

# Board of Directors - held in Public

Thu 04 June 2026, 09:30 - 12:30

Meeting held in person in New mill room 4.03



The Board of Directors held in Public meeting is held in public rather than being public meetings: this means that the public are very welcome to attend but cannot take part.

We welcome stakeholders to submit questions at least 5 days in advance to the Board of Directors held in Public.(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 - 04.06.2026 v5.pdf (4 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 May 2026.pdf (6 pages)

### 09:35 - 09:35 **3. Trust Risk Appetite Matrix (enclosure)**

0 min

Information Fran Stead

📄 Item 03.0 - Risk Appetite Matrix.pdf (1 pages)

### 09:35 - 09:35 **4. Questions received (verbal)**

0 min

Discussion Sarah Jones

### 09:35 - 09:35 **5. Minutes of the previous meeting held on 2 April 2026 (enclosure)**

0 min

Decision Sarah Jones

📄 Item 05. 0 - Public Board minute 2 April 2026 - Chair Approved.pdf (12 pages)

### 09:35 - 09:35 **6. Matters arising (verbal)**

0 min

Information Sarah Jones

### 09:35 - 09:40 **7. Action log (enclosure)**

5 min

Sarah Jones

📄 Item 07.0 - Public Board of Directors - Action Log - for June 2026.pdf (6 pages)


### 09:40 - 10:00 **8. Presentation Early Language Support for Every Child Project (presentation)**

20 min

Trawally Rachel  
03/06/2026 11:18:23

**10:00 - 10:05 9. Chair's Report (enclosure)**


5 min

*Sarah Jones* Item 09.0 - Chair's Report - 4 June final .pdf (4 pages)**10:05 - 10:40 10. Chief Executive's Report (enclosure)**


35 min

*Discussion* *Therese Patten* Item 10.0 - Chief Executive Report - Public June 26.pdf (9 pages)**10.1. Emerging issues: People and Organisational Development Collaboration (presentation)***Discussion* *Bob Champion/Jo Harrison* ITEM 10.0a -AFT and BDCFT People and OD Collaboration Board Discussion.pdf (11 pages)**10.2. Integrated Neighbourhood update (presentation)***Discussion* *Phillipa Hubbard* Item 10.0b - INT Board.pdf (12 pages)**Quality and Safety****10:40 - 10:45 11. Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held 21 May 2026 (enclosure)**

5 min

*Discussion* *Warren Brown* Item 11.0 - Effective Oversight Escalation and Assurance - 21 May 2026 - Chair Approved.pdf (3 pages)**10:45 - 10:55 12. Alert, Advise, Assure and Decision Report: Quality and Safety Committee held 15 April 2026 and 20 May (enclosures)**

10 min

*Discussion* *Alyson McGregor* Item 12.0 - AAAD - Effective Oversight Escalation and Assurance - QSC April 2026. Chair Approved.pdf (2 pages) Item 12.0b - AAAD - Effective Oversight Escalation and Assurance - QSC May 2026 - Chair approved.pdf (3 pages)**10:55 - 11:00 Break (10.55 – 11.00)**

5 min

**People and Culture****11:00 - 11:05 13. Alert, Advise, Assure and Decision Report: People and Culture Committee held 21 May 2026 (enclosed)**

5 min

*Discussion* *Mark Rawcliffe* Item 13.0 - AAAD - Effective Oversight Escalation and Assurance - PCC May 2026.pdf (3 pages)**11:05 - 11:15 14. Freedom to Speak up thematic report (enclosure)**

10 min

*Discussion* *Rebecca Wixey* Item 14.0 - Freedom to Speak Up Guardian Annual Activity Report - June 2026.pdf (15 pages)**11:15 - 11:15 15. 2025 NHS Staff survey results (enclosure)**Travelling Recluse  
07/06/2026 11:18:24

0 min

*Information* *Bob Champion*

For information only


 Item 15 - NSS25 Staff Survey results - Board in public 04 June 2026 HF.pdf (11 pages)

## Finance and Sustainability

11:15 - 11:20  
5 min

### 16. Alert, Advise, Assure and Decision Report: Finance and Performance Committee held 25 March 2026 and 27 May 2026 (enclosures)

*Discussion* *Cleveland Henry*

 Item 16.0a - AAAD - Effective Oversight Escalation and Assurance - FPC March 2026 CHAIR AND EXEC APP.pdf (3 pages)

 Item 16.0b - AAAD - Effective Oversight Escalation and Assurance - FPC May 2026 CHAIR EXEC APP.pdf (3 pages)

11:20 - 11:30  
10 min

### 17. Finance Report (enclosure)

*Discussion* *Mike Woodhead*

 Item 17.0 - Finance Report Trust Board (Month 1 - April 2026).pdf (7 pages)

## Strategy and partnerships

11:30 - 11:40  
10 min

### 18. Strategic Assurance and Performance Report (enclosure)

*Discussion* *Kelly Barker & Phillipa Hubbard*

 Item 18.0 - Board Integrated Performance Report Cover Paper - June 2026 kb DRAFT excl SORR.pdf (5 pages)

 Item 18.0 - Board Integrated Board Performance Report - June 2026.pdf (15 pages)

11:40 - 11:50  
10 min

### 19. Strategic Risk Summary (enclosure)

*Decision* *Fran Stead*

 Item 19.0 - Appendix 1 - 2026.04 - Strategic Risk Assurance Report WHOLE v.2.1.pdf (30 pages)

 Item 19.0 - Strategic Risk Assurance Report - Board - April 2026 - v.1.2.pdf (13 pages)

11:50 - 12:05  
15 min

### 20. Strategy refresh update (presentation)

*Discussion* *Farhan Rafiq/Fran Stead/Catherine Sunter*


 Item 20.0 - Strategy refresh Draft slides - board of Directors 5th June.pdf (6 pages)

## Governance and well led

12:05 - 12:10  
5 min

### 21. Alert, Advise, Assure and Decision Report: Audit Committee held on 26 March 2026 (enclosure)

*Discussion* *Christopher James Malish*

 Item 21.0 - AAAD - Effective Oversight Escalation and Assurance - Audit Committee 26.03.2026 - Chair Approved.pdf (3 pages)

12:10 - 12:20  
10 min

### 22. Well-led development plan update (enclosure)

*Discussion* *Fran Stead*

 Item 22.0 -2026.05 - Well Led Development Plan - Board.pdf (19 pages)

 Item 22.0.1 - Appendix 1 - NED attendance 2025-26.pdf (3 pages)

 Item 22.0.2 - Appendix 2 - Message to Board from Sarah Jones.pdf (1 pages)

Transparency Pack  
03/06/2026 11:32

📄 Item 22.0.3 - Appendix 3 - Item 11.0b - PSED REPORT 2025-26 251120 P&CC.pdf (36 pages)

📄 Item 22.0.4 - Appendix 4 - Well led Imp Plan EPRR.pdf (7 pages)

**12:20 - 12:25 23. Governance report (enclosure)**

5 min

*Decision Fran Stead*

📄 Item 23.0.0 - Governance Report - Board of Directors - 4 June 2026.pdf (6 pages)

📄 Item 23.0.1 - Appendix 1 -Chair in Common Governance Framework May 2026 final draft.pdf (9 pages)

📄 Item 23.0.2 - Appendix 2 - Board COG and Sub-Comm dates final 2026-27.pdf (2 pages)

**12:25 - 12:25 24. Partnership reports (enclosure)**

0 min

*Information Information*

📄 Item 24.0 - Provider Collaboratives WYMHDLA Board April 2026 updated for Cinc.pdf (4 pages)

📄 Item 24.0 - WYCHS Escalation and Assurance Report - 7.4.26 v0.1.pdf (3 pages)

**12:25 - 12:25 25. Board of Directors public meeting work plan 2026-27 (enclosure)**

0 min

*Information Information*

📄 Item 25.0 - Work Plan - Board 202627 DRAFT .pdf (2 pages)

**12:25 - 12:30 26. Any other business (verbal)**

5 min

*Discussion Sarah Jones*

Trawally Rachel  
03/06/2026 11:28:24

## Board of Directors – held in public

**Date: Thursday 4 June 2026**

**Time: 9.30 until 12.30**

**Venue: Meeting to be held in person at New Mill room 4.03**



We Care



We Listen



We Deliver

### AGENDA

The Board of Directors held in Public meeting is held in public rather than being public meetings: this means that the public are very welcome to attend but cannot take part.

We welcome stakeholders to submit questions at least 5 days in advance to the Board of Directors held in Public.(contact details are at the end of the agenda).

This meeting will normally 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	Purpose	Time
GG	1	<b>Welcome and apologies for absence</b> (verbal)	SJ	For information	9.30
	2	<b>Declaration of any conflicts of interest</b> (enclosure)	SJ	For information	
	3	<b>Trust Risk Appetite Matrix</b> (enclosure)	FS	For information	
BUOR	4	<b>Questions received</b> (verbal)	SJ	For discussion	
GG	5	<b>Minutes of the previous meeting held on 2 April 2026</b> (enclosure)	SJ	For decision	
	6	<b>Matters arising</b> (verbal)	SJ	For information	
	7	<b>Action log</b> (enclosure)	SJ	For decision	9.35
BQS	8	<b>Board Story Presentation –Early Language Support for Every Child Project</b> (presentation)	PH/SH/ Nichola Rodgers	For discussion	9.40
All	9	<b>Chair’s Report</b> (enclosure)	SJ	For discussion	10.00
	10	<b>Chief Executive’s Report</b> (enclosure)	TP	For discussion	10.05
		<ul style="list-style-type: none"> <li><b>Emerging issues: People and Organisational Development Collaboration</b> (presentation)</li> </ul>		BC/JH	10.10

	10a	Integrated Neighbourhood update (enclosure)	PH	For discussion	10.35
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**Quality and Safety**

BQS	11	Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held 21 May 2026 (enclosure)	WB	For discussion	10.40
	12	Alert, Advise, Assure and Decision Report: Quality and Safety Committee held 15 April 2026 and 20 May 2026 (enclosures)	AM	For discussion	10.45

Break (10.55 – 11.00)

**People and Culture**

BPTW	13	Alert, Advise, Assure and Decision Report: People and Culture Committee held 21 May 2026 (enclosure)	MR	For discussion	11.00
	14	Freedom to Speak up thematic report (enclosure)	R Wixey	For discussion	11.05
	15	2025 NHS Staff Survey results (enclosure)	For info	For information	-

**Finance and Sustainability**

BUOR	16	Alert, Advise, Assure and Decision Report: Finance and Performance Committee held 25 March 2026 and 27 May 2026 (enclosures)	CH	For discussion	11.15
	17	Finance Report (enclosure)	MW	For discussion	11.20

**Strategy and partnerships**

All	18	Strategic Assurance and Performance Report (enclosure)	PH/ KB	For discussion	11.30
	19	Strategic Risk Summary (enclosure)	FS	For decision	11.40
	20	Strategy refresh update (presentation)	FS/FR/ C Sunter	For discussion	11.50

**Governance and well led**

GC	21	Alert, Advise, Assure and Decision Report: Audit Committee held 26 March 2026 (enclosure)	CM	For discussion	12.05
	22	Well-led development plan update (enclosure)	FS	For discussion	12.10

	23	<b>Governance report</b> (enclosure)	FS	For decision	12.20
	24	<b>Partnership reports</b> (enclosure) <ul style="list-style-type: none"> <li><b>MHLDA Programme Update: Committees-in-Common April 2026</b> West Yorkshire Community Health Services Provider Collaborative (WYCHS) Quarterly Chairs and Executives Leads meeting held in 7 April 2026 (enclosure)</li> <li><b>West Yorkshire Commissioning Hub</b> held on 16<sup>th</sup> April 2026</li> </ul>	For info	For information-	
	25	<b>Board of Directors public meeting work plan 2026-27</b> (enclosure)	For info	For information	
	26	<b>Any other business</b> (verbal)	SJ	For discussion	12.25
	27	<b>Comments from public observers</b> (verbal)	SJ	For information	-
	28	<b>Meeting evaluation</b> (verbal) <b>Was the meeting conducted in line with the Trust values?</b> (verbal)	SJ	For discussion	-

**Date of the Next Meeting:** 23 July 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](mailto:fran.stead@bdct.nhs.uk)

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

Email: [sarah.jones@bdct.nhs.uk](mailto:sarah.jones@bdct.nhs.uk)

Expressions of interest to observe the meeting using Microsoft Teams:

Email: [corporate.governance@bdct.nhs.uk](mailto: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

	<b>Theme 2</b> – Learning for improvement	<b>BQS:T2</b>
	<b>Theme 3</b> – Improving the experience of people using our services	<b>BQS:T3</b>
<b>Best Partner</b>	Co-production, working together, presence, insight	<b>BP</b>
<b>Good Governance</b>	Governance, accountability and effective oversight	<b>GG</b>

Trawally Rachel  
03/06/2026 11:28:24

Name2	Directorships, including	Ownership or part own	Majority or controlling s
Robert (Bob) champion	None	None	None
Therese Patten	None	None	None
Phillipa Hubbard	Director of Nursing and Quality within WY ICB working into Bradford District and Craven	Langtry-Langton Architects	None
Farhan Rafiq	Not applicable	Not applicable	Not applicable
Tim Rycroft	NA	NA	NA
Sal Uka	Nil	Nil	Nil
Warren Brown	Nil	Nil	Nil
Mike Woodhead	none	none	none
Sally Napper	None	None	None
Christopher Malish	Bradford College	N/A	N/A
Mark Rawcliffe	Horse and Jockey Horbury Bridge Limited Park Tavern Ossett Limited Dark Industries Limited	As above 50% holding	N/a
sarah Jones	Trust Chair at Airedale N	None	None
Cleveland Henry	None	None	None
Alyson McGregor	None	None	None

Trawally Rachel  
03/06/2026 11:51:24

Kelly Barker

No

No

No

Trawally Rachel  
03/06/2026 11:28:24

Position of authority in	Any connection with a	Any substantial or influe	Any other commercial o
None	None	None	None
Trustee NHS Providers due to cease imminently	None	None	None
None	None	None	None
Not applicable	Not applicable	Not applicable	Not applicable
NA	NA	NA	NA
Trustee Overgate Hospice in Halifax	Nil	Nil	Nil
Nil	Nil	Nil	Nil

none	none	none	none
None	None	None	None
Outside my Non-exec rol	No	No	No
N/a	N/a	N/a	N/a
None	None	None	None
None	None	None	Employed at EMIS Health/Optum UK (Software supplying to NHS) Director of Leeds Digital Ball CIC
None	Altogether Better (NHS hosted organisation): Director ( <i>declared 06/03/24</i> ) Health Foundation Common Ambition Programme Advisory Group: Expert Advisor ( <i>declared 06/03/24</i> )	None	None
None		None	None

Trawally Rachel  
03/06/2026 11:28:24

No

No

No

No

Trawally Rachel  
03/06/2026 11:28:24

Declarations made in res

None

Husband a social worker with North Yorkshire Council

None

Not applicable

NA

Nil

Spouse is a member of Ilkley Town Council

Louise Rigg (Elite Consulting and Training Ltd) is providing service to BDCT and is a family friend.

None

None

N/a

None

Wife, Lead Cancer Nurse, Leeds Teaching Hospital Trust NHS

None

Trawally Rachel  
03/06/2026 11:28:24

My husband Carl  
Retnam is a team leader  
band 7 with Early  
Intervention in  
Psychosis Service

Trawally Rachel  
03/06/2026 11:28:24

# Risk Appetite Matrix

	<b>0 - None</b> Avoidance of risk is a key organisational objective.	<b>1 - Minimal</b> Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	<b>2 - Cautious</b> Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	<b>3 - Open</b> Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	<b>4 – Seek</b> Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	<b>5 - Significant</b> Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
<b>FINANCIAL</b> How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
<b>REGULATORY</b> How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
<b>QUALITY</b> How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	We prefer risk avoidance. But, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
<b>REPUTATION</b> How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. SI Pho ACC	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable taking decisions that may expose us to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes SK
<b>PEOPLE</b> How will we be perceived by our current / future workforce?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment / retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve their skills /capabilities. We recognize innovation is likely to cause short term disruption with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.

Travis Rachel  
03/05/2026 11:28:24

**Board of Directors Meeting in Public**  
**On Thursday 2 April at 09:30**  
**Hybrid meeting held on Microsoft Teams and in Room 4.03 at**  
**New Mill**

**Members present in person:**

Sarah Jones	Chair in Common
Therese Patten	Chief Executive Officer
Kelly Barker	Chief Operating Officer
Warren Brown	Non-Executive Director
Bob Champion	Chief People Officer
Cleveland Henry	Non-Executive Director
Phil Hubbard	Director of Nursing, Professions and Care Standards, Deputy Chief Executive
Chris Malish	Non-Executive Director
Alyson McGregor	Non-Executive Director
Farhan Rafiq	Director of Transformation, Improvement and Productivity
Mark Rawcliffe	Non-Executive Director and Deputy Chair
Tim Rycroft	Chief Information Officer
Dr Sal Uka	Chief Medical Officer
Mike Woodhead	Chief Finance Officer

**In Attendance in person:**

J Bridges	Individual Placement and Support (IPS) Service Manager (agenda item 07.0)
R Boota	Employment Specialist (agenda item 07.0)
Holly Close	Corporate Governance Officer (Secretariat)
Fran Stead	Trust Secretary
X	Individual Placement and Support (IPS) Service User (agenda item 07.0)

**In Attendance on MS Teams:**

Suzanne Hala	Senior Involvement Officer
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**Observers**

Anthony Davidson	Deputy Director of Nursing (secondment)
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Nimisha Deakin

Associate Director of Nursing and Patient  
Experience at The Tavistock and Portman  
NHS Foundation Trust (from item 07.0)

Nazmeen Khan

Corporate Governance Officer

**Apologies:**

Sally Napper

Non-Executive Director and Senior  
Independent Director

Rachel Trawally

Corporate Governance Manager and  
Deputy Trust Secretary

Trawally Rachel  
03/06/2026 11:28:24

## MINUTES

Item	Discussion	Action
<b>1</b>	<p><b>Welcome and Apologies for Absence</b> (agenda item 1)</p> <p>The Chair opened the meeting in public and welcomed Cleveland Henry, Non-Executive Director, to their first Board meeting. It was noted that this was the Chair's first public Board meeting. Apologies for absence were noted, and the meeting was confirmed as quorate.</p>	
<b>2</b>	<p><b>Declarations of interest</b> (agenda item 2)</p> <p>The Chair declared that they were Chair of Airedale NHS Foundation Trust and also served as Co-Chair of the organisation. <b>It was noted that this declaration had not been included on the declarations register and would be added accordingly.</b></p> <p>No other declarations of interest were made.</p>	RT
<b>3</b>	<p><b>Questions received</b> (agenda item 3)</p> <p>No questions were received.</p>	
<b>4</b>	<p><b>Minutes of the previous meeting held on 5 February 2026</b> (agenda item 4)</p> <p>The minutes of the Public Board of Directors held on 5 February 2026 were approved as a true and accurate record.</p>	
<b>5</b>	<p><b>Matters arising</b> (agenda item 5)</p> <p>No matters arising had been received.</p>	
<b>6</b>	<p><b>Action log</b> (agenda item 6)</p> <p>The Chair presented the action log, and it was noted that the two outstanding actions remained open.</p> <p><b>The Board of Directors:</b></p> <ul style="list-style-type: none"> <li>• <b>noted the contents of the action log;</b></li> <li>• <b>agreed to close the actions listed as complete; and</b></li> <li>• <b>noted that no further actions were required on any actions listed.</b></li> </ul>	
<b>7</b>	<p><b>Presentation Individual Placement and Support (IPS)</b> (agenda item 7)</p> <p>P Hubbard, Director of Nursing, Professions and Care Standards, Deputy Chief Executive presented a service user case study from the Individual</p>	

Item	Discussion	Action
	<p>Placement and Support (IPS) service, which supported people with long-term mental health conditions into substantive employment.</p> <p>J Bridges, IPS Employment Service Manager, and members of the IPS team were introduced. X, a former IPS service user, was welcomed and thanked for attending to share their personal experience. The Chair expressed the Board's appreciation and acknowledged the importance of hearing directly from people with lived experience.</p> <p>X described their mental health journey and the impact of illness on their confidence and employment, outlining how support from IPS enabled a more considered return to work. They reflected on the importance of personalised support, including reviewing skills and preferences, practical assistance with recruitment, and in-work support. It was noted that adjustments to working hours had supported recovery and that X had remained in employment for nearly three years, continuing to access IPS support as required.</p> <p>The Chair acknowledged the continuity and quality of support provided by the IPS team. In response to a question from A McGregor, assurance was provided that re-referral to IPS was accessible when additional support was needed. J Bridges advised that the service was expanding locally and nationally, including into primary care networks, to reduce gaps between services.</p> <p>T Patten, Chief Executive Officer explained that the IPS service was recognised as highly performing, nationally benchmarked, and award-winning. They acknowledged that supporting people back into work required time, consistency, and thoughtful planning, and could not be achieved through short-term interventions alone.</p> <p>K Barker, Chief Operating Officer highlighted that, despite difficult national decisions within the NHS ten year plan, IPS had remained a priority with continued investment, reflecting the importance of recovery and meaningful employment.</p> <p>The Board thanked X and the IPS team. Appreciation was expressed for the conversational format of the presentation, which enabled a deeper understanding of personal impact compared to a traditional presentation.</p> <p><b>The Board welcomed the presentation and were assured by the update.</b></p>	
<p><b>8</b></p>	<p><b>Chair's Report</b> (agenda item 8)</p> <p>The Chair presented the Report, outlining key changes since the last reporting period. No questions were raised.</p>	

Trawally Patel  
03/06/2026 11:28:24

Item	Discussion	Action
	<p><b>The Board of Directors noted the continuing engagement that has taken place with external partners, internally at the Trust, and with the Council of Governors</b></p>	
<p><b>9</b></p>	<p><b>Chief Executive’s Report</b> (agenda item 9)</p> <p>T Patten presented the report, highlighting staff recognition initiatives and improved recruitment times. Updates were provided on patient safety reporting arrangements, including public reporting of inquests and incidents, with detailed scrutiny undertaken through the Quality and Safety Committee. It was noted that a review of learning and assurance processes was underway.</p> <p>Clarification was provided on a Coroner’s narrative report, confirming that it identified pathway issues between general practice and community mental health services, with no further systemic concerns requiring escalation.</p> <p>T Patten also highlighted national recognition received by the Pharmacy team for the Trust’s Green Plan and provided an update on Integrated Care Board (ICB) leadership changes and organisational restructuring, including consultation and anticipated workforce impacts.</p> <p>The Board received staff survey headlines from B Champion, Chief People Officer, noting a 50% response rate, improvement across three domains, and the introduction of World Café events to support engagement and action planning. In response to a question from C Henry, Non-Executive Director regarding hotspots, it was confirmed that early analysis showed improved engagement in mental health services, with further detail to follow. Results would be shared with the Council of Governors in May.</p> <p>No further questions were raised.</p> <p><b>The Board of Directors noted the contents of the paper and sought any further clarification as appropriate.</b></p>	
<p><b>10</b></p>	<p><b>Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held 19 March 2026</b> (agenda item 10)</p> <p>W Brown, Non-Executive Director reported that there were no matters arising from the previous meeting requiring escalation to the Board. The Board was provided with assurance regarding recruitment to Associate Hospital Manager roles, with recent appointments made and further recruitment approaches being explored. It was confirmed that the Mental Capacity Act team had stabilised, with training and delivery continuing to be monitored.</p> <p>Positive Care Quality Commission Mental Health Act monitoring visits were noted, including improvements from <i>requires improvement</i> to <i>good</i> in some areas. Concerns were raised regarding awareness of recent Mental Health</p>	

Trawally R.C. (11/29/24)  
03/06/2026 11:29:24

Item	Discussion	Action
	<p>Act reforms, particularly practical implications, with implementation timelines remaining unclear pending revisions to the Code of Practice. It was confirmed that a deep-dive would be undertaken at the May Committee meeting, supported by Board and Governor activity, and that a new strategic risk had been added.</p> <p>It was emphasised that Mental Health Act reform remained a Board-level issue, with ongoing monitoring through the Committee.</p> <p><b>The Board of Directors were assured by the update.</b></p>	
11	<p><b>Alert, Advise, Assure and Decision Report: Quality and Safety Committee held 18 February 2026 and 18 March 2026</b> (agenda item 11)</p> <p>A McGregor reported that Quality and Safety alerts remained consistent with previous months, reflecting ongoing workforce and sustainability pressures, access and demand challenges, and persistent inequalities. Capacity risks associated with the forthcoming zero to nineteen procurement were noted, alongside continued substantial assurance across supervision, sexual safety, absence without leave, and the Care Quality Commission quarter three report.</p> <p>T Patten advised that the invitation to tender for the zero to 19 procurement had been delayed, enabling further discussion to be brought back to the Board before decisions were required.</p> <p>P Hubbard outlined the Quality Assurance Framework, describing targeted deep dives in response to risk, incidents, or staff concerns, supported by anonymous staff surveys. In response to a question from W Brown, it was confirmed that survey response rates were strong and more targeted than the staff survey.</p> <p><b>The Board of Directors were assured by the update.</b></p>	
12	<p><b>Alert, Advise, Assure and Decision Report: People and Culture Committee held 19 March 2026</b> (agenda item 12)</p> <p>M Rawcliffe reported key People and Culture risks, including dissatisfaction with the three point three per cent national pay award and the associated risk of industrial action, alongside ongoing sickness absence pressures impacting service resilience. It was noted that sickness absence remained above seven per cent in some areas, that six employment tribunals were being closely monitored, and that a formal review of e-rostering was underway.</p> <p>In discussion, the Chair sought assurance on safe staffing oversight, and it was confirmed that safe staffing was reviewed six-monthly and reported to the Board across all Trust services.</p>	

Trawally Raw  
03/06/2026 11:28:24

Item	Discussion	Action
	<p>In response to questions on industrial action risk raised by C Malish, Non-Executive Director, assurance was provided that while unions were considering next steps, the immediate local risk remained limited. It was further noted that pay awards continued to have a disproportionate financial impact on mental health trusts.</p> <p>The Board was advised that further resident doctor industrial action was due to commence, with planning in place, and that sickness absence trends reflected a wider regional and national picture, with the Trust no longer an outlier. Ongoing wellbeing and support measures remained in place.</p> <p><b>The Board of Directors were assured by the update.</b></p>	
<p><b>13</b></p>	<p><b>Alert, Advise, Assure and Decision Report: Finance and Performance Committee held 25 March 2026 (agenda item 13)</b></p> <p>M Rawcliffe provided a verbal update from the Finance and Performance Committee, noting that delivery against the £11.8m Operational Sustainability and Performance Board (OSPB) target remained behind plan and supported by non-recurrent funding, with improved governance and capacity giving increased confidence for the coming year. Out of area placements continued to present a financial risk, alongside ongoing work to improve data quality, accountability, and development of an end-to-end digital plan.</p> <p><b>The Board of Directors were assured by the update.</b></p>	
<p><b>14</b></p>	<p><b>Finance Report (agenda item 15)</b></p> <p>M Woodhead presented the finance report, noting that the Trust had entered the new financial year with an agreed plan in place.</p> <p>Out of area placements were then discussed. It was established that current numbers reported at 34 against a plan of 33, highlighting the volatility of this area. It was noted that while significant work was underway to reduce placements, small changes could result in rapid increases. P Hubbard shared that a quality review of out of area placement was to be undertaken more formally through the Quality and Safety Committee.</p> <p>K Barker explained that quality reviews and monitoring arrangements were in place, including regular oversight, access to clinical records, and quality visits. The Board was advised that the majority of placements sat within a block contract forming part of the Trust's bed base and were quality assured, with a smaller number managed outside the contract but subject to the same governance framework.</p> <p>W Brown asked whether a variance of one out of area placement above or below plan represented a direct cost pressure or benefit to the Trust. It was</p>	

Trawally Rachel  
03/06/2026 14:29:44

Item	Discussion	Action
	<p>confirmed that each placement had an equivalent financial impact and that, due to volatility, maintaining placement numbers below plan was necessary to create headroom and manage financial risk effectively.</p> <p>The Board noted the wider system context, including national expectations for early delivery against plan and limited tolerance for variance.</p> <p><b>The Board of Directors:</b></p> <ul style="list-style-type: none"> <li>• <b>Noted the challenging financial position, and the actions being taken to deliver the agreed financial position;</b></li> <li>• <b>Noted the level of risks and actions being taken to mitigate and</b></li> <li>• <b>Highlighted any further assurances required.</b></li> </ul>	
<p><b>15</b></p>	<p><b>Green Plan Update</b> (agenda item 15)</p> <p>The Board received the revised Green Plan, which had been previously considered by the Finance and Performance Committee, noting that updates primarily reflected progress over the previous 12 months.</p> <p>C Malish asked about how the Trust sourced national benchmarking data. M Woodhead responded and confirmed that national benchmarking data was sourced through the Trust's Sustainability Lead and applied consistently for comparison. The Chair commented on the uptake on training. M Woodhead shared that that training uptake of around 10% was in line with expectations, as participation was voluntary and newly introduced, and that greater emphasis was being placed on active engagement through sustainability initiatives rather than training completion alone.</p> <p><b>The Chair encouraged colleagues to do the training and asked Board colleagues to undertake the training, which would be confirmed by the Sustainability Manager.</b></p> <p><b>The Board of Directors approved the revisions to the Green Plan.</b></p>	<p><b>Emma Clarke</b></p>
<p><b>16</b></p>	<p><b>Strategic Assurance and Performance Report</b> (agenda item 16)</p> <p>The Chair introduced the report and raised a query regarding the volume and presentation of data. K Barker presented the Integrated Strategic Assurance Report, confirming that the Trust remained in a broadly stable position, with increasing assurance around people, culture, and leadership, alongside continued challenges relating to access and flow driven by system pressures. It was confirmed that there had been no material deterioration in overall assurance and that areas of lower assurance were well understood and managed through Committee oversight.</p> <p>The Board noted improvement in the Trust's National Oversight Framework position to Segment Three and received assurance regarding ongoing review</p>	

Item	Discussion	Action
	<p>of strategic risks, reporting arrangements, and the safe maintenance of inpatient services. It was also confirmed that there had been no red shifts during the reporting period.</p> <p><b>The Board of Directors:</b></p> <ul style="list-style-type: none"> <li>• <b>Noted the data and associated narrative and triangulation as discussed within each delegated committee, detailed within the AAA+D</b></li> <li>• <b>Accepted the Board Assurance Framework Assurance levels as confirmed within each delegated committee, detailed within the report and in the AAA+D</b></li> </ul>	
<p><b>17</b></p>	<p><b>NHS Oversight Framework Quarterly Update</b> (agenda item 18 – agenda item taken out of order)</p> <p>The Board received an update from F Rafiq, Director of Transformation, Improvement and Productivity confirming that the Trust had improved its National Oversight Framework position from Segment Four to Segment Three, reflecting sustained operational improvement and improved data quality. Key improvements were noted across access, effectiveness, experience, patient safety, and productivity, including the elimination of fifty-two-week waits at the point of measurement and improved crisis care response times. Sickness absence was reported as broadly unchanged, reflecting national trends.</p> <p>Challenges were noted in relation to children and young people’s access metrics, with concern that national methodology did not fully reflect the Trust’s delivery model. It was confirmed that these issues had been raised nationally and that further clarification and metric development were ongoing.</p> <p>The Board discussed the relative nature of Framework movement and noted that progression beyond Segment Three was dependent on financial delivery. The Chair emphasised the importance of simplifying reporting to focus on headline assurance. Clarification was provided on the interpretation of fifty-two-week wait data and evolving national metrics, with assurance that the Trust continued to engage with NHS England to improve clarity and consistency.</p> <p><b>The Board of Directors:</b></p> <ul style="list-style-type: none"> <li>• <b>Noted the progress to date.</b></li> <li>• <b>Provided feedback on the reporting format and the information presented.</b></li> <li>• <b>Advised on any further assurance required.</b></li> </ul>	
<p><b>18</b></p>	<p><b>Strategic Risk Assurance Report</b> (agenda item 18 – agenda item taken out of order)</p>	

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03/06/2026 14:28:04

Item	Discussion	Action
	<p>The Board considered the Strategic Risks report, presented by F Stead, Trust Secretary, and noted ongoing work to refine the Board Assurance Framework, developed with Committee oversight and internal audit input. It was reported that 12 strategic risks had been identified for the forthcoming year, each with a named Senior Responsible Officer and oversight Committee, with monthly monitoring to be introduced and fuller reporting to follow.</p> <p>The Board noted the Audit Committee’s role in assuring the effectiveness of the framework and strategic risk management arrangements, alongside planned Board development to strengthen assurance and escalation processes.</p> <p>In discussion, T Patten highlighted the need for clearer articulation of productivity and sustainability benefits within Strategic Risk Owner Four. <b>It was agreed that the wording and assurance measures for this risk would be reviewed.</b></p> <p><b>The Board of Directors:</b></p> <ul style="list-style-type: none"> <li>• <b>Noted the update provided and the next steps as part of the agreed development work for this area</b></li> <li>• <b>Noted the Strategic Risks for 2026 have been discussed by each Committee, and were being finalised by the Executive Management Team</b></li> <li>• <b>Noted that each strategic risk was assigned to a lead Executive, who is populating the assurance report</b></li> <li>• <b>Approved the strategic risks, noting that a discussion will take place in Board held in Private on a proposed partnership strategic risk that was emerging</b></li> <li>• <b>Agreed any further actions in support of delivering this work.</b></li> </ul>	<p><b>BC</b></p>
<p><b>19</b></p>	<p><b>Care Trust Way Quality Management System Update</b> (agenda item 19)</p> <p>The Board received an update from F Rafiq on the development of the Quality Management System, following the Board development session held in March. It was noted that the system aimed to strengthen alignment between quality improvement, assurance, performance, and governance, improving the Board’s line of sight to frontline delivery. Key themes included improved triangulation of information and balancing quality, productivity, and sustainability.</p> <p><b>The Board noted that a twelve-month implementation plan and integrated quality dashboard would be developed and brought back in June.</b></p> <p><b>The Board of Directors noted the content of the report.</b></p>	<p><b>FR</b></p>

Trawally Rachel  
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Item	Discussion	Action
20	<p><b>Alert, Advise, Assure and Decision Report: Audit Committee held 29 January 2026 and 26 March 2026</b> (agenda item 20)</p> <p>C Malish presented the reports, noting confirmation of the annual report and accounts timetable, approval of the internal audit plan, and assurance regarding year-end and external audit arrangements. An alert was noted from the Board Assurance Framework audit, where limited assurance related to recording issues, with remedial action underway. It was confirmed that there were no new losses or special payments and that counter-fraud arrangements remained effective.</p> <p><b>The Board of Directors were assured by the update.</b></p>	
21	<p><b>Well-led development plan update</b> (agenda item 21)</p> <p>The Board received an update on the Well-led Development Plan, bringing together actions from recent governance and effectiveness reviews. Progress was noted in strengthening evidence tracking, consolidating actions under single Committee oversight, and aligning reporting within existing governance structures, with the Audit Committee providing oversight.</p> <p>The Chair emphasised the need to prioritise and theme actions to focus on areas of greatest impact. <b>It was agreed that further work would be undertaken to refine categorisation, with updates to be brought back to the Board.</b></p> <p><b>The Board of Directors:</b></p> <ul style="list-style-type: none"> <li>• <b>Was assured on the process being delivered as a new process agreed by the Board</b></li> <li>• <b>Noted &amp; discussed the updates provided</b></li> <li>• <b>Agreed any actions associated with the work and the above actions</b></li> <li>• <b>Noted that the full report will be presented to the Audit Committee; &amp; Board held in public, as outlined above.</b></li> </ul>	FS
22	<p><b>Governance report</b> (agenda item 22)</p> <p>F Stead presented the governance report, highlighting preparations for the forthcoming Annual Members' Meeting and planned governance activity relating to Committee effectiveness. The outcome of the Provider Capability Assessment was shared, confirming an amber-green rating consistent with the Trust's self-assessment, with no concerns raised by regulators.</p> <p>The Board approved the Committee Terms of Reference and the Annual Governance Report, <b>noting that further updates on Committee meeting frequency and membership would be brought back in due course.</b></p>	RT

Trawally B. Patel  
03/06/2026 11:28:24

Item	Discussion	Action
	<p><b>The Board of Directors:</b></p> <ul style="list-style-type: none"> <li>• <b>Noted the date of September’s Annual Members’ Meeting: 24 September 2026</b></li> <li>• <b>Considered &amp; approve the Committee’s Terms of Reference;</b></li> <li>• <b>Noted the content of the Annual Governance Report including the effectiveness review action plans &amp; be assured that the Committee’s have worked within its Terms of Reference, escalated appropriately any key issues through the escalation &amp; assurance reports made by the Chair of the Committee; &amp;</b></li> <li>• <b>Considered &amp; approved the Committee’s Annual Governance and Effectiveness Review Reports for 2025/26</b></li> </ul>	
23	<p><b>West Yorkshire ICS MHLDA Committee in Common AAAD held 28 January 2026 (agenda item 23)</b></p> <p><b>The West Yorkshire ICS MHLDA Committee in Common AAAD held 28 January 2026 was noted for information.</b></p>	
24	<p><b>Board of Directors public meeting work plan 2025-26 (agenda item 24)</b></p> <p><b>The Board of Directors were assured with the content of the report, which was provided for information.</b></p>	
25	<p><b>Any Other Business (agenda item 23)</b></p> <p>The Board recorded its thanks to Maz Ahmed, Non-Executive Director, for their contribution over six years of service. The Board also noted that Ian McBeath, Director of Integration, would be leaving the organisation to take up a role with NHS England and recorded its thanks for their contribution.</p> <p>No other business was raised.</p>	
26	<p><b>Comments from public observers (agenda item 24)</b></p> <p><b>The observers were thanked for their attendance. No comments were received.</b></p>	
27	<p><b>Meeting evaluation (agenda item 25)</b></p> <p>The Chair thanked colleagues for their contributions, and the Board reviewed the effectiveness of the meeting, confirming it had been conducted in line with Trust values.</p> <p><b>The meeting was closed at 12:00.</b></p>	

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

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 June	<b>The Board is asked to consider this action closed.</b> A position statement has been developed and is included, see appendix 1 to this document for information.
2. 05/02/2026	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		<b>The Board is asked to consider this action closed.</b> The apology letter has been produced, and is a generic apology rather than specifically to any one individual. It is currently with Head of Comms and Marketing to agree how we 'publish' this.
3. 02/04/2026	<u>Declarations of interest</u> The Corporate Governance Manager and Deputy Trust Secretary to add The Chair's declaration of interest to the declarations register	R Trawally	June 2026	<b>The Board is asked to consider this action closed.</b> This had already been received and was already on the declaration of interest document, therefore no further action is required.

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
<p><b>4.</b> <b>02/04/2026</b></p>	<p><b><u>Green Plan Update</u></b> The Sustainability Manager to share the net zero NHS training with Board members</p>	<p>Emma Clarke</p>	<p>June 2026</p>	<p><b>The Board is asked to consider this action closed.</b> Training link shared with Board members on 13/04/2026</p>
<p><b>5.</b> <b>02/04/2026</b></p>	<p><b><u>Strategic Risk Assurance Report</u></b> The Chief People Officer to update the wording and assurance measures for SRO 4.</p>	<p>B Champion</p>	<p>June 2026</p>	<p><b>Ongoing:</b> Update to be provided at the meeting</p>
<p><b>6.</b> <b>02/04/2026</b></p>	<p><b><u>CTW Quality Management System Update</u></b> The Director of Transformation, Improvement and Productivity to bring back the 12 month QMS Plan to June's Public Board.</p>	<p>F Rafiq</p>	<p>June July 2026</p>	<p><b>Ongoing:</b> this has been moved to the July meeting agenda</p>
<p><b>7.</b> <b>02/04/2026</b></p>	<p><b><u>Well-led development plan update</u></b> The Trust Secretary to refine categorisation for the well led actions and focus on the most impactful areas</p>	<p>F Stead</p>	<p>June July 2026</p>	<p><b>Ongoing:</b> The well led development plan is being updated and is presented within the papers. It is on the agenda as a regular item going forward and will be reviewed as part of the ongoing iterative process. The Board related actions are presented in June papers and the full report will go to Audit Committee in June and an update presented at July Board focusing on the most impactful areas.</p>

Trawally Rachel  
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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
7. 02/04/2026	<b>Governance report</b> The Corporate Governance Manager and Deputy Trust Secretary provide updates on refreshed committee meeting frequency and membership to a future governance report	R Trawally	June	<b>The Board is asked to consider this action closed.</b> The revised dates have been circulated and amended invitations sent. The schedule was provided within the May Board held in private papers and is included within the governance report for information.
<b>Actions closed at the last meeting</b>				
05/02/2026	<u>Chairs report</u>  To request access to and if available to circulate the recording.	S Lewis	April	<b>Closed:</b> SL confirmed he was unable to access the copy of the recording. <b>The Board considered this action closed.</b>
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	<b>Non returning:</b> this has been added to board schedule for suggested topics – need to identify a date once further details on legislative changes are confirmed. <b>The Board considered this action closed.</b>

Trawally, Rachel  
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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
05/02/2026	<p><u>Meeting evaluation</u></p> <p>to be taken forward consideration on equipment to support recording sound quality of board stories.</p>	P Hubbard	May	<p><b>Non returning:</b> to investigate options with S Hala. <b>The Board considered this action closed.</b></p>

Trawally, Rachel  
03/06/2026 11:28:24

Appendix 1:

**Bradford District Care NHS Foundation Trust’s Rainbow Alliance position statement on the historical use of Electric Shock Aversion Therapy (ESAT) and on Conversion Therapy**

Bradford District Care NHS Foundation Trust (BDCFT) and the trust’s Rainbow Alliance are united in their position that Electric Shock Aversion Therapy (ESAT) and all forms of “conversion therapy” are harmful practices with no clinical justification and are incompatible with NHS values, professional ethics and evidence-based care.

We recognise and acknowledge that ESAT has been reported to be used within healthcare settings, including at Lynfield Mount Hospital in the 1970s, as part of now-discredited approaches to sexual orientation and gender identity. We acknowledge the profound harm, trauma and lifelong impact these practices have had on individuals subjected to them. We are deeply sorry to those who experienced this harm.

We firmly reject any suggestion that sexual orientation or gender identity are conditions that require treatment or change. Lesbian, gay, bisexual, trans and other LGBTQ+ identities are a natural and valued part of human diversity. Practices that seek to suppress, change or “cure” these identities are unethical and damaging.

We align fully with NHS England’s position that conversion therapy, in any form, is unacceptable. This includes practices that are coercive, pathologising or that undermine a person’s sense of self, dignity or autonomy, whether delivered formally or informally, explicitly or implicitly.

The NHS has a responsibility not only to ensure that such practices have no place in modern healthcare, but also to acknowledge past harms and learn from them. This includes listening to survivors, being open and transparent about historical practices where they occurred and ensuring that apologies and remedial actions are meaningful and compassionate.

In line with the Equality Act 2010 and the NHS commitment to inclusive, person-centred care, the Rainbow Alliance supports:

- The eradication of conversion therapy in all its forms.
- The promotion of affirmative, respectful and inclusive care for LGBTQ+ people.
- Ongoing education and awareness for staff to ensure that past harms are not repeated.
- A culture of openness, accountability and learning where historical harms are acknowledged rather than minimised.

Trawson, Rachael  
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We welcome national work, including NHS England guidance and memoranda of understanding, which help set clear expectations around ethical practice and safeguarding for LGBTQ+ people. We will continue to work constructively with colleagues across the organisation to ensure our local approach reflects these national principles.

The Rainbow Alliance exists to advocate for dignity, safety, and equality for LGBTQ+ people - patients, service users and staff alike. Our position on ESAT and conversion therapy is grounded in our commitment to NHS values, human rights, and compassionate care.

This position does not prevent individuals from accessing ethical therapeutic support to explore distress, identity or lived experience, provided such support is free from any agenda to change sexual orientation or gender identity.

Trawally, Rachel  
03/06/2026 11:28:24

## Board of Directors – meeting held in public

**4 June 2026**

<b>Paper title:</b>	Chair of the Trust's Report	<b>Agenda Item</b>  <b>09.0</b>
<b>Presented by:</b>	Sarah Jones Chair in Common	
<b>Prepared by:</b>	Corporate Governance team	
<b>Committees where content has been discussed previously</b>	People & Culture Committee	
<b>Purpose of the paper</b> Please check <b>ONE</b> box only:	<input type="checkbox"/> For approval <input type="checkbox"/> For information <input checked="" type="checkbox"/> For discussion	

<b>Relationship to the Strategic priorities and Board Assurance Framework (BAF)</b>		
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

<b>Purpose of the report</b>
Chair's Report to inform Board members on activities over the last two months.

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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"/> <b>Yes</b> (please set out in your paper what action has been taken to address this)  <input checked="" type="checkbox"/> <b>No</b>

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

<b>Links to the Strategic Organisational Risk register (SORR)</b>	N/A
<b>Care Quality Commission domains</b> Please check <b><u>ALL</u></b> that apply	<input type="checkbox"/> Safe <span style="margin-left: 150px;"><input type="checkbox"/> Caring</span> <input type="checkbox"/> Effective <span style="margin-left: 150px;"><input checked="" type="checkbox"/> Well-Led</span> <input type="checkbox"/> Responsive
<b>Compliance &amp; regulatory implications</b>	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: <ul style="list-style-type: none"> <li>Well-Led Compliance</li> <li>NHS Code of Governance</li> <li>NHS Act</li> <li>Health and Social Care Act</li> <li>Health and Care Act</li> <li>Nolan Principles</li> <li>Provider Licence</li> </ul>

Trawally Rachel  
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## **Board of Directors – Meeting held in Public**

### **4 June 2026**

### **Chair of the Trust Report**

#### **Partnerships and strategy**

Over the last two months I have met with various stakeholders to continue discussions on key issues and to develop the role of Chair in Common.

#### **Chair in Common**

The first quarterly review of the Chair in Common role has taken place involving a discussion with both Trust Lead Governors and Trust Secretaries. It has been agreed that at the six month review point the Trusts Senior Independent Directors should also be invited into the discussion.

As part of my induction, I am visiting teams across Bradford District Care Trust. These are informal introductory visits, not part of the Trust GoSee programme. So far I have visited six teams over five sites and all the visits have been very insightful.

I attended the BDCT Long Service Celebration for colleagues who were celebrating 25 and 40 years respectively with the Trust; the Staff Survey World Café which was an opportunity to discuss in a wider setting the Staff Survey Results; and the ground breaking event for the Lynfield Mount redevelopment.

I have also now been to two of the leadership events – Leading Better Lives Together which are impressive in terms of the wider leadership team engagement. The last event was attended by 70 colleagues.

#### **Council of Governors**

I chaired my first meeting as Chair in Common on 13 May 2026.

The Quality Account and Staff Survey results were shared. These items sparked meaningful quality discussions among everyone present.

It was noted that Cllr Sabiya Khan stepped down as she was not re-elected in local elections. The Trust thanked Cllr Khan for her work with the Trust whilst in office and a letter of thanks has been sent to her.

#### **Trust Board**

We have been joined by Cleveland Henry who is an experience NHS NED having previously served two terms with Leeds and York Partnership NHS Foundation Trust. With both Warren and Cleveland new to the Board, I have taken the opportunity to review committee memberships and changes have been implemented during May.

## **Further Updates**

Chairs and CEOs across North East and Yorkshire were invited to a Regional Roadshow in April 2026. The subject of the Roadshow was to discuss the key priorities for 2026-27. This was an invaluable opportunity to discuss priorities and ways of working with regional and national colleagues, including newly appointed regional Chair Bill McCarthy.

I have also met with the new ICB Chair Mark Chamberlin and will be inviting him shortly to visit our Lynfield Mount site.

Sarah Jones  
Chair in Common

Trawally Rachel  
03/06/2026 11:28:24

## Board of Directors – Meeting held in Public

4 June 2026

<b>Paper title:</b>	Chief Executive's Report	<b>Agenda Item</b>  <b>10.0</b>
<b>Presented by:</b>	Therese Patten, Chief Executive	
<b>Prepared by:</b>	Therese Patten, Chief Executive	
<b>Committees where content has been discussed previously</b>	N/A	
<b>Purpose of the paper</b> Please check <b>ONE</b> box only:	<input type="checkbox"/> For approval <input checked="" type="checkbox"/> For information <input checked="" type="checkbox"/> For discussion	

<b>Relationship to the Strategic priorities and Board Assurance Framework (BAF)</b>		
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

<b>Purpose of the report</b>
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"> <li>▪ Lynfield Mount Redevelopment</li> <li>▪ Hospital Rooms Futures Fund</li> <li>▪ Medical Education</li> <li>▪ Keeping My Chest Healthy</li> <li>▪ Modern Service Frameworks</li> <li>▪ Nature Week and wider Green Therapy work</li> <li>▪ Awards and Recognition</li> <li>▪ CQC Notifiable Incidents, Regulatory Matters and Visits</li> <li>▪ Media Coverage</li> <li>▪ West Yorkshire Integrated Care Board</li> <li>▪ New Secretary of State for Health and Care</li> </ul>	
<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"/> <b>Yes</b> (please set out in your paper what action has been taken to address this)</p> <p><input checked="" type="checkbox"/> <b>No</b></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>

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

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**Board of Directors – Meeting held in Public  
4 June 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**

**Lynfield Mount Redevelopment**

As you know, in January 2026, we received approval from the Department of Health and Social Care to begin redevelopment work on the central building of Lynfield Mount Hospital to create a facility that supports the recovery and wellbeing of our service users. In March, we signed a contract with McAvoy, a market leader in the precision manufacture of modular buildings. The McAvoy team arrived at Lynfield on 15 April to set up their compound, erect hoarding and prepare the site for the next phases of the redevelopment.

On Monday 18 May, we officially broke ground on phase two of the project, which includes the construction of a new two-storey, two-ward block and the refurbishment of central areas. To mark this important milestone, we held a small celebration event at Lynfield Mount Hospital for those who have been involved in and supported the project over the years. This was an opportunity to say thank you for their contribution and to update them on the progress that we have made and the upcoming stages of the redevelopment.

**Hospital Rooms Futures Fund**



Hospital Rooms is an arts and mental health charity with 10 years’ experience delivering high quality art and creative programmes in clinical mental health environments. The charity began when a friend of the co-founders was sectioned under the mental health act and stayed in a dilapidated and run-down mental health inpatient ward.

Now, across the most restrictive mental health settings, artists work with communities of patients and staff to radically transform mental health environments. As well as environmental changes, creative programmes and activities are intrinsic to the projects, ensuring beautiful spaces are complimented by opportunities for meaningful occupation of time, wellbeing and connection

The Trust has applied to the Hospital Rooms Futures Fund to deliver a co-produced arts and creative programme alongside the wider redevelopment of Lynfield Mount Hospital. Hospital Rooms will work with the Trust to transform our physical environments into an active therapeutic asset, combining estates improvement with cultural and clinical innovation through high-quality, evidence-based creative interventions with patients and staff.



The project will deliver a comprehensive programme across both new and existing wards, including creative co-production to inform bespoke artworks and ward environments, museum-quality installations meeting clinical safety standards, structured creative programmes, Digital Art School resources, staff training and wellbeing support, and partnerships with local cultural organisations to support engagement post-discharge.

The programme aims to improve patient experience and recovery by reducing distress and institutional feel, enhance staff wellbeing and retention, and promote inclusion, with a particular focus on creating environments that are accessible and meaningful for diverse and neurodivergent populations. Delivery will align with redevelopment milestones over three years and be supported through a phased, matched funding model.

### Medical Education

On 23 April the Trust participated in the Senior Leader Engagement assurance visit with colleagues from NHS England. The purpose of the visit was to discuss the quality of education

and training across all medical learner groups (undergraduate and postgraduate) and provide constructive challenge and support for improvement where required.

The Trust is yet to receive a formal report, however verbal feedback on the day highlighted excellence in undergraduate education and training noting that the most recent National Education and Training Survey ranks BDCT top across Yorkshire and Humber. Whilst there was a dip in performance in the General Medical Council's 2025 National Training Survey comparative to previous years there was assurance that actions are underway to address this; it was suggested that incident reporting involving trainees and learning from this is a specific area for development. Overall, the visit was well received, and feedback continues to highlight excellence in education and training at the Trust.

### **Keeping My Chest Healthy**

We are pleased to confirm continued progress with securing external partnerships for the Keeping My Chest Healthy (KMCH) programme. Mersey Care NHS Foundation Trust has purchased one-year licences to support implementation and evaluation across two of their teams, with plans to roll out to further teams next year. In addition, following a successful year as a free KMCH pilot site, Bolton has now committed to a five-year licence, demonstrating confidence in the model's value.

### **Modern Service Frameworks**

NHS England is developing a set of new Modern Service Frameworks (MSF) for a range of pathways and presenting needs. This year will see the development and launch of the MSF for Severe Mental Illness, which will set the ten-year ambition for improving outcomes, equity and experience for people whose lives are significantly impacted by serious mental health difficulties.

The national team is inviting providers and partners to submit evidence-based and practice-led proposals that demonstrate how the system can improve physical health outcomes, reduce harm and restrictive practices, strengthen assertive and relational models of care, and develop creative, community-based approaches that better support people from marginalised and underserved groups.

The Trust is taking a coordinated approach to contributing, drawing on our strong track record of place-based working, innovation, lived-experience-informed practice and research. We are supporting clinical, operational and system leaders to identify and submit exemplars of impactful work across adult, older people's and partnership services, ensuring that our contributions both influence national policy and showcase the outstanding practice delivered across Bradford and district. We are adopting the same approach to the other MSF developments that include frailty and dementia and Children and Young People.

### **Nature Week and wider Green Therapy work**

Over the last few months our Green Therapy programme, including Nature Week and the Nature in Mind partnership with Bradford District and Craven Mind, have demonstrated clear

therapeutic value for both patients and staff. Specifically, it has shown improved wellbeing, confidence, social connection and recovery through accessible, nature-based activities.

Feedback shows the programme has been very well received, with service users reporting increased confidence, purpose and inclusion, and staff reporting improved morale and wellbeing, and tangible progression into volunteering and leadership roles. The programme has been delivered through strong partnerships and significant in-kind support, approximately £11,000 VCSE and £7,000 volunteer time. This represents good value for money, with an estimated social return on investment of more than £420k for £100k Trust spend. This reinforces green therapy as a credible, mental health intervention aligned with the Trust's strategic priorities on prevention, workforce wellbeing, and community partnership. A service evaluation will be completed this year which will be used to demonstrate value and long-term sustainability.

### 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><b>Mar 26</b></p> <p><b>We care – Stacey Knowles, Continence Team Leader</b> For developing a comprehensive, clear and standardised catheter resource pack to support phone triage and healthcare professionals across multiple areas of practice. Stacey's contribution has made a meaningful difference to staff confidence, patient safety, and service quality.</p> <p><b>We Listen – Kelly Bentley Simon, Specialist Neurodevelopmental Practitioner (Social Worker and Practice Educator), and Karen Gilbank Psychological Therapies Team Manager, (CAMHS)</b> For sharing powerful, insightful, thought provoking information at the Beacon Network to help people better understand neurodiversity. Their analogies and personal experiences prompted self-reflection and they answered questions as role models supporting people to enhance their personal understanding of self.</p> <p><b>We Deliver – Hannah Searle-Jones, Digital Clinical Systems Lead, adult physical Community Health services</b> For working with the self-management facilitators to mitigate safety risks and improve time management, by developing a clinical hazard log and piloting the use of Microsoft booking systems so visits are visible to the whole team and can be moved between members. The team now feel safer and have more time for patient focused activity.</p>
<p><b>Apr - 26</b></p> <p><b>We care – Emily Pepper, Staff Nurse</b> Emily makes crochet hearts to give to palliative patients and their families - 1 heart goes with the patient following their passing and the other heart or hearts stay with the family / loved ones. Emily makes these hearts in her own time; they are incredible and come in a bag with a tag with a beautiful message. Emily did this without the management team knowing and I feel she deserves this awareness as she is demonstrating we care and we deliver values of the Trust.</p> <p><b>We Listen - Catherine Nevin, Mental Health Practitioner</b> Catherine received exceptional feedback from a student "I cannot thank Catherine enough for all her support and encouragement throughout my placement. Her approach has created a safe and supportive environment where I've felt able to grow in confidence and develop my skills. What has stood out most is her approach</p>

when working with children and parents. She demonstrates genuine empathy, patience, and respect, building strong relationships while always maintaining professionalism. Observing her practice has been invaluable in shaping my own understanding of how to engage effectively and compassionately with families.

**We Deliver - The Flow Team**

The BDCFT Flow Team exemplifies our ‘We deliver’ value through relentless focus on patient flow during an exceptionally challenging period. Over the last eight weeks, unprecedented demand for inpatient beds and significant discharge barriers could have compromised care. Instead, the team rose to the challenge, working shoulder to shoulder with adult mental health services and LA colleagues. Their compassionate, solution focused approach has enabled more people to be safely supported Closer to Home, while protecting inpatient capacity for those who need it most..

**Thanks a Bunch Nominations**

This award recognises and celebrates the achievements of individuals and teams who have gone out of their way to truly make a difference to colleagues, their service, service users, the Trust or the communities we work with. Each month, ten individuals or teams across the Trust are rewarded for their contribution with a voucher.

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
Mar 26	12	8	12	0	0	8	0	0

We continue to see nominations coming from across the Trust, in March this includes adult physical health, health visiting, clinical admin services, digital services and long-term health conditions.

**4 CQC Notifiable Incidents, Regulatory Matters and Visits (13 Mar – 11 May 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 has been one Mental Health Act visit during this time period to Heather Ward 28 April.

**Unannounced inspections**

There were no unannounced inspections during the reporting period with the exception of the MHA visit noted above.

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13/05/2026 11:28:24

### 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

12 inquests were concluded during this period in which BDCFT provided some level of evidence to the Coroner - of these staff were not called by the coroner in any of the cases. There was no criticism made of the Trust by the Coroner in any of the cases. The coroner's conclusions for all cases were:

- Misadventure x 1
- Drug related x 1
- Accident x 1
- Accidental drugs related death x 1
- Road traffic collision x 1
- Suicide x 3
- Natural causes x 1
- Narrative x 2
- Naturally occurring disease contributed to by immobility and hypothermia 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 all in the mental health care group.

There are nine open PSIIs, currently and there are three Structured Judgement Reviews (SJR) and five Local Learning Reviews (LLRs) on-going currently.

## 5 Media Coverage

Media and news highlights since the last Board meeting.

Area / dates	Details
Social worker recognised in national awards - 18 March 2026	The 'Amazing Social Workers' awards aim to highlight the achievements of individuals and teams in the profession, whilst also raising the profile and public understanding of the critical role of social work in our communities. Social worker, Charlotte Hall, from BDCT received national recognition in the awards for her outstanding contribution to the social work profession.

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NHS Care Trust shares top tips to avoid feeling blue after retirement - 8 April 2026	Bradford District and Craven Talking Therapies is offering wellbeing support to retirees, as according to recent studies, retirement is associated with a higher risk of depression and anxiety. The loss of social connections and sense of purpose that often accompany leaving the workforce can contribute to feelings of loneliness and low self-esteem. Financial concerns can also add to mental health challenges.
NHS Trust gets ready to race the dragon - 19 April 2026	Staff and supporters from BDCT will be competing in this year's dragon boat festival to raise funds for its Better Lives charity. The teams will be joining the crowds at Roberts Park in Saltaire to race for the sixth year, on Sunday 5 July.
New 'Little Sparks, Big Starts-Health Visiting' resource launched to support babies' emotional development - 29 April 2026	BDCT has collaborated with the Institute of Health Visiting to launch a new resource, Little Sparks, Big Starts-Health Visiting, to support parents, caregivers and professionals in nurturing strong early relationships with babies. The initiative aligns with the Trust's wider Ready to Relate resource, which promotes early relational health as a cornerstone of lifelong wellbeing.
Golfers invited to tee-off for NHS charity - 29 April 2026	BDCT Better Lives charity is inviting local people and organisations across Bradford, Airedale, Wharfedale and Craven to sign-up to its annual golf day on Friday 12 June.
Roll-out of decision support tool for community mental health services to benefit patients - 05 May 2026	BDCT has introduced the Management and Supervision Tool (MaST). This tool will help Community Mental Health teams, Early Intervention in Psychosis, and Older Adults Community Mental Health teams to manage their caseloads more effectively, making sure people that use the service receive the best possible care.
First UK commercial Alzheimer's disease study opens at Care Trust - 11 May 2026	BDCT has become the first mental health trust in Yorkshire and the Humber to successfully open a commercial clinical study in dementia, marking a significant milestone for research and innovation in the region.

## 6 National, Place and System

### West Yorkshire Integrated Care Board Organisational Change

The ICB has now closed its staff consultation and on 11 May all staff received an initial People Impact Assessment (PIA) status. Colleagues have been informed whether they will slot into a post in the new structure, whether they will be in a competitive ringfenced pool, or whether they have not been matched to a post and will, therefore be placed at risk. The ICB has begun a resolution process to address any challenges from staff and hopes to confirm final PIA status with all staff on 1 June.

Recruitment to posts in the new structure will then commence with a current suggested end date of late July. With the above timeline in mind, it is anticipated that the new operating model will commence from early August, once the majority of new posts have been appointed to. June and July will be a transitional period during which the ICB will endeavour to maintain business continuity for all its key functions and responsibilities.

### New Secretary of State for Health and Care

On 14 May the prime minister appointed a new health and social care secretary, following Wes Streeting's resignation. James Murray has been a minister in the Treasury since the 2024 general election, and chief secretary to the Treasury since September last year. He was elected to Parliament in 2019 for the Ealing North constituency.



**Airedale**

**NHS Foundation Trust**



**Bradford District Care**

**NHS Foundation Trust**

Trawally Raza  
03/06/2026 11:28:24

# People and Organisational Development Collaboration

Airedale Foundation Trust (AFT) and Bradford  
District Care Trust (BDCT) Joint CPO

June 2026



**Bradford District and Craven**  
Health and Care Partnership

# Introduction

- Following the establishment of a chair in common between and AFT and BDCT, we have been exploring options to extend the principle of joint appointments to other senior leadership roles.
- The BDCT CPO gave notice of resignation from the position in December 2025
- Initial discussions took place with the Chief Executive Officers, the current Chief People Officers and Deputy Chief People Officers to explore the approach to a shared role
- Nine principles for the collaboration were outlined to define the development of a joint CPO model across both Trusts
- The recommendations were supported by the Executives and Boards of both organisations

This document seeks to outline the approach to the joint CPO model in line with the principles

Trawally Rachel  
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# Purpose

1. Establish a shared Chief People Officer (CPO) role across AFT and BDCT
2. Aims to drive collaboration through integrated strategic leadership
3. To standardise and improve People and OD services across both organisations, while preserving organisational sovereignty, and identity
4. Expedite opportunities across BDC outlined in the Corporate Target Operating Model and the NHS England Transforming People Services programme

Trawally Rachel  
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# Principles

- **Two-way collaboration first:** between AFT and BDCFT
- **No Year 1 savings target:** Focus on capability, service reliability, standardisation, supporting infrastructure
- **Site Directors prioritise BAU:** Local grip and continuity of service provision across People and OD function
- **Continuous review:** Formal checkpoints at with data and team/colleague feedback
- **First 12 months focus on creating the conditions for success:** Standardisation, shared vision/workplan, joint team capability, BAU stability, assessment of capacity of joint role and deputies
- **Balance transformation with BAU:** Explicit capacity plan and sequencing (e.g., BDCT early adoption [FWS], BD&C Corporate TOM)
- **Remit and breadth agreed with CEOs:** confirm arrangements for the Joint CPO portfolio to protect time for collaboration and transformation
- **Shared executive roles considered:** Parallel track for feasibility scan and lessons learned.

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# Shared CPO Role – role purpose

- Single post-holder, dual accountability to both CEOs.
- Remit and breadth agreed with CEOs; focus on strategic leadership, transformation, and collaboration.

## **Primary focus**

- People strategy across both Trusts
- Executive leadership and assurance
- Collaboration, standardisation and transformation
- Place and system interface (BDC, NHSE, BTHT)

## **Key accountabilities**

- Two separate Boards and CEOs
- Delivery of agreed collaborative workplan
- Alignment to NHS England Transforming People Services
- Balancing BAU delivery with transformation
- Principle alignment: strategic focus, shared executive leadership

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# Director of People (previously Deputy role) – role purpose

- Local operational leadership, BAU grip, and staff engagement.
- Succession plan and additional resources to support deputies stepping into site director roles.

## **Primary Purpose**

- Act as lead People professional on site
- Maintain organisational identity, priorities and culture
- Ensure day-to-day continuity and performance

## **Accountabilities**

- Operational delivery of People services
- Local leadership of People teams
- Local workforce strategy delivery
- Interface with Care Groups / Divisions
- Principle alignment: sovereignty, continuity, succession planning

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# Milestones and Timelines

Timeframe	Phase	Outcomes/Artefacts
Apr-May 2026	Finalise scope and mobilise	Governance, appointments, comms, baseline
Jun-Aug 2026	Stabilise	BAU grip, leadership cadence, listening
Sep-Nov 2026	Design	Shared vision, roadmap, prioritised backlog
Dec 2026-Feb 2027	Deliver	Standardised processes, manager enablement
Mar-May 2027	Embed	12-month review, Year 2 benefits plan

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# Risk Management

**Approach:** Risks actively managed through executive teams and joint people governance group.

## **Key Risks and Mitigations:**

- **BAU service degradation during transition** – Mitigated through Site Director roles with clear operational ownership, BAU performance dashboards, and early escalation routes.
- **Role overload and insufficient capacity at senior level** – Mitigated by explicitly agreeing the Joint CPO portfolio with CEOs, delegating local delivery to Site Directors, and maintaining a capacity plan separating BAU and transformation activity.
- **Loss of organisational identity or staff confidence** – Mitigated through consistent communications, visible site-based leadership, active staff-side partnership, and reinforcement of Trust sovereignty.
- **Slow progress on collaboration and standardisation** – Mitigated by time-bound milestones, and formal review points.
- **Misalignment with system priorities (BDC TOM, HR/OD Futures)** – Mitigated through a defined system/place alignment interface and ongoing coordination with system partners.

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# Review and Assurance

- Risks formally reviewed at least quarterly
- 12-month effectiveness review to confirm sustainability of the model and readiness for Year 2 benefits and potential place-wide expansion.

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# Day 1/ Day 30/ Day 90

- **Day 1:** Joint CPO remit published; Site Directors confirmed (current Deputies); escalation routes live
- **Day 30:** BAU dashboard established; joint leadership cadence embedded; listening underway
- **Day 90:** Shared prioritised plan; standardisation initiatives selected; Year 1 roadmap draft

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# Discussion

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# Our Integrated Neighbourhood Health and Care Model

May 2026



Travally Rachel  
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# Vision for Integrated Neighbourhood Health and Care

Our plan is to create a health and care system across Bradford district and Craven that is increasingly neighbourhood focussed, integrating services to enable people to lead healthier, more independent lives.

We will make improvements across the breadth of factors that matter to local people, taking a whole population health, care, and wellbeing approach.

**We 'Act as One' supporting people to be 'Happy, Healthy, at Home'**



*Drawn by Rachel  
05/06/2026 11:28:24*



**PRIMARY CARE**  
Primary Care Networks,  
GP Practices,  
Pharmacy, Dental,  
Optometry



**COMMUNITY HEALTH**  
Nursing, Therapy,  
Mental Health,  
Allied Health  
Professionals



**SOCIAL CARE & LOCAL AUTHORITY PUBLIC HEALTH**  
Adults, Children  
& Families



**ACUTE & SPECIALIST CARE**  
Hospitals,  
Specialist Services

# INTEGRATED NEIGHBOURHOODS BRADFORD DISTRICT AND CRAVEN

Acting as One supporting people to be Happy Healthy at Home



SERVING POPULATIONS OF  
**25,000 TO 80,000**  
PEOPLE



**VOLUNTARY COMMUNITY & SOCIAL ENTERPRISE (VCSE)**  
Local groups, Faith organisations,  
Charities



**EDUCATION**  
Schools, Colleges,  
Lifelong Learning



**HOUSING & ENVIRONMENT**  
Housing, Transport,  
Parks, Green  
Spaces



**EMPLOYMENT & ECONOMY**  
Employers, Job  
Centres, Skills  
& Training

## INTEGRATED NEIGHBOURHOOD DELIVERY

### INTEGRATED NEIGHBOURHOOD HEALTH FOUNDATION GOALS TO IMPROVE

- 1. Health outcomes (priority cohorts)**
- 2. Access to General Practice**
- 3. Planned care experience**
- 4. Urgent & emergency access**
- 5. Citizen & staff satisfaction**

**CORE20**

**TARGETING THE CORE20**  
The most deprived 20% of the population as a minimum

Focus on the 20% most deprived and marginalised communities

**Maternity**

**Severe Mental Illness (SMI)**

**Chronic Respiratory Disease**

**Early Cancer Diagnosis**

**Hypertension Case-finding**

**PLUS 5**

Additional focus on groups at greater risk of health inequalities

**Ethnicity minority communities**

**Inclusion health**

**People with disabilities**

**LGBTQ+**

**Children & young people**

**MULTIDISCIPLINARY TEAM**  
Focusing on high priority cohorts with personalised, holistic support

**WORKING TOGETHER AS A 'TEAM OF TEAMS'**

**Holistic Assessment**

**Personalised Care Planning**

**Coordinated Care & Support**

**Medication Review**

**Regular MDT Case Reviews**

**FOCUS ON HIGH PRIORITY COHORTS**

**Frailty and Dementia**

**People with multiple long term conditions**

**Severe mental illness**

**People with disabilities**

**Palliative and end of life**

**Children & young people with complex needs**

**OUR POPULATION**  
Thriving individuals, stronger families, healthier communities

**COMMUNITY PARTNERSHIP**  
Focusing on prevention, reducing inequalities and wider determinants of health across the whole population

**WORKING TOGETHER TO PREVENT AND IMPROVE WELLBEING**

**Healthy Lifestyles**

**Mental Wellbeing**

**Community Connection**

**Early Help & Support**

**Financial Wellbeing**

**Safe, Clean & Green Environments**

**SUPPORTING TACKLING THE WIDER DETERMINANTS OF HEALTH**

**Income & Poverty**

**Education & Skills**

**Housing Quality**

**Employment & Opportunity**

**Transport & Access**

**Community Safety**

**ENABLED BY**

- Shared Data & Insights
- Digital Tools & Interoperability
- Population Health Management
- Community Engagement
- Workforce Development
- Strong Governance & Accountability

**NEIGHBOURHOOD CONNECT LED BY BRADFORD COUNCIL**  
Local area coordination across our neighbourhoods building resilience, unlocking support earlier, stopping things from reaching crisis point

- IMPACT FOR OUR NEIGHBOURHOODS**
- Better health for all
  - Reduced health inequalities
  - Sustainable services
  - Empowered communities
  - Value for public money

Trawally Rachel  
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## A WIDE RANGE OF SERVICES

- Primary care
- Mental health
- Social care
- Community health services
- Housing support
- Public Health
- Voluntary Community & Social Enterprise Sector
- Children and family services
- Lifestyle and wellbeing
- Benefits and financial advice

## TARGETING SUPPORT WHERE IT'S NEEDED MOST

Using population health data and local insights to identify high priority cohorts

## INITIAL FOCUS: PEOPLE WITH THE MOST COMPLEX NEEDS

Those with complex health and social care needs who are frequent users of emergency healthcare services

# MULTIDISCIPLINARY TEAMS

Working together across health, social care and the Voluntary Community & Social Enterprise Sector to support people to be happy healthy at home



## FLEXIBLE WAYS OF WORKING TOGETHER

**GREATER CO-LOCATION**  
Opportunities for staff from different organisations to work together in local hubs

**VIRTUAL WORKING**  
Working across a close network of staff – virtually and flexibly

Teams are being developed to enable staff from different organisations to work together adopting a 'team of teams' approach.

## CLOSE INTERFACE WITH WIDER SERVICES



Working together to improve access to care outside hospital so people only go to emergency departments when they really need to. People are supported to receive care and interventions in communities closer to where they live.

## PROACTIVE, CO-ORDINATED, WRAPAROUND CARE

- Proactively identify people at risk of deterioration
- Provide co-ordinated wraparound care and support
- Enable individuals to maintain their independence and stay well at home

## BETTER OUTCOMES FOR OUR PEOPLE AND STAFF

- Fewer emergency department attendances
- Avoided hospital admissions
- Improved health and wellbeing and independence
- Improved experience for staff
- Stronger, more connected communities
- A supported and valued workforce

## BETTER TOGETHER

Right care, right time, right place – closer to home



Trawally, Rachel  
03/06/2026 11:26:22

# COMMUNITY PARTNERSHIPS

WORKING TOGETHER TO REDUCE HEALTH INEQUALITIES,  
PREVENTION AND BUILDING OVERALL RESILIENCE ACROSS OUR LOCAL COMMUNITIES



Community Partnerships are an integral part of our Integrated Neighbourhood Model.

Working together to reduce health inequalities, prevention and building overall resilience across our local communities.

## WORKING ALONGSIDE MDTs



Community Partnerships complement the direct patient care provided by wider services across the integrated neighbourhood footprint and our emerging MDTs.



They will work alongside the MDTs to support delivery of targeted community-based health and wellbeing initiatives tailored to local neighbourhood health priorities, including projects funded through the Core20Plus5 reducing health inequalities programme.

## LOCAL, FLEXIBLE, COLLABORATIVE



Community Partnerships are not formal entities but are local collaboratives.



There are 13 Community Partnerships across BdC, and most share aligned footprints with PCNs.



Community Partnerships bring together a wide range of partners with a shared commitment to improving the health and wellbeing of local communities.

## FOCUS OF COMMUNITY PARTNERSHIPS ACTIVITIES



Primary prevention of disease risk factors



Secondary prevention (e.g. community health checks)



Projects relating to reducing health inequalities and the wider determinants of health



Building community resilience

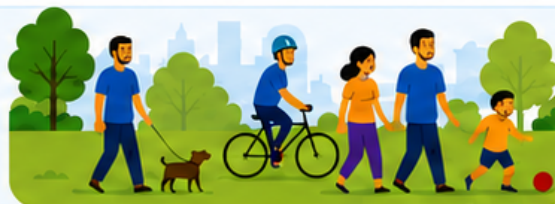


Developing a community asset-based approach to improving general population health and wellbeing

## ENGAGING COMMUNITIES



Community Partnerships have a wider role in engaging communities to improve their own health and live more healthy lifestyles.



## IMPROVING HEALTH TOGETHER

Working together locally to create healthier communities, reduce inequalities and support people to thrive.



Trawally Rachel  
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# Benefits for people 'I' Statements

I experience joined up care, where health, social care, and community services work together so I don't have to repeat my story and everything feels coordinated.

I can get care closer to home, with more support available in my community, making it easier to access help when I need it.

I am supported early, with potential health risks spotted quickly so I can get help before problems become serious.

I have clear points of contact, so I know who to turn to and my care feels consistent and well-organised.

I am supported to live well, at every stage of life, including managing long-term conditions and receiving compassionate, coordinated care at the end of life, focused on what matters to me.

I feel empowered to manage my health, with support to express my needs, plan ahead, and achieve what matters most to me.



# Benefits for staff

## 'We' statements

We work as one team, guided by shared values, a clear mission, and joint responsibility for the care we provide.

We have opportunities to grow, developing skills, knowledge, and experience across roles and organisations to build confidence and resilience.

We share responsibility for complex needs, working in a culture of trust, collaboration, and joint ownership across organisational boundaries.

We focus on proactive care, reducing duplication, unnecessary admin, and reactive "fire-fighting" through better coordination.

We make every contact count, using our skills to support people's needs, contribute to prevention, guide care, and provide early intervention.



# Benefits for place and system 'Together We' statements

Together we reduce pressure on emergency care by acting earlier and providing stronger community support.

Together we help people leave hospital sooner by improving discharge planning, community care, and coordination.

Together we make sure hospital care is used wisely, focusing on those who need it most.

Together we use our resources well, investing more in prevention, early help, and keeping people healthy.

Together we improve health and fairness while building a system that is stronger, more efficient, and financially sustainable.



**Working together • Reducing avoidable demand • Using resources wisely  
Improving outcomes • Building a sustainable, fair and resilient system**

# Working together to deliver better outcomes

## Our commitments to each other



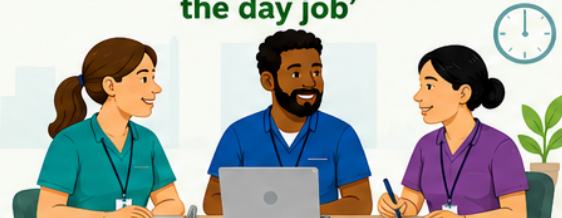
**System buy in and ownership across all levels 'joint accountability'**



We take shared responsibility and are accountable together for our communities.



**Staff released to enable them to engage in the MDTs and wider INH work 'As part of the day job'**



We give staff the time and support to collaborate and make a difference.



**Trusting relationships 'compassionate culture'**



We build trust and kindness in everything we do.



**Local leadership with everyone treated equally 'a one team approach'**



We lead inclusively and value every voice, working together as one team.



**Permission for staff at the coal face to innovate, test and introduce new ways of working**



We empower ideas, learn together and continuously improve.



**Opportunities to celebrate success 'build confidence and momentum'**



We recognise our achievements and celebrate together to keep building momentum.



**Stronger together • Better for our communities • Better for each other**



Trawally Rachel  
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## Priority population cohorts' system service transformation

Work together and use data and local insight to design services that meet the needs of the people who need them most.

- Focus on people, not buildings, prioritise the needs, experiences, and outcomes of the population.
- Agree on shared goals to guide improvements and service delivery.
- Organise services around neighbourhoods wherever possible.
- Work as one team across different organisations.
- Create a single, seamless pathway instead of multiple separate services and referral rules.
- Design care around people's journeys, making sure services are joined-up, coordinated, and centred on what matters most to them.

Travis Rachel  
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## Early intervention, prevention and reducing inequalities

Prioritise prevention and early support to reduce inequalities and help people stay healthier in the long term.

- Create a clear story on prevention and inequality, making the most of existing programmes while avoiding duplication.
- Start with people's needs, not services, focusing on priority groups supported by integrated neighbourhood MDTs.
- Define and track prevention and inequality goals alongside other key performance measures.
- Focus on actions that make the biggest difference, targeting interventions that reduce demand and inequalities.
- Deliver support at the neighbourhood level, with shared responsibility for local populations and coordinated care.
- Follow the principle of proportionate universalism, offering universal services while directing extra resources where they are most needed to reduce inequalities.

Trawally Rachel  
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“Integration is not about structures —  
it’s about *trust*,  
*relationships* and  
*shared accountability.*”

Trawally Rachel  
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# Effective Oversight: Escalation and Assurance

<b>Report to:</b>	<b>Board</b>	<b>Meeting date:</b>	<b>04/06/2026</b>
<b>Report from:</b>	<b>Mental Health Legislation Committee</b>	<b>Meeting date:</b>	<b>21/05/2026</b>
<b>Quorate?</b>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
<b>Members present</b>	<ul style="list-style-type: none"> <li>Warren Brown Non-Executive Director (Chair of Committee)</li> <li>Kelly Barker Chief Operating Officer</li> <li>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 item 07.0 – 10.0)</li> <li>Therese Patten Chief Executive Officer (from item 01.0 – 07.0)</li> <li>Sarah Jones Chair in Common</li> <li>Alyson McGregor, MBE Non-Executive Director</li> <li>Sal Uka, Chief Medical Director</li> </ul>		
<b>In attendance</b>	<ul style="list-style-type: none"> <li>Holly Close Corporate Governance Officer (Secretariat)</li> <li>Simon Binns Mental Health Legislation Lead</li> <li>Marilyn Bryan Associate Hospital Manager</li> <li>Richard Cliff Head of Legal Services</li> <li>Keith Double Involvement Partner</li> <li>Karan Essien Involvement Partner</li> <li>Mary Litchfield Associate Hospital Manager</li> <li>Baljit Kaur Nota LA Team Manager</li> <li>Teresa O’Keefe Mental Health Act Advisor</li> <li>Thabani Songo Head of Nursing – Mental Health</li> <li>Jo Tiler Mental Capacity Act Clinical Lead</li> <li>Rachel Trawally Corporate Governance Manager and Deputy Trust Secretary</li> </ul>		
<b>Observers</b>	<ul style="list-style-type: none"> <li>Masira Hans Appointed Governor: Hope and Light (Observer)</li> </ul>		
<b>Apologies</b>	<p>Apologies from (members and attendees):</p> <ul style="list-style-type: none"> <li>Dr Anita Brewin - Consultant Clinical Psychologist, Deputy Director of Professions (CPPO; Chief Psychological Professions Officer)</li> <li>Chris Dixon – Deputy Director of Nursing and Professions</li> <li>Fran Stead - Trust Secretary</li> </ul>		
<b>Best Quality Services</b>	<b>Theme 1 – Access and Flow</b>		<b>BQS:T1</b>
	<b>Theme 2 – Learning for improvement</b>		<b>BQS:T2</b>
	<b>Theme 3 – Improving the experience of people using our services</b>		<b>BQS:T3</b>
<b>Agenda items</b>	<ul style="list-style-type: none"> <li>Risk Appetite Matrix</li> <li>Minutes/AAAD of the Committee held on 22 January 2026</li> </ul>		

	<ul style="list-style-type: none"> <li>• Action Log</li> <li>• Mental Health Act 2025 Deep Dive</li> <li>• Feedback from Involvement Partners</li> <li>• Strategic Performance Report</li> <li>• Strategic Risk Report</li> <li>• Alert, Advise, Assure + Decision Report: Positive &amp; Proactive Group</li> <li>• Associate Hospital Manager's Report</li> <li>• Mental Capacity Act update (including Liberty Protection Safeguarding; Action Plan updates)</li> <li>• Annual Report on the use of the Mental Health Act</li> <li>• Alert, Advise, Assure + Decision Report: Clinical Board</li> <li>• Well Led Implementation Plan</li> <li>• Confirmation of Escalation Reporting including Confirming strategic priority assurance levels</li> <li>• Mental Health Legislation Committee: Annual Work Plan</li> <li>• Any Other Business</li> <li>• Meeting Evaluation</li> </ul>
<p><b>Alert</b> items agreed by Committee</p>	<ul style="list-style-type: none"> <li>• Associate Hospital Manager's Report – An alert was highlighted relating to parking constraints at Lynfield Mount Hospital (LMH) which could impact the delivery of Associate Hospital Manager hearings and tribunal processes, with potential implications for patient access and rights. The Committee agreed this issue warranted escalation to the Lynfield Mount redevelopment programme board for further consideration and mitigation and also the Board so that creative solutions might be considered around the location of hearings</li> </ul>
<p><b>Advise</b> items agreed by Committee</p>	<ul style="list-style-type: none"> <li>• Strategic Performance Report – Concerns were raised regarding the quality of some clinical reports, noting that while measures for timeliness were in place, there was currently no formal metric to assess report quality.</li> <li>• Annual Report on the use of the Mental Health Act – The Committee was advised that there was a continued need to recruit additional Hospital Managers and noted a continued decline in appeals to Hospital Manager panels compared with tribunals.</li> <li>• Annual Report on the use of the Mental Health Act – Concerns were also raised regarding tribunal delays, which had resulted in some patients not receiving a hearing before discharge, and highlighted extended use of the Section 136 suite impacting availability.</li> </ul>
<p><b>Assure</b> items agreed by Committee</p>	<ul style="list-style-type: none"> <li>• Mental Health Act 2025 Deep Dive – The Committee received a presentation on the difference between the Mental Health Act 1983 and 2025 and were assured that structured planning was underway for the implementation of the Mental Health Act 2025.</li> <li>• Strategic Performance Report – The Committee received assurance that overall performance remained strong, with all metrics above target.</li> </ul>

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	<ul style="list-style-type: none"> <li>• Strategic Performance Report – The Committee received assurance that timeliness of reports to Hospital Managers had improved, with medical, nursing, and social circumstances reports near full compliance, whilst tribunal report performance, although less consistent, was improving and training compliance remained above the Trust’s stretch target.</li> <li>• Strategic Risk Report – The Committee was assured that the 2026 strategic risks had been drafted, with ongoing development work to the reporting template introduced.</li> <li>• Alert, Advise, Assure + Decision Report: Positive &amp; Proactive Group – Assurance was provided that there had been a reduction in incidents of violence and aggression.</li> <li>• Alert, Advise, Assure + Decision Report: Positive &amp; Proactive Group – It was shared that there had been an increase in physical restraint, but this was attributed to specific areas particularly female wards where restraint was primarily used to prevent self-harm.</li> <li>• Well Led Development Plan – The Committee was assured that the Well Led Development Plan was evolving with further refinement planned throughout the year and via the annual effectiveness review.</li> <li>•</li> </ul>		
<b>Decisions made by Committee</b>	<ul style="list-style-type: none"> <li>• Item 04.0 – Mental Health Legislation Committee Minutes – 19 March 2026</li> <li>• Item 04.0.1 – Effective Oversight Escalation and Assurance – 19 March 2026</li> <li>• Item 11.0 – Associate Hospital Managers’ Group Report</li> <li>• Item 13.0 – Mental Health Act Annual Activity Report</li> <li>• Item 15.0 – Well Led Development Plan</li> </ul>		
<b>New risks identified by Committee</b>	<ul style="list-style-type: none"> <li>• No significant new risks identified.</li> </ul>		
<b>Items to be considered by other Committees/Groups</b>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>		
<b>Feedback following discussion at ‘parent’ meeting</b>			
<b>Report completed by</b>	Senior Corporate Governance Officer & Executive Support Manager	<b>Date</b>	21/05/2026
<b>On Behalf of Chair</b>	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:	15.04.2026
Quorate?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Members present	Alyson McGregor MBE, Sally Napper, Christopher Dixon		
In attendance	Alix Jeavons, Anthony Davison, Rachel Trawally, Bob Champion, Sal Uka, Kelly Barker, Anita Brewin, Michelle Holgate,  Presenters for items: Clare White		
Observers			
Apologies	Philippa Hubbard, Rebecca Le Hair, Carla Smith, Rebecca Jowett,		
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"> <li>• LFYE: Vulnerable Children Information Team and Vulnerable Children School Nurse Team</li> <li>• Deep Dive: Out of Area Placements</li> <li>• Severe Weather Plan</li> <li>• Industrial Action Plan</li> <li>• Notification of future meeting dates</li> <li>• Alert, Advise, Assure + Decision Reports .1 AAAD Clinical Board .2 AAAD Report - Patient Safety and Learning Group .3 AAAD report: Senior Leadership Team Quality, Safety</li> <li>• Confirmation of Alert; Advise; Assure + Decision Reporting Workplan 2025/26</li> <li>• Any Other Business</li> <li>• Meeting Evaluation-Was the meeting conducted in line with the Trust values</li> </ul>		
Alert items agreed by Committee	<p>Alert:</p> <ul style="list-style-type: none"> <li>• no new alerts were raised for escalation</li> </ul>		
Advise items agreed by Committee	<p>Advise:</p> <ul style="list-style-type: none"> <li>• no new advise was raised</li> </ul>		
Assure items agreed by Committee	<p>Items providing evidence of good practice, compliance, or positive progress.</p> <ul style="list-style-type: none"> <li>• <b>LFYE: Vulnerable Children Information Team and Vulnerable Children School Nurse Team</b> – The Committee received assurance that safeguarding demand within Vulnerable Children’s services is being managed effectively through dedicated teams,</li> </ul>		

	<p>clear governance arrangements, and supporting evidence including KPIs and audit activity.</p> <p><b>Deep Dive: Out-of-Area Placements</b> – Assurance was provided that clear plans and mitigations are in place to manage the associated quality and safety risks, both in areas the Trust can directly influence and where it is dependent on the wider system, including alignment with national policy expectations and local risk management arrangements.</p>		
<p><b>Decisions made by Committee</b></p>	<p>The following items were approved by the Committee,</p> <ul style="list-style-type: none"> <li>• Item 3 - Minutes and AAAD report of the previous March 2026</li> <li>• Item 5 - Action Log</li> <li>• Severe Weather Plan</li> <li>• Industrial Action Plan</li> </ul>		
<p><b>New risks identified by Committee</b></p>	<ul style="list-style-type: none"> <li>• There were no new risks identified.</li> </ul>		
<p><b>Items to be considered by other Committees/Groups</b></p>			
<p><b>Feedback following discussion at 'parent' meeting</b></p>			
<p><b>Report completed by</b></p>	<p>Nazmeen Khan Corporate Governance Officer</p>	<p><b>Date</b></p>	<p>15.04.2026</p>
<p><b>On Behalf of Chair</b></p>	<p>Ayson McGergor MBE (NED/Chair)</p>		

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# AAAD: Effective Oversight: Escalation and Assurance

<b>Report to:</b>	<b>Public Board</b>	<b>Meeting date:</b>	<b>XXX</b>
<b>Report from:</b>	<b>Quality and Safety Committee (QSC)</b>	<b>Meeting date:</b>	<b>20.05.2026</b>
<b>Quorate?</b>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
<b>Members present</b>	Alyson McGregor, Sally Napper, Philippa Hubbard		
<b>In attendance</b>	Chris Dixon Fran Stead, Rachel Trawally, Sal Uka , Kelly Barker, Anita Brewin, Catherine Scofield, Jacqueline Rigby (ICB), Rachel Trawally, Rebecca Le-Hair  Presenters for items: Zoe Howell, Jaspreet Sohal, Mark Dawson		
<b>Observers</b>			
<b>Apologies</b>	Chris Malish, Thabani Songo, Bob Champion, Carla Smith, Sayma Mirza, Tricia George		
<b>Best Quality Services</b>	<b>Theme 1 – Access and Flow</b>		<b>BQS:T1</b>
	<b>Theme 2 – Learning for improvement</b>		<b>BQS:T2</b>
	<b>Theme 3 – Improving the experience of people using our services</b>		<b>BQS:T3</b>
<b>Agenda items</b>	<ul style="list-style-type: none"> <li>• LFYE: Highlights from the Proof of Concept South &amp; West Community Mental Health Team Inpatient Caseload</li> <li>• Strategic Assurance Reports - Integrated Performance Report, Strategic Narrative</li> <li>• Strategic Risk Summary</li> <li>• Well Led Development Plan – Actions</li> <li>• Quality Assurance Framework Update</li> <li>• Resilience Group ToR</li> <li>• Incident Response Plan</li> <li>• Research &amp; Development Annual Report</li> <li>• Controlled Drugs Annual Report</li> <li>• Quarter 4 CQC Activity and Engagement</li> <li>• Notification of future meeting dates</li> <li>• Alert, Advise, Assure + Decision Reports .1 AAAD Clinical Board .2 AAAD Report - Patient Safety and Learning Group .3 AAAD report: Senior Leadership Team Quality, Safety .4 AAAD Report: Senior Leadership Team – Care Group Assurance Meeting (CGAM), .5 AAAD PCREF Accountability Group</li> <li>• Confirmation of Alert; Advise; Assure + Decision Reporting Workplan 2026/27</li> <li>• Any Other Business</li> <li>• Meeting Evaluation</li> </ul>		
<b>Alert items agreed by Committee</b>	<b>Alert:</b> <ul style="list-style-type: none"> <li>• No New alerts</li> </ul>		

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<b>Advise items agreed by Committee</b>	<b>Advise:</b> <ul style="list-style-type: none"> <li>• Committee reflected on:</li> <li>• The need to strengthen learning loops and early identification of issues, particularly drawing on insights from Quality Assurance Framework reviews.</li> <li>• Continued focus on data quality and triangulation to support governance and decision-making.</li> <li>• Importance of maintaining balanced decision-making, particularly where financial pressures intersect with patient safety and experience.</li> <li>• Reinforced the importance of amplifying staff and service user voice to inform improvement and service redesign.</li> </ul>		
<b>Assure items agreed by Committee</b>	Items providing evidence of good practice, compliance, or positive progress. <ul style="list-style-type: none"> <li>• Proof of Concept South West CMHT Inpatient Caseload</li> <li>• Well Led Development Action Plan</li> <li>• Research &amp; Development Annual Report</li> <li>• Controlled Drugs Annual Report</li> <li>• Governance processes remain robust, including structured reporting through committees and AAAD framework.</li> <li>• Action tracking and monitoring arrangements (e.g., Safeguard system and operational oversight) are in place.</li> <li>• Positive progress is being made across several areas, including workforce safeguards, CQC engagement, and research activity.</li> <li>• A consistent approach is being taken to ensure patient safety remains the priority in decision-making.</li> </ul>		
<b>Decisions made by Committee</b>	The following items were approved by the Committee, <ul style="list-style-type: none"> <li>• Minutes and AAAD report of the previous April 2026</li> <li>• Action Log</li> <li>• Strategic Risk Assurance Report</li> <li>• Well Led Development Plan</li> <li>• Resilience Group ToR</li> <li>• Incident Response Plan</li> <li>• CQC Activity and Engagement: Quarter 4</li> </ul>		
<b>New risks identified by Committee</b>	<ul style="list-style-type: none"> <li>• There were no new risks identified.</li> </ul>		
<b>Items to be considered by other Committees/Groups</b>			
<b>Feedback following discussion at 'parent' meeting.</b>			
<b>Report completed by</b>	Nazmeen Khan Corporate Governance Officer	<b>Date</b>	20.05.2026

**On Behalf of Chair**

Ayson McGergor (NED/Chair)

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# AAAD: Effective Oversight: Escalation and Assurance

<b>Report to:</b>	<b>Board of Directors (Public)</b>	<b>Meeting date:</b>	<b>04/062026</b>
<b>Report from:</b>	<b>People and Culture Committee</b>	<b>Meeting date:</b>	<b>21/05/2026</b>
<b>Quorate?</b>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
<b>Members present</b>	Mark Rawcliffe (Chair/NED), Sally Napper (NED), Bob Champion, Mike Woodhead, Phil Hubbard, Kelly Barker, Dr Sal Uka		
<b>In attendance</b>	Rachel Trawally, Jess Greenwood-Owens (Secretary), Dr. Anitha Mukundan, Michelle Holland, Lisa Wright, Fay Davies, Terence Calvert  <b>Timed business:</b> Emma Stott, Claire Ingle, Danielle Stephenson, Fran Stead, Helen Farrar, Naomi Fernandez, Stuart Scarfe		
<b>Observers</b>	Aidan Jones (Governor).		
<b>Apologies</b>	Tim Rycroft, Farhan Rafiq, Paula Hanson, Therese Patten		
<b>Best Place to Work</b>	<b>Theme 1</b> – Looking after our people	<b>BP2W:T1</b>	
	<b>Theme 2</b> – Belonging in our organisation	<b>BP2W:T2</b>	
	<b>Theme 3</b> – New ways of working and delivering care	<b>BP2W:T3</b>	
	<b>Theme 4</b> – Growing for the future	<b>BP2W:T4</b>	
<b>Agenda items</b>	<ul style="list-style-type: none"> <li>• Strategic Narrative Report</li> <li>• Integrated Strategic Performance Report (dashboard)</li> <li>• Recruitment Activity Update</li> <li>• Employee Relations Activity</li> <li>• Rostering Activity</li> <li>• Medical Workforce Report including 10 Point Plan</li> <li>• Staff Survey Results</li> <li>• Apprenticeship Levy Annual Report</li> <li>• Workforce Race Equality Standard Report (WRES)</li> <li>• Workforce Disability Equality Standard Report (WDES)</li> <li>• Alert, Advise, Assure + Decision AAA+D Reports</li> <li>• Well-Led Implementation Plan Update</li> <li>• Strategic Risks</li> <li>• Committee Workplan 2026–27</li> </ul>		
<b>Alert items agreed by Committee</b>	<ul style="list-style-type: none"> <li>• Recruitment data showed disparity, with white candidates more likely to be appointed after shortlisting, and disproportionality remained in disciplinary processes for ethnically diverse staff.</li> <li>• Disabled staff reported higher levels of perceived bullying and harassment, particularly from colleagues and managers.</li> <li>• Sickness absence remained a key organisational risk requiring sustained improvement through cultural and management practice changes.</li> <li>• Data quality issues with the rostering system provider (RL Datix) has resulted in limited full assurance on workforce deployment.</li> </ul>		

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	<ul style="list-style-type: none"> <li>A number of people-related policies were out of date and were undergoing review and risk assessment.</li> </ul>		
<b>Advise items agreed by Committee</b>	<ul style="list-style-type: none"> <li>Continued focus was required on leadership visibility and clear messaging should be promoted regarding equality, inclusion and organisational values.</li> <li>The “avoidable harm” approach needed to be embedded further to reduce formal employee relations cases and improve staff experience.</li> <li>Management capability needed strengthening to support absence management, workforce development and staff wellbeing.</li> <li>Workforce development needed to balance high apprenticeship uptake with assurance on quality of in-role experience.</li> <li>Further development of workforce data integration was required to support insight-led decision making.</li> </ul>		
<b>Assure items agreed by Committee</b>	<ul style="list-style-type: none"> <li>Workforce indicators showed improvement, including reduced sickness absence, improved return-to-work rates and stable turnover.</li> <li>Employee relations performance was improving, with fewer formal cases and more timely resolution.</li> <li>Staff survey results remained strong relative to regional and national benchmarks.</li> <li>Apprenticeship levy utilisation and workforce development activity remained strong and well embedded.</li> <li>Governance arrangements were in place, with well-led actions and strategic workforce risks actively</li> </ul>		
<b>Decisions made by Committee</b>	The following items were approved: <ul style="list-style-type: none"> <li>Minutes of previous meeting and AAAD</li> <li>Action log</li> <li>Workforce Race Equality Standard Report (WRES)</li> <li>Workforce Disability Equality Standard Report (WDES)</li> <li>Strategic Risks</li> <li>Well Led Implementation Plan Update</li> </ul>		
<b>New risks identified by Committee</b>	<ul style="list-style-type: none"> <li>N/A</li> </ul>		
<b>Items to be considered by other Committees/Groups</b>	<ul style="list-style-type: none"> <li>N/A</li> </ul>		
<b>Feedback following discussion at ‘parent’ meeting</b>	TBC		
<b>Report completed by</b>	Jess Greenwood-Owens Corporate Governance Officer	<b>Date</b>	<b>21/05/2026</b>

**On Behalf of Chair**

Mark Rawcliffe (NED/Chair)

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## Board of Directors – Meeting held in Public

**4 June 2026**

<b>Paper title:</b>	Freedom to Speak Up Guardian Annual Report 2025/26	<b>Agenda Item</b>  <b>14.0</b>
<b>Presented by:</b>	Rebecca Wixey – Freedom to Speak Up Guardian	
<b>Prepared by:</b>	Rebecca Wixey – Freedom to Speak Up Guardian Emma Greenwood – Deputy Freedom to Speak Up Guardian	
<b>Committees where content has been discussed previously</b>	Not applicable	
<b>Purpose of the paper</b> Please check <b>ONE</b> box only:	<input type="checkbox"/> For approval <input type="checkbox"/> For information <input checked="" type="checkbox"/> For discussion	

<b>Relationship to the Strategic priorities and Board Assurance Framework (BAF)</b>		
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	
	Growing for the future	
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	
	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**

This paper provides information about Freedom to Speak Up activity for the financial year 2025/26. It is presented in a format to comply with the Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts, published by the office of the National Guardian FTSU and NHSE/I in July 2019.

**Executive Summary**

The key issues are:

1. A total of 130 cases have been reported to the BDCT Guardian team during 2025/26 (an increase of 18 cases compared to the previous year).
2. The number of anonymous concerns increased again in Q4, bringing the total to 12% for the year. This is in line with our average but higher than we would like.
3. The number of cases with perceived disadvantageous or demeaning treatment as a result of speaking up is slightly below the national average of 3%. Two fact finds have been completed during the year and both found that detriment had been caused.
4. A number of concerns relate to poor culture/leadership/management behaviours, and inappropriate attitudes/behaviours.
5. Speaking up cases continue to contribute to the broader improvement strategy.

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 contents of this report.

<p><b>Links to the Strategic Organisational Risk register (SORR)</b></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"> <li>• n/a</li> </ul>
<p><b>Care Quality Commission domains</b> Please check <b>ALL</b> that apply</p>	<p><input checked="" type="checkbox"/> Safe <span style="margin-left: 200px;"><input checked="" type="checkbox"/> Caring</span>  <input checked="" type="checkbox"/> Effective <span style="margin-left: 150px;"><input checked="" type="checkbox"/> Well-Led</span>  <input checked="" type="checkbox"/> Responsive</p>
<p><b>Compliance &amp; regulatory implications</b></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"> <li>• n/a</li> </ul>

## Board of Directors – Meeting held in Public 4 June 2025

### Freedom to Speak Up Annual Report 2025/26

#### 1 Purpose

This paper provides information about FTSU activity for the period 1 April 2025 to 31 March 2026 with a focus on Q3 & Q4. The format complies with the 2018 and 2019 publications by the National Guardians Office (NGO) and NHS Improvement published guidance concerning FTSU Guardians Board Reporting.

Section 1 - Assessment of FTSU cases April 2025 to March 2026

Section 2 - Themes

Section 3 - Learning and improvement undertaken

Section 4 - Actions taken to improve access to the FTSU Guardian route

Section 5 - Speaking up/listening up culture and actions taken to improve culture

Section 6 - National/regional activities and information

Section 7 - Future actions

#### Section 1 - Assessment of FTSU cases 2025/26

Figure 1 shows the number of FTSU cases by quarter. Only cases that involve colleagues directly contacting the Guardian or the Deputy Guardian for advice or support in speaking up can be classified as FTSUG cases. As noted in the bi-annual report, there were a high number of cases reported in Q2 which related to some clusters of concerns around: inpatient staffing, an HR matter within the mental health directorate, managerial/leadership concerns reported from several people within the same team in the mental health and clinical directorates. According to NGO guidance each person speaking up to a Freedom to Speak Up Guardian should be counted as a separate case even if they are speaking up about the same issue, together or separately.

Figure 1

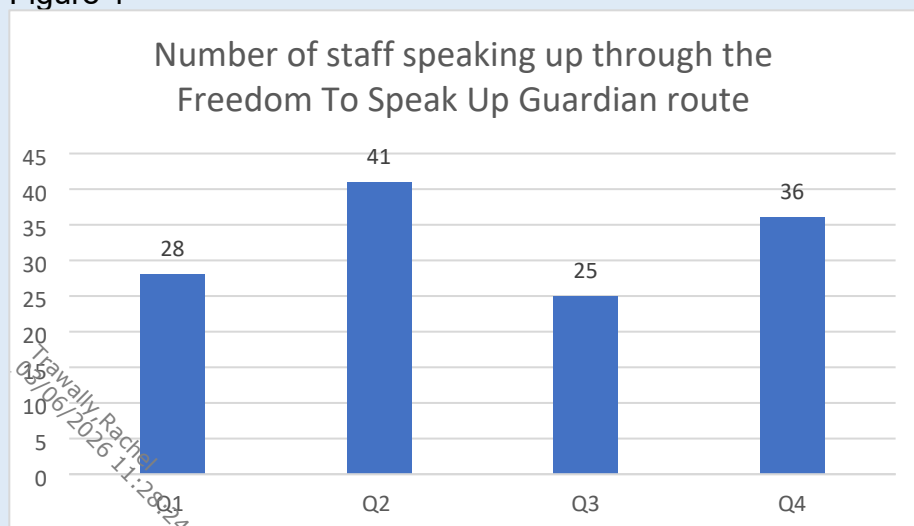
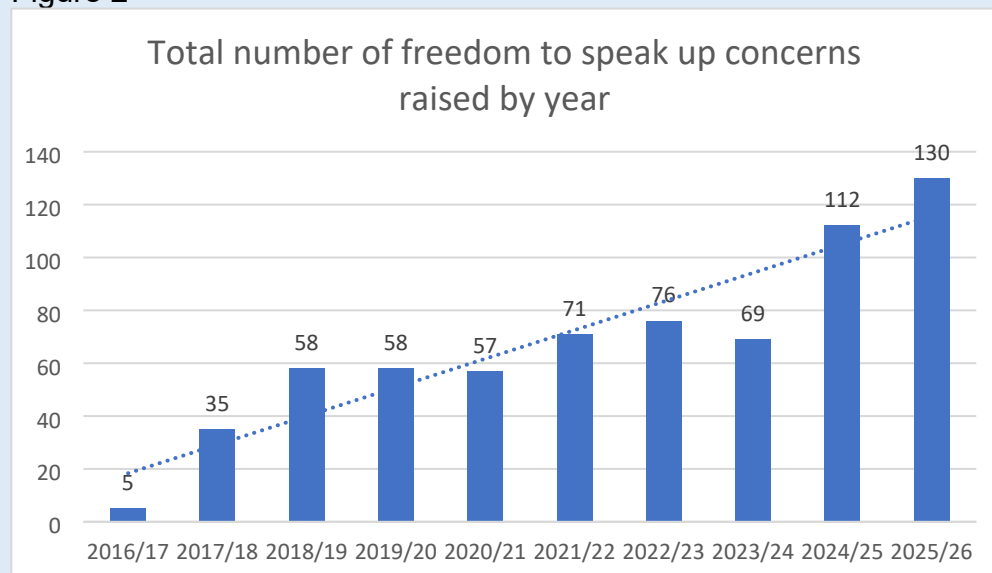


Figure 2 shows the number of cases reported per year, since the FTSU Guardian role was established at the Trust. There has been a general upward trend in reporting over the last 10 years, demonstrating the impact of our publicity, communications and training campaign, and that colleagues are aware of the Guardian route as an option for raising their concerns.

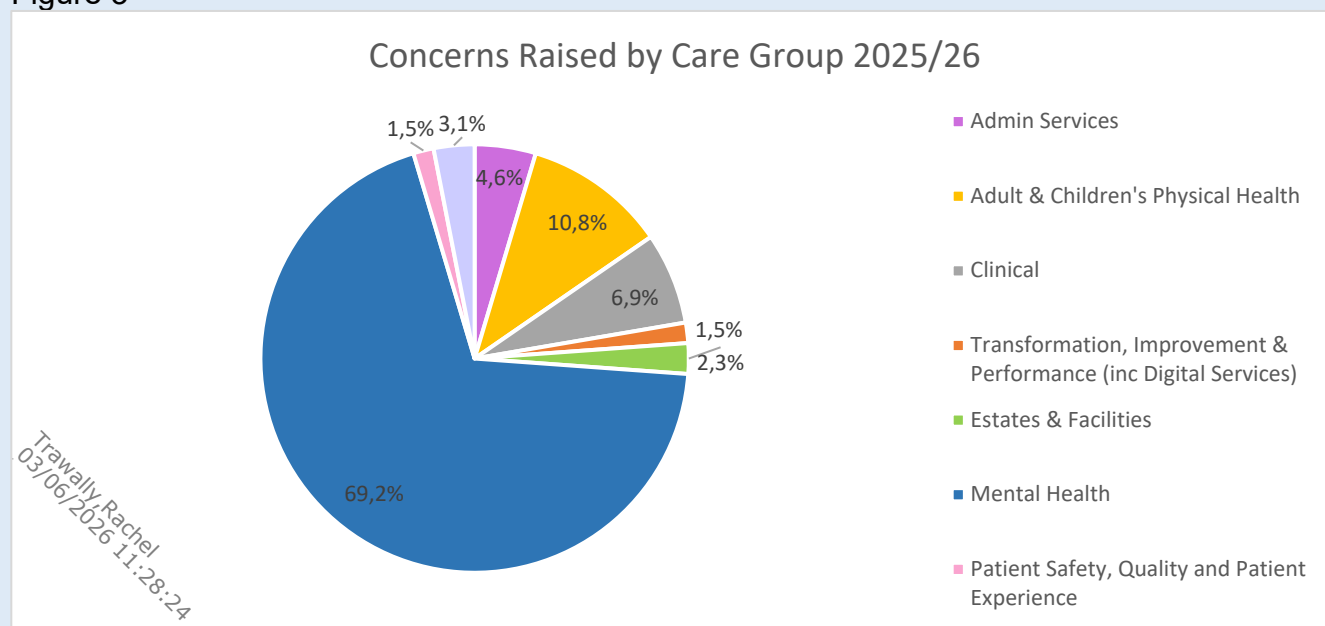
Figure 2



### Concerns Raised by Area

Figure 3 shows the areas in which concerns were raised this year. The mental health care group continues to be the biggest reporter, followed by adults and children’s physical health. The clinical care groups account for 87% of activity, and the corporate areas account for 13%. Please note that for ease Finance & Contracting has not been included in the graph as there were no concerns raised from that area within the year.

Figure 3



### Number of colleagues speaking up by professional groups in 2025/26

As can be seen from Table 1, registered nursing colleagues are the highest reporters, which is in line with previous years, followed by admin and clerical.

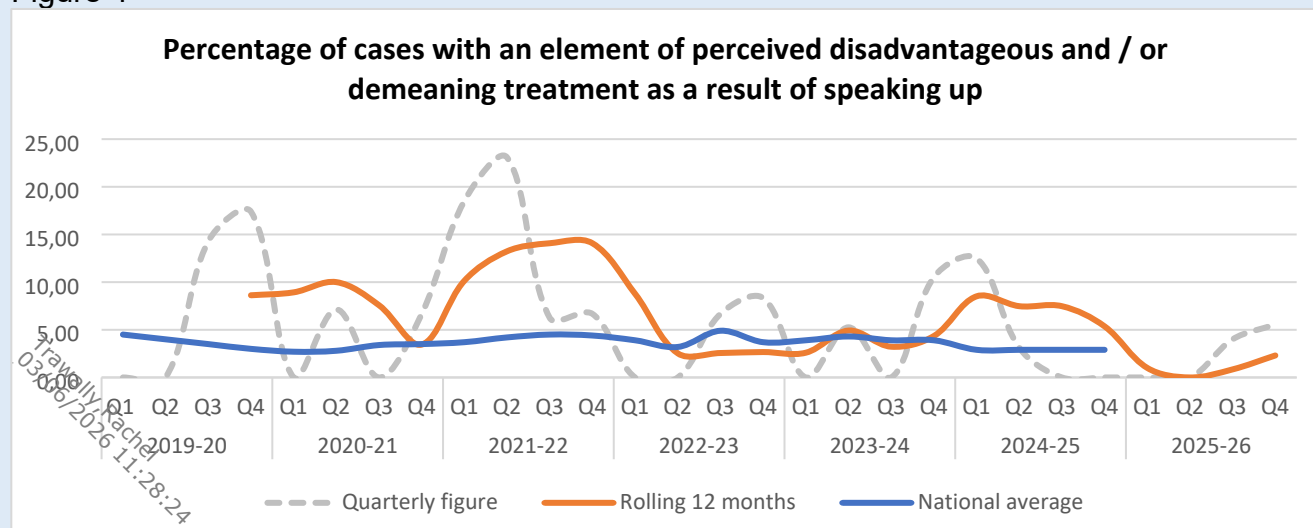
Table 1

	Q1	Q2	Q3	Q4	Total
Additional clinical services	1	2	0	3	6
Additional professional scientific and technical	3	6	6	6	21
Administrative and clerical	4	9	7	11	31
Allied Health Professionals	4	5	2	2	13
Estates and ancillary	1	0	0	1	2
Healthcare scientists	0	0	0	0	0
Medical and dental	1	0	0	0	1
Nursing and midwifery registered	13	16	4	8	41
Students	0	0	2	2	4
Other	0	2	0	0	2
Not known	1	1	4	3	9
<b>Total</b>	<b>28</b>	<b>41</b>	<b>25</b>	<b>36</b>	<b>130</b>

### Number of colleagues with an element of perceived disadvantageous and/or demeaning treatment as a result of speaking up

Figure 4 shows the percentage of cases with an element of perceived disadvantageous and/or demeaning treatment (detriment) as a result of speaking up. Our percentage has decreased from 2024/25, dipping back below the national average of 3%.

Figure 4



During Q4 a fact find was undertaken into a case of perceived detriment, the conclusion of which was that detriment had occurred because of speaking up but was not deemed to be deliberate or malicious. A number of points for learning were identified including the importance of psychological safety within teams, ensuring staff feel supported in raising patient safety concerns, and the importance of structured supervision.

There has also been learning for the FTSU team in how this process was carried out, and we have used it to update our guidance and flow chart to improve how the fact find is experienced by those involved moving forwards.

### Closure of Concerns

As at 11/05/2026, of the 130 cases raised during the year, 112 have been closed (86%) and 18 remain outstanding. (It should be noted that 3 of those outstanding all relate to the same issue within a team who came forward together). The mean time taken to closure was 46 days (median 27 days), with a range of zero (closed on the same day) to 254.

### Section 2 – Themes

Table 2 shows the total number of cases from 1 April 2025 to 31 March 2026, broken down into those with an element of patient safety/quality of care, bullying and harassment, worker safety or wellbeing and other inappropriate attitudes or behaviours. The table also shows the numbers of colleagues who wanted to remain anonymous to the Guardian and the numbers who considered they had experienced disadvantageous and/or demeaning treatment because of speaking up. Please note that some cases involve a number of different matters, and this is reflected in the figures. Interestingly there has been a notable drop in the number of bullying & harassment concerns being reported via the Guardian this year.

Table 2

Item	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Total no of cases	57	71	76*	69	112	130
Patient safety and quality of care concerns	9 (16%)	16 (23%)	20 (26%)	17 (25%)	46 (41%)	40 (31%)
Bullying and harassment concerns	21 (37%)	33 (47%)	19 (25%)	27 (39%)	43 (38%)	19 (15%)
Worker safety or wellbeing concerns**	Not collected	13 (18%)	59 (78%)	54 (78%)	88 (79%)	104 (80%)
Concerns related to other inappropriate attitudes or behaviours	Not collected	Not collected	41 (54%)	41 (59%)	72 (64%)	70 (54%)
Colleagues wishing to remain anonymous to Guardian	8 (14%)	4 (6%)	8 (11%)	14 (20%)	12 (11%)	15 (12%)
Colleagues perceiving an element of disadvantageous and/or demeaning treatment as a result of speaking up	2 (4%)	10 (14%)	2 (3%)	3 (4%)	6 (5%)	3 (2%)

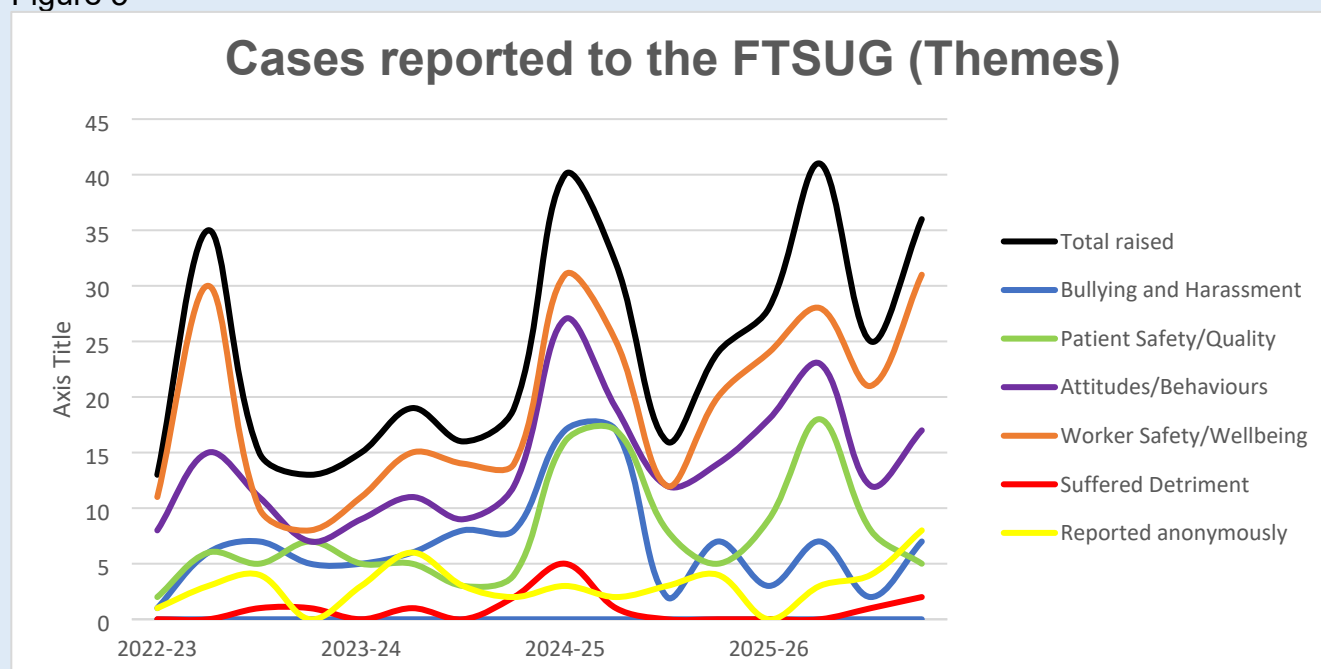
\* Corrected figure, originally reported as 75 in the 2022/23 annual report

\*\* Please note change in wording to include worker wellbeing from 1 April 2022. This may have influenced the rise in cases compared to 2021/22.

Staff who fear victimisation by colleagues can speak up anonymously via the FTSU online reporting form. Colleagues can also speak up openly but ask for their information to be kept confidential via the Guardian. We monitor the number of anonymous contacts, with a low number being an indicator of staff’s confidence in the system. The percentage of anonymous cases has remained similar to last year and in line with the average for our Trust, although higher than we would like to see.

Figure 5 provides a longitudinal view of FTSU cases and the frequency in which different themes have appeared since 2022/23. Over the 4-year period, more colleagues have spoken up with concerns about attitudes and behaviours, and worker safety and wellbeing than direct patient safety/quality concerns, which is in line with a national trend. However, it should be noted that these types of concerns can still have an indirect impact on patient/service user safety and quality.

Figure 5



The main themes spoken up about were poor culture, leadership and management behaviours. This seems to be an underlying thread that we see running through the vast majority of concerns raised to the Guardian – often being cited as reasons people have felt unable to speak up within their management structure or where concerns have been raised previously but the issue has not been resolved.

Other themes that have come through during the year are:

- Staffing levels, mainly but not exclusively related to the inpatient wards
- Staff mental health – burnout and stress
- Poor communication
- Discontent with ongoing HR processes (timeliness, communication)
- A number of concerns are specifically alleging racial and/or disability discrimination as a component of their experience.

## Worker safety & wellbeing

For the last 4 years, since the worker safety and wellbeing category was introduced, this has consistently been the theme with the highest number of concerns. To help with organisational understanding, this year we have done some further analysis on the 104 concerns which recorded an element of this to pick out the main subject within these cases.

Table 3

Key elements	Count
Leadership & management behaviours	28
Staffing	13
Unfair treatment	11
Personal employment issues	10
Bullying & harassment	9
Racism or discrimination	9
Sexual safety	7
Culture	7
Processes	6
Service changes	5
Pregnancy/maternity	5

Key elements	Count
Communication	5
Health & safety	3
Lack of support following an incident	3
Grievance process	3
Breach of confidentiality	3
Staff who have also been S/Us	3
Professional boundaries	2
Flexible working	2
Clinic space/room access	2
Verbal abuse from S/U family	2
Safeguarding	1

## Equality, Diversity & Inclusion – Protected Characteristics

The information below shows equality monitoring data gathered from staff who have spoken up to the Freedom to Speak Up team. Just under half of the people speaking up (63 of the 130 cases) have chosen to provide some or all of this information. This is a similar proportion to the number who provided this data in 2024/25.

Table 4

Ethnicity	Number
Black or Black British	<5
Asian or Asian British	14
White British	35
White – any other group	<5
Other ethnic groups	<5
Not answered	<5
Prefer not to answer	<5

Disability	Number
No	40
Yes	17
Prefer not to say	<5
Not answered	<5

Sexual Orientation	Number
Bisexual	6
Gay	0
Heterosexual	44
Lesbian	<5
Prefer not to say	6
Prefer to self-describe	<5
Not answered	<5

Gender	Number
Female (including transgender women)	47
Male (including transgender men)	9
Prefer not to say	<5
Not answered	<5

Age	Number
Under 20	0
21-30	10
31-40	20
41-50	15
51-60	12
61-70	<5
Not answered	<5

### Racism & Disability Discrimination

Seven of the cases reported in this period related to disability discrimination and 4 related to racism, with 2 of the cases having an element of both. This points to the intersectionality of protected characteristics and the additional challenges some colleagues face in relation to this.

## Section 3 - Learning and improvement

Managers/leaders are asked to identify the changes made, lessons learnt and any transferable learning that results from FTSU cases. They are responsible for ensuring the implementation of the learning relevant to their service area and for sharing transferable learning within appropriate forums/structures.

The Guardian shares themes and overall learning from cases at the Board of Directors, Patient Safety and Learning group, Senior Leadership Team and the six-weekly triangulation meeting with People Services and the EDI leads.

Actions and learning following colleagues speaking up through the FTSU Guardian route in Quarters 3 & 4:

- A number of colleagues were signposted to the appropriate HR process and supported to access their Trade Union representative.
- Other colleagues were signposted to the childcare support service, wellbeing@work, staff support & therapy service and staff networks.
- Updates to the induction information for medical students to include making a note of patients' names for any records/IG issues and explaining how best to escalate these concerns.
- A Local Learning Review was completed following a patient incident on Oakburn ward, with various actions agreed to improve governance and safety.
- Professional appearance policy added to next team meeting as a reminder
- Feedback provided about estates' plans to make New Mill more accessible including introduction of 30 min drop off zone
- Rationale for shift patterns provided by service manager and assurances regarding process for ensuring staff get their breaks. Encouraged individual to report any specific incidences of staff not getting their break
- Organisational learning for the handling of future sexual safety cases where witnesses want to remain anonymous; learning from the HR investigation has been fed into the Sexual Harassment Policy Steering Group and new draft policy/procedure.

### Case Studies

The following case studies give insight into the FTSU process, the changes made and identified learning:

#### Case Study 1

X came to Freedom to Speak Up concerned that her 1-1 meetings on MS Teams with her line manager were being recorded. AI software was being used to generate transcripts and action points. At the start of the meeting, the manager briefly stated that the conversation would be recorded "for notes" and turned the recording on. X was not clearly asked for informed consent, nor offered an alternative.

These meetings should be an opportunity for staff to discuss their wellbeing and any concerns they may have. However, during the meeting X felt uncomfortable and guarded, choosing not to raise any concerns about workload pressures and a recent near miss. X was worried about who might see the recording or have access to the AI-generated notes, how this information could be used and whether declining recording would be viewed negatively. Afterwards, X stated they felt less safe speaking openly and would be less likely to raise concerns in future 1-1s.

Following this, the Freedom to Speak Up Guardian became aware that the Trust AI policy was under review. The Freedom to Speak Up team were able to feed in concerns about the impact of recording and the use of AI on psychological safety and consent. However, there remains a concern that managers may not consistently consider issues of consent and psychological safety when recording meetings on Microsoft Teams.

## **Case Study 2**

Two anonymous feedback forms were received by FTSU raising concerns regarding conduct of a team supervisor including favouritism, misuse of the rota system, and breaches of policy related to shift allocation. FTSU shared the concerns with the Operational Manager, who undertook a fact find, supported by People Services. She also proactively organised some open-door sessions for the team to allow everyone to have their voice heard in a safe and confidential environment.

### **Learning**

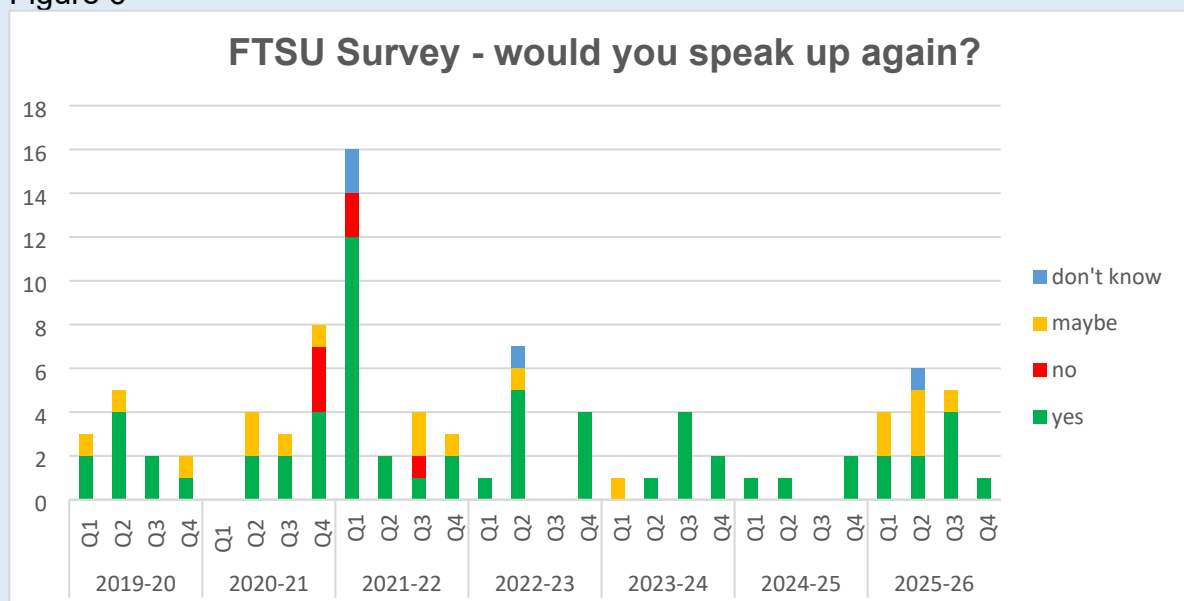
Following the open-door sessions the Operational Manager had a much better understanding of how the team were feeling and it brought to light some additional concerns regarding privacy and confidentiality, which were addressed in a team 'reset' communication highlighting the importance of behaving in line with the Trust values. The fact find identified some issues regarding adherence to policies and procedures, and this was picked up in the form of a personal responsibility letter.

### **Feedback about FTSU process**

Once a case is closed a survey is sent to the person who spoke up asking questions about their experience of the FTSU process and if they would speak up again. Figure 6 shows the number of people completing the survey and the response to the question "would you speak up again?" Unfortunately, the number of people completing the survey remains low despite efforts on the part of the FTSU team to ensure that all reporters receive the link on closure of their case and are encouraged to complete it. Please note cases may be closed in a different quarter to when they were raised, so numbers saying they would speak up do not necessarily relate to cases raised in that quarter.

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Figure 6



Qualitative feedback provided to the team is generally positive, however a couple of people voiced this time that they didn't feel the management response was full and transparent.

“Nice to feel heard”

“Felt comfortable and able to speak confidentially on sensitive topics”.

“I am happy for you to close the case and I appreciate the help and support you have provided.”

“FTSU has come a long way from when I started in the trust 12 years ago. The experience this time was positive”.

“Some Questions not answered fully and maybe misinterpreted”

“I do feel the service takes staff feedback seriously when concerns are raised. However, there could be more transparency around what actions are being taken in response. Sharing updates or outcomes, either service wide or with impacted individuals depending on the situation, would help ensure staff feel genuinely heard and reassured that their feedback is being acted upon”.

“I felt listened to and supported, by the FTSU team but also by management/executive team”.

“I feel like this needs to be a process outside of the Trust/NHS even so that proper recognition of serious issues can be addressed”

#### Section 4: Actions taken to improve access to the FTSU Guardian route

- Much of the team’s communications plan is now embedded practice, though the team reviews this regularly to ensure it remains fit for purpose and to include any *ad-hoc* items identified.
- in addition to presenting to new staff at the Trust Welcome, the FTSU team continues to attend a range of events and away days which all provide additional opportunities to raise the positive profile of ‘speaking up’ in our organisation.

- Our Speak Up Ambassadors also continue to form a crucial part of our network, promoting the ‘Speak Up, Listen Up’ message and signposting to the Guardian. During 2025/26 we inducted 12 new Ambassadors, bringing our active total in the network to 29.
- We also undertook several additional promotional activities during October ‘Speak Up’ Week, including:
  - ✓ a mention in the Chief Executive’s vlog
  - ✓ use of MS Teams backgrounds
  - ✓ ‘wear something green’ Wednesday
  - ✓ a display in the Health Promotion Library at Lynfield Mount Hospital
  - ✓ creation of a video of some of our Ambassadors talking about what attracted them to the role
  - ✓ a piece in eUpdate, and
  - ✓ Ambassadors also pledged to do something such as a presentation in their own service areas.

## Section 5 – Speaking up/listening up culture

### We each have a voice that counts - Staff Survey Results 2025

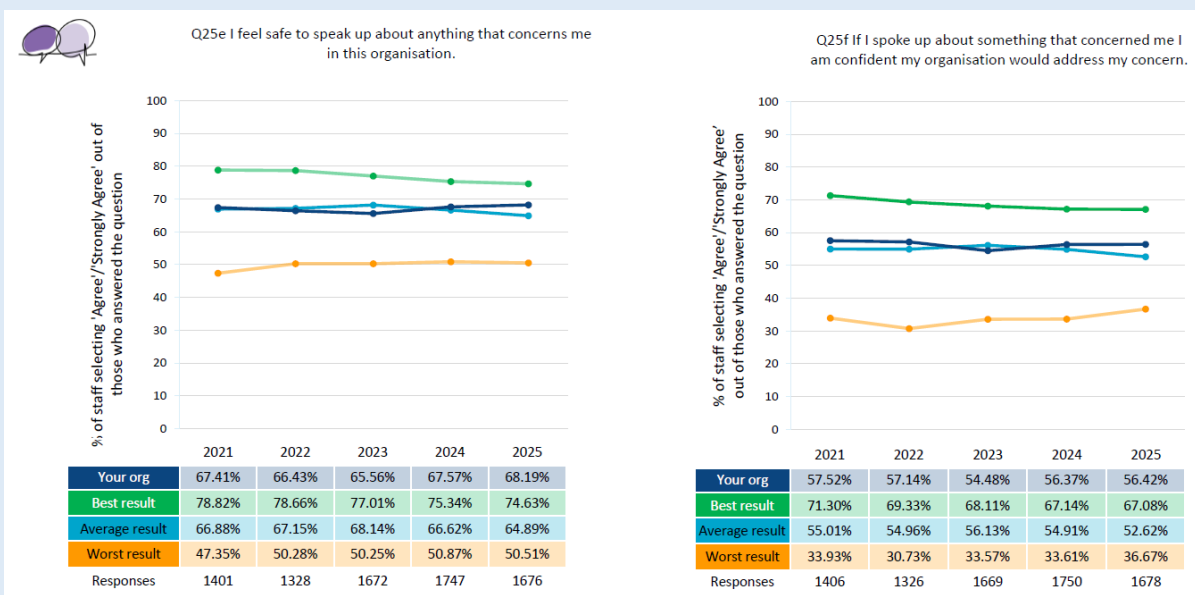
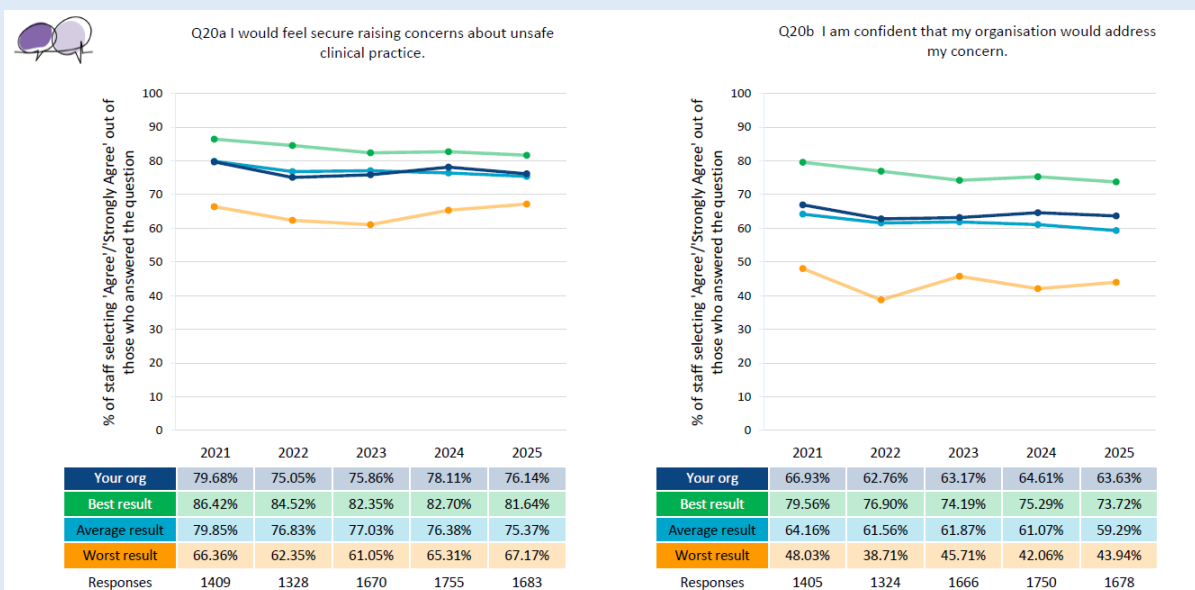


Speaking up is an enabler to a positive compassionate culture and vice versa.

The latest National Staff Survey results (2025) shine a light on the speaking and listening up culture within the Trust. Our results for the ‘raising concerns’ subsection remained slightly above the national average for the second year running, although we saw a small dip on our score compared to 2024.

Looking at the breakdown of the questions in more detail, our results for all 4 questions also remain above the national average for the second year running.

We can also see that respondents are consistently more likely to say they feel secure speaking up about unsafe clinical practice, than speaking up about anything that concerns them generally. This is in line with a national trend. Results over the last 5 years for people being confident that the organisation would address their concern are consistently lower than for feeling safe to speak up, and again this is in line with a national trend indicating we all have more work to do in this area to demonstrate that we are listening to and crucially acting on those concerns that are raised to us.



The FTSU team attended some of the staff survey world café events organised by the OD team to offer support around the raising concerns results and action planning.

### National Education and Training Survey 2025

The overall result for the 'raising concerns' section in the NETS for BDCT was 89.09%. The table below shows further detail on scores for the individual questions. Out of 55 respondents, 10 stated that they did not know how to access support from the FTSU Guardian. However, the majority did state that they knew how to raise concerns, i.e. who to tell and how to go about it, so it is encouraging that learners were aware of alternate routes for speaking up.

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Indicator	Ascale Question Text	1 (Worst)		5 (Best)	
		% Users	Users	% Users	Users
Raising Concerns	Do you feel comfortable raising concerns?	9.09%	5	90.91%	50
	Do you know how to access support from your Freedom to Speak Up Guardian?	18.18%	10	81.82%	45
	Do you know how to raise concerns (i.e. who to tell, and how to go about it)?	5.45%	3	94.55%	52

Off the back of these results we liaised with colleagues in the Centre for Clinical Education and Professional Development and reviewed our comms plan to ensure it adequately captures learners across disciplines.

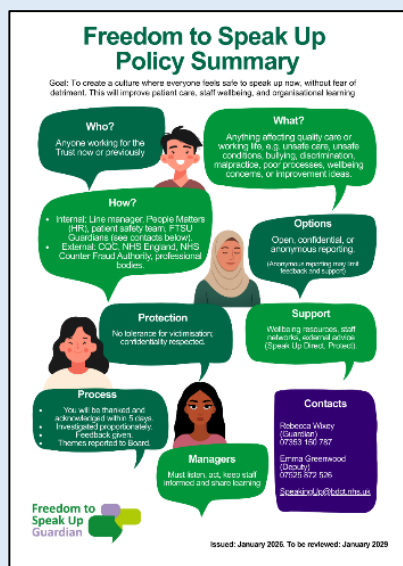
**Action taken to improve the ‘speak up, listen up, follow up’ culture.**

The Trust took the decision to mandate the National Guardian’s Office “Speak Up” eLearning in 2021, and as at 11/05/2026, 3262/3530 staff members required have completed it (92.41%). However, the continuing improvement in the culture (making speaking up business as usual) depends not only on staff having access to the FTSU Guardian arrangements and feeling they can speak up, but much more importantly on the behaviour and response by our managers when they hear concerns, either directly from their team members or via the Guardian.

We inform new staff from day one that the expectation is that any concerns they have that affect the quality of care we are providing or their experience of working in the Trust should in the first instance be raised with their line manager or direct supervisor. To support our managers in responding appropriately to the person speaking up, we continue to offer managers’ study sessions that recognise the challenges they face in incorporating this often unscheduled and unpredictable part of their leadership role. It is also important that managers and leaders who are navigating issues raised via Freedom to Speak are properly supported not just by the Guardian, but by their line management structure and other relevant mechanisms.

A Board development session was held in December 2025 which focussed on red flags for harmful cultures and completion of the Board Reflection & Planning Tool. The finalised tool was then shared with SLT QSG for assurance.

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The FTSU policy underwent a thorough review and was approved by SLT in December 2025 along with a 'policy on a page', developed to improve accessibility following feedback from colleagues in the Beacon Network. This summary document serves to complement the policy as an easy reference guide for staff who may struggle to read a full policy document.

The FTSU Strategy was also reviewed and refreshed, with the new document covering 2025/26 to 2027/28. This continues to drive the team's improvement efforts.

## Section 6 - National/Regional activities and information

- The National Guardian's Office is due to close at the end of June 2026 and is currently transitioning some of its responsibilities to NHS England. NHSE has published a document setting out the revised responsibilities for Freedom to Speak Up across the NHS: [The future of Freedom to Speak Up](#)
- Due to the closure of WY Mental Health and Wellbeing Hub, regional Guardian supervision is now being provided by Mid Yorkshire NHS Trust
- The Guardian continues to attend the reflective practice group, in addition to the regular regional network meetings and peer support sessions.
- The Guardian attended the North East & Yorkshire Regional Leadership Conference in May 2025.
- Regional work is underway on the deanery platform to improve access to information for medical colleagues.
- There has been one new case review published by the NGO since the last report - Temporary Workers, Permanent Voices: A Speak Up Review. The Guardian is currently part of a working group looking at the recommendations as we believe there may be some opportunities for regional collaboration to enhance consistency and avoid duplication of effort.

## Section 7 – Future actions

- Gap analysis against the newly published NHS England guidance to check compliance
- Move to organisational data submission through the national data collection process from Q1 2026/27 - access to this data will be through the Model Health System
- Board Reflection & Planning Tool will next be due in December 2027.

**Name of author/s:** Rebecca Wixey and Emma Greenwood  
**Title/s:** Freedom to Speak Up Guardian and Deputy Guardian  
**Date paper written:** 21 May 2026

## Board of Directors – Held in Public

**04 June 2026**

<b>Paper title:</b>	2025 NHS Staff Survey – Results	<b>Agenda Item 15.0</b>
<b>Presented by:</b>	Bob Champion – Chief People Officer	
<b>Prepared by:</b>	Helen Farrar – Staff Engagement Manager	
<b>Committees where content has been discussed previously</b>	This paper has been considered by Board in private on 07 May 2026; Council of Governors on 13 May 2026 and People and Culture Committee on 21 May 2026.	
<b>Purpose of the paper</b> Please check <b>ONE</b> box only:	<input type="checkbox"/> For approval <input checked="" 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	
	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
This paper reports a summary of the Trust-wide published results for the NHS Staff Survey 2025 and actions to analyse and disseminate at all levels. It has been considered by Board in private on 07 May 2026; Council of Governors on 13 May 2026 and People and Culture Committee on 21 May 2026, and is for information only.

Executive Summary	
<p>The NHS Staff Survey 2025 (NSS2025) took place from 22 September to 28 November 2025, along with a comprehensive and targeted engagement programme amongst staff and bank workers. Draft results at all levels were received from delivery provider Quality Health/IQVIA (QH) from December 2025 to February 2026, followed by the publication of the national results reports at trust and service level on 12 March 2026. This paper confirms the key findings from all the results received to date and outlines the dissemination and action planning arising.</p>	
<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 checked="" type="checkbox"/> <b>Yes</b> (Results, once ratified, will form the basis of Workforce Race and Disability Equality Standards reports)</p> <p><input type="checkbox"/> <b>No</b></p>

Recommendation(s)
<p>This paper is for information only. The Board of Directors has already:</p> <ul style="list-style-type: none"> <li>Discussed the results presented, supported the World Café approach to engaging staff and considered the proposed recommendations for ongoing analysis and response of the results, both corporately and locally, including monitoring actions arising</li> </ul>

<p><b>Links to the Strategic Organisational Risk register (SORR)</b></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"> <li>Manager capability &amp; competence, in light of new financial pressures/challenges.</li> <li>Threat to culture change in light of additional performance/financial pressures as 2024/25 progresses.</li> </ul>
<p><b>Care Quality Commission domains</b> Please check <u>ALL</u> that apply</p>	<p><input type="checkbox"/> Safe <input checked="" type="checkbox"/> Caring</p> <p><input type="checkbox"/> Effective <input checked="" type="checkbox"/> Well-Led</p> <p><input checked="" type="checkbox"/> Responsive</p>
<p><b>Compliance &amp; regulatory implications</b></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"> <li>The Staff Survey results provide evidence in the CQC Well-led domain and contribute to key metrics in NHS Oversight Framework scores</li> </ul>

Trawally Rachel  
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# Board of Directors – Held in Public

04 June 2026

## 2025 NHS Staff Survey

### 1 Purpose

Staff satisfaction and engagement are key to delivering high quality care and directly associated with patient experience and outcomes. The Staff Survey results provide evidence in the CQC Well-led domain and contribute to key metrics in NHS Oversight Framework scores. The NHS Staff Survey is an important element in our varied methods of engaging with our workforce, towards the NHS people Promise of ‘We each have a voice that counts’. It is an annual, mandated, validated, national survey that provides a robust and benchmarked measure of employee experience. Results of all elements of our people engagement activities are monitored, triangulated, actioned, and fed back to colleagues by our senior leaders in a timely manner.

The latest annual survey was held late 2025. Quarterly Pulse Staff Surveys (QPSS) were also held in April and July 2025 and January and April 2026, which repeated the staff engagement questions from the annual survey. Our provider supporting the delivery of the annual survey was Quality Health/IQVIA (QH). This paper summarises the final results received, once the national embargo lifted on 12 March 2026.

### 2 Delivery and Response

The NHS Staff Survey 2025 (NSS2025) took place from 22 September to 28 November 2025, along with a comprehensive, effective and targeted engagement and Board-supported prize-giving programme, amongst substantive colleagues and Bank workers.

- The Trust-wide response rate to NSS2025 was **50%** or 1,690 staff. This was down slightly from 2024 (53%) but retained the overall improvement over the last three years. The overall national response rate was 49%, and all Trusts in our sector\* averaged 52%.
- The Bank Survey response rate was **22%** or 88 staff – representing a significant reduction on the 2024 response of 35%, but similar to the previous year and to average for all for comparable Trusts\*
- Variations in response rates in each Directorate/Care Group grouping is shown in **Appendix 5**

\* 50 Mental Health Learning Disability Community Trusts in benchmark group nationally

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### 3 Results

#### Theme Scores

For the fifth year running survey questions align to the seven elements of the NHS People Promise and with the two themes of engagement and morale. All themes are based on a score out of ten. Beneath the nine themes lie 21 sub-themes and 111 questions or question parts.

- In 2025, **all** NHS People Promise and themes are slightly higher than those of the sector\*, with most significant being 'We work flexibly', 'Morale', 'We are recognised and rewarded' and 'We are safe and healthy'. **All** the themes are also very similar to 2024 Trust scores, with most improved being 'We work flexibly', 'Morale', 'We are compassionate and inclusive' and most declined being 'We are always learning'.
- For Bank workers\*\*, four of the theme scores were significantly lower than those for substantive staff, and one was significantly higher, 'We are safe and healthy'. Three of the theme scores were significantly higher than 2024, the remainder similar to 2024.

*\*\* Bank worker scores are based on early indicative scores and not on final published scores, as these have only recently been received. The following results relate to substantive staff scores only.*

- Analysis of five-year trends show that 7 of the 9 People Promise/theme scores have improved since 2021, 4 significantly so. Only 2 theme scores have reduced since 2021, both only slightly, and in line with national trends. Overall, the trend is one of consistency and modest improvement.

**Appendix 1** Illustrates NSS 2025 summary results infographics.

**Appendix 2** Illustrates five-year trends of People Promise/theme and sub-theme scores

#### Question scores

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

**Appendix 3** Illustrates key question scores summaries and variances.

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## Free text comments

238 detailed comments from staff have recently been received as part of the 'free text' option at the end of the survey. Detailed analysis is underway using AI, the new NHS qualitative analysis framework and professional reflection, such as alongside Freedom to Speak Up intelligence. The themes and issues arising will be shared with senior leaders, for consideration alongside the quantitative results, and with clear response back to colleagues.

**Appendix 4** Summarises some early findings, comparing qualitative sentiment vs. Trust performance; and **Appendix 5** contains the breakdown of comments against Directorates/Care Groups.

More detailed analysis may be tabled at the Board Meeting and/or subsequent People and Culture Committee and Senior Leadership Team meetings.

## Service and Team level scores

- The local results indicated a wide variance of experience and engagement across different work areas and other categories, such as demographics or colleague group.
- In recognition of such local variance, the Trust has held a series of **World-Café style events** for local teams during March and April 2026, as part of a new 'ground-up' approach to responding to the Survey results. These facilitated, supported spaces enabled teams to reflect on their results and determine strengths and priorities. Bespoke infographic reports were prepared for each of the 90+ team groupings and creative tools enabled colleagues to turn their voices into clear intentions, aligned with the NHS People Promise themes. Executive Directors supported and promoted the events.
- A summary of these events and intentions and actions arising at the team level, will be shared at the Board meeting, with more detailed findings shared at the next People and Culture Committee meeting.

## Ongoing action planning

- The World-Café events also enabled colleagues to consider Trust-wide issues and opportunities. These findings, along with local results reports, detailed results tables, collation of team intention plans from the World Café events, and further team discussions are being shared with senior leaders to embed and inform the Trust-wide response.
- The granular level intelligence also feeds into Trust-wide developments, such as in workforce planning, wellbeing support, learning and development strategy or raising concerns. It also enables triangulation with other data, such as absence rates, management skills analysis or employee relation cases.

Further manager coaching drop-ins, and team support sessions are planned for May-June 2026, including for teams or services showing a decline in scores or those unable to attend the facilitated sessions. This ensures all are encouraged to view

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their results, explore together areas for improvement and celebration in their service and identify and embed required actions into existing improvement work or new action plans.

- Services and teams that have particularly positive scores, improving response rates or embedded intention plans, are being identified and analysed as examples of good practice.

## **Communications**

- Trust-wide results have been shared with all colleagues, including a dedicated Broadcast, Chief Executive Vlog, bespoke SharePoint page, screensavers/posters, and a variety of presentations to key audiences, such as Council of Governors and Senior Leadership Team.
- Local results have been shared across all services and teams, utilising bespoke reporting and the innovative 'world café' events as described above.
- Our Staff Networks for protected characteristics are working with the Equality and Inclusion Team to explore the Workforce Race and Disability scores and other diversity related results alongside the Belonging and Inclusion Plan

## **4 Next steps and recommendations**

- The Board, People and Culture Committee (PCC), Executive Management Team, and Senior Leadership Team (SLT) should continue to respond to further reported data as it becomes available, including
  - the benchmarking of results against Place, ICB and regional scores
  - the review of Bank worker scores
  - results of recent quarterly pulse surveys
  - themes arising from the further analyses of free text comments
  - corporate learning recommendations from the World Café events
  - WRES and WDES reports and analysis
- 'We each have a voice that counts' has been voted by staff as the leading People Promise priority for the Trust this coming year, and a key target for an improved score in 2026. Senior leaders are asked to support current integrated measures towards this goal including
  - This year's 'ground-up' approach to team-level Staff Survey responses
  - Current Lynfield Mount redevelopment colleague engagement activity
  - The proposed Trust-wide consultation and conversation on the 2026 refreshment of the Better Lives Together Strategy.

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- Consideration of an in-house interactive results portal/dashboard to enable smarter data triangulation, results dissemination and sharing of feedback and actions across all levels of the Trust, has been deferred to the 2026 Staff Survey.
- PCC and SLT will monitor and track outcomes and actions arising from the 2025 Staff Survey, including locality goals, feed these back to staff, thank them for their engagement, and roll these into preparation for the 2026 Staff Survey as part of a continuum of engagement.

The Board of Directors is asked to note the final results presented, comment on issues arising, and support the proposed recommendations for ongoing analysis and response both corporately and locally, including monitoring actions arising.

**Helen Farrar**  
**Staff Engagement Manager**  
**23 April 2026**

**NOTE: Appendix 6** is added as new information has arisen demonstrating the benchmarking of Trust performance at a regional and local level. **21 May 2026**

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# Appendix 1: NHS Staff Survey 2025 summary results – Trust-wide

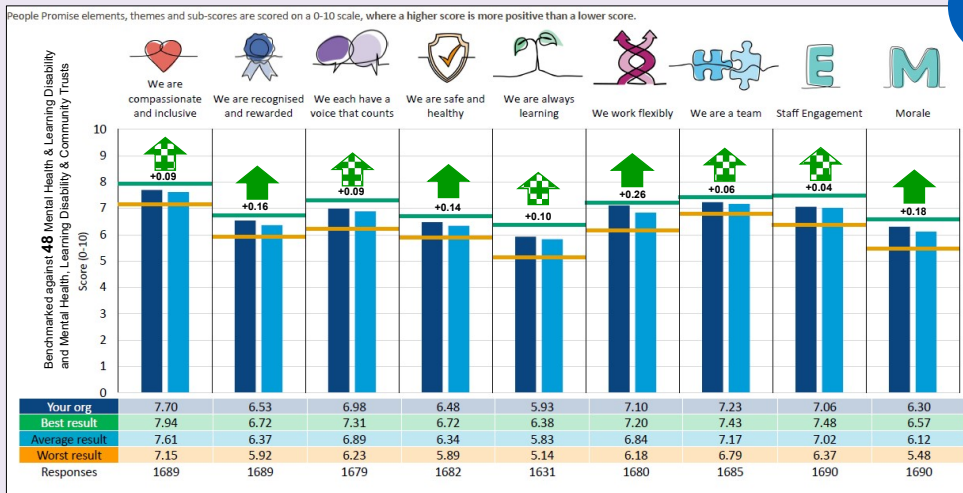
The Staff Survey results are grouped under the following:



## NHS Staff Survey 2025 Summary Results

Bradford District Care  
NHS Foundation Trust

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



2025 Response Rate **50%**  
2024: 53%  
Sector: 52%

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

Most significant:

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

Based on final released national results March 2026

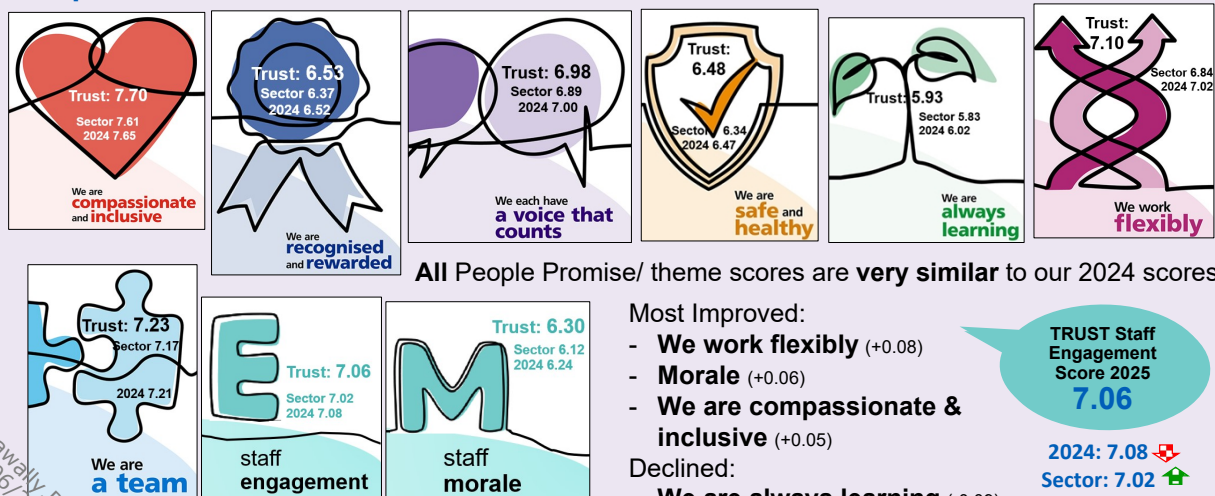
better lives, together

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## NHS Staff Survey 2025 Summary Results

Bradford District Care  
NHS Foundation Trust

### People Promise elements and themes against 2024 scores



Based on final released national results March 2026

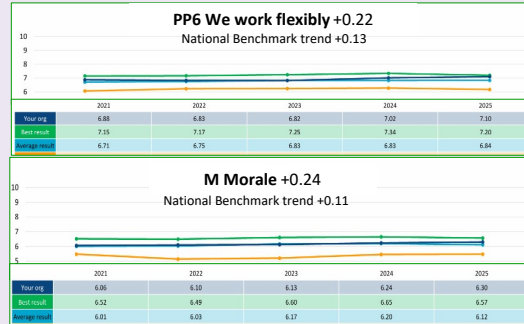
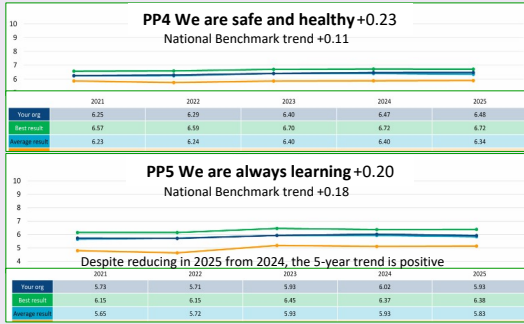
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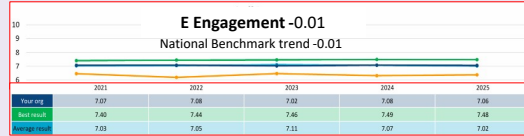
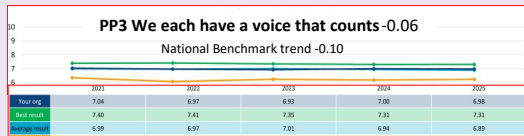
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# Appendix 2: NHS Staff Survey 2025 five-year trends of People Promise/theme/sub-theme scores

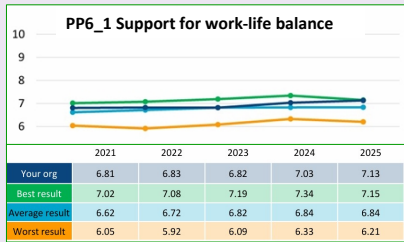
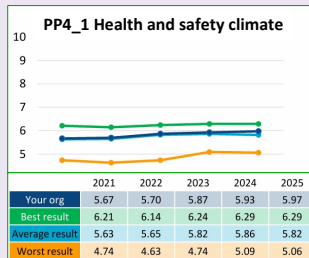
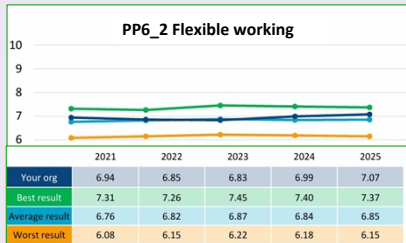
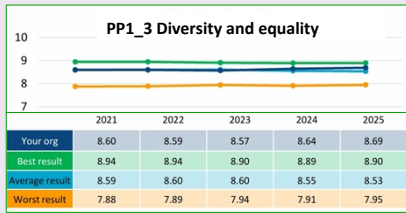
Seven People Promise/ theme scores have improved since 2021, four significantly so



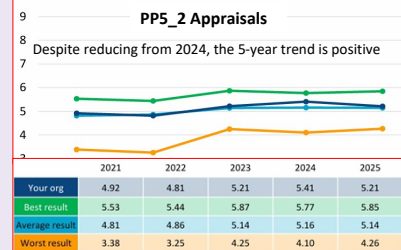
Two People Promise/ theme scores have reduced since 2021, both only slightly



**Most improving & better sub-themes**



**Most declining sub-theme since 2024**



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### Appendix 3: NHS Staff Survey 2025 key question score summaries and variances.

## NHS Staff Survey 2025 Question Summaries

Based on final released national results March 2026

Bradford District Care  
NHS Foundation Trust

**Significant question results compared to 2024**

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

**Significant question results compared to Sector**

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

**KEY QUESTIONS**

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

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

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

**Question trends since 2024**

**Top question scores BETTER compared to 2024 and to our sector**

- 59.2%** say teams within Trust work well together to achieve their objectives (2024 +4.8%, Sector +5.4%) (8a)
- 67.7%** say Trust treats staff who are involved in an error, near miss or incident fairly (2024 +3.9%, Sector +7.6%) (19a)

**Also significantly better than sector:**

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

**Top question scores WORSE compared to 2024 and to our sector**

- 61%** say last time they experienced harassment, bullying or abuse at work, they or a colleague reported it (2024 -3.8%, Sector -3.5%) (14d)
- 23%** say appraisal helped me to improve how I do my job (2024 -3.2%, Sector -2.4%) (23b)

**Also significantly worse than sector:**

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

**better lives, together**    Benchmarked against 48 Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts    W: [www.bdct.nhs.uk](http://www.bdct.nhs.uk)    T: @BDCFT

### Appendix 4: NHS Staff Survey 2025 Free Text strategic triangulation, comparing qualitative sentiment vs. Trust performance. (AI generated)

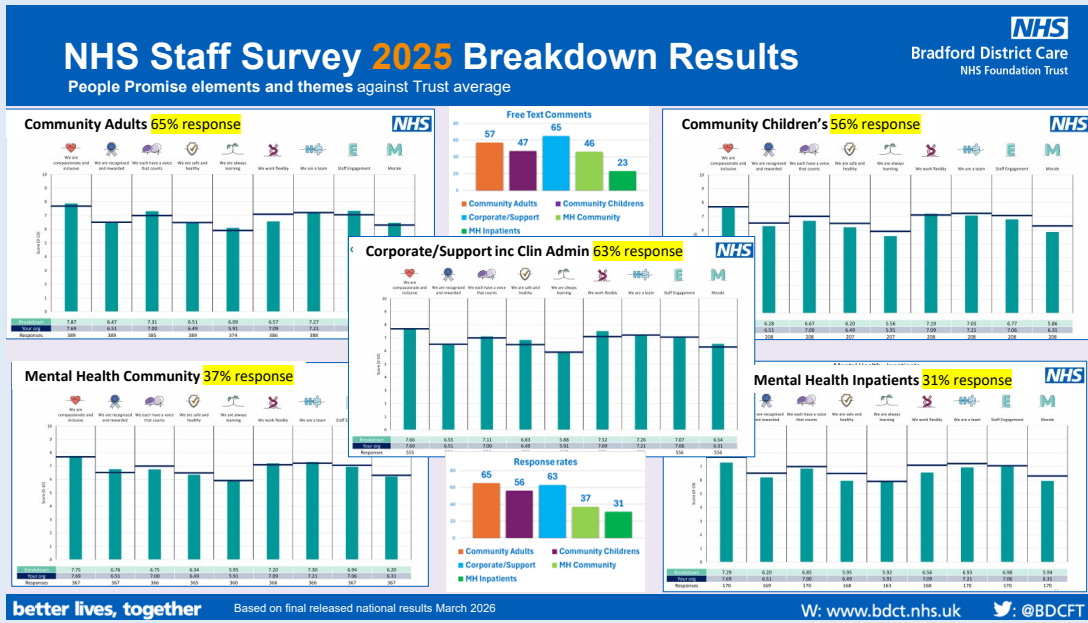
People Promise Theme	Trust Score	National Benchmark	Variance	Qualitative Contextualisation (n=X)
<b>We are safe and healthy</b>	6.48	6.34	+0.14	Despite positive variance, <b>109 comments (n=109)</b> reference burnout, fire-fighting, and exhaustion, indicating hidden wellbeing risk.
<b>We each have a voice that counts</b>	6.98	6.89	+0.09	<b>85 comments (n=85)</b> highlight a disconnect between supportive line managers and perceived inaction at organisational level.
<b>We are always learning</b>	5.93	5.83	+0.10	<b>40 comments (n=40)</b> cite reduced study budgets and inhibited development due to cost pressures.
<b>Morale</b>	6.30	6.12	+0.18	<b>64 comments (n=64)</b> link low morale directly to staffing shortages and workload pressure.

National benchmarks based on 2025 Mental Health, Learning Disability & Community Trust averages.

Further detailed analysis is ongoing

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## Appendix 5: Directorates/Care Groups summary breakdown results



## Appendix 6: Regional Benchmarking of Staff Engagement Scores

**NHS Staff Survey 2025 Regional benchmarking**  
Bradford District Care  
NHS Foundation Trust

**NHS England**  
**North East and Yorkshire**  
Staff Engagement Scores  
TRUST Staff Engagement Score 2025: 7.06

ICS	Trust Type	Trust	2025 Score
West Yorkshire	MH & LD and MH, LD & Community	South West Yorkshire Partnership NHS Foundation Trust	7.17
West Yorkshire	MH & LD and MH, LD & Community	Bradford District Care NHS Foundation Trust	7.06
West Yorkshire	Acute and Acute & Community	Bradford Teaching Hospitals NHS Foundation Trust	6.95
West Yorkshire	Acute and Acute & Community	Calderdale and Huddersfield NHS Foundation Trust	6.92
West Yorkshire	Community	Leeds Community Healthcare NHS Trust	6.92
West Yorkshire	MH & LD and MH, LD & Community	Leeds and York Partnership NHS Foundation Trust	6.92
West Yorkshire	Acute and Acute & Community	Leeds Teaching Hospitals NHS Trust	6.72
West Yorkshire	Acute and Acute & Community	Airedale NHS Foundation Trust	6.56
West Yorkshire	Acute and Acute & Community	Mid Yorkshire Teaching NHS Trust	6.52

WY ICS: 2 out of 9

Bradford District & Craven - Place: 1 out of 3

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**NHS Staff Survey 2025 Regional benchmarking**  
Bradford District Care  
NHS Foundation Trust

**NHS England**  
**North East and Yorkshire**  
Staff Engagement Scores  
TRUST Staff Engagement Score 2025: 7.06

ICS	Trust Type	Trust	2025 Score
West Yorkshire	MH & LD and MH, LD & Community	South West Yorkshire Partnership NHS Foundation Trust	7.17
Humber and North Yorkshire	MH & LD and MH, LD & Community	Humber Teaching NHS Foundation Trust	7.15
West Yorkshire	MH & LD and MH, LD & Community	Bradford District Care NHS Foundation Trust	7.06
West Yorkshire	MH & LD and MH, LD & Community	Leeds and York Partnership NHS Foundation Trust	6.92
North East and North Cumbria	MH & LD and MH, LD & Community	Tees, Esk and Wear Valleys NHS Foundation Trust	6.87
North East and North Cumbria	MH & LD and MH, LD & Community	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	6.84
South Yorkshire	MH & LD and MH, LD & Community	Rotherham Doncaster and South Humber NHS Foundation Trust	6.81
South Yorkshire	MH & LD and MH, LD & Community	Sheffield Health and Social Care NHS Foundation Trust	6.7

NE&Y MH & LD and MH, LD & Community: 3 out of 8

WY MH & LD and MH, LD & Community: 2 out of 3

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## Effective Oversight: Escalation and Assurance

<b>Report to:</b>	<b>Board of Directors</b>	<b>Meeting date:</b>	<b>TBC</b>
<b>Report from:</b>	<b>Finance &amp; Performance Committee</b>	<b>Meeting date:</b>	<b>25/03/2026</b>
<b>Quorate?</b>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
<b>Members present</b>	Mark Rawcliffe (Chair/NED), Sally Napper (NED), Kelly Barker, Mike Woodhead, Philippa Hubbard, Therese Patten, Bob Champion		
<b>In attendance</b>	Jess Greenwood-Owens (Secretary), Tim Rycroft, Farhan Rafiq, Rachel Trawally, Jaspreet Sohal, AnneMarie Dewhirst, Timed business: Alex Trigg, Emma Clarke, David Gibson.		
<b>Observers</b>	Cleveland Henry (New NED/Chair of FPC)		
<b>Apologies</b>	Fran Stead, Maz Ahmed, Clare Risdon, Dr Sal Uka, Maz Ahmed (Chair)		
<b>Best Quality Services</b>	<b>Theme 3 – Improving the experience of people using our services</b>	<b>BQS:T3</b>	
<b>Agenda items</b>	<ul style="list-style-type: none"> <li>• Apologies for absence &amp; confirmation of quoracy</li> <li>• Declaration of any conflicts of interest</li> <li>• Minutes of the previous meeting &amp; AAAD report (28 January 2026)</li> <li>• Matters arising</li> <li>• Action log</li> <li>• Integrated Strategic Performance Report</li> <li>• AAAD: Senior Leadership Team Care Group Accountability Meeting</li> <li>• AAAD: System Finance &amp; Performance Committee</li> <li>• Organisational Sustainability Board Update</li> <li>• Finance Report (including Capital Expenditure)</li> <li>• System Finance Update</li> <li>• Annual Financial &amp; Operational Plan</li> <li>• Data Quality Update</li> <li>• Lynfield Mount Hospital Redevelopment</li> <li>• Digital Programme Delivery 2026</li> <li>• Green plan updates</li> <li>• RIDDOR incidents and Martin’s Law</li> <li>• Well Led Implementation Plan – Update</li> <li>• Strategic Risk Report</li> <li>• Committee Annual Governance Report (including annual effectiveness review)</li> <li>• Terms of Reference 2026–27</li> <li>• Notification of future meeting dates</li> <li>• Draft Annual Workplan 2026–27</li> <li>• Confirmation of Escalation Reporting</li> <li>• Any Other Business</li> <li>• Meeting Evaluation</li> </ul>		

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<b>Alert items agreed by Committee</b>	<ul style="list-style-type: none"> <li>Continued pressure was noted within adult acute mental health services, particularly relating to out-of-area placements driven largely by system-wide flow and discharge constraints.</li> <li>The wider system financial position was identified as a potential risk with indirect impacts on the Trust.</li> </ul>
<b>Advise items agreed by Committee</b>	<ul style="list-style-type: none"> <li>The Committee advised continued system-level engagement with partners to address the structural causes of out-of-area placements, including discharge pathways and community capacity.</li> <li>It advised that planning assumptions for 2026/27 should remain realistic and deliverable, with appropriate phasing, validation and challenge prior to final sign-off.</li> <li>The Committee supported the continued development of digital and data initiatives, advising that benefits should be clearly articulated, monitored and aligned to productivity, quality and workforce sustainability.</li> <li>The Committee highlighted the challenge of balancing transformation activity with business-as-usual delivery, noting staff capacity pressures and the need to maintain safe and sustainable services.</li> </ul>
<b>Assure items agreed by Committee</b>	<ul style="list-style-type: none"> <li>Assurance was provided that financial control remained robust, with no unexpected issues reported and risks clearly understood and transparently reported (but noting that the risk levels remain high).</li> <li>The Committee was assured that governance, data quality and digital maturity had improved, supported by clearer accountability, strengthened oversight and demonstrable progress (but noted that there is still much further to go on data quality) .</li> <li>Assurance was provided that capital schemes and strategic programmes were progressing as planned, with appropriate approvals in place and risks actively managed.</li> <li>The Committee confirmed that it had discharged its responsibilities in line with its Terms of Reference, providing effective scrutiny, challenge and assurance to the Board.</li> </ul>
<b>Decisions made by Committee</b>	<p>The Committee approved the following reports:</p> <ul style="list-style-type: none"> <li>Minutes of previous meeting and AAAD</li> <li>Action log</li> <li>Annual Financial &amp; Operational Plan</li> <li>Well-Led Implementation Plan – Update</li> <li>Strategic Risk Report</li> <li>Committee Annual Governance Report (including annual effectiveness review)</li> <li>Terms of Reference 2026-27</li> </ul>
<b>New risks identified by Committee</b>	<p>The risk report was presented to the Committee.</p>

<b>Items to be considered by other Committees/Groups</b>	N/A		
<b>Feedback following discussion at 'parent' meeting</b>	TBC		
<b>Report completed by</b>	Jess Greenwood-Owens Corporate Governance Officer	<b>Date</b>	25/03/2026
<b>On Behalf of Chair</b>	Mark Rawcliffe		

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## Effective Oversight: Escalation and Assurance

<b>Report to:</b>	<b>Board of Directors</b>	<b>Meeting date:</b>	<b>TBC</b>
<b>Report from:</b>	<b>Finance &amp; Performance Committee</b>	<b>Meeting date:</b>	<b>27/05/26</b>
<b>Quorate?</b>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
<b>Members present</b>	Cleveland Henry (Chair/NED) Mark Rawcliffe (NED), Warren Brown (NED), Kelly Barker, Mike Woodhead, Bob Champion, Dr Sal Uka.		
<b>In attendance</b>	Jess Greenwood-Owens (Secretary), Clare Risdon, Catherine Sunter, Holly Close.		
<b>Observers</b>	N/A		
<b>Apologies</b>	Fran Stead, Rachel Trawally, Philippa Hubbard, Therese Patten, Tim Rycroft, Farhan Rafiq, Chris Dixon.		
<b>Best Quality Services</b>	<b>Theme 3 – Improving the experience of people using our services</b>	<b>BQS:T3</b>	
<b>Agenda items</b>	<ul style="list-style-type: none"> <li>• Apologies for absence and confirmation of quoracy</li> <li>• Declarations of conflicts of interest</li> <li>• Trust risk appetite</li> <li>• Minutes of the previous meeting and AAAD report</li> <li>• Matters arising</li> <li>• Action log</li> <li>• Integrated Strategic Performance Report</li> <li>• AAAD: Senior Leadership Team Care Group Accountability Meeting</li> <li>• Organisational Sustainability Board update</li> <li>• Finance report (including capital expenditure)</li> <li>• Data quality update</li> <li>• NHS Oversight Framework (NOF) update</li> <li>• Contracts update</li> <li>• Lynfield Mount Hospital redevelopment update</li> <li>• Lynfield Mount Hospital Terms of Reference (Project Delivery Group and Project Board)</li> <li>• Place Provider Partnership due diligence</li> <li>• Well-Led implementation plan update</li> <li>• Strategic Risk Assurance Report</li> <li>• Annual workplan 2026–27</li> <li>• Somerset surplus asset declaration</li> <li>• Confirmation of escalation reporting (including AAAA reporting to Board)</li> <li>• Any other business</li> <li>• Meeting evaluation</li> </ul>		

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<b>Alert items agreed by Committee</b>	<ul style="list-style-type: none"> <li>• Ongoing pressures in access and flow were highlighted, impacting operational delivery and financial performance.</li> <li>• CIP delivery risk remained significant, with Month 1 performance below plan and further mitigations required across the year.</li> <li>• Workforce pressures, temporary staffing, and data quality issues continued to present risks to delivery.</li> <li>• Operational volatility, particularly within out of area placements and inpatient flow, was highlighted, with early variance in Month 1 and ongoing dependency on system capacity.</li> <li>• System constraints, including limited specialist housing provision, community capacity pressures, and delays in multi-agency decision-making, continued to impact discharge flow and pathway resilience.</li> </ul>
<b>Advise items agreed by Committee</b>	<ul style="list-style-type: none"> <li>• Continued focus was advised on strengthening delivery confidence, including improved forecasting, risk tracking, and mitigation planning through OSPB.</li> <li>• Importance was placed on maintaining quality and patient safety alongside financial recovery.</li> <li>• Need to improve data quality and reduce administrative burden to support performance and decision-making was highlighted.</li> <li>• Further system-level work required to address flow constraints and build sustainable pathway capacity.</li> </ul>
<b>Assure items agreed by Committee</b>	<ul style="list-style-type: none"> <li>• Financial performance at Month 1 remained broadly on plan, with a forecast breakeven position.</li> <li>• Robust oversight through OSPB was in place, with active management of risks and delivery plans.</li> <li>• Mitigating actions and improvement programmes were underway, with positive progress noted in flow, waits, and service performance.</li> <li>• Assurance was received on the NOF position and approach to managing evolving performance measures.</li> <li>• Operational performance improvements were noted, including reductions in clinically ready for discharge patients and improvements in discharge flow. Patient experience remained strong, with no increase in harm or complaints associated with out of area placements. Positive performance was also reported in urgent community response and key services, alongside the elimination of 52-week waits in some areas.</li> </ul>
<b>Decisions made by Committee</b>  <i>Trawally Rachel 03/06/2026 11:28:24</i>	<p><b>The Committee approved the following reports:</b></p> <ul style="list-style-type: none"> <li>• Minutes of previous meeting and AAAD</li> <li>• Action log</li> <li>• Well-Led Implementation Plan – Update</li> <li>• Strategic Risk Report</li> <li>• Lynfield Mount Hospital Terms of Reference for the Project Delivery Group and Project Board.</li> </ul>

	<b>The Committee approved and recommended Board:</b>		
	<ul style="list-style-type: none"> <li>• 2026/27 Cygnet contract to (contracts update)</li> <li>• Somerset Surplus Asset <b>Disposal</b></li> </ul>		
<b>New risks identified by Committee</b>	The risk report was presented to the Committee.		
<b>Items to be considered by other Committees/Groups</b>	N/A		
<b>Feedback following discussion at 'parent' meeting</b>	TBC		
<b>Report completed by</b>	Jess Greenwood-Owens Corporate Governance Officer	<b>Date</b>	27/05/2026
<b>On Behalf of Chair</b>	Cleveland Henry		

Trawally Rachel  
03/06/2026 11:28:24

# Trust Board

4<sup>th</sup> June 2026

## Item 17 Finance Report – Month 1 (April 2026)

Trawally Rachel  
03/06/2026 11:28:24

# Financial Performance – Key Messages & Risks

## Key Messages

We are reporting slightly better than **plan at Month 1 by 41k** and at this early stage in the year we are forecasting to meet our planned **breakeven position**.

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 1 by £118k** and is **forecast to underdeliver by £780k** for the year.
- **Further risks** to delivery of the efficiency programme could worsen performance by **between £0.8m and £6.6m** – mainly in relation to the Purposeful and Productive and Difficult Decisions workstreams and programmes where plans are still in development.

The Trusts contingency has been partially deployed to mitigate under-delivery of the efficiency programme and to support the bottom-line financial position. A number of upsides are available to manage the financial risks, however at this point the financial position still requires de-risking by c£2.8m.

## Reporting breaches:

At Month 1, the Agency cap has been **achieved and forecast to achieve**.

There is a new Bank cap this year which we have **breached by £0.4m YTD** but **forecast to achieve by the year end**.

**Provider collaboratives:** The current contracts for the MHLDA Provider Collaboratives end in March 2027. National discussions are underway regarding changes to the footprints of the collaboratives. This in turn will lead to a change in Lead Providers. As work progresses, further updates will be provided to F&P Committee and Trust Board on the risks and opportunities that the changes will bring.

Trawally Rachel  
03/06/2026 11:28:24

# Efficiency Programme

The Month 1 position includes under delivery on the efficiency programme of £118k YTD and £760k forecast. To manage the delivery shortfall, the Trust will deployed its risk contingency and require the SRO leads for programmes to identify mitigating actions to cover risks to ensure that the Trust can deliver its breakeven duty.

The main pressures remain the achievement of the Purposeful and Productive Pathway.

The risk assessed delivery ranges from £776k to £8,632k, with a **likely case additional risk of £6,629k** (equates to a 5.2% delivery risk of the target for the remaining months). Plans are being developed, through the Trusts 'transformation pipeline' group, to fully mitigate the delivery risk.

Efficiency Plan	SRO	YTD Plan £'000	YTD Actual £'000	Variance from Plan £'000	Full Year Plan £'000	Forecast £'000	Variance from Plan £'000	Delivery Risk	BEST	LIKELY	WORST
1. Temporary Staffing	KB	119	0	119	1,428	1,186	242	High	242	480	825
1. LOS/Out of Area Placements	KB	50	0	50	3,541	3,372	169	High	169	2,802	3,343
<b>1. Purposeful and Productive Adult &amp; Community Pathway Total</b>		<b>169</b>	<b>0</b>	<b>169</b>	<b>4,969</b>	<b>4,557</b>	<b>411</b>		<b>411</b>	<b>3,282</b>	<b>4,168</b>
2. Medical Staffing	SU	42	16	26	447	391	56	Medium	56	84	186
3. Continence Service review	KB	58	47	11	349	223	126	High	126	364	560
4. Enteral Feeding consumables	KB	14	14	0	85	85	0	Low			
5. CYP Leadership restructure	KB	80	80	0	80	80	0	Low			
6. Clinical Admin Review	KB	21	21	0	257	214	43	Low	43	159	257
7. Corporate Service - People Matters	BC	17	17	0	200	200	0	High			
7. Corporate Service - Nursing	PH	16	16	0	154	154	0	Low			
7. Corporate Service -Digital	TR	39	25	15	470	470	0	High			
7. Corporate Service - Finance	MW	4	4	0	51	51	0	Low			
7. Corporate Service - Transformation	FR	14	14	0	39	39	0	Low			
7. Corporate Service - R&D	SU	1	0	1	14	14	0	Low			
8. Difficult Decisions CAMHS	KB	23	8	15	278	259	20	High	20	119	167
8. Difficult Decisions BANDS	KB	21	1	20	257	215	42	High	42	86	154
9. LMH Development	MW	25	25	0	305	305	0	Low			
10. Bracken Ward	KB	26	0	26	309	230	78	Medium	78	230	339
11. TrustWide Efficiency MHCG	KB	0	0	0	2,562	2,562	0	High	0	1,281	1,537
11. TrustWide Efficiency A&CCG	KB	0	0	0	868	868	0	High	0	434	521
11. TrustWide Efficiency Medical Directorate	SU	0	0	0	149	149	0	Medium	0	74	89
11. TrustWide Efficiency Estates	MW	0	0	0	368	368	0	Low	0	74	110
11. TrustWide Efficiency Trust General Management	TP	0	0	0	99	99	0	Low	0	20	30
11. TrustWide Efficiency Nursing	PH	0	0	0	51	51	0	Low	0	10	15
11. TrustWide Efficiency Transformation	FR	0	0	0	34	34	0	Low	0	7	10
11. TrustWide Efficiency Finance	MW	0	0	0	28	28	0	Low	0	6	8
12. Technical efficiencies	MW	42	42	0	500	500	0	Low			
13. Place Corporate efficiencies	TP	0	32	(£32)	300	300	0	Low			
14. Transformation target	FR	0	0	0	800	800	0	Medium	0	400	480
<b>Grand Total</b>		<b>612</b>	<b>362</b>	<b>250</b>	<b>14,023</b>	<b>13,247</b>	<b>776</b>		<b>776</b>	<b>6,629</b>	<b>8,632</b>

Efficiency Plan 2025/26 Delivered Non Recurrently	SRO	YTD Plan £'000	YTD Actual £'000	Variance from Plan £'000	Full Year Plan £'000	Forecast £'000	Variance from Plan £'000	Risk Rating	BEST	LIKELY	WORST
2. Medical Staffing	SU	19	19	0	233	233	0	Medium			
3. Continence service review	KB	29	29	0	349	349	0	High			
8. Corporate Services review - Digital	TR	3	3	0	30	30	0	High			
8. Corporate Services review - People Matters	BC	10	10	0	115	115	0	High			
10. Digital Optimisation (PKB)	TR	11	0	11	126	0	126	High			
15. Vacancy Factor MHCG	KB	176	196	(£20)	2,112	2,132	(£20)	High			
15. Vacancy Factor A&CCG	KB	60	172	(£112)	722	834	(£112)	High			
15. Vacancy Factor - Estates	MW	18	29	(£11)	220	231	(£11)	High			
<b>Total</b>		<b>326</b>	<b>458</b>	<b>(£132)</b>	<b>3,908</b>	<b>3,924</b>	<b>(£16)</b>		<b>0</b>	<b>0</b>	<b>0</b>

<b>OVERALL CIP PERFORMANCE</b>		<b>938</b>	<b>820</b>	<b>118</b>	<b>17,931</b>	<b>17,170</b>	<b>760</b>		<b>776</b>	<b>6,629</b>	<b>8,632</b>
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Contingency Deployed		0	118	(£118)	0	760	(£760)				
Non Recurrent Mitigations		0	0	0	0	0	0				
<b>Grand Total</b>		<b>938</b>	<b>938</b>	<b>0</b>	<b>17,931</b>	<b>17,931</b>	<b>0</b>		<b>776</b>	<b>6,629</b>	<b>8,632</b>

# Risks and Mitigations

## Headlines:

As part of the planning for 26/27 a sensitivity analysis was performed to evaluate the risks within the plan:

- The main risks is the delivery of the CIP programme in 26/27
- The planning assumption for the various Provider Collaboratives is a breakeven position. A risk has been highlighted that demand for OAPs may exceed planned levels
- Pay award funding for the 0-19 contract for 2026/27 is still to be agreed, work is ongoing to secure agreement

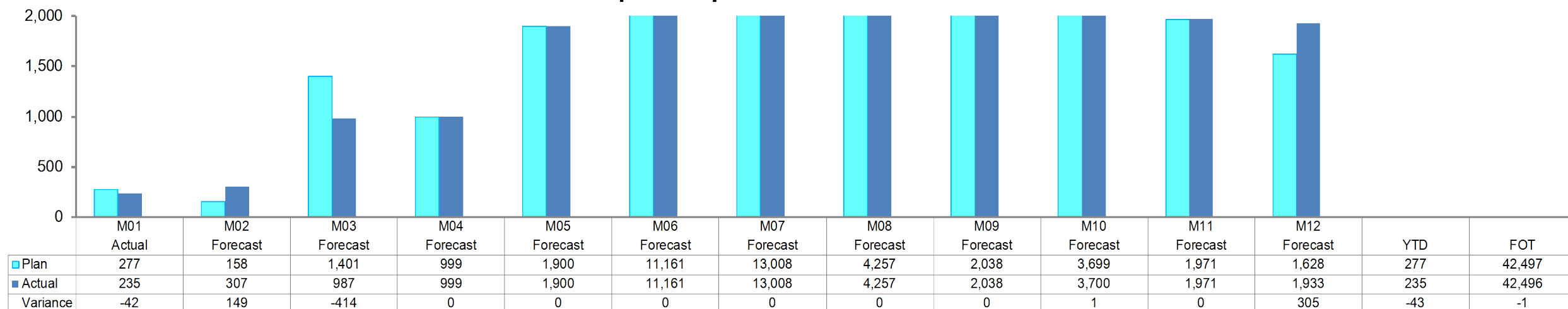
A number of upsides are available to manage the risks, however at this point the financial position still requires de-risking by c£2.8m.

*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.*

		2026/27		
Description	Value	Likelihood	Impact	
Upside 1	Risk Contingency	£3,126	100%	£3,126
Upside 2	Cost pressure review - target further reductions	£44	100%	£44
Upside 3	Non recurrent opportunities that arise during the year/ budget underspends	£1,096	100%	£1,096
Upside 4	Non recurrent income	£1,216	100%	£1,216
Upside 5	Cygnnet uplift for 26/27	£139	100%	£139
<b>Sub-total Upsides</b>		<b>£5,621</b>		<b>£5,621</b>
Downside 1	Purposeful & Productive: LOS reductions	(£3,715)	80%	(£2,972)
Downside 1	Purposeful & Productive: Temporary staffing	(£1,031)	70%	(£722)
Downside 1	Medical Staffing	(£466)	30%	(£140)
Downside 1	Continence	(£700)	70%	(£490)
Downside 1	Trust Wide CIP - achievability risk (Clinical)	(£3,578)	50%	(£1,789)
Downside 1	Trust Wide CIP - achievability risk (Corporate)	(£580)	20%	(£116)
Downside 1	Place Corporate efficiencies	(£300)	0%	£0
Downside 1	Transformation target	(£800)	50%	(£400)
Downside 1	Bracken Safer Staffing	(£308)	100%	(£308)
Downside 1	BANDS	(£257)	50%	(£129)
Downside 1	CAMHS Neuro	(£278)	50%	(£139)
Downside 1	Clinical Admin	(£201)	100%	(£201)
Downside 1	<b>CIP delivery risk</b>	<b>(£12,214)</b>	<b>61%</b>	<b>(£7,405)</b>
Downside 2	Vacancy factor 25/26 delivery risk	(£3,054)	2%	(£58)
Downside 3	2025/26 CIPs delivered non recurrently (PKB)	(£126)	50%	(£63)
Downside 2	Low Secure budgetary overspend	(£340)	50%	(£170)
Downside 3	ATU Provider collaborative risk share	(£100)	80%	(£80)
Downside 4	Adult Secure PC financial risk	(£119)	75%	(£90)
Downside 5	Additional Cost pressures	(£500)	50%	(£250)
Downside 6	0-19 Pay uplift for 25/26 (Full value £538k - NI amounts to £194k)	(£538)	36%	(£194)
Downside 7	0-19 Pay uplift for 26/27	(£286)	50%	(£143)
Downside 8	Fair deal for nurses (national JD reviews)	TBC		TBC
<b>Sub-total Downsides</b>		<b>(£17,277)</b>		<b>(£8,452)</b>
<b>Net (Downside) Risk</b>		<b>(£11,656)</b>		<b>(£2,831)</b>

# Capital Expenditure

### Capital Expenditure Plan vs Actual/Forecast



The capital position in April is underspent by £42k with a YTD spend of £235k.

The initial Trust capital plan is allocated as follows:

Operational Capital - £3.628m

IFRS16 Lease Renewals, Additions and Remeasurements - £1.124m

Initial PDC Plan Funding

£36.39m -Lynfield Mount Redevelopment

£0.85m – Estates Safety Fund

£0.5m – Community – Digital Integration

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

Trawally Rachel  
03/06/2026 11:28:24

<p><b>Self certification</b></p>	00ACTYTD																
<p><b>1. Declaration of review of submitted data</b> 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>	<div style="border: 1px solid gray; width: 40px; height: 40px; margin: 0 auto; display: flex; align-items: center; justify-content: center;">i</div>																
<p><b>Approved on behalf of the board of directors (normally by CFO and CEO):</b> 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><b>CFO</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="background-color: #fff9c4;">Name</td><td>Mike Woodhead</td></tr> <tr><td style="background-color: #fff9c4;">Email address</td><td>Mike.Woodhead@bdct.nhs.uk</td></tr> <tr><td style="background-color: #fff9c4;">Job title</td><td>Chief Finance Officer</td></tr> <tr><td style="background-color: #fff9c4;">Date</td><td>15/05/2026</td></tr> </table> <p><b>CEO or Chair</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="background-color: #fff9c4;">Name</td><td>Therese Patten</td></tr> <tr><td style="background-color: #fff9c4;">Email address</td><td>Therese.Patten@bdct.nhs.uk</td></tr> <tr><td style="background-color: #fff9c4;">Job title</td><td>Chief Executive Officer</td></tr> <tr><td style="background-color: #fff9c4;">Date</td><td>15/05/2026</td></tr> </table>	Name	Mike Woodhead	Email address	Mike.Woodhead@bdct.nhs.uk	Job title	Chief Finance Officer	Date	15/05/2026	Name	Therese Patten	Email address	Therese.Patten@bdct.nhs.uk	Job title	Chief Executive Officer	Date	15/05/2026
Name	Mike Woodhead																
Email address	Mike.Woodhead@bdct.nhs.uk																
Job title	Chief Finance Officer																
Date	15/05/2026																
Name	Therese Patten																
Email address	Therese.Patten@bdct.nhs.uk																
Job title	Chief Executive Officer																
Date	15/05/2026																
<p><b>2. Is the return consistent with the board report?</b> 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>	<div style="border: 1px solid gray; width: 40px; height: 40px; margin: 0 auto; display: flex; align-items: center; justify-content: center;">i</div>																
<p><b>3. 2026-27 Dissolution</b> Has the trust dissolved in the financial year? Number of months as a trust</p>	<p style="text-align: center; background-color: #fff9c4;">Yes</p> <p style="text-align: center; background-color: #fff9c4;">04/06/2026</p> <p style="text-align: center; background-color: #fff9c4;"> </p> <p style="text-align: center; background-color: #f5f5f5;">No</p> <p style="text-align: right; background-color: #f5f5f5;">12</p>																

## 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.

Trawally Rachel  
03/06/2026 11:28:24

## Board of Directors – Meeting Held in Public

**4 June 2026**

<b>Paper title:</b>	Board Integrated Performance Report	<b>Agenda Item</b> <b>18.0</b>
<b>Presented by:</b>	Phil Hubbard, Director of Nursing, Professions & Care Standards Fran Stead, Trust Secretary	
<b>Prepared by:</b>	Kelly Barker, Chief Operating Officer Cliff Springthorpe, Head of Business Support	
<b>Committees where content has been discussed previously</b>	Quality and Safety Committee Mental Health Legislation Committee People and Culture Committee Finance and Performance Committee Audit Committee	
<b>Purpose of the paper</b> Please check <b>ONE</b> box only:	<input checked="" type="checkbox"/> For approval <input type="checkbox"/> For information <input type="checkbox"/> For discussion	

<b>Relationship to the Strategic priorities and Board Assurance Framework (BAF)</b>		
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

## 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.

The Board Level Integrated Strategic Performance Report has been under review following the implementation of the National Oversight Framework and recent planning submissions. The redeveloped version will have updated indicators to enable further oversight and assurance. The new Integrated Strategic Performance and Quality Report will be used for Trust Board from July 2026 onwards.

## Executive Summary

This report brings together performance and assurance against the Trust's strategic priorities to support the Board in assessing **delivery confidence against "Better Lives, together."**

### Overall Position

The Trust continues to demonstrate **strong performance and assurance in workforce, culture, and governance**, with high levels of assurance across "Best Place to Work."

However, there are **material delivery risks** in core operational and financial domains:

- **Access & Flow – Limited / Low assurance**
- **Financial Sustainability – Low assurance**
- **Estates and Environment – Low assurance**

These areas represent the **greatest risk to delivery of strategy and quality outcomes.**

### Key Insight

Performance pressures are systemic and interdependent, rather than isolated, contributing to:

- Reduced access performance (e.g. Dental RTT 52.2% vs 92% target)
- Continued reliance on out-of-area placements
- Extended lengths of stay and flow challenges
- These pressures are driving financial risk and limiting recovery trajectory

Trust has improved its position within the National Oversight Framework (now Sector 3), some core operational metrics are challenged.

### Top Risks to Strategic Delivery

1. **Access & Flow Performance**
  - Patient experience, safety and outcomes
2. **Out of Area Placements**
  - Direct alignment to Risk 2609
3. **Workforce Capacity**
  - Safety, productivity, and staff experience
4. **Financial Sustainability**
  - Structural pressures linked to demand, workforce, access and flow
5. **Estate Constraints (Lynfield Mount)**
  - Limiting ability to optimise flow and outcomes

### Assurance Summary

- **Best Place to Work** – High assurance (stable/improving)
- **Best Quality Services**
  - Access & Flow – Low/Limited (not yet recovering consistently across all areas, variable performance)
  - Learning for Improvement – Significant (developing)
  - Experience – Limited (variable performance, however FFT score high, areas of complaint are within those with longest waits)
- **Best Use of Resources**
  - Financial Sustainability – Low (ongoing risk)
  - Environment & Estate – Low (however LMH Redevelopment now in progress)
- **Governance** – Significant (effective and embedded)

The Board is asked to note:

### 1. Access & Flow Recovery

- Quality Improvement plans in place across all areas where access and waits are noted to be challenged.
- System level accountability and actions to be taken forward are being progressed

**2. Workforce**

- Organizational focus on workforce wellbeing and productivity

**3. Financial Sustainability vs Quality**

- Alignment of OSPB sustainability programmes with EQIA processes
- Activity Based Budgeting programme aligning quality, finance and workforce data to ensure there is balanced decision making in regard to productivity and sustainability intervention.

The Trust remains strong on people, culture, and governance, providing a solid foundation. However, delivery risk is concentrated in operational performance and financial sustainability, driven by capacity and flow constraints.

This paper seeks to support the Board in:

- Focusing on the areas of greatest strategic risk
- Credibility of recovery plans
- Strengthening assurance over delivery of strategy

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:

- Take assurance in the current assurance levels and trajectories prescribed through committees
- Note and take assurance on the Quality Improvement and OSPB plans, priorities and programmes to progress recovery and strategic delivery
- Note system partner escalation and engagement
- Note triangulated position through ISPR and BAF

**Links to the Strategic Organisational Risk register (SORR)**

The work contained with this report links to the following corporate risks as identified in the SORR:

- 2609: Organisational risks associated with out of area bed use (finance, performance and quality)

	<ul style="list-style-type: none"> <li>• 2672: Lynfield Mount Hospital – Estate condition, associated impacts &amp; redevelopment requirements</li> </ul>						
<p><b>Care Quality Commission domains</b> Please check <b><u>ALL</u></b> 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><b>Compliance &amp; regulatory implications</b></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"> <li>• 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.</li> </ul>						

Trawally Rachel  
03/06/2026 11:28:24

# Board of Directors Integrated Strategic Performance Report and Board Assurance Framework

4<sup>th</sup> June 2026

Trawally Rachel  
03/06/2026 11:28:24



Good Governance; Accountability; Effective Oversight

# 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)

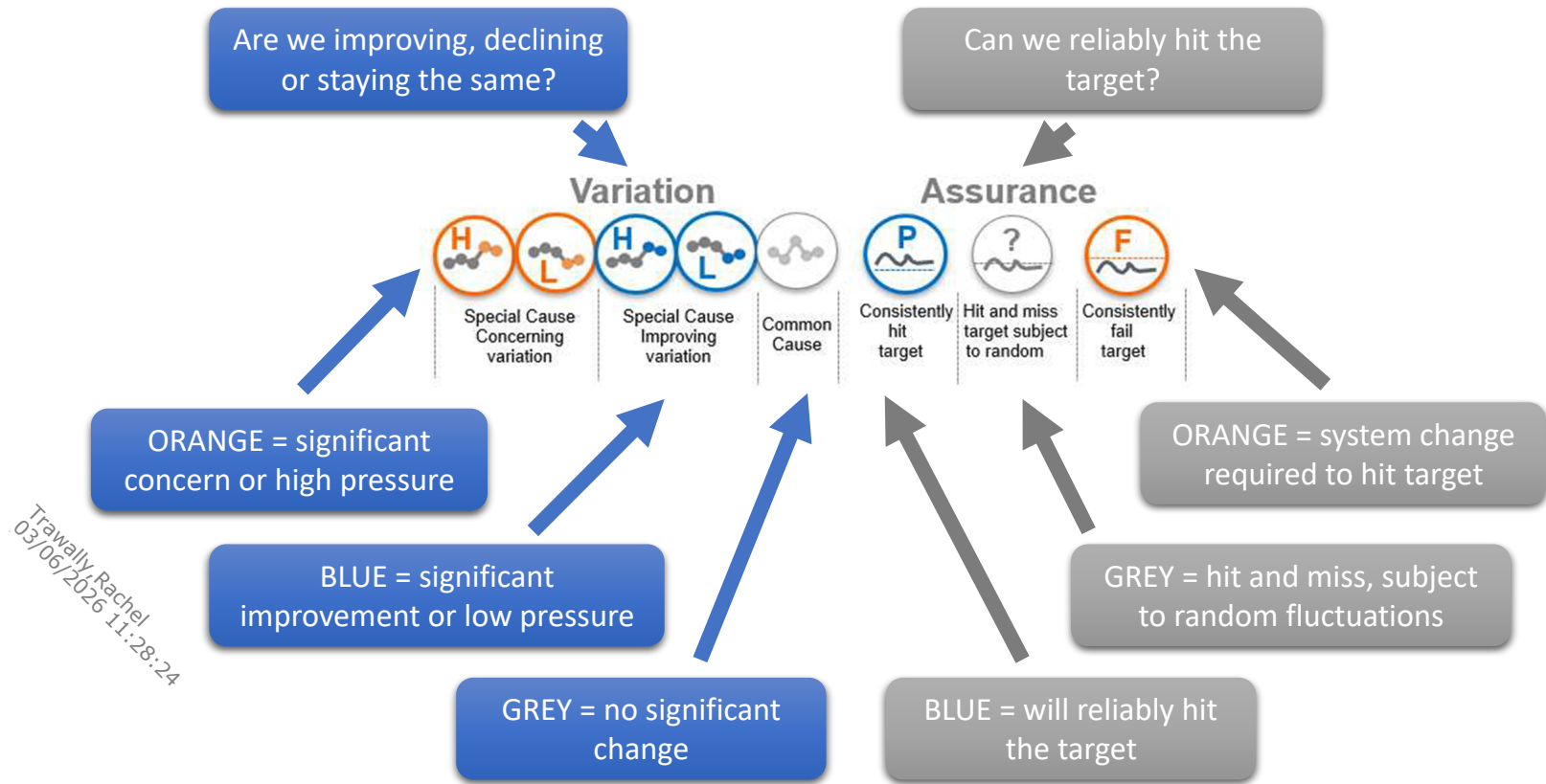
The performance overview also contains a section which uses a wide range of sources, including the performance data in this report, to describe how assured the Trust is that it is meeting the priorities and objectives described within the trust strategy, better lives, together and is operating safety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

**Theme 1: Looking after our people – we will**

- 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.

**We will know we have been successful when:**

- We have increased engagement with the NHS staff survey, with a focus on teams we hear less from. The NSS 2025 attracted a response of 50%, slightly reduced from last year (53%), but the new engagement around results is improving team voice.
- 3 survey themes show a higher score than the previous year, 'We work Flexibly', 'We are Compassionate & Inclusive'; 'Morale'.
- 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.

**PROPOSED  
Current  
Assurance  
Level:**

**4. High**

**Theme 2: Belonging in our organisation – we will**

- 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

**We will know we have been successful when:**

- 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.

**PROPOSED  
Current  
Assurance  
Level:**

**4. High**

## 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	2025	7.06	7.4 (best)	Staff engagement score remains stable/reduced slightly at 7.06 (0.02);																																				
Staff survey - % would recommend the Trust as a place to work	Strategic	64.28%	2025	65.4%	63% (sector)	<table border="1"> <thead> <tr> <th></th> <th>2021</th> <th>2022</th> <th>2023</th> <th>2024</th> <th>2025</th> </tr> </thead> <tbody> <tr> <td>Your org</td> <td>62.98%</td> <td>63.93%</td> <td>62.15%</td> <td>64.24%</td> <td>65.40%</td> </tr> <tr> <td>Best result</td> <td>73.53%</td> <td>73.02%</td> <td>75.50%</td> <td>78.17%</td> <td>76.39%</td> </tr> <tr> <td>Average result</td> <td>64.05%</td> <td>62.75%</td> <td>65.53%</td> <td>65.22%</td> <td>64.00%</td> </tr> <tr> <td>Worst result</td> <td>43.58%</td> <td>39.48%</td> <td>39.70%</td> <td>42.69%</td> <td>42.89%</td> </tr> <tr> <td>Responses</td> <td>1412</td> <td>1329</td> <td>1671</td> <td>1755</td> <td>1682</td> </tr> </tbody> </table>		2021	2022	2023	2024	2025	Your org	62.98%	63.93%	62.15%	64.24%	65.40%	Best result	73.53%	73.02%	75.50%	78.17%	76.39%	Average result	64.05%	62.75%	65.53%	65.22%	64.00%	Worst result	43.58%	39.48%	39.70%	42.69%	42.89%	Responses	1412	1329	1671	1755	1682
	2021	2022	2023	2024	2025																																					
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Responses	1412	1329	1671	1755	1682																																					
Labour turnover	Strategic	13.68%	Apr 26	10.1%	10%																																					
Number of leavers in 1st 12 months of employment	Supporting	93 (19.3%)	Apr 26	75 / 370 (20.3%)	N/a	<p>The top 3 reasons for leaving (excluding resignation – other/not known) are retirement, VR – Relocation and VR – promotion. 11.35% left due to the end of a FTC, 18.38% through retirement and 4.05% through dismissal.</p>																																				
Sickness absence related to stress/ anxiety	Strategic	2.6% of the 6.6% (39.04% of all absence)	Apr 26	2.7% of the 6.51% (41.05% of all absence)	N/a																																					
Sickness absence (Overall)	Supporting	6.6%	Apr 26	6.51%	4.0%																																					
Return to Work Interviews –% (based on RTW's being recorded in a timely manner)	Supporting	N/a	Apr 26	50.36% (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)	Apr 26	1 Grievances 3 Disciplinaries (10.81% of all ER Casework-excluding sickness)	N/a	
Annual Appraisal Rates	Strategic	69.08%	Apr 26	78.6%	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	Apr 26	82.65% 2.43% Agency 80.22% Bank 17.35% Unfilled	100%	A reduction in agency and in bank but an increase 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	Apr 26	5072 requested 123 Agency 4069 Bank 880 Unfilled	N/a	
Bank & Agency Usage (WTE)	Strategic	30.01 Agency 313.70 Bank Ratio: 8.73% Agency 91.27% Bank	Apr 26	16.95 Agency 241.03 Bank Ratio: 6.57% Agency 93.43% Bank	N/a	
Vacancy rates	Strategic	7.4%	Apr 26	6.6%	10%	Increase

## 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	Apr 26	147	63	Reduction
Number 'new' roles recruited to (inc NAs and ANPs)	Strategic	1	Apr 26	-5	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><b>Theme 1: Access &amp; Flow – we will</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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</li> </ul>	<p><b>We will know we have been successful when:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• We can demonstrate equitable access to all of our services.</li> <li>• Use high quality information and analysis to drive predictive health interventions, clinical decision making and service planning to reduce health inequalities.</li> <li>• Service users have the choice to access our services using safe and secure digital tools where appropriate, to stay as healthy as possible.</li> </ul>	<p><b>Confirmed Current Assurance Level (QSC – quality perspective):</b></p> <p><b>2. Limited</b></p> <hr/> <p><b>Confirmed Current Assurance Level (Finance and Performance perspective):</b></p> <p><b>1. Low</b></p>
<p><b>Theme 2: Learning for improvement – we will</b></p> <ul style="list-style-type: none"> <li>• Share best practice and learning across integrated multi-disciplinary teams, to improve clinical effectiveness and social impact for service users, carers and families.</li> <li>• Continue to embed the Care Trust Way training and support in service delivery to support continuous quality improvement, adopt innovation and reduce waste.</li> </ul>	<p><b>We will know we have been successful when:</b></p> <ul style="list-style-type: none"> <li>• We consistently adopt a continuous improvement approach, share learning and creating opportunities for our people to develop their improvement and innovation skills.</li> <li>• We have a vibrant portfolio of research that guides clinical and service decisions</li> </ul>	<p><b>Confirmed Current Assurance Level:</b></p> <p><b>3. Significant</b></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	Apr 26 Feb-Apr (3m)	302 944				421	
Average Length of Stay (Acute wards)	Supporting	Apr 26	67.2	NA			58.0	
Number of people with inpatient length of stay <=3 days (Acute wards)	Strategic	Apr 26	1	TBC			3	
Consultant led waiting times (incomplete) referral to treatment	Strategic	Apr 26	52.2%	92%			67.0%	

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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 – Mar 26	12	N/A	
% of staff trained as a CTW Champion	Strategic	Mar 26	43.7%	50%	
% of staff trained as a CTW Leader	Strategic	Mar 26	23.4%	20%	
% of staff trained as a CTW Practitioner	Strategic	Mar 26	33.2%	3%	
% of staff trained as a CTW Sensei	Strategic	Mar 26	73.5%	0.5%	
No of participants in research studies (YTD)	Strategic	Mar 26	20	400	DATA UNAVAILABLE FOR MAR

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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	Mar 26	37	0	N/A	N/A	N/A	
No of complaints relating to people whilst waiting for services**	Strategic	Mar 26	12	0	N/A	N/A	N/A	
FFT / local patient survey – patient experience score	Strategic	Mar 26	96.48%	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><b>Theme 1: Financial Sustainability – we will</b></p> <ul style="list-style-type: none"> <li>• 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</li> </ul>	<p><b>We will know we have been successful when:</b></p> <ul style="list-style-type: none"> <li>• We are consistently delivering a financially balanced position at Trust and care group level.</li> <li>• We can demonstrate the return on investment and value for money of investments in our physical and digital infrastructure</li> </ul>	<p><b>Confirmed Current Assurance Level:</b></p> <p><b>1. Low</b></p>
<p><b>Theme 2: Our environment and workspaces – we will</b></p> <ul style="list-style-type: none"> <li>• Ensure that our people have opportunities to shape, test and implement digital solutions to stimulate innovation and creativity in service delivery.</li> <li>• Co-design a revised green plan to embed sustainable healthcare models and to continually drive environmental improvements and innovation.</li> <li>• 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.</li> <li>• Provide a robust, resilient and secure digital infrastructure that enables our people to do their job from anywhere, anytime</li> </ul>	<p><b>We will know we have been successful when:</b></p> <ul style="list-style-type: none"> <li>• Services are co-located in shared health and care delivery spaces across Bradford and Craven, reducing our overall footprint.</li> <li>• 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.</li> <li>• 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.</li> <li>• We have assessed our organisation as being digitally mature, including meeting/ exceeding all 10 standards within the data security protection toolkit</li> </ul>	<p><b>Confirmed Current Assurance Level:</b></p> <p><b>1. Low</b></p>
<p><b>Theme 3: Giving back to our communities – we will</b></p> <ul style="list-style-type: none"> <li>• Contribute to the social, economic and cultural development of our place through social value led approaches, programmes and procurement</li> </ul>	<p><b>We will know we have been successful when:</b></p> <ul style="list-style-type: none"> <li>• We can demonstrate that social value is built into all material investment and procurements.</li> <li>• We have delivered the ambitions in our joint climate change adaptation plan, shared with Bradford Teaching Hospitals NHS Trust and Airedale NHS Foundation Trust.</li> </ul>	<p><b>Confirmed Current Assurance Level:</b></p> <p><b>2. Limited</b></p>

# Strategic Priorities – Assurance Summary

<b>Good governance:</b> Good governance, accountability and effective oversight		
<p><b>We will</b> Have in place good governance arrangements that ensure we make the best decisions</p>	<p><b>We will know we have been successful when:</b> We have well embedded governance processes that are clear and effective</p>	<p><b>CONFIRMED</b> <b>Current assurance level:</b> <b>3. Significant</b></p>

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2026/27									
Risk Ref	Risk Description	Strategic Priority					Executive Lead	Assuring Committee	Target Assurance Rating
		BPW	BUoR	BQS	BP	GG			
SR01	If pressure on workforce increases, then it could impact on the quality of care to patients resulting in poorer patient experience and outcomes.			✓			Director of Nursing, Professions and Care Standards	Quality & Safety Committee	
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.			✓			Chief Operating Officer	Quality & Safety Committee	
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.			✓			Chief Medical Officer	Mental Health Legislation Committee	
SR04	If services don't optimise the opportunity to actively recruit to vacant posts, then there may be a negative impact on colleague morale, wellbeing and culture.	✓					Chief People Officer	People and Culture Committee	
SR05	In the context of current and impending financial challenges, if management capability, capacity & competence isn't 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.	✓					Chief People Officer	People and Culture Committee	
SR06	If the organisation continues to focus on productivity and financial performance measures, then there may be a threat to organisational culture, which could change from the current level of good colleague engagement, morale and inclusion.	✓					Chief People Officer	People and Culture Committee	
SR07	If services don't optimally deploy and utilise their people, using effective rostering, then there will be a continued increase in temporary staffing costs and risk of reducing consistency and quality of care delivery.		✓				Chief People Officer	People and Culture Committee	
SR08	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.		✓				Director of Transformation, Productivity & Improvement	Finance and Performance Committee	

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SR09	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.		✓				Chief Information Officer	Finance and Performance Committee	
SR10	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.		✓				Chief Finance Officer	Finance and Performance Committee	
SR11	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.		✓				Chief Finance Officer	Finance and Performance Committee	
SR12	If the Trust does not have robust & effective governance, risk & compliance processes in place, then it will not comply with NHS licencing conditions, CQC, NHSE regulatory & Code of Governance requirements. Resulting in the Trust breaching licence conditions.					✓	Director of Nursing, Professions and Care Standards	Audit Committee	
SR13	If the Trust does not work together with partners strategically, as Lead/Host Provider for relevant services, then opportunities will be lost to maximise improved service delivery for the population, including efficiencies. Resulting in poorer outcomes and experiences for communities, continuation of health inequality, lack of improvement and financial efficiencies, and reputational damage for the Place.				✓		Chief Executive	Board of Directors	

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Strategic Objective	1. Best Quality Services					Risk appetite			
Strategic Risk						Quality - Seek			
						Assuring Committee	Quality & Safety Committee		
If pressure on workforce increases, then it could impact on the quality of care to patients resulting in poorer patient experience and outcomes.						Executive lead	Phil Hubbard, Director of Nursing, Care Standards & Professions		
Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6			
	Low								
Contributory risks from the directorate risk register				Risk Score					
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1 (end of May)	Period 2 (end of July)	Period 3 (end of September)	Period 4 (end of November)	Period 5 (end of January)	Period 6 (end of March)
			Risk and Compliance						
Executive Lead Narrative: Date:									
Key controls in place		Assurance that controls are effective			Date				
Ref	The main controls/systems in place to manage principle risks	Sources of assurance that demonstrate the controls are effective			Date of assurance				
SR01.000	<ul style="list-style-type: none"> <li>•Good compliance with mandatory and essential training</li> <li>•Quality Strategy approved by the Board</li> <li>•Professionals strategy</li> <li>•BDCFT Trust Strategy</li> <li>•NHS England » Patient Safety Incident Response Framework</li> <li>•Being Open Policy</li> <li>•NHSE Safeguarding Assurance Framework Developing-workforce-safeguards</li> <li>•NHS England » National Quality Board guidance on Safe Staffing</li> <li>•Recruitment plan and schedule for newly qualified nurse, and HCSW Recruitment via recruitment centers</li> <li>•EQIA process and panel</li> <li>•Revised Clinical Governance, Quality and Safety Group</li> <li>•Quality assurance framework</li> </ul>	<ul style="list-style-type: none"> <li>•Safer Staffing Annual and Board Assurance Reports</li> <li>•Quality Board and Quality &amp; Safety Committee reports triangulating staffing, incidents and patient experience</li> <li>•Quality assurance Framework (QAF) reviews and responsive assessments in pressured services</li> <li>•Performance &amp; Intelligence via Daily lean management</li> <li>•Incident trends (PSIRF),</li> <li>•complaints and</li> <li>•Friends &amp; Family Test data</li> <li>•Workforce metrics: vacancies, sickness, turnover, agency usage</li> <li>•Risk Register</li> <li>•IPR</li> <li>•Bi Annual safer staffing paper</li> </ul>							
Significant gaps in controls									
Ref	The main areas of weakness which result in ineffective or absent controls								
SR01.001	Quality strategy due for ratification June 2026								
SR01.002	Target for mandatory and statutory not met in month. For monthly review.								
SR01.003	BDCFT Trust strategy currently under review								
Significant gaps in assurance									
Ref	The main areas of weakness which result in ineffective or absent assurances								
SR01.004	Compliance NHSE Workforce Safeguards, gap analysis								
SR01.005	Review of patient safety learning process in line with PSIRF implementation								
Mitigating actions underway for controls and assurance:									
Ref	Actions required to mitigate weaknesses			Lead		Target Date		Progress	

SR01.006	Complete the NHSE Workforce Safeguards gap analysis and deliver the associated action plan, aligned to the forthcoming NHSE safer staffing audit.	Phillipa Hubbard	2.4.2026	Annual review by NHSE undertaken with assurance on system and processes in place, including governance arrangements, public transparency workforce data, reporting and
SR01.007	Progress the Quality Strategy to formal ratification by June 2026 and implement a structured communication and embedding plan across clinical services.	Christopher Dixon and Phillipa Hubbard	30.6.2026	work with professional councils being undertaken to review the professional strategy and incorporate performance metrics. Engagement with all professionals and is currently being reviewed within
SR01.008	Ensure the refreshed BDCFT Trust Strategy explicitly reflects workforce sustainability, safer staffing, staff wellbeing and quality impact during periods of increased demand	Phillipa Hubbard	Jul-26	I will be responsible for ensuring clear lines of accountability and metrics within the BDCFT Trust Strategy in reflection of workforce sustainability, pipelines and safer staffing including the well being of support services to
SR01.009	Review and strengthen patient safety learning process in line with PSIRF implementation, ensuring learning from incidents related to staffing pressure is consistently captured, shared and acted upon.	Phillipa Hubbard	Jun-26	The current ToR for the patient safety and learning group are being updated this will include the refresh of the patient safety strategy which was completed in January 2026 and ensuring there is clear evidence of safer staffing measures which are monitored through daily DLM, Safer staffing group, deep
SR01.010	Further embed triangulation of workforce metrics (vacancies, sickness, turnover, agency usage) with patient safety, compliance and experience data through Quality and Safety Committee reporting	Phillipa Hubbard	May-26	Bi annual review of safer staffing assurance which incorporates, recruitment, management/deployment of staff vacancies, complaints these are presented to board and
SR01.011	Use QAF reviews and responsive assessments to identify services under sustained pressure and implement time limited improvement and workforce support plans.	Phillipa Hubbard	continuous	Annual review of Quality Assurance Framework in line with CQC oversight Framework a plan is developed and adapted dependent on identified risk within services, increase in patient safety incidents/clinical incidents and staff experience

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<b>Strategic Objective</b>		<b>Best Quality Services</b>				<b>Risk appetite</b>			
						<b>Quality - Seek</b>			
		<b>Strategic Risk</b>				<b>Assuring Committee</b>	Quality and Safety Committee		
		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.				<b>Executive lead</b>	Kelly Barker, Chief Operating Officer		
<b>Assurance rating (bi-monthly) (low; limited; significant; high)</b>	<b>Period 1</b>	<b>Period 2</b>	<b>Period 3</b>	<b>Period 4</b>	<b>Period 5</b>	<b>Period 6</b>			
	Low								
<b>Contributory risks from the directorate risk register</b>					<b>Risk Score</b>				
<b>Safeguard Ref</b>	<b>Description</b>	<b>Risk Lead / responsible director</b>	<b>Overseeing group</b>	<b>Period 1 (end of May)</b>	<b>Period 2 (end of July)</b>	<b>Period 3 (end of September)</b>	<b>Period 4 (end of November)</b>	<b>Period 5 (end of January)</b>	<b>Period 6 (end of March)</b>
N/A	N/A	N/A	N/A	N/A					
<b>Executive Lead Narrative: Kelly Barker</b> Date: 30 April 2026		The assurance rating for SR02 remains Limited. While strong foundations are now in place – including a named Executive Lead, developing Health Equity Strategy, PCREF delivery, population health data, and a commitment to increasing visibility through the IPR – the Trust cannot yet consistently demonstrate and evidence measurable improvements in equity of access, experience and outcomes across all services. Key gaps remain in service-level ownership, data completeness and data quality, and the translation of population health insight into sustained, outcome-based improvement. A clear programme of work is underway, aligned to the Trust Strategy refresh, to strengthen governance, data quality, committee accountability and co-production, but it is too early for the Board to rely on evidence of impact. Limited assurance therefore appropriately reflects the current stage of maturity and trajectory of delivery.							
<b>Key controls in place</b>			<b>Assurance that controls are effective</b>			<b>Date</b>			
<b>Ref</b>	The main controls/systems in place to manage principle risks		Sources of assurance that demonstrate the controls are effective			Date of assurance			

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SR02.001	<ul style="list-style-type: none"> <li>Developing Health Equity Strategy &amp; Health Equity Ctt/Board</li> <li>Named Executive for health equity</li> <li>Development of population health management data (including deprivation, ethnicity, protected characteristics)</li> <li>Engagement and co-production approaches</li> <li>Workforce Equality, Diversity and Inclusion (EDI) strategy and Workforce Race Equality Standard (WRES) actions</li> <li>PCREF Organisational Plan</li> <li>Clinical audit and quality improvement programmes focused on unwarranted variation</li> <li>Safeguarding, inclusion health and personalised care policies</li> </ul>	<p>1st line:</p> <ul style="list-style-type: none"> <li>Health Equity Strategy and Inequalities delivery plan progress reports</li> <li>IPR &amp; Service-level dashboards showing access, experience and outcome metrics by population group</li> <li>Quality Improvement projects/programmes updates focused on equity</li> <li>Community engagement feedback and lived experience insight</li> </ul> <p>2nd line:</p> <ul style="list-style-type: none"> <li>Quality Safety Committee reports on health equity and unwarranted variation</li> <li>People Committee oversight of WRES, WDES and staff inclusion indicators</li> <li>Internal policy compliance reviews</li> </ul> <p>3rd line:</p> <ul style="list-style-type: none"> <li>Internal Audit reviews of health equity governance and data quality</li> <li>External regulatory feedback (CQC, NHS England)</li> <li>Benchmarking against peer Trusts</li> </ul>	
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Significant gaps in controls	
Ref	The main areas of weakness which result in ineffective or absent controls
SR02.002	Inconsistent translation of population data into
SR02.003	Variable ownership and accountability at service level
SR02.004	Limited capacity and capability in population health data management and analytics to link to health inequalities improvement methodologies and programmes
SR02.005	Inconsistent engagement with underserved communities and groups across pathways
SR02.006	Insufficient alignment between workforce EDI actions and patient equity outcomes
Significant gaps in assurance	
Ref	The main areas of weakness which result in ineffective or absent assurances
SR02.007	Variable quality and consistency of data on
SR02.008	Validation of tangible impacts – outcomes vs activity
SR02.009	Length of time between interventions and measurable population level outcomes being achieved

Mitigating actions underway for controls and assurance:				
Ref	Actions required to mitigate weaknesses	Lead	Target Date	Progress
SR02.010	Set up BDCFT Health Equity Board & Strategy working Group	Kelly Barker	jul-26	Aligning into BDCFT Strategy Refresh which is on track for completion July 2026.
SR02.011	Develop BDCFT wide Health Equity Delivery Plan with clear outcomes and milestones	Kelly Barker	sep-26	Work carried out across 25/26 in relation to developing Health Equity Strategy and delivery plan completed. Aligning its deployment into BDCFT Strategy Refresh and development of Organisational

SR02.012	Embed health equity metrics within IPR corporate and service-level performance frameworks	Farhan Rafiq	sep-26	IPR development underway. Board development session held in April 2026 looking at refreshed IPR to include specific focus on health equity. Operational level data now drillable into health equity domains within mental
SR02.013	Improve data quality and completeness for protected characteristics	Farhan Rafiq	mar-27	Baselining current data completeness compliance to agree month of month trajectories of impvment and associated improvement activity delivery
SR02.014	Each Committee to agree one health equity measure & outcome it wants to focus on – understanding the data, Root Cause and achievable action (Do one thing)	Kelly Barker with committee chairs	sep-26	Links to actions 010, 011, 012 - discussion with each committee chair will be tabled alongside the Stratgey refresh and IPR to identify the health equity focus measure and outcomes
SR02.015	Build organisational capability in health equity and improvement	Kelly Barker	nov-26	Links to actions 010, 011, 012 - as part of the delivery plan an organisational capability assessment will be completed to understand the development plan needed cross organisation and more targeted where we identify areda if focus
SR02.016	Strengthen community co-production and lived experience assurance	Phillipa Hubbard	mar-27	Co Production Strategy is being re written and out to consultation. Once launched there will be measurables out puts and outcomes aligned to the strategy to improve co production and lthe voice of
SR02.017	Align workforce EDI actions more explicitly to patient outcomes	Lisa Wright	des-26	Kelly Barker & Lisa Wright are meeting during June and July to map current workforce data and identify opportunities to show via data and dashbaord reports with insights how equity imprvment correlate with improved patient outcomes and expereince. Also link to PCREF and
SR02.018	Commission targeted internal audit or deep dive reviews where risk is highest	Kelly Barker	mar-26	By end of Q4 a schedule of audit topics linked to the risk will be agreed based on the work of committees driven by actions

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Strategic Objective	Best Quality Services					Risk appetite			
Strategic Risk							Quality - Seek		
							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.		
Executive lead	Sal Uka, Chief Medical Officer								
Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6			
	Significant								
Contributory risks from the directorate risk register				Risk Score					
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1 (end of May)	Period 2 (end of July)	Period 3 (end of September)	Period 4 (end of November)	Period 5 (end of January)	Period 6 (end of March)
N/A	N/A	N/A	N/A	N/A					
<b>Executive Lead Narrative: Sal Uka</b> <b>Date: 30 April 2026</b>		<ul style="list-style-type: none"> <li>•A Tribunal Training Day will be delivered to 35 multi-professional colleagues on 13 May 2026. Pending evaluation this can be repeated on a regular basis to ensure that all colleagues involved in tribunals are able to keep up to date.</li> <li>•A deep dive into Mental Health Act legislative reforms has been planned for MHLC in May. This will include a review of the current act, proposed changes and timescale, planning and readiness for these, and an assessment of future risk. This will be followed by a Board Development session on the Mental Health Act with contributions from external agencies such as the CQC and local authority.</li> <li>•The MHA Code of Practice review is anticipated to take place across 2026-27 although exact dates for this remain unknown.</li> <li>•Local authority representation to the MHLC remains a gap in control pending the appointment of an interim Director of Adult Social Care. The Chief Operating Officer continues to engage with colleagues with the local authority about current and future MHA joint working.</li> <li>•Further work is still required to ensure timely and high-quality reports to MHA reviews and tribunals. Again, this remains a gap in controls. It is proposed that the MHLC receive an update on this by the end of Q2.</li> <li>•No new risks or mitigations in controls are noted</li> </ul>							
Key controls in place		Assurance that controls are effective				Date			
Ref	The main controls/systems in place to manage principle risks	Sources of assurance that demonstrate the controls are effective				Date of assurance			
SR03.000	<ul style="list-style-type: none"> <li>•MHA and MCA training compliance</li> <li>•Purposeful and Productive group</li> <li>•Hospital Managers recruitment strategy</li> <li>•Patient Advocates as members of MHLC</li> </ul>	<ul style="list-style-type: none"> <li>•MH performance report includes data with supporting narrative on MHS and MCA training as well as a range of metrics specific to the MHA. This reports to every MHLC meeting.</li> <li>•Hospital Managers bimonthly report.</li> <li>•PCREF reporting</li> <li>•Purposeful and Productive group</li> </ul>							
<b>Significant gaps in controls</b>									

Ref	<i>The main areas of weakness which result in ineffective or absent controls</i>
SR03.001	Local Authority representation at MHLC
<b>Significant gaps in assurance</b>	
Ref	<i>The main areas of weakness which result in ineffective or absent assurances</i>
SR03.002	Cancelled or delayed tribunals
	Late reports
SR03.003	
	Inadequate preparation and/or presentation skills at MH panels
SR03.004	

<b>Mitigating actions underway for controls and assurance:</b>				
Ref	<i>Actions required to mitigate weaknesses</i>	<i>Lead</i>	<i>Target Date</i>	<i>Progress</i>
SR03.005	Revised report submission data by staff group including Local Authority			
SR03.006	Revised training offer for all staff with targeted sessions for Responsible Clinicians			

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<b>Strategic Objective</b>	<b>Best place to work</b>					<b>Risk appetite</b>		
						<b>People - Seek</b>		
<b>Strategic Risk</b>							<b>Assuring Committee</b>	People and Culture Committee
If services don't optimise the opportunity to actively recruit to vacant posts, then there may be a negative impact on colleague morale, wellbeing and culture.							<b>Executive lead</b>	Bob Champion, Chief People Officer
<b>Assurance rating (bi-monthly) (low; limited; significant; high)</b>	<b>Period 1</b>	<b>Period 2</b>	<b>Period 3</b>	<b>Period 4</b>	<b>Period 5</b>	<b>Period 6</b>		
	Low							

<b>Contributory risks from the directorate risk register</b>				<b>Risk Score</b>					
<b>Safeguard Ref</b>	<b>Description</b>	<b>Risk Lead / responsible director</b>	<b>Overseeing group</b>	<b>Period 1 (end of May)</b>	<b>Period 2 (end of July)</b>	<b>Period 3 (end of September)</b>	<b>Period 4 (end of November)</b>	<b>Period 5 (end of January)</b>	<b>Period 6 (end of March)</b>
	Failure to recruit to vacant posts in a timely manner introduces risk of increased costs for temporary replacements and loss of business continuity in services where cover is not established.	Bob Champion	People & Culture Committee and Safer Staffing Group	Limited					

**Executive Lead Narrative:**  
**Date:** This is a novel approach and will take some time to bed in, so is very much work in progress and will be iterative in nature.

<b>Key controls in place</b>		<b>Assurance that controls are effective</b>	<b>Date</b>
<b>Ref</b>	<i>The main controls/systems in place to manage principle risks</i>	<i>Sources of assurance that demonstrate the controls are effective</i>	<i>Date of assurance</i>
SR04.000	Assess management skills in recruitment and selection process and actions Implement streamlined end to end processes Ensure optimisation of induction and onboarding	Provision of coaching and training Migration to "ESR2" Streamline processes Implement generic JDs	Coaching etc - 30/09/26; ESR 2 - 01/04/27; Streamlining - 30/09/26; Generic JDs - 30/06/26

<b>Significant gaps in controls</b>	
<b>Ref</b>	<i>The main areas of weakness which result in ineffective or absent controls</i>
SR04.001	Understanding of policy and practices
SR04.002	Understanding of system (TRAC) usage
SR04.003	Understanding of vacancy and turnover data
SR04.004	Understanding of workforce approval process
SR04.005	Outdated job descriptions
<b>Significant gaps in assurance</b>	
<b>Ref</b>	<i>The main areas of weakness which result in ineffective or absent assurances</i>
SR04.006	Management capacity to attend training
SR04.007	Delays in roll out of "ESR2"

SR04.008 Lack of engagement with principles of generic JDs

Mitigating actions underway for controls and assurance:				
Ref	Actions required to mitigate weaknesses	Lead	Target Date	Progress
SR04.009	Include in TNA for SR04	Bob Champion/Michelle Holland	30.09.2026	NTR
SR04.010	Support and invest in adherence to timetable for "ESR2" roll out	Bob Champion/Michelle Holland	31.03.2027	NTR
SR04.011	EMT support for generic JDs			

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<b>Strategic Objective</b>	<b>Best place to work</b>					<b>Risk appetite</b>		
						<b>People - Seek</b>		
<b>Strategic Risk</b>							<b>Assuring Committee</b>	People and Culture Committee
In the context of current and impending financial challenges, if management capability, capacity & competence isn't 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.							<b>Executive lead</b>	Bob Champion, Chief People Officer
<b>Assurance rating (bi-monthly) (low; limited; significant; high)</b>	<b>Period 1</b>	<b>Period 2</b>	<b>Period 3</b>	<b>Period 4</b>	<b>Period 5</b>	<b>Period 6</b>		
	Low							

<b>Contributory risks from the directorate risk register</b>				<b>Risk Score</b>					
<b>Safeguard Ref</b>	<b>Description</b>	<b>Risk Lead / responsible director</b>	<b>Overseeing group</b>	<b>Period 1 (end of May)</b>	<b>Period 2 (end of July)</b>	<b>Period 3 (end of September)</b>	<b>Period 4 (end of November)</b>	<b>Period 5 (end of January)</b>	<b>Period 6 (end of March)</b>
	Ineffective leadership will result in poor management practices and a negative impact on productivity, morale and colleague engagement.	Bob Champion	People & Culture Committee	Limited					

**Executive Lead Narrative:**  
**Date:** This is a novel approach and will take some time to bed in, so is very much work in progress and will be iterative in nature.

<b>Key controls in place</b>		<b>Assurance that controls are effective</b>	<b>Date</b>
<b>Ref</b>	<i>The main controls/systems in place to manage principle risks</i>	<i>Sources of assurance that demonstrate the controls are effective</i>	<i>Date of assurance</i>
SR05.000	Management skills training needs analysis Management job descriptions and job plan review Assess environmental fitness for purpose	Previous management skills TNA template available Ongoing work to review JDs Liaison with E&F to establish fit for purpose premises Review work plans of managers to establish protected time to manage	TNA etc - 30/09/26; JD Review - 31/12/26; Premises review - 31/03/27; Manager plans - 30/09/26

<b>Significant gaps in controls</b>	
<b>Ref</b>	<i>The main areas of weakness which result in ineffective or absent controls</i>
SR05.001	Capacity to undertake audit
SR05.002	Inconsistent availability and content of job descriptions and objectives
SR05.003	Restrictions imposed by shape, size and condition of estate

<b>Significant gaps in assurance</b>	
<b>Ref</b>	<i>The main areas of weakness which result in ineffective or absent assurances</i>
SR05.004	Management engagement
SR05.005	Balance between clinical practice and management time
SR05.006	Onerous admin tasks

**Mitigating actions underway for controls and assurance:**

Ref	Actions required to mitigate weaknesses	Lead	Target Date	Progress
SR05.007	Review and refresh TNA template	Bob Champion/Michelle Holland	30.09.2026	NTR
SR05.008	Audit manager JDs for fitness for purpose	Michelle Holland	31.12.2026	NTR
SR05.009	Streamline transactional processes and tasks	Michelle Holland	30.09.2026	NTR

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<b>Strategic Objective</b>	<b>Best place to work</b>					<b>Risk appetite</b>		
						<b>People - Seek</b>		
<b>Strategic Risk</b>							<b>Assuring Committee</b>	People and Culture Committee
If the organisation continues to focus on productivity and financial performance measures, then there may be a threat to organisational culture, which could change from the current level of good colleague engagement, morale and inclusion.							<b>Executive lead</b>	Bob Champion, Chief People Officer
<b>Assurance rating (bi-monthly) (low; limited; significant; high)</b>	<b>Period 1</b>	<b>Period 2</b>	<b>Period 3</b>	<b>Period 4</b>	<b>Period 5</b>	<b>Period 6</b>		
	Low							

Contributory risks from the directorate risk register				Risk Score					
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1 (end of May)	Period 2 (end of July)	Period 3 (end of September)	Period 4 (end of November)	Period 5 (end of January)	Period 6 (end of March)
	Too much focus on finance rather than workforce wellbeing and positive colleague experience in the workplace can disengage colleagues.	Bob Champion	People & Culture Committee	Limited					

**Executive Lead Narrative:**  
Date: This is a novel approach and will take some time to bed in, so is very much work in progress and will be iterative in nature.

Key controls in place		Assurance that controls are effective	Date
Ref	The main controls/systems in place to manage principle risks	Sources of assurance that demonstrate the controls are effective	Date of assurance
SR06.000	Communicate and engage effectively and regularly with staff at all levels Solicit feedback from staff to contribute solutions and inform decision making	Survey workforce to establish views and opinions and audit of current models of communication Adapt style, presentation, content and mechanism to achieve optimal effectiveness Use other survey mechanisms e.g. NSS	

Significant gaps in controls	
Ref	The main areas of weakness which result in ineffective or absent controls
SR06.001	Reach, impact and effectiveness of current internal
SR06.002	Willingness and motivation of employees to engage with providing feedback

Significant gaps in assurance	
Ref	The main areas of weakness which result in ineffective or absent assurances
SR06.002	Appropriate sample size for survey and participation
SR06.003	Availability of appropriate devices on which to access communications
SR06.004	Time within working days to access communications
SR06.005	Appropriate mechanism to facilitate feedback

Mitigating actions underway for controls and assurance:			
Ref	Actions required to mitigate weaknesses	Lead	Target Date
			Progress

SR06.006	Encourage information sharing at team level by managers	Fiona Bray	Complete	Audit complete; recommendations agreed and activity on-going – responses representative of all areas.
SR06.007	Simplify e-Update and Connect landing page	Fiona Bray	30.09.2026	All IC channels are monitored on an on-go
SR06.008	Consider SMS messaging to personal devices	Fiona Bray	31.03.2027	NTR
SR06.009	Optimise Viva	Fiona Bray	30.09.2026	NTR
SR06.010	Optimise Weekly Broadcast medium	Fiona Bray	30.09.2026	NTR
SR06.011	Use bespoke questions in NSS	Naomi Fernandez	31.08.2026	NTR

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<b>Strategic Objective</b>	<b>Best place to work</b>					<b>Risk appetite</b>		
						<b>People - Seek</b>		
<b>Strategic Risk</b>							<b>Assuring Committee</b>	People and Culture Committee
If services don't optimally deploy and utilise their people, using effective rostering, then there will be a continued increase in temporary staffing costs and risk of reducing consistency and quality of care delivery.							<b>Executive lead</b>	Bob Champion, Chief People Officer
<b>Assurance rating (bi-monthly) (low; limited; significant; high)</b>	<b>Period 1</b>	<b>Period 2</b>	<b>Period 3</b>	<b>Period 4</b>	<b>Period 5</b>	<b>Period 6</b>		
	Low							

<b>Contributory risks from the directorate risk register</b>				<b>Risk Score</b>					
<b>Safeguard Ref</b>	<b>Description</b>	<b>Risk Lead / responsible director</b>	<b>Overseeing group</b>	<b>Period 1 (end of May)</b>	<b>Period 2 (end of July)</b>	<b>Period 3 (end of September)</b>	<b>Period 4 (end of November)</b>	<b>Period 5 (end of January)</b>	<b>Period 6 (end of March)</b>
	Ineffective use of resources will maintain employee and worker costs at unsustainably high levels and reduce quality of care.	Bob Champion	People & Culture Committee; Safer Staffing Group	Limited					

**Executive Lead Narrative:**  
**Date:** This is a novel approach and will take some time to bed in, so is very much work in progress and will be iterative in nature.

<b>Key controls in place</b>		<b>Assurance that controls are effective</b>	<b>Date</b>
<b>Ref</b>	<i>The main controls/systems in place to manage principle risks</i>	<i>Sources of assurance that demonstrate the controls are effective</i>	<i>Date of assurance</i>
SR07.000	Complete whole Trust roll out of HealthRoster Train and refresh managers in rostering skills Ensure all contracted hours are rostered for every employee	EMT pledge Oversight through OSPB Maintain funding for current establishment Establish and support rolling management training Implement performance management and accountability	All ongoing

<b>Significant gaps in controls</b>	
<b>Ref</b>	<i>The main areas of weakness which result in ineffective or absent controls</i>
SR07.001	Organisational support (EMT) for whole-Trust roll out
SR07.002	Capacity in WISPA Team to implement and train
SR07.003	Knowledge gap of managers once trained
SR07.004	Improper usage of full functionality
<b>Significant gaps in assurance</b>	
<b>Ref</b>	<i>The main areas of weakness which result in ineffective or absent assurances</i>
SR07.005	Conflicting priorities
SR07.006	Reconciliation of non-cashable productivity gains

SR07.007	Conflict with corporate cost cut demands
SR07.008	Capacity of WISPA and managers to commit to training
SR07.009	Appetite for performance management

<b>Mitigating actions underway for controls and assurance:</b>				
Ref	Actions required to mitigate weaknesses	Lead	Target Date	Progress
SR07.010	EMT reiterate commitment	Bob Champion	31.05.2026	NTR
SR07.011	OSPB retain oversight of rostering roll out	Michelle Holland/Danielle Stephenson	Ongoing	NTR
SR07.012	Maintain current establishment funding	Michelle Holland	30.06.2026	NTR
SR07.013	Develop and establish capacity for training	Michelle Holland/Danielle Stephenson	30.06.2026	NTR
SR07.014	Implement performance framework	Michelle Holland	30.04.2026	NTR

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<b>Strategic Objective</b>		<b>Best use of Resources</b>				<b>Risk appetite</b>				
						<b>Regulatory - Open</b>				
		<b>Strategic Risk</b>				<b>Assuring Committee</b>		Finance and Performance Committee		
		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.				<b>Executive lead</b>		Farhan Rafiq Director of Transformation, Productivity & Improvement		
<b>Assurance rating (bi-monthly) (low; limited; significant; high)</b>		<b>Period 1</b>	<b>Period 2</b>	<b>Period 3</b>	<b>Period 4</b>	<b>Period 5</b>	<b>Period 6</b>			
		Low								
<b>Contributory risks from the directorate risk register</b>						<b>Risk Score</b>				
<b>Safeguard Ref</b>	<b>Description</b>	<b>Risk Lead / responsible director</b>		<b>Overseeing group</b>	<b>Period 1 (end of May)</b>	<b>Period 2 (end of July)</b>	<b>Period 3 (end of September)</b>	<b>Period 4 (end of November)</b>	<b>Period 5 (end of January)</b>	<b>Period 6 (end of March)</b>
2676	FRS/ALPS crisis data recorded on a non-mental-health SystemOne Out of Hours module, not part of the MHSDS extract; risk to accurate capture/reporting of crisis face-to-face activity within 24 hours	Farhan Rafiq		Data Quality Improvement Working Group	Limited					
<b>Executive Lead Narrative:</b> Date:		May 2026 position statement: Limited assurance is recommended for SR08 at the 30 April reporting point. There is clear evidence of progress since January: Data Quality Improvement Working Group governance has strengthened, data quality has been recognised as a strategic risk, monthly enhanced internal NOF reporting has been established, and the crisis response module went live on 2 March 2026. The Trust has also moved from retrospective correction towards more sustainable process redesign, including appointment outcoming improvements, SNOMED/PROMs readiness, and early tracking of proposed 2026/27 NOF metrics. However, assurance remains limited rather than significant because the Trust-wide Data Quality Framework and three-year/12-month delivery plan are still being developed; operational accountability, policy alignment, implementation sequencing, and evidence of sustained impact across services are not yet fully embedded. Immediate priorities are to complete the Data Quality Policy review, finalise the 12-month delivery plan, agree pace/resource requirements, strengthen routine FPC reporting, and confirm the operational risk linkage and assurance route for appointment outcoming, crisis data flows, CYP 104-week waits, paired outcome measures and workforce sickness data quality.								
<b>Key controls in place</b>				<b>Assurance that controls are effective</b>				<b>Date</b>		
<b>Ref</b>	<i>The main controls/systems in place to manage principle risks</i>			<i>Sources of assurance that demonstrate the controls are effective</i>				<i>Date of assurance</i>		

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SR08.000	<ul style="list-style-type: none"> <li>•Performance and finance reporting aligned to national datasets (NOF, reference costs, productivity)</li> <li>•EMT and Finance &amp; Performance Committee triangulation</li> <li>•Internal validation prior to national data submissions</li> </ul> <p>Performance and finance reporting aligned to national datasets, including NOF, reference costs, productivity and National Cost Collection/PLICS. Executive-led Data Quality Improvement Working Group with operational, clinical, digital, BI, finance, workforce and governance representation.</p> <p>Monthly enhanced internal NOF reporting, including current 2025/26 metrics and selected proposed 2026/27 measures, to provide earlier oversight before national publication.</p> <p>Internal validation prior to national data submissions, including pre-MHSDS submission review and discussion of exceptions.</p> <p>Targeted improvement workstreams: crisis face-to-face contact within 24 hours (OF0016), relative difference in costs (OF0086), appointment outcoming, SNOMED coding, paired outcome measures/PROMs, CYP 104-week waits and workforce sickness data quality.</p> <p>Process redesign and mistake-proofing at source, including SystemOne configuration, self-service dashboards, training/e-learning and service coordinator support.</p> <p>Executive oversight through EMT, Finance and Performance Committee, Board cycle and links to OSPB/productivity governance where data quality intersects with productivity and activity-based budgeting.</p> <ul style="list-style-type: none"> <li>•Productivity, CIP and transformation programmes informed by data</li> <li>•Executive oversight through EMT and Board cycle</li> </ul>	<p>1st line: Directorate performance and finance reporting; BI-led validation; MHSDS submission checks; local NOF dashboards; operational review of exceptions; service-level data quality review meetings.</p> <p>2nd line: Data Quality Improvement Working Group scrutiny; EMT oversight of productivity, NOF and finance; Finance and Performance Committee updates; triangulation across activity, finance, workforce and productivity workstreams.</p> <p>3rd line / external: External benchmarking through NOF, Model Health System/Model Hospital, reference costs and National Cost Collection; internal audit/governance review routes where commissioned or scheduled.</p>	6th May 2026
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**Significant gaps in controls**

Ref	The main areas of weakness which result in ineffective or absent controls
SR08.001	Trust-wide Data Quality Framework and Data Quality Policy not yet fully
SR08.002	Variable data quality maturity across services, with differing levels of process discipline, administrative support, clinical engagement and system configuration.
SR08.003	Limited understanding in some areas of the drivers behind poor benchmarking, segmentation and productivity metrics, including how activity, workforce and finance data interact.
SR08.004	Weakness remains in the linkage between data quality improvement, operational accountability, clinical ownership and routine management action.
SR08.005	Inconsistent organisational understanding of national datasets, emerging 2026/27 NOF measures, MHSDS requirements, SNOMED, PROMs and costing/reference cost implications.

**Significant gaps in assurance**

Ref	The main areas of weakness which result in ineffective or absent assurances
SR08.006	Limited assurance that data quality improvement actions are consistently
SR08.007	Evidence of impact on benchmarking, segmentation, productivity and funding assumptions is improving but remains inconsistent and partly dependent on future national publications and metric methodology
SR08.008	Forward-looking assurance for future funding models, activity-based budgeting, monthly productivity measures and emerging 2026/27 NOF metrics remains under development.

**Mitigating actions underway for controls and assurance:**

Ref	Actions required to mitigate weaknesses	Lead	Target Date	Progress
SR08.009	Finalise and implement a Trust-wide Data Quality Framework, supported by a refreshed Data Quality Policy and a three-year strategic view with a practical 12-month delivery plan	Catherine Sunter / Raj Gohri / Operational and Clinical Leads	jun-26	Data quality is agreed as a strategic risk. Three-year strategic view and 12-month delivery plan are being developed; Data Quality Policy review has been requested for DQIWG agenda.
SR08.010	Clarify executive, operational, clinical, digital, BI, finance and workforce accountability for data quality, including hand-off to productivity/activity-based budgeting governance where appropriate.	Catherine Sunter / Anne Marie Dewhirst / Claire Risdon / Raj Gohri / Cliff Springthorpe / Alix Jeavons / Misbah Mahmood / Danielle Stephenson / Tim Rycroft	jul-26	DQIWG governance strengthened and membership expanded. Further work required to formalise ownership, escalation routes and links with OSPB/productivity governance.

SR08.011	Strengthen triangulation across activity, workforce, productivity and finance, including relative difference in costs, appointment outcoming, PLICS/National Cost Collection, sickness data and activity-based budgeting.	Catherine Sunter / Anne Marie Dewhirst / Claire Risdon / Raj Gohri / Cliff Springthorpe / Alix Jeavons / Misbah Mahmood / Danielle Stephenson / Tim Rycroft	jul-26	Monthly enhanced NOF reporting is in place. Further work required to evidence sustained triangulation and translate insight into operational management action.
SR08.012	Routine FPC reporting on data quality risks, assurance, progress against workstreams, impact evidence and strategic risk movement	Farhan Rafiq / Catherine Sunter / Raj Gohri	May 2026 onwards	January and March 2026 FPC updates provided. May SRR reporting should now bring SR08 into the strategic assurance cycle with a clear position statement and assurance rating
SR08.013	Improve organisational understanding of national datasets and benchmarking, including NOF 2026/27 measures, MHSDS, SNOMED, PROMs, productivity and reference cost/National Cost Collection implications.	Catherine Sunter / Raj Gohri / Operational and Clinical Leads	Ongoing through 2026/27 planning cycle	Specific focus areas include crisis 24-hour/possible 4-hour measures, CYP 104-week waits, paired outcome measures and workforce sickness data quality

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Strategic Objective	Best use of Resources					Risk appetite			
<b>Strategic Risk</b>  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.						Regulatory - Open			
						Assuring Committee	Finance and Performance Committee		
						Executive lead	Tim Rycroft, Chief Information Officer		
Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6			
	Limited								
Contributory risks from the directorate risk register				Risk Score					
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1 (end of May)	Period 2 (end of July)	Period 3 (end of September)	Period 4 (end of November)	Period 5 (end of January)	Period 6 (end of March)
	The Digital Services directorate faces ongoing risk relating to reliance on a small number of staff with specialist cyber security, infrastructure, and application knowledge, alongside recruitment and succession challenges. Loss of key personnel would significantly reduce the Trust's ability to prevent, detect, respond to, and recover from a major cyber incident or digital system failure.	Tim Rycroft / CIO	OCIO/IGG	Limited					
<b>Executive Lead Narrative: Tim Rycroft</b> Date: 30/04/2026		Cyber security and digital resilience remain a significant strategic risk given the Trust's dependence on digital services and external system partners. Core cyber controls are in place and operating; however, assurance is currently partial due to variability across legacy systems, privileged access, and third-party suppliers, and a reliance on self-assessment. Targeted actions are underway to strengthen independent validation, improve supplier and legacy system assurance, and shift focus from compliance to control effectiveness. Despite a dynamic threat environment, the overall direction of travel is positive, with increasing confidence expected as assurance maturity improves.							
Key controls in place			Assurance that controls are effective				Date		
Ref	The main controls/systems in place to manage principle risks		Sources of assurance that demonstrate the controls are effective				Date of assurance		
SR09.000	Core cyber controls are in place, including DSPT compliance, MFA, endpoint protection, patching, access controls, supplier assurance, and staff training.		Management reporting via DSPT, cyber dashboards, policy compliance, and internal audit provides assurance on control presence and compliance.						
Significant gaps in controls									
Ref	The main areas of weakness which result in ineffective or absent controls								
SR09.001	Control implementation is inconsistent across legacy								
Significant gaps in assurance									
Ref	The main areas of weakness which result in ineffective or absent assurances								

SR09.002 Assurance relies heavily on self-assessment with		Mitigating actions underway for controls and assurance:		
Ref	Actions required to mitigate weaknesses	Lead	Target Date	Progress
SR09.003	Strengthen independent testing, improve assurance over legacy systems and suppliers, and shift assurance focus from compliance to effectiveness.	TBD	On-going	Pen Test in progress External Audit of the DSPT Completion of DSPT (June 2026)
SR09.004	External threats / International events and proactive actions, as well as reactive response when issues arise	Temitayo	On-going	Regular Threat intelligence briefing through subscribed platforms with NHSE (e.g TISP - Threat Intelligence Sharing Platform, MDE - Microsoft Defender for Endpoints, bi-monthly briefing with Regional Security Lead, CAN Forum, WY Cyber Associates forum - weekly Place
SR09.005	Emerging tech - AI / Data quality assessment	Delphine / Temitayo	On-going	Re-evaluating the Trust data governance and management processes through the reconfiguartion of Microsoft Purview to align with the proposed Trust-wide rollout
SR09.006	System changes internally (e.g. ESR, Copilot) and externally (Cerner at Airedale, Liquid Logic at Bradford Council)	Tim / Delphine		Regular briefing and evaluation through the Digital Steering Group
SR09.007	Cyber strategy / determining risk appetite.	TBD	On-going	Update of the Cyber Strategy on-going to align with current situations
SR09.008	Annual Cyber Resilience Tabletop Exercise	Temitayo	On-going	Annual exercise to test the Trust's Cyber resilience processes and identify gaps to be closed.
SR09.009	Security Awareness Campaigns	Temitayo	On-going	On-going effort to educate colleagues on the importance of ensuring cyber hygiene are maintained.

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Strategic Objective	Best use of Resources					Risk appetite			
Strategic Risk							Financial - Cautious		
							Assuring Committee	Finance and Performance Committee	
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.							Executive lead	Mike Woodhead Chief Finance Officer	
Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6			
	Limited								
Contributory risks from the directorate risk register				Risk Score					
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1 (end of May)	Period 2 (end of July)	Period 3 (end of September)	Period 4 (end of November)	Period 5 (end of January)	Period 6 (end of March)
N/A	N/A	N/A	N/A	N/A					
<b>Executive Lead Narrative: Mike Woodhead</b> Date: 30/04/2026		We have limited assurance because there are under-developed/incomplete implementation plans for significant CIP areas, and we are under-delivering on the Purposeful and Productive pathway (OAP numbers are above target).							
Key controls in place		Assurance that controls are effective			Date				
Ref	The main controls/systems in place to manage principle risks	Sources of assurance that demonstrate the controls are effective			Date of assurance				
SR10.000	Monthly reporting SFIs, SoD and SOs Implementation Plans Management controls Budgets and plans	FPC, Audit and Board meetings OSPB and Pipeline Group EMT and SLTs Internal Audit							
Significant gaps in controls									
Ref	The main areas of weakness which result in ineffective or absent controls								
SR10.001	Incomplete/ under-developed implementation plans								
SR10.002	Gaps in management controls								
Significant gaps in assurance									
Ref	The main areas of weakness which result in ineffective or absent assurances								
SR10.003	Pipeline group not fully effective yet								
SR10.004	OSPB unable to effectively fulfil role in absence of implementation plans								
Mitigating actions underway for controls and assurance:									
Ref	Actions required to mitigate weaknesses	Lead	Target Date	Progress					

SR10.005	Agree full implementation plans by end April			First OSB workshop completed, rest diarised, plan in development
SR10.006	Review and strengthen management controls			Looking at other Trusts to compare controls around vacancies in over-
SR10.007	Review and strengthen performance management framework			Performance management framework under review
SR10.008				
SR10.009				

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Strategic Objective	Best use of Resources					Risk appetite			
<b>Strategic Risk</b>  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.						Financial - Cautious			
						Assuring Committee	Finance and Performance Committee		
						Executive lead	Mike Woodhead Chief Finance Officer		
Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6			
	Low								
Contributory risks from the directorate risk register				Risk Score					
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1 (end of May)	Period 2 (end of July)	Period 3 (end of September)	Period 4 (end of November)	Period 5 (end of January)	Period 6 (end of March)
N/A	N/A	N/A	N/A	N/A					
<b>Executive Lead Narrative: Mike Woodhead</b> Date: 30/04/2026		We have limited assurance because there are under-developed/incomplete implementation plans for significant CIP areas, and we are under-delivering on the Purposeful and Productive pathway (OAP numbers are above target).							
Key controls in place		Assurance that controls are effective			Date				
Ref	The main controls/systems in place to manage principle risks	Sources of assurance that demonstrate the controls are effective			Date of assurance				
SR11.000	Monthly reporting SFIs, SoD and SOs Implementation Plans Management controls Budgets and plans	FPC, Audit and Board meetings OSPB and Pipeline Group EMT and SLTs Internal Audit							
Significant gaps in controls									
Ref	The main areas of weakness which result in ineffective or absent controls								
SR11.001	Incomplete/ under-developed implementation plans								
SR11.002	Gaps in management controls								
Significant gaps in assurance									
Ref	The main areas of weakness which result in ineffective or absent assurances								
SR11.003	Pipeline group not fully effective yet								
SR11.004	OSPB unable to effectively fulfil role in absence of implementation plans								
Mitigating actions underway for controls and assurance:									
Ref	Actions required to mitigate weaknesses		Lead		Target Date		Progress		

SR11.005	Agree full implementation plans by end April			First OSB workshop completed, rest diarised, plan in development
SR11.006	Review and strengthen management controls			Looking at other Trusts to compare controls around vacancies in over-
SR11.007	Review and strengthen performance management framework			Performance management framework under review
SR11.008				
SR11.009				

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Strategic Objective	Good Governance, Effective Oversight and Accountability					Risk appetite			
Strategic Risk	If the Trust does not have robust & effective governance, risk & compliance processes in place, then it will not comply with NHS licencing conditions, CQC, NHSE regulatory & Code of Governance requirements. Resulting in the Trust breaching licence conditions.					Regulatory - Open			
						Assuring Committee	Audit Committee		
						Executive lead	Phil Hubbard, Director of Nursing, Professions & Care Standards		
Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6			
Significant									
Contributory risks from the directorate risk register				Risk Score					
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1 (end of May)	Period 2 (end of July)	Period 3 (end of September)	Period 4 (end of November)	Period 5 (end of January)	Period 6 (end of March)
Executive Lead Narrative: Date:									
Key controls in place		Assurance that controls are effective				Date			
Ref	The main controls/systems in place to manage principle risks	Sources of assurance that demonstrate the controls are effective				Date of assurance			
SR12.000	Compliance & Risk Group Quality Management & Assurance Framework Patient Safety Executive Panel Patient Safety & Learning Group Effectiveness Review process Clinical board & Mandatory Oversight Daily Lean Management Senior Leadership Team meetings Policy & Procedure compliance Annual Governance Report Strategic meetings	Annual Report Annual Governance Statement Quality Account External Audit Internal Audit Well Led external review Well Led Internal Audit BAF/Risk Management Internal Audit Code of Governance Internal Audit CQC assurance reporting CQC engagement meetings Provider Capability Assessment Quality Assurance Programme Deep Dive of Services Go See							
Significant gaps in controls									
Ref	The main areas of weakness which result in ineffective or absent controls								
SR12.001	Representative effectiveness reviews								
SR12.002	Annual process for review of operational quality governance meeting structure								
Significant gaps in assurance									
Ref	The main areas of weakness which result in ineffective or absent assurances								
SR12.003									
SR12.004									
Mitigating actions underway for controls and assurance:									

Ref	Actions required to mitigate weaknesses	Lead	Target Date	Progress
SR12.005	Development of the Audit Committee			Planned progress is continuing to take place, with an update on the actions presented to each meeting. This work is also captured within the Well Led Development Plan
SR12.006	Review of Quality Governance operational structure			A revised Quality Governance structure is in process. This includes a proposal to separate Patient Safety and Learning from Deaths (mortality) reporting up to a revised Executive Panel. In addition, the current Patient Safety Learning Group will have amended TOR to reflect learning from a wider range of sources. Importantly, this group will report into QSG SLT beneath QSC. This will inform the trust's Quality Priorities and the resources required to deliver this through Care Trust Way. Parallel to this the trust's is also developing an approach to its Quality Management System (see below).
SR12.007	Mobilisation of Quality Management System			A Board development session on BDCT's Care Trust Way QMS (Quality Management System) was held on 5 March 2026. The QMS centres on four core components quality planning, quality control, quality improvement, and quality assurance. With support from the Board the Director of Transformation and Head of Transformation will work with colleagues to implement the QMS. This includes a monthly group to oversee implementation with progress

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Strategic Objective	Being the Best Partner					Risk appetite			
Strategic Risk	If the Trust does not work together with partners strategically, as Lead/Host Provider for relevant services, then opportunities will be lost to maximise improved service delivery for the population, including efficiencies. Resulting in poorer outcomes and experiences for communities, continuation of health inequality, lack of improvement and financial efficiencies, and reputational damage for the Place.					Reputation - Seek			
						Assuring Committee	Board of Directors		
						Executive lead	Therese Patten, Chief Executive		
Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6			
Limited									
Contributory risks from the directorate risk register				Risk Score					
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1 (end of May)	Period 2 (end of July)	Period 3 (end of September)	Period 4 (end of November)	Period 5 (end of January)	Period 6 (end of March)
Executive Lead Narrative: Date:									
Key controls in place		Assurance that controls are effective				Date			
Ref	The main controls/systems in place to manage principle risks	Sources of assurance that demonstrate the controls are effective				Date of assurance			
SR13.000	CEO chair Joint Cttee to keep focus on delivery group outputs DOF SRO for internal assurance procure team to support Strategic gateways for board decisions set out Link with IHO pilots, other lead providers to share work Secure legal advice Executive oversight through EMT and board cycle	Place self-assessment tool SRO workplan Board engagement and decision making WY due diligence work PSR process Provider capability rating							
Significant gaps in controls									
Ref	The main areas of weakness which result in ineffective or absent controls								
SR13.001	Due diligence not done								
SR13.002	Understanding of lead-host arrangements								
SR13.003	Not all partners bought in to same vision								
SR13.004	Integrator capacity and capability								
SR13.005	ICB loss of skill in reorganisation								
SR13.006	Trust occupied with delivery in challenged year								
SR13.007	Trust occupied with delivery in challenged year								
SR13.008	Detailed hosting and contractual agreements								

SR13.009	Regular reporting on progress/ delivery
<b>Significant gaps in assurance</b>	
Ref	<i>The main areas of weakness which result in ineffective or absent assurances</i>
SR13.010	Regular reporting (internally to Trust and externally

<b>Mitigating actions underway for controls and assurance:</b>				
Ref	<i>Actions required to mitigate weaknesses</i>	<i>Lead</i>	<i>Target Date</i>	<i>Progress</i>
	SRO stand up due diligence team and develop plan			Initial workplan agreed Regular meetings in train with WY colleagues Due diligence team resourced and about
SR13.011	Schedule board OD time			
SR13.012	Establish EMT focus group			
SR13.013	Schedule board discussions and decision gateways			
SR13.014	Schedule board OD time			

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## Board of Directors

**4 June 2026**

<b>Paper title:</b>	Strategic Risk Assurance Report	<b>Agenda Item 19.0</b>
<b>Presented by:</b>	Fran Stead – Trust Secretary	
<b>Prepared by:</b>	Holly Close, Senior Corporate Governance Officer & Executive Support Manager	
<b>Committees where content has been discussed previously</b>	Mental Health Legislation Committee; Quality & Safety Committee; Finance & Performance Committee, Audit Committee, People & Culture Committee; Board of Directors	
<b>Purpose of the paper</b> Please check <b>ONE</b> box only:	<input checked="" 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 changes to the reporting template and cycle that took place in April 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 changes to the reporting template and cycle that took place in April 2026 alongside confirmed risk appetite levels for 2026. The Committee is asked to be re-assured that this is an iterative process, with all improvements being tracked over the coming months within this report.

It is a requirement for all Trust Boards to ensure there is an effective process in place to identify, understand, address, and monitor risks. This includes the requirement to have a Board Assurance Framework (BAF) that sets out the risks to the strategic plan by bringing together all the relevant information on the strategic risks to the Board being able to deliver the organisation’s objectives.

The report is in place to provide to the Board a key source of evidence that links our Trust strategy to the strategic risks, controls and assurances. It acts as a tool to support internal control. A target risk appetite for each strategic risk will be agreed in May and proposed to the Board held in public, June to be agreed. Tracking of progress will take place throughout the year.

The Audit Committee has a key role in relation to the BAF in providing assurance to the Board that the systems and processes are effective. A Board discussion will take place to consider how the Audit Committee gains assurance from other Board Committees around the identification and scrutiny of strategic risks.

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

<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"/> <b>Yes</b> (please set out in your paper what action has been taken to address this)</p> <p><input checked="" type="checkbox"/> <b>No</b></p>
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Recommendation(s)
<p>The Board of Directors is asked to:</p> <ul style="list-style-type: none"> <li>• note the update provided and the next steps as part of the agreed development work for this area</li> <li>• note the confirmed risk appetite levels for 2026 as agreed at the Board Development Session on 30 April 2026</li> <li>• note the changes to the reporting template and cycle that took place in April 2026</li> <li>• agree the assurance ratings presented as part of the report (including the target assurance rating), which will be presented to the Board held in public</li> <li>• agree any additional actions required to receive further assurance.</li> </ul>

<b>Links to the Strategic Organisational Risk register (SORR)</b>	<p>The work contained with this report links to the following corporate risks as identified in the SORR:</p> <p>Not applicable</p>
<b>Care Quality Commission domains</b> Please check <b><u>ALL</u></b> that apply	<input type="checkbox"/> Safe <span style="margin-left: 150px;"><input type="checkbox"/> Caring</span> <input type="checkbox"/> Effective <span style="margin-left: 130px;"><input checked="" type="checkbox"/> Well-Led</span> <input type="checkbox"/> Responsive
<b>Compliance &amp; regulatory implications</b>	<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"> <li>- Well Led</li> <li>- Provider Licence</li> <li>- NHS Act 2006</li> <li>- Health &amp; Care Act 2022</li> <li>- Trust Constitution</li> <li>- NHS Code of Governance</li> </ul>

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## Board of Directors – 4 June 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.

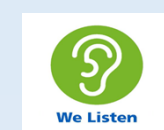
We will do this by supporting people to feel as healthy as they can be at every point in their lives & connecting people to the best quality care when & where they need it to make every contact count.

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 in 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



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

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Better Lives, Together strategy being delivered. A suggested strategic risk on ‘partnership working’ & ‘health equity’ is included for consideration.

During April 2026, changes were made to the reporting template, informed by benchmarking with other NHS Trusts. The revised format now includes a standardised Excel template to support consistency and clarity in reporting. The reporting template now also features bi-monthly reporting.

The template has been enhanced to include expanded and additional fields including an Executive Lead narrative section. This narrative will be used to provide a clear update to the Committee on key changes during the reporting period.

Information relating to gaps in controls and gaps in assurance has been expanded and separated out to allow clearer distinction between each, strengthening transparency and enabling more focused scrutiny. Actions have also been redesigned so that each action is recorded on a single line, allowing actions to be tracked, monitored, and closed more effectively, with new actions added where required.

In addition, a new, improved, and simplified overview sheet has been introduced, providing the Board with a high-level summary to support assurance and decision-making.

### 3.1 Assurance rating

The Strategic Risks will be monitored bimonthly. 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.



### 3.2 Strategic Risks 2026/27

The 2026/27 strategic risks can be found in the below table. This has been presented in its fullest format to support triangulation across the Board Sub-Committees and to inform discussion.

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2026/27									
Risk Ref	Risk Description	Strategic Priority					Executive Lead	Assuring Committee	Target Assurance Rating
		BPW	BUoR	BQS	BP	CG			
SR01	If pressure on workforce increases, then it could impact on the quality of care to patients resulting in poorer patient experience and outcomes.			✓			Director of Nursing, Professions and Care Standards	Quality & Safety Committee	
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.			✓			Chief Operating Officer	Quality & Safety Committee	
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			✓			Chief Medical Officer	Mental Health Legislation Committee	

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	breaches of statutory and regulatory obligations, potential enforcement action resulting in non-compliance, operational disruption, adverse impacts on quality, safety, reputation, and financial sustainability.							
SR04	If services don't optimise the opportunity to actively recruit to vacant posts, then there may be a negative impact on colleague morale, wellbeing and culture.	✓					Chief People Officer	People and Culture Committee
SR05	In the context of current and impending financial challenges, if management capability, capacity & competence isn't 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.	✓					Chief People Officer	People and Culture Committee
SR06	If the organisation continues to focus on productivity and financial performance measures, then there may be a threat to organisational culture, which could change from the current level of good colleague engagement, morale and inclusion.	✓					Chief People Officer	People and Culture Committee

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SR07	If services don't optimally deploy and utilise their people, using effective rostering, then there will be a continued increase in temporary staffing costs and risk of reducing consistency and quality of care delivery.	✓					Chief People Officer	People and Culture Committee	
SR08	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.		✓				Director of Transformation, Productivity & Improvement	Finance and Performance Committee	
SR09	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		✓				Chief Information Officer	Finance and Performance Committee	

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	reporting and financial processes, and compromise data sharing. Consequences may include patient harm, regulatory breach, financial loss, operational disruption, and reputational damage.							
SR10	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.		✓			Chief Finance Officer	Finance and Performance Committee	
SR11	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.		✓			Chief Finance Officer	Finance and Performance Committee	

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SR12	If the Trust does not have robust & effective governance, risk & compliance processes in place, then it will not comply with NHS licencing conditions, CQC, NHSE regulatory & Code of Governance requirements. Resulting in the Trust breaching licence conditions.				✓		Director of Nursing, Professions and Care Standards	Audit Committee	
SR13	If the Trust does not work together with partners strategically, as Lead/Host Provider for relevant services, then opportunities will be lost to maximise improved service delivery for the population, including efficiencies. Resulting in poorer outcomes and experiences for communities, continuation of health inequality, lack of improvement and financial efficiencies, and reputational damage for the Place.			✓			Chief Executive	Board of Directors	

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### 3.3 Strategic Risks 2026/27 for Board of Directors

The 2026 Strategic Risk that the Board of Directors is assurance receiver for can be found in appendix 1.

The Strategic Risk Report has been subject to review by all Board Committees during May 2026. All Committees were satisfied that the Report continued to reflect appropriately the risks to the achievement of the Trust Strategic Ambitions. All Committees were satisfied that the risks were being managed appropriately and received assurance that risks were subject to ongoing active review.

The Audit Committee will review the Report in its entirety at its meeting 18 June 2026 to gain assurance on the robustness of the risk management process. The Committee will be asked then if it is satisfied that appropriate controls are in place reflecting the Trusts approach to risk management and if internal audit planning continued to reflect the key risks and challenges facing the Trust.

## 4 Risk appetite & associate tolerance

The Board uses the Good Governance Institute matrix for risk appetite. A Board Development Session took place in April 2026 facilitated by the Risk Management Team to enable the Board to agree the appetite for the five domains (financial; regulatory; quality; reputation; people). Version one of this matrix, which can be found in Item 03.0 of this Committee agenda was created and there will be a follow-on Board Development Session to develop it further in the coming months.

## 5 Next steps

### Introduction of the Three Lines of Defence (3LoD)

As the Strategic Risk Assurance Report continues to evolve, a clear and consistent Three Lines of Defence (3LoD) model will be introduced to strengthen the Board's oversight of strategic risk and assurance. This will provide a structured approach to risk management and ensure clarity around roles and responsibilities.

- **Level One – Operational oversight:** ownership and management of strategic risks at operational and Executive level, including delivery of mitigating actions and controls.
- **Level Two – Oversight through reports and metrics:** monitoring and scrutiny through Board and Committee reporting, key performance indicators, and assurance mechanisms.
- **Level Three – Independent assurance:** sources of external oversight and scrutiny, including audit, regulators, and external reviews.

The introduction of the 3LoD model will support consistency across strategic risks and provide the Board and Committees with improved visibility of assurance and gaps.

### Future reporting timetable

To support a robust and timely reporting cycle, a clear timetable will be established for future iterations of the Strategic Risk Assurance Report.

### **Approach to data collection and reporting**

Work will continue to review how information is collected and reported for the Strategic Risk Assurance Report. Opportunities to streamline and automate data collection will be explored, with the aim of improving efficiency, reducing duplication, and supporting consistency of reporting across risks and Directorates.

### **Integration with governance and assurance structures**

Further consideration will be given to how the Strategic Risk Assurance Report aligns with existing assurance reporting, including the Integrated Strategic Performance Report (ISPR), and how assurance is escalated through Committees to the Board. This work will reflect feedback from the external Well Led review and support ongoing governance development.

### **Ongoing development and review**

Progress against these actions will be kept under review, with further updates provided to the relevant Committees and the Board. Any agreed changes to process or reporting will be embedded into governance workplans and tracked through existing assurance and development arrangements.

The Board of Directors is asked to:

- note the update provided and the next steps as part of the agreed development work for this area
- note the confirmed risk appetite levels for 2026 as agreed at the Board Development Session on 30 April 2026
- note the changes to the reporting template and cycle that took place in April 2026
- agree the assurance ratings presented as part of the report (including the target assurance rating), which will be presented to the Board held in public
- agree any additional actions required to receive further assurance.

**Holly Close**

**Senior Corporate Governance Officer & Executive Support Manager**

**April 2026**

**Fran Stead**

**Trust Secretary**

**May 2026**

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# Refreshing the BDCFT Strategy

## Leading Better Lives Together

Board of Directors  
June 2026



### Better lives, together



Good governance, effective oversight & accountability



We Care



We Listen



We Deliver

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## What we plan to cover

- The context – key points from the project mandate
- What we have achieved to date
- Approach to engagement
- Timeline for strategy development

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# Our Better Care Together strategy refresh mandate

- A **clear, focused strategic narrative** that is simple, memorable, and guides decision-making
- **Fewer, higher-impact priorities**, with explicit choices about what to stop or do differently
- A strong focus on **measurable outcomes**, the North Star metrics that will tell us if we have achieved what we have set out to do
- **Tighter alignment to the Care Trust Way**, ensuring strategy translates into day-to-day practice
- **Clear line of sight from Board to frontline**, supported by meaningful data, accountability, and continuous improvement
- A **defined system leadership role**, with clarity on how BDCFT contributes to place and partnership priorities, particularly considering the implications of leading the Provider Partnership
- **Better use of finite resources**, ensuring effort is directed where it delivers greatest impact and reduces inequalities



# Working Progress – our plan on a page

## Our Proposed and Refreshed Purpose:

We will work with our communities and partners to improve health, reduce inequalities and deliver safe, high-quality care, by supporting people to stay well for longer, providing accessible care earlier and closer to home, and creating a compassionate, inclusive workplace where our people can thrive.

## Our Proposed and Refreshed Vision:

Healthier lives, fairer outcomes, and thriving communities – delivered together with our partners, closer to home

**Proposed and refreshed strategic priority 1:**  
Our people are supported to be the best they can be

**Proposed and refreshed strategic priority 2:**  
Delivering high quality and safe care

**Proposed and refreshed strategic priority 3:**  
Resources are used in the most impactful and sustainable way

**Proposed and refreshed strategic priority 4:**  
Trusted system leader and partner

**Areas of possible strategic focus:**

- Inclusive, skilled & trauma-informed workforce
- Neighbourhood teams and modern roles
- Reduce admin burden
- improve wellbeing and retention

**Areas of possible strategic focus:**

- Tackle inequalities
- Prevention & early intervention
- Safe, personalised care
- Improve access & flow
- Lived experience & co-production

**Areas of possible strategic focus:**

- Releasing time for care and improving productivity
- financial sustainability
- Digital and data transformation
- Sustainable estate and social value

**Areas of possible strategic focus:**

- Releasing time to care and improving productivity
- financial sustainability
- Digital and data transformation
- Sustainable estate and social value

Delivered in line with Our Values



We Care



We Listen



We Deliver

## How we are engaging

*Engaging with our staff:* Through a structured survey, 3 on-line engagement sessions, available forums such as the leading better lives together forum.

*Engaging with the population we serve:* Through a structured survey sent to our involvement partners and carers champions.

*Engaging with our partners:* Through a structured survey sent to our partners for dissemination through their organisation.

*Engaging with our board:* Through a structured session on the 9<sup>th</sup> July.

Once the initial engagement has closed and an initial strategy drafted 'you said we did' sessions will be held to validate changes made as a result of the feedback



# Roadmap to a refreshed strategy

- **W/C 8<sup>th</sup> June:** Initial engagement window closes
- **W/C 15<sup>th</sup> June:** First draft of the strategy drafted
- **W/C 22<sup>nd</sup> June:** ‘You said we did’ validation sessions
- **9<sup>th</sup> July:** Board engagement session
- **10<sup>th</sup> July:** Final draft strategy produced
- **W/C 20<sup>th</sup> July:** BDCFT Board Sign off
- **August / September:** Strategy Deployment Planning
- **September:** Sign off with council of members



## Effective Oversight: Escalation and Assurance

<b>Report to:</b>	<b>Board of Directors</b>	<b>Meeting date:</b>	
<b>Report from:</b>	<b>Audit Committee</b>	<b>Meeting date:</b>	<b>26 March 2026</b>
<b>Quorate?</b>	<b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/>		
<b>Members present</b>	Chris Malish, Warren Brown		
<b>In attendance</b>	Fran Stead, Francessca Shaw, Leanne Sobratee, Salma Younis, Mike Woodhead, Chris Smith, Lee Swift		
<b>Observers</b>			
<b>Apologies</b>	Apologies were noted from Sally Napper,		
<b>Good Governance</b>	Governance, accountability, and effective oversight		<b>GG</b>
<b>Agenda items</b>	<ul style="list-style-type: none"> <li>• Strategic Narrative Report &amp; Well Led Development Plan</li> <li>• Compliance and Risk Group Terms of Reference</li> <li>• Compliance and Risk Group AAAD Report</li> <li>• Review of Losses &amp; Special Payments</li> <li>• Waiver of Standing Orders &amp; Standing Financial Instructions</li> <li>• Proposed Write Off of Outstanding Debt</li> <li>• External Audit: Interim Audit</li> <li>• External Audit: Audit Plan</li> <li>• Internal Audit: Progress report</li> <li>• Internal Audit: Draft 2026/27 Internal Audit Plan</li> <li>• Internal Audit: Follow Up Report</li> <li>• Local Counter Fraud: Progress Report</li> <li>• Annual Governance Report</li> <li>• Terms of Reference</li> <li>• Notification of Future Meeting dates</li> <li>• Alert, Advise, Assure and Decision Report to Board of Directors</li> </ul>		
<b>Alert items agreed by Committee</b>	<ul style="list-style-type: none"> <li>• The Committee noted that internal audit actions required clearer, time-bound completion dates, particularly where actions had been closed but evidence was still required for verification.</li> <li>• It was highlighted that the Board Assurance Framework had received a limited assurance opinion, which came as an unexpected issue; however, this was now understood and being actively addressed.</li> </ul>		
<b>Advise items agreed by Committee</b>	<ul style="list-style-type: none"> <li>• The Committee advised that further work was required to complete actions arising from the limited assurance opinion on the Board Assurance Framework, to ensure these were fully addressed before year-end.</li> </ul>		

	<ul style="list-style-type: none"> <li>• It was noted that this work was underway and should not have an adverse impact on the Head of Internal Audit Opinion, provided actions were completed as planned.</li> <li>• The Committee emphasised the importance of maintaining momentum on audit actions and evidencing completion, particularly where assurance opinions could affect overall governance conclusions.</li> </ul>
<b>Assure items agreed by Committee</b>	<ul style="list-style-type: none"> <li>• The Committee received the Strategic Assurance Report, including updates on actions taken in respect of the strategic risks and the risk register.</li> <li>• The Well Led Development Plan and process was noted, including agreed improvement work and the Committee was assured</li> <li>• The Organisational Compliance and High Risk Report was received, with assurance noted subject to the requirement for clearer timescales on follow-up actions.</li> <li>• The Review of Losses and Special Payments confirmed that there were no new losses, special payments, waivers of Standing Orders, or proposed write-offs of outstanding debt.</li> <li>• The External Audit interim update confirmed that audit work was progressing in line with plan and that the Value for Money risk assessment identified no significant risks.</li> <li>• The Internal Audit Progress Report confirmed that audit actions were being closed at a reasonable rate and that overall performance remained satisfactory.</li> <li>• The Committee received assurance from Counter Fraud updates, noting appropriate handling of cases and recovery of funds where applicable.</li> <li>• The Committee approved the Annual Governance Report and Terms of Reference, confirming that the Committee had operated in line with its remit.</li> </ul>
<b>Decisions made by Committee</b>	<ul style="list-style-type: none"> <li>• Approved minutes and AAAD</li> <li>• Strategic Narrative Report</li> <li>• Compliance and Risk Group Terms of Reference</li> <li>• Approved the Internal Audit Plan for 2026/27, noting that Executive Directors had been involved in its development and were aware of audit timing and expectations.</li> <li>• Approved the Annual Governance Report and updated Terms of Reference for onward recommendation to the Board.</li> <li>• The Committee noted the Audit Committee Work Plan for 2026/27 for information.</li> </ul>
<b>New risks identified by Committee</b>	<ul style="list-style-type: none"> <li>• No New risks identified</li> </ul>
<b>Feedback following discussion at 'parent' meeting</b>	

<b>Report completed by</b>	Nazmeen Khan – Corporate Governance Officer	<b>Date</b>	<b>26.03.2026</b>
<b>On Behalf of Chair</b>	<b>Chris Malish, Non-Executive Director</b>		

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## Board of Directors

**4 June 2026**

<b>Paper title:</b>	Well Led Development Plan – May 2026	<b>Agenda Item</b>  <b>22.0</b>
<b>Presented by:</b>	Fran Stead, Trust Secretary	
<b>Prepared by:</b>	Fran Stead, Trust Secretary and Corporate Governance team	
<b>Committees where content has been discussed previously</b>	Board Committees; Board of Directors during 2025 & 2026	
<b>Purpose of the paper</b> Please check <b>ONE</b> box only:	<input checked="" type="checkbox"/> For approval	<input type="checkbox"/> For information
	<input checked="" type="checkbox"/> For discussion	

<b>Relationship to the Strategic priorities and Board Assurance Framework (BAF)</b>		
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

<b>Purpose of the report</b>
The purpose of this report is to provide an update as of May 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 third iteration of the report, which includes updates made following feedback received. 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.

Colleagues are reminded that this work has two phases, they are:

- Phase 1: delivery of the originally agreed action
- Phase 2: ensuring the actions are embedded

Both phases will be supported by evidence gathering. All evidence will be presented to the oversight meeting, who will be asked to confirm completion of each phase of the work.

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:

- 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
- consider the evidence presented for those actions that have been listed as complete for phase 1, and agree to close the actions
- consider the and approve any extension requests for actions in phase 1
- note that further updates on phase 2 (embedding) will be presented for all actions

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- note that the full report will be presented to the Audit Committee (June); & Board held in public (July), as outlined above.

<b>Links to the Strategic Organisational Risk register (SORR)</b>	<p>The work contained with this report links to the following corporate risks as identified in the SORR:</p> <p>Not applicable</p>						
<b>Care Quality Commission domains</b> Please check <u><b>ALL</b></u> that apply	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Safe</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Caring</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Effective</td> <td style="border: none;"><input checked="" type="checkbox"/> Well-Led</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Responsive</td> <td style="border: none;"></td> </tr> </table>	<input type="checkbox"/> Safe	<input type="checkbox"/> Caring	<input type="checkbox"/> Effective	<input checked="" type="checkbox"/> Well-Led	<input type="checkbox"/> Responsive	
<input type="checkbox"/> Safe	<input type="checkbox"/> Caring						
<input type="checkbox"/> Effective	<input checked="" type="checkbox"/> Well-Led						
<input type="checkbox"/> Responsive							
<b>Compliance &amp; regulatory implications</b>	<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"> <li>- Well Led</li> <li>- Provider Licence</li> <li>- NHS Act 2006</li> <li>- Health &amp; Care Act 2022</li> <li>- Trust Constitution</li> <li>- NHS Code of Governance</li> <li>- Trust Strategy: Better Lives, Together</li> </ul>						

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## Board of Directors held in public

### Well Led Development Plan – May 2026

#### 1 Purpose

The purpose of this report is to provide an update as of May 2026 on the delivery of the new Well Led Development Plan, & the actions within the Plan that the Board held in public is assurance receiver for.

#### 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.

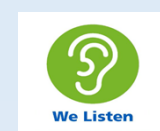
Everything the Trust does during this period will be focused upon making better lives, together.

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 third iteration of the report, which includes updates made following feedback received. As an iterative process, further feedback will be gathered to refine the reporting process throughout 2026. Key changes made include:

- Action leads submitting evidence for completed actions & confirm embedding plans.
- Creation of performance metrics to allow for progress tracking to take place.
- Inclusion of the performance monitoring part that shows the assurance tracking, & progress for each group of actions within each quality statement that relate to this meeting.
- Inclusion of the 4-point assurance ratings for phase 1 of this work (for individual actions, & for the group of actions within each quality statement).

Planned improvements:

- Creation of a process for action leads to schedule any discussion & presenting of evidence to corporate governance meetings.
- Inclusion of any new agreed actions following the 2025/26 effectiveness review recommendations being gathered.
- Planned discussion to take place with the new Chair & Trust Secretary on the Well Led Plan, current process & future improvements.
- Process for presenting plans for phase 2 (embedding) back to oversight group.

#### 5 Assurance rating

The Well Led Development Plan will be monitored bimonthly. They will be scored using the 4 assuring ratings, which will be tracked throughout the year & included within future iterations of the report.

As the work continues to be delivered & evidence provided for each phase, a tracking system will support colleagues understanding how the work for each action & the actions within each quality statement, progressing to 'high' assurance. Colleagues are asked to note that 'high' assurance will be achieved at the end of phase 2 only, to show that evidence has been received for the embedding part. The 4-point assurance ratings are outlined below.



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## 6 Performance monitoring

Below is the new performance monitoring for the actions the Board is the oversight group for:

Quality Statement reference	Quality Statement	Total number of actions in Quality Statement	Number of actions for Board in Quality Statement	Completion performance (phase 1 delivery)	Progress						Comments	
					May	Jul	Sep	Nov	Jan	Mar		
QS1	Shared direction & culture	5	3	0%	Low							2 actions not due yet, 1 action past due date, extension request (QS1.3)
QS2	Capable, compassionate & inclusive leaders	5	3	66%	Limited							2 actions completed for phase 1 (evidence presented May 2026) 1 action requesting extension (QS2.1)
QS3	Freedom to speak up	3	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
QS4	Workforce equality, diversity & inclusion	2	1	100%	Significant							Action completed for phase 1 (evidence presented May 2026)
QS5	Governance, management & sustainability	30	7	30%	Low							2 actions listed as complete (evidence presented May 2026) 1 action not due yet (QS5.7) 4 actions passed due date, extension request (QS5.2; QS5.10; QS5.11; QS5.26)
QS6	Partnerships & communities	5	3	33%	Low							1 action complete (evidence presented April 2026) 1 action not due yet 1 action passed due date, extension request (QS6.3)
QS7	Learning, improvement & innovation	4	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
QS8	Environmental sustainability	3	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

A fuller report on complete progress against the whole Well Led Development Plan will be presented at the July board held in public. This will include performance measures for all Committees, as of May 2026 (Quality & Safety Committee; Mental Health Legislation Committee; People and Culture Committee; Finance and Performance Committee), and as of June 2026 (Audit Committee).

## 7 Progress update: May 2026

Below are the actions within the Plan that are assigned to this Committee, including a progress update.

The table shows the evidence that is included for any actions that have been presented as 'complete' for phase 1. These actions are presented to Committee for approval to close the phase 1 element. The Committee is asked to be re-assured that further updates will be presented here on the phase 2 plans for all actions closed for phase 1. The supporting evidence is appended to this report for the actions listed as 'closed for phase 1'.

Travis Ratchford  
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**Areas to note/action:**

Actions note due yet for phase 1 (no action required at this stage)

- QS1.1
- QS1.4
- QS5.17
- QS6.1

Actions listed as 'complete' for phase 1 (presented to Committee to be **approved** as phase 1 complete)

- QS2.2
- QS2.3
- QS4.2
- QS5.1
- QS5.7
- QS6.4

Overdue actions for phase 1 (**assurance to be received** from delivery leads on progress & timescale for delivery)

None reported

Actions requesting a new delivery date (supported by lead Executive, presented to Committee to be **approved**)

- QS1.3 (Farhan Rafiq)
- QS2.1 (Fran Stead)
- QS5.2 (Fran Stead)
- QS5.10 (Fran Stead)
- QS5.11 (Fran Stead)
- QS5.26 (Fran Stead)
- QS6.3 (Fran Stead)

**Quality Statement 1: Shared direction and 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.

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Ref.	Action	Due	Delivery lead	Board/ EMT lead	Oversight group	Progress	Evidence	Phase 1 assurance rating
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	TBC	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		Limited (action not due yet)
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  (extension request to 31/07/2026)	Clifton Springtorpe	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 highlighted. 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		

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						where a new Integrated Performance Report will be shared for further development and use, ensuring it meets the Board's requirements. <b>EXTENSION REQUEST: to July 2026 when the new version of the ISPQR will be presented as a working draft.</b>		
<b>QS1.4</b>	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	TBC	Board of Directors	This work will be considered as part of the strategy development process, due for completion next Summer.		Limited (action not due yet)

**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

Ref.	Action	Due	Delive ry lead	Board/ EMT lead	Oversight group	Progress	Evidence	Phase 1 assurance rating
<b>QS2.1</b>	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  (extension require 30/08/2026)	Rachel Trawally	Sarah Jones/ Fran Stead	Board Nomination & Remuneration Committee	Following the recent appointment of two new NEDs have been appointed. One started on 19 Jan and the other started on 1 April 2026. The new Chair in Common role commenced on 1 March 2026. Work has started to review the skills matrix and chairs on committees to ensure this aligns with the balance of the updated NED membership. This will be updated after the NED appraisals in May/June. <b>EXTENSION REQUEST: to Sept</b>		

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						2026 due to changes introduced by new Chair in common commencing the role in March.		
QS2.2	Board members should prioritise attendance at Board & committee meetings wherever possible to help discharge personal & corporate responsibilities and liabilities. <b>Committee:</b> 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 and improvements to in-person attendance has been made. It was agreed for April 2026 onwards the new schedule will combine Go See visit on Board in private meeting dates which will support commitment to attend. However following the new Chair in Common, from 1 May Board meetings will be held in person, with the exception of May and Dec which will be online. A full board in person development session will be held in July. Board development sessions have been moved back to board held in private days to reduce meeting times and combine meetings on same day. Two new NEDs recently started and commitment was stressed as part of the interview process and application. Committees will continue as hybrid meetings. The committee schedule was reviewed and presented to Board in April and discussions are being held around expected attendance and feasibility of in person meetings at May NED Appraisals. Going forward any attendance issues will be raised with the Chair at regular governance catch ups to	Committee attendance tracker	Significant (appendix 1)

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						address any issues as they arise. The new Chair in Common is undertaking 121s with all NEDs where the importance of attendance will be highlighted. COMPLETE		
<b>QS2.3</b>	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 has been implemented as part of the new Chair onboarding. As above QS2.2 encouraging improvements have been made to in person attendance. The new Chair has communicated her intention for all Board meetings to be held in person only and this will be progressed from 1 May 2026. Committees will continue as hybrid meetings. COMPLETE	Email of new ways of working sent to all Board members	Significant (appendix 2)

**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

<b>QS4.2</b>	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	Public Sector Equality Duty Report	Significant (appendix 3)
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						<p>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.</p>	
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**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

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Ref.	Action	Due	Deliver lead	Board/ EMT lead	Oversight group	Progress	Evidence	Phase 1 assurance rating
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. The reports are going to each of the sub committees, to Audit Committee and Board.	Well Led Development Plan presented to all Corporate Governance meetings	Significant (evidence already presented to Corporate Governance meetings)
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 Extension required (30/09/2026)	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. <b>EXTENSION REQUEST: work has commenced but has not been completed- September 2026</b>		
QS5.7	The Trust should ensure that the Board retains adequate oversight of the effectiveness of EPRR.	31/01/2026	Chris Wright	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	Report on EPRR processes	Significant (appendix 4)

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						<p>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).</p>		
<p><b>QS5.10</b></p>	<p><b>Committee:</b> an induction would be beneficial for joiners.</p>	<p>31/03/2026</p> <p>Extension require (30/09/2026)</p>	<p>Rachel Trawally</p>	<p>Sarah Jones &amp; Fran Stead</p>	<p>Board of Directors</p>	<p>Following feedback and building on a successful past delivery model, work is taking place to re-set the Induction programme for Board members. On behalf of the Trust Secretary, the DTS is leading this work and it 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. Inductions meetings are also being introduced for new</p>		

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						committee members, and documentation has been drafted for new chairs and being developed for new committee members. <b>Extension request: September to allow time for the work to be finalised and cross referenced with Place</b>		
<b>QS5.1 1</b>	<b>Committee:</b> further work to do on the flow & interaction across Committee's & Board. Formalise Joint Committee.	31/03/2026  Extension require (30/09/2026)	Rachel Trawally	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 have been 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. Joint Committees are not to be a standard committee, and where possible agenda items will be covered as part of Board/Board development. <b>EXTENSION REQUEST: September to include effectiveness review actions in updated plan</b>		
<b>QS5.1 7</b>	<b>Committee &amp; CoG:</b> make the work of the Board & Committees, Governors more visible.	30/09/2026	Rachel Trawally	Sarah Jones & Fran Stead	Board of Directors Council of Governors	Work is currently being undertaken to review and update content on the intranet and external website. Introduced Governance report to Board and CoG, and a Go See report to Board.		Limited (not due yet)
<b>QS5.2 6</b>	<b>IA:</b> The Trust should ensure the Board of Directors Nomination and Remuneration Committee Terms of Reference	31/03/2026  Extension reques	Rachel Trawally	Sarah Jones/ Fran Stead	Board of Directors	Current ToR in place. Review of ToR to be undertaken during 2026. Draft 1 produced, benchmarking taking place during Spring. Final draft to be shared for consultation, scheduled to be		

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document is reviewed and updated, as required.	t (31/07/2026)				approved at Board Nomination & Remuneration Committee, June 2026, & to be ratified by the Board July 2026. <b>Extension request July 2026</b>		
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**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

Ref.	Action	Due	Delivery lead	Board/ EMT lead	Oversight group	Progress	Evidence	Phase 1 assurance rating
QS6.1	The Trust should consider the merits / demerits if 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	TBC	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.		Limited (not due yet)
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  Extension require (30/09/2026)	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		

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						<p>triangulation will take place to consider the various data and experience reporting processes. This process will also be discussed with the new chair. UPDATE: the new chair has moved board development sessions back to private board days when Go See visits were being planned. A presentation is being prepared to go to EMT for discussion on improvements in May 2026 and progress will be updated after this.</p> <p><b>EXTENSION REQUEST: September 2026 in order to introduce the changes once approved by EMT and the Chair/Board</b></p>		
<b>QS6.4</b>	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	<p>Considered as part of the annual effectiveness review process.</p>	Findings of the 2025/26 annual effectiveness reviews – presented to Board April 2026 as part of the Annual Governance Reports	Significant (evidence presented April 2026)

**Next steps**

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

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- agree any actions associated with the work and the above actions
- consider the evidence presented for those actions that have been listed as complete for phase 1, and agree to close the actions
- consider the and approve any extension requests for actions in phase 1
- note that further updates on phase 2 (embedding) will be presented for all actions
- note that the full report will be presented to the Audit Committee (June); & Board held in public (July), as outlined above.

**Fran Stead**  
**Trust Secretary**  
**May 2026**

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**NED attendance 2025-26**

People and Culture Committee

Name	Number of business meetings attended	22 May 2025	17 July 2025	18 September 2025	18 December 2025*	22 January 2026	19 March 2026
Mark Rawcliffe	6/6	√*	√*	√*	√*	√*	√*
Sally Napper	6/6	√	√	√	√	√	√

\*PCC Nov moved to dec re chair late apologies

Finance and Performance Committee

Name	Number of business meetings attended	28 May 2025	23 July 2025	24 September 2025	26 November 2025	28 January 2026	25 March 2026
Maz Ahmed	3/6	√*	√*	Apols	Apols	√*	Apols
Mark Rawcliffe	6/6	√	√	√*	√*	√	√*
Alyson McGregor	1/1	-	-	√	-	-	-
Sally Napper	1/1	-	-	-	-	-	√

Alyson and Sally stepped in to help re quorum

Mental Health Legislation Committee

Name	Number of business meetings attended	22 May 2025	17 July 2025	10 October 2025	20 November 2025	22 January 2026	19 March 2026
Warren Brown		N/A				√	√
Simon Lewis		Apols	√*	√*	√*	N/A	In att
Alyson McGregor		√*	√	Apols	√	√*	√

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Audit Committee

Name	Number of business meetings attended	19 June 2025	23 July 2025	25 September 2025	27 November	29 January 2026	26 March 2026
Simon Lewis	1/6	n/A	n/a	n/a	✓	n/a	n/a
Chris Malish	6/6	✓	✓	✓	✓	✓	✓
Sally Napper	5/6	✓	✓	apols	✓	✓	-
Warren Brown	2/6	N/A	N/A	N/A	N/A	✓	✓

Simon stepped in to help re quorum. NED requirement was increased from 2 to 3

Charitable Funds Committee

Name	Number of business meetings attended	29 October 2025	19 February 2026
Maz Ahmed	0/2	Apols	Apols-
Alyson McGregor	2/2	N/a	✓
Mark Rawcliffe	2/2	~✓*	✓*

Alyson stepped in to help re quorum

Quality and Safety Committee

Name	Number of business meetings attended	21 May 2025	16 July 2025	17 September 2025	19 November 2025	21 January 2026	18 February 2026	18 March 2026
Alyson McGregor	6/7	✓*	✓*	✓*	✓*	-	✓*	✓*
Simon Lewis	1/1	N/A	N/A	N/A	N/A	✓**	N/A	N/A
Sally Napper	4/7	✓	apols	apols	apols	✓*	✓	✓

Simon stepped in to help re quorum

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**Board attendance 2025/26**

Key

X = attended, A=apologies, P = attended part of meeting

Name	No. of mtgs attended	1/5/25 Private	5/6/25 Private and Public	24/7/25 Private and public	2/10/25 private and public	6/11/25 Private	4/12/25 private	15/1/26 Private	5/2/26 Private and Public	5/3/26 Private
Simon Lewis	8/12	X	X, X	A, A	A	X	A	X	X, X	x
Maz Ahmed	2/12* part of one	X	A, P	A, P	A	A	A	A	A, A	A
Sally Napper	9/12	X	A, A	X, X	X	X	A	X	X, X	X
Alyson McGregor	10/12* part of one	X	A, A	X, X	X	X	X	X	A, P	X
Chris Malish	10/12	X	X, X	X, X	A	X	X	A	X, X	X
Mark Rawcliffe	10/12* part of two	X	X, P	P, X	X	X	A	A	X, X	X
Warren Brown	3/3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	X, X	X

Board extraordinary meetings

Name	No. of mtgs attended	26/6/25	16/10/25	22/10/25	13/11/2025
Simon Lewis	3/4	A	X	X	X
Maz Ahmed	1/4	A	A	A	X
Sally Napper	4/4	X	X	X	X
Alyson McGregor	4/4	X	X	X	x
Chris Malish	4/4	X	X	X	X
Mark Rawcliffe	4/4	X	x	x	X

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# Bradford District Care Foundation Trust

## How We Meet the Public Sector Equality Duty Report 2025 - 2026

Equality, Diversity and Inclusion; not just the salt and pepper but the whole meal,  
(Cultural Curiosity Group, July 2021).

For further information on any of the content in this report or to request it in a  
different format please contact [EDI@bdct.nhs.uk](mailto:EDI@bdct.nhs.uk),

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## Introduction

At Bradford District Care Foundation Trust (BDCFT), we aspire to create better lives together through delivering the best quality services, making the best use of resources and by being the best partner and place to work.

There is a proven link between equality and the quality of care. Equality, diversity and inclusion are key strategic priorities that underpin delivery of our goals. Those aspirations need to be experienced by all the diverse Bradford, Airedale and Craven communities and by all our workforce.

Quantitative and qualitative data continues to demonstrate the impact of inequality on quality of life, experience of work and life expectancy. This makes our dedication to furthering equality, increasing diversity and acting inclusively more important than ever.

This report provides a summary of the work undertaken, the equality position and performance over the last year at Bradford District Care Foundation Trust. The report supports compliance with the Equality Act 2010 Public Sector Duties.

Equality performance discussions happen regularly throughout our governance and engagement processes to ensure progress and prioritisation of the work. Much of this information is available to the reader on the Trust website. For more information about any of the information in the report please contact the Equality, Diversity and Inclusion Team on [EDI@bdct.nhs.uk](mailto:EDI@bdct.nhs.uk)



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# Chapter One: Strategic Priorities, Drivers and Reporting

There are many equality, diversity and inclusion strategic drivers and compliance requirements which we work hard to meet throughout the year. These provide the basis to our priorities as an organisation and help us to identify where we are doing well and what we need to improve. A summary of some of those are as follows:



## NHS England's Equality, Diversity and Inclusion Improvement Plan

In June 2023 NHS England published the EDI Improvement Plan. The plan set out six High Impact Actions for NHS organisations to undertake to make improvements in the NHS. These actions are:

### High-impact actions

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

<p><b>Measurable objectives on EDI for Chairs Chief Executives and Board members.</b></p> <p><b>Success metric</b></p> <p>1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).</p>	<p><b>Overhaul recruitment processes and embed talent management processes.</b></p> <p><b>Success metric</b></p> <p>2a. Relative likelihood of staff being appointed from shortlisting across all posts</p> <p>2b. NSS Q on access to career progression and training and development opportunities</p> <p>2c. Improvement in race and disability representation leading to parity</p> <p>2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity</p> <p>2e. Diversity in shortlisted candidates</p> <p>2f. NETS Combined Indicator Score metric on quality of training</p>	<p><b>Eliminate total pay gaps with respect to race, disability and gender.</b></p> <p><b>Success metric</b></p> <p>3a. Improvement in gender, race, and disability pay gap</p>
<p><b>Address Health Inequalities within their workforce.</b></p> <p><b>Success metric</b></p> <p>4a. NSS Q on organisation action on health and wellbeing concerns</p> <p>4b. National Education &amp; Training Survey (NETS) Combined Indicator Score metric on quality of training</p> <p>4c. To be developed in Year 2</p>	<p><b>Comprehensive Induction and onboarding programme for International recruited staff.</b></p> <p><b>Success metric</b></p> <p>5a. NSS Q on belonging for IR staff</p> <p>5b. NSS Q on bullying, harassment from team/line manager for IR staff</p> <p>5c. NETS Combined Indicator Score metric on quality of training IR staff</p>	<p><b>Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.</b></p> <p><b>Success metric</b></p> <p>6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)</p> <p>6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)</p> <p>6c. NETS Bullying &amp; Harassment score metric (NHS professional groups)</p>

In response to these requirements, over the last two year we have:

- Ensured members of our Executive have specific equality objectives within their portfolio.
- Identified Board sponsors to support each of our equality workstreams and our staff networks.

- Reviewed where we are assessing performance and experience information linked to equality in our governance structures and developed plans to enhance that.
- Delivered a comprehensive apprenticeship programme, analysing take up and impact regularly by equality demographics.
- Delivered another cohort of our reciprocal mentoring programme for ethnically diverse staff with plans to expand this to cover more equality protected groups in 2026.
- Maintained representation of ethnically and culturally diverse communities at 8a and above which is equal to the rest of the organisation at 29%.
- Published our Gender, Ethnicity and Disability Pay Gap information.
- Reviewed and continued to implement our Disability Policy and Flexible Working Policy.
- Offered and evaluated a comprehensive wellbeing offer for our workforce and ensured that wellbeing is a feature in our management supervision, appraisal, processes and in our team meeting agendas to give staff every opportunity to discuss how they are.
- Supported international recruits and appointed a specialist People Matters professional to support medical staffing and international recruitment.
- Delivered on our anti-racism framework and our See it, Say it, Stop it campaign for tackling abuse from patients and the public to staff.
- Implemented the Sexual Safety Charter, developed associated policies and procedures to meet the new equality legalisation amendments for employers.
- Launched a revised 'We are compassionate' programme to replace our Kind Life approach.



Our Trust strategy was refreshed in 2023 after comprehensive engagement. **From Ambition to Action** sets out the priorities for the organisation over the next three years. Belonging and Inclusion continue to be at the heart and centre of our ambitions. Being the best place to work and delivering the best quality services is an aspiration for all our staff and to all the patients and carers we meet across all equality protected groups.



## From Ambition to Action

2023-2026 strategy refresh

### Best place to work

We will continue to strive to be a smarter working organization, working together so that everyone is proud to work here, feels they belong and are valued.

#### We will focus on:

- Looking after our people.
- Belonging in our organisation.
- New ways of working and delivering care.
- Growing for the future.

### Making best use of resources

We will deliver effective and sustainable services, considering the environmental impact and social value of everything we do.

#### We will focus on:

- Financial sustainability.
- Our environment and workspaces.
- Giving back to our communities.



### Deliver best quality services

We will consistently deliver good quality, safe and effective services, making every contact count, meeting the needs of our communities, and focusing on reducing health inequalities.

#### We will focus on:

- Improving access and flow.
- Learning and improvement.
- Improving the experience of people who use our services.

### Be the best partner

We will be at the forefront of integration, improvement and innovation, working with partners to deliver services that enable people to live happier, healthier lives.

#### We will focus on:

- Partnership working.

better lives,  
together



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To support our aspirations to be the best place to work and make best use of resources we have been delivering a programme of training that encourages inclusion in our services and teams, enabling our workforce to bring their own lived experience into the way we plan and deliver our services. 356 staff have engaged with the programme taking their learning back into their teams. We have focused on introducing models for valuing difference, giving appreciation and providing constructive feedback to breed a culture of continuous improvement around equality.

We have developed a Health Equity Approach to further support our intention to deliver the best quality services to all; reducing health inequality of access, experience and health outcome experienced by equality protected and inclusion health groups.

### Chief Executive Officers (CEO) Pledge to Equality Diversity

On 21st May 2021 Therese Patten CEO made a Pledge to Equality, Diversity and Inclusion. The Belonging and Inclusion plan aim is to support and bring alive Therese’s pledge and delivery on the strategic objectives to drive, embed and sustain equality, diversity, and inclusion throughout the organisation, improving the staff and patient experience. The pledge continues to drive our equality work across all workstreams.



#### CEO PLEDGE

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

The Trust is striving to be an anti-racist organisation. In 2020 we made a pledge to support our aim. We have reissued this pledge in 2025 to ensure our workforce are aware of our aspirations and what we expect of our people.

#### OUR PLEDGE

Have **conversations** about race and racism. Listen. Challenge racist language as well as actions. Don't be a bystander when something unjust is happening, use your voice to speak out and do your best to help or get help.

Continue to **educate** yourself. None of us ever know everything, so it's important to be open to learning the facts.

Make a **change**. Do something as well as saying something. Small acts do make a difference. Have a think about what you can do in your life and sphere of influence to make positive change

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Reflective spaces continue to be held across the organisation giving people the opportunity to come together and share their feelings, experiences and concerns and to be strong together in the delivery of our anti-racism pledge.

## Public Sector Equality Duty (PSED)

The Equality Act 2010 states that public authorities must comply with the public sector equality duty. This is in addition to their duty to comply with the General Duties of the Act.

The duty aims to ensure public authorities think about things like discrimination and the needs of people who are disadvantaged or suffer inequality, when they make decisions about how they provide their services and implement policies.

The [Public Sector Equality Duty](#) came into force in April 2011.

## Bradford District Care Foundation Trust Equality Objectives

Every four years we publish a set of equality objectives. The Equality Objectives are part of our Public Sector Equality Duties. The Equality Objectives set the priorities for all our Equality, Diversity and Inclusion work. Our current set of objectives are in our Belonging and Inclusion Plan 2024 – 2028.

Strategic Priority	Equality Objective	Focusing on
<b>Workforce Equality</b>		
We will be the <b>best place to work</b> for everyone.	We will identify and address inequality of experience and under-representation within the workforce.	<ul style="list-style-type: none"> <li>The 9 NHS Workforce Race Equality Indicators<sup>i</sup>.</li> </ul>
	We will identify, celebrate and spread good practice.	<ul style="list-style-type: none"> <li>The 3 NHS Bank Workforce Race Equality Standard indicators.<sup>ii</sup></li> </ul>
	We will engage with stakeholders in this work to inform and provide scrutiny of our performance.	<ul style="list-style-type: none"> <li>The 3 Medical Workforce Race Equality Standard indicators.<sup>iii</sup></li> </ul>
		<ul style="list-style-type: none"> <li>Reducing the Trusts Gender Pay Gap, Ethnicity Pay Gap and Disability Pay Gap.</li> </ul>
		<ul style="list-style-type: none"> <li>Going for Gold with the NHS Rainbow Badge Assessment.</li> </ul>
		<ul style="list-style-type: none"> <li>The 13 NHS Workforce Disability Standard indicators<sup>iv</sup>.</li> </ul>
<b>Health Inequalities</b>		
We will deliver the <b>best quality services</b> to all.	We will identify and address inequalities of access, patient experience and health outcomes.	<ul style="list-style-type: none"> <li>The Patient and Carer Race Equality Framework core and local indicators<sup>vi</sup>.</li> </ul>
	We will identify, celebrate and spread good practice within and outside of the Trust.	<ul style="list-style-type: none"> <li>The NHS England Health Inequalities Statutory Duty requirements<sup>vii</sup>.</li> </ul>
	We will engage with stakeholders in this work to inform and provide scrutiny of our performance.	<ul style="list-style-type: none"> <li>Accessible Information Standard.</li> </ul>
		<ul style="list-style-type: none"> <li>The EDS22 Domain 1 indicators.</li> </ul>
		<ul style="list-style-type: none"> <li>Sexual Orientation Mentoring Standard.</li> </ul>
		<ul style="list-style-type: none"> <li>Unicef Baby Friendly Gold Accreditation</li> </ul>

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## Belonging and Inclusion Plan 2021 – 2024

Our Belonging and Inclusion Plan sets the direction of our equality, diversity and inclusion (EDI) ambitions and work. It reflects the Trust's commitment to ensuring that our services are completely equitable, accessible for all and that they are person centred and equipped to meet the individual and diverse needs of the communities that we serve. Belonging and Inclusion is a key element of our Trusts [From Ambition to Action](#).

These strategies are a call to action to our people to view and carry out their roles through an EDI Lens. Additionally, it highlights our workforce aspirations and supports the organisation's strategic priority to promote diversity, belonging and inclusion for all staff and to empower all staff to be leaders within an open culture in line with our values and aspirations for inclusivity and diversity.

Our vision for the plan is threefold:

- To provide the best quality care and meet the individual needs of our service users.
- To have a workforce that fully reflects and understands the communities we serve and has a fair and compassionate culture where everyone feels that they belong, are included, valued and respected and can progress as a unique individual.
- An organisation that:
  - collectively, consistently, and actively works to dismantle inequality wherever it is found and in all its forms.
  - ensures that barriers to progression are identified and addressed and, is an example of best practice.



To view the plan please visit [BDCFT Belonging and Inclusion Plan 2025-2028](#).

## NHS Equality Delivery System 2022 (EDS22)

In 2025 we assessed our equality, delivery and inclusion performance using the NHS England Equality Delivery System 22. More information on this framework can be found here [NHS England » Equality Delivery System 2022](#).

The process provides our BDCFT workforce, voluntary, community, faith and health sector partners, carers and people using our services the opportunity to comment on our equality performance. There are three domains within the EDS22:

- Domain 1 – Provided and Commissioned Services (focusing on access, safety, meeting health needs and patient experience)
- Domain 2 – Workforce Health and Wellbeing
- Domain 3 – Inclusive Leadership

For Domain 1 we focused our 2025 assessment on Suicide Prevention and Early Diagnosis. Three services were selected for analysis. They were Mental Health Intensive Home Treatment, Physical Health and Wellbeing and Palliative Care. A partnership engagement event was held with our Acute Sector and Commissioning partners to approve our draft scores for these services.

Below are links to the full reports of the assessment for those services, plus our scores for the health and wellbeing of our workforce and our leadership in relation to inclusion. A peer review was conducted with our West Yorkshire Mental Health partners to ensure our scoring was on a par with theirs.

EDS Domain	Score
<b>Domain 1: Provided and Commissioned Services</b>	
• Domain 1 <a href="#">Intensive Home Treatment</a>	8
• Domain 1 <a href="#">Palliative Care</a>	11
• Domain 1 <a href="#">Physical Health and Wellbeing</a>	8
Sub-Total	27
<b>Mean Average</b>	<b>8</b>
<b>Domain 2</b> <a href="#">Workforce Health and Wellbeing 2025</a>	8
<b>Domain 3:</b> <a href="#">Inclusive Leadership 2025</a>	6
<b>Total</b>	<b>22 - Achieving</b>

Following the completion of this assessment the Trust was deemed to be ‘achieving’ as defined with the framework. The equality impact assessment findings action plan and engagement summary have been completed and published as evidence. These actions became part of EDI priorities for 2024 / 2025 and will be embedded into our Belonging and Inclusion Work Programme.

We are currently carrying out our 2026/2025 assessment of three new services. The outcome of that assessment will be published in February 2026. To get involved please contact [EDI@bdct.nhs.uk](mailto:EDI@bdct.nhs.uk)

## Chapter Two: The Bradford and Craven Community

### The Populations We Serve – Demographics

BDCFT provides services to Bradford District which in 2021 was estimated to have a resident population of 547,000 an increase of 4,800 since the mid 2020 population estimates. Bradford is the fifth largest population in England. The population density is 4,493 people per square kilometer which is the highest in West Yorkshire.



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51.5% of residents described themselves as female and 48.5% described themselves as male. 91.7% identified with the sex they were registered at birth and 0.1% (547 people) identified as a Trans woman or a Trans man. 0.5% (2735 people) did not specify an identity or chose other gender identities.

Life expectancy at birth is 77.3 years for males and 81.5 years for females. Bradford has a youthful population with 23% of the total population aged under 16 years old the fourth highest young population in England.

32% of Bradford residents identified their ethnic category within the Asian, Asian British or Asian Welsh category up from 27% in 2011. 61% of Bradford residents identified their ethnic group within the White category compared with 67% in 2011. 2.7% identified their ethnic group within the Mixed or Multiple category. 2.0% identified their ethnic group as Other.



There is a wide diversity of ethnic groups living in the Bradford District and as a result over 125 different languages are spoken by its residents. The Trust spends around £350,000 a year on interpreting to support quality care for people using our services and their families. The five most regularly interpreted languages are Urdu, Punjabi, Arabic, Slovakian and Polish.

28% of Bradford residents reported having no religion in the 2021 census. 33% described themselves as Christian a reduction from 46% in 2011 while 31% described themselves as Muslim up from 25% in 2011. Religion and belief is an important identify for many Bradfordians and so features within our care assessments where appropriate being driven by our Spiritual Care Policy. 10% of the Bradford District population shared that they had a disability in the 2021 census. 9% of Bradford residents provide unpaid care for other people.

Bradford has a thriving LGBT+ community. It is estimated that between 5% and 7% of the national population is LGBT+ which equates to approximately 31,350 people in Bradford. 2.3% of the Bradford population identified as Gay, Lesbian, Bisexual or an other sexual orientation. 88.9% of residents identify as straight of heterosexual. The Trust is committed to delivering LGBT+ friendly and competent services.

Craven has a population of 56,900 people. In contrast to Bradford this is the third least densely populated of Yorkshire and Humbers 21 Local Authority areas. The district spreads from a boundary which extends north from Skipton. The average median age of residents has increased from 47 to 50 years of age. 39% of Craven residents reported to have no religion, 54% reported to be Christian, 1.1% identified as Muslim, 0.4% identified as other, 0.2% are Buddhist and Hindu and 0.1% reported to be Jewish. 97% of the Craven population identified as White in the 2021 census. 1.7% identified as Asian, Asian British or Asian Welsh.



56% of the Craven population reported to be Disabled a decrease from 7% in 2011. It is estimated that 7% (3752) people in the Craven community are Lesbian, Gay or Bisexual.

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# Chapter Three: Our People

## People Promise



### Workforce Equality Standards and Reporting Requirements

We monitor the demographic make-up of our workforce and aim to ensure that our workforce reflects the community that we serve at every level of the organisation. Every six months we analyse a workforce demographics report to support our work.

A summary of our most recent analysis from June 2025 provides the following information. The definitions and categorisations are taken from the Electronic Staff Record.

Equality Protected Characteristic	Staff Data Jan – Jun 2024
Gender	79% Women and 21% Men
Disability – reducing the % of staff who leave this category blank has been a top priority for us. It has reduced to 2% in 2025.	86% non-Disabled 12% Disabled
Age	0.1% Aged under 20 16% Aged 21 to 30 25% Aged 31 – 40 28% Aged 41 – 50 23% Aged 51 - 60 8% Aged 61+
Ethnicity	63% White and 34% BME
Sexual Orientation – reducing the % of staff who do not share their sexual orientation has been a big priority for us. This has reduced since 2024 by 2%.	2.09% Lesbian or Gay 1.77% Bisexual 0.62% Other sexual orientation 12% Not Stated 83% Heterosexual or Straight

Religion or belief is also an important factor. The table below reflects the diversity of religion and belief of our people.

	Number	Percentage
Atheism	561	16.50
Buddhism	22	0.65

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	Number	Percentage
Christianity	1267	37.28
Hinduism	35	1.03
Islam	617	18.15
Judaism	<5	0.09
Jainism	<5	0.00
Sikhism	38	1.12
Other	255	7.50
Undisclosed	601	17.68

## NHS Workforce Equality Standards

The NHS has a set of workforce standards and reporting requirements that are aimed to ensure that we are identifying and addressing any inequality, discrimination and good practice that affects our staff. At BDCFT we aim to be the Best Place to Work. We want our workforce to thrive and enjoy coming to work. We want people to feel they can bring their 'whole selves to work' celebrating their diversity in an inclusive environment. The following sections outline what we have been doing to meet our goals.

### NHS Workforce Race Equality Standard 2024



The Workforce Race Equality Standard (WRES) programme was established in 2015. It requires NHS trusts to report against nine indicators of race equality comparing the experiences between White and Black and Minority Ethnic (BME) staff. The WRES programme continues to support improvement driven by data and mandates that NHS trusts produce action plans to tackle the root causes of discrimination.

The WRES uses the term “Black and Minority Ethnic” which is expressed as the acronym BME, to refer to members of the NHS workforce who do not identify as White. This is largely driven by the data collection process. The definitions of “Black and Minority Ethnic” and “White” used have followed the national reporting requirements of ethnic category in the NHS data model and technical guidance and are also used in NHS Digital data. At the time of publication of this guidance, these definitions were based upon the 2021 ONS Census categories for ethnicity. Within our Trust and the Act as One Partnership we have adopted the terminology Ethnically and Culturally Diverse (ECDC) which you may see within our reports.

The data is taken from the 2024 NHS BDCFT Staff Survey and from a snapshot of workforce information on 31<sup>st</sup> March 2025. In the 2025 WRES return there have been improvements across six of the nine metrics, two metrics have stayed static and one has decreased. There are still considerable gaps in the experiences between Black, Asian and Minority Ethnic (BMAE) staff when compared with White staffs experience. The table below presents the 2025 WRES data taken from the Electronic Staff Record on 31<sup>st</sup> March 2025 and People Services records over the reporting period.

WRES Metric No.	Metrics	2024	2025
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce		
	Ethnically diverse staffs representation in the whole workforce	28%	30%
	Ethnically diverse staffs representation 8a and above	29%	29%
	Ethnically diverse staffs representation 8c and above	40%	41%
2	Relative likelihood of staff being appointed from shortlisting across all posts	2.11	1.25
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	2.56	4.08
4	Relative likelihood of staff accessing non-mandatory training and CPD	1.03	1.03
9	Percentage difference between the organisations' Board voting membership and its overall workforce	-16%	-11%

The Trust has equal representation across senior bands when compared with the whole organisation which is an excellent achievement. The impact of the inclusive recruitment project is reflected in the improvement of the inclusive recruitment indicator. NHS England identified BDCFT as a national case study for success in this area in 2022/3. The population of Bradford has changed with the BME population increasing from 36% in 2011 to 43% in 2021 meaning the workforce is still under-representative of the local ethnic diversity.

The likelihood of ethnically diverse staff entering a formal disciplinary process has increased and is a top priority to reduce. A workstream to reduce this score has been established with further analysis of disciplinary data to identify and address the root cause of this over representation.

This table shows the data taken from the 2024 staff survey.

WRES Metric No.	Metrics	2024				2023		2022	
		BDCFT		National Benchmark		White	BME*	White	BME*
		White	BME*	White	BME*				
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	18%	24%	21%	32%	20%	26%	22%	29%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	16%	17%	16%	21%	17%	19%	18%	21%
7	Percentage of staff believing that the organisation provides equal opportunity for career progression and promotion	63%	53%	61%	51%	63%	52%	60%	52%
8	Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	5%	11%	6%	13%	7%	11%	6%	13%

The percentages are green, amber or red depending on how we perform when compared to our 2023 data and the national benchmark.

There has been a 2% reduction in ECDC staff reporting they have been bullied, abused or harassed by staff and patients, relatives or the public. The Trust performs better than the national performance benchmark for these metrics. There is still a 6% gap between White and ECDC staffs experiences of abuse from patients and the public. Reducing the gap is an important priority for us. The Trusts performs better than the benchmark for this indicator

The Trust takes abuse to staff seriously and has a strategic framework for supporting our anti-racist approach to abuse.

## A strategic framework



### Aims:

- To be clear about our zero-tolerance approach and expectations.
- To create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.
- Ensure we have a consistent response and support offer for all staff.

<p><b>1. Policy and Process</b></p> <ul style="list-style-type: none"> <li>• We have an effective policy which is applied consistently.</li> <li>• Teams have an agreed and understood way of responding to abuse which fits within the policy framework.</li> </ul>	<p><b>2. Oversight and Accountability</b></p> <ul style="list-style-type: none"> <li>• We know where abuse is happening within the organisation in real time.</li> <li>• We each know our responsibilities in responding to and reducing abuse and supporting staff who have experienced abuse.</li> </ul>	<p><b>3. Performance and Governance</b></p> <ul style="list-style-type: none"> <li>• We have set targets relating to metric 5 and we monitor progress against these regularly.</li> <li>• Levels of abuse, its impact and the support offer is monitored regularly to provide assurance.</li> </ul>
<p><b>4. Training and awareness</b></p> <ul style="list-style-type: none"> <li>• We have a comprehensive offer of training that support all staff in meeting our aims.</li> <li>• We have an awareness campaign that runs throughout the year.</li> </ul>	<p><b>5. Confidence and Consistency</b></p> <ul style="list-style-type: none"> <li>• We will increase staffs confidence to speak out, report and tackle abuse.</li> <li>• We will ensure consistency across the Trust in how abuse is addressed and staff are supported.</li> </ul>	<p><b>6. Communication</b></p> <ul style="list-style-type: none"> <li>• We will speak openly and regularly about abuse and its impacts.</li> <li>• We will talk about the challenges and solutions in implementing our policy.</li> <li>• We will share our experiences and learning for growth around this agenda.</li> </ul>

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2% more ECDC staff than the national benchmarked average feels the Trust acts fairly regarding career progression and promotion this is a 11% increase since 2019. There is a 10% gap in the perception of White and ECDC staff relating to this metric. The Trust continues to deliver reciprocal mentoring schemes to support career development and organisational intelligence about the active barriers to career progression. We report progress regularly to our People and Culture Committee on the priorities identified in this data.

The full Workforce Race Equality Standard Report and subsequent action plan is available here [Equality and diversity reports - Bradford District Care NHS Foundation Trust](#).

### Medical workforce race equality standard

The [Medical workforce race equality standard \(MWRES\) 2020 report](#) follows the work of the Workforce Race Equality Standard (WRES) with a specific focus on doctors and dental staff measured against eleven indicators.

The report has the following key roles: -

To enable organisations to understand the challenges that exist in the medical workforce, with the aim of encouraging improvement by learning and sharing good practice.

- To provide a national picture of MWRES in practice, to colleagues, NHS organisations, royal colleges and the public on the developments in the workforce race equality agenda.

We are delivering on these national priorities through our work to implement the:

- Act Against Racism Royal College of Psychiatrists Campaign,
- NHS EDI Improvement Plan High Impact Action Five

## Bank Workforce Race Equality Standard

The Trust has a bank of workers who can work across the Trust as and when required. These are valuable and respected resource. Understanding their experiences as a cohort is important.

There are nine metrics in the Bank WRES which provide an over view of the experience and representation of BME staff within the NHS Bank workforce [NHS England » Technical guidance for the Bank Workforce Race Equality Standard \(Bank WRES\)](#).

For the first time in 2024 a Bank NHS Staff Survey was taken. The findings showed significant differences between experiences of ECDC bank staff when compared with White bank staff. It also showed significantly worse experiences than substantive ECDC staff were sharing in the staff survey. The Trust performed better than the national average in two metrics and worse in five. Improving the experiences of bank staff across all metrics is a high priority for 2025.

## NHS Workforce Disability Equality Standard

The NHS Workforce Disability Equality Standard (WDES) programme was established in 2018. It requires NHS trusts to report against thirteen indicators of disability equality comparing the experiences of disabled and non-disabled staff in our workforce. The data is analysed and used to produce actions to tackle the root causes of discrimination and differing experiential outcomes for disabled staff.

The WDES uses the term "disabled", to refer to members of the NHS workforce who identify themselves as having a disability within the annual NHS staff survey or the Trusts Electronic Staff Record (ESR) system. One of our key actions in this work is always to increase the number of staff who feel able to share information with their manager about their health, disability and wellbeing.

WDES Metric No.	Metrics	2025	2024
1	Percentage of staff from AfC paybands or medical and dental subgroups and very senior managers (including Executive Board Members) compared with the percentage of staff in the overall workforce.		
	Percentage of disabled staff in the whole organisation	17%	14%
	Percentage of disabled staff in bands 8a and above	16%	14%

	% difference between an organisation's board voting membership and its overall workforce	<b>2%</b>	4%
<b>2</b>	Relative likelihood of non-disabled applicants compared to disabled applicants being appointed from shortlisting across all posts.	<b>2.08</b>	0.47

The percentages are green, amber or red depending on how we perform when compared to our 2023 data and the national benchmark.

20 staff have entered into a capability from 1<sup>st</sup> April 2024 – 31<sup>st</sup> March 2025. None of those staff entered into the process solely on the ground of ill health.

The table below provides the metric data taken from the BDCFT 2024 Staff Survey.

WDES Metric No.	Metrics	2024				2023	
		BDCFT		National Benchmark		With LTC	Without LTC
		With LTC*	Without LTC	With LTC	Without LTC		
<b>4</b>	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months.	<b>24%</b>	18%	<b>27%</b>	22%	27%	19%
<b>5</b>	Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.	<b>11%</b>	7%	<b>11%</b>	6%	11%	6%
<b>6</b>	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.	<b>16%</b>	11%	<b>19%</b>	11%	20%	11%
<b>7</b>	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	<b>64%</b>	62%	<b>63%</b>	64%	68%	66%
<b>8</b>	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.	<b>57%</b>	62%	<b>55%</b>	61%	56%	61%
<b>9</b>	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	<b>15%</b>	11%	<b>18%</b>	12%	18%	13%
<b>10</b>	Percentage of staff satisfied with the extent to which their organisation values their work.	<b>48%</b>	56%	<b>44%</b>	54%	48%	56%
<b>11</b>	Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.	<b>84%</b>	N/A	<b>80%</b>	N/A	79%	N/A
<b>12</b>	Staff engagement score (0-10)	<b>6.89</b>	7.20	<b>6.74</b>	7.20	6.72	7.20

The number of staff sharing their disability status on ESR has increased significantly to 17% in 2025. The number of disabled staff who are in bands 8a and above is 16%. The percentage difference between the Trusts board voting membership and its overall workforce is 2% a reduction from 4% in 2024.

We have worked hard over the last six years to increase staff confidence to share information about their health, wellbeing and disability status with their line manager and in the electronic staff record.

There has been a 3% reduction in the number of staff with a long-term condition (LTC) saying that they have experienced harassment, abuse or bullying in the last 12 months from patients, relatives and the public (24%). This is a further 3% from 2022. The Trust is performing better than the national benchmark for this metric with 3% less staff at BDCFT responding to say they have experienced harassment, bullying or abuse from patients, carers and the public in the last 12 months. Despite these positive moves in performance there is still a 6% gap between the experiences of staffs with LTC and those without in the 2024 staff survey, that is a reduction in the gap by 2% since 2023.

There has been a 4% reduction since 2023 in the number of staff with LTC saying that they have experienced harassment, abuse or bullying in the last 12 months from other colleagues (16%). The Trust is performing 2% above the average national benchmark (18%). The gap between staff with and without LTC's experience of abuse, bullying and harassment from a colleague has closed from 9% to 5% in the 2024 results.

More disabled staff have shared that they believe the organisation provides equality of opportunities for career progression or promotion increasing from 56% to 57%. The Trust is 2% above the national benchmark.

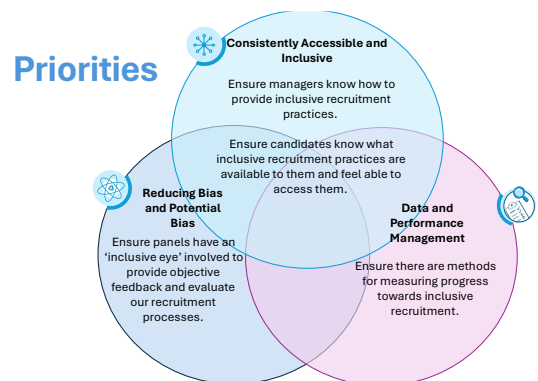
These improvements have been made through consistent implementation of the Disability Policy and development of a suite of training and resources for staff and managers to use to ensure the Disability Policy is effectively implemented.

Despite these improvements there are still gaps in staffs experience in all metrics which need closing.

The Trusts performance has dropped in two metrics; The relative likelihood of a non-disabled applicants being shortlisted when compared with disabled candidates has increased from 0.47 to 2.08.

This is a top priority for improvement and has led to the launch of our Inclusive Recruitment Programme.

The percentage of disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it has also reduced by 4%. We will work with the Freedom to Speak Up team to increase this.



## Gender Pay Gap

The Equality Act 2017 Regulations require organisations with more than 250 staff to publish their Gender Pay Gap (GPG) and Bonus Gender Pay Gap (BGPG) data on the Governments reporting website by 31<sup>st</sup> March annually. There is clear guidance<sup>[1]</sup> on how to carry out the calculations in a way that can be benchmarked nationally. The data is a snapshot of the workforce on 31<sup>st</sup> March from the previous year meaning the data presented here is from 31<sup>st</sup> March 2024.



The mean GPG is 5.62%; The median GPG is -6.11%.

The BGPG is calculated from Clinical Excellence Awards (CEA) within the Trust. A CEA may be awarded to eligible consultants who have at least one year's service and are able to demonstrate that they have made a significant difference above and beyond their role to research and / or delivery of new or innovative ways of working or developing the service. The BGPG is -31.92%. The fluctuations in the BGPG from year to year are due to the small number of staff eligible for the Clinical Excellence Award. The aspiration is that the Trust remains in the top performing quartile of Foundation Trusts. The following is a summary of the actions included in our Board report and Belonging and Inclusion Delivery Plan.

- Increase the use of national pay contracts in place of local pay arrangements for hospital doctors – a Medical Staffing Lead has been recruited as a new resource to support this requirement.
- Promote a flexible working culture to all staff including supporting male staff to work 'less than full time' (LTFT). The Trust has been working with the West Yorkshire Mental Health Collaborative to develop resources that promote and support flexible working with our Trusts. These include a toolkits for managers and colleagues, 'Top Tips', poster campaign and a video - [Flexible working in West Yorkshire](#). These have been launched, shared and are being embedded throughout our communication platforms and policies.
- Talent management and training programmes should be used to develop staff and increase appointment of a more balanced senior workforce, such as Associate Specialist, GP Partners, Professors and Consultants. The Reciprocal Mentoring Programme is about to launch its fourth cohort, and a graduate network has been established. The evaluation shows positive impacts on progression and recruitment for participant progression from bands 5 and 6 into more senior roles. The NHS Equality Delivery System 2022 evaluation process completed in January 2025 looked in detail at representation at bands 8c and above.
- Further analysis is required into the pay gap for qualified nurses.
- Continue to implement retention, re-entering and retraining policies to retain women. New processes have been set in place to reduce attrition and check in with new staff at nine and eighteen months to support retention. Staff turnover targets are in place and monitored at the People and Culture Committee.
- Include the gender, ethnicity and disability pay gap data as part of the NHS Workforce Equality Standard Reporting processes to the Board. The Trust is complying with this and is planning a new programme to report on religion and belief in the future.
- Increase the number of staff completing the personal information relating to disability and ethnicity in the electronic staff record to enable more detailed analysis.

These actions are monitored alongside the Belonging and Inclusion Plan and reported to the People and Culture Committee at least annually. More information about our Gender Pay Gap and subsequent actions can be found here [Equality and diversity reports - Bradford District Care NHS Foundation Trust](#).

<sup>[1]</sup> <https://gender-pay-gap.service.gov.uk/public/assets/pdf/gender-pay-gap-explained.pdf>

## Chapter Four: Best Place to Work

### Key Areas of Activity and Support for our Staff

#### Trust Induction

EDI is weaved throughout the Trust Induction. New staff come together in their first few weeks for a Corporate Induction where they meet our executives and support teams, hear about our policies and procedures, our staff networks and wellbeing offer, they learn about our equality priorities and what they can do to further the equality act within their new role. They are introduced to our Chaplains and our EDI training and support offer.



Here to support **everyone** by providing spiritual, religious and pastoral care.

Our Chief People Officer checks in with new staff nine months into their appointment to see how they are doing, learn about their experiences so we know what has gone well and what we could improve. This includes demographic information so we can identify themes and trends of how different protected equality groups are experiencing their induction period.

#### Staff Networks

We are committed to staff engagement and ensuring everyone's voice matters. To support this, we have developed thriving and vital staff networks. These networks are a space for staff from protected equality groups to come together and share their lived experience of working in the Trust. The networks work to develop this collective voice and escalate and advise the Trust on matters of equality, celebrating their diversity and developing inclusive services and workplace cultures.



The networks are led by staff voluntarily alongside their substantive roles. Chairs are given time each month to coordinate the network and staff are supported and encouraged to attend within their work time. Each network has a small budget to support them with their priorities. We would like to take this opportunity to thank all those colleagues who participate and lead the networks. They are vital to our EDI work and Trust values.

## Rainbow Alliance

The LGBT+ equality agenda has evolved over time, and whilst we acknowledge that lots of positive progress has been made, keeping LGBT+ equality high on the agenda remains important.

The main aims of our Rainbow Alliance are to:

- Provide a safe space in which all its members feel able to discuss and provide informal support to each other on any LGBT+ related issues that may arise within the workplace.
- Contribute to supporting our Trust commitment to become a happy and safe place to work and where equality remains high on the agenda.



The Alliance have met with our Board this year for a group reciprocal mentoring session to share their lived experiences of work and in health care provision. They have also advised the EDI Team and our Board on how to respond to the Supreme Court Ruling on the definition of biological sex and responded to the draft Code of Practice consultation that followed. The network now includes 70 staff from across the Trust and continues to grow. The Chair of the Rainbow Alliance stood down after 10 years of dedicated leadership. The Alliance celebrated the former Chairs fantastic impact and achievements and welcomed new Co-Chairs in October.

## Beacon Network



The Beacon Network supports staff with long term health conditions, visible or invisible disabilities, carer responsibilities and any physical or mental health need. The network aims to be a beacon to all staff offering a safe space to discuss health, work and caring challenges with peers and people that understand through lived experience.

The network creates a collective voice in sharing lived experiences across the Trust in strategic forums to improve equality for disabled staff and carers. The network aims to utilise their energy and ideas to run campaigns that raise awareness of disability, equality and carer issues throughout the year. The Trust is a Mindful, Disability and Carer Confident Employer. The Beacon Network support our commitment to these standards. The network launched in 2020 and now has 170 members and three thriving sub-groups offering specific support to its members.

*"The ADHD support session has provided me with a work-based support network, that understand the same things as me and can provide tailored support."* – Member of ADHD Support Group



- Launched after a successful trial during ADHD Awareness Month in October 2024.
- 16 members across corporate and front-line services.
- Links with Staff Support and Therapy Service to deliver bespoke sessions around support for ADHD at work.

### Autism Peer Support Staff Group Our Year in Review

- 1. About the group**
  - The group launched in 2022
  - The group is a welcoming, safe space for discussion and connection - come as you are!
  - We meet on the first Wednesday of each month on Teams.
- 2. Our Impact**
  - Provided input and helped shape the BDCFT disability policy and reasonable adjustments form
  - Shared strategies for wellbeing
  - Presented at the staff broadcast for Autism Awareness Month
  - Being recognised as an 'official' group and part of the Beacon network 'family'
- 3. Personal Growth & Empowerment**

We do this by...

  - Creating new friendships and building stronger social networks
  - Sharing coping strategies
  - Creating a safe space to share experiences and signpost to staff wellbeing services
- 4. Looking Ahead...**

Our plans include

  - Invite guest speakers on areas chosen by the group – for e.g support Access to Work (ATW)
  - Continue to build a library of files on a range of topics related to autism and AuDHD
  - Plans for mentoring / buddy up scheme



## Working Carers Group

- The Working Carers Group meets quarterly on Teams.
- It's an informal and confidential space to connect with other colleagues who are juggling caring and work at the Trust.
- Teamed up with Patient and Carer Experience and Involvement Team to promote events over Carers Week.
- Comms campaign highlighting positive actions taken by working carers at the Trust.



## Aspiring Cultures Staff Network

The Aspiring Cultures Staff Network (ACSN) represents our ethnically and culturally diverse staff as well as welcoming allies. The network offers peer support and comes together to act as a collective voice within the organisation celebrating the ethnic and cultural diversity of our workforce. The network has over 400 members and watches over the effective implementation of our Anti-Racism Framework and policies.



The prime purpose of the Network is to:

- Support staff and our organisation to improve BAME workforce issues and working lives.
- Support BDCFT to implement our core values: We Care, We Listen, We Deliver.
- Achieve Better Lives Together for staff and all those who use our service.

ACSN meets monthly and has a steering group and newsletter. In the last year the ACSN has been involved in highlighting, discussing and promoting Race Equality Week and Anti-Racism, an Iftar event, Black Lives Matter, Black History Month and South Asian Heritage Month.

The network has also provided their lived experience views into the work we are doing to improve mental health services for ethnically diverse services users and carers via the NHS Patient and Carer Race Equality Framework.



## Menopause

Bradford District Care Foundation Trust celebrates diversity in our workforce, and we will endeavour to support staff and managers through the menopause journey. In 2022 we launched Menopause Cafes. These are peer support groups



for staff affected by the menopause to come together and share their experiences.

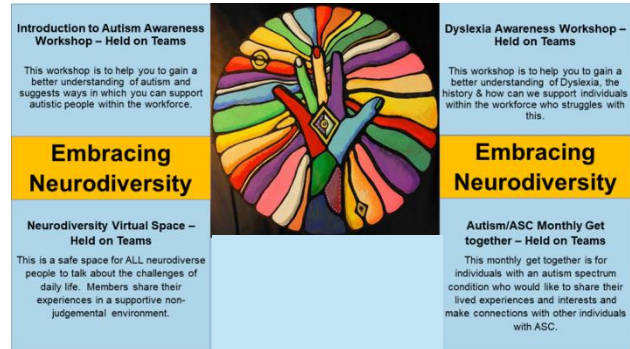
The groups have provided a strategic influence around the issues affecting staff which is being used to inform policies and strategy. The Menopause Workforce Policy launched in 2023 along with our Menopause Buddy system. In addition to the peer support group the Staff Psychological Support Service have been organising workshops that enable managers to ensure staff affected by the menopause are well supported.

In 2024 we achieved the Hen Picked Menopause Accreditation which we are very proud of maintaining in 2025.

## Neurodiversity

Support for neurodivergent staff has grown over the past year. Training and resources for making reasonable adjustments and accessible and inclusive work environments is in place.

In September 2024 we completed the Autistica Neurodivergent Employers Index. This gave us an assessment of our accessibility and inclusion for neurodiverse staff and applicants to our employment. We were awarded bronze status through the programme and have embedded actions into our Belonging and Inclusion Plan to move towards silver and gold status. The assessment is part of our commitment to the Bradford, Airedale and Craven Health and Care Partnerships aim to be a neurodiverse friendly city.



## Veterans



## Veteran Aware Accreditation

Our Trust has been awarded the NHS Veteran Aware accreditation after successfully meeting 8 standards demonstrating commitment to the Armed Forces Covenant. We also successfully revalidated the Defence Employer Recognition Scheme Silver Award in 2024, which covers how we recruit and promote veterans.

The accreditation marks our commitment to supporting the region's serving personnel, service families, veterans and cadets.

If you are part of the Armed Forces Community or a Service Family and would like further information about the accreditation and what our Trust offers, please email [edi@bdct.nhs.uk](mailto:edi@bdct.nhs.uk)



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better lives, together

W: [www.bdct.nhs.uk](http://www.bdct.nhs.uk) @BDCFT

## Workforce Wellbeing

The trust has a comprehensive wellbeing offer for staff supporting our strategic ambition to be the Best Place to Work. We monitor the take up and outcomes of this wellbeing offer to ensure it is equitable and have strategic objectives to target it into teams or groups of staff who need it most.

We assess our offer and its effectiveness as part of the NHS Equality Delivery System annual assessment. In 2025 our offer was rated as scoring 8 out of 12 when considering targeting priority health conditions, abuse, bullying and harassment at work, access to independent support and how likely staff are to recommend the Trust as somewhere to work and be treated with an EDI lens.



## Smarter Spaces and Redeveloping our Estate

The trust wants to offer the best possible facilities to our staff and the people using our services.

During 2025 we have started an exciting renovation of our Trust Headquarters, New Mill in Saltaire. We have opened a new multiuse workplace after extensive engagement with staff and service users about how we can make our environment inclusive and accessible.

The new workspace includes drop in and bookable workstations, meeting rooms, pods, booths and training rooms. The provision includes sound proofing, adaptable lighting and temperature control, sit to stand desks and accessible toilets and prayer rooms and quiet spaces.

The current renovation of our new clinical spaces will have similar accessibility and inclusion features. Feedback from those using the spaces has been positive with our Staff Networks praising the engagement and co-production processes used to ensure equality has been considered throughout.

We have carried out an equality impact assessment of our plans to redevelop Lynfield Mount Hospital and are excited about the next steps on the journey.



## Chapter Five: Developing policy to deliver our EDI priorities

Policies set the expectations for our organisation and our staff in meeting the standards we aspire to be the Best Place to Work and enable our communities to

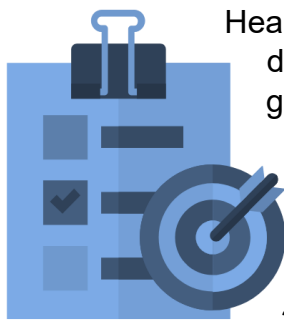
create better lives together. Over the past year we have developed and updated a range of policies and strategic intents including our Disability Policy, Spiritual Care Policy, Sexual Safety Policy and Wellbeing Strategic Intent.

We are in the process of updating our Recruitment Policy, Trans Equality Policy and developing a Sexual Harassment Procedure.



We evaluate the impact of our policies using key performance measure that are linked to them. We use the findings to update and review their implementation targeting our training and support into hotspot services and areas.

## Chapter Six: Improving Health Equity



Health inequalities are differences in health status or the distribution of health determinants between different population groups. Within Bradford there are stark differences in health status and determinants both geographically and by protected characteristic groups.

Bradford has a high level of deprivation and is one of the most deprived local authority areas in England ranking 21<sup>st</sup> out of 317. [What are health inequalities? | The King's Fund](https://www.kingsfund.org.uk/what-are-health-inequalities/)

[\(kingsfund.org.uk\)](https://www.kingsfund.org.uk/).

In 2023 and 2025 we analysed our workforce data, mapping it to the Index of Multiple Deprivation for the West Yorkshire region. We use this information to target our EDI work.

The consequences of health inequalities are wide ranging. There is a ten-year difference in life expectancy between the most deprived and affluent wards of the district. [Bradford JSNA](#).

In our Belonging and Inclusion Plan we have committed to being proactive in the identification of health inequalities in our services. We have developed a Health Equity Approach to improve health equity, specifically access, experience and health outcomes for protected equality and inclusion health groups. We intend to launch this to support our Ambition to Action aspiration to deliver the best quality services; to all.



We have developed an integrated dashboard which gives a live view of our case load in mental health broken down by ethnicity, sex, sexual orientation, age and index of multiple deprivation. This enables the 600 staff with access to view all the experience and access data we hold through an equality lens. We are focused on upskilling our staff to confidently use this data within their operational planning to improve health equity and to build patient related outcome measures into the system.

We have developed new training for service leads in using the Equality Impact Assessment (EIA) Policy to systematically screen our policies, procedures, services and decision-making processes. We have used our EIA process to assess quality and equality when developing business cases and policies across the Trust.

The Trust is a member of the West Yorkshire Integrated Care System (ICS) Reducing Health Inequalities Academy aiming to tackle health inequalities across the ICS footprint. We hosted a secondment from the alliance to support us in developing our approach, launching a Health Literacy Project in 2025 in partnership with our Library Service.

## EDI Influencers

We have a network of EDI Influencers across the Trust. These colleagues from our operational services support the mobilisation and delivery of the Belonging and Inclusion Plan at service and team level. They are leading innovation and equality interventions within their role. We share good practice, identify priorities and influence how we deliver on our equality objectives. The case studies in this section are led by EDI Influencers.



Some examples of our key priorities are set out below: -

## Accessible Information Standard

The Trust is required to be compliant with the Accessible Information Standard. The Standard is as follows [NHS England » Accessible Information Standard](#)



As part of the Accessible Information Standard, organisations that provide NHS care or adult social care must do five things. They must:

1. Ask people if they have any information or communication needs and find out how to meet their needs.
2. Record those needs clearly and in a set way.
3. Highlight or flag the person's file or notes so they have information or communication needs and how to meet those needs.
4. Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.
5. Take steps to ensure that people receive information which they can access and understand and receive communication support if they need it.

In 2016 the Trust prepared for the implementation of the standard by developing e-learning and establishing recording and flagging mechanisms in patient records. We established a task group that met monthly to ensure services were well placed to meet the needs of people using our services. We called upon the expertise and services of voluntary and community sector partners and our peers across the region.

Almost 10 years on we have evaluated our compliance and we intend to strengthen our performance around the five requirements.

In 2025 we will be reviewing and updating the categorisation of disabilities and long-term health conditions in our patient records so we have better data to understand patient experience.

Our EDI Influencers have developed resources to support patients and carers understand and engage with their care effectively. These Easy Read resources have made a huge difference to health outcomes. Some examples are included below.



### Keeping my chest healthy

Name: xxxxx  
Date of plan: xxx  
NHS Number: xxxxxx

### Key Information

NAME has a **contact directory**. Please use it to find the right help and advice for health problems.

NAME needs extra support to stay safe. He is at high risk of harm from:

- Falls and injury. Always supervise him. Remove any trip hazards.
- Distress and pain from severe constipation.

NAME CAN'T tell you what he needs

HE CAN'T tell you about pain	HE WILL NOT ask for help	NAME DOES NOT understand time
If he has pain, where it is, how bad it is	HELP: Help with a problem Food or drink The toilet or pad change	He can't tell if it is day or night. Walking is difficult and stressful.

STOP when NAME says "No!" and "Stop!"

- He will be upset and angry for a long time if you carry on.
- Never force NAME to do something unless it is an emergency.

Look at the 'key words' section for more information. My key words

### How to make soft and bite sized choori (IGOS Level 6)

Step by step instructions for making choori (chapati soaked in thin curry sauce called shora)

- Coproduced with family
- Practical session creating recipe and testing methods.
- Involved family in process – shared knowledge.

What you need:

- Fresh, hot chapati
- 300ml shora (1 bowl full)
- 1 large cup.
- 1 large spoon.
- 2 bowls: One for mixing, One for serving.

How to make the choori:

- Break up the chapati while it is hot and soft.
- Tear it into 4 big pieces first. Work on one at a time.
- Keep the other big pieces warm: Wrap in the cloth and put in the basket.
- Break up each big piece into very small bits.
- Small bits must be no bigger than your thumb nail.

### Patient Knows Best

We have launched the Patient Knows Best programme that enables patients to access their own NHS information in accessible formats via an application.

<b>Patient Engagement Platform</b> Patients Knows Best (PKB)	<b>Digital Letter invites started:</b> <b>29/01/2025</b> <small>(Podiatry invited circa 95%)</small>	<b>Patient Invites sent:</b> <b>38,713</b> <small>From Children in Care / Community Dental &amp; Podiatry services</small>	<b>Patient Registrations</b> <small>via Patients Knows Best (PKB)</small> <b>4,518</b> <small>(70% of patients invited via email &amp; majority from 65+ age group)</small>
<b>Digital Letters sent via PKB</b> <b>3,856</b> <small>(Letters to registered patients = 121)</small>	<b>Number of accessible letters read by patients via PKB App:</b> <b>194 Letters Read</b> <small>(Equivalent to an approx. £300.00 cost saving in printing and posting avoidance)</small>	<b>92% of Digital Letters read via the PKB app within 48 hours of sending</b>	<b>Children In Care 32 Healthcare Passports</b> <small>created using PKB Care Plan functionality 65 of which were one by the patient themselves</small>

## Health Literacy

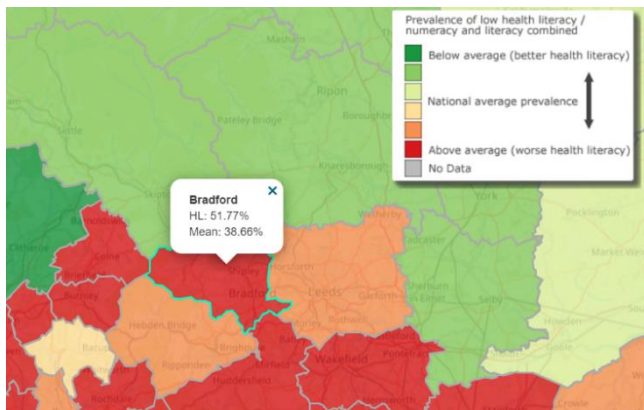
People need trustworthy information to make decisions about health, but **Patient Information Forum figures** (published in 2023) show that;

- 5 million adults cannot find relevant data in standard health information
- 1.7 million are unable to explain symptoms and feelings over the phone
- 1 million cannot follow a letter from a GP surgery or hospital department
- 6.5 million cannot measure or record height and weight on a chart
- 9 million people are unable to use digital tools without help

Health literacy means more than just the ability to read and understand health-related information. It also includes the confidence to navigate healthcare services and make well-informed decisions about self-management. Health literacy is a life skill for everyone. In Bradford it is estimated that 52% of adults (16-65) have low health literacy. It is estimated that 70% of adults (16-65) have low levels of health literacy and numeracy.

Trawley, M. 2026. 03/06/2026. 12:29:44

This information is taken from Geodata <http://healthliteracy.geodata.uk/> .



We have launched Health Literacy Training and e-learning for professionals to understand how to make information accessible to our population.

We have developed an intranet page for staff with resources and guidance on creating easy read material, assessing the reading age required to read core leaflets, letters and information we use and as a portal to ask questions and for support.

*Prevalence of Low Health Literacy in Bradford*

## Rainbow Badge Phase II

In 2021 the Trust became a pilot project for Phase II of the NHS Rainbow Badge Scheme, The Chair and former Vice Chair of the Rainbow Alliance ensured that we were one of 10 Trusts taking part in the pilot to develop and test out an assessment framework to award Trusts Bronze, Silver or Gold for the LGBT+ equality.



A third of our staff have attended the Rainbow Badge Training, made a pledge and now proudly wear their badge. The badge is a visible signal to LGBT+ people that they are welcome, supported and can approach our staff to talk about any issues relating to their care, their sexual orientation or gender identity. We use the badge to proudly demonstrate our alliance with the LGBT+ community as an organisation. In 2025 we revised the training to include more local data and case studies.

In the initial assessment the Trust was assessed as Bronze against the pilot framework. This is an excellent start and testament to the relentless efforts of our Rainbow Alliance. The network has convened a steering group and along with the EDI Team aim to move the Trust towards Silver rated performance over the next few years.

Key activities this year include the following:

- Delivering Trans Equality Training to staff to inform them of current legislation and expectations within the NHS.
- Increased visibility of LGBT+ people in our resources for patients.
- Providing appropriate resources and information to encourage signposting of LGBT+ people to specialist support agencies.
- Ongoing review of policies and clinical paperwork to remove gendered language.



Developing inclusive signage and imagery in our new spaces and online resources.

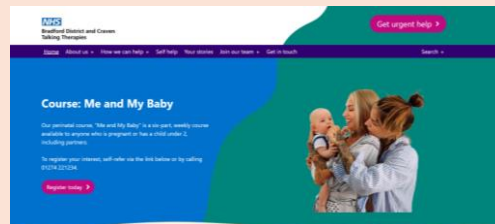


## Talking Therapies LGBT+ Special Interest Group

Launched in 2022 to improve health outcomes for LGBT clients in therapy. The service aims to be affirmative validating a persons identity within their care, ensuring there is space for them to express their identity in the way they wish to, viewing gender and sexual differences positively rather than something that needs to be hidden away.

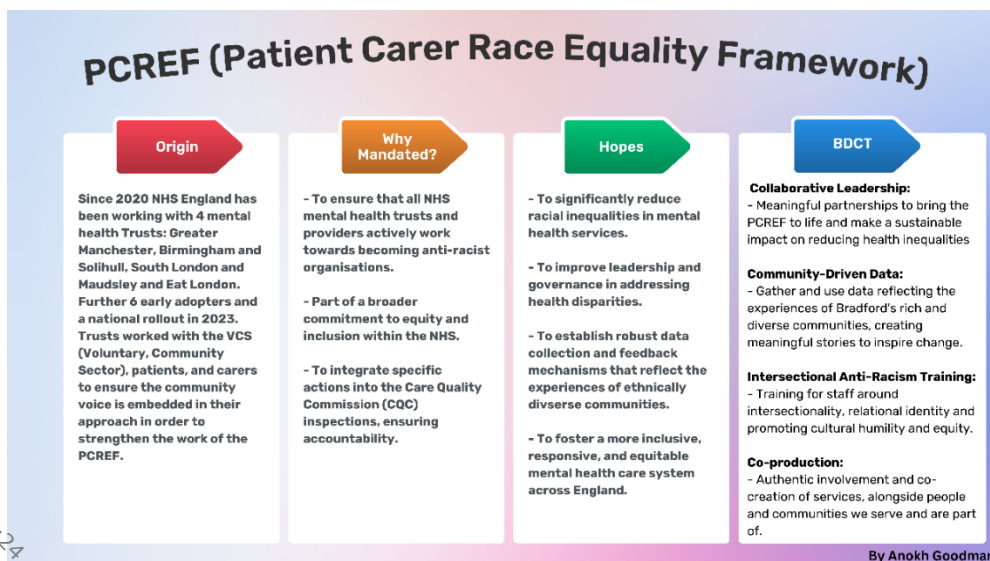
The group have delivered:

- Training to over 100 therapists increasing the use of pronouns and wearing of rainbow lanyards and badges.
- Created a clinical guide to support clinicians to adapt therapy to the needs of LGBTQ+ people, how to be affirmative and be aware of intersectionality.
- Regularly monitor service against best practice benchmarks as set out in the NHS Talking Therapies LGBTQ+ Positive Practice Guide.
- Set up an LGBTQ+ clinical query email address for clinicians to access support when working with LGBTQ+ people.
- Creating promotional posters and leaflets that represent the community.



## Patient and Carer Race Equality Framework (PCREF)

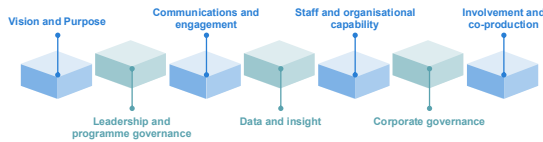
The draft PCREF sets out three components with several tests for NHS mental health service providers to undertake to assess their performance relating to equality of access, patient experience and health outcome for ethnically diverse people using our services. The aim of the framework is to improve the trust and confidence in mental health services for these groups.



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PCREF Partnership has seven workstreams aimed at implementing the PCREF and making sustained and innovative change in partnership with our Act as One Partners.

These 7 workstreams divide our PCREF ambitions into manageable components:



With our Health and Social Care Partners we have commissioned a Hope and Light Project to provide scrutiny, involvement and support community voice across Bradford, Airedale and Craven.

A representative place has been established at our Trusts Council of Governors, and the leads of the project are an integral member of the PCREF Partnership.

We are reporting progress on implementation and performance to our Mental Health Legislation Committee, Quality and Safety Committee and Trust Board. We are working in partnership with our national and West Yorkshire Mental Health Peers to share resources, data and information and we will be reporting our progress to the Healthy Minds Partnership. You can read our annual [PCREF Annual Report 2025](#) for detailed information.

Some highlights include:

- Launching our Cultural Competency and Humility Programme for staff, training 70 staff since the launch in June 2025. Using stories to create connection and begin significant change.

Created by Anokh Goodman ©

## Stories as Vehicles for Change - PCREF

**Building Connection and Empathy**  
Stories unite staff, service users, and carers, fostering deeper relationships and a compassionate culture.

**Challenging Bias and Stereotypes:**  
By amplifying diverse voices, storytelling challenges assumptions, reshaping narratives around equity and inclusion.

**Bridging the Gap Between Vision and Culture:**  
Stories make inclusivity tangible, aligning us with the organization's goals and aspirations with PCREF.

**Catalyst for Culture Change:**  
Stories spark action, transforming values into lived experiences and driving cultural shifts.

**Empowering Service Users and Carer Voices:**  
Narratives give service users and carers the power to shape their care and share their needs.

**Stories as a Force for Change:**  
Stories offer powerful insights that can bring the PCREF to life and drive meaningful change.

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**NEW: Cultural Competency and Humility Training**

Equality Diversity Inclusion | 0255 Bradford District Council

In person | Open to all staff | Half day

**What To Expect**  
Join us in a supportive space to explore how cultural assumptions and biases shape our work. Develop cultural competency and humility to better connect, collaborate, and respond to the diverse people and communities we work with.

**What You'll Gain**

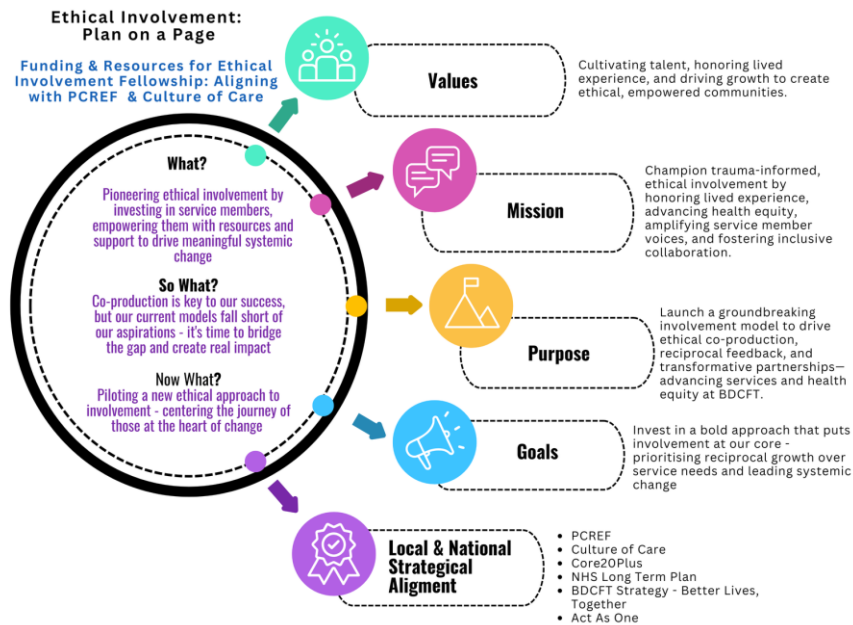
- Understand your own personal biases and cultural assumptions
- Deepen your cultural self-awareness
- Recognising how culture shapes our interactions
- Embrace humility, listening and learning from lived experience

**Book Your Place**  
Search 'EDI Training' on ESR

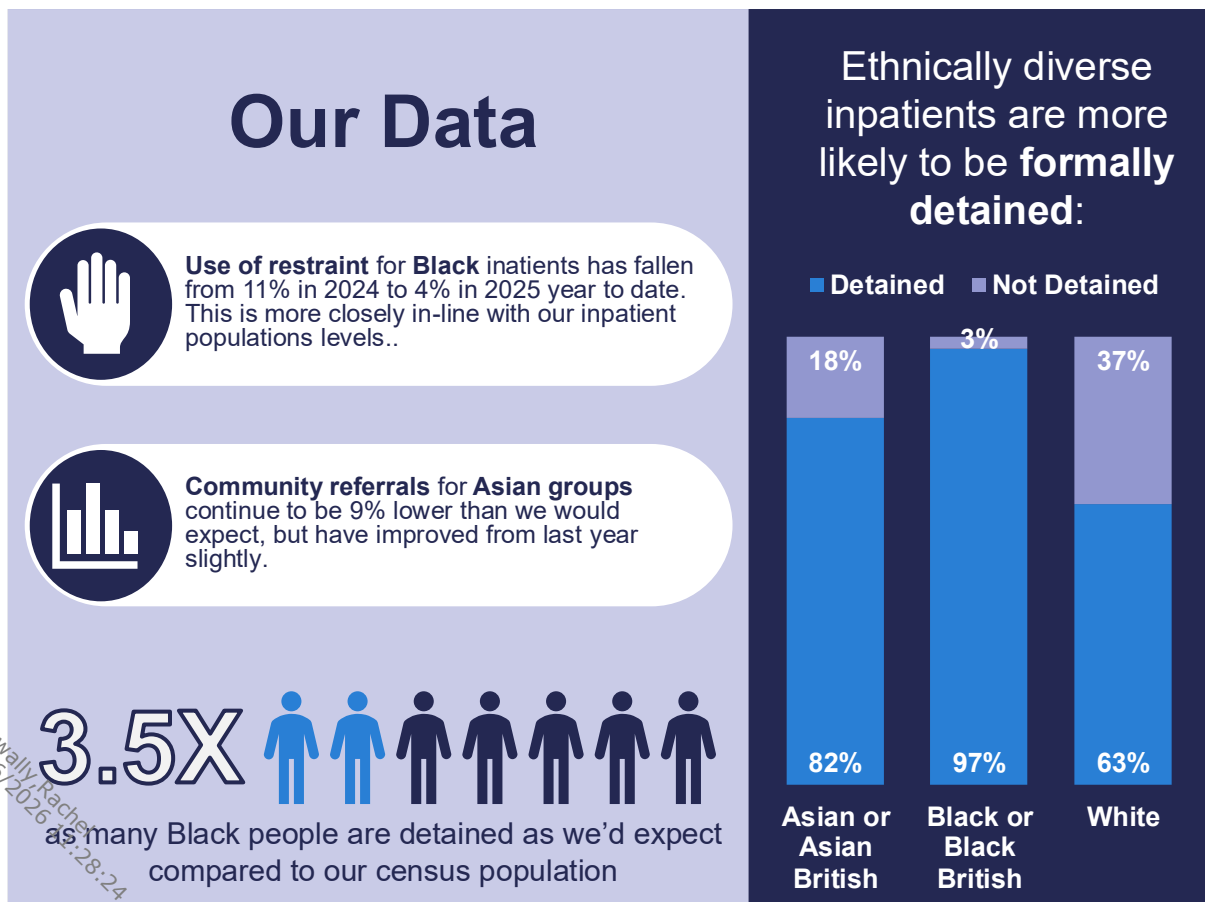
### Reflective Sessions Feedback

- "Fantastic hour spent sharing experiences and ideas with a group of relative strangers. It really goes to show that we are more similar than we are different."
- "Fantastic space to reflect, was lovely hearing about everyone's experiences too and being able to somewhat relate to most stories"
- "Each face, voice and story is enriching for my personal and professional development. These spaces are a passageway to wellness"
- "Really value the time to share ideas and delve deeper into ourselves as people, lots of food for thought and learning which I take away from each session. So much depth, thank you everyone"

- Developing an Involvement Fellowship to create meaningful community coproduction within the programme.



- Launching a PCREF data dashboard which enables us to see our performance, track our progress and identify areas of priority at the touch of a button.



- Continuing to roll out new culturally appropriate ways of working for example the Stepping Stones to Wellbeing Groups

**Stepping Stones to Wellbeing Groups**  
Community Mental Health Teams

**intro**  
Stepping Stones to Wellbeing Group is a **new offer; co-created** by our community for people under the care of community mental health teams (CMHTs) across BDCFT. We co-designed a 9-week programme, which decolonised the existing offer to strengthen **connection and belonging**, set in a local venue.

**Session Themes**

- Connection & Belonging
- Values & Identity
- Recharge & Restore
- Creativity & Expression
- Mind, Body & Spirit
- Community & Relationships
- Culture, Faith & Spirituality
- Growth, Dreams & Giving Back

**vision**  
Aligned with BDCFT's mission, Stepping Stones to Wellbeing groups prioritise **inclusivity, improved access and racial equity**, leading to **more meaningful outcomes** from group members and an approach more aligned with staff values.

With its blend of **accessibility, innovation** and a focus on **reducing racial inequalities**, the groups offer a promise of hope to all on their journey to wellbeing.

**spaces of belonging**  
Beyond traditional healthcare, Stepping Stones to Wellbeing creates sanctuaries where we **celebrate cultural diversity** and create space to connect in a meaningful way, which can lead to individual and relational transformation.

**crafting care together**  
At the heart of Stepping Stones to Wellbeing lies **co-creation**, where **ethnically and culturally diverse group** of staff, involvement partners, voluntary and community sector partners and users of our service have collaborated to shape tailored **support groups**.

Here, **inclusivity** isn't just a word, it's the foundation, honouring both expertise and lived experience alongside each other.

It is very rewarding to see the groups developing and growing - the interaction, not just with us, but also other group members is growing week to week - *facilitator*

**partnership working**  
We have teamed up with **Mind in Bradford** to highlight the strength of partnerships for community wellness. This collaboration shows we are more than the sum of our parts.

Our groups have been awarded an **innovation award**, highlighting how our co-creation approach is cultivating a sense of community, hope and reciprocal growth for both group members and facilitators.

**Contact:**  
Anokh Goodman, BDCFT  
07947 553621 | anokh.goodman@bdct.nhs.uk

**NHS Bradford District Care NHS Foundation Trust**  
**Mind in Bradford**

- Improving Interpreting Experiences in Therapy Project

This initiative aims to enhance communication in therapeutic settings for non-native speakers, ensuring that language differences do not become barriers to care.

**Improving Interpreting Experiences within Psychological Therapy**

**Background and Aims**  
In 2021, **90%** of therapy referrals within the Bradford District Care NHS Foundation Trust's (BDCT) community mental health psychological services (CMHPS) were for white British females, highlighting **underrepresentation** of other communities. Service users requiring interpreters also faced **longer waits** for therapy.

The **Improving Interpreting Services in Psychological Therapy project** explores experiences of therapists, interpreters, and service users to enhance **equitable access** and **improve therapy outcomes** when interpreters are involved.

**Bradford Context**  
Bradford is a diverse city of around 546,000 people, where **153 languages** are spoken, including Urdu, Punjabi, Polish, and Bengali. About **36%** of the population are ethnically diverse, with the largest groups being **Pakistani** (20%), **Indian** (3%), followed by **Eastern European** communities.

Bradford is also **religiously diverse**, with 64% identifying as Christian, 25% as Muslim, and smaller groups practicing Sikhism, Hinduism, and Judaism.

**Methods**  
We collected quantitative and qualitative data from:  
**65** therapists within BDCT  
**97** interpreters working across the UK via Enable 2

**Emerging Themes**

- Emotional Load:** Interpreters often struggle with maintaining neutrality, feeling emotionally involved, especially in trauma or family therapy sessions.
- Role Clarity:** Confusion around roles for both therapists and interpreters can lead to blurred boundaries.
- Consistency:** Both therapists and interpreters emphasised the need for a consistent interpreter to build trust and ensure smooth communication.
- Cultural Understanding:** Therapists highlighted the importance of cultural sensitivity, while interpreters stressed that understanding the service user's culture and religion aids effective interpretation.
- Training Needs:** Interpreters expressed a need for more specialised training in therapy approaches, while therapists called for joint training to clarify roles and expectations.

**We need your help!**  
The next stage of our project focuses on engaging **service users** to share their **experiences and insights**, helping us to improve interpreting services in therapy. Your support will help us to shape a more inclusive and effective service. If you're interested in connecting us with service users, **please let us know by scanning the QR code.**

**Dr Charlotte Scott** - ST7 Psychiatry Trainee - Medical Psychotherapy and CAMHS.  
charlotte.scott@bdct.nhs.uk  
**Anokh Goodman** - Clinical Lead for Cultural Connection, Transformation and Belonging & Systemic Family Therapist. anokh.goodman@bdct.nhs.uk

**NHS Bradford District Care NHS Foundation Trust**

Ensuring spoken family language is a major consideration in the Speech and Language Therapy *Early Language Support for Every Child* project,

Bradford is a pathfinder site for ELSEC, screening children on their language skills. The Speech and Language Team are using two unique screening tools, one of which they have developed within their service to find the child's strongest language. This will improve access and health outcomes.

For more information on these or our other examples of improving health equity please contact [EDI@bdct.nhs.uk](mailto:EDI@bdct.nhs.uk).

## Chapter Seven: Other EDI activity in the Trust

### EDI Calendar

The Trust has an interactive equality calendar. The purpose of the calendar is to celebrate, raise awareness, visibility and understanding of significant events for people who may identify with different diversity groups. Some of the occasions that the Trust has marked: - International Women's Day, LGBT+ History month and Pride, South Asian Heritage Month, Black History Month, Disability History month as well as religious and health days. This has been through a variety of mediums such as internal communication, presentations, and social media.



#### Equality, Diversity and Inclusion Calendar

This calendar is a resource to provide information about key awareness dates which reflect and support the diverse population of our workforce and the people using our services. The calendar has been developed in line with the Trust's commitment to equality, diversity and inclusion. It is important to remember that people practice their faith in different ways and information in this calendar may be useful to consider when scheduling home appointments and visits.

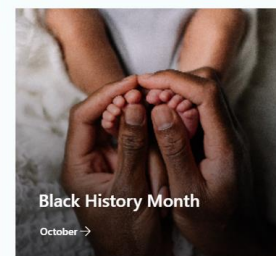
Use this calendar to:

- Learn about equality, diversity and inclusion dates and events.
- Break down barriers and promote an inclusive environment.
- Support you in organising events, campaigns and activities within the Trust.
- Promote wellbeing among our workforce and people using our services.
- Avoid event clashes.

\*\*Please note, this is not an exhaustive list of all the celebrations and events throughout the year, but a selection of those we have chosen to mark this year.

For equality related advice and queries, please contact the Equality, Diversity and Inclusion team: [EDI@bdct.nhs.uk](mailto:EDI@bdct.nhs.uk)

October is...



### Reciprocal mentoring

A network of graduates from the Trusts reciprocal mentoring programme was launched in 2025. The programme is aimed at ECDC staff and senior managers in bands 8a and above.

Reciprocal mentoring is a powerful tool which impacts on individuals career aspirations, progression and self-confidence. Within the Belonging and Inclusion Plan Reciprocal Mentoring was identified as a key component of our WRES metrics delivery plan.

In 2024 many of our executive leaders were part of reciprocal mentoring pairs as part of their commitment to the NHS EDI Improvement Plan.

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## We are Compassionate

In April 2025 the Trust launched the 'we are compassionate' programme which includes workshops for teams to consider the Trusts values, behaviours and their own ways of working.



The project supports the delivery of our Belonging and Inclusion Plan and strengthens our "we care" value across the Trust and all our services. The project includes an incivility campaign supporting a compassionate culture in which bullying, and harassment are unacceptable. Throughout 2025 the EDI team have been delivering training across the organisation to support teams in identifying what makes a good and a bad day at work; how we can have more good days through value, appreciation, constructive feedback and a culture of kindness.

This aligns with the NHS Long Term Plan 'levels of bullying and harassment must come down if the NHS is to achieve its aims of becoming the best place to work and being an employer of excellence' and with the NHS People Plan, 'Compassionate and inclusive culture at the very heart of the NHS'.

The project introduces an intranet page for staff with e-learning and resolution resources which sit alongside our Trust policies to support staff in speaking up around incivility and building inclusive, thriving workspaces.

We hope that the programme will impact on a whole host of issues experienced by the NHS including sickness absence costs, employee turnover, productivity, presenteeism, discrimination and costs of industrial relations associated with bullying, harassment and incivility.

## Anti-racist tool kit

To support our pledge to be an antiracist organisation and continue the dialogue about race equity we developed an Anti-racist tool kit.

The tool kit is located on the Trust's intranet. It is split into 3 sections 'The Fear Zone' (explores the barriers to these conversations), 'The Learning Zone' (educating and raising awareness around race), 'Growth Zone' (support about how to have those conversations).



The EDI Team are developing the online resource into an e-learning tool kit to support staff to move to the growth zone and disrupt systemic racism.

## Partnership Working across the Integrated Care System

The EDI agenda spans across geographical and organisational boundaries.

Bradford District Care Foundation Trust is a partner in the Bradford District and Craven – Act as One. Act as One is the guiding principle of how we work together across the health, care, community, voluntary and independent organisations in Bradford District and Craven. Act as One brings senior leads formally together with clear governance arrangements and shared decision-making processes. Together they have responsibility for delivering our shared strategy for our communities, of Happy, Healthy at Home. This means that every organisation is committed to developing and delivering joined-up health care with our local communities.

We have been working with our Bradford District colleagues in the Bradford System Equalities Group as a subgroup of that partnership to deliver shared equality goals and share resources.

The West Yorkshire Integrated Care System is leading work to coordinate our approaches to addressing health inequality and inequalities within the workforce. We are a member of many specialist communities of practice sharing resources, information and working together for change. Our staff networks have been engaged in ICS programmes and in national initiatives giving them a louder voice for change.

## Chapter Eight: Resourcing, Review and Audit

### Equality, Diversity and Inclusion Resourcing

Equality, Diversity and Inclusion is a high priority in the Trust. A dedicated EDI Team is employed to deliver on the ambitious agenda. The team consists of a 0.8 full time equivalent Head of Equality, Diversity and Inclusion, a Reducing Inequalities Lead and an EDI Team Administrator. There are many other colleagues across the Trust supporting and driving change within their networks, roles, services and partnerships.

### Equality, Diversity and Inclusion Governance

Equality, Diversity and Inclusion accountability and scrutiny is provided through various mechanisms such as the Board meetings, People and Cultures Committee, Quality and Safety Committee, Senior Leadership Team, these structures ensure that robust mechanisms are in place to ensure that the EDI agenda continues to progress for the workforce and our service users. Progress is reported regularly to the People and Culture Committee, Quality and Safety Committee and Trust Board.

For more information about anything in this report or to receive the information in alternative formats please email [EDI@bdct.nhs.uk](mailto:EDI@bdct.nhs.uk)

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<sup>i</sup> [WRES \(england.nhs.uk\)](https://www.england.nhs.uk/wres/)

<sup>ii</sup> [NHS England » Technical guidance for the Bank Workforce Race Equality Standard \(Bank WRES\)](https://www.england.nhs.uk/technical-guidance-for-the-bank-workforce-race-equality-standard/)

<sup>iii</sup> [MWRES-DIGITAL-2020\\_FINAL.pdf \(england.nhs.uk\)](https://www.england.nhs.uk/mwres-digital-2020-final/)

<sup>iv</sup> [NHS England » NHS Workforce Disability Equality Standard: Metrics](https://www.england.nhs.uk/nhs-workforce-disability-equality-standard-metrics/)

<sup>v</sup> [NHS England » Equality Delivery System 2022](https://www.england.nhs.uk/equality-delivery-system-2022/)

<sup>vi</sup> [NHS England » Patient and carer race equality framework](https://www.england.nhs.uk/patient-and-carer-race-equality-framework/)

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vii [NHS England » NHS England's statement on information on health inequalities \(duty under section 13SA of the National Health Service Act 2006\)](#)

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## Well led 'EPRR' Review – Well led improvement plan

### QS5.30

### QS5.7

Emergency Preparedness, Resilience and Response (EPRR): What “Well-Led” Looks Like, Board Actions, and Assurance Framework

#### 1. Executive Summary

Emergency Preparedness, Resilience and Response (EPRR) is a core component of organisational governance, safety and continuity. NHS England sets Core Standards for EPRR which form the basis of the annual EPRR assurance process led through NHS England/ICBs and require providers to self-assess and evidence compliance across defined domains.

Under the Care Quality Commission (CQC) Single Assessment Framework, “Well-Led” requires an inclusive culture of learning and improvement, effective governance and risk management, and strong system partnership working—each of which is directly tested through how the Board leads and assures EPRR.

In response to BDCFT Well led audit findings in regard to EPRR a review of best practice has been undertaken to identify improvement opportunities for BDCFT in regard to this element of well led.

This document seeks to set:

1. What “Well-Led” looks like for EPRR in a mental health and community provider trust;
2. Recommended Board actions to strengthen and evidence Board oversight, alignment to planning and BAU, and organisational resilience;
3. A Board Assurance Checklist (Appendix A) aligned to NHS EPRR Core Standards and good governance practice;
4. A mapping of assurance evidence to the CQC Well-Led quality statements (Appendix B).

All of which will support our improvement journey and support the building of evidence for our Board Capability Assessments going forward.

#### 2. Recommendations

The Board is asked to:

##### A. Agree what “Well-Led” looks like for EPRR

1. **Note and adopt** the description of “Well-Led EPRR” in Section 5 as the Trust’s reference standard for Board oversight.

##### B. Strengthen Board assurance and governance

2. **Approve** the Board Assurance Checklist (Appendix A) as the Trust’s annual EPRR Board assurance framework (to be used by the Board and relevant committees).
3. **Approve** the CQC Well-Led mapping (Appendix B) for use as the Trust’s EPRR inspection/assurance evidence index.

##### C. Embed EPRR into BAU and planning

4. **Commission** an annual EPRR work programme update that explicitly links to:

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- corporate strategy and annual planning
- corporate risk/BAF and key operational risks
- BAU arrangements (business continuity, on-call, training, exercising)

#### **D. Assure capability, capacity, and learning**

5. **Request** a 6-monthly committee update (Audit & Risk / Quality Committee as locally agreed) on:
  - EPRR compliance gaps and delivery of action plans
  - learning from incidents and exercises (including multi-agency)
  - organisational readiness metrics (training, exercising, BCP coverage)
  -

### **3. Background and Context**

#### **3.1 Why EPRR matters to the Board**

EPRR is a statutory and contractual expectation across NHS-funded services, supported by the NHS England EPRR framework and Core Standards, and it is monitored through the annual assurance process.

The Core Standards define expectations across multiple domains (including governance, risk assessment, planning, command and control, training/exercising, business continuity and warning/informing).

#### **3.2 The annual EPRR assurance process**

NHS England’s annual assurance process requires organisations to self-assess compliance against the Core Standards, identify gaps, and use findings to drive the annual work programme and improvement priorities; ICBs lead assurance locally with providers.

#### **3.3 How this links to “Well-Led”**

CQC “Well-Led” focuses on culture, governance, risk management, learning/improvement and system partnership—all of which are demonstrated through how the Board and executives lead EPRR.

### **4. Purpose of this Paper**

This paper provides the Board with:

- a clear, agreed **definition of “Well-Led EPRR”**;
- a practical set of **Board-level actions** to strengthen assurance, embed EPRR into planning and BAU, and evidence compliance.
- an **assurance checklist** and **CQC mapping** to support consistent governance, committee reporting, and inspection readiness.

### **5. What “Well-Led” Looks Like for EPRR (Board-level Standard)**

A “Well-Led” approach to EPRR in a mental health and community provider trust is evidenced when the Board can demonstrate **all** of the following:

#### **5.1 Clear accountability and effective governance**

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- A named **Accountable Emergency Officer (AEO)** and clear executive accountability with defined governance routes to Board/committees.
- Board-approved EPRR policy/statement of intent and an annual EPRR work programme aligned to Core Standards.

## 5.2 Board receives structured assurance and evidence

- Annual Board reporting of EPRR compliance (self-assessment outcome, gaps, and time-bound action plans).
- In-year oversight of readiness, exercising, learning from incidents, and progress against any compliance gaps.

## 5.3 EPRR is integrated into corporate risk and BAU - not a standalone function

- EPRR risks are visible in corporate risk management, including the BAF, with clear controls and assurance sources.
- Business continuity and response arrangements are embedded in BAU processes (service BCPs, on-call, resilience of critical functions).

## 5.4 A learning culture that improves resilience over time

- Exercises and incidents result in demonstrable learning, tracked actions, and updated plans/training.
- Leaders promote a positive improvement culture consistent with Well-Led expectations (learning, continuous improvement, use of risk/performance information).

## 5.5 Strong system partnership working

- The Trust works effectively with system partners through ICB-led assurance and resilience arrangements, contributing to collective preparedness and response.

## 6. Suggested Actions to the Board (Proposed Improvement / Embedding Plan)

To strengthen Board assurance and provide clear evidence of “Well-Led EPRR”, it is recommended the Trust implements the following in addition to existing processes:

### 6.1 Adopt a consistent Board assurance cycle (minimum standard)

- **Annual** EPRR assurance paper to Board aligned to Core Standards (compliance rating, gaps, work programme) to be supplemented with **6-monthly** committee update focused on:
  - progress against EPRR work programme
  - status of key risks and mitigations
  - exercise schedule and learning completion

### 6.2 Make EPRR a visible part of BAU governance

- Ensure EPRR is explicitly referenced in:
  - corporate risk reporting (BAF)
  - annual planning and operational resilience planning
  - estates, digital/cyber, and workforce plans

### 6.3 Strengthen evidence quality

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- Maintain an indexed EPRR evidence set aligned to:
  - Board Assurance Checklist (Appendix A)
  - CQC Well-Led mapping (Appendix B)

#### 6.4 Board development and scenario testing

- Schedule an annual **Board EPRR deep dive / tabletop** (e.g., cyber outage; loss of a community base; inpatient surge; severe weather) to evidence leadership readiness and learning culture.

### 7. Quality, Patient Safety and Operational Impact

Strong EPRR governance supports continuity of safe care during disruption and strengthens organisational risk controls and learning systems, aligning with the Well-Led requirement for effective governance and using risk/performance information to improve care.

### 8. Risks and Assurances

- **Primary risk:** Insufficient preparedness/response capability leading to patient safety incidents, prolonged service disruption, workforce harm, reputational damage, and non-compliance with Core Standards.
- **Assurance approach:** Use Appendix A checklist as the Board's minimum assurance standard; use Appendix B to evidence Well-Led requirements during internal and external reviews plus to support evidence for Board Capability Assessments

### 9. Equality and Health Inequalities Considerations

CQC Well-Led places emphasis on inclusive leadership and culture. The Trust should ensure EPRR planning considers impacts on vulnerable groups and staff equality considerations as part of BAU governance and learning. Example being BDCFT 2025/26 Winter Plan had specific considerations and actions pertaining to health equity and was referenced in the NHSE BAF submission.

### 10. Next Steps (If approved)

1. Agree committee route for **6-monthly EPRR updates** and incorporate into annual Board workplan.
2. Establish an **EPRR evidence index** using Appendices A and B (single source of truth).
3. Align the annual EPRR work programme to corporate planning, BAU and BAF (explicit cross-references).

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## **Appendix A — Board Assurance Checklist (EPRR)**

### **A1. Board leadership, accountability and governance**

- Named **AEO** at Executive Director level with clear authority and capacity.
- EPRR responsibilities explicit in scheme of delegation, exec portfolios, and committee ToR.
- Board-approved EPRR policy/statement of intent in place and in date.
- Annual EPRR work programme approved and monitored.

### **A2. Board assurance and reporting**

- Annual Board paper on Core Standards self-assessment and assurance outcome (compliance rating and evidence).
- In-year reporting to committee(s) on exercises, incidents, and action plans.
- Clear action plans for any gaps with owners, milestones and residual risk.

### **A3. Risk management and BAF integration**

- EPRR risks mapped to corporate risk register and **BAF**, with assurance sources identified.
- Board understands risk appetite for disruption/resilience and reviews changes.

### **A4. Alignment to strategy, planning and BAU**

- EPRR reflected in strategy/annual planning and linked to delivery priorities.
- Business continuity planning embedded across services/directorates and assured routinely.
- EPRR aligns with estates, digital/cyber and workforce resilience plans.

### **A5. Preparedness, training and exercising**

- Command & control arrangements are defined, current and tested.
- Training requirements for on-call/senior roles are defined and monitored.
- Exercise programme is in place (including multi-agency where appropriate) and learning is tracked.

### **A6. Incident response, learning and improvement**

- Significant incidents and debrief learning are reported through governance routes with action tracking.
- Plans/training are updated based on learning (evidence of improvement over time).

### **A7. System working and external assurance**

- Active engagement with ICB/NHSE EPRR assurance processes and any partner frameworks.
- Mutual aid/escalation arrangements are understood and tested.

### **A8. Board capability and confidence**

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- Board can describe top EPRR risks, readiness gaps, and immediate (24–72h) response capabilities.
- Annual Board development/scenario session completed and recorded.

## Appendix B — Mapping: EPRR Board Assurance → CQC Well-Led Quality Statements

**Note:** This mapping is intended to function as an evidence index for Board/committee minutes, papers, policies, exercises, and action logs.

### B1. Shared direction and culture

**CQC focus:** Vision, strategy, values, culture support safe, sustainable care and improvement.

**EPRR evidence examples:**

- Board-approved EPRR policy/statement of intent; annual work programme linked to strategy.
- Board narrative links EPRR to continuity, safety and resilience in mental health/community pathways.

### B2. Capable, compassionate and inclusive leaders

**CQC focus:** Leaders are competent, accountable and support staff to deliver safe care.

**EPRR evidence examples:**

- Named AEO and trained incident leadership/on-call roles; evidence of leadership readiness.

### B3. Freedom to speak up

**CQC focus:** People can raise concerns; organisations listen and learn.

**EPRR evidence examples:**

- Staff escalation routes for safety/continuity risks; debriefs reflect staff voice; no-blame learning culture.

### B4. Workforce equality, diversity and inclusion

**CQC focus:** Inclusive leadership and fair workforce experience.

**EPRR evidence examples:**

- Equality/impact considerations in EPRR planning (redeployment, on-call impact, staff safety).

### B5. Governance, management and risk management

**CQC focus:** Robust systems to manage risk and performance; effective oversight.

**EPRR evidence examples:**

- Annual assurance to Board; in-year committee oversight; EPRR risks mapped to BAF.

### B6. Learning, improvement and innovation

**CQC focus:** Continuous improvement, learning, innovation.

**EPRR evidence examples:**

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- Exercise and incident learning tracked to completion; plans/training updated; evidence of sustained improvement.

### **B7. Partnerships and system working**

**CQC focus:** Works effectively with partners to plan/manage services.

**EPRR evidence examples:**

- ICB/NHSE assurance engagement; multi-agency exercising; mutual aid arrangements.

### **B8. Environmental sustainability and long-term resilience**

**CQC focus:** Planning for future risks, sustainability and long-term resilience.

**EPRR evidence examples:**

- Alignment of EPRR with estates, digital/cyber and workforce resilience planning; scenario planning for emerging risks.

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## Board of Directors – meeting held in public

**4 June 2026**

<b>Paper title:</b>	Governance Report	<b>Agenda Item</b>  <b>23.0</b>
<b>Presented by:</b>	Fran Stead, Trust Secretary	
<b>Prepared by:</b>	Holly Close, Senior Corporate Governance Officer & Executive Support Manager	
<b>Committees where content has been discussed previously</b>		
<b>Purpose of the paper</b> Please check <b>ONE</b> box only:	<input checked="" type="checkbox"/> For approval <input type="checkbox"/> For information <input type="checkbox"/> For discussion	
<b>Link to Trust Strategic Vision</b> Please check <b>ALL</b> 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	
<b>Care Quality Commission domains</b> Please check <b>ALL</b> that apply	<input type="checkbox"/> Safe <input type="checkbox"/> Caring <input type="checkbox"/> Effective <input checked="" type="checkbox"/> Well-Led <input type="checkbox"/> Responsive	

<b>Purpose of the report</b>
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.

<b>Executive Summary</b>
<p>This report provided an overview of key governance developments and updates over the previous two months, alongside highlighting upcoming matters for the Board of Directors' awareness.</p> <p>In relation to Governor engagement, the Council of Governors noted the departure of Councillor Sabiya Khan following the recent local elections, and formally recorded its thanks for her contribution and commitment during her time in office.</p> <p>Significant progress has been made in strengthening governance arrangements through the development of a Chair in Common Governance Framework between Airedale NHS</p>

Foundation Trust and Bradford District Care NHS Foundation Trust. The framework establishes clear principles, safeguards and accountability arrangements, ensuring that both organisations retain full statutory independence. The framework has been approved by the Council of Governors and is now presented for Board approval.

The Board is also asked to approve the appointment of Sally Napper as Senior Independent Director, backdated to 1 May 2026, noting this has already been supported by the Council of Governors.

A number of changes to governance structures have been implemented for 2026/27, including a revised Board and Sub-Committee meeting cycle and updated Non-Executive Director membership arrangements. These changes are intended to enhance oversight, improve the flow of business and ensure alignment with the Trust's priorities. The Board is further reminded that all Board meetings will now be held in person, strengthening transparency and accessibility.

Finally, the Corporate Governance Team has commenced a refresh of the Integrated Governance Guide, supported by staff engagement through a Trust-wide survey. Further updates on this work will be provided in due course.

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)

- Approve the Chair in Common Governance Framework
- Approve the Senior Independent Director Appointment
- Note the changes to the 2026/27 Board and Sub-Committee meeting cycle and the revised Non-Executive Director membership arrangements across Committees and support the updating of Terms of Reference to reflect these changes.
- Note the transition to all Board meetings being held in person, recognising the increased transparency and accessibility this provides.
- Note the commencement of the refresh of the Integrated Governance Guide and support continued staff engagement to inform its development.

**Links to the Strategic Organisational Risk register (SORR)**

N/A

**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 |  |

**Compliance & regulatory implications**

The following compliance and regulatory implications have been identified as a result of the work outlined in this report:

- 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**

**04 June 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**

##### Appointment and Resignations:

Following the Local District Council Elections in Bradford, Appointed Governor: Councillor Sabiya Khan lost her seat and therefore is no longer one of our Appointed Governors for Bradford Council. On behalf of the Trust, the Council thanked Councillor Khan for their commitment and hard work whilst in office.

### **Accountability and Governance**

#### Chair in Common Governance Framework

As part of ongoing arrangements to support effective, lawful and transparent governance, a Governance Framework for a Chair in Common arrangement across Airedale NHS Foundation Trust and Bradford District Care NHS Foundation Trust has been developed. The framework sets out the principles, safeguards and accountability structures that underpin the appointment of a single Chair across the two Foundation Trusts, while fully preserving the statutory responsibilities, decision-making powers and legal accountability of each individual Board and Council of Governors. It explicitly confirms that the arrangement does not constitute a merger or transfer of statutory powers and places strong emphasis on clarity of decision-making, robust management of conflicts of interest and the continued independence of each Council of Governors.

The full Governance Framework is attached to this report as an Appendix 1 for consideration by the Board of Directors. In line with the approval route set out within the document, the framework requires formal approval by the Board and Council of Governors of each Trust before it can be adopted and implemented. At their Public Council of Governors meeting held on 13 May 2025, Governors approved the framework.

The Board is now therefore asked to review the appended document and provide formal approval, satisfying themselves that the proposed arrangements support effective governance, protect the interests of members and the public, and enable the Council of Governors to remain able to continue to discharge its statutory duties independently.

## People Matters

### Non-Executive Directors – Appointment of the Senior Independent Director

The Board is asked to approve the appointment of Sally Napper as Senior Independent Director (SID) backdated from 1 May 2026. This proposal has been supported by the Council of Governors at their meeting on 13 May 2026. The Board will be aware that Sally Napper currently undertakes the Senior Independent Director (SID) role (since 1 May 2024), in addition to their Non-Executive Director (NED) role.

## Accountability and Governance

### Revised Board and Sub-Committee meetings for 2026/27

Following the Board's recent agreement on the revised committee cycle for 2026/27, the Board is reminded that a number of immediate changes have been implemented to the dates and frequency of Board and Sub-Committee meetings, as outlined in Appendix 2.

These changes reflect a more tailored approach to the Board's current governance and assurance needs. This includes both an increase in the frequency of some Committees to strengthen oversight in key areas, and a reduction in others where this is considered proportionate and appropriate.

In particular, the Audit Committee will now meet quarterly, while the Charitable Funds Committee will move to three meetings per year. The Finance & Performance Committee and the People Committee will each increase to seven meetings annually, reflecting the breadth and pace of activity within these portfolios. The Quality & Safety Committee will adopt a monthly cycle (excluding August), further supporting robust oversight of quality and patient safety. The Mental Health Legislation Committee will, for the time being, remain on its existing two-monthly schedule.

Board members are therefore asked to note the updated meeting structure and schedule, as set out in Appendix 2.

### Revised Committee Membership

The Board is asked to note the revised arrangements for Non-Executive Director (NED) representation across Board Sub-Committees. Under the new structure, three NEDs will sit on all Committees, with the exception of the Charitable Funds Committee, which will have two. In addition, the People and Culture Committee and the Audit Committee will include an Associate Non-Executive Director once this role has been appointed.

The updated NED allocations are set out in the table below. The Corporate Governance Team will now begin updating the Terms of Reference for each Committee to reflect these changes where required.

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Finance & Performance (FPC)	MH Legislation (MHCL)	Quality & Safety (QSC)	People & Culture (PCC)	Audit (AC)	Charity (CFC)
Cleveland (Chair)	Warren (Chair)	Alyson (Chair)	Mark (Chair)	Chris (Chair)	Sally (Chair)
Mark (Member)	Alyson (Member)	Sally (Member)	Cleveland (Member)	Sally (Member)	Sarah (Member)
Warren (Member)	Sarah (Member)	Chris (Member)	Associate NED (once appointed) (Member)	Associate NED (once appointed) (Member)	-
<b>Frequency</b>					
<b>2 per Qrt (7)</b>	<b>Bi Monthly (6)</b>	<b>Monthly (11)</b>	<b>2 per Qrt (7)</b>	<b>Quarterly (4)</b>	<b>3 per Year (3)</b>

In person Board Meetings:

The Board is to be reminded that, in line with the revised governance arrangements, all Board meetings will now be held in person rather than as hybrid sessions.

Integrated Governance Guide

The Board is asked to note that the Corporate Governance Team has commenced a refresh of the Trust’s Integrated Governance Guide. As part of this work, a survey has been circulated across the Trust to gather feedback from colleagues on their awareness of the resource, how it is currently used within practice, and opportunities for improvement.

This engagement will help to ensure the guide remains relevant, accessible and aligned to the needs of staff. Further updates, including proposed revisions, will be brought back to the Board in due course.

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# Governance Framework

## Chair in Common arrangement

**Organisations:** Airedale NHS Foundation Trust ('AFT') and Bradford District Care NHS Foundation Trust ('BDCFT')

**Version:** 0.2

**Date:** May 2026

**Document owner:** Trust Secretary, AFT and BDCFT

**Approval route:** Board of AFT and BDCFT and Council of Governors of AFT and BDCFT

**Review date:** October 2026 (and thereafter annually)

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## Purpose

This document sets out the governance framework supporting the appointment of a single chair across two NHS foundation trusts while preserving the statutory responsibilities, accountabilities and decision-making powers of each board and the separate statutory role of each council of governors. It recognises the opportunity and efficiencies a shared role creates whilst maintaining the statutory responsibilities, governance requirements and legal accountability of individual Trusts.

## Document Control

Version	Date	Summary of amendments	Author/owner
0.1	13.04.26	Initial review by Trust Secretary and Lead Governors – AFT & BDCFT	Trust Secretary
0.2	May 26	COGs & AFT Board review draft	
0.3	June 26	BDCFT Board review draft	
1.0	June 26	Approved version	

## Approvals

Approving body	Date	Decision	Minute reference
Board of AFT	06.05/2026		
Board of BDCFT	04/06/2026		
CoG of AFT	20/05/2026		
CoG of BDCFT	13/05/2026		

## Associated documents at sovereign organisations

Standing Orders (including Standing Financial Instructions and Scheme of Delegation)

Conflicts of Interest Policy

Constitution

Provider Licence

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## Executive Summary

This Governance Framework (the ‘framework’) establishes the arrangements to facilitate a Chair in Common arrangement across AFT and BDCFT. Its purpose is to enable closer strategic alignment, lawful collaboration and strong leadership while preserving the separate statutory responsibilities, accountabilities and decision-making powers of each foundation trust. It works in response to existing governance frameworks within individual trusts.

The framework outlines that a Chair in Common arrangement does not create a merger, a unitary board or a transfer of statutory powers. Each board remains legally responsible and accountable for its own duties, and the council of governors of each foundation trust retains its separate statutory role in relation to the appointment, appraisal and holding to account of the chair and non-executive directors.

The document also defines the principal safeguards required for lawful and effective operation, including a clear decision-making architecture, robust conflict of interest management, explicit governor engagement and assurance arrangements, and formal review points to test whether the arrangement remains in the best interests of each foundation trust and the communities it serves.

### 1. Introduction

This framework sets out the arrangements supporting the appointment of a Chair in Common across AFT and BDCFT (the ‘foundation trusts’).

It is intended to support lawful, effective and transparent governance in line with the code of governance for NHS providers, relevant NHS England guidance, the Nolan Principles of public life, each trust’s standing orders and standing financial instructions and each council of governors statutory role.

In the event of any inconsistency between this framework and a statutory requirement the National Health Service Act 2006, Health and Care Act 2022 and, or any other formal constitutional document or statutory or constitutional requirement shall prevail.

### 2. Purpose and objectives

The objectives of the Chair in Common arrangement are to:

- strengthen collaboration between the foundation trusts
- support the delivery of safe, effective and sustainable services
- align strategy where appropriate
- foster collective leadership across the foundation trusts and their wider system relationships

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- provide a governance model capable of supporting alliance working, pathway integration, place-based collaboration and future organisational development.

Each Trust Board shall identify the benefits of the arrangement at the outset, and as part of succession planning, and keep delivery of those benefits under periodic review. Those reviews shall include formal consideration by each council of governors of whether the arrangement continues to support the effective discharge of the Chair's duties and the interests of the trust's members and the public.

### **3. Scope**

This framework applies to the Chair in Common, the boards of the foundation trusts, their committees and any committees in common (if applicable), The council of governors, and executive and non-executive directors involved in implementing or assuring these arrangements.

It covers role clarity, decision-making boundaries, meeting and committee structures, management of conflicts of interest, information sharing arrangements and review or exit arrangements.

It does not create a merger, acquisition, group structure or transfer of statutory powers.

### **4. Legal and statutory position**

Each foundation trust remains a distinct statutory body and retains its own board, council of governors, duties, accountabilities, liabilities and powers as a lawful structural change is not being made.

The appointment of a Chair in Common does not dilute or transfer the statutory duties of directors, nor does it remove the accountability of each board for quality, safety, finance, workforce, strategy, performance and governance. It also does not diminish the statutory functions of each council of governors in relation to the chair and non-executive directors.

Each board and each council of governors must continue to satisfy itself that decisions and assurance arrangements are managed through the correct governance route, in the interests of the own foundation trust, and with due regard to patients, members, staff and local communities.

### **5. Governance principles**

The foundation trusts will operate this arrangement in accordance with the following principles:

- separate statutory accountability
- clarity of decision making
- transparency

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- effective board leadership
- compliance with regulatory requirements and governance expectations
- robust management of conflicts of interest
- subsidiarity and proportionality
- respect for governors, members, patients, staff and local accountability including the distinct statutory role of each council of governors.

## **6. Role of the Chair in Common**

The Chair in Common shall chair the boards of AFT and BDCFT in accordance with the terms of appointment applying to each role, this framework, and the relevant provisions of each foundation trust constitution and governor arrangements. Following national statutory requirements, governance expectations and regulator guidance, include the Leadership Competency Framework (NHS England).

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

The Chair in Common shall not act as a substitute for the statutory board of either foundation trust, exercise decision making powers reserved to one foundation trust through the governance route of the other or assume executive functions other than those properly delegated.

## **7. Relationship with chief executives and executive leadership**

The Chair in Common is responsible for board leadership and effective governance; chief executives remain responsible for executive leadership, operational management and implementation within their respective foundation trusts.

## **8. Role of the Boards and Council of Governors**

Each board remains responsible for setting strategy, determining risk appetite, overseeing quality and patient safety, approving the annual plan and major investments, receiving assurance on performance, workforce, finance and governance, and discharging the duties of the unitary board for its own foundation trust.

The boards may work together through aligned meeting cycles, joint development sessions, meetings in common, and aligned reporting arrangements, provided always that the legal status and authority of each arrangement are defined in advance.

Each council of governors remains responsible for holding the non-executive directors, individually and collectively, to account for the performance of their board,

and for representing the interests of members and the public in the governance of the foundation trust.

## **9. Decision-making and matters reserved to each board**

Each foundation trust will maintain its own scheme of delegation and standing orders. Where aligned decisions are appropriate each foundation trust will approve separately through its own board or committee decision-making processes and in accordance with those matters reserved as set out in each respective standing orders.

The default position is that no matter shall be treated as jointly decidable unless the legal basis, delegated authority and governance route are explicitly clear and pre-agreed.

## **10. Meetings in common**

The foundation trusts may hold meetings in common that where both boards meet contemporaneously to consider shared matters. Each Trust Board can propose this as part of the formal Board meeting, keeping the council of governors informed of any situation that arises for joint discussions.

Meetings in common shall be convened in accordance with the standing orders of each foundation trusts, with a clear agenda identifying which items are for information, assurance, recommendation or separate decision.

Minutes shall clearly distinguish between joint discussion and any separate resolutions and where a matter requires approval by both foundation trusts the minute shall record the separate decision of each board.

The foundation trust may establish committees in common where there is a lawful and practical benefit in doing so. Committees that provide core assurance, such as audit and risk, quality, remuneration or charitable funds committees, shall only be shared where the boards are satisfied that assurance lines remain clear and effective.

## **11. Conflicts of interest**

The foundation trusts will manage conflicts of interest in accordance with NHS England guidance and each respective conflicts policy.

The Chair in Common must declare any actual, potential or perceived conflict arising from holding office across both foundation trusts.

A conflict may arise when the interests of the foundation trust diverge, one foundation trust is negotiating with or scrutinising the other, confidential information from one foundation trust cannot properly be used in the interests of the other, or the chair's impartiality could reasonably be questioned.

All conflict decisions shall be recorded in the minutes of the respective meeting and held on the register for Board declarations.

## **12. Deputy Chair and Senior Independent Director arrangements**

Each foundation trust shall maintain a clear arrangement for deputy chairing when the Chair in Common is unavailable, has a conflict of interest, is subject to appraisal or another sensitive process, or is otherwise unable to act.

Each board shall approve its own deputy arrangements and ensure it is known in advance of any conflict event.

In such circumstances, the Deputy Chair is solely responsible for their own Trust and will not chair or act as Chair for the other organisation.

The appointment process for the Deputy Chair and Senior Independent Director is a matter for individual trusts, following existing processes they hold.

## **13. Information sharing and confidentiality**

Effective collaboration requires timely and proportionate information sharing, but legal, governance and confidentiality boundaries must be respected.

Information may be shared where there is a legitimate governance, planning or assurance purpose, the sharing is lawful, confidentiality obligations are respected, and the information is necessary and proportionate, and in accordance with GDPR regulations.

## **14. Accountability to governors, members and regulators**

Each council of governors retains its separate statutory role in relation to the appointment, reappointment, removal and appraisal of the chair and the appointment and removal of the other non-executive directors, in accordance with the foundation trust constitution and the law.

Governors shall be kept appropriately informed of the rationale for the arrangement, expected benefits, governance safeguards and periodic evaluation findings. They shall also receive sufficient information to enable them to assess whether the Chair in Common continues to act in the best interests of their own foundation trust,

As a minimum, the governors of each foundation trust should receive a periodic report on the operation of the Chair in Common arrangement, including benefits realised, conflicts managed, material governance issues, and any recommendation to continue, amend or conclude the arrangement.

Each council of governors must remain able to discharge its statutory duties independently.

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## **15. Board assurance and reporting**

The boards and council of governors shall receive at periodic intervals, assurance on the operation of this framework.

As a minimum, assurance reporting shall cover benefits realised, significant decisions taken through meetings in common or parallel approval routes, conflicts of interest arising and how they are managed, impact on board effectiveness, stakeholder evidence, and risks associated with capacity, resilience and continuity.

## **16. Risk management**

Risks arising from the Chair in Common arrangement shall be identified and managed through each foundation trust risk management framework.

Typical risks may include, but not limited to, confusion over decision-making authority, unmanaged conflicts of interest, reduced board focus on one foundation trust, over extension of the Chair in Common, stakeholder concern, confidentiality breaches and assurance gaps across any shared committees (if applicable).

## **17. Capacity and support**

The foundation trusts shall ensure that the Chair in Common is supported by sufficient administrative and secretariate resource, aligned board calendars where possible, coordinated induction and development, clear prioritisation of agenda items, and access to advice from the Trust Secretary, in addition to use support, on topics such as, but not limited to, conflicts, governance, strategic alignment and regulatory matters.

The boards shall keep under review whether the time commitment remains realistic and sustainable.

## **18. Review of effectiveness**

This arrangement shall be reviewed formally at six months after commencement, at 12 months after commencement, and annually thereafter.

Reviews shall consider delivery of intended benefits, board effectiveness, impact on statutory accountability, governor confidence, adequacy of conflict management, quality of engagement with members and stakeholders, efficiencies for both trusts and the wider NHS, and whether the arrangement remains in the best interest of each foundation trust.

Effectiveness reviews shall be conducted as a two-way process between governors and the Chair in Common with input from the Senior Independent Director. The reviews will be supported by the Trust Secretary.

## **19. Variation, suspension and termination**

This framework may be amended only by approval of both boards and council of governors.

Either foundation trust may propose, after consultation with NHS England, suspension or termination of the arrangement where it is no longer in the foundation trust best interests, conflicts of interest have become unmanageable, the arrangement is no longer lawful or practicable, significant governance or performance concerns arise, or a formal structural change supersedes this framework.

Termination shall be managed in an orderly way and (with input from NHS England), with due regard to continuity of board leadership, appointment processes, council of governor involvement, internal and external communication, and any required changes to constitutions or delegated authorities.

## **20. Equality, inclusion and public interest**

In applying this framework, the foundation trusts will have due regard to the equality, inclusion and public sector duties and will act at all times in the public interest.

The Chair in Common shall uphold openness, integrity, accountability and leadership consistent with the Nolan Principles. As a NHS Board member, the Chair in Common role remains the same as any Board member role within the NHS with regards to the behaviours, capability expectations and performance. Following all statutory requirements and national guidelines associated with Board member positions with the NHS.

## **21. Review of document**

This document shall be reviewed no later than 31st October 2026, or sooner if there is a material change in law, guidance, organisational form or governance arrangements.

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## Board, Council of Governors and Sub-Committees Meeting Schedule

### Board

Name of meeting	Day	Dates 26/27	Time
Board held in Private	Thursday	02/04/2026	12.45-14.00
Board held in Public	Thursday	02/04/2026	9.30-12.15
Board Development 1	Thursday	30/04/2026	9.00-12.00
Board held in Private (online)	Thursday	07/05/2026	9.30-11.00
Board held in Public	Thursday	04/06/2026	9.30-12.30
Board held in Private	Thursday	04/06/2026	12.30-15.00
Board Nominations and Remuneration Committee (online)	Wednesday	10/06/2026	9.30-10.00
Extraordinary Board held in Private (online)	Thursday	25/06/2026	9.00-10.00
Board Development 2 (ALL DAY)	Thursday	09/07/2026	10.30-16.00
Board held in Public	Thursday	23/07/2026	9.30-12.30
Board held in Private	Thursday	23/07/2026	12.30-15.00
Board held in Public	Thursday	10/09/2026	9.30-12.30
Board held in Private	Thursday	10/09/2026	12.30-15.00
Board held in Private	Thursday	01/10/2026	9.30-11.30
Board Development 3	Thursday	01/10/2026	11.30-15.00
Board held in Public	Thursday	05/11/2026	9.30-12.30
Board held in Private	Thursday	05/11/2026	12.30-15.00
Board held in Private (online)	Thursday	03/12/2026	9.30-11.30
Board development 4 (online)	Thursday	03/12/2026	11.30-15.00
Board held in Public	Thursday	14/01/2027	9.30-12.30
Board held in Private	Thursday	14/01/2027	12.30-15.00
Board held in Private	Thursday	04/02/2027	9.30-11.30
Board development 5	Thursday	04/02/2027	11.30-15.00
Board held in Public	Thursday	04/03/2027	9.30-12.30
Board held in Private	Thursday	04/03/2027	12.30-15.00

- Please note a lunch break is not shown on the timings but will be incorporated within the Board sessions

### Council of Governors

Name of meeting	Day	Dates 26/27	Time
Council of Governors Private	Wednesday	13/05/2026	16.30-17.00
Council of Governors Public	Wednesday	13/05/2026	17.00-18.30
Council of Governors Nominations and Remuneration Committee (online)	Wednesday	10/06/2026	10.00-10.30
Council of Governors Private	Wednesday	29/07/2026	16.30-17.00
Council of Governors Public	Wednesday	29/07/2026	17.00-18.30
Council of Governors Private	Wednesday	11/11/2026	16.30-17.00
Council of Governors Public	Wednesday	11/11/2026	17.00-18.30
Council of Governors Private	Wednesday	10/02/2027	16.30-17.00
Council of Governors Public	Wednesday	10/02/2027	17.00-18.30

**AMM**

Annual Members Meeting	Thursday	24/09/2026	13.00-17.00
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**Sub-Committees**

Name of meeting	Day	Dates 26/27	Time
Audit Committee	Thursday	18/06/2026	9.30-12.00
Audit Committee	Wednesday	23/09/2026	13.00-15.30
Audit Committee	Thursday	10/12/2026	9.30-12.00
Audit Committee	Thursday	25/03/2027	9.30-12.00
Charity Funds Committee	Thursday	25/06/2026	10.00-12pm
Charity Funds Committee	Thursday	29/10/2026	9.30-11.00
Charity Funds Committee	Thursday	18/02/2027	9.30-11.00
Finance and Performance Committee	Wednesday	27/05/2026	9.30-11.30
Finance and Performance Committee	Wednesday	22/07/2026	9.30-11.30
Finance and Performance Committee	Wednesday	23/09/2026	9.30-11.30
Finance and Performance Committee	Wednesday	25/11/2026	9.30-11.30
Finance and Performance Committee	Wednesday	16/12/2026	9.30-11.30
Finance and Performance Committee	Wednesday	24/02/2027	9.30-11.30
Finance and Performance Committee	Wednesday	24/03/2027	9.30-11.30
Mental Health Leg Committee	Thursday	21/05/2026	9.30-11.30
Mental Health Leg Committee	Thursday	16/07/2026	9.30-11.30
Mental Health Leg Committee	Thursday	17/09/2026	9.30-11.30
Mental Health Leg Committee	Thursday	19/11/2026	9.30-11.30
Mental Health Leg Committee	Thursday	21/01/2027	9.30-11.30
Mental Health Leg Committee	Thursday	18/03/2027	9.30-11.30
People and Culture Committee	Thursday	21/05/2026	12.30-14.30
People and Culture Committee	Thursday	18/06/2026	12.30-14.30
People and Culture Committee	Thursday	17/09/2026	12.30-14.30
People and Culture Committee	Thursday	22/10/2026	12.30-14.30
People and Culture Committee	Thursday	17/12/2026	12.30-14.30
People and Culture Committee	Thursday	21/01/2027	12.30-14.30
People and Culture Committee	Thursday	18/03/2027	12.30-14.30
Quality and Safety Committee	Wednesday	15/04/2026	9.30-11.00
Quality and Safety Committee	Wednesday	20/05/2026	9.30-12.00
Quality and Safety Committee	Wednesday	17/06/2026	9.30-11.30
Quality and Safety Committee	Wednesday	15/07/2026	9.30-12.00
Quality and Safety Committee	Wednesday	16/09/2026	9.30-12.00
Quality and Safety Committee	Wednesday	21/10/2026	9.30-11.30
Quality and Safety Committee	Wednesday	18/11/2026	9.30-12.00
Quality and Safety Committee	Thursday	17/12/2026	9.30-11.30
Quality and Safety Committee	Wednesday	20/01/2027	9.30-12.00
Quality and Safety Committee	Wednesday	17/02/2027	9.30-11.30
Quality and Safety Committee	Wednesday	17/03/2027	9.30-12.00

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## Escalation and Assurance Report

Report from: West Yorkshire Commissioning Hub

Date of the meeting: 16<sup>th</sup> April 2026

**Key discussion points and matters to be escalated from the discussion at the meeting:**

### **Alert/Action:**

#### **WY Commissioning Hub**

- Formal notification was received 9<sup>th</sup> March from NHSE regarding the population of St Andrew's Hospital Northampton. WYCH are engaged with national and regional colleagues to support the transition, transfer and discharge of the patient group effected by the expiration of the NHSE contract. Requests from NHSE have been acted upon within timescales. There are 2 people originating from WY, and ICB colleagues have been engaged in Calderdale and Leeds. WYCH are meeting with national NHSE teams as coordinators with the request that individuals are transferred by end of June 2026. Whilst we are confident this will be achieved for 1 of our gentlemen, WYCH are working closely with Calderdale to support an optimum transfer for the other, who has complex needs and co-morbidities.
- NHSE are working closely with Lead Provider (LP) Executive Directors in response to the expiry of NHSE/ LP contracts (March 2027); this in anticipation of Provider Selection Regime to identify the most suitable (Lead) Provider for proposed revised geographies. The development of OPIC is progressing as planned.
- The proposed transfer of Dynamic Support Register / Community (Education) Treatment Reviews function from NHS West Yorkshire Integrated Care Board (ICB) to WYCH (LYPFT) is currently in the consultation phase. The proposals include the TUPE measures for staff and will ensure a centralised approach to West Yorkshire specialised commissioning CeTRs.

#### **Children and Young People PC**

- Remedial works on RKV PICU are progressing according to schedule. The Trust and WYCH continue to monitor progress via tactical and strategic level groups. The completion date of end of April remains in place. A restoration and re-occupancy plan will be co-created between WYCH and RKV.

#### **Adult Secure PC**

- A review of "waiting" has been conducted, highlighting the significant challenge in achieving the 28day transfer target (MH Bill, 2022). The paper has made a number of recommendations, which will be "reviewed and refined" through a board approved quality improvement task and finish group.
- The PC have the highest number in AS cohort since March 2022, and increased OOA placements, supporting the overall data of increased demand across the secure service line. Given the challenges with national secure hospital estate (above), this is likely to continue as PCs respond to a reduced bed base.

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### Adult Eating Disorders

- Business Continuity at Ward 6 CONNECT has concluded, a number of stabilising actions have been agreed upon with WYCH, which will draw upon the support of LYPFT nursing directorate.

### Perinatal Mental Health PC

- There are national occupancy pressures which might materialise into increased referrals for those outside Yorkshire & Humber and/ or challenge in accessing alternative MBU provision for those originating from the Y&H region.

### Advise:

### WY Commissioning Hub

- WYCH are exploring population prediction tools using retrospective data. It is anticipated WYCH will share this across respective PC boards to inform future QI.
- WYCH are developing a quality dashboard for commissioning and quality activity undertaken by WYCH
- The successful regional review of pathways for secure care, will be rolled out across CYPs in the coming 2 months, and will include regional LDA (T4) pathways.

### Children and Young People PC

- SY ICB are leading on an external review into the care and treatment of a complex young gentleman originating from WY, placed within Rotherham Hospital after placement breakdown. Recommendations will be shared.
- Following the access assessment project which completed in October 25, WYCH Quality Lead is working with the PC Lead, to develop a proposed model and business case of future advice/guidance for CAMHS, outreach and a robust access assessment function. Work with neighbouring PCs is underway to ensure a consistent, regional approach.

### Adult Secure PC

- Reconfiguration of secure beds and an options appraisal has been developed and discussed at PC board, who supported an approach for region-wide data collection and analysis. Our first regional face to face event revealed opportunities for Y&H.
- WY AS PC Lead is leading a regional SPA review, to promote and strengthen consistency of approach for secure referrals.

### Adult Eating Disorders

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**Perinatal Mental Health PC**

- PMH case manager project for those women admitted to AMH/ PICU pathways is experiencing some challenge in accessing information. An in-depth discussion is expected at PC board to strengthen the support for the project.

**Assure:**

**WY Commissioning Hub**

- In-line with our approved PSIRF SOP, the WYCH has included a deep dive within Q1 contracts reviews.

**Children and Young People PC**

- There remains no young person placed by WYCH in LSU, and no young person in receipt of restrictive LTS/ EPCs. This has been consistent since July 2025.

Case Manager review compliance:

- Children and Young People = 100% of ALL service users; in and out of WY

**Adult Secure PC**

- A service user AGM has been planned and arranged. This inaugural meeting is scheduled for this month and is supported by the Y&H involvement network.

Case Manager review compliance:

- Adult Secure = 90.49% of ALL service users; in and out of WY

**Adult Eating Disorders**

- There are no WY service users currently out of area.
- SPC metrics continue to evidence positive changes in processes and systems.

Case Manager review compliance:

- Adult Eating Disorders = 100% \* *There are no OOA placements*

**Perinatal Mental Health PC**

- PC Assurance Board has given support to begin informal conversations with providers and ICB's to explore potential options system working in overseeing quality across the whole PMH pathway (community, MBU, adult acute/PICU)

Case Manager review compliance:

- Perinatal Mental Health = 100% of ALL service users.

**Report completed by:** Sarah Sams **Date:** 7<sup>th</sup> April 2026

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<p>3. Executive sponsorship of priority collaborative programmes, particularly WY SaLT, low-level falls, reablement/intermediate care pathways, and shared learning to reduce duplication and variation across places.</p>	<p>Review assurance success measures at system level (e.g. reduction in variation, improved flow, productivity gains).</p> <p>Consider protected capacity for staff involved in collaborative design, testing and implementation.</p> <p>Support shared learning reports to ensure scaling of what works and avoidance of duplication across places.</p>	<p>All</p>	<p>Ongoing</p>
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**Advise:**

West Yorkshire community collaborative delivery is progressing, but there are emerging risks requiring organisational attention: pace of delivery against agreed transformation priorities (particularly Speech & Language Therapy), continued variation across community services (most notably children’s pathways), data maturity inconsistencies limiting benchmarking and outcomes assurance, and a risk that place-based decisions on 2026/27 community uplift funding could inadvertently increase unwarranted variation across West Yorkshire if not sufficiently coordinated. Community dental recovery and ND/community waiting pressures also remain areas of concern.

**Assure:**

The collaborative has delivered demonstrable system benefits over the last year, including strengthened urgent community care pathways, approved recurrent investment in the WY falls model, successful mobilisation of the Community Dental Collaborative, progress toward the 48-hour reablement ambition, and improved system-wide transparency on community performance and priorities. Governance remains active, recurrent funding has been secured for key programmes, and a formal review of strategic priorities/governance arrangements will ensure continued alignment with 2026/27 system objectives and the NHS planning framework.

**Report completed by:**

Becca Spavin  
 Programme Director: West Yorkshire Community Healthcare Provider Collaborative  
 29.4.26

**Report distribution:**

Chairs and Company Secretaries of Airedale NHSFT, Bradford District Care Trust, Calderdale and Huddersfield NHSFT, Harrogate and District NHSFT, Leeds Community Healthcare NHS Trust, Locala, Mid Yorkshire Teaching Hospital NHS Trust and Yorkshire Ambulance Service

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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	Date 02.04.26	Date 04.06.26	Date 23.07.26	Date 10.09.26	Date 5.11.26	Date 14.01.27	Date 04.03.27
Good Governance	Apologies	Verbal	X	X	X	X	X	X	X
Good Governance	Declarations of conflicts of interest	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X
Good Governance	Risk appetite matrix	FS (Trust Secretary)		X	X	X	X	X	X
Good Governance	Service User or Carer Story	Suzanne Hala	X	X	X	X	X	X	X
Good Governance	Minutes of last meeting	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X
Good Governance	Matters arising	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X
Good Governance	Action log	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X
Good Governance	Work Plan	RT (Deputy Trust Secretary)	X	X	X	X	X	X	X
Good Governance	Any other business	Verbal	X	X	X	X	X	X	X
Good Governance	Comments from public observers	Verbal	X	X	X	X	X	X	X
Good Governance	Meeting evaluation	Verbal	X	X	X	X	X	X	X
All	Chairs Report	MH (Executive Assitant)	X	X	X	X	X	X	X
All	Chief Executive Report	TP (Chief Executive)	X		X	X	X	X	X
All	Strategic Assurance and Performance Report	FS (Trust Secretary)	X	X	X	X	X	X	X
All	Strategic Risk Assurance Report/Summary	FS (Trust Secretary)	X	X	X	X	X	X	X
Best Quality Services	Suicide prevention annual report	SU (CMO)			X				
Best Quality Services	Winter planning	KB (COO)				X	X	X	
Best Quality Services	Access and waits	KB (COO)			X				x tbc
Best Quality Services	NHS England Emergency Preparedness, Resilience and Response Assessment and Declaration (TBC)	KB (COO)				X			
Best Quality Services	Learning from Deaths report (date TBC)	SU (CMO)							
Best Quality Services	Organisational Risk Register/Reporting	FS (Trust Secretary)	X	X	X	X	X	X	X
Best Quality Services	Risk Management - update on RMS/risk tolerance	Paula Riely					X		
Best Quality Services	AAAD Mental Health Legislation Committee	WB (NED)/CGT		X	X		X	X	X
Best Quality Services	AAAD Quality and Safety Committee	AM (NED)/CGT	X	X	X		X	X	X
Best Quality Services	Compliance Against Care Quality Commission Registration (as required)				X				
Best Quality Services	Care Quality Commission Update and Developments (as required)								
Best Quality Services	NHS England Quarterly Submissions	C Risdon			X		X		
Best Quality Services	Complaints annual report	Rebecca Le-Hair/Elizabeth Hadley-Day			X				
Best Quality Services	Annual quality account (for info)	L Graham		X					
Best Quality Services	GoSee report thematic learning report (annual)	RT (Deputy Trust Secretary)						X	
Best Place to Work	Staff Survey Results	H Farrar	X	X					
	Annual safer staffing report			X					
Best Place to Work	AAAD People and Culture Committee	MR (NED)/CGT		X	X		X	X	X

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Best Place to Work	Freedom to speak up guardian bi-annual thematic report	R Wixey		X				X	
Best Place to Work	Medical appraisal and revalidation annual report	SU (CMO)			X				
Best Place to Work	Guardian of safe working annual report				X				
Best Place to Work	Gender pay gap annual report (include in PCC AAAD report)	L Wright	X						X
Best Use of Resources	Final financial plan 2025-26 (tbc)	C Risdon							
Best Use of Resources	Operational plan 2026-27 (tbc)	C Risdon							
Best Use of Resources	Finance report	C Risdon	X	X	X	X	X	X	X
Best Use of Resources	Green plan	Emma Clarke	X		X				
Best Use of Resources	AAAD Finance and Performance Committee	CH (NED)/CGT		X		X	X	X	X
Best Use of Resources	AAAD Charity Funds Committee	MR (NED)/CGT			X		X		X
Good Governance	NHS Oversight Framework quarterly report	FR (ED TIP)	X		X		X	X	
Good Governance	AAAD Audit Committee	CM (NED)/CGT		X	X		X	X	
Good Governance	Annual Declaration of Interest for the Board of Directors	Executive Assistant		X	X				
Good Governance	Annual Declaration of Fit and Proper Person Regulation for the Board of Directors	Executive Assistant		X	X				
Good Governance	Annual Declaration of Independence (NED)	Executive Assistant		X	X				
Good Governance	Annual Review of Division of Duties of the Chair and Chief Executive (timing tbc)	FS (Trust Secretary)							
Good Governance	Scheme of Delegation and Standing Financial Instruction Ratification	C Risdon					X		
Good Governance	Use of the Trust Seal - annual report	FS (Trust Secretary)			X				
Good Governance	BoD Annual Effectiveness Review	FS (Trust Secretary)			X				
Good Governance	BoD Terms of reference annual review	FS (Trust Secretary)			X				X
Good Governance	Sub-Committee annual reports	CGT	X						X
Good Governance	Sub-Committee annual terms of reference report	CGT	X		X				X
Good Governance	Sub-Committee annual effectiveness review report	CGT	X		X				X
Best Use of Resources	Senior Information Risk Owner Annual Report	Delphine Fitouri (Head of Digital Services)			X				
Good Governance	Annual Review of the Constitution	FS (Trust Secretary)				X			
Good Governance	Health Safety and Security Annual Report				X				
Good Governance	Board Development Programme Work Plan	CGT			X			X	X
	Board of Directors meeting Annual work plan	CGT	X	X	X	X	X	X	X
	Notification future public meeting dates	CGT	X	X				X	
Good Governance	AAA: WY&H Mental Health, Learning Disabilities and Autism Committee in Common (as received)	RT (Deputy Trust Secretary)				X			
Good Governance	AAA: WY Commissioning Hub (as received)	RT (Deputy Trust Secretary)		X					
Good Governance	AAA: Committees in Common (CinC) for the Community Collaborative (as received)	RT (Deputy Trust Secretary)							
Good Governance	Annual Review of Board Skills Matrix	CGT				X			
Best Use of Resources	Green plan	E Clarke	X						
Good Governance	Well led development plan	FS (Trust Secretary)	X	X	X	X	X	X	X