Shaping the Quality Management System

Several consistent themes emerged from the Board discussions and are now directly influencing the design and implementation of the Quality Management System.

A strong emphasis was placed on **psychological safety** and **organisational culture**. Board members were clear that an effective QMS depends on an open and supportive environment in which staff feel able to raise concerns, admit problems and learn from mistakes. This was seen as essential to identifying issues early and preventing escalation, rather than relying on retrospective assurance.

There was also sustained focus on the need to **balance quality with financial and operational sustainability**. The Board recognised the increasing pressure to deliver efficiency and financial balance but was explicit that this must not compromise patient safety or experience. The QMS is therefore expected to support more informed decision-making by highlighting where financial pressures may introduce quality risks and where improvement opportunities can enhance both quality and efficiency.

Another key theme was the elimination of blind spots and the aspiration for a genuine no-surprises culture. Board members reflected on instances where performance reports had appeared positive shortly before serious issues emerged. This reinforced the importance of triangulating quantitative data with qualitative intelligence, including staff and patient feedback and direct Board engagement through Go See visits. The QMS is intended to provide earlier warning of emerging risks and a more accurate, real-time picture of frontline conditions.

The Board also discussed the distinction between organisational and system-wide risks. While acknowledging that some challenges arise from factors beyond the Trust's direct control, there was clear expectation that the QMS should help clarify

these dependencies, ensure appropriate escalation and support the Trust in mitigating impact on patients wherever possible.

Finally, Board members highlighted the importance of improving line of sight across a large and geographically dispersed organisation. Strengthening the connection between Board-level data, Go See visits and routine governance processes was identified as a priority and will be addressed as part of QMS implementation.

Quality Management System Framework

At the Board learning session on 5 March 2026, the proposed Quality Management System framework was reviewed in detail. The framework brings together four interconnected components that collectively describe how the Trust plans for quality, manages performance, improves services and assures itself that standards are being met. While these elements already exist in practice across the organisation, the purpose of the QMS is to connect them into a single, coherent system rather than allowing them to operate independently.

The Board recognised these components as familiar concepts, but welcomed the clarity provided by linking them explicitly within one management system. This approach reflects established practice in high-performing healthcare organisations and provides a common language for quality governance from Board to frontline.

The first component, **quality planning**, focuses on setting clear objectives, priorities and standards based on the needs of the population and the Trust's strategic ambitions. This begins with the Board establishing the overall direction for quality, including what the organisation is seeking to achieve, for whom, and by when. Quality planning ensures that supporting plans, such as workforce, finance and digital strategies, are aligned to these priorities so that there is a clear line of sight from Board-level intent to operational delivery. The Board emphasised the importance of this alignment in achieving meaningful and sustainable improvement.

The second component, **quality control**, relates to the day-to-day management of services and the mechanisms that ensure care is delivered safely and consistently. This includes routine performance monitoring, operational dashboards, team huddles and defined escalation processes. The Board described this as the organisation's internal assurance heartbeat, providing real-time visibility of how services are functioning. A key expectation is that issues identified through daily management are escalated promptly when required, rather than being allowed to persist or only surface through retrospective reporting.

The third component, **quality improvement**, provides the structured approach for continuously improving outcomes and processes. The Board discussed the importance of distinguishing between strategic improvement priorities, which are set at organisational level, and local improvement activity led by teams in response to

issues they experience in practice. Under the QMS, the Trust will maintain a clear portfolio of priority improvement programmes aligned to strategic objectives, while also supporting frontline teams to use established improvement methods, such as Plan-Do-Study-Act cycles, to test and implement changes locally. This ensures that improvement activity is purposeful, coordinated and focused on delivering tangible benefits.

The fourth component, **quality assurance**, brings together the mechanisms that provide confidence to the Board and external stakeholders that quality standards are being achieved. This includes internal governance processes, audits, quality reports and external assessments. The Board highlighted the distinction between reassurance and true assurance, noting that assurance must be grounded in evidence rather than relying solely on positive reports. The QMS aims to strengthen assurance by ensuring that information from planning, control and improvement activities is integrated and reviewed systematically, providing a credible and timely picture of organisational performance.

Across the discussion, Board members noted that none of these components are new in isolation. The value of the Quality Management System lies in connecting them so that each informs and reinforces the others. Quality planning sets direction, quality control monitors delivery, quality improvement addresses gaps, and quality assurance confirms whether intended outcomes are being achieved. Over time, this integrated approach is expected to embed quality and safety into everyday management practice, supporting the Trust's ambition to operate as a learning organisation.

Next Steps and Recommendations

Drawing on the Board's feedback from the recent development and learning sessions, the following next steps are proposed to finalise and embed the Quality Management System across the Trust. These actions are intended to move the QMS from design into routine operation, ensuring it becomes the standard way in which quality is planned, managed, improved and assured.

The first priority is to consolidate and formalise the learning and commitments arising from the Board sessions. This will involve documenting the key expectations articulated by Board members, including the cultural principles they wish to see reinforced, the types of risks they want earlier visibility of, and the questions they expect the QMS to help them ask more effectively. Making these expectations explicit will provide clear direction for implementation and support continued Board ownership of the system.

The Trust will then proceed to implement the integrated QMS framework as the core operating model for quality governance. This will involve embedding the four components of the QMS into existing governance and management arrangements

rather than creating parallel structures. A revised, integrated quality dashboard will be developed to bring together key indicators relating to quality, safety, performance and experience, with the ability to drill down from Board level to services and teams. Committee reporting will be aligned to the QMS domains so that planning, control, improvement and assurance are consistently addressed through routine governance processes.

Clear executive leadership arrangements will underpin delivery of the QMS. Responsibility for coordinating implementation will sit with the Director of Transformation, supported by the Head of Improvement and Innovation, working alongside relevant executive and operational leads for each component of the system. This will ensure that the QMS is owned collectively across the organisation rather than being seen as a standalone improvement initiative.

A regular governance cadence will be established to maintain oversight and momentum. **The Care Trust Way Guiding Team will provide monthly executive-level review of QMS progress, focusing on emerging risks, delivery issues and learning.** Standing updates will be provided to the Quality and Safety Committee and other relevant Board committees, ensuring Non-Executive Directors have early sight of issues and reducing the risk of late escalation. In addition, a brief update on QMS progress will be included in the Chief Executive's report to the Public Board while the system is being embedded.

Commented [CH1]: We do need to review this, as per previous discussions

The Trust will also strengthen peer learning and external engagement to accelerate QMS maturity. This will include continued participation in national improvement and NHS Impact networks, as well as targeted learning from organisations with established quality management systems. Opportunities for site visits, knowledge exchange and mentoring will be pursued to inform local implementation and avoid reinventing proven approaches.

Embedding the QMS will require sustained communication and capability building across the organisation. Training materials will be updated so that the QMS is clearly understood as the Trust's operating model for management and improvement, rather than an additional framework. Simple communication resources will be developed to help staff understand how their day-to-day work contributes to the QMS and how issues or improvement ideas can be escalated. Expectations for managers to routinely reference the QMS in team meetings and reviews will be reinforced to support consistent language and practice across services.

Finally, existing priority improvement programmes will be formally aligned to the QMS governance structure. Work already underway, such as community mental health team redesign and inpatient flow improvement, will continue, but with progress and impact monitored through the QMS dashboard and review processes. This will ensure that improvement activity contributes to overall system learning and assurance, and that successful approaches are identified, sustained and shared more widely.

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Through these actions, the Quality Management System is expected to become fully embedded over the coming months. The overarching aim is to ensure that quality governance and continuous improvement are integrated into everyday management practice, providing stronger assurance for the Board and better outcomes for patients, staff and communities.

Conclusion

This paper has outlined progress in developing and implementing the Trust's Quality Management System, informed by recent Board development and learning sessions. The engagement undertaken has provided clear insight into the Board's assurance needs and has helped shape a QMS that is grounded in organisational reality rather than theoretical design.

The proposed Quality Management System brings together planning, day-to-day control, continuous improvement and assurance into a single, integrated approach. By connecting these elements, the QMS is intended to strengthen line of sight from Board to frontline, support earlier identification of risk and reduce the likelihood of unexpected issues emerging without warning. Importantly, it provides a framework through which quality, safety, operational performance and financial sustainability can be considered together rather than in isolation.

The next phase of work will focus on embedding the QMS into routine governance and management processes so that it becomes the standard way the Trust operates. This includes aligning reporting, strengthening daily management and improvement capability, and reinforcing a culture that supports openness, learning and accountability at all levels of the organisation.

The Board is asked to note the progress described in this paper and the proposed next steps. Continued Board engagement and leadership will be critical to maintaining momentum and ensuring that the Quality Management System delivers meaningful improvement in outcomes for patients, staff and communities, alongside stronger and more reliable assurance.

Effective Oversight: Escalation and Assurance

Report to:	Board of Directors	Meeting date:	
Report from:	Audit Committee	Meeting date:	29 January 2026
Quorate?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Members present	Chris Malish, Sally Napper, Warren Brown		
In attendance	Fran Stead, Claire Risdon, Helen Higgs, Leanne Sobratee, Salma Younis, Farhan Rafiq, Kelly Barker, Mike Woodhead, Paula Otley		
Observers			
Apologies	Apologies were noted from Stacey Pearson		
Good Governance	Governance, accountability, and effective oversight		GG
Agenda items	<ul style="list-style-type: none"> • Strategic Narrative Report & Well Led Development Plan • Compliance and Risk AAAD Report • Review of Losses & Special Payments • Waiver of Standing Orders & Standing Financial Instructions • Proposed Write Off of Outstanding Debt • Review of Standing Financial Instructions & Scheme of Delegation • 2025/26 Year-end Accounts Timetable • Annual Report & Annual Governance Statement- project plan • External Audit Risks – 2025/26 • Internal Audit: Progress report • Review of Taxi Travel • Out of Area Placements • Cost Improvement Plan • Internal Audit: Follow up reports • Fit and Proper Person Policy and Procedure • Alert, Advise, Assure and Decision Report to Board of Directors 		
Alert items agreed by Committee	<ul style="list-style-type: none"> • No alerts raised during the meeting. C Malish confirmed there were no significant risks, issues, or urgent concerns requiring immediate escalation. 		
Advise items agreed by Committee	<p>Accounts and Annual Report Timetables</p> <p>Key deadlines were confirmed:</p> <ul style="list-style-type: none"> • Unaudited accounts: 27 April 2026 • Audited accounts: 26 June 2026 • Mid-May briefing for Audit Committee members to be arranged <p>Internal Audit Plan Development</p> <ul style="list-style-type: none"> • Draft plan for 2026/27 progressing through SMT • Additional audits to include: 		

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	<ul style="list-style-type: none"> ○ Fit & Proper Persons ○ Policy Management <p>Work Plan Updates</p> <p>The Chair advised that updates are required to:</p> <ul style="list-style-type: none"> ● Reflect the new external audit manager (Francesca Shaw) ● Embed recurring private meetings with internal and external auditors <p>Reinforcement of Evidence-Based Closure of Audit Actions</p> <p>The Committee requested that directorates be reminded that evidence must be provided when closing recommendations, following issues identified in the Right to Work audit.</p>
<p>Assure items agreed by Committee</p>	<p>Strategic Risk and Well-Led Framework Progress</p> <p>The Committee received assurance from Fran Stead that significant work has progressed on:</p> <ul style="list-style-type: none"> ● Updated strategic risk reporting templates ● Development of the Well-Led improvement plan ● Strengthened governance reporting across committees <p>Robust Financial Reporting Processes</p> <p>The Committee was satisfied that:</p> <ul style="list-style-type: none"> ● Month 9 accounts were submitted on time ● Year-end processes are established and well-resourced ● Losses and special payments are being appropriately scrutinised ● No material control failures were identified in the financial reporting cycle <p>External Audit</p> <p>Stable Risk Profile KPMG reported:</p> <ul style="list-style-type: none"> ● No significant changes to the Trust's risk profile ● Full asset valuation processes are appropriately supported by specialist advisors ● Materiality thresholds are appropriate ● No new significant audit concerns <p>Internal Audit Progress on the Annual Plan</p> <p>The Committee noted positive progress with 76% of the annual plan delivered, with clarity on:</p> <ul style="list-style-type: none"> ● Three reports completed ● Assurance ratings ● Follow-up positions ● Progress on planning for 2026/27

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	Fit and Proper Persons Policy Ratified		
	The Committee approved the updated Fit and Proper Persons Policy, noting alignment with new NHS England requirements and strengthened internal processes.		
Decisions made by Committee	<ul style="list-style-type: none"> • Approval minutes and AAAD • Approval of Fit and Proper Person Policy. 		
New risks identified by Committee	<ul style="list-style-type: none"> • No New risks identified 		
Feedback following discussion at 'parent' meeting			
Report completed by	Nazmeen Khan – Corporate Governance Officer	Date	29.01.2026
On Behalf of Chair	Chris Malish, Non-Executive Director		

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Board of Directors held in public

2 April 2026

Paper title:	Well Led Development Plan – January 2026	Agenda Item 21.0
Presented by:	Fran Stead, Trust Secretary	
Prepared by:	Fran Stead, Trust Secretary and Corporate Governance team	
Committees where content has been discussed previously	Board Committees; Board of Directors during 2025	
Purpose of the paper Please check ONE box only:	<input type="checkbox"/> For approval <input type="checkbox"/> For information <input checked="" type="checkbox"/> For discussion	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	
	Belonging to our organisation	
	New ways of working and delivering care	
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	
	Improving the experience of people who use our services	
Making Best Use of Resources	Financial sustainability	
	Our environment and workplace	
	Giving back to our communities	
Being the Best Partner	Partnership	
Good governance	Governance, accountability & oversight	X

Purpose of the report

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The purpose of this report is to provide an update at March 2026 on the actions within the Well Led Development Plan.

Executive Summary

As an improvement organisation it is important to undertake regular effectiveness reviews to encourage reflection & inform development work. As an NHS organisation, the Trust is required to ensure good standards of governance, in line with the Provider Licence & Constitution. Plus, to undertake an external ‘well led’ review every 3-5 years, as outlined with the NHS Code of Governance.

This new assurance report is the culmination of 3 processes that the Trust ran 2025 to assess the Trust’s governance, including independent review. The agreed recommendations from the processes, have become actions within the new ‘Well Led Development Plan’. This report will be presented to each Committee that is an assurance receiver on the work; the Audit Committee as an entire report, to assess compliance within the framework; & the Board held in public to provide public accountability.

The report will be a standing item at the above-mentioned meetings. Discussion will be scheduled for Board during 2026/27 to consider the effectiveness of the process to ensure ongoing improvement takes place.

This is the second iteration of the report, which includes updates made following feedback received during the January & February reporting cycle. As an iterative process, further feedback will be gathered to refine the reporting process throughout 2026 & will be tracked within this report. The whole process will be reviewed as part of the annual effectiveness plans.

<p>Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?</p>	<p><input type="checkbox"/> Yes (please set out in your paper what action has been taken to address this)</p> <p><input checked="" type="checkbox"/> No</p>
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Recommendation(s)

- The Board is asked to:
- be assured on the process being delivered as a new process agreed by the Board
 - note & discuss the updates provided
 - agree any actions associated with the work and the above actions
 - note that the full report will be presented to the Audit Committee; & Board held in public, as outlined above.

<p>Links to the Strategic Organisational Risk register (SORR)</p>	<p>The work contained with this report links to the following corporate risks as identified in the SORR:</p> <p>Not applicable</p>
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Board of Directors held in public

Well Led Development Plan – 2 April 2026

1 Purpose

The purpose of this report is to provide an update at April 2026 on the delivery of the new Well Led Development Plan which has also been presented to the Board Committees during March.

2 Better Lives Together (BLT)

The Trust strategy describes our role to connect people to the best quality care, where & when they need it, & be a national role model as an employer.

We will do this by supporting people to feel as healthy as they can be at every point in their lives & connecting people to the best quality care when & where they need it to make every contact count.

Everything the Trust does during this period will be focused upon making better lives, together.

During the refresh of the Trust's strategy 2022/23, a commitment was made to ensure 'governance, effective oversight & accountability' underpins the 4 strategic objectives as a golden thread & enabler. This was further supported 2024 through a Board Development Session, where the Board agreed the Trust's Well Led ambition to support this work, it is:

We have an inclusive & positive culture of continuous learning & improvement. This is based on meeting the needs of people who use our services, wider communities & ensuring health equity.



Better lives, together



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All our leaders & colleagues share this. Leaders proactively support colleagues to collaborate with partners to delivery care that is safe, collaborative, person-centred & sustainable.

3 Assessing governance and compliance requirements

As an improvement organisation we welcome the opportunity to review the effectiveness of our work & utilise national guidance to supplement our wider reflection & compliance requirements. This supports our commitment as an NHS provider to ensure safe, high-quality, compassionate care is provided to patients & communities.

In support of tracking progress against our Well Led framework & 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 & be a new tool for our Trust to assess & enable the supporting principle for the strategy of, 'good governance, effective oversight, accountability'.

The Plan is the culmination of 3 effectiveness review processes, they are:

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

The processes form part of the compliance requirements with the NHS Code of Governance; Provider Licence; Constitution; NHS England Leadership Competency Framework; NHSE Provider Capability Assessment & National Oversight Framework; NHSE Insightful Board. Work has taken place to review the Plan & the Provider Capability Assessment, which has confirmed alignment of improvement activity.

The categories within the Plan are the CQC well led quality statements (shared direction & culture; capable, compassionate & inclusive leaders; freedom to speak up; workforce equality, diversity & inclusion; governance, management & sustainability; partnerships & communities; learning, improvement & innovation; environmental sustainability). For consistency purposes, as assurance reporting progresses, this will include alignment to the 'assurance' statements that Internal Audit use.

The Audit Committee will be accountable for monitoring:

- individual actions assigned to the Audit Committee within the development plan
- the whole Well Led Development Plan, compliance against delivery, as the Trust's governance system.

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4 Process improvements

As an improvement organisation & with this being a new process it will be iterative throughout 2026. This is to learn, facilitate co-production, & ensure the process is effective. Following which, it will be reviewed as part of the annual effectiveness plans.

This is the second iteration of the report, which includes updates made following feedback received during the January & February reporting cycle. As an iterative process, further feedback will be gathered to refine the reporting process throughout 2026. Key changes made include:

- Planned discussion to take place with the new Chair & Trust Secretary on the Well Led Plan, current process & future improvements.
- All actions that were for multiple 'committees' will now be reported on to Audit Committee as the Committee responsible for 'good governance, effective oversight & accountability'.
- Move to a digital system to make data gathering & reporting more efficient.
- Monitoring document to include new fields for 'embedded due date' & 'embedded evidence'.
- Creation of a process for actions leads to submit evidence, when the action is completed & when the action is considered embedded.

Planned improvements:

- Action leads to submit evidence for completed actions & confirm embedding plans.
- Creation of a process for action leads to schedule any discussion & presenting of evidence to corporate governance meetings.
- Creation of performance metrics to allow for progress tracking to take place.
- Inclusion of any new agreed actions following the 2025/26 effectiveness review recommendations being gathered.

5 March progress update

Appended to this report is the full action plan. All actions have an oversight meeting, which receives the actions they are responsible for. The January Audit Committee meeting received the whole Plan.

6 Next steps

The Committee is asked to

- be assured on the process being delivered as a new process agreed by the Board

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- note & discuss the updates provided
- agree any actions associated with the work and the above actions
- note that the full report will be presented to the Audit Committee; & Board held in public, as outlined above.

Fran Stead
Trust Secretary
March 2026

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Good governance, accountability and effective oversight

Quality Statement 1: Shared Direction & Culture

We have a shared vision, strategy & culture. This is based on transparency, equity, equality & human rights, diversity & inclusion, engagement, & understanding challenges & the needs of people & our communities in order to meet these.

Covering: Strategy & vision – organisational culture – values – addressing social impact these.

Reference	Action	Due	Delivery lead	Board/EMT lead	Oversight group	Progress	Evidence	Embedding date & evidence
QS1.1	The Trust should consider ways in which it can reinforce its strategy & objectives through day-to-day operations including greater linkage with operational plans, team meetings, supervision etc.	31/07/2026	Fran Stead	Sarah Jones & Therese Patten	Board of Directors	This work will be considered as part of the strategy development process, due for completion next Summer. Part of this will be the introduction of a Quality Management System, which will support with strategy deployment, integration & alignment of the strategy with the Care Trust Way, as our accountability & performance framework. There will be further discussion with the Board on the strategy deployment phase, & creation of the Quality Management System		
QS1.2	The Trust should review its approach to receiving feedback in terms of its feedback loops i.e., 'You said, We did'.	31/12/2025	Fiona Bray	Bob Champion & Mark Rawcliffe	People & Culture Committee	This is embedded in Trust-wide activity where data is available eg. staff survey, efficiencies (via open Q&A/ FAQ), development of Trust strategy.		
QS1.3	The Trust should consider expanding its current range of measurements to oversee the delivery of its strategy within the context of the Board's Integrated Performance & Assurance Report. To include consideration of corporate performance.	30/04/2026	Clifton Springthorpe	Farhan Rafiq	Board of Directors	Executive workshop due to take place October 2025, aligned to Insightful Board guidance. Dec 25 Update - A rearranged executive workshop took place on 17th November. This reviewed the current ISPR, looked at strengths and gaps, and discussion took place around what need to be included going forwards to make it fit for purpose while being flexible to ensure current challenges are highlights. Feb 26 Update - The aim remains to have a revised version in place for April 2026 and a Board Development session is planned for 30th April where a new Integrated Performance Report will be shared for further development and use, ensuring it meets the Board's requirements.		
QS1.4	The Trust should ensure that it has an up-to-date suite of connected enabling strategies that together support delivery of the overarching Trust strategy.	31/07/2026	SLT lead's	Fran Stead	Board of Directors	This work will be considered as part of the strategy development process, due for completion next Summer.		
QS5.6	Consideration to be given to values & culture performance, staff engagement & feedback loops for this.	31/12/2025	Michelle Holland & Fiona Bray	Bob Champion & Mark Rawcliffe	People & Culture Committee	This is already captured in the work undertaken on Staff Survey each year which is fed back into Trust and also Directorate teams.		

Good governance, accountability and effective oversight

Quality Statement 2: Capable, compassionate & inclusive leaders

We have inclusive leaders at all levels who understand the context in which we deliver care, treatment & support & embody the culture & values of their workforce & organisation. They have the skills, knowledge, experience & credibility to lead effectively. They do so with integrity, openness & honesty.

Covering: Leadership competency, support & development – safe recruitment of leaders / FPPR – compassionate & capable leaders – roles & accountability – succession planning / talent management

Reference	Action	Due	Delivery lead	Board/EMT lead	Oversight group	Progress	Evidence	Embedding date & evidence
QS2.1	The Trust should consider its overall NED capacity alongside the requirements of the Trusts forward agenda & the need for postholders to fulfil in-role responsibilities.	31/03/2026	Rachel Trawally	Sarah Jones	Board Nomination & Remuneration Committee	Following the recent appointment of two new NEDs have been appointed. One started on 19 Jan and the other is due to start on 1 April 2026. One of the NEDs standing in as Chair during the transition to the new Chair in Common role. Worked has started to review the skills matrix and chairs on committees to ensure this aligns with the balance of the updated NED membership.	Updated Board Skills Matrix document. Succession planning report to next Board Nominations and Remuneration Committee	
QS2.2	Board members should prioritise attendance at Board & committee meetings wherever possible to help discharge personal & corporate responsibilities and liabilities. Committee: including in-person attendance, suggested at twice / year minimum.	31/03/2026	Rachel Trawally	Sarah Jones	Board of Directors	Board members have been asked to attend Board in person where possible and improvements in in-person attendance has been made. For April 2026 onwards the new schedule will combine Go See visit on Board in private meeting dates which will support commitment to attend. We have two new NEDs starting and commitment was stressed as part of the interview process and application. The committee schedule has being finalised at Board in January and a discussion will be held around expected attendance and feasibility of in person meetings at this session. Going forward any attendance issues will be raised with the Chair at regular governance catch ups to address any issues as they arise. The new Chair in Common has commenced her role on 1 March 2026 and she is undertaking 121s with all NEDs where the importance of attendance will be highlighted.	Committee attendance trackers. Attendance in committee effectiveness review reports and annual report	
QS2.3	The Trust should consider the merits / demerits of continuing its current approach to hybrid meetings for all Board & committee meetings.	31/03/2026	Rachel Trawally	Sarah Jones	Board of Directors	This is being considered and will be discussed with the new Chair on onboarding. As above QS2.2 encouraging improvements have been made to in person attendance. The new Chair has expressed her intention for al Board meetings to be held in person only and this will be progressed from 1 April 2026. Committees will continue as hybrid meetings	Board discussion where hybrid and in person attendance discussed. New chair and NED induction meeting discussions	
QS2.4	IA: Steps should be taken to ensure the Trusts compliance target of 80% of staff having completed an appraisal in the last 12 months is achieved, as a minimum.	31/03/2026	Fay Davies	Bob Champion & Mark Rawcliffe	People & Culture Committee	The importance of appraisals and the process to be undertaken is included in the Management Essentials training. This is supported by a variety of robust guidance documents for both appraiser and appraisee. Reports detailing those staff who are out of date is produced every month. Training is also offered to appraisers and appraisees to promote a quality appraisal process.		
QS2.5	IA: The Trust should seek to review and update their Clinical Workforce Strategy: Future Proofing Our Clinical Workforce 2021-2024, to ensure that it reflects current aims and objectives of the Trust.	31/10/2025	Chris Dixon	Phil Hubbard & Committee Chair's	Quality & Safety Committee & People & Culture Committee	Discussed at Clinical Board 26th September – task and finish group to support the revision of professional strategy and the development of a Clinical Strategy incorporating LMH hospital redevelopment.		

Quality Statement 3: Freedom to Speak Up

We foster a positive culture where people feel that they can speak up & that their voice will be heard. Covering: Speaking up culture – Freedom to Speak Up Guardian – Whistleblowing – Closed Cultures

Covering: Speaking up culture – Freedom to Speak Up Guardian – Whistleblowing – Closed Cultures

Reference	Action	Due	Delivery lead	Board/EMT lead	Oversight group	Progress	Evidence	Embedding date & evidence
QS3.1	The Trust should continue to respond effectively to identified cultural hot spots & matters of concern with a Board-led emphasis that focusses on 'shifting the dial' for these intransigent 'sticky' issues.	31/12/2025	Rebecca Wixey	Phil Hubbard & Chris Malish	Quality & Safety Committee	This is explored within the FTSU monthly reports to SLT QSG and six monthly to Board. The report has been strengthened to include a stronger focus on themes, see QS3.2.	FTSU bi-annual Board report	
QS3.2	The Board should consider the format & content of the FTSU report, beyond national requirements to focus more so on themes, learning and actions.	31/12/2025	Rebecca Wixey	Phil Hubbard & Chris Malish	Quality & Safety Committee	The bi-annual report to Board in December 2025 reflected these areas and addressed key learning. Future reports will follow this format moving forward to ensure a focus on themes.	FTSU bi-annual Board report	
QS3.3	The Board should review its approach to the setting of mandatory training targets & have forensic oversight over delivery.	31/01/2026	Fay Davies	Bob Champion & Mark Rawcliffe	People & Culture Committee	Other Trusts have been contacted re their mandatory training targets. From those who have responded 85% appears to be the standard mandatory training compliance target. A paper will be going to the next Mandatory Learning Oversight Group (MLOG) proposing a move to an 85% compliance target for each mandated subject.		

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Good governance, accountability and effective oversight

Quality Statement 4: Workforce equality, diversity & inclusion

We value diversity in our workforce. We work towards an inclusive & fair culture by improving equality & equity for people who work for us. We foster a positive culture where people feel that they can speak up & that their voice will be heard.

Covering: Fair & equitable treatment of staff – staff human rights – well-being of workforce – gender pay gap – workforce diversity – flexible working arrangements – WRES & WDES

Reference	Action	Due	Delivery lead	Board/EMT lead	Oversight group	Progress	Evidence	Embedding date & evidence
QS4.1	The Trust should consider how it can improve the collection & use of diversity data to inform action planning & tracking of outcomes across all protected characteristics.	31/03/2026	Lisa Wright	Bob Champion & Mark Rawcliffe	People & Culture Committee	13.45% for sexual orientation which has reduced to 12.5% in June 2025, the baseline for 10.80% which has reduced to 9.90% and the baseline for religion or belief was 18.11% which has reduced to 17.68% in June 2025. Action plans are in place to use this data alongside staff survey results to improve staff experience. As well as the WRES and WDES required action planning the Trust has a set of LGBT Metrics and plans and a religion and belief plan delivered by the Spiritual Care Reference Group.		
QS4.2	The Trust should continue to actively consider ways in which it can attain a representative Board & senior leadership cohort.	31/03/2026	Lisa Wright & Rachel Trawally	Bob Champion & Sarah Jones	Board Nomination & Remuneration Committee	The WRES, WDES and Gender Pay Gap review representation at senior levels and across all care groups, directorates, bands and professions. The intention is to increase diversity at all levels to be representative of the local population. The data on this is reported regularly to the People and Culture Committee and is available on the BDCFT website in the Publication Scheme pages. The most recent data reported shows that for the WRES representation in the Trust went from 26% in 2023 to 28% in 2024, at 8a and above representation has gone from 27 - 29% and at 8c and above it is 40%. For the WDES 14% of staff at organisation and 8a and above level are have shared they have a disability. This data is looked at in detail to compare where under-representation remains. An inclusive recruitment programme has been delivered during 2025 to support consistent performance. For VSM inclusive recruitment includes positive action in advertising, core statements in adverts, sharing the Trusts charter marks relating to EDI, stakeholder panels including stakeholders from the Trusts staff networks, involvement from service users and specific questions relating to EDI and values. The representation of disabled people on the Board when compared to the organisation has gone from -2% in 2023 to 4% in 2024. For ethnicity the representation had reduced in 2024 from -12.03% to -15.60%. This has changed with increased representation through recruitment in 2025.		

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Good governance, accountability and effective oversight

Quality Statement 5: Governance, management & sustainability

We have clear responsibilities, roles, systems of accountability & good governance. We use these to manage & deliver good quality, sustainable care, treatment & support. We act on the best information about risk, performance & outcomes, & we share this securely with others when appropriate.

Covering: Roles, responsibilities & accountability – governance, quality assurance & management – cyber security, data security & protection toolkit (DSPT) – emergency preparedness, including climate events – sustainability, including financial & workforce – data security/data protection – statutory & regulatory requirements – workforce planning – external actions (e.g. safety alerts) – records / digital records

Reference	Action	Due	Delivery lead	Board/EMT lead	Oversight group	Progress	Evidence	Embedding date & evidence
QS5.1	The Trust should consider the outcome of this review & ensure that it has adequate & effective Board & Committee oversight and governance processes of all relevant aspects of Trust business.	30/04/2026	Rachel Trawally	Sarah Jones & Fran Stead	Board of Directors	A well led action plan has been developed also incorporating committee effectiveness review actions. A review of this alongside the Provider Capability Assessment has taken place to ensure the work is aligned. A new strategic risk is being proposed which is focused on governance & compliance.	Well led action plan. Provider capability assessment submission. Strategic risk register including the new risk. Well led reports presented at Jan and March committees, and Board April	
QS5.2	The Trust should consider ways in which the Audit Committee can effectively discharge its role of overseeing an effective system of internal control without duplicating the work of other Committees.	31/03/2026	Rachel Trawally	Fran Stead & Chris Malish	Audit Committee	Benchmarking has been undertaken on Terms of Reference, a self-review exercise has taken place aligned to the national HFMA guidance on how an effective NHS Audit Committee would operate. A service against HFMA model ToR for an NHS Audit Committee has also taken place. A development plan has been established, approved by Fran & Chris. Which will be delivered by Rachel in her role of ensuring the Board and Committees are effective.	Audit committee strategic narrative report. Audit committee development plan. Benchmarking output documentation against HFMA guidance. Audit Committee papers confirming delivery of agreed actions	
QS5.3	The Trust should clarify governance reporting flows, especially between SLT QSG, QSC & the Board, & ensure all forums have formal workplans to ensure that an appropriate flow is maintained.	31/12/2025	Chris Dixon	Phil Hubbard & Alyson McGregor	Quality & Safety Committee	These will be reviewed as part of the process for every Committee, exploring our development plans.		
QS5.4	The Trust should continue to pursue the implementation of an effective performance & accountability framework.	30/04/2026	Chris Hunt	Farhan Rafiq & Maz Ahmed	Finance & Performance Committee	Ongoing work as part of the Quality Management System (QMS) planning. Next discussion scheduled for October 2025. Dec 25 Update. This is connected to action QS1.1 and 1.3 and part of the Care Trust Way reset and new strategy development and deployment process. Feb 26 Update: Board learning and development topic taking place on the QMS on 5th March 2026. Further meeting with Chair of FPC to be arranged on this recommendation in April 2026.		
QS5.5	The Trust should consider strengthening support for governors & the effectiveness of the Council of Governors meetings to enable effective discharge of their role. CoG: training on the role of Senior Independent Director (& other roles). CoG: consider framework for Governor Time Out sessions. JA: The Trust should ensure that discussions during Governor's meetings are aligned with the activities, roles and responsibilities required of the governor role, as per their job descriptions.	31/12/2025	Rachel Trawally	Sarah Jones & Fran Stead	Council of Governors	The work is being reset as part of the ongoing developments of the Corporate Governance service. A training plan and informal sessions are being progressed to support the governors. The induction process. Welcome session and governor handbook has been reviewed. Feedback has been gathered on the governor timeout sessions and we are working with the Lead Governor on engagement from some of the less involved governors, and how these sessions can be more beneficial. More regular communication, training and guidance is being developed for governors to support them in the clarity of their roles. CGT reviewing training for governors to include SID role, CoG effectiveness review being undertaken and governor training documents being developed	Governor training materials, CoG effectiveness review output, time out session feedback.	
QS5.6	The Trust should ensure that it implements its development plans to address recognised inadequacies in the current approach to risk management.	31/03/2026	Chris Dixon	Phil Hubbard & Sally Napper	Quality & Safety Committee	The Risk Management Strategy is currently being reviewed, work will be undertaken to embed this within the organisation, including our approach to risk management, clinical risk assessment management policy, patient safety strategy has just been ratified and how training and education support practice		

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Good governance, accountability and effective oversight

QSS.7	The Trust should ensure that the Board retains adequate oversight of the effectiveness of EPRR.	31/01/2026	Chris Wight	Sarah Jones & Kelly Barker	Board of Directors	The Board receive an annual report on EPRR activities for the Trust. They are also updated on the annual assessment of EPRR Core Standards (the EPRR equivalent of a CQC inspection) as led by NHS England and receive copies of all audit reports from external specialists. In addition, the routine oversight and management of EPRR activities is regularly maintained by the Trust's Resilience Group, which is made up of representatives from across all areas of BDCFT services. This group provides the necessary governance, management and quality assurance for all EPRR activities, policies, plans and incidents. Chaired by Kelly Barker, Chief Operating Officer (and Accountable Emergency Officer for the Trust).	Opportunities for improvement scoped and documented into a paper with suggested Board and committee developments to take forward. To agree with Chair and then incorporate into 2027 workplan and Board Development sessions.
QSS.8	The Trust should review its approach to minuting of meetings to ensure that discussions, agreed outcomes & any required follow through is adequately captured. Committee: ensure timely circulation of minutes & actions.	31/01/2026	Rachel Trawlay	Fran Stead Committee Chair's	Audit Committee Committee's (all)	Corporate Governance have reviewed the standardisation across the committee secretaries and changed the reporting of attendance and membership. Supported by the introduction of co-pilot to support the production of the minutes, incorporating feedback from the Well Led external review to ensure specific questions/comments are noted in minutes to demonstrate challenge and discussion. Deadlines are more robust for production of minutes with ongoing discussion with Committee Chair's on timeliness of approving requests. This will be discussed with the new Chair to capture her views on the current process and minutes.	Activity based action - to produce one page summary on activity undertaken - could be in the format of a governance update report to AC summarising improvements made. Evidence - committee minute tracker showing deadlines and completion, updated minute guidance and templates
QSS.9	Committee: some reports were too operational. CoG: consideration on inclusivity & accessibility of reports.	30/09/2026	Rachel Trawlay	Fran Stead	Audit Committee Council of Governors	This work is part of the Integrated Governance Guide framework, which will be developed by Rachel in the coming months. The work includes training, standardisation, and acts as an information sharing guide to support colleagues, including templates. Opportunity to engage EDI colleagues to strengthen accessibility templates and guidance	Refreshed Integrated Governance Guide Training materials for report writers. Updated report templates and guidance. Evidence of EDI input
QSS.10	Committee: an induction would be beneficial for joiners.	31/03/2026	Rachel Trawlay	Sarah Jones & Fran Stead	Board of Directors	Following feedback and building on a successful past delivery model, work is taking place to re-embed the induction programme for Board members. On behalf of Fran, Rachel is leading this work and will be used to onboard the 2 new NEDs over the coming months. A welcome pack has been introduced for new starters and induction meetings are underway for the two new NEDs and the new Chair. Induction documentation is also being developed by Committee secretaries for new members to support them joining a committee.	Induction schedules and materials. Records of induction sessions held. Induction documentation embedded into governance guidance documentation
QSS.11	Committee: further work to do on the flow & interaction across Committee's & Board. Formalise Joint Committee.	31/03/2026	Rachel Trawlay	Sarah Jones & Fran Stead	Board of Directors	This is being considered as part of the annual effectiveness review for Board and Committee meetings. The committee board effectiveness review results are currently being processed and will be presented at March committee meetings. Any new actions will be built in to the updated version of the well led development plan for taking forward	Board and committee effectiveness review reports. Board papers summarising findings and actions
QSS.12	Committee: workplan review, benchmarking & development to take place. Aligned to mapping of oversight & assurance reporting.	31/03/2026	Rachel Trawlay	Fran Stead & Committee Chair's & Lead Directors	Committee's (all)	The Corporate governance team have arranged work plan meetings with the executive leads and/or NED Chairs to review the workplans and review the terms of reference, considering any benchmarking undertaken and to ensure all relevant items are on the updated workplans. Effectiveness reviews are currently being undertaken for the committees and the findings will be presented to the March committee meetings. A review of the Terms of Reference is also taking place, aligned to the annual effectiveness discussion. Findings will be presented for discussion at the committee meetings and outcomes of the effectiveness review will be incorporated into the updated version of the well led development plan for taking forward	Updated workplans. Updated terms of reference. Assurance reports to board/committees summarising outcomes
QSS.13	Committee & CoG: ensure timely circulation of paperwork, including presentations.	30/09/2026	Rachel Trawlay	Fran Stead	Committee's (all) Council of Governors	Work is aligned to action QSS.8. A Board agreed paperwork circulation process is in place which includes the dates of paperwork submission and circulation. There are some challenges still with paperwork being received in time, it has been agreed that Corporate Governance will circulate all received papers on the agreed circulation date. This will also be considered as part of the annual effectiveness review outcomes.	Integrated governance guide. Committee circulation deadline tracker. Annual effectiveness review outcomes feedback
QSS.14	Committee & CoG: undertake annual review of membership & attendance, & work with the Chair to ensure all members & attendees contribute.	31/03/2026	Rachel Trawlay	Committee Chair's Sarah Jones	Committee's (all) Council of Governors	This work is aligned to action QSS.12. Inductions for new NEDs will include contributions and the new chair will be working with NEDs on engagement and attendance. A new attendance table will be introduced by Corporate Governance from 1 April to track attendance throughout the year as opposed to at the end of the year only where it features within the Annual Governance Report.	Attendance trackers from committee trackers. Annual attendance reporting through the annual effectiveness review report and annual report. Terms of reference report March 2026
QSS.15	Committee: work with the Chair & members to ensure non-quorate meetings are avoided.	30/01/2026	Rachel Trawlay	Committee Chair's	Committee's (all)	Combine with action QSS.14. This is an ongoing discussion with all Board members, something that the new Chair is raising with NEDs. Some progress has been noted but it remains a risk to effective meetings. It will feature within the new strategic risk on governance & compliance.	As above. Also introducing attendance table at each committee meeting from 1 April 2026. Committee minutes evidencing quorum
QSS.16	Committee & CoG: consideration on how health equity becomes embedded across all reports.	31/03/2026	Lisa Wright	Kelly Barker & Committee Chair's	Committee's (FPC, MHLG, PCC, QSG) Council of Governors	Working in partnership with Farhan to revise the ISPR. Health Equity Dashboard linked to PCREF in test mode. Mental Health will happen much quicker due to PCREF. Health Equity Review planned - to include, papers, guidance and training for committee members. Development of draft Health Equity Approach to be embedded into the review of the Organizational Strategy. Inclusion of Health Equity domain to the 2025 - 2028 Belonging and Inclusion Plan which is reviewed every 6 months with deep dive topics in between.	

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Good governance, accountability and effective oversight

QSS.17	Committee & CoG: make the work of the Board & Committees, Governors more visible.	30/09/2026	Rachel Trawaly	Sarah Jones & Fran Stead	Board of Directors Council of Governors	Work to be undertaken on intranet and external website. Introduced Governance report to Board and CoG, and a Go See report to Board.	Governance and go see board report and to CoG. Screenshots internet updates. Board and CoG reports
QSS.18	Committee: work with the Chair to understand how decision making & reflection takes place within the meetings.	31/03/2026	Rachel Trawaly	Committee Chair's	Committee's (all)	To develop guidance and include as part of induction documents for new NEDs to support chairing meetings. The CoG Team is in the process of arranging consistent pre meet/agenda setting meetings with all chairs and exec leads as appropriate, to enable regular interactions with committee chairs and provide further support on governance requirements. This work will be part of the Integrated Governance Guide review work.	Updated integrated governance guide. Induction materials for NEDs and Chair. Consider committee chairs and provide further support on governance requirements. This work will be part of the Integrated Governance Guide review work.
QSS.19	Committee: consideration on how all members & attendees can be involved with the annual review of the Terms of Reference.	31/03/2026	Rachel Trawaly	Committee Chair's	Committee's (all)	Rachel will create a process for this, which will feed into the 2026 annual review of the Terms of Reference. The CoG team are currently reviewing the terms of reference for each committee, and meeting with exec leads to discuss membership and the updated terms of references will be presented to committee meetings in March. Further work will then be undertaken in relation to benchmarking exec and NED membership on committees, and any suggested changes to be agreed with the new Chair and members.	Committee terms of reference reports to March meetings. Committee minutes noting discussions of ToR agenda item. Benchmarking evidence or email showing changes made.
QSS.20	Committee: consideration on how Trust priorities & strategy feature in assurance escalation reporting.	31/03/2026	Rachel Trawaly	Fran Stead & Committee Chair's	Committee's (PPC, MHL, PCC, OSC)	This will be considered within the Integrated Governance Guidance refresh. Plus within the Strategy Development programme. FR work linked on strategic narrative reporting	Strategy development paperwork Updated assurance/escalation report template. Board discussions linking strategy to assurance. Board development session agenda.
QSS.21	Committee: consideration of regular review of Committee priorities to support dynamic governance & emerging issues.	31/03/2026	Rachel Trawaly	Committee Chair's	Committee's (all)	This is done as part of the workplan review work and as part of agenda setting. Workplan to be discussed in committees and meetings held to discuss workplans with exec leads and/or NED Chair. Further work to do following the introduction of the new Board Assurance Framework reports, to understand how that work drives Committee activity.	Benchmarking analysis. CoG meeting schedule. CoG effectiveness review outputs. Governor training and engagement evidence
QSS.22	CoG: review frequency of meetings.	31/03/2026	Rachel Trawaly	Sarah Jones	Council of Governors	National guidance suggests 4 CoG meetings per year, which the Trust is in line with. Benchmarking undertaken, results show other foundation trusts having between 2 & 4 meetings per year. More work to do on promotion of Annual Members Meeting being recognised by governors as one of their business meetings. The annual effectiveness review for CoG is currently being undertaken and any feedback from this will be considered and added to the updated well led action plan.	Benchmarking analysis. CoG meeting schedule. CoG effectiveness review outputs. Governor training and engagement evidence
QSS.23	IA: The Trust should ensure the Appraisal and Pay Progression Procedure document is reviewed and updated, as required.	30/11/2025	Michelle Holland	Bob Champion	SLT PPI	This links to QSS.4 regarding appraisals. Work in progress to review the links to Pay Progression and apply this within the Trust. Whilst existing documentation, training materials exist this needs a full review and communication plan developing before it can be introduced. The proposal is that this could be in place from 1/4/26 if accepted by the Trust as a new way of working.	
QSS.24	IA: The Trust should ensure the Disclosure & Barring Service (DBS) Procedure document is reviewed and updated, as required.	30/11/2025	Michelle Holland	Bob Champion	SLT PPI	On going. The procedure complies with existing legal requirements. This is included in the policy/process review cycle for all People Policies.	
QSS.25	IA: The Trust should ensure the Fit & Proper Persons Regulations Procedure document is reviewed and updated, as required.	31/12/2025	Fran Stead	Fran Stead	Audit Committee	Policy updated and ratified by SLT PPI on 08/01/2026.	FPFR policy. SLT minutes
QSS.26	IA: The Trust should ensure the Board of Directors Nomination and Remuneration Committee Terms of Reference document is reviewed and updated, as required.	31/03/2026	Rachel Trawaly	Sarah Jones	Board of Directors	Current ToR in place. Review of ToR to be undertaken	Updated ToR document. Board minutes to evidence approval of amendments
QSS.27	IA: The Trust should ensure that the Data Quality Steering Group Terms of Reference is ratified by the Information Governance Group.	31/03/2026	Raj Gohri	Farhan Raik	Information Governance Group	New governance group on data quality being established who will undertake this responsibility. New governance group on data quality being established who will undertake this responsibility. Feb update - DQWG ToR were ratified at the Information Governance Group Meeting on the 02/02/26 Dec 25 Update - The Data Quality Working Group (DQWG) (which is BOCFT Data Quality Steering Group) has been established. A Terms of Reference has been created and approved by the DQWG. The ToR will also be circulated to the Information Governance Group for review and ratification in January, and tabled at February Information Governance Meeting.	
QSS.28	IA: The Trust should ensure that the Council of Governors Declaration of Interest Register is updated at least annually, the date that each Governor makes a declaration should also be documented.	31/03/2026	Rachel Trawaly	Fran Stead	Audit Committee	A process is in place for annual update & throughout the year when a change takes place. This includes all declarations required for Board members and governors. The process is being trained within a Local Working Instruction so activity is clear and the current annual declaration of interest request is currently being undertaken. The date completed has been added to the DoI document	Declaration of interest register on date added. Annual report disclosure
QSS.29	IA: The Trust should deploy improved governance and oversight of work to support improvements in data quality (from a clinical perspective) to support improved national performance on productivity, patient outcomes and quality	31/03/2026	Raj Gohri	Farhan Raik & Maz Ahmed	Finance & Performance Committee	A Data Quality Improvement Plan is now in place and being delivered with Executive Oversight. The plan is to achieve and sustain a segmentation score of 3 by 31st March 2026. Monthly data quality performance reports on data quality are being submitted to Finance & Performance Committee to support assurance and delivery. Feb 2026 update. Latest NQF estimates for Quarter 3 (2025/26) show improved data quality outcomes. Further work still needed.	

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Good governance, accountability and effective oversight

Quality Statement 6: Partnerships & communities

We understand our duty to collaborate & work in partnership, so our services work seamlessly for people. We share information & learning with partners & collaborate for improvement.

Covering: Sharing good practices & learning - integration health & social care - partnership working & collaboration

Reference	Action	Due	Delivery lead	Board/EMT lead	Oversight group	Progress	Evidence	Embedding date & evidence
QS6.1	The Trust should consider the merits / demerits of wider involvement of the whole Board in system/partnership engagement including Board oversight & ownership of the external communications strategy/plan and stakeholder mapping.	30/09/2026	Fran Stead	Sarah Jones Therese Patten	Board of Directors	This will be considered as part of the strategy development programme with a discussion item to be scheduled at Board.		
QS6.2	The Trust should consider ways in which it can increase service user involvement in relevant system/partnership service redesign discussions.		Chris Dixon	Phil Hubbard & Sally Napper	Quality & Safety Committee	This is being explored through the service user engagement work, including attendance at key committees, interview panels, developments including OSPB workstreams and engagement in Lynfield Mount Hospital redevelopment.		
QS6.3	The Trust should consider its approach to 'Go See' visits with an aim to improve the value add for all participants. IA: The Trust should ensure that all areas on their 'Go See' tracker that have been identified for a visit, are visited as scheduled by an Executive Director or Non-Executive Director. Where visits have not taken place, steps should be made to re-arrange.	31/03/2026	Rachel Trawally	Fran Stead	Board of Directors	The current process for Go See is being developed with the schedule being planned in further advance. Reporting on the process has now commenced at Board. The committee planner schedule went to Board in January which included scheduled Go See visits on Board held in private days from may onwards to provide additional time to carry out visits. A discussion on triangulation will take place to consider the various data and experience reporting processes. This process will also be discussed with the new chair. A presentation is being prepared to go to EMT for discussion on improvements	Board and committee schedule for 25/26 showing GoSee visits on board day. Minute extract from Jan board approval to introduce GoSee visits on board day. Go see annual report to Board dec 2025. EMT presentation once drafted	
QS6.4	The Trust should consider the adequacy of current qualitative feedback in Board & Committee meetings & whether there is an appropriate balance of quantitative & qualitative feedback to inform discussions.	31/03/2026	Rachel Trawally	Sarah Jones & Fran Stead	Board of Directors	This links to action QS6.3.		
QS6.5	The Trust should ensure that the staff appraisal rate is improved & that the target is sufficiently stretching & benchmarks well with other providers.	31/03/2026	Fay Davies	Bob Champion & Mark Rawcliffe	People & Culture Committee	Awaiting progress update		

Good governance, accountability and effective oversight

Quality Statement 7: Learning, improvement & innovation

We focus on continuous learning, innovation & improvement across our Trust & the local system. We encourage creative ways of delivering equality of experience, outcome & quality of life for people. We actively contribute to safe, effective practice & research.

Covering: Innovation - learning & improvement - research - learning from deaths

Reference	Action	Due	Delivery lead	Board/EMT lead	Oversight group	Progress	Evidence	Embedding date & evidence
QS7.1	The Trust should consider how it can strengthen thematic learning & improvement planning from its quality governance outcomes & ensure effective cross organisational communication & learning is in place.	31/03/2026	Chris Dixon	Phil Hubbard & Sally Napper	Quality & Safety Committee	Revision of the patient safety strategy has taken place with engagement of staff and management. This has included our approach to patient safety and learning group, embedding safety huddles daily and triangulation of data across the organisation. Accessible learning for all, service user engagement. Board development sessions, QUOPS and all Committees		
QS7.2	The Trust should consider strengthening its approach to benefits realisation in relation to its investment in its transformation & change capabilities.	30/04/2026	Ava Green	Farhan Rafiq & Maz Ahmed	Finance & Performance Committee	Additional scoping beyond Organisational Sustainability Programme Board to take place. Dec 2025 Update - 'The Trust has established a new Transformation Pipeline as well as a strengthened Project Mandate (PID) process to ensure more rigorous testing of benefits before projects go live, and a new in-year exec-level assurance process to review performance and risks to benefits. Feb 2026 Update: a new management information system to support work on programme management and benefits tracking will be in place within Quarter 1 of 2026/27. A business case of options is being prepared for approval by EMT by end of March 2026 to take this work forward.		
QS7.3	The Trust should consider ways in which it can improve coordination & governance alignment across its QI, research, & patient safety activities.	31/07/2026	Chris Hunt	Farhan Rafiq & Alyson McGregor	Quality & Safety Committee	Ongoing work as part of the Quality Management System (QMS) planning. Next discussion scheduled for October 2025. Dec 2025. Feb 2026 Update: Board development session taking place on the QMS on 5th March 2026. Follow up engagement needed with led NED post this session to check and challenge (in April 2026).		
QS7.4	The Trust should consider ways in which it can a) Raising the profile and value of research which will be delivered through a revised trust research strategy b) Supporting health inequalities improvements by embedding this into the trust's QI, innovation and research activities.		Mark Dawson	Sal Uka	Quality & Safety Committee	a) We extended the previous strategy to the end of Dec '26, so the plan will be to re-engage with stakeholders, re-raft and issue the new strategy this year. Discussed in Feb REG meeting. Confirmed plan and works to start in Apr/Mar 2026 for completion in Dec 26. b) Plans are to establish a Health Equity Board and delivery plan to support this recommendation. Work on this will be tied into the development of the new and refreshed Trust strategy (by Sep 2026 and firming up by Dec 2026)		

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Good governance, accountability and effective oversight

Quality Statement 8: Environmental sustainability – sustainable development

We understand any negative impact of our activities on the environment & we strive to make a positive contribution in reducing it & support people to do the same.

Staff awareness & education – carbon reduction – health promotion & prevention – estates & facilities – efficient service delivery with resource optimisation

Reference	Action	Due	Delivery lead	Board/EMT lead	Oversight group	Progress	Evidence	Embedding date & evidence
QS8.1	The Trust should consider ways in which it can strengthen consistency of consideration of sustainability impacts when considering service or policy changes.	31/03/2026	Emma Clarke	Mike Woodhead	Audit committee	Sustainability team in discussion with PMO team to encourage transformation projects to have a sustainability assessment. Not yet being done. If the sustainability team is provided with details of in progress and in pipeline work, we can support. Working with KPO team to embed SusQI into smaller improvement work. Greater progress but similar to above with PMO.		
QS8.2	IA: The Trust should demonstrate that it is actively seeking to improve the assurance level/rating as the Trust helps support the NHS's net zero ambition. It should actively monitor progress against the areas outlined in 2024-2027 Green Plan to address areas identified for improvement where it has been identified that the Trust is performing below the national average.	31/03/2026	Emma Clarke	Mike Woodhead & Maz Ahmed	Finance Performance Committee	The Trust provides quarterly Green Plan data to NHS England/ Greener NHS which is used for benchmarking. The areas we've performed less well with are areas that are difficult to evidence and link to the above (e.g. clinical transformation) and delays in the electronic patient meal ordering which contributes to the Food and Nutrition area. Our clinical lead for sustainability may be able to help make quicker progress.		
QS8.3	IA: The Trust should seek to confirm whether it has taken action to reduce its actual carbon emissions, through the implementation of identified opportunities. Action should also be taken to identify and implement new opportunities to reduce carbon emissions to build on improvement works completed in 2024/25.	31/03/2026	Emma Clarke	Mike Woodhead & Maz Ahmed	Finance & Performance Committee	The Trust continues to focus on energy efficiency. The recent heating work at NM should reduce gas usage and ACMH is now 100% LED lit. Regular review of the building management system and working with Maintenance will help to address energy inefficiency. In 2026, boilers will be replaced at Moorlands View and Airedale Centre for Mental Health. We are not in a position to move to low carbon heat currently, therefore replacing end of life assets with modern, efficient boilers will help reduce some gas usage. They will provide winter resilience when the transition does occur within the next 5-10 years. The Sustainability team has quarterly discussions with the lead for each area but engagement differs across each theme.		

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Board of Directors – meeting held in public

02 April 2026

Paper title:	Governance Report	Agenda Item 22.0
Presented by:	Fran Stead, Trust Secretary	
Prepared by:	Holly Close, Corporate Governance Officer	
Committees where content has been discussed previously		
Purpose of the paper Please check ONE box only:	<input type="checkbox"/> For approval <input checked="" type="checkbox"/> For information <input type="checkbox"/> For discussion	
Link to Trust Strategic Vision Please check ALL that apply	<input type="checkbox"/> Providing excellent quality services & seamless access <input type="checkbox"/> Creating the best place to work <input type="checkbox"/> Supporting people to live to their fullest potential <input type="checkbox"/> Financial sustainability, growth & innovation <input checked="" type="checkbox"/> Governance & well-led	
Care Quality Commission domains Please check ALL that apply	<input type="checkbox"/> Safe <input type="checkbox"/> Caring <input type="checkbox"/> Effective <input checked="" type="checkbox"/> Well-Led <input type="checkbox"/> Responsive	

Purpose of the report

Governance Report to the Board of Directors on key governance matters that have taken place over the last two months, & upcoming areas of interest for the Board of Directors to be aware of.

Executive Summary

Governance Report to inform Board of Directors on key updates on governance matters from the past two months and highlighted upcoming areas for Board attention. Planning for September 2026, Annual Member’s Meeting will begin with key updates provided as the process continues. All Board Committee Terms of Reference were reviewed and updated, and Committees completed their Annual Governance Reports, providing assurance on their delegated duties and the outcomes of recent effectiveness reviews. Forward-planning work for the Board, Committees and Council of Governors was finalised, supported by analysis of previous work plans. The Trust also welcomed Cleveland Henry as a new Non-Executive Director and thanked Maz Ahmed and Simon Lewis for their valued service.

<p>Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?</p>	<p><input type="checkbox"/> Yes (please set out in your paper what action has been taken to address this)</p> <p><input checked="" type="checkbox"/> No</p>
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<p>Recommendation(s)</p>
<ul style="list-style-type: none"> • Note the date of September’s Annual Members’ Meeting: 24 September 2026 • Consider & approve the Committee’s Terms of Reference; • Note the content of the Annual Governance Report including the effectiveness review action plans & be assured that the Committee’s have worked within its Terms of Reference, escalated appropriately any key issues through the escalation & assurance reports made by the Chair of the Committee; & • Consider & approve the Committee’s Annual Governance and Effectiveness Review Reports for 2025/26

<p>Links to the Strategic Organisational Risk register (SORR)</p>	N/A
<p>Care Quality Commission domains Please check <u>ALL</u> that apply</p>	<p><input type="checkbox"/> Safe <input type="checkbox"/> Caring</p> <p><input type="checkbox"/> Effective <input checked="" type="checkbox"/> Well-Led</p> <p><input type="checkbox"/> Responsive</p>
<p>Compliance & regulatory implications</p>	<p>The following compliance and regulatory implications have been identified as a result of the work outlined in this report:</p> <ul style="list-style-type: none"> • Well-Led Compliance • NHS Code of Governance • NHS Act • Health and Social Care Act • Health and Care Act • Nolan Principles • Provider Licence • Trust Constitution • Insightful Board Guidance

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Board of Directors – meeting held in public

02 April 2026

Governance Report

Background / Context:

This report will provide key updates on governance matters that have taken place over the last two months and will be used to share upcoming areas of interest for the Board of Directors to be aware of.

Engagement and Involvement

Council of Governors

Annual Members' Meeting

Work will soon be taking place to agree the format for this year's Annual Members' Meeting, which will take place on Thursday 24 September 2026 (exact timings to be confirmed). Board colleagues will receive further details soon along-with an agreed proposal for the event & formal 'Notice of the Meeting'. This key statutory event is a chance for our Trust members, service users, carers, staff, Governors, Directors & members of the public to come together to learn more about Trust services, achievements & future vision. The Deputy Trust Secretary will oversee the event, working alongside Jess Greenwood-Owen, Corporate Governance Officer, who is leading the planning and organisation. The event management strategy will be finalised over the coming months, supported by a Task and Finish Group and in close collaboration with the Governors.

Accountability and Governance

Committee Annual Effectiveness and Governance Reports and Committee Terms of Reference

The Trust follows good governance principles, as required by its Provider Licence, Constitution and the NHS Code of Governance. As part of this, the Corporate Governance Team carried out the annual review of all Board Committee Terms of Reference, with proposed amendments approved by each Committee in March 2026 before being presented to the Board for ratification. Each Committee is also required to produce an Annual Governance Report to give the Board assurance on how it has delivered its delegated duties during the financial year. These reports, reviewed and approved by Committees in March 2026 and again submitted to the Board for ratification, outline the governance processes in place, the work undertaken during 2025 to 2026, any issues for escalation, and detail actions from the committee effectiveness reviews undertaken in February 2026. Both the Terms of References and Annual Governance and Effectiveness review for each Committee can be found in the appendices to this report.

Forward planning and Board development

The Board is asked to note that the Corporate Governance Team alongside executive leads have undertaken the review of the Board, Board Sub-Committees, and Council of Governors workplans. To support this work, analysis of the annual work plans from previous years has

been undertaken to understand any changes made to business and consideration of tactical meetings that report formally to each Committee.

As a Board work will continue for the ongoing Board development sessions, with a continued focus on the Trust-wide governance improvements that continue to take place and become embedded alongside the development of the Trust strategy. Further information will be provided on the Board development programme.

Provider Capability Assessment

The Trust completed a Provider Capability Assessment under the National Oversight Framework in October 2025, submitting partial compliance in most domains and full compliance in financial oversight. The regional team reviewed the submission statements and evidence, which was triangulated with other relevant regional data/intelligence, to support them in reaching a holistic view across the six domains and to assign a single overall capability rating. Following this process, we have received confirmation from NHSE that Bradford District Care NHS Foundation Trust has been allocated a capability rating of Amber-Green for 2025/26. Thanks were noted to you and your teams for your continued hard work towards delivering improvements to ensure the population of the North East & Yorkshire region has timely access to high quality care.

People Matters

Non-Executive Director recruitment

We warmly welcome Cleveland Henry, who began his position as Non-Executive Director and Chair of the Finance and Performance Committee on 1 April 2026. The Trust would also like to express gratitude to Maz Ahmed, whose term will end on 28 April 2026. Maz has made significant contributions over his six years with the Trust. Simon Lewis, Non-Executive Director and former Acting Chair, concluded his term on 27 March 2026. On behalf of the Board, we sincerely thank both Maz and Simon for their dedicated service, valuable insight, and commitment during their time in office.

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Agenda
Item

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Audit Committee
Annual Governance Report
01 April 2025 to 31 March 2026

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1. Period covered by the report

This report covers the period between 1 April 2025 and 31 March 2026.

2. Introduction

The Audit Committee (Committee) has been formally established by the Board of Directors as one of its sub-committees. It is authorised to seek and obtain evidence of assurance on the effectiveness of the Trust's quality and safety systems and processes, and the quality and safety of the services provided. This includes identifying and seeking assurance on the management of quality and safety related risks at an operational and strategic level. The Committee monitors and reports to the Board on the effectiveness of these systems and processes. The Committee's key objectives are to seek assurance that:

It seeks high-level assurance on the effectiveness of:

- the Trust's governance
- risk management, and
- systems of internal control.

It reports to the Board on its level of assurance gained. The Committee receives assurance from the Executive Management Team and other areas of the organisation through reports, both regular and bespoke. It validates the information it receives through the work of Internal Audit, External Audit, and Local Counter Fraud.

Should the Trust's External Auditors (currently KPMG) carry out any non-audit work, the Audit Committee has responsibility for ensuring that their independence is maintained. The Committee will do this by reviewing and approving the scope of the work and the fees charged prior to the work being undertaken.

This report covers the work the Committee has undertaken at the formal meetings held during 2025/26. It seeks to assure the Board on the work it has carried out and the assurances it has received, and to demonstrate that it has operated within its Terms of Reference.

The Trust welcomes and encourages feedback and recognises the importance of being a learning organisation. This approach provides an opportunity for Board members to triangulate, build relationships with Trust colleagues, and support the Board's ongoing journey for Board visibility and accessibility to the workforce.

Secretariat support is provided by the Corporate Governance team, who work with the Trust Secretary and Deputy Director of Finance in relation to agenda planning; minutes; managing cumulative action logs; and general meeting support.

3. Assurance

The Committee receives assurance from the Executive Director members of the Committee and from the subject matter experts who attend the meetings as required dependant on the agenda items being discussed.

Assurance is provided through written reports, both regular and bespoke, through critical challenge by members of the Committee and by members seeking to validate the information provided through wider knowledge of the Trust; specialist areas of expertise; attending Board of Directors',

and Council of Governors' meetings; visiting services, talking to colleagues, and observing operational meetings at the Trust as required.

The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge.

The Committee meetings are hybrid which allowed Committee members to attend in person or via Microsoft Teams.

The Committee receives assurance from the Executive and from the subject matter experts who attend the meetings as required dependant on the agenda items being discussed.

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; attending Board, Council of Governors' and other sub-committee meetings; visiting services; and talking to colleagues.

Part of the Committee's assurance role is to receive the Board Assurance Framework (BAF); a primary assurance document for the Board, which details those key controls in place to ensure that the risks to achieving the strategic objectives are being well managed. The BAF lists those committees that are responsible for receiving assurance in respect of the effectiveness of those controls. The Committee reviews the BAF at each meeting prior to it being presented to the Board. Additionally, the agenda has been modified so that the BAF is appraised prior to other agenda items so these items can be viewed in the context of the BAF.

Non-Executive Director members of the Committee independently meet both Internal and External Auditors to receive additional assurance. The meetings are convened as required throughout the year and can be on specific topics nominated by Committee members or the auditors.

The Committee reviews the BAF at each meeting prior to it being presented to the Board. Additionally, the agenda has been modified so that the BAF is appraised prior to other agenda items to allow items to be viewed in the context of the BAF. In order to promote consistency across the Trust, including alignment with the approach of the Internal Audit team, the Trust will use 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.

The Committee therefore received a number of key documents which included an Integrated Strategic Performance Report which directly aligned to those priority areas delegated to the Committee. Within these reports, informed by Executive oversight of operational grip and control systems, will be a proposed BAF assurance rating for each priority and theme. At the end of each Committee meeting the Chair made 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.

4. Terms of Reference for the Audit Committee

The updated Terms of Reference will be presented for approval by Committee, following which they will be presented to the Board of Directors to be ratified.

A third NED was added to the Terms of reference, the increase in NEDs came from a previous Audit Committee effectiveness review against the HFMA national framework that specified 3 NEDs as minimum. The title of Medical Director was updated to Chief Medical Officer in line with the new appointment during 2025.

5. Meetings of the Committee

During 2025/26 the Committee met six times during this period. Details of the meeting dates are listed below:

- 19 June 2025 – informal meeting with NEDs
- 23 July 2025
- 25 September 2025
- 27 November 2025
- 29 January 2026
- 26 March 2026

On an annual basis, a dedicated NED session is held to allow full scrutiny of the draft Annual Accounts in advance of finalising the audited accounts in June. The session was held on 19 June 2025.

The draft agenda for each meeting is presented to the Chair of the Committee, the Trust Secretary, and the Deputy Director of Finance by the Committee Secretariat.

Paperwork for the Committee is circulated seven calendar days prior to the meeting taking place. Exception items may be received within seven days where this has been agreed by the Chair. All actions pertaining to the meetings of the Committee are tracked on an action log and presented to each meeting for assurance with progress made.

Pre meets were introduced from sept 2025 following a request to add pre-meets for the NEDS and auditors (Internal & external) before every Audit Committee.

6. Membership of the committee and attendance at meetings

Attendance at meetings for substantive members and those in attendance were as follows:

Name	19 June 2025	23 July 2025	25 September 2025	27 November 2025	29 January 2026	26 March 2026
Substantive Members						
Chris Malish, Non-Executive Director (Chair of Committee)	X	X	X	X	X	X
Simon Lewis, Non-Executive Director	X			X		
Sally Napper, Non-Executive Director	X	X		X	X	
Warren Brown, Non-Executive Director	N/A				X	X
Mark Rawcliffe, Non-Executive Director	N/A		X	N/A		
In Attendance						
Mike Woodhead, Director of Financing, Contracting & Estates			X		X	X
Claire Risdon, Deputy Director of Finance, Planning & Performance	X	X		X	X	
Leanne Sobratee, Internal Audit Manager (Audit Yorkshire)	X	X	X	X	X	X
Helen Higgs, Head of Internal Audit (Audit Yorkshire)	X		X	X	X	
Chris Boyne, Deputy Director (Audit Yorkshire)						X
Lee Swift, Local Counter Fraud Specialist (Audit Yorkshire)	X					X
Salma Younis, KPMG	X	X		X	X	X
Francesca Shaw, KPMG Audit Manager						X
John Blewit, KPMG			X			
Stacey Pearson, Head of Financial Accounting	X		X	X		
Fran Stead, Trust Secretary			X		X	X
Rachel Trawally, Corporate Governance Manager and Deputy Trust Secretary	X		X	X		X
Nazmeen Khan, Corporate Governance Officer (Secretariat)			X	X	X	X
Sarah Denton, Executive Assistant (Secretariat)	X					
Attending for specific items						
Bob Champion, Chief People Officer				X		
Phil Hubbard, Director of Nursing, Professions and Care Standards and Deputy Chief Executive	X	X				
Richard Cliff, Head of Legal Services		X				
Therese Patten, Chief Executive Officer	X					
Rebecca Le-Hair, Head of Compliance, Quality Assurance & Patient Experience						
Tim Rycroft, Chief Information Officer			X			
Shane Embleton, Deputy Director, Estates & Facilities						

Delphine Fitouri, Head of Digital Services				X		
Osama Rathore, Audit Assistant Manager, KPMG	X					
AnneMarie Dorrington, Head of Community Dental Services		X				
Rebecca Wixey, Freedom to speak up guardian			X			
Kelly Barker, Chief Operating Officer					X	
Farhan Rafiq, Director of Transformation, Improvement & Productivity					X	
Attending as an observer						
Stephenie Alexander, KPMG Manager						

7. Report made to the Board of Directors

The Chair of the Audit Committee makes an Alert, Assurance, Advice, Decision (AAAD) report regarding the most recent meeting of the Committee to the next available Board of Directors' meeting. This report seeks to assure the Board on the main items discussed by the Committee and, should it be necessary, to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself. Where items are considered to be of significance and a certain urgency, the Chair of the Committee may make use of Exceptional Escalation Reports to the Trust Chair and Chief Executive, and where appropriate the Board of Directors.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the Committee the Board may ask for these to be looked at in greater detail by the Committee.

The below table outlines the date that the assurance and escalation report was presented by the Chair of the Committee to the Public Board of Directors meeting. In addition, a copy of Committee-ratified minutes is presented to the Board for information.

Date of meeting	Assurance and escalation report to Board by Chair
19 June 2025	24 July 2025
23 July 2025	02 October 2025
25 September 2025	06 November 2025
27 November 2025	04 December 2025
28 January 2026	05 March 2026
26 March 2026	Due to be reported 02 April 2026

Each year, the Committee presents an annual report to the Board of Directors to provide assurance on how the Committee has carried out activity in line with its Terms of Reference. Each Board sub-committee also provides a Chair's Report to the formal Council of Governors meetings. The reports outline areas where assurance had been received by the Committee and those areas requiring further development. This provides an opportunity for the Governors to further understand the work of the Trust whilst observing the Non-Executive Directors fulfilling their role

8. The work of Audit Committee during the year between April 2025 and March 2026.

The Chair of the Committee confirms that during 2025/26 the Committee has carried out its role in accordance with its terms of reference. Further details of all these areas of work can be found in the minutes and papers of the Committee.

A high-level presentation of areas of work on which the Committee has received assurance and during 2025/26 are listed below:

Risk Management:

- The Director of Nursing, Professions and Care Standards Directorate presents a litigation report annually to the Committee.

Strategic Assurance Report and Organisational Compliance and High Risk Report:

- Received the Strategic Assurance Report for assurance on both the content and the process and also the Organisational Compliance and High Risk Report.

Annual Report and Accounts for 2025/26:

- The Annual Report and Accounts for 2025/26 will be reviewed prior to being presented and recommended to the Board of Directors for adoption in June 2026.
- The ISA 260 (which is the report to those charged with governance on the annual accounts) was also received and the findings from the audit of the annual accounts discussed, including the conclusion that the accounts have been prepared on a going concern basis.
- The Value for Money Assessments was received, and the findings were discussed.
- Reviewed the wording for the year-end Management Representation Letter.
- The Head of Internal Audit Opinion and the Annual Governance Statement were reviewed, supported and recommended to Trust Board.

Internal Audit:

- Approved the Internal Audit Annual Plan.
- Received internal audit progress reports on a regular basis to update the committee on the major findings, with assurance being provided on the actions taken to address any weaknesses in the systems of control.
- The Internal Audit Annual Report was received which brought together all the findings from across the year.
- In addition to the update reports received from Internal Audit the committee also received specific assurances from the lead Executive Directors in respect of “limited assurance” reports. The lead Executive Directors assured the committee on the actions being taken to address the recommendations and also on the progress against those actions.
- Received the internal audit review of the mandatory HFMA Self-Assessment

Local Counter Fraud:

- Approved the Local Counter Fraud Annual Plan.
- Received assurances about the processes in place to tackle fraud and bribery.
- Local Counter Fraud progress reports were received on a regular basis in respect of those cases that can be reported to the Committee in order to update the Committee on the major findings and any lessons learnt from individual cases.
- The Local Counter Fraud Annual Report was also received which brought together to work from across the year.
- Received regular fraud awareness newsletters and notices.

External Audit:

- Reviewed and approved the work plan and the associated fee.
- Received regular update reports about the work of the auditors and also information about changes within the health sector which will impact on the Trust.
- Received details of relevant sector updates along with assurances on how the executive directors had implemented or taken account of the guidance contained in the update report.

Committee compliance:

- Recommended the Audit Committee Annual Report to Trust Board
- Completed the Audit Committee effectiveness review
- Reviewed the Committee Terms of Reference
- Reviewed and recommended changes to the Standing Financial Instruction and Standing Orders.

Action Tracking:

- Received regular reports in respect of progress with the implementation by managers of agreed audit recommendations and sought assurance on progress in particular with a number of outstanding actions. The Committee also received specific assurance on the process for dealing with and monitoring outstanding actions.

Registers:

- The Committee reviewed the Hospitality, Sponsorship and Gifts Register to ensure the appropriateness and completeness of the content.
- Reviewed the waiver of standing orders and standing financial instructions; proposed write-off of outstanding debt; and losses and special payments registers.

Other governance items:

- Received the Annual Report for Information and Data Assurance.
- Presentation of the Charitable Funds Committee Annual Report and Account, ISA 260 and Letter of Representation.
- Agreed the Assurance and Escalation Report to Trust Board
- Well Led Development

As the primary governance sub-committee of the Board of Directors the Audit Committee preserved its independence from operational management by not having executive membership (although members of the Executive Management Team support the Committee by providing information and context only). It added value by maintaining an open and professional relationship with Internal Audit; External Audit; and Local Counter Fraud. It carried out its work diligently, discussed issues openly and robustly, and kept the Board apprised of any possible issues or risks.

The Chair of the Audit Committee considers that the Committee has fulfilled its role as the Board of Directors' senior governance committee and provided assurance to the Board on the adequacy and effective operation of the organisation's risk management and internal control systems.

Members of the Audit Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

The Board is asked to recognise how the Committee supports the ongoing continuous improvement journey both at the Trust and on its own effectiveness.

The Chair sincerely thanks all Committee members, for their integrity, engagement, constructive challenge and commitment to ongoing improvement.
Nazmeen Khan – Corporate Governance Office

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Audit Committee

Terms of Reference

Version:	13.0
Approved by:	Audit Committee
Ratified by:	Board of Directors
Date approved:	TBC
Date ratified:	TBC
Job title of author:	Corporate Governance Team
Job title of responsible Director:	Non-Executive Director and Chair of the Audit Committee
Date issued:	March 2026
Review date:	TBC
Frequency of review:	Annual
Amendment Summary:	A third NED was added, the increase in NEDs came from a previous Audit Committee effectiveness review against the HFMA national framework that specified 3 NEDs as minimum. The title of Medical Director was updated to Chief Medical Officer in line with the new appointment during 2025.

1 Name of Committee

Audit Committee.

2 Composition of the Audit Committee

Members: full rights

Title	Role in the group / committee
Non-executive Director	Independent Chair
Non-executive Director	Deputy Chair and member
Non-executive Director	Member

It should be noted that any Bradford District Care NHS Foundation Trust non-executive director, other than the Chair of the Trust, is recognised as a member of the Audit Committee. Should they attend the meetings, they would count towards the quorum.

In attendance: in an advisory capacity

Title	Role in the group / committee
Chief Finance Officer	Executive lead for financial resources within the Trust. Assurance and escalation provider to the Finance and Performance Committee.
Trust Secretary	Trust Secretary, provides independent advisory support to the Audit Committee.
Operational Director of Finance	Lead for operational finance within the Trust.
External Audit Representative	Independent assurance providers.
Internal Audit Representative	Independent assurance providers.
Local Counter Fraud Specialist	Independent assurance providers.

In addition to anyone listed above, the Chair of the Committee may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

Executive Directors attend by invitation in order to present agenda items, in particular when a low/limited assurance report has been issued by Internal Audit and is on the agenda to be discussed.

The Chief Executive should attend when the Committee considers the draft Internal Audit Plan and the draft Annual Report, and Accounts. The Chief Executive should have a standing invitation to attend the meeting and as a minimum will need to attend the meeting annually, to discuss the process for assurance that supports the Annual Governance Statement.

2.1 Governor Observers

The Committee welcomes and encourages governors to attend its meetings. The role of a governor at Board sub-committee meetings is to observe the work of the Committee. The governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust. At the meeting the governor observer(s) will be required to declare any interest they may have in respect of any of the items to be discussed.

3 Quoracy

Number: The minimum number of members for a meeting to be quorate is two. Attendees do not count towards quoracy. If the Chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by one of the other non-executive directors.

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Deputies: Non-executive directors do not have deputies. Non-core non-executive directors may be asked to attend if there is a risk to the meeting not being quorate.

It may also be appropriate for attendees to nominate a deputy to attend in their absence. A schedule of deputies, attached at appendix 1a, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting will be confirmed at the next quorate meeting and documented in the minutes.

4 Meetings of the Committee

Frequency: The Committee will meet as a minimum six times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. At least once a year the Committee should meet privately with the External and Internal Auditors.

Urgent meeting: Any member of the Committee may request an urgent meeting.

Minutes: The Committee Secretariat will be provided by the Corporate Governance Team.

Assurance and Escalation (Alert, Advise, Assure and Decision – AAAD) Effective Oversight: Escalation and Assurance Reporting: The Chair of the Committee will provide an update of key issues arising from the meeting to the next Public Board of Directors meeting.

5 Authority

Establishment: In accordance with the NHS Act 2006 and the Foundation Trust Code of Governance the Board of Directors is required to establish an Audit Committee as one of its sub-committees.

The Audit Committee is accountable to the Board and will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation and the integration of governance arrangements.

Powers: The Committee is a non-executive sub-committee of the Board and has no executive powers. The Committee is authorised by the Board to seek assurance on any activity. It is authorised to seek information or reports it requires from any Trust colleagues, function, group or committee.

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Cessation: The Committee is a standing sub-committee of the Board and is a statutory requirement.

6 Role of the Committee

6.1 Purpose of the Committee

The Committee shall provide the Board with a means of independent and objective review of financial and corporate governance, and risk management. In addition, the Committee shall provide assurance of independence for external and internal audit. As agreed by the Board July 2023 within the Better Lives Together strategic framework, the Audit Committee is responsible for overseeing 'good governance, accountability and effective oversight' as a supporting objective to the four strategic priorities.

- Being the Best Place to Work
- Delivering the Best Quality Services
- Making the Best Use of Resources
- Being the Best Partner

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Committee

In carrying out their duties members and attendees of the Committee must ensure that they act in accordance with the values of the Trust, which are:

- we care
- we listen
- we deliver.

6.2 Duties of the Committee

The duties of the Audit Committee can be categorised as follows:

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The Committee will review, challenge and assess the adequacy and effectiveness of the Trust's risk management systems and processes, including the Risk Management Strategy, and provide assurance to the Board in that respect. In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, other Board Committees and other assurance functions, but will not be limited to these sources.

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It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it. As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages.

In particular, the Audit Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance statement and declarations of compliance with Care Quality Commission registration (the latter led through the Quality and Safety Committee), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- the Trust's arrangements for its employees and contractors to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.
- how cyber security arrangements are being managed including appropriate risk mitigation strategies.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from executive directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

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Internal Audit

The Committee shall ensure 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. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation has identified in the Assurance Framework.
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources.
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- annual review of the effectiveness of internal audit.

External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor, in line with the Trust's Constitution and the statutory guide for Foundation Trust Governors.
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.
- approval of the External Auditor's annual fee.
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- review all External Audit reports, including agreement of the annual audit letter before submission to the Trust Board and any work carried

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outside the annual audit plan, together with the appropriateness of management responses.

Counter fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review outcomes of counter fraud work. The Committee shall review the adequacy of the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS England, NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Management

The Committee shall request and review reports and positive assurances from executive directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- changes in, and compliance with, accounting policies and practices unadjusted mis-statements in the financial statements.

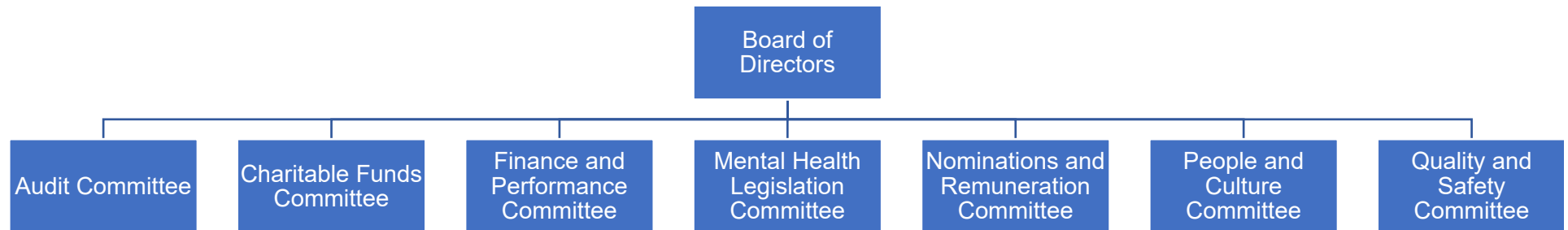
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- major judgemental areas.
- significant adjustments resulting from the audit.
- qualitative aspects of financial reporting.
- letters of representation from Directors.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

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7 Relationships with other groups and committees



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The Committee does not have any sub-committees. It is linked to the Trust's operational groups as an assurance receiver and provides a route of escalation to the Board of Directors.

8 Duties of the Chair

The Chair of the Committee shall be responsible for:

- agreeing the agenda in partnership with the Trust Secretary and Operational Director of Finance
- directing the meeting ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion
- giving direction to the secretariat and checking the draft minutes
- ensuring the agenda is balanced and discussion is productive
- ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee.

It should be noted that the Chair of the Committee is not permitted to chair any other Board Committee whilst acting in this role.

9 Reviews of the terms of reference and effectiveness

All elements of the Audit Committee Terms of Reference will be monitored by the Corporate Governance Team, reviewed annually by the Committee and reported in its Annual Report to the Board. The Committee may choose to invite external organisations and individuals to present issues and reports from time to time.

It will be the responsibility of the Chair of the Committee to ensure that it carries out an assessment of effectiveness annually, and ensure the outcome is reported to the Board of Directors along with any remedial action to address weaknesses. The Chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

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Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below “no deputy required”.

Full member (by job title)	Deputy (by job title)
Not applicable as non-executive directors do not have deputies	

Attendee (by job title)	Deputy (by job title)
Chief Executive	Deputy Chief Executive
Operational Director of Finance	Head of Financial Accounting and Capital
Trust Secretary	Deputy Trust Board Secretary
Chief Operating Officer	Deputy Director of Operations
Director of Nursing, Professions and Care Standards	Deputy Director of Nursing
Chief People Officer	Deputy Chief People Officer
Chief Medical Officer	Deputy Medical Director/Chief Pharmacist
Chief Information Officer	Head of Digital Services

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Finance and Performance Committee

Annual Governance Report

April 2025 to March 2026

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Contents

Section	Topic
1	Period covered by this report: 1 April 2025 to 31 March 2026.
2	Introduction
3	Assurance
4	Terms of Reference
5	Meetings of the Committee
6	Membership and attendance at meetings
7	Reports made to Board of Directors
8	Work of the Committee during 2025/2026
9	Conclusion
	Appendix A - Survey Results
	Appendix B - Action Plan

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1 Period covered by the report

This report covers the work of the Finance and Performance Committee for the financial year 1 April 2025 to 31 March 2026.

2 Introduction

The Finance and Performance Committee (Committee) has been formally established by the Board of Directors as one of its sub-committees. It is authorised to seek assurance on the controls and management in respect of financial governance, operational performance, and business and growth opportunities focusing on areas including: the financial data for submission to the Board; the financial plan; the procurement strategy; income contracts; the digital technology and information governance workstreams; the capital programme; estates workstream; business planning; and elements of workforce topics that are associated with financial and performance management.

The Committee will monitor and report to the Board on the effectiveness of the supporting systems and processes. The Committee's key objectives are to:

- monitor financial performance of the Trust against plan and provide assurance to the Board on the delivery of key financial targets;
- receive assurance on operational performance within the Trust;
- identify the key financial risks and drivers to achievement of financial targets, investigate significant variances and report any proposed remedial action to the Board as necessary;
- receive assurance on delivery of the Trust's workforce; estates (including health and safety, and environmental); and digital strategies;
- provide an oversight of the development and implementation of financial systems across the Trust; and
- provide an oversight of financial performance and key risks across the Bradford and Craven Place and wider West Yorkshire Integrated Care System.

This report covers the work the Committee has undertaken at the formal meetings held during 2025/26. It seeks to assure the Board on the work it has carried out and the assurances it has received, and to demonstrate that it has operated within its Terms of Reference.

Secretariat support is provided by the Corporate Governance Team, who work with the Chief Finance Officer in relation to agenda planning; minutes; managing cumulative action logs; and general meeting support.

3 Assurance

The Committee receives assurance from the Executive Director members of the Committee and from the subject matter experts who attend the meetings as required dependant on the agenda items being discussed.

Assurance is provided through written reports, both regular and bespoke, through critical challenge by members of the Committee and by members seeking to validate the information provided through wider knowledge of the Trust; specialist areas of expertise; attending Board of Directors, and Council of Governors meetings; visiting services, talking to colleagues, and observing operational meetings at the Trust as required.

The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plan are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.

Committee meetings are hybrid which allow Committee members and attendees to attend in person or via Microsoft Teams.

The delegated responsibilities aligned to Finance and Performance Committee is:

Making Best Use of Resources

- Theme 1: financial sustainability
- Theme 2: Our environment and workspaces
- Theme 3: Giving back to our community

Delivering Best Quality Services

- Theme 1: Access and flow

The Committee was responsible for two Strategic Objectives (SO):

BAF objective: SO5: To make effective use of our resources to ensure that services are clinically, environmentally, and financially sustainable.

BAF objective: SO6: To make progress in implementing our digital strategy to support our ambition to become a digital leader in the NHS.

The Committee reviews the BAF at each meeting prior to it being presented to the Board. Additionally, the agenda has been modified so that the BAF is appraised prior to other agenda items to allow items to be viewed in the context of the BAF.

The Chair of the Committee provides an update report to Council of Governor meetings held in public on the activities of the Committee, including areas where assurance had been received and areas requiring further development. This provides the Governors will an opportunity to hear more on the work of the Trust and see the Non-Executive Director fulfilling their role.

To promote consistency across the Trust, including alignment with the approach of the Internal Audit team, the Trust will use 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.

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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.

The Committee therefore received a number of key documents which included an Integrated Strategic Performance Report which directly aligned to those priority areas delegated to the Committee. Within these reports, informed by Executive oversight of operational grip and control systems, will be a proposed BAF assurance rating for each priority and theme. At the end of each Committee meeting the Chair made 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.

4 Terms of Reference

The updated Terms of Reference are presented for approval by Committee, following which they will be presented to the Board of Directors to be ratified.

5 Meetings of the Committee

In 2025/26, the Committee met seven times (including as part of extra-ordinary/Joint meetings). The dates of the meetings are as follows:

- 28/05/2025
- 23/07/2025
- 24/09/2025
- 13/11/2025 *Extra-Ordinary Combined Private Board & Finance and Performance Committee*
- 26/11/2025 *Finance and Performance Committee and an extra-Ordinary Combined Private Board & Finance and Performance Committee*
- 28/01/2026
- 25/03/2026

The draft agenda for each meeting is presented to the Chair of the Committee and the Chief Finance Officer by the Operational Director of Finance and the Committee Secretariat.

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Paperwork for the Committee is circulated seven calendar days prior to the meeting taking place. All actions pertaining to the meetings of the Committee are tracked on a cumulative action log and presented to each meeting for assurance with progress made.

6 Membership of the Committee and attendance at meetings

The minimum number of members for a meeting to be quorate is three, two of whom must be Non-Executive Directors (NED) and one Executive Director. Meetings that were not quorate during the period, had items for approval circulated after the meeting and reported to the next meeting.

During this period the Committee was chaired by a Non-Executive Director (NED), Maz Ahmed and Mark Rawcliffe (as deputy Chair).

Due to the nature of the position that they hold, all Executive and Non-Executive Directors as Board members can attend any Board sub-committee. Upon doing so they will assume full member rights and responsibilities.

Subject area experts are also invited to attend the meetings as appropriate, to provide expertise and knowledge on the areas that they are responsible for. On these occasions, they are attendees and do not count towards the membership of the meetings as outlined in the Terms of Reference.

The Trust also invites Governors to observe Board sub-committee meetings. This opportunity allows Governors to observe the work of the Committee, rather than to be part of its work as they are not part of the formal membership of the Committee. Governors observe Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe Non-Executive Directors appropriately challenging the Executive Directors about the operational performance of the Trust.

In addition to the meeting dates listed below the Committee met on a number of occasions as an Extra-Ordinary Combined Private Board & Finance and Performance Committee to approve specific items.

Attendance at meetings for substantive members and those in attendance were as follows:

Full Name	Role on Committee	28.05.25	23.07.25	24.09.25	26.11.25	28.01.26	25.03.26
Member							
Maz Ahmed	Member - Chair	X	X			X	
Mark Rawcliffe	Member – NED (Deputy Chair)	X	X	X	X	X	X
Phil Hubbard	Member	X	X			X	X
Bob Champion	Member	X		X		X	X
Therese Patten	Member			X		X	X
Mike Woodhead	Member	X	X	X	X	X	X
Dr David Sims	Member	X	X	<i>Retired</i>			
Dr Sal Uka	Member	<i>Started at the Trust Oct 2025</i>			X	X	
Kelly Barker	Member	X		X	X	X	X
Tim Rycroft	Member		X	X	X	X	X

Alyson McGregor	Member - NED			X			
Sally Napper	Member - NED						X
Regular Attendee							
Claire Risdon	In attendance	X	X		X	X	
Farhan Rafiq	In attendance	X	X	X	X	X	X
Fran Stead	In attendance			X	X	X	
Rachel Trawally	In attendance	X	X	X		X	X
Jess Greenwood-Owens	Corporate Governance Officer				X	X	X
Holly Close	Corporate Governance Officer	X	X	X			
Alix Jeavons	Attending on behalf of K Barker		X				
Michelle Holland	Attending on behalf of B Champion		X				
Chris Dixon	Attending on behalf of P Hubbard			X	X		
Jaspreet Sohal	Attending for S Uka						X
AnneMarie Dewhirst	Attending for C Risdon						X
Timed Business							
Theresa Fawcett	Presenter	X	X				
Shane Embleton	Presenter	X	X	X			
Emma Clarke	Presenter	X					X
Dean Davidson	Presenter	X					
David Gibson	Presenter		X				X
Alex Trigg							X
Observer							
Mike Gill	Observer	X					
Paul Hodgson	Observer	X	X	X			
Cleveland Henry	New NED in place from April 2026, attending March 2025 to observe						X

7 Reports made to the Board of Directors

The Chair of the Committee makes an Alert, Advise, Assure and Decision escalation report regarding the most recent meeting of the Committee to the next available Public Board of Directors' meeting and Council of Governors meeting. This report seeks to assure the Board on the main items discussed by the Committee and, should it be necessary, to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself. Where items are considered to be of significance and a certain urgency, the Chair of the Committee may make use of Exceptional Escalation Reports to the Trust Chair and Chief Executive, and where appropriate the Board of Directors. From January 2025, these reports are now called Effective Oversight Escalation and Assurance Reports.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the Committee the Board may ask for these to be looked at in greater detail by the Committee.

The below table outlines the date that the assurance and escalation report was presented by the Chair of the Committee to the Board of Directors' meeting. In addition, a copy of Committee-ratified minutes is presented to the Board for information.

Date of meeting	Assurance and escalation report to Board by Chair
28/05/2025	05/06/2025
23/07/2025	02/10/2025
24/09/2025	04/12/2025
13/11/2025	N/A (Extra-Ordinary Combined Board & Finance and Performance Committee)
26/11/2025	05/02/2026
28/01/2026	05/02/2026
25/03/2026	TBC

8 The work of the Committee during the year 1 April 2025 until 31 March 2026

The Chair of the Committee can confirm that the Committee has carried out its role in accordance with its Terms of Reference. Further details of all these areas of work can be found in the minutes and papers of the Committee.

A high-level presentation of areas of work on which the Committee has received assurance and update during 2025/26 are as follows:

Assurance on:

- Integrated Strategic Performance Report
- System Finance Update
- AAAD: Senior Leadership Team – Care Group Assurance Meeting
- AAAD: System Finance & Performance Committee

Reports and presentation on:

- Annual Financial & Operational Plan
- Committee Annual Effectiveness review
- Committee Annual Governance Report
- Contracts Updates
- Data Quality Update

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- Digital Updates
- Green Plan Updates
- Lynfield Mount Hospital Re-development
- Microsoft Licencing Update
- Organisational Sustainability Board Update
- RIDDOR incidents and Martin's Law
- Strategic Risk
- Well Led Implementation Plan update

9 Annual Effectiveness Review Summary

The Committee undertook an Annual Effectiveness Review in the form of a Survey sent to regular attendees and members in February 2026. Seven colleagues responded to the survey.

The survey comprised of a set of standard questions with 'agree', 'disagree' and 'other' within the areas of A. Committee Operation, B. Committee Administration, C. Terms of Reference and E. Strategy. The facility for providing additional feedback was used by some people which enriched the data with constructive comments and suggestions, including areas where further work should be considered.

Feedback shows that the **Finance and Performance Committee is functioning well**, with strong governance, good chairing and high-quality papers. Members feel meetings are purposeful, aligned to strategy, and supportive of effective challenge.

A few areas show variability, particularly around induction, agenda balance, and cross-committee working.

Things We're Doing Well

- **Clear structure & governance:** Strong Terms of Reference, appropriate membership and resources.
- **Effective meetings:** Right frequency, good flow of debate, values-aligned discussion, productive reflections.
- **Strong chairing:** Helps maintain focus and supports constructive challenge.
- **High-quality information:** Papers and minutes are timely, clear, and enable good decision-making.
- **Strategic alignment:** Work supports Trust priorities and contributes positively to assurance.
- **Joint working:** Effective when issues span committees.

Areas for Improvement

- **Induction & training:** Some members feel onboarding and support for new members could be strengthened.
- **Agenda pressure:** Full agendas sometimes limit discussion time; meeting focus could be sharpened further.
- **Cross-committee links:** Mixed views on whether interaction is sufficient - opportunity to formalise connections.

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- **Consistency in papers:** Mostly positive, but occasional mixed responses on timeliness and variation in quality.
- **Health equity:** Could feature more clearly in work plans.
- **Learning from your experience** suggestion to add a “learning from experience” standing item.

10 Conclusion

The Chair of the Committee would like to assure the Board that the Committee worked hard to fulfil its Terms of Reference during 2025/26, managing the priority areas for consideration and agreeing items for deferral. The Board is asked to recognise how the Committee supports the ongoing continuous improvement journey both at the Trust and on its own effectiveness.

The Committee adds value by maintaining an open and professional relationship with officers of the Trust and it has carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues, risks, or learning. Organisational learning drives this Committee and is one of its core values; further improvements will be made to advance this critical aspect of quality and safety.

Members of the Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

The Chair sincerely thanks all Committee members, for their integrity, engagement, constructive challenge and commitment to ongoing improvement.

Jess Greenwood-Owens - Corporate Governance Officer

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Appendix A – Survey Response

Question - 7 people responded to the survey - if anyone chose 'not able to answer' their reply to those questions was removed from the analysis	Agree %	Disagree %	Other %
The Committee reports regularly to the Board	100%	0%	0%
The Committee has established a work plan for the year which is relevant to the terms of reference	100%	0%	0%
The Committee meets the appropriate number of times to deal with planned matters.	100%	0%	0%
At the end of each meeting the Committee discusses the outcomes and reflects back on decisions made and what worked well or not so well.	86%	14%	0%
Discussion aligns to the Trust values, we care, we listen, we deliver.	100%	0%	0%
The quality of Committee papers received allows me to perform my role effectively.	100%	0%	0%
Reports received have the right format and content.	100%	0%	0%
Committee papers are distributed in sufficient time to give them due consideration.	86%	0%	14%
Minutes are accurate and of a high quality and are received as soon as possible after meetings, setting out key actions and assurances received.	100%	0%	0%
The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	100%	0%	0%
Each member contributes sufficient time to fulfil their role.	100%	0%	0%
Members, particularly those new to the Committee, are provided with induction and training.	71%	14%	14%
The Board ensures that members have sufficient knowledge of the Trust to identify key risk areas and to challenge on issues.	100%	0%	0%
Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints.	86%	0%	14%
The Committee has written Terms of Reference that define the Committee's role.	100%	0%	0%
The Committee is empowered to take action and make decisions, aligned to the Terms of Reference.	100%	0%	0%
Sufficient attention and time is given to discuss strategic risks.	86%	14%	0%
Does the Committee interact sufficiently with other Committees to support integrated governance.	71%	14%	14%
Health equity is proactively considered by the Committee and features on its work plan.	86%	0%	14%
Formal reporting is supplemented by opportunities to gather people's experience in support of triangulation.	86%	14%	0%
The work plan supports effective oversight to support assurance reporting, escalation and triangulation.	100%	0%	0%
The Committee's work is aligned clearly with the Trust strategy & strategic objectives.	100%	0%	0%
The Committee ensures that its decisions contribute to strategic direction of the Trust.	100%	0%	0%
The Committee's priorities are regularly reviewed to ensure alignment with changing priorities and risks.	100%	0%	0%
The Committee has made a positive contribution to work of the Trust over the last year.	100%	0%	0%
There is a process for communicating the Committee's outcomes.	100%	0%	0%

Appendix B - Action Plan

Issued raised	Actions planned/undertaken	Responsible	Priority Level
Induction & training: Some members feel onboarding and support for new members could be strengthened.			
Agenda pressure: Full agendas sometimes limit discussion time; meeting focus could be sharpened further.			
Cross-committee links: Mixed views on whether interaction is sufficient - opportunity to formalise connections.			
Consistency in papers: Mostly positive, but occasional mixed responses on timeliness and variation in quality.			
Health equity: Could feature more clearly in work plans.			
Learning from your experience suggestion to add a “learning from experience” standing item.			

Close Holly
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Finance and Performance Committee

Terms of Reference

Version:	<u>4.0- 5.0</u>
Approved by:	Finance and Performance Committee
Ratified by:	Board of Directors
Date approved:	<u>Tbc</u>
Date ratified:	<u>Tbc</u>
Job title of author:	Corporate Governance Manager / Deputy Trust Board Secretary
Job title of responsible Director:	Non-executive Director and Chair of the Finance and Performance Committee
Date issued:	<u>Tbc</u>
Review date:	<u>Tbc</u>
Frequency of review:	Annual
Amendment Summary:	<ul style="list-style-type: none"> - <u>Update from Medical Director to Chief Medical Officer</u> - <u>Update to quoracy 'and one Executive Director.'</u> - <u>Update to Trust Secretary or Deputy Trust Secretary</u>

1 Name of group / committee

Finance and Performance Committee.

2 Composition of the Committee

Members: full rights

Title	Role in the group / committee
Non-executive Director	Committee Chair
Non-executive Director	Additional non-executive member
Chief Executive	Accountable Officer for the Trust
Chief Finance Officer	Executive lead for financial resources within the Trust. Assurance and escalation provider to the Finance and Performance Committee.
Chief Operating Officer	Executive lead with day-to-day responsibility for operational delivery of services. Assurance and

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Title	Role in the group / committee
	escalation provider to the Finance and Performance Committee.
Chief People Officer	Executive lead for workforce development. Assurance and escalation provider to the Finance and Performance Committee. Attendance at meetings will be dependent on the agenda items being discussed.
Chief Information Officer	Executive lead for digital services.
Director of Nursing, Professions and Care Standards	Executive lead for nursing, professions, risk management, compliance, care standards. Assurance and escalation provider to the Finance and Performance Committee.
Medical Director Chief Medical Officer	Executive lead with responsibility for clinical services, KPO, Pharmacy, Research and Development. Assurance and escalation provider to Finance and Performance Committee.
Director of Transformation, Productivity and Improvement	Executive Lead for transformation, productivity and improvement. Responsibility for the Project Management Office and Business Support and Performance.

The Operational Director of Finance, and Trust Secretary or Deputy Trust Secretary will attend all meetings. In addition to anyone listed above, the Chair of the Committee may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

2.1 Governor Observers

The Committee welcomes and encourages governors to attend its meetings. The role of a governor at Board sub-committee meetings is to observe the work of the Committee. The governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust. At the meeting the governor observer(s) will be required to declare any interest they may have in respect of any of the items to be discussed.

3 Quoracy

Number: The minimum number of members for a meeting to be quorate is three, two of whom must be non-executive directors and one Executive Director. Attendees do not count towards quoracy.

If the Chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by one of the other non-executive directors.

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Deputies: Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal “acting up” arrangements. A schedule of deputies, attached at appendix 1a, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must be approved virtually by full rights members and formally reviewed at the next quorate meeting.

4 **Meetings of the committee**

Frequency: Normally bi-monthly to deliver six Committee meetings per year, with the option of having additional meetings if required.

Urgent meeting: Any member of the Committee may request an urgent meeting.

Joint Committee Meetings: Joint Committee meetings can take place between Board sub-committees. It will be for the Executive Directors in partnership with Non-Executive Director Chairs to agree when a meeting will be convened. Joint Committee meetings will be facilitated by the Corporate Governance team and will either be formal meetings, or development sessions. When Joint meetings are convened the relevant Terms of Reference will be adhered to.

Minutes: The Committee Secretariat will be provided by the Corporate Governance Team.

Effective Oversight Escalation and Assurance Reporting: The Chair of the Committee will provide an update of key issues arising from the meeting to the next Public Board of Directors meeting.

5 **Authority**

Establishment: The Committee is a sub-committee of the Board of Directors and has been formally established by the Board.

Powers: Its powers, in addition to the powers vested in the executive members in their own right, are detailed in the Trust’s Scheme of Delegation.

Cessation: The Committee is a standing Board sub-committee in that its responsibilities and purpose are not time limited. However, the Committee has a responsibility to review its effectiveness annually.

6 **Role of the committee**

6.1 Purpose of the committee

The purpose of the Finance and Performance Committee is to support the Board's strategic direction and stewardship of the Trust's finances, investments and sustainability.

In particular, the Committee is to provide the Board with assurance concerning aspects of finance and performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for service users and carers. It will seek assurance that there is adequate organisational oversight of the financial, workforce, estates (including health and safety, and environmental), and informatics risks to the Trust's ability to achieve its strategic objectives

The Committee review the financial and non-financial targets of the Board, to ensure that appropriate arrangements are in place to deliver against organisational performance measures, to secure economy, efficiency, and effectiveness in the use of all resources, and provide assurance that the arrangements are working effectively. The Committee will oversee the ongoing development of a performance management culture in the Trust where performance management is seen as part of the day job striving for excellence and focussing on improvement in all aspects.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Committee

In carrying out their duties members of the Committee and any attendees must ensure that they act in accordance with the values of the Trust, which are:

- we care
- we listen
- we deliver.

As agreed by the Board July 2023 within the Better Lives Together strategic framework, the Committee operates aligned to the four strategic priorities:

- Being the Best Place to Work
- Delivering the Best Quality Services
- Making the Best Use of Resources
- Being the Best Partner

6.3 Duties of the Committee

The Committee's key objectives are to:

- monitor financial performance of the Trust against plan and provide assurance to the Board on the delivery of key financial targets;

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- identify the key financial risks and drivers to achievement of financial targets, investigate significant variances and report any proposed remedial action to the Board as necessary;
- receive assurance on delivery of the Trust's workforce; estates (including health and safety, and environmental); and informatics strategies;
- provide an oversight of the development and implementation of financial systems across the Trust; and
- provide an oversight of financial performance and key risks across the Bradford Place and wider ICS.

The Committee will:

1) Finance

- scrutinise the Trust's in-year financial performance, delivery of Cost Improvement Plans and other key financial targets;
- review the annual budget, regulator targets, and regulator information requests prior to recommendation to the Board of Directors;
- review the development of the Trust's five-year financial plan, ensuring it is aligned with clinical, estates, workforce, informatics and other business strategies;
- review the financial risks and mitigations of the ICP/ ICS;
- review development and implementations of the business strategies that drive the financial planning and performance of the organisation;
- maintain an oversight of, and receive assurances on the robustness of the Trust's key income sources and contractual safeguards;
- review internal and external corporate benchmarking reports;
- consider and recommend to Board proposals for investment in commercial business cases; and
- review the process for determining capital expenditure projects and their monitoring, including post-implementation reviews.

2) Workforce issues affecting the Trust's financial strategy

- receive assurance on progress made against the Workforce Strategy;
- consider the control and mitigation of workforce related risks and provide assurance to the Board that such risks are effectively controlled and managed;
- receive reports on the delivery of other Trust strategies and initiatives that interlink with the workforce and organisational development workstream; and
- receive assurance on statutory workforce standards such as agenda for change.

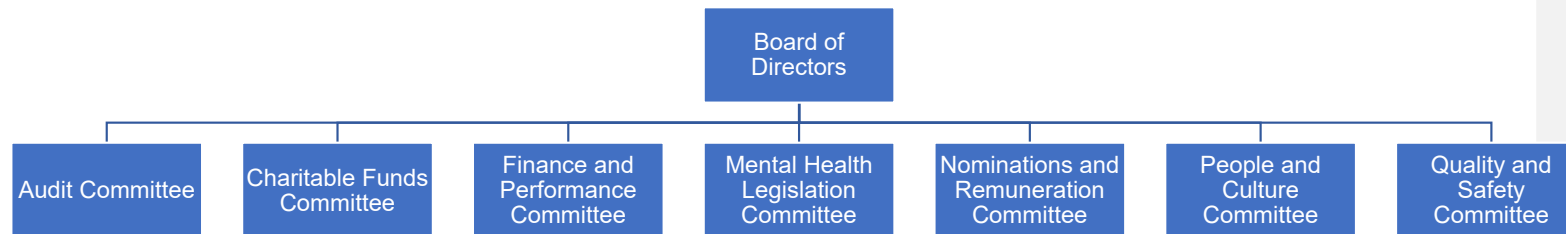
3) Procurement issues affecting the Trust's financial strategy

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- receiving assurance that the Trust's plan is increasing efficiencies; and
 - review operational reports to monitor compliance with effective procurement procedures and policies.
- 4) Estate issues (including environmental and health and safety) affecting the Trust's financial strategy
- receiving assurance on delivery of the Trust's estate's strategy;
 - receiving assurance on the Bradford place estate's strategy;
 - receiving assurance on statutory health and safety requirements; and
 - reports on the Trust's proactive approach to health and safety management, and environmental issues.
- 5) Informatic issues affecting the Trust's financial strategy
- receive progress updates on delivery of the Trust's digital strategy;
 - receive assurance on the Trust's preparedness to support appropriate cyber security; and
 - assurance against statutory data requirements and compliance with requirements set by the Information Commissioners Office.
- 6) System-wide partnership working
- As required, receive assurance on the governance arrangements that support system-wide partnership working.
- 7) Receiving assurance on the Trust's performance against:
- annual budgets, capital plans, and Cost Improvements;
 - quality, innovation, productivity and transformation; and
 - clinical activity and key performance indicators. Seek assurance that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support the operational management of the organisation.

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7 Relationships with other groups and committees



The Committee does not have any sub-committees. It is linked to the Trust's operational groups as an assurance receiver and provides a route of escalation to the Board of Directors.

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8 Duties of the Chair

The Chair of the Committee shall be responsible for:

- agreeing the agenda in partnership with the Chief Finance Officer;
- directing the meeting ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion;
- giving direction to the secretariat and checking the draft minutes;
- ensuring the agenda is balanced and discussion is productive; and
- ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee.

9 Reviews of the terms of reference and effectiveness

The terms of reference shall be reviewed by the Committee at least annually and be presented to the Board of Directors for ratification.

It will be the responsibility of the Chair of the Committee to ensure that it carries out an assessment of effectiveness annually, and ensure the outcome is reported to the Board of Directors along with any remedial action to address weaknesses. The Chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below "no deputy required".

Full member (by job title)	Deputy (by job title)
Non-executive Director Chair	Another Non-executive Director
Non-executive Director	Another Non-executive Director
Chief Executive	Deputy Chief Executive
Chief Finance Officer	Operational Director of Finance
Chief Operating Officer	Deputy Director of Operations
Chief People Officer	Deputy Chief People Officer
Chief Information Officer	Head of Digital Services
Director of Nursing, Professions and Care Standards	Deputy Director of Nursing, Professions and Care Standards
Medical Director Chief Medical Officer	Deputy Medical Director/Chief Pharmacist

Attendee (by job title)	Deputy (by job title)
Operational Director of Finance	Head of Finance
Trust Secretary	Deputy Trust Secretary

Commented [JG1]: Do we need to change this as Fran coming for timed business only now?

Agenda
Item

22.0.5

Mental Health Legislation Committee

Annual Governance Report

1 April 2025 to 31 March 2026

DRAFT

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Contents

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1 Period covered by the report

The report covers the period from 1 April 2025 to 31 March 2026.

2 Introduction

The Mental Health Legislation Committee (Committee) has been formally established by the Board of Directors as one of its sub-committees. It is authorised to seek and obtain evidence of assurance on the effectiveness of the Trust's mental health legislative systems and processes, and the quality of the services provided. The Committee will monitor and report to the Board on the effectiveness of these systems and processes. The Committee's key objectives are to seek assurance that:

- systems and processes are effective, and wherever possible evidence-based
- the quality of services provided is good and continuously improving
- the experience of people using Trust services is good and continuously improving.

The Committee also seeks to:

- monitor, review and report to the Board on all the above; highlighting assurances received and risks to assurance identified
- receive relevant mental health legislation update for information and assurance.

This report covers the work the Committee has undertaken at the formal meetings held during 2025/26. It seeks to assure the Board on the work it has carried out and the assurances it has received, and to demonstrate that it has operated within its Terms of Reference.

The Trust welcomes and encourages feedback and recognises the importance of being a learning organisation. An experience or story is presented at the start of each Committee meeting, with the view that the input will be linked to one of the identified priorities the Committee is responsible for. This new approach will provide an opportunity for Board members to triangulate, build relationships with Trust colleagues, and support the Board's ongoing journey for Board visibility and accessibility to the workforce.

Secretariat support is provided by the Corporate Governance Team who work with the Chair of the Committee, the Chief Medical Officer and Mental Health Legislation Lead in relation to agenda planning.

3 Assurance

The Committee receives assurance from the Executive Director members of the Committee and from the subject matter experts who attend the meetings as required dependant on the agenda items being discussed.

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Assurance is provided through written reports, both regular and bespoke, through critical challenge by members of the Committee and by members seeking to validate the information provided through wider knowledge of the Trust; specialist areas of expertise; attending Board of Directors', and Council of Governors' meetings; visiting services, talking to staff, and observing operational meetings at the Trust as required.

The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge.

The Committee meetings are hybrid which allowed Committee members to attend in person or via Microsoft Teams.

The delegated responsibilities aligned to Mental Health Legislation Committee are outlined as Best Quality Services – Theme 3 – Improving the experience of people using our services (specifically in relation to restrictive practices).

In order to promote consistency across the Trust, including alignment with the approach of the Internal Audit team, the Trust will use 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 being achieved and is embedded within usual practice. There are example: 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 there is evidence these are mitigated / responded to rapidly and appropriate
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 effective plans to address and significant works needs to be undertaken to bring these areas up to standard.

The Committee therefore received a number of key documents which included an Integrated Strategic Performance Report which directly aligned to those priority areas delegated to the Committee. Within these reports, informed by Executive oversight of operational grip and control systems, will be a proposed BAF assurance rating for each priority and theme. At the end of each Committee meeting the Chair made a formal

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decision to either ratify that assurance level or change it, based on the intelligence considered across the entirety of the business of the Committee.

3 Terms of Reference

The updated Terms of Reference are presented for approval by Committee, following which they will be presented to the Board of Directors to be ratified.

4 Membership of the committee and attendance at meetings

The minimum number of members for a meeting to be quorate is three, two of whom must be Non-Executive Directors (NED) and one Executive Director. All meetings in the period were quorate apart from two meetings; 22 May 2025, and 10 October 2025 where any decisions and ratifications were done outside of the meeting via email and confirmed under the 'matters arising section' at the next meeting. During this period, the 10 October 2025 Committee meeting should have taken place on 18 September 2025, but due to Non-Executive Director availability the meeting date was changed.

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, 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.

Due to the nature of the position that they hold, all Executive and Non-Executive Directors as Board members can attend any Board sub-committee. Upon doing so they will assume full member rights and responsibilities.

Subject area experts are also invited to attend the meetings as appropriate, to provide expertise and knowledge on the areas that they are responsible for. On these occasions, they are attendees and do not count towards the membership of the meetings as outlined in the Terms of Reference.

The Trust also invites Governors to observe Board sub-committee meetings. This opportunity allows Governors to observe the work of the Committee, rather than to be part of its work as they are not part of the formal membership of the Committee. Governors observe Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe Non-Executive Directors appropriately challenging the Executive Directors about the operational performance of the Trust.

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Experience and involvement continued to be a key focus for the Trust with identified Involvement Partners, who are supported by the Patient Experience Team. The Committee has been supported by two service user Involvement Partners.

The Committee is also supported by two hospital managers who each attend on alternate meetings

Attendance at meetings for substantive members and those in attendance were as follows:

Name	22 May 2025	17 July 2025	10 October 2025	20 November 2025	22 January 2026	19 March 2026
Substantive Members						
Simon Lewis, Chair, Non-Executive Director		X	X	X		X
Warren Brown, Chair, Non-Executive Director	N/A				X	X
Alyson McGregor, MBE, Non-Executive Director	X	X		X	X	X
Dr David Sims, Medical Director	X	X	N/A			
Dr Sal Uka, Chief Medical Officer	N/A		X	X	X	
Philippa Hubbard, Director of Nursing, Professions and Care Standards and Deputy Chief Executive		X	X	X	X	X
Kelly Barker, Chief Operating Officer			X	X	X	X
Others in attendance						
Keith Double, Involvement Partner	X	X	X	X	X	X
Karan Essien, Involvement Partner	X				X	X
Marilyn Bryan, Associate Hospital Manager		X	X		X	X
Mary Litchfield, Hospital Manager	X			X		
Simon Binns, Mental Health Legislation Lead	X	X	X	X	X	X
Teresa O'Keefe, Mental Health Act Advisor	X	X		X	X	X
Joanne Tiler, Mental Capacity Act Clinical Lead	X	X				X
Dr Anita Brewin, Head of Psychological Therapies	X			X		
Chris Dixon, Deputy Director of Nursing & Professions	X	X			X	X
Thabani Songo, Head of Nursing – Mental Health						
Fran Stead, Trust Secretary			X	X	X	X
Rachel Trawally, Deputy Trust Secretary		X			X	X
Holly Close, Corporate Governance Officer (Secretariat)		X		X	X	X
Nazmeen Khan, Corporate Governance Officer (Secretariat)	X	N/A				
Richard Cliff, Head of Legal Services	X	X	X	X	X	X
Rachel Howitt, Head of Patient Safety						

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Baljit Kaur Nota, AHMP – Local Authority Team Manager		X				
Dr Phalaksh Walishetty, Deputy Chief Medical Officer for Quality and Patient Safety, Mental Health Legislation, Inpatients/Intensive Home Treatment Team/Liaison Psychiatry/Forensic Psychiatry and Intellectual Disability, Performance			X	X	X	X
Attending for specific items						
Mathew Cook, Management of Violence and Aggression Trust Lead			X			
Katie Eacret, Ward Manager, Clover Ward (PICU – Psychiatric Intensive Care Unit)			X			
Raj Gohri, BI Integration Manager				X		
Attending as an observer						
Natalie McMillan, Well Led Observer	X					
Dr Phalaksh Walishetty		X				
Masira Hans, Governor Observer			X			
Tricia George, Head of Patient Safety					X	X

5 Report made to the Board of Directors

The Chair of the Mental Health Legislation Committee makes an Effective Oversight Escalation and Assurance Report regarding the most recent meeting of the Committee to the next available Board of Directors’ meeting. This report seeks to assure the Board on the main items discussed by the Committee and, should it be necessary, to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself. Where items are considered to be of significance and a certain urgency, the Chair of the Committee may make use of Exceptional Escalation Reports to the Trust Chair and Chief Executive, and where appropriate the Trust Board.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the Committee the Board may ask for these to be looked at in greater detail by the Committee.

The below table outlines the date that the an Effective Oversight Escalation and Assurance Report was presented by the Chair of the Committee to the Public Board of Directors meeting. In addition, a copy of Committee-ratified minutes is presented to the Board for information.

Date of meeting	Assurance and escalation report to Board by Chair
-----------------	---

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22 May 2025	5 June 2025
17 July 2025	2 October 2025
10 October 2025	4 December 2025
20 November 2025	4 December 2025
22 January 2026	5 February 2026
19 March 2026	02 April 2026

6 The work of the Committee during the year between April 2025 and March 2026.

The Chair of the Committee can confirm that the Committee has carried out its role in accordance with its Terms of Reference. Further details of all these areas of work can be found in the minutes and papers of the Committee.

High-level and more detailed presentations of areas of work on which the Committee has received assurance and during the year were as follows:

Assurance on:

- AAAD: Positive & Proactive Group
- AAAD: Clinical Board

Reports and presentations on:

- Feedback from Involvement Partners
- Strategic Performance Report
- Strategic Risk Report
- Mental Health Act Reform
- Associate Hospital Manager's Report
- Care Quality Commission Update: Mental Health Act Monitoring Review Visits
- Mental Capacity Act update (including Liberty Protection Safeguarding; Action Plan updates)
- Mental Capacity Act audit results, 6 month Annual update
- Mental Capacity Act Annual Report
- Annual Report on the use of the Mental Health Act
- Ligature Assessment Annual Report
- Timeliness of reports to tribunals & Hospital Managers
- Learning from your experience: The use of Seclusion and long term segregation
- Community Treatment Orders update
- Searching of patients & their property
- Annual Effectiveness Review
- Learning from your experience: Business Intelligence Team – Pilot Dashboard
- Annual Report on the use of the Mental Health Act

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- Learning from your experience: Intensive Home Treatment Team (IHTT)

7 Annual Effectiveness Review Summary

The Committee undertook an Annual Effectiveness Review in the form of a Survey sent to regular attendees and members in February 2026. 5 colleagues responded to the survey.

The survey comprised of a set of standard questions with 'agree', 'disagree' and 'other' within the areas of A. Committee Operation, B. Committee Administration, C. Terms of Reference and E. Strategy. The facility for providing additional feedback was used by some people which enriched the data with constructive comments and suggestions, including areas where further work should be considered.

Overall Summary

The Mental Health Legislation Committee is performing strongly overall, with members consistently agreeing that it meets governance standards, operates in line with Trust values, and contributes positively to the organisation. Core processes (papers, minutes, debate, strategic alignment) are viewed as effective. A few recurrent improvement themes emerge around the work plan, agenda/time management, inter-committee links, and induction/training.

Things We're Doing Well:

- **Governance foundations are solid:** Clear Terms of Reference, good strategic alignment, empowered to act, and contributes positively to the Trust.
- **Meeting operation is effective:** Right frequency, constructive debate, reflective end-of-meeting practice, and alignment to Trust values.
- **Information quality is good:** Papers generally high-quality and timely; minutes accurate and helpful.
- **Supportive culture:** Officers provide strong support; members feel able to contribute.

Areas for Improvement:

- **Work plan needs refreshing:** Seen as repetitive; requires update due to changes in mental health legislation; difficulty finding leads for some items.
- **Agenda/time pressure:** Some meetings overrun or allow too much unstructured discussion.
- **Report format consistency:** A few comments that report content/format is inconsistent or incomplete.
- **Induction and training gaps:** A member not aware of any induction/training offer.
- **Inter-committee links (especially with Q&S):** Could be more aligned to support integrated governance.
- **Role clarity:** Hospital Managers and Patient Advocates' roles need clearer support and definition.
- **Health equity focus:** Considered present but not strongly embedded by all members.

8 Conclusion

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The Chair of the Mental Health Legislation Committee would like to assure the Board that the Committee worked hard to fulfil its Terms of Reference during 2025/26. The Board is asked to recognise how the Committee supports the ongoing continuous improvement journey both at the Trust and on its own effectiveness.

The Committee adds value by maintaining an open and professional relationship with officers of the Trust and it has carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues, risks, or learning. Organisational learning drives this Committee and is one of its core values; further improvements will be made to advance this critical aspect of quality and safety.

Members of the Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

The Chair sincerely thanks all Committee members, for their integrity, engagement, constructive challenge and commitment to ongoing improvement.

Holly Close – Corporate Governance Officer

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Appendix A – Survey Response

Question - <i>5 people responded to the survey - if anyone chose 'not able to answer' – their reply to those questions was removed from the analysis</i>	Agree %	Disagree %	Other %
The Committee reports regularly to the Board	100%	0%	0%
The Committee has established a work plan for the year which is relevant to the terms of reference	100%	0%	0%
The Committee meets the appropriate number of times to deal with planned matters.	100%	0%	0%
At the end of each meeting the Committee discusses the outcomes and reflects back on decisions made and what worked well or not so well.	100%	0%	0%
Discussion aligns to the Trust values, we care, we listen, we deliver.	100%	0%	0%
The quality of Committee papers received allows me to perform my role effectively.	100%	0%	0%
Reports received have the right format and content.	80%	20%	0%
Committee papers are distributed in sufficient time to give them due consideration.	100%	0%	0%
Minutes are accurate and of a high quality and are received as soon as possible after meetings, setting out key actions and assurances received.	100%	0%	0%
The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	100%	0%	0%
Each member contributes sufficient time to fulfil their role.	100%	0%	0%
Members, particularly those new to the Committee, are provided with induction and training.	40%	40%	20%
The Board ensures that members have sufficient knowledge of the Trust to identify key risk areas and to challenge on issues.	100%	0%	0%
Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints.	100%	0%	0%
The Committee has written Terms of Reference that define the Committee's role.	100%	0%	0%
The Committee is empowered to take action and make decisions, aligned to the Terms of Reference.	100%	0%	0%
Sufficient attention and time is given to discuss strategic risks.	100%	0%	0%
Does the Committee interact sufficiently with other Committees to support integrated governance.	60%	20%	20%
Health equity is proactively considered by the Committee and features on its work plan.	60%	20%	20%
Formal reporting is supplemented by opportunities to gather people's experience in support of triangulation.	100%	0%	0%
The work plan supports effective oversight to support assurance reporting, escalation and triangulation.	80%	20%	0%
The Committee's work is aligned clearly with the Trust strategy & strategic objectives.	100%	0%	0%
The Committee ensures that its decisions contribute to strategic direction of the Trust.	100%	0%	0%
The Committee's priorities are regularly reviewed to ensure alignment with changing priorities and risks.	100%	0%	0%
The Committee has made a positive contribution to work of the Trust over the last year.	100%	0%	0%
There is a process for communicating the Committee's outcomes.	100%	0%	0%

Appendix B - Action Plan

Issued raised	Actions planned/undertaken	Responsible	Priority Level
Work plan needs refreshing: Seen as repetitive; requires update due to changes in mental health legislation; difficulty finding leads for some items.			
Agenda/time pressure: Some meetings overrun or allow too much unstructured discussion.			
Report format consistency: A few comments that report content/format is inconsistent or incomplete.			
Induction and training gaps: A member not aware of any induction/training offer.			
Inter-committee links (especially with Q&S): Could be more aligned to support integrated governance.			
Role clarity: Hospital Managers and Patient Advocates' roles need clearer support and definition.			
Health equity focus: Considered present but not strongly embedded by all members			

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Mental Health Legislation Committee

Terms of Reference

Version:	187.0
Approved by:	Mental Health Legislation Committee
Ratified by:	Board of Directors
Date approved:	TBC
Date ratified:	TBC
Job title of author:	Corporate Governance Team
Job title of responsible Director:	Non-Executive Director and Chair of the Mental Health Legislation Committee
Date issued:	March 2026 July 2025
Review date:	July 2026 March 2027
Frequency of review:	Annual
Amendment Summary: <ul style="list-style-type: none"> • <u>Changing the title of the Medical Director position to Chief Medical Officer</u> Renaming of Assurance & Escalation reporting to Effective Oversight: Escalation and Assurance - <u>Inclusion of Medical Lead for Mental Health from Chief Medical Officers Office to the list of attendees and deputies list.</u> 	

1 Name of Committee

Mental Health Legislation Committee.

2 Composition of the Mental Health Legislation Committee

Members: full rights

Title	Role in the group / committee
Non-Executive Director	Committee Chair
Non-Executive Director	Additional Non-Executive member
Medical Director <u>Chief Medical Officer</u>	Executive lead for Committee. Assurance and escalation provider to the Mental Health Legislation Committee.
Chief Operating Officer	Executive with day-to-day responsibility for operational delivery of services. Assurance and escalation provider to the Mental Health Legislation Committee.

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Director of Nursing, Professions and Care Standards	Assurance and escalation provider to Mental Health Legislation Committee
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Any Executive and Non-Executive Director can attend a Board sub-committee meeting because of the position that they hold. When carrying out this duty they will assume full member rights.

In addition, the following individuals will attend each meeting:

Job Title
Associate Hospital Manager
Mental Capacity Act and DOLS Clinical Lead (Also a DOLS Best Interest practitioner)
Mental Health Legislation Lead
Mental Health Act Advisor
Approved Mental Health Professionals Manager
Deputy Director for Professions / Chief Psychological Therapies Officer (Joint Chair of Positive & Proactive Steering Group)
Head of Legal Services
Head of Patient Safety
Trust Secretary
<u>Medical Lead for Mental Health from Chief Medical Officers Office</u>

In addition to anyone listed above, the Chair of the Committee may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

2.1 Governor Observers

The Committee welcomes and encourages governors to attend its meetings. The role of a Governor at Board sub-committee meetings is to observe the work of the Committee. The Governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe Non-Executive Directors appropriately challenging the Executive Directors for the operational performance of the Trust. At the meeting the Governor observer(s) will be required to declare any interest they may have in respect of any of the items to be discussed.

Quoracy

Number: The minimum number of members for a meeting to be quorate is three, two of whom must be Non-Executive directors and one Executive Director. Attendees do

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not count towards quoracy. If the Chair of the Committee is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by one of the other Non-Executive directors.

Deputies: Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal “acting up” arrangements.

A schedule of deputies, attached at appendix 1a, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4 **Meetings of the Committee**

Frequency: The Committee will meet at least six times a year. There will be separate meetings if required by the Board.

Urgent meeting: Any member of the Committee may request an urgent meeting. The Chair of the Committee will normally agree to call an urgent meeting to discuss the specific matter, unless the opportunity exists to discuss the matter in a more expedient manner.

Joint Committee Meetings: Joint Committee meetings can take place between Board sub-committees. It will be for the Executive Directors in partnership with Non-Executive Director Chairs to agree when a meeting will be convened. Joint Committee meetings will be facilitated by the Corporate Governance Team and will either be formal meetings, or development sessions. When Joint meetings are convened the relevant Terms of Reference will be adhered to.

Minutes: The Committee Secretariat will be provided by the Corporate Governance Team.

Effective Oversight: Escalation and Assurance Reporting: The Chair of the Committee will provide an update of key issues arising from the meeting to the next Board of Directors meeting held in public.

Voting: It is at the discretion of the Chair of the meeting to call a vote during a meeting. When voting, decisions at meetings shall be determined by a majority of the votes of the Executive and Non-Executive Directors present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

5 **Authority**

Establishment: The Committee is a sub-committee of the Board of Directors and has been formally established by the Board.

Powers: Its powers, in addition to the powers vested in the executive members in their own right, are detailed in the Trust's Scheme of Delegation.

Cessation: The Committee is a standing Board sub-committee in that its responsibilities and purpose are not time limited. However, the Committee has a responsibility to review its effectiveness annually.

6 Role of the Committee

6.1 Purpose of the Committee

The overall aim of the Committee is to monitor, review and report to the Board the adequacy of the Trust's processes to support the operation of mental health legislation. As agreed by the Board July 2023 within the Better Lives Together strategic framework, the Mental Health Committee is responsible for Best Quality Services – Theme 3 – Improving the experience of people using our services (specifically in relation to restrictive practices) as a supporting objective to the four strategic priorities:

- Being the Best Place to Work
- Delivering the Best Quality Services
- Making the Best Use of Resources
- Being the Best Partner

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Committee

In carrying out their duties members and attendees of the Committee must ensure that they act in accordance with the values of the Trust, which are:

- we care
- we listen
- we deliver.

6.2 Duties of the Committee

The Committee's key objectives are to:

- monitor, review and report to the Board of Directors on all aspects of mental health legislation;
- receive assurances against Care Quality Commission (CQC) inspection action plan and routine CQC related activity;
- be assured that there are systems, structures and processes in place to support the operation of mental health legislation, within both inpatient and community settings and ensure compliance with associated codes of practice and recognised best practice;
- be assured that our care and treatment in the Trust embraces the core values of current mental health legislation and protects service users and the community of which they are members;

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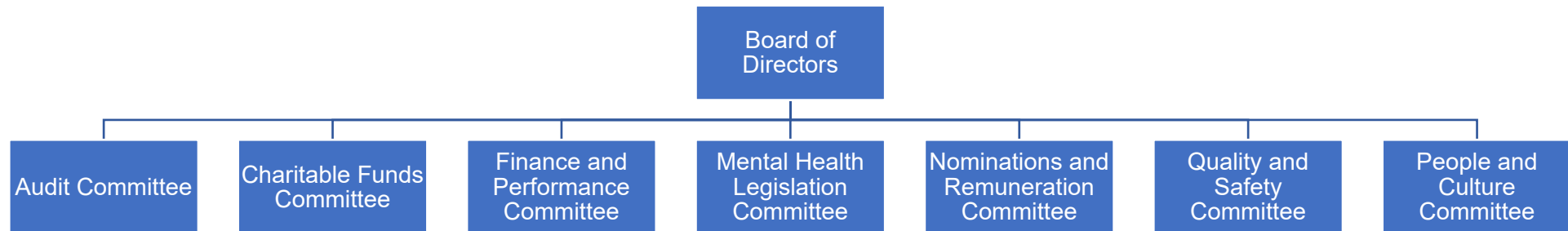
- be assured that the Trust has in place and utilises appropriate policies and procedures in relation to mental health legislation and to facilitate the publication, distribution and explanation of the same to all relevant staff, service users and manager;
- be assured that Associate Hospital Managers and appropriate staff groups receive guidance, education and training in order to understand and be aware of the impact and implications of all new relevant mental health associated legislation;
- to consider opportunities, challenges and requirements of our local place and regional health care systems and partnerships;
- supporting the Trust's continuous improvement journey, both internal and external learning will be considered by the Committee. This will be within the remit as set out in the terms of reference and supporting work plan for the Committee who will be acting as an agent of the Board of Directors.

In particular the Committee shall review the adequacy of:

- the implementation and performance of operational arrangements in relation to mental health legislation through quarterly dashboard reporting of key performance indicators;
- oversight of restrictive practices through the dashboard, exception reporting and a summary of actions taken by the Positive and Proactive Group;
- reports from inspecting authorities and the development of action plans in response to recommendations;
- progress against any other action plans and any risks identified within the Corporate Risk Register relevant to mental health legislation;
- analysis and information reports in relation to the use of the Mental Health Act and to make recommendations in response to findings;
- the schedule of powers and responsibilities of the Associate Hospital Managers, including those powers and responsibilities delegated to officers of the Trust;
- information provided to Associate Hospital Managers of their legal duties and appropriate training to support their duties under mental health legislation;
- the process of recruitment, induction, appraisal and development of Associate Hospital Managers (through the Trust Chair and Chair of the Mental Health Legislation Committee);
- implementation and requirements of any new and amended mental health legislation, establishing groups to undertake detailed implementation work as required;
- the provision of adequate guidance, information, education and training on mental health legislation to staff, service users, carers and other stakeholders;
- joint working arrangements around the use of mental health legislation with partner agencies, notably including local authorities, other NHS commissioners and providers, and the police.

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7 Relationships with other groups and committees



The Committee does not have any sub-committees. It is linked to the Trust's operational groups (and in addition it receives updates from the Positive and Proactive Group and the Associate Hospital Managers Group) as an assurance receiver and provides a route of escalation to the Board of Directors.

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8 Duties of the Chair

The Chair of the Committee shall be responsible for:

- agreeing the agenda in partnership with the Chief Medical Director/Officer;
- directing the meeting ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion;
- giving direction to the secretariat and checking the draft minutes;
- ensuring the agenda is balanced and discussion is productive; and
- ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee.

9 Reviews of the terms of reference and effectiveness

The terms of reference shall be reviewed by the Committee at least annually and be presented to the Board of Directors for ratification.

It will be the responsibility of the Chair of the Committee to ensure that it carries out an assessment of effectiveness annually, and ensure the outcome is reported to the Board of Directors along with any remedial action to address weaknesses. The Chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

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Schedule of Deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below “no deputy required”.

Full member (by job title)	Deputy (by job title)
Non-Executive Director Chair	Another Non-Executive Director
Non-Executive Director	Another Non-Executive Director
Medical Director <u>Chief Medical Officer</u>	<u>Medical Lead for Mental Health from Chief Medical Officers Office</u> Deputy Medical Director/Chief Pharmacist
Chief Operating Officer	Deputy Operations Director

Attendee (by job title)	Deputy (by job title)
Trust Secretary	Deputy Trust Secretary
Mental Health Legislation Lead	Mental Capacity Act Lead Mental Health Act Advisor
Deputy Director for Professions / Chief Psychological Therapies Officer	Head of Nursing, Mental Health

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People and Culture Committee
Annual Governance Report
April 2025 to March 2026

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Section	Topic
1	Period covered by this report: 1 April 2025 to 31 March 2026.
2	Introduction
3	Terms of Reference for the Committee
4	Meetings of the Committee
5	Membership and attendance at meetings
6	Reports made to the Board of Directors
7	Work of the Committee between April 2025 and March 2026
8	Annual Effectiveness Review
9	Conclusion
Appendix A	Survey Results
Appendix B	Action Plan

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1. Period Covered by the Report

This report covers the work of the People and Culture Committee for the financial year 1 April 2025 to 31 March 2026.

2. Introduction

The People and Culture Committee was established in March 2020 by the Board of Directors as one of its sub-committees. This was following a recommendation from the external Well Led review undertaken by Deloitte that the Trust should establish a Committee to strengthen the Board's connection to the delivery of the People Development Strategy and provide oversight on this key area within the Trust. In July 2023 the Committee's name was changed from 'Workforce and Equality Committee' to 'People and Culture Committee' to reflect the terminology more commonly used within the NHS People Plan, and that within the Trust.

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 of Directors, the Committee monitors key workforce performance metrics, risks and mitigations, and delivery of the Trust's People Development Strategy with supporting workforce plans and underpinning strategies.

This report covers the work the Committee has undertaken at the formal meetings held during 2025-26. The Committee reports to the Board of Directors and assures it on the work it has carried out, the assurances it has received and escalates specific concerns; demonstrating that it has operated within its Terms of Reference.

Secretariat support is provided by the Corporate Governance Team, who work with the Chief People Officer and their Deputy in relation to agenda planning, minutes, managing cumulative action logs and general meeting support.

The Trust welcomes and encourages feedback and recognises the importance of being a learning organisation. A colleague experience or story is presented at the start of each People and Culture meeting, with the view that the input will be linked to one of the identified priorities being discussed at that meeting. This new approach will provide an opportunity for Board members to triangulate, build relationships with Trust colleagues, and support the Board's ongoing journey for Board visibility and accessibility to the workforce.

Assurance

The Committee receives assurance from the Executive Director members of the Committee, Staff Network Leaders, and from the subject matter experts who attend the meetings as required, dependant on the agenda items being discussed.

Assurance is provided through written reports, both regular and bespoke, through critical exchange and challenge by Committee members who validate the information provided through wider knowledge of the Trust; specialist areas of expertise; attending Board of Directors', and Council of Governors' meetings; visiting services, talking to staff, and observing operational meetings at the Trust as required.

The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge.

There is one Strategic Objectives (SO) aligned to the People and Culture Committee, **SO2: Prioritising our people, ensuring they have the tools, skills and right environment to be effective leaders within a culture that is open, compassionate, improvement-focused and inclusive culture.** This Strategic Objective has a number of in-year ambitions:

- Looking after our people
- Belonging in our organisation (including leadership)
- New ways of working and delivering care
- Growing for the future

In order to promote consistency across the Trust, including alignment with the approach of the Internal Audit team, the Trust will use 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.

The Committee therefore received a number of key documents which included an Integrated Strategic Performance Report which directly aligned to those priority areas delegated to the Committee. Within these reports, informed by Executive oversight of operational grip and control systems, will be a proposed Board Assurance Framework (BAF) assurance rating for each priority and theme. At the end of each Committee meeting the Chair made 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.

3. Terms of Reference for the People and Culture Committee

The updated Terms of Reference are presented for approval by Committee, following which they will be presented to the Board of Directors to be ratified.

4. Meetings of the Committee

During the 2025/26 financial year, the Committee met six times:

- 22/05/2025
- 17/07/2025
- 18/09/2025
- 18/12/2025
- 22/01/2026
- 19/03/2026

The draft agenda for each meeting is presented to the Chair of the Committee (Mark Rawcliffe); and the executive lead (Chief People Officer).

Paperwork for the Committee is circulated seven calendar days prior to the meeting taking place. Exception items may be received within seven days where this has been agreed by the Chair. All actions pertaining to the meetings of the Committee are tracked on a cumulative action log and presented to each meeting for assurance with progress made.

5. Membership of the Committee and attendance at meetings

The Committee is made up of two Non-Executive Directors (or associate Non-Executive Directors); the Chief People Officer, the Chief Operating Officer, the Medical Director, Chief Finance Officer and the Director of Nursing, Professions and Care Standards. There were a number of meetings not quorate during the period, items for approval were circulated after the meeting.

Due to the nature of the position that they hold, all Executive and Non-Executive Directors as Board members can attend any Board sub-committee. Upon doing so they will assume full member rights and responsibilities.

Subject area experts are also invited to attend the meetings as appropriate, to provide expertise and knowledge on the areas that they are responsible for. On these occasions, they are attendees and do not count towards the membership of the meetings as outlined in the Terms of Reference.

The Trust also invites Governors to observe Board sub-committee meetings. This opportunity allows Governors to observe the work of the Committee, rather than to be part of its work as they are not part of the formal membership of the Committee. Governors observe Board sub-committee meetings to get a better understanding of the work of the Trust and to observe Non-Executive Directors appropriately challenging the Executive Directors about the operational performance of the Trust.

Committee meetings are hybrid which allow Committee members and attendees to attend in person or via Microsoft Teams.

The Committee shall be quorate when three members attend the meeting, two of which must be Non-Executive Directors and one Executive Director. Attendees do not count towards quoracy.

If the Committee Chair is unable to attend a meeting, and if otherwise quorate, the meeting will be chaired by one of the other Non-Executive Directors.

Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate unless the deputy is representing the member under formal “acting up” arrangements.

A non-quorate meeting may go ahead unless the Chair decides not to proceed. Any decisions made by a non-quorate meeting must be reported to the next meeting.

The table below show attendance at the Committee for the meetings that took place during 2025/26

Full Name	Job Role / Title	May-25	Jul-25	Sep-25	Dec-26	Jan-26	Mar-26
Member							
Mark Rawcliffe	Chair	X	X	X	X	X	X
Sally Napper	SID and Deputy Chair	X	X	X	X	X	X
Bob Champion	Chief People Officer	X		X	X	X	X
Phil Hubbard	Director of Nursing	X	X				
David Sims	Medical Director		X	<i>Retired from the Trust</i>			
Sal Uka	Chief Medical Officer	<i>Started at the Trust Oct 2025</i>			X	X	
Kelly Barker	Chief Operating Officer	X		X		X	
Mike Woodhead	Chief Finance Officer		X	X			
Therese Patten	Chief Executive			X		X	
Regular Attendee							
Anitha Mukundan	Deputy Medical Director Community Mental Health, Deputy Responsible Officer & CMHT Consultant	<i>Not required (as Medical Director in position)</i>		X		X	X
Tim Rycroft	Chief Information Officer						
Fran Stead	Trust Secretary (from Jan 2026 timed business)			X		X	X
Rachel Trawally	Deputy Trust Secretary		X		X	X	X
Fay Davies	Deputising for Michelle Holland	X	X	X			
Lisa Wright	Head of EDI	X	X	X	X	X	X
Michelle Holland	Deputy Chief People Officer	X	X				X
Farhan Rafiq	Executive Director TIP		X			X	
Jess Greenwood-Owens	Corporate Governance Officer	X	X	X	X	X	X
Jeanette Homer	Staff Side Chair						
Timed Business							
Jo Wilson	Head of Medical Staffing and Education		X	X	X	X	
Claire Ingle	Head of People services	X	X	X	X	X	X
Emma Stott	Resourcing Manager	X	X	X	X	X	
Danielle Stephenson	Head of Workforce Intelligence, Systems, Planning & Analysis	X		X	X	X	X
Helen Farrer	Presenter			X			
Thabani Songo	Learning from your exp					X	

Andrew Cooper	Presenter (external to the Trust)						X	
Catherine Jowitt	Learning from your exp					X		
Sefat Roshny	Presenter					X		
Naomi Fernandez	Presenter		X					
Stuart Scarfe	Presenter	X				X		
Chris Farquar	Presenter	X				X		
Michelle Holgate	On behalf of Kelly Barker		X			X		
Chris Hunt	Presenter					X		
Brontë Dines-Allen	Presenter		X					
Kathryn Callaghan	Presenter		X					
Wali Nazar	Presenter		X					
Jonathan Guy	Learning from your exp				X			
Chris Dixon	On behalf of Phil Hubbard				X	X		
Ruth Ozolins	Presenter				X			
Claire Wiseman	Learning from your exp							X
Observer								
Cornelle Parker	Observer/Well Led	X						
Robert James	Governor							X

6. Reports Made to the Board of Directors

The Chair of the Committee makes an Alert, Advise, Assure (AAA) escalation report regarding the most recent meeting of the Committee to the next available Board of Directors' meeting. This report seeks to assure the Board on the main items discussed by the Committee and, should it be necessary, to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the Committee the Board may ask for these to be looked at in greater detail by the Committee.

The below table outlines the date that the AAAD report was presented by the Chair of the Committee to the Board of Directors' meeting. In addition, a copy of Committee-ratified minutes is presented to the Board for information.

Date of meeting	Assurance and escalation report to Board by Chair
22/05/2025	05/06/2025
17/07/2025	02/10/2025
18/09/2025	02/10/2025
18/12/2025	05/02/2026
22/01/2026	05/02/2026
19/03/2026	TBC

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7. The Work of the People and Culture Committee During the Year between April 2025 and March 2026

The Chair of the Committee can confirm that the Committee has carried out its role in accordance with its Terms of Reference. Further details of all these areas of work can be found in the minutes and papers of the Committee.

High-level and more detailed presentations of areas of work on which the Committee has received assurance and during the year were as follows:

Assurance on:

- Strategic Narrative Report
- Integrated Performance Report
- Medical Staffing Update
- Recruitment activity update
- Employee Relations Activity
- Rostering Activity including OSPB highlights report
- AAAD Report/s: Place Regional and National Updates
- AAAD Leading better Lives Together Update
- AAAD Senior Leadership Team, People, Planning & Innovation
- AAAD Staff Partnership Forum
- AAAD Strategic EDI Partnership Group
- AAAD Workforce Productivity (OSPB)

Reports and presentations on:

- Annual Governance Report
- Annual Report on Leadership & Management Development
- Apprenticeship Levy Annual Report
- Apprenticeship Levy mid-year update
- Aspiring Cultures Annual Report
- Attendance Management
- Avoidable Harm
- BDCT & Multiverse Partnership
- Beacon Network Annual Report
- Belonging and Inclusion Update
- Committee annual effectiveness review
- Committee annual Terms of Reference review
- Committee Work Plan
- EDS22 reporting
- Gender Pay Gap Annual Report
- Guardian of Safe working (Working time directives)
- Learning from your experience – various topics
- NHS Workforce Equality Standards inclusive recruitment
- Notification of future meeting dates
- Public Sector Equality Duty Report
- Rainbow Alliance Annual Report
- Right to Work Policy
- Sickness absence report

- Staff Survey results
- Staff Survey Update – progress report
- Staff Survey, mid-point update
- Strategic Risks
- Subject Focus: Employee Relations Casework Review
- Subject focus: Sexual Harassment in the Workplace
- Trust and Service Level 5-year Workforce Plans
- Trust Sickness and Absence Project
- Volunteering
- Well Led Implementation Plan Update
- Workforce Disability Equality Standard Report (WDES)
- Workforce Race Equality Standard Report (WRES)

8. Annual Effectiveness Review (summary of findings)

The Committee undertook an Annual Effectives Review in the form of a Survey sent to regular attendees and members in February 2026. 6 people responded to the survey.

The survey comprised a set of standard questions with ‘agree’ ‘disagree’ and ‘other’ within the areas of A. Committee Operation; B. Committee Administration; C. Terms of Reference and E. Strategy. The facility for providing additional feedback was used by some people which enriched the data with constructive comments and suggestions, including areas where further work should be considered.

The People & Culture Committee is viewed as high-performing, well-chaired, and strategically aligned. Core governance functions—Terms of Reference, work plan, values-based discussion, and decision-making—are consistently rated positively. A minority of responses highlight operational gaps: confidence/participation of some members, timeliness of chair approved minutes, occasional heavy paper loads, and opportunities to strengthen health-equity focus and cross-committee links.

Things We’re Doing Well

- **Strong leadership & meeting effectiveness:** Chairing, debate, and balance of data vs. discussion are praised.
- **Clear governance structure:** Terms of Reference, annual work plan, strategic alignment, and assurance processes work well.
- **Paper quality:** Formats/content generally enable effective scrutiny.
- **Positive culture:** Deliberations align with Trust values and support constructive challenge.
- **Contribution to Trust priorities:** PCC is seen as positively influencing strategic direction and workforce priorities.

Areas for Improvement

- **Induction:** Some members, especially new ones, need stronger induction and support to participate confidently and challenge effectively.

- **Minutes:** The production timeline for minutes was met; however, delays in the approval process meant that some minutes were issued alongside subsequent meeting papers or later than planned.
- **Papers:** Occasionally too many papers; some variation in format and quality.
- **Health equity** is sometimes included; but not consistently embedded across all papers and discussions.
- **Cross-committee integration:** Opportunities to strengthen links with other committees and route certain items (e.g., NETs/NTS) through PCC before Board.
- The following statements were agreed by 67% of contributors and may warrant further investigation a) *Each member contributes sufficient time to fulfil their role;* b) *Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints.*

9. Conclusion

The Chair of the Committee would like to assure the Board that the Committee worked hard to fulfil its Terms of Reference during 2025/26, including monitoring and advising on key human resources metrics via the dashboard, promoting the Trust's values and vision through a wide range of staff development including the Trust's comprehensive leadership and management programme. The Board is asked to recognise how the Committee supports the ongoing continuous improvement journey both at the Trust and on its own effectiveness.

The Committee adds value by maintaining an open and professional relationship with officers of the Trust and it has carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues, risks, or learning. Organisational learning drives this Committee and is one of its core values; further improvements will be made to advance this critical aspect of quality and safety.

Members of the Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

The Chair sincerely thanks all Committee members, for their integrity, engagement, constructive challenge and commitment to ongoing improvement.

Jess Greenwood-Owens - Corporate Governance Officer

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Appendix A – Survey Response

Question - 6 people responded to the survey - if anyone chose 'not able to answer' their reply to those questions was removed from the analysis	Agree %	Disagree %	Other %
The Committee reports regularly to the Board	100%	0%	0%
The Committee has established a work plan for the year which is relevant to the terms of reference	83%	0%	17%
The Committee meets the appropriate number of times to deal with planned matters.	100%	0%	0%
At the end of each meeting the Committee discusses the outcomes and reflects back on decisions made and what worked well or not so well.	100%	0%	0%
Discussion aligns to the Trust values, we care, we listen, we deliver.	100%	0%	0%
The quality of Committee papers received allows me to perform my role effectively.	83%	0%	17%
Reports received have the right format and content.	83%	0%	17%
Committee papers are distributed in sufficient time to give them due consideration.	83%	17%	0%
Minutes are accurate and of a high quality and are received as soon as possible after meetings, setting out key actions and assurances received.	67%	17%	17%
The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	100%	0%	0%
Each member contributes sufficient time to fulfil their role.	67%	17%	17%
Members, particularly those new to the Committee, are provided with induction and training.	33%	67%	0%
The Board ensures that members have sufficient knowledge of the Trust to identify key risk areas and to challenge on issues.	83%	17%	0%
Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints.	67%	33%	0%
The Committee has written Terms of Reference that define the Committee's role.	100%	0%	0%
The Committee is empowered to take action and make decisions, aligned to the Terms of Reference.	100%	0%	0%
Sufficient attention and time is given to discuss strategic risks.	83%	17%	0%
Does the Committee interact sufficiently with other Committees to support integrated governance.	67%	0%	33%
Health equity is proactively considered by the Committee and features on its work plan.	67%	17%	17%
Formal reporting is supplemented by opportunities to gather people's experience in support of triangulation.	83%	0%	17%
The work plan supports effective oversight to support assurance reporting, escalation and triangulation.	100%	0%	0%
The Committee's work is aligned clearly with the Trust strategy & strategic objectives.	100%	0%	0%
The Committee ensures that its decisions contribute to strategic direction of the Trust.	100%	0%	0%
The Committee's priorities are regularly reviewed to ensure alignment with changing priorities and risks.	83%	0%	17%
The Committee has made a positive contribution to work of the Trust over the last year.	100%	0%	0%
There is a process for communicating the Committee's outcomes.	100%	0%	0%

Appendix B - Action Plan

Issued raised	Actions planned/undertaken	Responsible	Priority Level
Induction: Some members, especially new ones, need stronger induction and support to participate confidently and challenge effectively.			
Minutes: The production timeline for minutes was met; however, delays in the approval process meant that some minutes were issued alongside subsequent meeting papers or later than planned.			
Papers: Occasionally too many papers; some variation in format and quality.			
Health equity is sometimes included; but not consistently embedded across all papers and discussions.			
Cross-committee integration: Opportunities to strengthen links with other committees and route certain items (e.g., NETs/NTS) through PCC before Board.			
Fewer respondents agreed that debate was allowed to flow and conclusions reached without being cut short or stifled due to time constraints and that each member contributes sufficient time to fulfil their role			

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People and Culture Committee

Terms of Reference

Version:	<u>5-0 6.0</u>
Approved by:	People and Culture Committee
Ratified by:	Board of Directors
Date approved:	<u>Tbc</u>
Date ratified:	<u>Tbc</u>
Job title of author:	Corporate Governance Team
Job title of responsible Director:	Non-Executive Director and Chair of the People and Culture Committee
Date issued:	<u>Tbc</u>
Review date:	<u>Tbc</u>
Frequency of review:	Annual
Amendment Summary:	
<ul style="list-style-type: none"> - <u>Update from Medical Director to Chief Medical Officer</u> - <u>Update to quoracy 'and one Executive Director.'</u> - <u>Remove references to freedom to speak up.</u> - <u>Addition of new staff member - Executive Director of Transformation, Improvement & Productivity</u> - <u>Update to job titles</u> - <u>Update to Trust Secretary or Deputy Trust Secretary</u> 	

1 Name of group / committee

People and Culture Committee (Committee).

2 Composition of the Committee

Members: full rights

Title	Role in the group / committee
Non-Executive Director	Committee Chair
Non-Executive Director	Additional non-executive member
Chief People Officer	Executive lead for workforce development. Assurance and escalation provider to the Committee.
Chief Finance Officer	Executive lead for finance and resources. Assurance and escalation provider to the Committee.

Title	Role in the group / committee
Chief Operating Officer	Executive lead with day-to-day responsibility for operational delivery of services. Assurance and escalation provider to the Committee.
Medical Director Chief Medical Officer	Executive lead for medics. Assurance and escalation provider to the Committee.
Director of Nursing, Professions and Compliance	Executive lead for nursing and professional standards. Assurance and escalation provider to the Committee.
<u>Executive Director of Transformation, Improvement & Productivity</u>	<u>Executive lead for Transformation, Improvement & Productivity. Assurance and escalation provider to the Committee.</u>

Any Executive and Non-Executive Director can attend a Board sub-committee meeting because of the position that they hold. When carrying out this duty they will assume full member rights. It is expected that the Committee will be of particular interest to the Non-Executive Director champion for Leadership Development, Equality and Diversity and Staff Wellbeing.

The Deputy Chief People Officer; ~~the Freedom to Speak Up Guardian~~; Head of Equality and Diversity; and the Trust Secretary or Deputy Trust Secretary will attend all meetings. In addition to anyone listed above, the Chair of the Committee may also request individuals to attend on an ad-hoc (or regular) basis to provide advice, support, or to otherwise contribute to the Committee's work.

2.1 Governor Observers

The Committee welcomes and encourages governors to attend its meetings. The role of a governor at Board sub-committee meetings is to observe the work of the Committee, in order to get a better understanding of the work of the Trust and the extent which Non-Executive Directors appropriately challenge and support the Executive Directors. At the meeting the governor observer(s) will be required, along with other participants, to declare any potential or actual conflicts of interest they may have in respect of any of the items to be discussed.

2.2 Invitees

An open invite to be extended to the Staff Side Chair or delegated member of the Staff Partnership Forum and Local Negotiating Forum for each meeting and also to the Staff Network Chairs or delegated member.

3 Quoracy

Number: The minimum number of members for a meeting to be quorate is three, two of whom must be Non-Executive Directors and one Executive Director. Attendees do not count towards quoracy.

If the Chair is unable to attend a meeting, and if otherwise quorate, the meeting will be chaired by one of the other Non-Executive Directors.

Deputies: Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate unless the deputy is representing the member under formal “acting up” arrangements.

A schedule of deputies, attached at appendix 1a, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by a non-quorate meeting must be reviewed at the next quorate meeting.

4 Meetings of the Committee

Frequency: The Committee will meet at least six times a year. There will be separate meetings if required by the Board.

Urgent meeting: Any member of the Committee may request an urgent meeting. The Chair of the Committee will normally agree to call an urgent meeting to discuss the specific matter unless the opportunity exists to discuss the matter in a more expedient manner.

Minutes: Minutes and diary arrangements will be managed by the Corporate Governance Team.

Joint Committee Meetings: Joint Committee meetings can take place between Board sub-committees. It will be for the Executive Directors in partnership with Non-Executive Director Chairs to agree when a meeting will be convened. Joint Committee meetings will be facilitated by the Corporate Governance Team and will either be formal meetings, or development sessions. When Joint meetings are convened the relevant Terms of Reference will be adhered to.

Alert, Advise, Assure and Decision (AAA+D) Effective Oversight: Escalation and Assurance : The Chair of the Committee will provide an update of key issues and assurances arising from the meeting to the next Board of Directors meeting held in public.

Voting: It is at the discretion of the Chair of the meeting to call a vote during a meeting. When voting, decisions at meetings shall be determined by a majority of the votes of the Executive and Non-Executive Directors present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

5 Authority

Establishment: The Committee is a sub-committee of the Board of Directors and has been formally established by the Board.

Powers: Its powers, in addition to the powers vested in the executive members in their own right, are detailed in the Trust’s Scheme of Delegation.

Cessation: The Committee is a standing Board sub-committee in that its responsibilities and purpose are not time-limited. However, the Committee has a responsibility to review its effectiveness annually.

6 Role of the committee

6.1 Purpose of the committee

The Committee's purpose is to provide strategic oversight of significant workforce and equality matters. It will seek assurance on the same, and the extent to which the Trust has effective strategies/systems in place to fully support (among other things) a high performing, engaged and motivated workforce, with a positive, compassionate, inclusive, people-centred and improvement-focused culture free from discrimination, bullying and harassment, to support the delivery of the Trust's wider strategic objectives.

As agreed by the Board July 2023 within the Better Lives Together strategic framework, the Mental Health Committee is responsible for Best Quality Services – Theme 3 – Improving the experience of people using our services (specifically in relation to restrictive practices) as a supporting objective to the four strategic priorities:

- Being the Best Place to Work
- Delivering the Best Quality Services
- Making the Best Use of Resources
- Being the Best Partner

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Committee

In carrying out their duties, members of the Committee and any attendees must take all reasonable steps to ensure they act in accordance with the values of the Trust, which are:

- we care
- we listen
- we deliver.

Duties of the Committee

To the extent that what follows is reasonably practicable, the Committee will:

1. Seek appropriate and adequate levels of assurance regarding:
 - a. the development, implementation and/or effectiveness of any overall strategic people plan and/or other **strategic plans and projects** at the Trust relating directly

to workforce and equality matters. Initially, therefore, the primary focus of the Committee shall be on matters relating to:

- the Trust’s current “People Development Strategy (2021-2024)” and its four themes (Looking after our People, Belonging in the organisation, New ways of working and delivering care, Growing for the future); and
- the Trust’s current set of “Strategic Priorities Programme” relating to the same.

b. strategic management and significant risks/issues relating **more generally** to areas such as:

- overall workforce capacity, capability, and performance;
- leadership and wider organisational culture (with an emphasis on the development of a positive, compassionate, inclusive, people-centred and improvement-focused **leadership culture**, free from discrimination, bullying and harassment, which can engage and inspire all people across the workforce);
- equality, diversity and inclusion;
- ~~the “Freedom to Speak Up” programme and “whistleblowing”;~~
- staff engagement and experience;
- staff wellbeing and safety (both physically and mentally);
- staff absence;
- organisational design, roles, and ways of working;
- recruitment and retention;
- leadership, talent and management development;
- career and professional development, training and education;
- individual performance/capability/conduct issues; or could broaden to effectiveness of key employment policies and practices
- any relevant matters arising from increased system / partnership working; and
- any other strategic workforce and equality matter considered to be sufficiently relevant to the work of the Committee.

c. strategic management and significant risks/issues relating **more specifically** to the “protected characteristics” and the “public sector equality duty” set out in the Equality Act 2010, other relevant **legislation** (including the Employment Rights Act 1996) and/or **best practice**, including the prevention/management of:

- discrimination in its various forms;
- harassment, victimisation, and other unlawful detriment (including in relation to whistleblowers); and
- bullying, violence, abuse, and other serious misconduct.

2) Receive (whether in relation to paragraph 1 or otherwise) and seek appropriate and adequate levels of assurance regarding any statutory, mandatory or otherwise **relevant reports** relating to strategic workforce and equality matters, including:

a. the NHS Staff Survey;

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b. the Equality, Diversity and Inclusion Annual Report,
~~c. the Freedom to Speak Up Report; and~~
~~d.c.~~ _____ other necessary or relevant reports, such as those relating to:

- the gender pay gap;
- the workforce race equality standard; and
- the workforce disability equality standard; and
- the patient & carer race equality framework.

3) Seek (whether in relation to paragraphs 1 or 2 or otherwise) appropriate and adequate levels of assurance regarding any necessary or otherwise desirable **alignment** between the Trust’s strategic approach to workforce and equality matters and:

- a. the Trust’s wider organisational strategy (i.e. “Better Lives, Together”, incorporating within it, as it does, “Best Place to Work”) and relevant key areas of focus (including the Board Assurance Framework);
- b. relevant national strategic workforce and equality guidance and best practice, etc, from the NHS (including any overall NHS people plan) and/or other relevant organisations;
- c. relevant requirements, opportunities and/or significant risks/issues relating to the Trust’s participation in the local/regional healthcare system (e.g. the West Yorkshire and Harrogate Health and Care Partnership) and the Trust’s wider partnering arrangements.

4) Endeavour to be **forward-looking** as well as backward-looking in the course of its work, and, when doing so, to consider longer-term opportunities and risks.

5) Use data and intelligence informedly to identify patterns, themes and areas of particular, priority focus for the committee through triangulation and receipt of qualitative as well as quantitative analysis.

6) Connect appropriately with **other committees** of the Trust Board, where strategic workforce and equality matters overlap with their respective remits.

7) Provide adequate updates to the **Trust Board**, of both material risks/issues and material assurances, relating to strategic workforce and equality matters at the Trust.

8) To consider opportunities, challenges and requirements of our local place and regional health care systems and partnerships.

9) Supporting the Trust’s continuous improvement journey, both internal and external learning will be considered by the Committee. This will be within the remit as set out in the terms of reference and supporting work plan for the Committee who will be acting as an agent of the Board of Directors.

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7 Relationships with the Board of Directors



The Committee does not have any sub-committees. It is linked to the Trust's operational groups as an assurance receiver and provides a route of escalation to the Board of Directors.

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8 Duties of the Chair

The Chair of the Committee shall be responsible for:

- agreeing the agenda in partnership with the Chief People Officer;
- directing the meeting, ensuring as far as possible that it operates in accordance with the Trust's values and that all attendees have a reasonable opportunity to contribute to the discussion;
- giving appropriate direction to the secretariat and checking the draft minutes;
- ensuring that the agenda is appropriately balanced and relevant, and that discussion is productive; and
- ensuring that sufficient information is presented to the Board in respect of the work of the Committee.

9 Reviews of the terms of reference and effectiveness

The terms of reference shall be reviewed by the Committee at least annually and be presented to the Board of Directors for ratification.

It will be the responsibility of the Chair of the Committee to ensure that the Committee carries out an assessment of its effectiveness annually, and to ensure the outcome is reported to the Board, along with any remedial action to address weaknesses. The Chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

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Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case, please state below “no deputy required”.

Full member (by job title)	Deputy (by job title)
Non-executive Director Chair	Another Non-executive Director
Non-executive Director	Another Non-executive Director
Chief People Officer	Deputy Chief People Officer
Chief Finance Officer	Operational Director of Finance
Chief Operating Officer	Deputy Director of Operations
Medical Director <u>Chief Medical Officer</u>	Deputy Medical Director/Chief Pharmacist
Director of Nursing, Professions, and Compliance	Deputy Director of Nursing, Professions and Care Standards

Attendee (by job title)	Deputy (by job title)
Deputy Chief People Officer	Head of Workforce Development Head of Workforce Performance Head of Workforce Planning Head of People Services Head of Workforce Information Systems Planning and Analysis Head of People Development
Head of Equality, Diversity and Inclusion	Head of Workforce Development Head of Workforce Performance Head of Workforce Planning EDI Project Officer Health Inequalities Lead
Freedom to Speak Up Guardian	Deputy Freedom to Speak Up Guardian
Trust Secretary	Deputy Trust Secretary
Staff Side Chair	Delegated member of the Staff Partnership Forum or Local Negotiating Forum
Staff Network Chairs	Delegated member as agreed by the Network Chair

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Agenda
Item

22.0.9

Quality and Safety Committee
Annual Governance Report
01 April 2025 to 31 March 2026

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Annual Report

01 April 2025 to 31 March 2026

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1. Period covered by the report

This report covers the period between 1 April 2025 and 31 March 2026.

2. Introduction

The Quality and Safety Committee (Committee) has been formally established by the Board of Directors as one of its sub-committees. It is authorised to seek and obtain evidence of assurance on the effectiveness of the Trust's quality and safety systems and processes, and the quality and safety of the services provided. This includes identifying and seeking assurance on the management of quality and safety related risks at an operational and strategic level. The Committee monitors and reports to the Board on the effectiveness of these systems and processes. The Committee's key objectives are to seek assurance that:

- systems and processes are effective, and wherever possible evidence-based,
- the quality of services provided is good and continuously improving, and
- the experience of people using Trust services is good and continuously improving.

The Committee also seeks to:

- monitor, review and report to the Board on all the above; highlighting assurances received and identifying any threats to assurance,
- support the range of quality and safety initiatives in place within the Trust, providing advice where appropriate,
- support and promote an organisational culture which is open, just and sensitive to risk, as part of a positive approach to investigating and learning from adverse events and receive relevant strategies for information and assurance.

This report covers the work the Committee has undertaken at the formal meetings held during 2025/26. It seeks to assure the Board on the work it has carried out and the assurances it has received, and to demonstrate that it has operated within its Terms of Reference.

The Trust welcomes and encourages feedback and recognises the importance of being a learning organisation. A service experience or story is presented at the start of each Committee meeting, with the view that the input will be linked to the identified priorities the Committee is responsible for. This approach provides an opportunity for Board members to triangulate, build relationships with Trust colleagues, and support the Board's ongoing journey for Board visibility and accessibility to the workforce.

Secretariat support is provided by the Corporate Governance Team, who work with the Director of Nursing, Professions and Care Standards and Deputy Chief Executive in relation to agenda planning; minutes; managing cumulative action logs; and general meeting support.

3. Assurance

The Committee receives assurance from the Executive Director members of the Committee and from the subject matter experts who attend the meetings as required dependant on the agenda items being discussed.

Assurance is provided through written reports, both regular and bespoke, through critical challenge by members of the Committee and by members seeking to validate the information provided through wider knowledge of the Trust; specialist areas of expertise; attending Board of Directors', and Council of Governors' meetings; visiting services, talking to colleagues, and observing operational meetings at the Trust as required.

The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge.

During this period Committee meetings moved from exclusively being held in a virtual format, through the use of Microsoft Teams, to becoming hybrid which allowed Committee members and attendees to attend in person or via Microsoft Teams.

The delegated responsibilities aligned to Quality and Safety Committee are outlined as 'Best Quality Service:

- Theme 1 – Access & flow (quality perspective)
- Theme 2 – Learning for improvement
- Theme 3 - Improving the experience of people using our services

The Committee continues to have two Strategic Objectives (SO) aligned to the Quality and Safety Committee (QSC), SO1 and SO3:

- SO1: Engaging with our patients, service users and wider community to ensure they are equal partners in care delivery.
- SO3: Maximising the potential of services to deliver outstanding care to our communities.

Within SO1 there are 4 in-year ambitions which Committee has had oversight of - SO1.1-1.4.
SO1.1 – this will continue to be monitored under **Best Quality Services Theme 3** – Improving the experience of people using our services.

SO1.2 – this will continue to be monitored under **Best Quality Services Theme 3** – Improving the experience of people using our services.

SO1.3 – the focus has now shifted to exploring partnership working and so will be monitored under **Best Partner**.

SO1.4 – this will continue to be monitored under **Best Quality Services Theme 3** – Improving the experience of people using our services.

Within SO3 there are 4 in-year ambitions which Committee has had oversight of - SO3.1-3.4.
SO3.1 – this will continue to be monitored under **Best Quality Services Theme 2: Learning for Improvement**.

SO3.2 – this will continue to be monitored under **Best Quality Services Theme 2: Learning for Improvement** and also by Audit Committee under **Good Governance**.

SO3.3 – this will continue to be monitored under **Best Quality Services Theme 2: Learning for Improvement**.

SO3.4 – this will continue to be monitored under **Best Quality Services Theme 1: Access and Flow** (at both QSC and Finance & Performance Committee) as well as under **Best Partner**.

To promote consistency across the Trust, including alignment with the approach of the Internal Audit team, the Trust will use 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.

The Committee therefore received a number of key documents which included an Integrated Strategic Performance Report which directly aligned to those priority areas delegated to the Committee. Within these reports, informed by Executive oversight of operational grip and control systems, will be a proposed BAF assurance rating for each priority and theme. At the end of each Committee meeting the Chair made 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.

4. Terms of Reference for the Quality and Safety Committee

The updated Terms of Reference are presented for approval by Committee, following which they will be presented to the Board of Directors to be ratified.

5. Meetings of the Committee

During 2025-26 the Committee met seven times during this period. Details of the meeting dates are listed below:

- 21 May 2025
- 16 July 2025
- 17 September 2025
- 19 November 2025
- 21 January 2026
- 18 February 2026
- 18 March 2026

The draft agenda for each meeting is presented to the Chair of the Committee (Alyson McGregor); and the Executive lead (Director of Nursing, Care Standards and Professions).

Paperwork for the Committee is circulated seven calendar days prior to the meeting taking place. Exception items may be received within seven days where this has been agreed by the Chair. All actions pertaining to the meetings of the Committee are tracked on a cumulative action log and presented to each meeting for assurance with progress made.

6. Membership of the committee and attendance at meetings

The Committee is made up of two Non-Executive Directors (or associate Non-Executive Directors); the Director of Nursing, Professions and Care Standards, the Chief Operating Officer and the Medical Director. All meetings in the period were quorate. where any decisions and ratifications were done outside of the meeting via email and confirmed under the 'matters arising section' at the next meeting.

Membership of the Committee has changed during this year, reflecting changes in the Non-Executive portfolio and Executive Management Team of the Trust, specifically:

- Christopher Dixon was appointed as Deputy Director of Nursing for the Trust.
- Thabani Songo as the Head of Mental Health Nursing.

During this period the Committee was chaired by a Non-Executive Director (NED), Alyson McGregor.

Due to the nature of the position that they hold, all Executive and Non-Executive Directors as Board members can attend any Board sub-committee. Upon doing so they will assume full member rights and responsibilities.

Subject area experts are also invited to attend the meetings as appropriate, to provide expertise and knowledge on the areas that they are responsible for. On these occasions, they are attendees and do not count towards the membership of the meetings as outlined in the Terms of Reference.

The Trust also invites Governors to observe Board sub-committee meetings. This opportunity allows Governors to observe the work of the Committee, rather than to be part of its work as they are not part of the formal membership of the Committee. Governors observe Board sub-committee meetings to get a better understanding of the work of the Trust and to observe Non-

Executive Directors appropriately challenging the Executive Directors about the operational performance of the Trust.

Experience and involvement continued to be a key focus for the Trust with identified Involvement Partners, who are supported by the Patient Experience Team. The Committee has been supported by the service user Involvement Partner.

Committee meetings moved from exclusively being held in a virtual format, through the use of Microsoft Teams, to becoming hybrid which allowed Committee members to attend in person or via Microsoft Teams. Involvement Partners and Governors were proactively encouraged to attend and were provided with access to the MS Teams meeting to enable this.

The table below show attendance at the Committee for the meetings that took place during 2025/2026.

Full Name	Job Role / Title	21.05.25	16.07.25	17.09.25	19.11.25	21.01.26	18.02.26	18.03.26
Member								
Alyson McGregor	Member - Chair	X	X	X	X	X	D	
Bob Champion	Chief People Officer	X	D	X	X	X	X	
Dr Sal Uka	Medical Officer				X	X	X	
Kelly Barker	Chief Operating Officer	X	D	X	D	X	D	
Phil Hubbard	Director of Nursing	X	D	D	X	X	X	
Sally Napper	SID and Deputy Chair	X	D	D	X	X	X	
Simon Lewis	NED (Covering AM)					X		
Regular Attendee								
Catherine Schofield	Deputy Director of AHP	X	D	X	X	D	X	
Christopher Dixon	Deputy Director of Nursing	X	X	X	X	X		
Dr Anita Brewin	Deputy Director for Professions/Chief Psychological Therapies Officer	D	D	X	X	X		
Fran Stead	Trust Secretary	D	D	X	X	X	D	
Jess Greenwood-Owens	Corporate Governance Officer - Secretary	D	X	X	X			
Prabhdeep Sidhu	Deputy Chief Pharmacist and Medicines Safety Officer			X		X		
Rachel Howitt	Head of Patient Safety	X	X	X				
Rachel Trawally	Deputy Trust Secretary	D	X	X		X	D	

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Rebecca Jowett	Head of Nursing (job share with CS)	D	D	X	X	X	X	
Carla Smith	Head of Nursing (job share with RJ)					D	D	
Jaspreet Sohal	Chief Pharmacist	X	X		X			
Rebecca Le Hair	Interim Head of Compliance, Quality Assurance & Patient Experience		X	X	X	X		
Thabani Songo	Head of Nursing	X	X	X	D	X	D	
Grainne Eloi	Interim Deputy Director of Nursing and Quality Bradford ICB	X	D	D	D			
Debbie Winder	Associate Director of Nursing and Quality (Bradford Place) On behalf of GE					X		
John Hartley	Assistant Director Quality & SEND On behalf of GE				X			
Nazmeen Khan	Corporate Governance Officer - Secretary				X	X	X	D
Tricia George	Head of Patient Safety						X	
Timed Business - presenter								
Michelle Holgate	Deputy Director of Operations	X	X					
Lucy Bennett	Service Manager - Children's Community Services							
Lisa Wright	Head of EDI			X	X	X		
Bronte Dines Allen	Reducing Health Inequalities Lead				X			
Dawn Lee	Head of Community Children's Services				X		X	
Timed Business - presenter								
Anthony Davison	Deputy Director of Nursing Observer						D	X
Trevor Ramsay	Governor Observer							X

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7. Report made to the Board of Directors

The Chair of the Quality and Safety Committee makes an Alert, Assurance, Advice, Decision (AAAD) report regarding the most recent meeting of the Committee to the next available Board of Directors' meeting. This report seeks to assure the Board on the main items discussed by the Committee and, should it be necessary, to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself. Where items are considered to be of significance and a certain urgency, the Chair of the Committee may make use of Exceptional Escalation Reports to the Trust Chair and Chief Executive, and where appropriate the Board of Directors.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the Committee the Board may ask for these to be looked at in greater detail by the Committee.

The below table outlines the date that the assurance and escalation report was presented by the Chair of the Committee to the Public Board of Directors meeting. In addition, a copy of Committee-ratified minutes is presented to the Board for information.

Date of meeting	Assurance and escalation report to Board by Chair
21 May 2025	5 June 2025
16 July 2025	2 October 2025
17 September 2025	2 October 2025
19 November 2025	4 December 2025
21 January 2026	5 February 2026
18 February 2026	April 2026
18 March 2026	April 2026

8. The work of Quality and Safety Committee during the year between April 2025 and March 2026.

The Chair of the Committee can confirm that the Committee has carried out its role in accordance with its Terms of Reference. Further details of all these areas of work can be found in the minutes and papers of the Committee.

The work of the Committee continues to be underpinned by the work of the Safer Staffing group, Clinical Board and the Patient Safety and Learning Group. These groups have continued to evolve and adapt to the changing circumstances of the Trust, and along with the Care Group Quality and Operational Groups, support the Committee in continued oversight of the quality of services. Furthermore, it has been reassuring for the Committee to receive

ongoing updates on continued quality improvement activity across all spheres of the Trust's activity.

A high-level presentation of areas of work on which the Committee has received assurance on during 2025/26 are as follows:

Assurance on:

- AAAD report: Clinical Board
- AAAD report: Patient Safety & Learning Group
- AAAD report: Senior Leadership Team Quality, Safety, Governance
- AAAD report: System Quality Committee
- AAAD Report: Quarterly combined report: Patient and Carer Involvement, and Volunteering.
- AAAD Report: Senior Leadership Team – Care Group Assurance Meeting (CGAM) – New Group introduced mid-way through the year.
- AAAD Report – PCREF Accountability Group

Reports/presentations on:

- Quarterly CQC update
- Quality Assurance Framework update
- Winter Planning update
- Equality Impact Assessment update
- Learning report - biannual
- Quarterly Patient Safety, Incidents, and Experience and feedback
- Quality Account project plan
- Quality Account
- Research & Development Annual Report
- NICE Compliance Annual Report
- Risk Management Annual Report
- Controlled Drugs Annual Report
- Medicines Management Annual Report
- Waiting List: Bi-Annual Update
- Safer Staffing report
- Safer Staffing Report 6 month report
- Guardian of Safe Working Hours
- Notification of future meeting dates
- Update on last year's EDS22
- EDS22 next 3 services for domain 1
- Strategic Risks
- Smoke Free Implementation Update
- Learning from your experiences – various
- PCREF update
- Organisational Learning from improvement
- Committee annual Effectiveness Review

- Committee annual Terms of Reference Review
- Committee Annual Governance Report
- Specialist Education Needs and Disabilities Framework Update
- Volunteering and Patient Carer Experience and Involvement Quarter Update
- Pressure Ulcer Strategy Report
- Suicide Prevention Annual Report
- Infection Prevention & Control Annual Report
- NHSE the Knowledge & Library Service Quality Improvement Outcomes and Framework Report
- Patient Safety Annual Review of Plan
- NHS CPD Submission plan 2025/26

9. Annual Effectiveness Review (summary of findings)

The Committee undertook an Annual Effectives Review in the form of a Survey sent to report writers, regular attendees, presenters and members in February 2026.

Overall Summary

The Quality & Safety Committee is generally regarded as effective, committed and aligned to Trust priorities, but its efficiency is reduced by **overloaded agendas, inconsistent paper quality, limited time for discussion, and lack of structured induction/training**. Most governance foundations are strong, but operational pressures and variation in processes limit the committee's ability to fully maximise assurance and strategic oversight.

Things we're doing well

- Strong governance and purpose: Clear Terms of Reference, good authority and resourcing. Work aligns well to Trust strategy and strategic objectives.
- Engaged and committed membership: Members contribute time, discussions reflect Trust values, and debate is constructive.
- Meeting quality: Minutes and admin support are consistently praised. Increasing meeting frequency has improved assurance.
- Positive influence: Committee is seen as adding value to Trust work and providing effective challenge.

Areas for Improvement

- Agendas too full: Most common issue. Discussion time is squeezed, leading to rushed scrutiny.
- Paper quality and consistency: Need clearer templates, expectations, and more concise presentations. Presenters sometimes over-explain instead of highlighting key points.
- Variable contribution in meetings: Some members speak less, despite opportunities given.

- Induction and training: New members and presenters lack structured onboarding. Training needed for presenting, report writing, and understanding committee roles.
- Strategic risk and reporting flow. Some uncertainty about:
 - depth of strategic risk scrutiny
 - clarity of reporting between subgroups → committee → Board
 - attention to health equity
 - completeness of the work plan

10. Conclusion

The Chair of the Committee would like to assure the Board that the Committee worked hard to fulfil its Terms of Reference during 2025/26 despite the challenges presented by the volume of work the Committee oversees. The Board is asked to recognise how the Committee supports the ongoing continuous improvement journey both at the Trust and on its own effectiveness.

The Committee adds value by maintaining an open and professional relationship with officers of the Trust, having carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of actual and potential issues, risks, or learning. Organisational learning drives this Committee and is one of its core values; further improvements will be made to advance this critical aspect of quality and safety.

Members of the Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties. The Committee would like to specifically recognise the hard work and continued dedication of all of the Trust's staff in delivering high quality, safe care despite the context of increasing demand on services with ongoing workforce pressures.

The Chair sincerely thanks all Committee members, for their integrity, engagement, constructive challenge and commitment to ongoing improvement.

Nazmeen Khan
Corporate Governance Officer

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Appendix A

10 people responded

Question - <i>10 people responded to the survey - if anyone chose 'not able to answer' – their reply to those questions was removed from the analysis</i>	Agree %	Disagree %	Other %
The Committee reports regularly to the Board	100%	0%	0%
The Committee has established a work plan for the year which is relevant to the terms of reference	80%	0%	20%
The Committee meets the appropriate number of times to deal with planned matters.	80%	0%	20%
At the end of each meeting the Committee discusses the outcomes and reflects back on decisions made and what worked well or not so well.	90%	10%	0%
Discussion aligns to the Trust values, we care, we listen, we deliver.	100%	0%	0%
The quality of Committee papers received allows me to perform my role effectively.	100%	0%	0%
Reports received have the right format and content.	80%	10%	10%
Committee papers are distributed in sufficient time to give them due consideration.	89%	11%	0%
Minutes are accurate and of a high quality and are received as soon as possible after meetings, setting out key actions and assurances received.	100%	0%	0%
The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	100%	0%	0%
Each member contributes sufficient time to fulfil their role.	60%	20%	20%
Members, particularly those new to the Committee, are provided with induction and training.	33%	56%	11%
The Board ensures that members have sufficient knowledge of the Trust to identify key risk areas and to challenge on issues.	100%	0%	0%
Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints.	80%	10%	10%
The Committee has written Terms of Reference that define the Committee's role.	100%	0%	0%
The Committee is empowered to take action and make decisions, aligned to the Terms of Reference.	100%	0%	0%
Sufficient attention and time is given to discuss strategic risks.	60%	20%	20%
Does the Committee interact sufficiently with other Committees to support integrated governance.	90%	0%	10%
Health equity is proactively considered by the Committee and features on its work plan.	80%	10%	10%
Formal reporting is supplemented by opportunities to gather people's experience in support of triangulation.	100%	0%	0%

The work plan supports effective oversight to support assurance reporting, escalation and triangulation.	90%	0%	10%
The Committee's work is aligned clearly with the Trust strategy & strategic objectives.	90%	10%	0%
The Committee ensures that its decisions contribute to strategic direction of the Trust.	80%	10%	10%
The Committee's priorities are regularly reviewed to ensure alignment with changing priorities and risks.	89%	11%	0%
The Committee has made a positive contribution to work of the Trust over the last year.	100%	0%	0%
There is a process for communicating the Committee's outcomes.	90%	10%	0%

Appendix B - Action Plan – Quality and Safety Committee 2025/2026

Issued raised	Actions undertaken/planned	Responsible	Priority Level
Agendas too full: Most common issue. Discussion time is squeezed, leading to rushed scrutiny.	The meeting schedule has been changed for 2026 – 2027 additional meetings have been agreed, this will feel less rushed and more time for scrutiny	CGT P Hubbard	
Paper quality and consistency: Need clearer templates, expectations, and more concise presentations. Presenters sometimes over-explain instead of highlighting key points.	Since December 2025 P Hubbard has requested all presenters to create a slide deck of key highlights. 5-minute presenting time and 5 minutes discussion	P Hubbard	
Variable contribution in meetings: Some members speak less, despite opportunities given			
Induction to Committee: Induction practices are unclear and attendees/members may benefit from mentorship or buddy systems to facilitate effective challenges from members.			

Quality & Safety Committee

Terms of Reference

Document details:	Terms of Reference for the Quality & Safety Committee
Version:	21.0
Approved by:	Quality & Safety Committee
Ratified by:	Board of Directors
Date approved:	TBC
Date ratified:	TBC
Job title of author:	Corporate Governance Team
Job title of responsible Director:	Chair of the Quality & Safety Committee (Non-Executive Director)
Date issued:	March 2026
Review date:	March 2027
Frequency of review:	At least annual
Amendment Summary:	
<ul style="list-style-type: none"> • Changing the title of the Medical Director position to Chief Medical Officer • Updating the Deputy list for the Chief Medical Officer 	

1 Name of the Committee

Quality & Safety Committee.

2 Composition of the Committee

Members: full rights

Title	Role in the group / committee
Non-executive Director	Committee Chair
Non-executive Director	Committee Deputy Chair / Non-executive member

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Director of Nursing, Professions and Care Standards	Executive lead for the Committee. Assurance & escalation provider to the Quality & Safety Committee.
Chief Medical Officer	Executive lead with responsibility for clinical services. Assurance & escalation provider to the Quality & Safety Committee.
Chief Operating Officer	Executive lead with day-to-day responsibility for operational delivery of services. Assurance and escalation provider to the Quality & Safety Committee.

Any Executive and Non-executive Director can attend a Board sub-committee meeting because of the position that they hold. When carrying out this duty they will assume full member rights.

In attendance: in an advisory capacity

Job Title
Trust Secretary
Deputy Director of Patient Safety, Compliance and Risk
Deputy Director of Nursing
Deputy Director for Professions / Chief Psychological Therapies Officer
Deputy Director for Professions / Chief Allied Health Professions Lead
Head of Nursing – Mental Health Care Services
Head of Nursing – Adults and Children’s Physical Health
Head of Patient Safety / Patient Safety Specialist
Deputy Director of Nursing and Quality Bradford ICB

In addition to anyone listed above as a member or attendee, at the discretion of the Chair of the Committee, the Committee may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

2.1 Governor Observers

The Committee welcomes and encourages governors to attend its meetings. The role of a Governor at Board sub-committee meetings is to observe the work of the Committee. The Governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe Non-executive Directors appropriately challenging the Executive Directors for the operational performance of

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the Trust. At the meeting the Governor observer(s) will be required to declare any interest they may have in respect of any of the items to be discussed.

3 Quoracy

Number: The minimum number of members for a meeting to be quorate is three, comprising at least two Non-executive Directors and one Executive Director. Attendees do not count towards quoracy. If the Chair of the Committee is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by one of the other Non-executive Directors.

Deputies: Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal “acting up” arrangements. In this case the deputy will be deemed a full member of the committee.

It may also be appropriate for attendees to nominate a deputy to attend in their absence.

A schedule of deputies, attached at Appendix 1a, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4 Meetings of the Committee

Frequency: Meetings will be held 2 months aligned to new reporting cycles agreed by the Board of Directors. Additional deep dive meetings can be convened in agreement between the Executive and Non-Executive Directors. There will be separate meetings if required by the Board.

Urgent meeting: Any member of the Committee may request an urgent meeting. The Chair of the Committee will normally agree to call an urgent meeting to discuss the specific matter, unless the opportunity exists to discuss the matter in a more expedient manner.

Joint Committee Meetings: Joint Committee meetings can take place between Board sub-committees. It will be for the Executive Directors in partnership with Non-Executive Director Chairs to agree when a meeting will be convened. Joint Committee meetings will be facilitated by the Corporate Governance Team and will either be formal meetings, or development sessions. When Joint meetings are convened the relevant Terms of Reference will be adhered to.

Minutes: The Committee Secretariat will be provided by the Corporate Governance Team.

Alert, Advice, Assure and Decision (AAA+D) Effective Oversight: Escalation and Assurance The Chair of the Committee will provide an update of key issues arising from the meeting to the next Board of Directors meeting held in public.

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Voting: It is at the discretion of the Chair of the meeting to call a vote during a meeting. When voting, decisions at meetings shall be determined by a majority of the votes of the Executive and Non-executive Director's present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

5 Authority

Establishment: The Committee is a sub-committee of the Board of Directors and has been formally established by the Board.

Powers: Its powers, in addition to the powers vested in the executive members in their own right, are detailed in the Trust's Scheme of Delegation.

Cessation: The Committee is a standing Board sub-committee in that its responsibilities and purpose are not time limited. However, the Committee has a responsibility to review its effectiveness annually.

6 Role of the Committee

6.1 Purpose of the Committee

The overall aim of the Committee is to seek and obtain evidence of assurance on the effectiveness of the Trust's quality and safety systems and processes and the quality and safety of the services provided. This includes identifying and seeking assurance on the management of quality and safety related risks at operational and strategic level.

The Committee will monitor and report to the board on the effectiveness of these systems and processes. As agreed by the Board July 2023 within the Better Lives Together strategic framework, the Quality and Safety Committee is responsible for Best Quality Services – Theme 3 – Improving the experience of people using our services (specifically in relation to restrictive practices) as a supporting objective to the four strategic priorities:

- Being the Best Place to Work
- Delivering the Best Quality Services
- Making the Best Use of Resources
- Being the Best Partner

6.2 Guiding principles for members (and attendees) when carrying out the duties of the group / committee

In carrying out their duties members of the Committee and any attendees of the Committee must ensure that they act in accordance with the values of the Trust, which are:

- we care

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- we listen
- we deliver.

6.3 Duties of the Committee

The Quality & Safety Committee's key objectives are to:

- Seek assurance that:
 - Systems and processes are effective;
 - The quality of services is good and continuously improving; and
 - The quality of the experience of people using our service is good and continuously improving.
- monitor, review and report to the Trust Board on all the above; highlighting assurances received and identifying any threats to assurance;
- support the range of quality and safety initiatives in place within the Trust, providing advice where appropriate;
- support and promote a risk awareness culture and positive approach to investigating and learning from adverse events; and
- receive relevant strategies for information and assurance.

The Quality & Safety Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

In particular the Committee shall review the adequacy of:

- the management of BAF risks which the QSC has responsibility for overseeing;
- assurance against CQC inspection action plans and routine CQC related activity;
- systems and processes to ensure monitoring and assessment of the quality and improvements in services;
- mechanisms to involve service users, carers, the public and partner organisations in improving services;
- arrangements for implementation and monitoring of clinical audit, clinical guidelines and protocols, NICE guidelines;
- systems for identifying, reporting, mitigating and managing quality and safety related risks including the monitoring of incidents and complaints, and any risks within the Operational Risk Register that have been allocated to the Committee;
- research governance structures and proposals and work programme for Research and Development;
- structures and processes for developing and assuring clinical effectiveness;
- performance monitoring relating to key quality and safety indicators; and
- the Trust's response to key external reports.

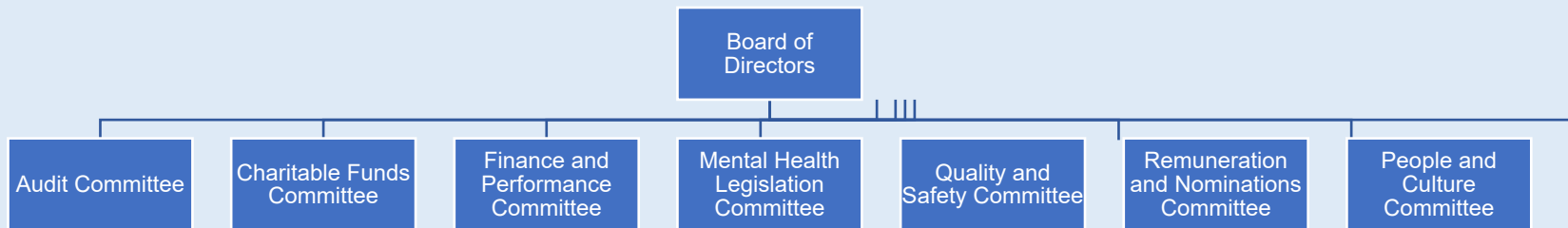
In addition, the Committee shall receive regular reports (including issues to escalate and assurances and, where applicable, key performance indicators) on activity within operational services and the work of the sub-groups of the Committee that contribute to the understanding and improvement of quality and safety.

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7 Relationships with other groups and committees



The Committee does not have any sub-committees. It is linked to the Trust's operational groups as an assurance receiver and provides a route of escalation to the Board of Directors.

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8 Duties of the Chair

The Chair of the Committee shall be responsible for:

- agreeing the agenda in partnership with the Director of Nursing, Professions and Care Standards;
- directing the meeting ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion;
- giving direction to the secretariat and checking the draft minutes;
- ensuring the agenda is balanced and discussion is productive; and
- ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee.

9 Reviews of the terms of reference and effectiveness

The terms of reference shall be reviewed by the Committee at least annually and be presented to the Board of Directors for ratification.

It will be the responsibility of the Chair of the Committee to ensure that it carries out an assessment of effectiveness annually, and ensure the outcome is reported to the Board of Directors along with any remedial action to address weaknesses. The Chair of the Committee will also be responsible for ensuring that the actions to address any areas of weakness are completed.

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Appendix 1a: Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case, please state below “no deputy required”.

Full member (by job title)	Deputy (by job title)
Non-Executive Director Chair	Another Non-Executive Director
Non-Executive Director	Another Non-Executive Director
Director of Nursing, Professions and Care Standards	Deputy Director of Nursing, Care Standards and Professions Deputy Director of Patient Safety, Compliance and Risk
Chief Operating Officer	Deputy Director of Operations
Chief Medical Officer	Medical Lead from Chief Medical Officers

Attendee (by job title)	Deputy (by job title)
Trust Secretary	Deputy Trust Secretary
Deputy Director of Patient Safety, Compliance & Risk	Head of Patient Safety, Compliance & Risk
Deputy Director of Nursing	Head of Nursing

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Escalation and Assurance Report

Report from: West Yorkshire (WY) Integrated Care System (ICS) Mental Health, Learning Disability & Autism (MHLDA) Committee-in-Common

Date of the meeting 28/01/2026

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert/Action:
<ul style="list-style-type: none"> No items
Advise:
<ul style="list-style-type: none"> WY MHIS and SDF discussions with the ICB will be discussed by CEOs at the forthcoming Collaborative Executive meeting. The WY MHLDA Programme Team will be responding to the ICB Consultation on future structures, with reflections on the impact of the changes to job roles and ways of working.
Assure:
<ul style="list-style-type: none"> There is a new pilot to link and underpin WY and Place Inpatient Quality Transformation. The Inpatient MH Assessment Tool (MH SAT IP) work will be launched formally in February, all Trusts are participating. The CinC was assured of the work ongoing in each Trust relating to inpatient quality, patient flow and culture of care. Particular recognition was given to the value of the presented co-production elements with service user voices demonstrating a powerful impact in influencing change. Continued collaboration to monitor and evaluate ongoing effectiveness will be a future task for WY. A jointly hosted Right Care Right Person event by WY Police and the WY MHLDA team offered a clear direction moving forward, this event was well attended by WY system partners with agreement into the next steps to align governance and data and deliver a 12 month workplan.

Report completed by: Keir Shillaker, WY MHLDA Programme Director **Date:** 02/02/2026

Distribution: Chairs and Company Secretaries of Bradford District Care NHS Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds & York Partnership NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust.

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Name of meeting: Board of Directors held in public
 NED Chair: Sarah Jones (SJ)
 Lead Director: Fran Stead (FS)
 Secretariat: Rachel Trawally (RT)
 Year: 2026-27 DRAFT

Category	Agenda item	Paper author	Item presenter	Lead Director	Lead PA/Admin	Date 02.04.26	Date 04.06.26	Date 23.07.26	Date 01.10.26	Date 03.12.26	Date 04.02.27	Date apr tbc	Notes
Good Governance	Apologies	Verbal	SJ (Chair)	SJ (Chair)	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X	
Good Governance	Declarations of conflicts of interest	RT (Deputy Trust Secretary)	SJ (Chair)	SJ (Chair)	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X	
Good Governance	Service User or Carer Story	Suzanne Hala	Suzanne Hala	PH (DoN, Deputy CE)	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X	
Good Governance	Questions received	Verbal	SJ (Chair)	SJ (Chair)	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X	
Good Governance	Minutes of last meeting	RT (Deputy Trust Secretary)	SJ (Chair)	SJ (Chair)	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X	
Good Governance	Matters arising	RT (Deputy Trust Secretary)	SJ (Chair)	SJ (Chair)	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X	
Good Governance	Action log	RT (Deputy Trust Secretary)	SJ (Chair)	FS (Trust Secretary)	Executive Assistant	X	X	X	X	X	X	X	
Good Governance	Work Plan	RT (Deputy Trust Secretary)	RT (Deputy Trust Secretary)	FS (Trust Secretary)	Executive Assistant	X	X	X	X	X	X	X	
Good Governance	Any other business	Verbal	SJ (Chair)	SJ (Chair)	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X	
Good Governance	Comments from public observers	Verbal	Chair	FS (Trust Secretary)	Executive Assistant	X	X	X	X	X	X	X	
Good Governance	Meeting evaluation	Verbal	SJ (Chair)	SJ (Chair)	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X	
All	Chairs Report	MH (Executive Assistant)	SJ (Chair)	FS (Trust Secretary)	MH (Executive Assistant)	X	X	X	X	X	X	X	
All	Chief Executive Report	TP (Chief Executive)	TP (Chief Executive)	TP (Chief Executive)	Executive Assistant	X	X	X	X	X	X	X	
All	Strategic Assurance and Performance Report	FS (Trust Secretary)	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant	X	X	X	X	X	X	X	replaced Board Integrated Performance report
All	Strategic Risk Assurance Report/Summary	FS (Trust Secretary)	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant	X	X	X	X	X	X	X	
Best Quality Services	Suicide prevention annual report	SU (CMO)	SU (CMO)	SU (CMO)	RS (Executive Assistant)			X					
Best Quality Services	Winter planning	KB (COO)	KB (COO)	KB (COO)	DS (Executive Assistant)				X	X			sept/oct 26
Best Quality Services	Access and waits	KB (COO)	KB (COO)	KB (COO)	DS (Executive Assistant)			X					bi-annual?
Best Quality Services	NHS England Emergency Preparedness, Resilience and Response Assessment and Declaration	KB (COO)	KB (COO)	KB (COO)	DS (Executive Assistant)				X				does it also need to go to every meeting as part of CE report - or just sept when mentioned within aaad qsc reports
Best Quality Services	Learning from Deaths report	SU (CMO)	SU (CMO)	SU (CMO)	RS (Executive Assistant)								
Best Quality Services	Organisational Risk Register	FS (Trust Secretary)	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant	X	X	X	X	X	X	X	OR BELOW
Best Quality Services	Risk Management - update on RMS/risk tolerance	FS (Trust Secretary) or Paula Riely	FS (Trust Secretary) or Paula Riely	FS (Trust Secretary) or Paula Riely	Executive Assistant				X				FS or PR
Best Quality Services	AAAD Mental Health Legislation Committee	WB (NED)/CGT	WB (NED)	SU (CMO)	RS (Executive Assistant)		X	X	X	X			
Best Quality Services	AAAD Quality and Safety Committee	AM (NED)/CGT	AM (NED)	PH (DoN/Deputy CE)	JR (Executive Assistant)		X	X	X				
Best Quality Services	Compliance Against Care Quality Commission Registration		PH (DoN/Deputy CE)	PH (DoN/Deputy CE)	JR (Executive Assistant)								annual july?
Best Quality Services	Care Quality Commission Update and Developments		PH (DoN/Deputy CE)	PH (DoN/Deputy CE)	JR (Executive Assistant)								as required
Best Quality Services	NHS England Quarterly Submissions	C Risdon	MW (CFO)	MW (CFO)	ZN (Executive Assistant)			X					went to nov private
Best Quality Services	Complaints annual report	Rebecca Le-Hair/Elizabeth Hadley-Day	PH (DoN/Deputy CE)	PH (DoN/Deputy CE)	JR (Executive Assistant)			X					
Best Quality Services	Annual quality account (for info)	L Graham	PH (DoN/Deputy CE)	PH (DoN/Deputy CE)	JR (Executive Assistant)		private	X for info					and to CoG and QSC first?
Best Quality Services	GoSee report thematic learning report	RT (Deputy Trust Secretary)	RT (Deputy Trust Secretary)	FS (Trust Secretary)	Corporate Governance Officer					X			new
Best Place to Work	Staff Survey Results	H Farrar	H Farrar	B Champion (CPO)	Executive Assistant	X	X						April brief update
Best Place to Work	Annual safer staffing report			P H (DoN/Deputy CE)	JR (Executive Assistant)		X						
Best Place to Work	AAAD People and Culture Committee	MR (NED)/CGT	MR (NED)	B Champion (CPO)	Executive Assistant		X	X	X				
Best Place to Work	Freedom to speak up guardian bi-annual thematic report	R Wixey	R Wixey	PH (DoN/Deputy CE)	JR (Executive Assistant)		X			X			previously advised annual by PH but RW advised requirement 6 monthly
Best Place to Work	Medical appraisal and revalidation annual report	SU (CMO)	SU (CMO)	SU (CMO)	RS (Executive Assistant)			X					HAS IT BEEN
Best Place to Work	Guardian of safe working annual report			B Champion (CPO)	Executive Assistant			X					HAS IT BEEN
Best Place to Work	Gender pay gap annual report (include in PCC AAAD report)	L Wright	B Champion (CPO)	B Champion (CPO)	Executive Assistant	X						X	
Best Use of Resources	Final financial plan 2024-25	C Risdon	C Risdon	MW (CFO)	ZN (Executive Assistant)								
Best Use of Resources	Operational plan 2025-26	C Risdon	C Risdon	MW (CFO)	ZN (Executive Assistant)								WHEN
Best Use of Resources	Finance report	C Risdon	C Risdon	MW (CFO)	ZN (Executive Assistant)	X	X	X	X	X	X	X	
Best Use of Resources	Green plan	Emma Clarke	Emma Clarke	MW (CFO)	ZN (Executive Assistant)			X					SEPT?
Best Use of Resources	AAAD Finance and Performance Committee	CH (NED)/CGT	CH (NED)	MW (CFO)	ZN (Executive Assistant)		X	X	X				
Best Use of Resources	AAAD Charity Funds Committee	MR (NED)/CGT	MR (NED)	MW (CFO)	ZN (Executive Assistant)		X						
Good Governance	NHS Oversight Framework quarterly report	FR (ED TIP)	FR (ED TIP)	FR (ED TIP)	LG (Executive Assistant)	X		X	X	X			
Good Governance	AAAD Audit Committee	CM (NED)/CGT	CM (NED)	FS (Trust Secretary)	Executive Assistant				X				
Good Governance	Annual Declaration of Interest for the Board of Directors	Executive Assistant	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant		X	X					June tbc
Good Governance	Annual Declaration of Fit and Proper Person Regulation for the Board of Directors	Executive Assistant	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant		X	X					June tbc
Good Governance	Annual Declaration of Independence (NED)	Executive Assistant	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant		X	X					June tbc
Good Governance	Annual Review of Division of Duties of the Chair and Chief Executive	FS (Trust Secretary)	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant								tbc
Good Governance	Scheme of Delegation and Standing Financial Instruction Ratification	C Risdon	C Risdon	MW (CFO)	ZN (Executive Assistant)				X				
Good Governance	Use of the Trust Seal - annual report	FS (Trust Secretary)	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant			X					tbc
Good Governance	BoD Annual Effectiveness Review	FS (Trust Secretary)	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant			X					
Good Governance	BoD Terms of reference annual review	FS (Trust Secretary)	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant			X					
Good Governance	Sub-Committee annual reports	CGT	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant			X					
Good Governance	Sub-Committee annual terms of reference report	CGT	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant			X					
Good Governance	Sub-Committee annual effectiveness review report	CGT	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant			X					
Best Use of Resources	Senior Information Risk Owner Annual Report	Delphine Fitouri (Head of Digital Services)	TR (CIO)	TR (CIO)	Executive Assistant			X					
Good Governance	Annual Review of the Constitution	FS (Trust Secretary)	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant				X				tbc
Good Governance	Health Safety and Security Annual Report			tbc	Executive Assistant			X					
Good Governance	Board Development Programme Work Plan	CGT	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant		X			X		X	to update
Good Governance	Board of Directors meeting Annual work plan	CGT	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant	X	X	X	X	X	X	X	
Good Governance	Notification future public meeting dates	CGT	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant					X			tbc
Good Governance	AAA: WY&H Mental Health, Learning Disabilities and Autism Committee in Common	RT (Deputy Trust Secretary)	For information only	Provided to us from WY&H	RT (Deputy Trust Secretary)				X				as received
Good Governance	AAA: WY Commissioning Hub	RT (Deputy Trust Secretary)	For information only	Provided to us	RT (Deputy Trust Secretary)								as received
Good Governance	AAA: Committees in Common (CiC) for the Community Collaborative scheduling to be confirmed	RT (Deputy Trust Secretary)	For information only	Provided to us from CiC	Executive Assistant								as received
Good Governance	Annual Review of Board Skills Matrix	CGT	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant				X				move to new year?
Best Use of Resources	Green plan	E Clarke	E Clarke	MW (CFO)	ZN (Executive Assistant)	X							3 year and annual review
Good Governance	Well led development plan	FS (Trust Secretary)	FS (Trust Secretary)	FS (Trust Secretary)	Executive Assistant	X	X	X	X	X	X	X	