

Board of Directors - held in Public

Thursday 10 September 2026, 09:30 - 12:30

Meeting to be held in person at 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 5 min	1. Welcome and apologies for absence (verbal) <i>Information Sarah Jones</i> Item 01.0 - Board of Directors Agenda - held in public - 10 Sept 2026 v3.pdf (3 pages)
09:35 - 09:35 0 min	2. Declaration of any conflicts of interest (enclosure) <i>Information Sarah Jones</i> Item 02.0 - Declarations of Interest - Board of Directors - September 2026.pdf (4 pages)
09:35 - 09:35 0 min	3. Trust Risk Appetite Matrix (enclosure) <i>Information Fran Stead</i> Item 03.0 - Risk Appetite Matrix.pdf (1 pages)
09:35 - 09:35 0 min	4. Questions received (verbal) <i>Discussion Sarah Jones</i>
09:35 - 09:35 0 min	5. Minutes of the previous meeting held on 4 June 2026 (to follow) <i>Decision Sarah Jones</i> Item 05.0 - Public Board minute 4 June 2026 - Chair approved.pdf (17 pages)
09:35 - 09:35 0 min	6. Matters arising (verbal) <i>Information Sarah Jones</i>
09:35 - 09:40 5 min	7. Action log (enclosure) <i>Sarah Jones</i> Item 07.0 - Public Board of Directors - Action Log - for 10 Sept 2026 v.2.pdf (2 pages)

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09:40 - 10:00 8. Board story - Inspired to Make a Difference: AI's Story (presentation)

20 min

Discussion

Phillipa Hubbard, Suzanne Hala and AM

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

5 min

Sarah Jones

 Item 09.0 - Chair's Report - 10 September 2026 (final)_.pdf (3 pages)

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

10 min

Discussion

Therese Patten

 Item 10.0 - CE Report Public Sept 26.pdf (10 pages)

Quality and Safety

10:15 - 10:25 11. Bradford and District Safe Staffing Assurance Report (enclosure)

10 min

Discussion

Phillipa Hubbard

 Item 11.0 - Bradford and District Safe Staffing Assurance Report (cover sheet).pdf (5 pages)

 Item 11.0.1 - FINAL BDCT Safe Staffing Assurance Report.pdf (29 pages)

10:25 - 10:35 12. Winter plans (enclosure)

10 min

Discussion

Kelly Barker

10:35 - 10:45 13. EPRR annual report (enclosure)

10 min

Approval

Kelly Barker

 Item 13.0 - Board Paper - EPRR Self Assessment (final).pdf (5 pages)

10:45 - 10:55 14. Medical appraisal and revalidation annual report (enclosure)

10 min

Decision

Sal Uka

 Item 14.0 - Public Board 10th September 2026 - Medical appraisal and revalidation annual report.pdf (24 pages)

10:55 - 11:05 Break (10.55 – 11.05)

10 min

Finance and Sustainability

11:05 - 11:15 15. Finance Report (enclosure)

10 min

Discussion

Mike Woodhead

 Item 15.0.0 - Finance Report (Cover paper).pdf (3 pages)

 Item 15.0.1 - Trust Board - Finance Report (Month 4 - July 2026).pdf (11 pages)

 Item 15.0.2 - appendix - letter - Ref 055_SA_RD_Bradford_District_Care_NHS_FT.pdf (4 pages)

11:15 - 11:30 16. AAAD Extraordinary Finance and Performance Committee held on 20 August 2026 (enclosure)

15 min

Close Holly
04/09/2026 14:22:33

Strategy and partnerships

11:30 - 11:40

10 min

17. Integrated Strategic Performance and Quality Report (enclosure)

Discussion

Kelly Barker & Phillipa Hubbard

 Item 17.0.0 - ISPQR - August 2026 - Trust Board Cover Paper FINAL.pdf (7 pages) Item 17.0.1 - ISPQR - August 2026 (July Data) FINAL.pdf (57 pages)

17.1. Board Assurance Framework (enclosure)

Fran Stead

 Item 17.1.0 - Board Assurance Framework - Public Board - 10 September 2026 - Final.pdf (7 pages)

11:40 - 12:05

25 min

18. Better Lives Together Strategy Refresh 2026-31 (enclosure)

Farhan Rafiq

 Item 18.0.0 - Public Board paper template - Better Lives Together Strategy Refresh 10th Sep FS.pdf (7 pages) Item 18.0.1 - Better_Lives_Strategy_3.926_FINAL.pdf (44 pages) Item 18.0.2 - Better Lives_Supporting_Delivery_Framework_3.9.26_FINAL.pdf (36 pages)

Governance and well led

12:05 - 12:15

10 min

19. SPA signing (enclosure)

Discussion

Fran Stead

 Item 19.0.0 - BDC Strategic Partnering Arrangement 2026.07 - September public.pdf (3 pages) Item 19.0.0 - SPA_2026-27 FinalCLEAN_070726 v4.0.pdf (71 pages)

12:15 - 12:25

10 min

20. Governance report (enclosure) • PCA update

Discussion

Fran Stead

 Item 20.0.0 - Governance report- v.0.2.pdf (6 pages) Item 20.0.1 - Appendix - Board Nom Rem ToR Draft update May 26 v2.pdf (8 pages)

12:25 - 12:25

0 min

21. Partnership reports (enclosure)

Information

None received

 Item 21.0 - WYCHS Escalation and Assurance Report - 7.7.26 v0.1.pdf (3 pages)

12:25 - 12:25

0 min

22. Board of Directors public meeting work plan 2026-27 (enclosure)

Information

Information

 Item 22.0 - Work Plan - Board 202627 DRAFT.pdf (2 pages)

12:25 - 12:30

5 min

23. Any other business (verbal)

Discussion

Sarah Jones

Close: Holly
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12:30 - 12:30
0 min

24. Meeting evaluation (verbal)

Discussion Sarah Jones

Was the meeting conducted in line with the Trust values?

Date of next meeting: 5 November 2026– final details to be confirmed by Corporate Governance Team

Board of Directors – held in public

Date: Thursday 10 September 2026

Time: 9.30 until 12.30

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



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	Welcome and apologies for absence (verbal)	SJ	For information	9.30
	2	Declaration of any conflicts of interest (enclosure)	SJ	For information	
GG	3	Trust Risk Appetite Matrix (enclosure)	FS	For information	
BUOR	4	Questions received (verbal)	SJ	For discussion	
GG	5	Minutes of the previous meetings held on 4 June 2026 and 23 July 2026 (enclosures)	SJ	For decision	
	6	Matters arising (verbal)	SJ	For information	
	7	Action log (enclosure)	SJ	For decision	9.35
BQS	8	Board Story Presentation –Critical Medicines Initiative (presentation)	PH/ Prabhdeep Sidhu	For discussion	9.40
All	9	Chair's Report (enclosure)	SJ	For discussion	10.00
	10	Chief Executive's Report (enclosure)	TP	For discussion	10.05

Quality and Safety

BQS	11	Bradford and District Safe Staffing Assurance Report (enclosure)	PH	For information	10.15
	12	Winter plans (enclosure)	KB	For discussion	10.25
	13	EPRR annual report (enclosure)	KB	For approval	10.35
	14	Medical appraisal and revalidation annual report (enclosure)	SU	For approval	10.45
Break (10.55 – 11.05)					

Finance and Sustainability

BUOR	15	Finance Report (enclosure)	MW	For discussion	11.05
	16	AAAD Extraordinary Finance and Performance Committee held on 20 August 2026 (enclosure)	CH	For discussion	11.15

Strategy and partnerships

All	17	Integrated Strategic Performance and Quality Report (enclosure)	PH/ KB	For discussion	11.30
		17.1 – Board Assurance Framework (enclosure)	FS		
All	18	Better Lives Together Strategy Refresh 2026-31 (enclosure)	FR/CS	For discussion	11.40

Governance and well led

GG	19	SPA signing (enclosure)	FS	For decision	12.05
	20	Governance report (enclosure) • PCA update	RT	For decision	12.15
	21	Partnership reports (enclosure) • tbc	For info	--	-
GG	22	Board of Directors public meeting work plan 2026-27 (enclosure)	For info	For information	-
	23	Any other business (verbal)	SJ	For discussion	12.25
	24	Meeting evaluation (verbal)	SJ	For discussion	-

		Was the meeting conducted in line with the Trust values? (verbal)			
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Date of the Next Meeting: 5 November 2026– final details to be confirmed by Corporate Governance Team

Questions for the Board of Directors can be submitted to:

Name: Fran Stead (Trust Secretary)

Email: fran.stead@bdct.nhs.uk

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

Email: sarah.jones@bdct.nhs.uk

Expressions of interest to observe the meeting using Microsoft Teams:

Email: corporate.governance@bdct.nhs.uk

Strategic Priorities (Key)

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

Close: Holly
04/09/2026 14:22:13

Name	Directorships, including Non-Executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).
Kelly Barker	No
Joanne Harrison	No
Phillipa Hubbard	Director of Nursing and Quality within WY ICB working into Bradford District and Craven
Therese Patten	None
Farhan Rafiq	Not applicable
Tim Rycroft	NA
Sal Uka	Nil
Mike Woodhead	none
Warren Brown	Nil
Cleveland Henry	None
Sarah Jones	Trust Chair at Airedale NHS FT
Chrisopher Malish	Bradford College
Alyson McGregor	None
Sally Napper	None
Mark Rawcliffe	Horse and Jockey Horbury Bridge Limited Park Tavern Ossett Limited Dark Industries Limited

Close/Held
04/09/2026 14:22:13

Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	Position of authority in a charity or voluntary organisation in the field of health and social care
Exec		
No	No	No
No	No	No
Langtry-Langton Architects	None	None
None	None	None
Not applicable	Not applicable	Not applicable
NA	NA	NA
Nil	Nil	Trustee Overgate Hospice in Halifax
none	none	none
Non Exec		
Nil	Nil	Nil
None	None	None
None	None	None
N/A	N/A	Outside my Non-exec role - none
None	None	None
None	None	None
As above 50% holding	N/a	N/a

Close/Holly
04/09/2016 14:22:13

Any connection with a voluntary or other organisation contracting for NHS services	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited...
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Executive Directors

No	No
Chief People Officer Co-Chair of the North East and Yorkshire CPO network, hosted by NHS Employers.	No
None	None
None	None
Not applicable	Not applicable
NA	NA
Nil	Nil
none	none

Executive Directors

Nil	Nil
None	None
None	None
No	No
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
N/a	N/a

Close, Holly
04/09/2026 14:22:13

Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not in...	Declarations made in respect of spouse, co-habiting partner, or close associate
No	Early Intervention in Psychosis Service
No	No
None	None
None	Spouse a social worker with North Yorkshire Council
Not applicable	Not applicable
NA	NA
Nil	Nil
none	Training Ltd) is providing service to BDCT
Nil	Spouse is a member of Ilkley Town Council
Employed at EMIS Health/Optum UK (Software supplying to NHS) Director of Leeds Digital Ball CIC	Spouse Lead Cancer Nurse, Leeds Teaching Hospital Trust NHS
None	None
No	None
None	None
None	None
None	None
N/a	N/a

Close/Holly
04/09/2016 14:22:13

Risk Appetite Matrix

	0 - None Avoidance of risk is a key organisational objective.	1 - Minimal Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 - Cautious Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 - Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 - Seek Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 - Significant Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL 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.
REGULATORY 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.
QUALITY 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.
REPUTATION 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
PEOPLE 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.

Agenda
Item
05.0

Board of Directors - held in Public
Thursday 4 June 2026 at 09:30
Meeting held in person 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
	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
	Sally Napper	Non-Executive Director and Senior Independent Director
	Farhan Rafiq	Director of Transformation, Improvement and Productivity
	Mark Rawcliffe	Non-Executive Director and Deputy Chair
	Dr Sal Uka	Chief Medical Officer
In attendance in person:	N Rodgers	Speech and Language Therapy Clinical Lead, Early Language Support for Every Child Project (agenda item 08.0)
	Rebecca Wixey	Freedom to Speak up Guardian (agenda item 14)
	Catherine Sunter	Deputy Director of Performance and Planning (agenda item 20)
	Fran Stead	Trust Secretary
	Claire Risdon	Operational Director of Finance (representing M Woodhead)
	Rachel Trawally	Corporate Governance Manager and Deputy Trust Secretary (Secretary)
Observer(s):	Jo Harrison	Incoming Joint Chief People Officer
	Mike Lodge	Lead Governor
Apologies:	Warren Brown	Non-Executive Director
	Tim Rycroft	Chief Information Officer
	Mike Woodhead	Chief Finance Officer

Close: Holly
04/09/2026 14:22:13

MINUTES

Item	Discussion	Action
28	Welcome and Apologies for Absence (agenda item 1) The Chair, S Jones opened the Board of Directors meeting held in Public and noted the attendance of M Lodge, Lead Governor as an observer and the incoming Joint Chief People Officer, J Harriison. Apologies for absence were noted, and the meeting was confirmed as quorate.	
29	Declarations of interest (agenda item 2) The Chair declared that they were Chair of Airedale NHS Foundation Trust and also served as Co-Chair of the organisation. No other declarations of interest were made.	
30	Trust Risk Appetite Matrix (agenda item 3) The Trust Risk Appetite Matrix was received for information.	
31	Questions received (agenda item 4) No questions were received.	
32	Minutes of the previous meeting held on 2 April 2026 (agenda item 5) The minutes of the Board of Directors held in Public on 2 April 2026 were approved as a true and accurate record.	
33	Matters arising (agenda item 6) No matters arising had been received.	
34	Action log (agenda item 7) The Chair presented the action log. B Champion, Chief People Officer confirmed that the one outstanding action for June was now complete. This was in relation to an action arising from discussion of the Strategic Risk Report and revised wording had been incorporated. The Board of Directors: • noted the contents of the action log; • agreed to close the actions listed as complete; and • noted that no further actions were required on any actions listed.	

Item	Discussion	Action
35	Board Story presentation: (agenda item 8) P Hubbard, Director of Nursing, Professions and Care Standards, Deputy Chief Executive introduced N Rodgers, Speech and Language Therapy Clinical Lead, who presented an overview of the Early Language Support for Every Child programme in Bradford, which aimed to identify and support speech, language and communication needs earlier, strengthen health and education links, reduce specialist referrals and build workforce capacity. In phase one, the programme supported 629 families across four schools and four nurseries in high-need wards, increasing children assessed as green from 32% to 64%, 46% of those initially red moved to amber or green; and 73% of those initially amber moved to green. Only five were referred to the core speech and language therapy service. Phase two expanded to 12 further nurseries for children aged two to five, with a focus on early years and school readiness through nursery staff coaching, video coaching, play-based group interventions and family engagement, including story bus visits, free books, parent workshops and interpreters. Feedback from children, parents and staff had been positive, with reported quick improvements where strategies were used consistently. Challenges included complex funding routes and short-term extensions, with re-screening, data analysis, national evaluation work and discussions on mainstreaming and potential expansion through future commissioning ongoing. A McGregor, Non-Executive Director, asked how the programme aligned with core speech and language therapy pressures and waiting lists. It was explained that the model supported triage and early intervention, subject to sufficient capacity and support in education settings. T Patten, Chief Executive, asked about family engagement given local literacy challenges. It was noted that trusted nursery settings and the National Literacy Trust story bus had supported engagement, although some families remained harder to reach. S Uka, Chief Medical Officer, asked about data sharing with Born in Bradford for longitudinal evaluation. It was confirmed that this was not yet formalised, although initial discussions had taken place. K Barker, Chief Operating Officer, highlighted the programme's wider social value, including potential benefits for mental health, family wellbeing, cost avoidance and alignment with neighbourhood working, community partnerships and care networks.	

Close: Holly
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Item	Discussion	Action
	F Rafiq, Director of Transformation, Improvement and Productivity, asked about standardising video coaching and spreading learning; it was explained that this supported staff reflection and could be delivered by skilled support workers, although further core service capacity would be needed for a rolling training programme. S Napper, Non-Executive Director, asked about links with other services for children known to multiple practitioners. It was explained that the programme strengthened the setting-based offer, including for some children already known to speech and language therapy, although links with health visiting and wider services could be better coordinated. The Board noted the positive outcomes achieved through the programme. The Board welcomed the presentation and were assured by the update.	
36	Chair's Report (agenda item 9) The Chair presented the report, highlighting key updates since the previous reporting period. The Chair reported that the Chair's appraisal had been undertaken by the Senior Independent Director and Lead Governor. The evaluation process for the Chair in Common role with Airedale NHS Foundation Trust had commenced, including completion of the first stage with the Lead Governor, with further review activity planned later in the year. The Board of Directors noted the report and the continued engagement with external partners, the Trust and the Council of Governors.	
37	Chief Executive's Report (agenda item 10) T Patten, Chief Executive presented the report and highlighted key areas of progress. The Board noted: • progress with the Lynfield Mount Hospital redevelopment, including the recent ground-breaking event. • that Keeping My Chest Healthy had won an HSJ Award and was now accredited and licensed, supporting the wider sharing of Trust innovation. • progress with modern service framework submissions despite national portal challenges. • that the new Secretary of State for Health and Care had met with Chief Executives and had given a positive message on delivery and continuity of existing plans.	

Close: Holly
04/09/2026 14:22:13

Item	Discussion	Action
	No questions were raised at this point in relation to the Chief Executive's Report. K Barker updated the Board on national modern service framework "moonshot" submissions, noting that at least one submission had been made for each areas, and examples of good practice had been submitted across serious mental health problems, children and young people, and frailty and dementia, although the feedback process remained unclear. S Uka advised that the Trust had received positive verbal feedback from an NHS England education and training assurance visit, including on actions following a dip in the General Medical Council National Training Survey, and had placed top in Yorkshire and Humber in the multi-professional National Education and Training Survey. S Uka also highlighted Lord Mann's report into antisemitism and racism in the NHS; further guidance was awaited, with the Trust's response to be considered through the People and Culture Committee and report back to Board. T Patten noted related work being undertaken through the Health Equity and Anti-Racism Strategy and Patient and Carer Race Equality Framework. A McGregor asked how the Board was addressing systemic racism and discrimination. It was agreed that the Board should have greater visibility of the breadth of the work, to be considered through a future Board development session on values, belonging and inclusion. Action: to include in the Board development schedule for 9 July 2026. M Rawcliffe, Non-Executive Director, asked whether the new Secretary of State's message had recognised system pressures. T Patten advised that the initial meeting was positive and confirmed continuity of direction, with a further face-to-face meeting expected to allow more detailed and challenging discussion. The Board of Directors noted the contents of the paper and sought any further clarification as appropriate.	SJ
38	Emerging issues: People and Organisational Development Collaboration B Champion presented the proposed Joint Chief People Officer model between the Trust and Airedale NHS Foundation Trust. The proposal reflected on the shared Chair arrangement and earlier joint working discussions, B Champion's planned departure, the emerging place provider partnership and wider direction of travel for people and organisational development services. The model aimed to strengthen strategic leadership across place, supported by clear deputy roles and infrastructure to maintain Board, committee and operational responsibilities. It had been discussed at Airedale's Board and BDCFT's Board Nomination and Remuneration Committee, with broad support in principle.	

Item	Discussion	Action
	J Harrison advised that her priorities would be dual accountability to both Boards and organisations, with a focus on strategic delivery, transformation and collaboration across Bradford District and Craven, while maintaining business as usual through deputy director roles, key metrics and developing the future model with co-production of teams. C Henry supported the proposal but emphasised transparency on what may need to slow down or change. S Napper asked that potential conflicts of interest be reflected in the model's risks and principles. It was confirmed that the role would be reviewed similarly to the Chair in Common role, with conflicts, workload and effectiveness addressed openly. T Patten reflected on learning from existing role arrangements and the Board noted the need for clear roles, relationships and support for deputy and site director roles. A McGregor asked whether the organisations would have shared strategic priorities and joint delivery arrangements. B Champion advised that partnership working was being considered through the strategy refresh and people services were moving towards a target operating model. J Harrison noted opportunities for synergy where priorities aligned, while recognising some priorities would remain sovereign to individual organisations. The Board welcomed J Harrison and agreed that the model would be kept under review, with a further update on progress, risks and impact once the arrangement had been implemented and developed in practice. The Board noted the arrangements and the planned review process.	
39	Emerging issues: Integrated Neighbourhood update P Hubbard presented an update on integrated neighbourhoods across Bradford District and Craven, underpinned by the local strategy and focused on prevention, reducing health inequalities and supporting people to live well at home. The Board was advised that the model was being developed system-wide with local authority, primary care, community, mental health, voluntary sector and community partners. Programme arrangements were being strengthened, with P Hubbard as lead senior responsible officer, supported by two GP senior responsible officers and programme support. The approach would be informed by population health data and national priorities, with initial focus areas including palliative and end of life care, frailty, neurodiversity and wider population health needs. T Patten advised that the work aimed to scale existing good practice, move beyond local pilots to a consistent district-wide approach. The Board noted the proactive care	

Item	Discussion	Action
	team as a strong example and requested future case studies on scale and impact on people and communities. Action: A request was made to bring a board story to a future Board held in public on the Proactive care team. K Barker advised that draft terms of reference for a BDCFT Integrated Neighbourhood Delivery Group would be considered by the Executive Management Team to provide strategic direction and team support. The Board emphasised that mental health should remain explicit and connected with wider system developments, including acute integration and community services. C Henry, Non-Executive Director, emphasised the importance of clear measures, agreed baselines and outcome indicators to demonstrate progress, impact and improved outcomes, alongside links with wider system developments. M Rawcliffe, Non-Executive Director, asked how the Board would be assured that deputies were supported where executives held multiple roles. It was explained that succession planning and talent management would be reported through the People Committee as appropriate. A McGregor asked whether acute sector partners were sufficiently visible. It was explained that further strategy work and supporting graphics would clarify programme links and the full care pathway. The Board noted the progress made and the ongoing development of governance and delivery arrangements.	PH
40	Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held 21 May 2026 (agenda item 11) A McGregor presented an update on behalf of W Brown, Non-Executive Director, from the Mental Health Legislation Committee, providing assurance on performance, compliance and statutory processes. Performance and compliance remained strong, key metrics were on track and no new risks had been identified. Good progress was noted on Mental Health Act 2025 implementation planning, with continued focus on report quality, tribunal delays, Section 126 pressures and hospital manager recruitment. A McGregor also highlighted an alert on estate and physical space constraints affecting access to hearings, noting the potential impact if people were unable to attend. The Board of Directors were assured by the update.	
41	Alert, Advise, Assure and Decision Report: Quality and Safety Committee held 15 April 2026 and 21 May 2026 (agenda item 12)	

Item	Discussion	Action
	A McGregor, Non-Executive Director, presented the Quality and Safety Committee AAAD reports, noting deep dives into the Children's Team and out of area placements, with assurance received on plans, mitigations and risks dependent on wider system partners. Governance remained robust, with progress across safeguarding, research, CQC engagement and well-led development. The Committee also considered patient flow, safety initiatives including the CMHT proof of concept, alongside strengthening learning, data quality and the balance between financial pressures, quality, safety and patient experience. T Patten asked how balanced decision-making was supported where financial pressures intersected with safety and experience. It was confirmed that processes were in place, with continued triangulation needed through relevant committees. P Hubbard noted that greater visibility of supporting papers in AAAD appendices would strengthen Board understanding. The Board of Directors were assured by the update.	
42	Alert, Advise, Assure and Decision Report: People and Culture Committee held 21 May 2026 (agenda item 13) M Rawcliffe, Non-Executive Director, presented the People Committee assurance report from 21 May, noting consideration of key workforce metrics including bank and agency use, vacancies, turnover and sickness absence. Concerns raised on equality, diversity and inclusion metrics, including disciplinary and appointment data, reinforced the need for continued visibility on the agenda. The Committee considered sickness absence and noted positive progress in employee relations, including reduced cases and quicker resolution, full utilisation of the apprenticeship levy, and the need to strengthen internal apprenticeship support. Assurance was received on improving workforce indicators, return-to-work processes and staff survey work, including positive feedback on the World Café approach. The Board of Directors were assured by the update.	
43	Freedom to Speak up Thematic report (agenda item 14) R Wixey, Freedom to Speak Up Guardian, presented the thematic report, noting 130 cases reported in 2025/26, indicating good use and visibility of the service alongside wider workforce, patient safety and equality data. The Board noted that 12% of concerns were anonymous, above the desired level but consistent with recent year Trust averages. Detriment cases were	

Item	Discussion	Action
	slightly below the national average. Two fact-findings identified detriment had occurred, these were not considered intentional or malicious, with learning identified around team culture, psychological safety and confidence to raise patient safety concerns. Further analysis of staff safety and wellbeing category, to provide more detail on themes which included leadership, management, communication and interpersonal issues. The Board welcomed proactive Freedom to Speak Up work, including communications, policy and strategy refreshes, service visits, listening activity and ambassador network development, and discussed the importance of linking data with wider equality, diversity and inclusion, employee relations and patient safety learning. P Hubbard highlighted the positive work of the Freedom to Speak Up Guardian and Deputy Guardian, including service visibility, listening activity, staff support and the ambassador network supporting staff to raise concerns. T Patten asked about the planned abolition of the National Guardian's Office. It was explained that some functions were expected to move to regional networks, with support arrangements to be monitored as they developed. J Harrison asked about sharing case studies and links between speaking up confidence, inclusion, protected characteristics, students and trainees. It was noted that demographic insight was being developed, disclosure remained voluntary, and data suggested some groups appeared less likely to speak up or share information which remained an area of focus. Students and trainees could raise concerns through other routes, and S Uka explained this was considered during the NHS England assurance visit, providing assurance on available support. C Henry asked how Freedom to Speak Up information linked with people, disciplinary and equality data. It was explained that regular discussions with Human Resources and equality, diversity and inclusion colleagues identified themes, with future reports to include compare against the wider staff cohort where possible. M Rawcliffe asked whether rising concerns reflected improved confidence or previously unreported issues. It was noted that the figure needed to be considered alongside wider data; R Wixey explained that use of the Freedom to Speak up route may indicate awareness and confidence in the service, while noting local resolution remained important where appropriate. S Napper asked about triangulation of patient safety and quality concerns, and whether harm or learning had been identified. It was explained that two	

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Item	Discussion	Action
	patient safety incidents had been picked up through the patient safety learning review process; other cases had not met the threshold. The Board thanked R Wixey and the team and noted ongoing work to triangulate data and strengthen speaking up culture across the Trust. The Board noted the report and the continuing development work being undertaken.	
44	NHS Staff Survey results 2025 (agenda item 15) B Champion noted that the NHS Staff Survey results were included for transparency and explained due to the timings of the meetings the report had been presented at the previous Board of Directors meeting held in private where a detailed analysis and discussion was held. The Board noted the content of the report.	
45	Alert, Advise, Assure and Decision Report: Finance and Performance Committee held 25 March 2026 and 27 May 2026 (agenda item 16) C Henry, Non-Executive Director, presented the Finance and Performance Committee assurance report from 27 May, noting that the March Committee had been verbally updated at the previous Board. The Committee had held robust discussion on finance, performance and delivery, and received assurance that the month one position was slightly ahead of plan, with a continued break-even forecast. C Henry noted operational improvements, including reduced clinically ready to discharge delays, improved urgent community response and elimination of 52-week waits, with previous actions beginning to show impact. Ongoing pressures remained in access and flow, out of area placements and volatile inpatient demand, which continued to present financial and operational risks. The Committee also considered cost improvement programme delivery risk and the need for transparent reporting, risk tracking and clear actions to strengthen confidence. Emerging risks included national nursing pay developments, potential provider collaborative geography changes and future work on deconstructing block contracts, with further modelling and due diligence required as detail became available. The Board of Directors were assured by the update.	
46	Finance Report (agenda item 17)	

Item	Discussion	Action
	C Risdon, Operational Director of Finance, presented the month one finance report on behalf of M Woodhead, noting the Trust was £41k ahead of plan and continued to forecast break-even although it was early in the financial year, and the financial risk assessment was broadly consistent with position agreed when the plan was approved. Key risks remained for inpatient demand, out of area placements, temporary staffing costs and cost improvement programme delivery. The programme was slightly off track at month one mainly due to out of area placement spend and higher April activity, although May was more in line with plan. The Trust continued to hold around £2.8m of financial risk to de-risk. Clarification was provided that the “fair deal for nurses” related to national work on nursing pay and conditions, including newly qualified nurse pay, preceptorship and Band 5 job descriptions. Modelling was underway, but any national funding was not expected to fully cover costs, creating a further financial risk. C Risdon noted that agency cap breaches were externally set and could lead to additional scrutiny if sustained, although performance would be considered in the round. A long-standing exceptional package of care was progressing towards discharge, which would help reduce agency-related pressures. The Board discussed potential changes to provider collaborative geographies. C Risdon advised that contracts ran to 31 March 2027 and NHS England was reviewing whether larger footprints could improve specialised service access and pathways. Further due diligence and discussion would be required. Clarification was provided on the Assessment and Treatment Unit, which was commissioned differently by the Integrated Care Board, but was specialised in nature and subject to ongoing work. C Henry, Non-Executive Director, asked about deconstructing block contracts. C Risdon advised that NHS England and commissioners were seeking greater clarity on services provided for agreed funding, with mental health and community services expected to receive greater focus. Initial modelling indicated a significant income risk, subject to further national data and assumptions work. S Uka highlighted accurate coding, activity capture and outcomes data as a key area of work. M Rawcliffe, Non-Executive Director, asked about agency cap breaches. C Risdon confirmed the cap was externally set and sustained breaches could lead to additional NHS England scrutiny, although performance would be considered in the round. A long-standing exceptional package of care was progressing towards discharge, which should reduce agency pressures.	

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Item	Discussion	Action
	The Board of Directors: • Noted the challenging financial position, and the actions being taken to deliver the agreed financial position; • Noted the level of risks and actions being taken to mitigate and • Highlighted any further assurances required.	
47	Strategic Assurance and Performance Report (agenda item 18) K Barker, Chief Operating Officer, presented the Integrated Strategic Assurance Report, noting that delivery against strategic objectives remained broadly stable, supported by strong governance, workforce and culture performance, with ongoing challenges in access and flow, financial sustainability, estate constraints and waiting times. The Board discussed the interconnected, system-wide nature of these challenges, including dental referral to treatment times, theatre capacity, industrial action, longer lengths of stay, clinically ready for discharge delays and independent sector bed use. K Barker advised that targeted improvement programmes, programme management support, improvement resource and executive oversight were in place, with focus on inpatient flow, community waits, neurodevelopmental and mental health pathways, workforce sustainability and productivity, considered alongside quality, finance and workforce planning. Active system engagement and daily, weekly and monthly escalation arrangements were in place, with early impact seen in clinically ready for discharge numbers. P Hubbard advised that challenges, including out of area placements and waiting lists, were considered through quality and governance arrangements, as well as performance and finance routes. The Board was assured that out of area placements were subject to the same governance approach as internal services, including ongoing monitoring, oversight and provider engagement to support safe care. Long waits remained in neurodiversity, speech and language therapy and dental services, affecting patient experience. The Board of Directors: • Took assurance in the current assurance levels and trajectories prescribed through committees • Noted and took assurance on the Quality Improvement and OSPB plans, priorities and programmes to progress recovery and strategic delivery • Noted system partner escalation and engagement • Noted triangulated position through ISPR and BAF	

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Item	Discussion	Action
48	Strategic Risk Summary (agenda item 19) F Stead, Trust Secretary, presented the Strategic Risk Summary and updated Board Assurance Framework, noting that all 30 strategic risks had been reviewed by the relevant Board committees and consolidated into a single report for Board oversight. Work continued to embed the revised strategic risk process, including providing evidence to internal audit following the previous limited assurance review of the Board Assurance Framework and strategic risk arrangements. Feedback was expected in the coming weeks and would be reported through the Audit Committee. Further development would include a three lines of defence model, creating a future reporting timetable, stronger assurance mapping, potential digital support for data collection, and clearer presentation of risk appetite and tolerance reporting. Further work was also required to ensure consistent application of current and target assurance ratings, with clearer descriptors based on internal audit assurance scales, further work would be undertaken before target ratings were introduced. The Board noted the significant progress made, expected to support a more positive internal audit opinion. No further questions were raised and no decisions were required. The Board of Directors: • noted the update provided and the next steps as part of the agreed development work for this area • noted the confirmed risk appetite levels for 2026 as agreed at the Board Development Session on 30 April 2026 • noted the changes to the reporting template and cycle that took place in April 2026 • agreed the assurance ratings presented as part of the report (including the target assurance rating), which will be presented to the Board held in public • agreed any additional actions required to receive further assurance.	
49	Strategy Refresh Update (agenda item 20) F Rafiq, Director of Transformation, Improvement and Productivity, and C Sunter, Deputy Director of Performance and Planning, updated the Board on the Better Lives Together strategy refresh, including work to develop a refreshed purpose, vision and strategic priorities. C Sunter advised that the refresh aimed to clarify Trust ambitions, support decision-making and business planning, and align priorities, measures and	

Item	Discussion	Action
	resources. Engagement had reached more than 500 staff through surveys, online sessions and a leadership forum, with further work underway to strengthen service user, carer and community input through involvement and volunteer services, alongside existing patient feedback, complaints insight and place-based engagement. K Barker welcomed progress and supported annual delivery plans to make the strategy more tangible and agile. S Jones thanked the team for progressing the work within limited time and resources. A McGregor asked about population engagement, accessible public language, and how values and behaviours would be reflected. F Rafiq noted that direct responses were lower than hoped due to the timeframe, with further targeted engagement and existing insight to support the work. F Rafiq agreed that clear, consistent language was important; core values were expected to remain broadly the same, with the behaviour framework likely to be refreshed to reflect expectations around how colleagues worked with each other, partners and communities. C Henry questioned whether a four-year strategy was too long and suggested a formal review mechanism and supporting material for different audiences. F Rafiq advised that annual delivery plans would provide flexibility, agreed a review process should be considered, and noted a similar approach had previously been used to described what the strategy meant for people, partners and the organisation. The Board welcomed the progress and supported continued engagement, validation and development. The Board of Directors noted the content of the report.	
50	Alert, Advise, Assure and Decision Report: Audit Committee held 26 March 2026 (agenda item 21) C Malish, Non-Executive Director, presented the Audit Committee AAAD report, highlighting the need to close outstanding audit actions promptly, including those relating to the Board Assurance Framework. C Malish advised that the matters raised would be considered further at the next Audit Committee. Work had been undertaken to address previous internal audit findings, with early feedback indicating the Trust was in a stronger position for a more positive audit outcome. The Board of Directors were assured by the update.	
51	Well-led development plan update (agenda item 22)	

Item	Discussion	Action
	F Stead presented the Well-led Development Plan update, noting that actions continued to be reported through the relevant Board committees, with the Board retaining oversight of actions assigned to it. Process improvements included clearer evidence requirements, performance measures and a four-point assurance scale to support consistent reporting. Actions were being managed in two phases: delivery and assessment of embedding. The Board considered actions not yet due, proposed closures, overdue actions and first extension requests. It was confirmed that the extension requests presented were first requests and reflected the need to refine actions and timescales as the detail of delivery had developed.. Future Board papers would review the volume of evidence included, with supporting evidence made available where required. The Board approved the proposed closures and extension requests, noting continued focus on governance arrangements, Board and committee induction, committee effectiveness, the integrated performance report, non-executive capacity and the Go See framework. The Board also noted work to seek staff and governor feedback on the Go See process and improve communication on the purpose of visits. F Stead agreed the survey could be opened more widely, noting governors' positive contribution and the need to include them in feedback and improvement work. The Board of Directors: • was assured on the process being delivered as a new process agreed by the Board • noted and discussed the updates provided • agreed 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 • considered the and approve any extension requests for actions in phase 1 • noted that further updates on phase 2 (embedding) will be presented for all actions • noted that the full report will be presented to the Audit Committee (June); & Board held in public (July), as outlined above.	
52	Governance report (agenda item 23) R Trawally, Corporate Governance Manager and Deputy Trust Secretary, presented the Governance report, noting Councillor Sabia Khan's departure as Governor following the local elections and that arrangements for appointing a replacement were being confirmed.	

Item	Discussion	Action
	The Board considered and approved the continuation of S Napper as Senior Independent Director for a further two-year term, backdated to 1 May 2026, following consultation with the Council of Governors Nomination and Remuneration Committee and Council of Governors support. R Trawally updated the Board on the revised Board and sub-committee meeting cycle, including changes to Non-Executive Director chairing and increased membership across main committees. A survey was underway to inform the Integrated Governance Guide refresh. F Stead, Trust Secretary, presented the Chair in Common Governance Framework, co-produced with governor representatives and Airedale NHS Foundation Trust colleagues and noted discussion with the Council of Governors. The framework supported the Chair in Common role and could be broadened for future joint Board roles. The Board approved the framework. The Board of Directors: • approved the Chair in Common Governance Framework • approved the Senior Independent Director Re-appointment • noted 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. • noted the transition to all Board meetings being held in person, recognising the increased transparency and accessibility this provides. • noted the commencement of the refresh of the Integrated Governance Guide and support continued staff engagement to inform its development.	
53	Partnership reports (agenda item 24) The MHLDA Programme Update: Committees-in-Common April 2026 West Yorkshire Community Health Services Provider Collaborative (WYCHS) Quarterly Chairs and Executives Leads meeting held in 7 April 2026 and the West Yorkshire Commissioning Hub held on 16th April 2026 were presented and noted for information.	
54	Board of Directors public meeting work plan 2026-27 (agenda item 25) The Board of Directors noted the report which was received for information.	
55	Any Other Business (agenda item 26)	

Item	Discussion	Action
	The Board recorded its thanks to B Champion, Chief People Officer, for their contribution over four years of service. No other business was raised.	
56	Comments from public observers (agenda item 27) The observers were thanked for their attendance. M Lodge, Lead Governor, commented positively on the meeting and agenda, particularly the Early Language Support for Every Child presentation and neighbourhood working discussion, and offered to share further reflections on neighbourhood working by email.	
57	Meeting evaluation (agenda item 28) 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. It was noted that discussions had been constructive, with good dialogue and well-presented papers. The meeting was closed at 12:27.	

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

Close, Holly
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Action Log for the Public Board of Directors' Meeting – 10 September 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
15. 23/07/2026	<u>AAAD People and Culture Committee</u> QMS quarterly report to be presented at alternative Board meetings held in public	RT	October 2026	Ongoing: to be added to the workplan from October onwards
12. 23/07/2026	<u>AAAD Quality and Safety Committee</u> To consider if a joint committee deep dive would be relevant relating to Community Nursing	PH	October 2026	The Board is asked to consider this action closed: A deep dive into community nursing had been presented previously and there will be a safer staffing paper in November 2026 which will encompass this.
Actions closed at the last meeting				
9. 04/06/2026	<u>Chief Executive report</u> To include a session on values as part of the Board development session	S Jones	July 2026	The Board is asked to consider this action closed. On the agenda for 9 July 2026 board development session
10.	<u>Board story</u>	P Hubbard	July 2026	The Board is asked to consider this action closed.

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
04/06/2026	Bring Board story on Proactive Care team			Added to list of board stories to be arranged this year
6. 02/04/2026	<u>CTW Quality Management System Update</u> The Director of Transformation, Improvement and Productivity to bring back the 12 month QMS Plan to June's Public Board.	F Rafiq	June July 2026	The Board is asked to consider this action closed. On the agenda for 23 July 2026 meeting
7. 02/04/2026	<u>Well-led development plan update</u> The Trust Secretary to refine categorisation for the well led actions and focus on the most impactful areas	F Stead	June July 2026	The Board is asked to consider this action closed. On the agenda for 23 July 2026 meeting

Close Holly
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Board of Directors – Meeting held in Public

10 September 2026

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

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

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

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

Recommendation(s)
The Board is asked to: note the continuing engagement that has taken place with external partners, internally at the Trust, and with the Council of Governors.

Links to the Strategic Organisational Risk register (SORR)	N/A
Care Quality Commission domains Please check <u>ALL</u> that apply	☐ Safe ☐ Caring ☐ Effective ☒ Well-Led ☐ 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

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Board of Directors – Meeting held in Public

10 September 2026

Chair of the Trust Report

Chair in Common

I have invited local Councillors to introductory meetings in September to discuss the Trust's work, current priorities, and our shared commitment to improving outcomes for local people across the district.

The meetings will also provide an opportunity to explore areas of mutual interest and potential future partnership working

I attended the North East Yorkshire (NEY) Regional Leadership event in July with fellow Chairs and CEOs. The event focused on our collective approach to values based, delivery focused, leadership and how we can develop collaborative ways of working for the future.

I have also met with the Board of our local Modality practice to hear their views on how we could develop our Community based services for the local population.

Council of Governors

I attended a meeting at the Airedale site with Governors from Bradford Teaching Hospitals NHS Foundation Trust, Airedale NHS Foundation Trust, and Bradford District Care NHS Foundation Trust. The discussion focused on the future role of Councils of Governors in the context of the proposals set out within the NHS 10-Year Plan and proposed legislation.

Further Updates

I attended a GoSee visit with the Admin team who showcased their work this gave me a real insight into the workings of this service. The visit also allowed the team to discuss any improvements and challenges which they face.

(fyi) A 'Go See' visit gives Executive Directors, Non-Executive Directors and Governors insight into day-to-day service delivery, including what is working well, key challenges, potential improvements, staff morale and team performance.

Sarah Jones
Chair in Common
September 2026

Board of Directors – Meeting held in Public

10 September 2026

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

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

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

Executive Summary

The areas covered in this report include:

- Individual Placement and Support Service
- GMC National Training Survey 2026
- Awards and Recognition
- NHS Staff Survey Update
- Health and Wellbeing
- Resourcing Update
- CQC Notifiable Incidents, Regulatory Matters and Visits
- Media Coverage
- Southport Inquiry
- Maternity Service National Reviews

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 the paper and seek any further clarification as appropriate.

Links to the Strategic Organisational Risk register (SORR)

N/A

Care Quality Commission domains
Please check **ALL** that apply

- | | |
|--|--|
| ☒ Safe | ☒ Caring |
| ☒ Effective | ☒ Well-Led |
| ☒ Responsive | |

Compliance & regulatory implications

N/A

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Board of Directors – Meeting held in Public 10 September 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

Individual Placement and Support service

Our Individual Placement and Support service (IPS) supports clients with enduring mental health needs into paid sustainable employment using the evidenced based model of IPS, both within community mental health teams and more latterly in some local Primary Care Networks. All IPS services are reviewed against a national framework, "The Fidelity Scale" which has 25 areas for a service to focus its quality delivery around. In July 26, IPS Grow released new Guidance for IPS services nationally around the Fidelity Scale for item 10, *The Mental Health Trust demonstrates a focus on competitive employment* and 11, *Mental Health Trust executive team members and directors assist with supported employment implementation and sustainability*.

Phil Hubbard, our IPS Service Executive Lead was highlighted in this guidance for her excellent practice in supporting and guiding our service.

"Bradford District Care NHS Foundation Trust – The IPS Service Manager has a regular one-to-one meeting with the Deputy Chief Executive to discuss the service and challenges. Executive support has included influencing PCN expansion and signposting to wider Trust initiatives on race equity."

Phil was interviewed as part of the 2025 Fidelity Review where reviewers commended her leadership and guidance as outstanding. She also presented in a South of England Commissioner and Senior Leadership event about how she provides excellent Executive leadership within IPS services. These events led her to being highlighted in the new National Guidance as delivering great practise in this area.

General Medical Council National Training Survey 2026

This month the Trust received its annual GMC National Training Survey results for 2026 which has shown a return to previously comparable outcomes across all domains for overall trainee feedback. Notably, all previous domains within the lower quartile have improved with two areas being positively in the above inter-quartile range. Furthermore, results for Foundation Year 1 and for Trainer feedback show significantly positive results with more than 50% of the domains within the upper quartile range.

Overall, this year's GMC NTS results demonstrate an improving picture testament to the Trust's commitment to education and training.

	Survey Year			2023		2024		2025		2026	
Trust/board	Indicator	Score	Outcome	Score	Outcome	Score	Outcome	Score	Outcome	Score	Outcome
Bradford District Care NHS Foundation Trust	Overall Satisfaction	80.74	Within IQR	78.33	Within IQR	73.28	Within IQR	85.60	Within IQR		
	Clinical Supervision	88.85	Within IQR	90.13	Within IQR	82.82	Q1 but not below	92.92	Within IQR		
	Clinical Supervision out of hours	87.27	Within IQR	88.75	Within IQR	84.15	Within IQR	89.08	Within IQR		
	Reporting Systems	67.38	Within IQR	72.10	Within IQR	61.73	Below	75.91	Within IQR		
	Workload	60.34	Within IQR	67.79	Above	67.25	Above	67.25	Above		
	Teamwork	77.78	Within IQR	78.42	Within IQR	76.04	Within IQR	82.83	Within IQR		
	Handover	59.92	Within IQR	69.03	Within IQR	68.28	Within IQR	69.36	Within IQR		
	Supportive Environment	78.33	Within IQR	81.41	Within IQR	74.53	Within IQR	82.20	Within IQR		
	Induction	78.15	Within IQR	86.09	Within IQR	75.63	Within IQR	86.80	Within IQR		
	Adequate Experience	76.85	Within IQR	75.00	Within IQR	67.19	Below	84.00	Within IQR		
	Educational Governance	69.75	Within IQR	77.78	Within IQR	63.28	Within IQR	79.33	Within IQR		
	Educational Supervision	78.94	Q1 but not below	86.54	Within IQR	86.91	Within IQR	88.25	Within IQR		
	Feedback	67.10	Within IQR	77.21	Within IQR	68.52	Q1 but not below	82.94	Within IQR		
	Local Teaching	85.83	Within IQR	86.41	Within IQR	84.90	Within IQR	83.11	Within IQR		
	Regional Teaching	62.31	Within IQR	57.37	Within IQR	63.80	Within IQR	64.44	Within IQR		
	Study Leave	66.03	Within IQR	82.92	Within IQR	67.39	Within IQR	78.13	Within IQR		
	Rota Design	62.35	Within IQR	74.73	Within IQR	64.58	Within IQR	76.25	Above		
	Facilities	74.28	Within IQR	73.85	Within IQR	74.18	Within IQR	70.45	Within IQR		

3 Awards and Recognition

Recognition activity remains strong, with 55 Thanks a Bunch nominations and 24 Living Our Values nominations received between April 2026 and July 2026, demonstrating continued colleague appreciation and celebration of Trust values.

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.

June 26

We care – Joanne Hardaker and Chantel Mullen, Linghouse and Holyfield district nursing team

For delivering non-discriminative care to a vulnerable service user with complex wounds. They handled the service user's care with dignity, respect, compassion, understanding and the upmost professionalism. They listened to his concerns, agreed support and care delivery, and left him joking and engaging with services.

We Listen – Nicola Macdonald, Payroll Service Manager

For her dedication to ensuring the pension department runs smoothly, starting early, leaving late and even working on her days off and through her lunch breaks to make sure she delivers excellent service. No matter how difficult the query is, Nicola is on hand to show her team how to resolve it.

We Deliver – Therapeutic Social Worker Sarah Gallagher and Specialist Health Visitors Helen Childs and Lorraine Ingram

For sharing good practice and putting Bradford in the spotlight on an online webinar to over 70 people during Infant Mental Health Awareness Week. Professionals joined from across the globe to hear how they can support families attune to their babies.

July 26
We Care – Vanessa Noble, Estates and Facilities Lead Nurse, Lynfield Mount Redevelopment For her thoughtfulness in recognising the impact that enabling works at Lynfield Mount had on teams and sending personalised letters acknowledging the challenges and thanking colleagues for their support and flexibility. Vanessa demonstrated genuine care for her colleagues and for the redevelopment's success. We Listen – Advanced Clinical Pharmacist Kiran Azeem For consistently delivering outstanding support to patients and multidisciplinary teams. Kiran provides timely, expert advice on complex clinical cases and is highly regarded for her knowledge, reliability and commitment to evidence-based care, going above and beyond to support staff learning and safe and effective treatment. We Deliver – Dr Yusuf Rangoonwala, Dannie Blowes and Alan Barclay, North Community Mental Health Team For giving up their own personal time to put the patient first, demonstrating person-centred care to reduce the anxiety of a patient whose two goats needed to be fed and watered whilst they were in hospital and other family members were on holiday. The team supported the goats for a few days, reducing the anxiety of the patient and avoiding the animals having to be put into short term foster placement.

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
June 26	14	10	10	1	3	8	0	2
July 26	14	9	11	2	1	7	1	1

We continue to see nominations coming from across the Trust.

4 Supporting our People

NHS Staff Survey Update

The OD team and other People Matters colleagues continue to work with the teams identified as priority from the NHS Staff Survey 2025 scores. Team intention plans from the World Café events are also being followed up. Work is underway to set up the 2026 Staff Survey, which will run from 21 September to 27 November 2026. A comprehensive programme of engagement during the fieldwork period is planned as per previous years.

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Health and Wellbeing

Health and Wellbeing support continues to be well utilised, with 295 attendances at wellbeing events at BDCFT and 94 colleagues accessing childcare support across BDCT, BTHFT between April-July 2026.

Health and wellbeing activity is now being targeted towards hotspot teams with lower staff survey scores and higher sickness absence to maximise impact. There are ten teams identified that we have increased support and engagement with managers and their teams, providing specialist advice and sessions for stress and multi skeletal areas.

There is a new health and wellbeing area to be launched in September at New Mill for staff, in the quiet room on the 3rd floor. This provides staff access at New Mill as well as LMH to a range of health and awareness equipment, body composition scales, blood pressure monitor and height measuring equipment as well as resources for childcare, wellbeing displays and leaflets.

The health and wellbeing champions programme is growing with 150 champions positioned in teams across the Trust, and there are quarterly updates, training and support in place. With teams identified that do not have a champion there are plans to develop further champions to ensure that they are represented and to improve access to health and wellbeing advice.

Resourcing Update

Over the past three months, the Recruitment Team has continued to deliver a high-performing and responsive service, achieving an average advert to unconditional offer time of 25.2 days, significantly exceeding the KPI target of 65 days. Performance from conditional offer to unconditional offer has also remained well within target, demonstrating the team's focus on maintaining momentum throughout the pre-employment process.

Over the past six months, the team have successfully recruited over 350 candidates, including:

- Misbah Mahmood - Chief Information and Clinical Safety Officer
- Marineo Llanaj - Education and Training Manager
- Philippa Greenwood - Modern Matron
- Naomi Fernandez - Head of People Development (interim)
- Mohammed Islam - Strategic Innovation Lead

Alongside strong operational performance, the team has successfully supported workforce planning for the Lynfield Mount Hospital redevelopment programme.

There is a new Band 2 Apprentice joining the team this month, demonstrating commitment to succession planning and developing internal talent. During the first 18 months, they will complete a Level 3 Resourcing Administration Apprenticeship. Subject to successful completion, they will be offered a substantive role working across both Recruitment and Temporary Staffing Services, helping to strengthen service resilience and promote

collaborative working across the teams. Apprenticeships are recognised nationally as an effective way of attracting, developing and retaining skilled staff while widening access to NHS careers

Continuous service improvement remains a priority, with the on-going development of a new AI guidance toolkit for hiring managers to support the appropriate and effective use of AI within recruitment processes while maintaining fairness, transparency and compliance.

Recruitment is working closely with Digital Services to support upcoming senior recruitment campaigns. Preparatory work has commenced, including the development of guidance on recruiting digital professionals, highlighting the challenges of the digital labour market and identifying actions to strengthen attraction and recruitment outcomes. This includes focusing on promoting the purpose and impact of digital roles, reviewing adverts and job descriptions, improving recruitment timelines, showcasing the wider NHS employment offer, and enhancing the candidate experience to help attract and retain high-quality digital talent.

5 CQC Notifiable Incidents, Regulatory Matters and Visits (12 May – 7 August 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 and Inspections

There have been 2 Mental Health Act visit during this time period:

- Ashbrook ward had an unannounced visit on 11th June 2026
- Baildon ward had an unannounced visit on 2nd July 2026

There were no unannounced inspections during this reporting period.

CQC Notifiable incidents

There were 4 notifiable incidents during this reporting period:

- 2 AWOLs from Baildon, both returned within 24 hours ,1 voluntarily and 1 was returned by hospital staff
- 2 AWOLs from Ilkley, both returned voluntarily within 24 hours

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

Sixteen inquests were concluded during this period in which the Trust provided some level of evidence to the Coroner. Of these, staff were called by the coroner in five 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:

- Accident x 2
- Narrative x 6
- Natural x 3
- Misadventure x 1
- Suicide x 1
- Alcohol and drug related x 1
- Drug related x 2

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, 2 suspected suicides and 1 unexpected death. There are nine open PSIIs, currently, three ongoing SJRs and six ongoing LLRs.

6 Media Coverage

Media and news highlights since the last Board meeting.

Area / dates	Details
New Lynfield Mount Hospital wards to be named following patient and staff survey – 3 August	Names for two new upcoming ward areas at Lynfield Mount Hospital have been chosen by Bradford District Care Trust colleagues, people who currently use the Trust's services and involvement partners.
Care Trust welcomes local people to attend Annual Members' Meeting – 6 August	People from across Bradford, Airedale, Wharfedale and Craven are invited to attend an Annual Members' Meeting, hosted by Bradford District Care Trust. The annual meeting is a valuable opportunity for people to come together with their local governors, put questions to the Board of Directors and learn more about the work Trust services have carried out for local communities over the past 12 months.
Care Trust's finalists announced for 21 st You're a Star Awards – 12 August	Proactivity, practicality, care, compassion and kindness are key characteristics amongst the 42 individuals and teams announced as finalists for Bradford District Care Trust's You're a Star Awards 2026.
Local partnership helps NHS mental health service users thrive through nature and community – 17 August	A partnership between Bradford District Care Trust and Morley Glass is continuing to make a positive difference to the lives of people using local mental health services, helping more people connect with nature, build confidence and develop new skills.

7 National News

Southport Inquiry Phase 1 Recommendation 57

The Southport Inquiry was established following the fatal attacks in Southport in July 2024 and examined the circumstances surrounding the incident, including opportunities to strengthen safeguarding, information sharing and multi-agency working arrangements.

Phase 1 of the Inquiry focused on immediate lessons to improve the identification, assessment and management of risks posed by children and young people, with a particular emphasis on the effective sharing and use of information across agencies. Recommendation 57 highlighted the need for information and advice from schools, colleges and education settings to be given appropriate weight within safeguarding decision-making processes, recognising the valuable insight these professionals can provide through their day-to-day contact with children and young people.

Bradford District and Craven safeguarding arrangements are already founded on strong partnership working across health, education, local authority and wider safeguarding partners. The guidance does not introduce any new statutory duties but serves as a timely reminder of the importance of effective information sharing, professional curiosity and collaborative decision making to safeguard children and young people. NHS England has advised that a national minimum dataset for child safeguarding will be introduced from September 2026 to support greater consistency in data sharing and intelligence gathering across systems. Bradford District have developed a multi-agency child protection team (MACPT), which BDCFT will be hosting the health component of this.

Maternity Service National Reviews

Baroness Valerie Amos published the final report of the Independent National Maternity and Neonatal Investigation on June 30, 2026. It concluded that England's maternity system is no longer fit to consistently deliver safe, compassionate care and requires an urgent, robust overhaul. Key findings and actions include:

- **Systemic Failings:** The report highlighted that women's concerns are repeatedly dismissed, leading to avoidable harm. Racism and discrimination were found to be embedded throughout the system, disproportionately affecting ethnic minority families.
- **Recommendations:** Baroness Amos set out eight main recommendations aimed at long-term systemic and cultural transformation, including the creation of a national maternity commissioner.
- **Government Response:** Health Secretary James Murray announced plans to create 1,000 temporary midwifery posts and make an extra £41m available to upgrade dilapidated maternity and neonatal facilities.

Read the full findings on the [National Maternity and Neonatal Investigation](#)

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The Independent Maternity Review (known as the Ockenden review) was led by Donna Ockenden and involved a multi-professional team. The report was published in June 2026 into the independent review of maternity services at the Nottingham University Hospitals NHS Trust (NUH) considered the quality of care relating to newborn, infant and maternal harm at the trust. The review team held individual meetings with over 500 families, and more than 830 current and former staff at NUH engaged with the review and was based on a review of 2,500 family cases that formed part of this investigation, the final report outlined:

- local actions for learning that staff at the trust must do
- system-wide learnings
- immediate and essential actions to improve maternity and neonatal care nationally

This Report demonstrates what ensues when leadership, governance and culture are not robust: poor practice is not investigated; learning is not integrated; and mothers and babies are failed by an organisation they should be able to rely upon absolutely during a period of acute vulnerability in their lives.

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Board of Directors – Meeting held in Public

Thursday 10 September 2026

Paper title:	Bradford District Care Safe Staffing Assurance Report 2026	Agenda Item 11.0
Presented by:	Phillipa Hubbard, Director of Nursing, Professions and Care Standards, DIPC and Deputy Chief Executive	
Prepared by:	Phillipa Hubbard, Director of Nursing, Professions and Care Standards, DIPC and Deputy Chief Executive	
Committees where content has been discussed previously	NHS England safer staffing assurance meeting (2 April 2026). Previous biannual safe staffing papers were presented to the Trust Board in July 2025 and January 2026.	
Purpose of the paper Please check ONE box only:	☐ For approval ☐ For discussion	
	☒ For information	

Relationship to the Strategic priorities and Board Assurance Framework (BAF)		
The work contained with this report contributes to the delivery of the following themes within the BAF		
Being the Best Place to Work	Looking after our people	x
	Belonging to our organisation	
	New ways of working and delivering care	
	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

Purpose of the report

To provide the Board with formal assurance on the Trust's arrangements for safe staffing and alignment with the Developing Workforce Safeguards (2018) and National Quality Board Safe Staffing Guidance (2016), drawing on the NHS England assurance review, supporting evidence and the agreed areas for continued development.

Executive Summary

The report brings together the NHS England Safe Staffing Assurance visit, reviews of the July 2025 and January 2026 biannual safe staffing papers, formal meeting notes and the agreed action plan. It concludes that the Trust has mature and well-embedded arrangements for workforce planning, establishment setting, deployment, escalation and governance, with strong Board and executive oversight. The overall position is reported as High, Level 4 Assurance. Development areas focus on strengthening transparency, monthly reporting, professional judgement documentation, red flag metrics, community staffing pressures, workforce supply and the completeness of evidence packs. No significant unmanaged workforce risks were identified during the assurance review.

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:

- Receive and note the Bradford District Care Safe Staffing Assurance Report 2026.
- Note the overall High, Level 4 Assurance position and the conclusion that no significant unmanaged workforce risks were identified during the assurance review.
- Note the strengths identified and the areas for continued development, which will be progressed through existing governance and assurance arrangements.

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:

-

Care Quality Commission domains

Please check **ALL** that apply

- | | |
|--|--|
| ☒ Safe | ☒ Caring |
| ☒ Effective | ☒ Well-Led |
| ☒ Responsive | |

Compliance & regulatory implications

The following compliance and regulatory implications have been identified as a result of the work outlined in this report:

- The report provides assurance against the National Quality Board Safe Staffing Guidance (2016) and

	Developing Workforce Safeguards (2018). It identifies enhancement actions relating to public transparency, monthly reporting, professional judgement, red flag metrics and updating the e-rostering procedure to reflect current expectations.
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Board of Directors – Meeting held in Public

[Date of meeting]

[Title of the paper]

Drafting note: the text in black should be used in our document. The red text is for guidance and should be removed from the final version and replaced with your own text.

Supporting papers must:

- Ideally be **no longer than four sides of A4** to ensure it remains clear and succinct for the reader and gets the message across quickly and efficiently. Only if the subject is particularly complex should it be longer than this but then by exception
- The document's author/s name and title and the date at the end of the paper.
- The use of bullets or flow charts within these paragraphs should be considered as a way of getting across complex issues in easy 'bite-size' pieces of information.

1 Purpose

Briefly explain what the paper is about. It should set out the highlights of the 'must know' information; what the issue is; and what action is needed.

2 Proposed Outcome

- What are we hoping to achieve
- What are the aspirations and goals
- What is being proposed

3 Options

- Options appraisal
- Possibilities
- Priorities
- Responsibility

4 Risk and Implications

- Key issues

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- The benefits and risks
- Impact on the quality / safety of care
- Resource implications
- Reputational implications

5 Results

- Where this has been considered previously and what the outcome was
- Next steps and measuring results

Name of author/s

Title/s

Date paper written

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Bradford District Care Safe Staffing Assurance Report 2026



Eileen Aylott, Head of Nursing and Midwifery, MSc (Healthcare Workforce Planning, Delivery and Assurance), MA (Advancing Practice), BSc (Hons) Gerontological Nursing, PGCE, Dip/HE RN

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Safer Staffing Assurance – Foreword

This report has been developed following the NHS England (NHSE) Safer Staffing Assurance review and forms part of the organisation’s annual assurance process against the Developing Workforce Safeguards (2018) and the National Quality Board (NQB) Safe Staffing Guidance (2016)

The purpose of the review was to assess the level of assurance that robust systems and processes are in place to ensure safe, effective, and sustainable staffing across inpatient and relevant clinical services.

The annual assurance process comprised:

- Completion of the NHSE self-assessment framework
- Submission and review of supporting evidence, including biannual safe staffing Board papers, workforce and safer staffing policies, escalation processes, and governance arrangements
- A face-to-face assurance meeting with executive, nursing and workforce leads to triangulate the self-assessment and documentary evidence and to test implementation in practice

Evidence was reviewed against the key lines of enquiry set out within national guidance, with particular focus on governance, decision-making, escalation, use of workforce data, and Board oversight of safe staffing.

Following triangulation of all available evidence, NHSE has assigned an overall assurance rating using the nationally agreed Red/Amber/Green (RAG) methodology. This rating reflects the organisation’s current level of alignment with national safer staffing expectations and the maturity of its workforce safeguards.

Assurance levels:	Score
Full assurance – Evidence of embedded and sustained improvement	4
Significant assurance – Evidence of improvement and the improvements becoming embedded, but yet to be sustained	4

Moderate assurance – Some evidence of improvement but this has yet to be embedded and sustained	3
Limited assurance – Limited evidence of improvement and limited evidence of the improvements being embedded or sustained	2
No assurance – No evidence of improvement.	1

The detailed feedback contained within this pack highlights areas of good practice, key findings, and recommended actions where applicable.

1. Executive Summary

This report provides the Trust's annual Safe Staffing Assurance, drawing together evidence from:

- The NHS England Safe Staffing Assurance visit (02 April 2026)
- A detailed review and mapping of Biannual Safe Staffing and Establishment Review papers for Nursing presented to the Trust Board (July 2025 and January 2026), against Developing Workforce Safeguards (DWS) and National Quality Board (NQB) requirements.
- The formal NHS England meeting notes and agreed action plan following the assurance visit.
- A full list of evidence provided in appendix 1.

Collectively, these sources provide robust, triangulated and externally validated assurance that Bradford District Care NHS Foundation Trust is meeting the intent and requirements of national safe staffing guidance for nursing and midwifery services.

Overall assurance position: High (Level 4) Assurance

The Trust has mature and well-embedded systems for workforce planning, establishment setting, deployment, escalation, and governance. Identified Amber actions relate to organisational maturity and good-practice enhancement and do not indicate unmanaged risk to patient safety.

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2. Purpose and Scope

This paper provides formal assurance to the Board that Bradford District Care NHS Foundation Trust (BDCT) has robust arrangements in place to assure safe staffing, and that it is compliant with the Developing Workforce Safeguards and National Quality Board (NQB) expectations.

It summarises:

- The current position regarding safe staffing governance and assurance
- Evidence reviewed with NHS England
- Areas of strength and good practice
- Actions identified to further strengthen transparency and assurance

Exclusions

This report focuses specifically on safe staffing assurance and does not provide a comprehensive review of all Trust operational performance. Non-clinical staffing groups and services outside the defined scope are excluded unless directly impacting safe staffing.

3. National Guidance and Assurance Frameworks

This report provides assurance against the National Quality Board (NQB) Safe Staffing Guidance (2016) and Developing Workforce Safeguards (DWS) (2018), which form the basis of the NHS England Safe Staffing Assurance process.

These frameworks set the national expectations for delivering safe, effective, and sustainable staffing through robust governance, workforce planning, professional judgement, and evidence-based decision-making.

National Quality Board (NQB) – Safe Staffing Guidance (2016)

The NQB framework requires organisations to ensure the right staff, with the right skills, are in the right place at the right time. Key expectations include Board accountability, evidence-based establishment setting, professional judgement,

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effective escalation processes, and triangulation of workforce, quality, and patient outcome data.

The Trust demonstrates alignment with these principles through established governance arrangements, regular safe staffing reporting, use of recognised workforce planning tools such as M-Host, and the integration of professional judgement within workforce establishment reviews and operational staffing decisions. Workforce information is routinely considered alongside quality, safety, and patient outcome measures to support decision-making and assurance.

Developing Workforce Safeguards (DWS) – NHS England (2018)

The DWS framework expands upon the NQB principles and focuses on workforce planning, workforce sustainability, deployment, governance, risk management and organisational accountability.

The Trust demonstrates compliance through structured workforce planning processes, regular establishment reviews, workforce modelling, recruitment and retention initiatives, safe staffing governance structures, and benchmarking against national and regional comparators. Workforce tools are supplemented by professional judgement to reflect local service requirements, patient complexity and multidisciplinary team working.

Assurance Against National Standards

The assurance review confirmed that safe staffing is embedded within the Trust's governance and operational processes. Workforce metrics are increasingly triangulated with quality and safety indicators, including patient acuity, Enhanced Therapeutic Observation and Care (ETOC), deferred community visits, incident reporting, staff wellbeing, and training compliance measures. This supports a more comprehensive understanding of the impact of staffing on patient care and outcomes.

Opportunities for further development include strengthening references to DWS and NQB compliance within public-facing governance documents, further

embedding ETOC and community staffing metrics within routine assurance reporting, and continuing to develop the documentation of professional judgement within workforce decision-making processes.

Assurance Statement – High Assurance (Green)

The Trust demonstrates strong alignment with both the NQB Safe Staffing Guidance (2016) and Developing Workforce Safeguards (2018). Governance arrangements, workforce planning processes, and staffing assurance systems are well established and supported by evidence-based methodologies, professional judgement, and executive oversight. Areas identified for development relate to the continued maturity and visibility of assurance processes rather than fundamental compliance concerns. No significant unmanaged workforce risks were identified during the assurance review.

4. Governance, Leadership and Board Oversight

The Trust has established and embedded governance structures for safe staffing, including:

- Board-level oversight via the Chief Nurse, with accountability for safe staffing assurance
- Monthly safe staffing reporting through the Integrated Performance Report (IPR)
- Bi-annual safe staffing reports to Board committees
- Dedicated professional oversight through a Safe Staffing Group
- Escalation processes in place of risks relating to staffing capacity and capability

The Chief Nurse remains the designated executive lead for safe staffing, with clear escalation routes to Executive Team and Board.

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4.1 Board-Level Transparency and Accountability

The Board receives regular, structured safe staffing reports (monthly and biannual), ensuring full transparency of workforce, quality, and safety metrics across all services.

Executive leadership maintain clear accountability through Chief Nurse oversight, with assurance formally reported to the Board and national teams, confirming organisational compliance and risk management.

Safe staffing is embedded within integrated performance reporting, enabling the Board to triangulate data on staffing levels, patient outcomes, incidents, and workforce indicators.

Governance arrangements ensure that any risks, gaps, or actions are clearly identified, escalated, and tracked through Board and committee structures, supporting transparent decision-making.

There is a strong emphasis on evidencing assurance, with leadership providing demonstrable data, documented processes, and clear audit trails to support Board scrutiny and external assurance.

Committees / Governance Forums Where Evidence is Tracked

- Board (via Integrated Performance Report and biannual safe staffing reports)
 - Receives triangulated evidence on staffing, quality, safety, and workforce indicators.
 - Holds overall accountability and assurance.
- Quality and Safety Committee
 - Reviews deep dives (e.g. community safe staffing, dashboards, risks, and actions)
 - Provides detailed scrutiny and escalation of issues to Board.
- Safe Staffing Group / Steering Group

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- Key operational governance forum
- Tracks metrics (e.g. fill rates, incidents, ETOC, red flags, workforce indicators)
- Oversees development of dashboards, policies, and improvement actions.
- Integrated Performance Reporting (monthly governance route rather than a standalone committee)
 - Brings together workforce, quality, safety, and activity data.
 - Forms the core evidence base feeding committees and Board.
- Corporate Governance (annual governance statement / assurance process)
 - Evidence collated and reviewed ahead of publication.
 - Confirms compliance with workforce safeguards and provides formal assurance narrative.

4.2 Executive Leadership

Executive leadership provide strong assurance on safe staffing, with clear accountability led by the Chief Nurse and senior team through structured governance, robust evidence triangulation, and regular board oversight. Assurance is underpinned by comprehensive reporting, integration of workforce, quality and safety metrics, and explicit alignment with national workforce safeguards. Leadership maintain oversight of risks and mitigations, ensuring that safe staffing is continuously monitored, transparently reported, and supported by both validated data and professional judgement. This approach enables confident assurance that staffing is safe, effective, and responsive to patient need across the organisation.

5. Workforce Planning and Establishment Review

- Consistent use of:
 - MHOST for inpatient mental health
 - Community Nursing Safer Staffing Tool

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- QNI workforce standards and red flag indicators
- Explicit acknowledgement of:
 - tool limitations
 - seasonal variation
 - need for triangulation with professional judgement

Judgement Strong alignment with the NQB principle that tools inform but do not replace judgement.

6. Deployment, Escalation and Responsiveness

- Clear descriptions of:
 - daily safety huddles
 - BRAG reporting
 - business continuity plans
 - escalation through operational and governance structures
- Examples of mitigation actions:
 - redeployment
 - bank and agency use
 - leadership oversight
 - review of observation levels

Mostly compliant - Gap - Escalation is described operationally but not consistently framed as “triggered by red flags”, which the guidance expects.

7. Quality, Safety and Workforce Outcomes (Triangulation)

- Triangulation across:
 - unfilled shifts / fill rates
 - observation hours
 - IREs citing staffing
 - medication errors
 - restraint/seclusion data
 - FFT feedback

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- staff survey indicators

This provides a clear narrative connecting staff pressure to care impact (deferrals, omissions, risk)

The trust is also Benchmarking with peer trusts and undertaking the following work to enhance quality and safety.

- RPIWs planned and underway
- Workforce redesign initiatives
- Productivity workstreams
- Repeat / seasonal data collection (e.g. MHOST summer/winter)

8. Mapping to DWS (2018) and NQB (2016)

The Trust's DWS gap analysis self-assessment was validated through NHS England assurance. All 14 Developing Workforce Safeguards requirements are met. The primary areas for improvement relate to clarity, articulation, and evidence presentation, particularly for external audiences, rather than gaps in safety, governance, or practice.

9. Key Strengths Identified

- **Strong executive leadership and governance**
Clear Chief Nurse accountability with robust assurance processes, regular board reporting, and high levels of organisational oversight.
- **Mature assurance approach (beyond compliance)**
Use of triangulated evidence (workforce, quality, safety, and outcomes) to support assurance rather than reliance on self-assessment alone.
- **Effective board transparency and reporting structures**
Safe staffing embedded within integrated performance reporting, biannual and monthly reporting cycles, supporting informed decision-making.

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- **Strong use of data and benchmarking**
Use of Model Hospital and comparative data with evidence of top quartile performance and outcome improvements.
- **Established workforce governance and planning**
Annual workforce plans, gap analysis, and forward planning (including retirement risk and skill mix review) are in place and actively managed.
- **Good progress in workforce capability and MDT model**
Successful recruitment to full MDT, enabling testing of assumptions and improvement in patient outcomes and flow (e.g. ETOC).
- **Evidence of innovation and best practice (ETOC and dashboards)**
Recognised regionally as best practice, with development of dashboards linking staffing to outcomes and patient flow.
- **Strong safety culture and focus on outcomes**
Increasing alignment between staffing decisions and patient outcomes, with CQC-recognised compassionate care and improving quality indicators.

10. Areas for Continued Development (Enhancement)

- **Clarity and explicitness of assurance statements**
Governance documents require clearer articulation of compliance with Developing Workforce Safeguards and NQB standards.
- **Strengthening public transparency of data**
Need to ensure ward-level CHPPD data (not just aggregated national reports) is consistently available and accessible.
- **Enhancing monthly reporting depth**
Broader inclusion of nurse-sensitive indicators and quality metrics within routine monthly safe staffing reports.
- **Formalising professional judgement**
Explicit documentation of how professional judgement is applied to complement staffing tools (e.g. M-Host) for assurance purposes.

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- **Development of red flag metrics and dashboards**
Further work required to standardise and embed red flag indicators (e.g. missed care, leave, deferred visits) into formal reporting.
- **Community staffing pressures**
Ongoing challenges with sickness, maternity cover, and service complexity impacting shift fill and delivery.
- **Workforce supply challenges**
Recruitment pressures in healthcare support worker roles and skill mix optimisation continue to impact delivery and require ongoing mitigation.
- **Consistency and completeness of evidence packs**
Need to ensure full local data (not snapshots or aggregated extracts) is routinely available for assurance review.

11. Overall Assurance Statement

Based on the evidence reviewed through the NHS England assurance process, Bradford District Care NHS Foundation Trust can be assessed as achieving Level 4 (High Assurance) in relation to safe staffing.

Executive leadership, led by the Chief Nurse, have demonstrated clear accountability and strong governance oversight, supported by regular Board reporting, established committee scrutiny, and embedded biannual and monthly safe staffing processes. The Trust has provided robust triangulated evidence across workforce, quality, safety, and patient outcomes, and has demonstrated compliance with the Developing Workforce Safeguards.

There is clear organisational grip on safe staffing, including effective workforce planning, use of recognised tools (MHOST), benchmarking, and innovation (e.g. ETOC), with evidence of improving outcomes and recognised best practice.

Risks (particularly within community services) are well understood, with mitigation plans in place and subject to ongoing governance oversight.

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Conclusion:

Taking account of the above, and the Chief Nurse's formal statement of assurance, NHS England can conclude that there is high confidence that safe staffing is appropriately governed, effectively monitored, and responsive to patient need, with a small number of areas identified to strengthen transparency and articulation of assurance for external scrutiny.

12. Safe Staffing Assurance Heatmap

Section	Evidence (from BDCFT diagnostic & assurance review)	NHSE Assurance Level	Score
1. NQB Guidance	NQB principles embedded through governance, Board reporting, and safer staffing policy; AGS references safe staffing but lacks explicit DWS/NQB wording	Significant assurance	4
2. Triangulation	Strong triangulation across workforce, quality, and outcomes through ISPR, dashboards and governance; further clarity needed on explicit "so what" outcome linkage	Significant assurance	4
3. Evidence-Based Tools Utilisation	MHOST used appropriately with national support; combined with professional judgement and MDT considerations	Significant assurance	4
4. No Tool Manipulation	Explicitly confirmed no manipulation; tools used with fidelity and external validation	Significant assurance	4
5. Monthly Actual vs Planned Staffing Reporting	Monthly reporting established via integrated performance reports; requires clearer visibility of nurse-sensitive indicators	Moderate assurance	3
6. Annual Governance Statement	Safe staffing included within AGS; requires explicit confirmation of compliance with DWS/NQB standards	Moderate assurance	3
7. Workforce Plan	Workforce strategy and planning in place; further development required for medium-term (age profile, retirement risk, sustainability)	Moderate assurance	3
8. Bi-Annual Establishment Reviews	Established and evidenced using MHOST; recent reviews shared and validated	Significant assurance	4
9. Quality Dashboards	Dashboards in place and developing (including Q&I and ETOC); improvements	Moderate assurance	3

	required in visibility and linkage of staffing to outcomes		
10. Quality Impact Assessments (QIA)	QIA/EQIA processes embedded and accepted; evidence exists within governance arrangements	Significant assurance	4
11. Risk Management & Escalation	Strong real-time escalation and risk management processes; community risks understood with mitigation plans	Significant assurance	4
12. Board Awareness	Clear Board oversight via QSC, ISPR, and biannual reporting; Chief Nurse assurance confirmed	Significant assurance	4

Score Summary

- Significant assurance (4): eight areas
- Moderate assurance (3): four areas
- Limited assurance (2): zero areas
- **Overall Score: Average $\approx 3.7 \rightarrow$ High (Level 4) Assurance**

13. Additional Areas of Discussion during the visit

13.1 Band 5–6 Workforce Review

The Trust is actively progressing a comprehensive review and standardisation of Band 5 to Band 6 roles, with over 245 role pathways assessed through a structured job description and panel review process. This work is aligned to national expectations and aims to ensure consistency, equity, and clarity of role function across services.

There is strong executive oversight of this programme, with recognition of its impact on safe staffing, skill mix, and workforce sustainability. The review reflects increasing service complexity and workforce expectations, particularly within community settings where supervision and role delineation present additional challenges.

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The Trust acknowledges that implementation will have significant implications for skill mix and workforce modelling, with potential uplift in Band 6 roles requiring careful management within existing resources and through robust governance processes.

The Trust is undertaking a large-scale, well-governed review of Band 5–6 roles to standardise practice, strengthen skill mix, and support safe staffing, with full executive oversight and recognition of future workforce impact.

13.2 CIP / Financial Efficiency

The Trust demonstrates awareness of financial and resource constraints, particularly in relation to workforce modelling and skill mix changes (e.g. Band 5–6 uplift and MDT expansion), with recognition that these must be managed within existing financial envelopes.

Workforce decisions (including recruitment, role development, and skill mix review) are being taken with consideration of both quality outcomes and cost implications, indicating a balanced approach between safety and efficiency.

Benchmarking (e.g. Model Hospital and peer comparison) is in place to understand cost position relative to outcomes, with acknowledgement that the current skill mix staffing model adopted may be higher cost but delivers improved patient outcomes and quality indicators.

Ongoing work (e.g. electronic rostering expansion, reduction in unfilled shifts, and improved workforce planning) supports efficiency and productivity improvements aligned to CIP expectations.

13.3 ETOC (Enhanced Therapeutic Observation Care)

The Trust is part of the National ETOC programme and will be used as a one of the national case studies presented to government.

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ETOC is identified as an area of established best practice within the Trust, with regional recognition and use as an exemplar model. It demonstrates a strong link between staffing, patient flow, and improved outcomes, including impact on length of stay.

ETOC data is being systematically embedded into governance, with inclusion planned within monthly safe staffing reporting, Integrated Performance Reports, and future biannual Board reports at ward level from April 2026.

Executive leadership have clear oversight of this work, and it forms part of a broader approach to strengthening the relationship between staffing levels, patient acuity, and quality outcomes.

✅ **Assurance position:** Positive assurance, with strong evidence of innovation, outcome impact, and continued integration into formal reporting structures

13.4 Preceptorship

The Trust received the Interim Preceptorship Quality mark for Nursing and is ready to apply for the national Multi Professional Quality mark as soon as applications open. They are active members of the NEY Regional Preceptorship Community of Practice.

The 'Inside Out' preceptorship programme supports newly qualified registrants across nursing and the allied health professions. It provides guidance and development support to help transition from education to first clinical roles.

13.5 Professional Nurse Advocates

The trust actively supports staff to undertake the PNA programme and to use the knowledge and skills to support colleagues. It has an active member of the Regional PNA Continuing Professional Development (CPD) Faculty supporting PNA development both inside the organisation and across the region.

The trust is currently reporting a PNA:RN ratio of 1:61 with 30 qualified PNA (13 of which are in children's services) and is working towards the national ambition

of 1:20. The Trust has a number of supervision programmes available to all staff and supervision is an embedded practice across professional groups.

There is a Trust PNA Strategy in place with two nominated Trust leads, however no protected time for PNAs has been agreed to enable PNA's to undertake activities outside of their designated roles, although there is an active PNA steering group.

13.6 CNO Safe Staffing Fellowship

The Deputy Director of Nursing has attended the 2-day introduction to safer staffing module and applied for a place on the CNO Fellowship Programme in 2025, just missing out on a place and being placed on a reserve list. It is hoped that he will be successful in 2026.

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Appendix 1 – Safe Staffing Assurance Evidence Table

Domain / Standard	Expectation (NQB / DWS)	Evidence from Bradford District Care	Source	Assessment	Score
Board Oversight	Board receives regular safe staffing assurance and workforce reporting	Annual Report, Integrated Service Performance Reports (ISPR), Safer Staffing Annual Report, 6-Month Safe Staffing Report	Annual Report 2024/25; February 2026 ISPR; December 2025 ISPR; Safer Staffing Reports	Established reporting framework provides Board visibility of workforce, quality, and staffing performance	4
Evidence-Based Workforce Planning	Workforce establishments determined through structured review and planning processes	Workforce Strategy and Safer Staffing documentation, six-month staffing reviews, annual staffing reports	Workforce Strategy & Safer Staffing; Safer Staffing Reports	Evidence of planned workforce review processes aligned to safer staffing expectations	4
Triangulation	Staffing decisions informed by workforce, quality, and performance information	ISPR reports, staffing audits, annual reports and gap analyses provide triangulated workforce intelligence	ISPR Reports; Annual Report; Safe Staffing Audit; Gap Analyses	Multiple data sources used to support assurance and decision-making	4
Skill Mix and Workforce Deployment	Right staff with the right skills in the right place	Workforce strategy and safer staffing reviews consider establishment and workforce models	Workforce Strategy & Safer Staffing; 6-Month Staffing Report	Evidence of workforce planning arrangements; detailed skill-mix metrics not explicitly evidenced	3
Real-Time Staffing Management	Processes in place to identify and manage staffing risks	Safe Staffing Policy and assurance audit review staffing governance arrangements	Safer Staffing Policy; Safe Staffing Assurance Audit	Clear governance framework for managing staffing risks and escalation	3
Establishment Review Process	Routine review of staffing establishments and requirements	Annual and six-month safe staffing reports assess establishment position and staffing risks	Safer Staffing Annual Report; 6-Month Staffing Report	Formal review cycle established and embedded	4
Temporary Workforce Management (DWS)	Monitoring and management of temporary staffing usage	Staffing reports and workforce planning documentation provide oversight of workforce deployment	Workforce Strategy; Staffing Reports	Evidence available, though direct bank and agency controls not fully evidenced in documentation reviewed	2

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Workforce Sustainability (DWS)	Long-term workforce planning and supply-demand management	Workforce Strategy & Safer Staffing document outlines future workforce requirements and planning	Workforce Strategy & Safer Staffing	Strong strategic intent with ongoing development of workforce sustainability measures	3
Rostering and Workforce Utilisation	Workforce deployed efficiently to meet service need	Safe staffing reviews and workforce performance reporting monitor staffing utilisation	ISPR Reports; Staffing Reviews	Workforce utilisation considered within performance reporting arrangements	3
Quality and Patient Outcomes	Staffing linked to quality outcomes and patient safety	Safe Staffing Audit and Board reports provide quality and safety oversight	Safe Staffing Audit; ISPR Reports; Annual Report	Evidence of quality monitoring linked to staffing assurance processes	3
Patient Experience	Patient voice incorporated within staffing assurance arrangements	Indirect evidence through quality governance and Board reporting	Annual Report; ISPR Reports	Limited direct evidence of patient experience informing staffing decisions	2
Staff Experience and Wellbeing	Staff wellbeing, retention, and workforce experience considered	Workforce Strategy references workforce sustainability and workforce development	Workforce Strategy & Safer Staffing	Some evidence available but limited explicit wellbeing measures identified	3
Operational Flexibility	Organisation able to respond to fluctuations in demand	Staffing governance framework and reporting arrangements monitor operational pressures	Safe Staffing Policy; ISPR Reports	Framework supports organisational response to changing service pressures	4
Risk Identification & Mitigation	Workforce risks identified, monitored, and mitigated	DWS Gap Analysis, Diagnostic Tool Assessment and Safe Staffing Audit	DWS Gap Analysis; Diagnostic Tool; Safe Staffing Assurance Audit	Robust system for identifying compliance gaps and monitoring improvement actions	4

Key Assurance Findings

Significant Assurance (Score 4)

- Board Oversight
- Evidence-Based Workforce Planning
- Triangulation
- Establishment Review Process
- Operational Flexibility

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- Risk Identification and Mitigation

Moderate Assurance (Score 3)

- Skill Mix and Workforce Deployment
- Real-Time Staffing Management
- Workforce Sustainability
- Rostering and Workforce Utilisation
- Quality and Patient Outcomes
- Staff Experience and Wellbeing

Limited Assurance (Score 2)

- Temporary Workforce Management
- Patient Experience

Overall Assurance Judgement

Assurance Area	Rating	Score
Governance and Oversight	Significant Assurance	4
Workforce Planning	Significant Assurance	4
Risk Management	Significant Assurance	4
Workforce Sustainability	Moderate Assurance	3
Outcomes and Experience	Moderate Assurance	3

Overall NHSE Assurance Rating- Significant Assurance (Score 4)

The evidence demonstrates clear improvement activity, well-established governance processes, and routine Board oversight. Workforce planning, safe staffing review processes, and risk management arrangements are becoming embedded. To achieve Full Assurance, further evidence would be required demonstrating sustained implementation over time, stronger outcome measures, explicit patient experience integration, and more comprehensive evidence relating to temporary staffing management and workforce wellbeing.

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Appendix 2 – Safe Staffing Policy Review

The Safer Staffing Policy demonstrates strong alignment with Developing Workforce Safeguards (2018) and National Quality Board (2016) guidance, with clear evidence that the Trust has embedded the fundamental principles of right staff, right skills, right place, and right time within its governance framework. The policy establishes robust Board accountability, defined lines of responsibility, and clear reporting mechanisms from frontline services to Board, supporting both strategic oversight and operational delivery.

There is comprehensive coverage of key safe staffing components, including the use of evidence-based tools (MHOST and CNSST), professional judgement in establishment setting, biannual review processes, and structured escalation frameworks. The inclusion of daily staffing review, OPEL alignment, red flag triggers, and incident reporting (IR-e) reflects a mature and responsive approach to managing real-time staffing risk and patient safety.

The policy also demonstrates good practice in triangulation, requiring the integration of workforce data, patient acuity, quality indicators, and professional judgement to inform staffing decisions. Governance processes are clearly articulated, including monthly Board reporting, six-monthly establishment reviews, and formal escalation routes through committee structures, providing assurance of organisational grip.

Areas for further enhancement relate to maturity rather than compliance gaps, including strengthening the explicit articulation of how data is presented externally, ensuring consistent linkage between staffing and quality outcomes, and enhancing visibility of workforce metrics within governance reporting. These do not detract from the overall position of strong assurance.

The policy demonstrates a well-developed e-rostering framework that was aligned to good practice at the time of publication. It includes:

- Clear governance arrangements from Board to ward level.
- Defined rostering KPIs.
- Six-week roster publication standards.
- Escalation processes for staffing shortfalls.
- Skill mix and safe staffing considerations.
- Annual leave and flexible working management.
- Regular roster audit requirements.

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However, against current NHS England safer staffing expectations, Developing Workforce Safeguards (DWS), NQB guidance and modern e-rostering best practice, the procedure would benefit from significant updating.

Overall Assurance Assessment- Significant Assurance (Score 4)

There is strong evidence of an established and embedded rostering framework; however, the policy does not fully reflect current national expectations regarding:

- Fatigue management.
- Employee health and wellbeing.
- Temporary staffing reduction strategies.
- Real-time workforce analytics.
- Safe staffing triangulation.
- Electronic rostering optimisation and productivity metrics.
- Equality and flexible working requirements have been introduced since 2021.

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Appendix 3 Review of E-Rostering Procedure Against Current Best Practice

E-Rostering Procedure (June 2021) Review date stated as **June 2025**, with original issue date June 2017.

Executive Summary

The policy demonstrates a well-developed e-rostering framework that was aligned to good practice at the time of publication. It includes:

- Clear governance arrangements from Board to ward level.
- Defined rostering KPIs.
- Six-week roster publication standards.
- Escalation processes for staffing shortfalls.
- Skill mix and safe staffing considerations.
- Annual leave and flexible working management.
- Regular roster audit requirements.

However, against current NHS England safer staffing expectations, Developing Workforce Safeguards (DWS), NQB guidance and modern e-rostering best practice, the procedure would benefit from significant updating.

Overall Assurance Assessment- Significant Assurance (Score 4)

There is strong evidence of an established and embedded rostering framework; however, the policy does not fully reflect current national expectations regarding:

- Fatigue management.
- Employee health and wellbeing.
- Temporary staffing reduction strategies.
- Real-time workforce analytics.
- Safe staffing triangulation.
- Electronic rostering optimisation and productivity metrics.
- Equality and flexible working requirements have been introduced since 2021.

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Strengths Identified

1. Robust Governance Framework

The procedure establishes clear accountability through:

- Board reporting.
- Quality and Safety Committee oversight.
- Safer Staffing Steering Group.
- Weekly performance meetings.
- Daily staffing reviews.

2. Roster Publication Standards

The policy requires:

- Eight-week rosters.
- Publication six weeks in advance.
- Formal approval processes.
- Two-tier managerial sign-off.

Good Practice Alignment

Strongly aligned with NHS e-rostering standards and workforce planning principles.

3. Safe Staffing Requirements

The procedure requires:

- Defined establishment levels.
- Agreed skill mix.
- Six-monthly reviews.
- Risk assessments where staffing falls below agreed minimums.
- Escalation procedures.

4. Audit and Compliance Monitoring

The policy includes:

- Six-monthly roster audits.
- KPI monitoring.
- Working Time Directive compliance checks.
- Fill rate monitoring.
- Annual leave monitoring.

Areas Requiring Enhancement

1. Fatigue and Rest Management

Current Position

Policy references:

- EWTD.
- Maximum working hours.
- Rest periods.
- Consecutive shift limits.

Missing Elements

Current NHS workforce guidance increasingly expects evidence of:

- Fatigue risk assessment.
- Long-shift monitoring.
- Staff well-being indicators.
- Break compliance reporting.
- Monitoring cumulative overtime and bank shifts.

2. Staff Wellbeing Measures

Current Position

Limited references to:

- Work-life balance.
- Flexible working.

Missing Elements

No reference to:

- Wellbeing dashboards.
- Retention monitoring.

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- Sickness trend analysis.
- Burnout indicators.
- Freedom to Speak Up intelligence.
- Staff survey triangulation.

3. Temporary Staffing Governance

Current Position

Policy requires vacant shifts to be sent to bank staff and encourages substantive staff deployment before agency usage.

Missing Elements

No explicit reference to:

- Agency reduction plans.
- NHSE agency controls.
- Temporary staffing expenditure monitoring.
- Bank utilisation KPIs.
- Red-to-green escalation processes.

4. Workforce Safeguards (DWS)

Current Position

The policy predates the Developing Workforce Safeguards framework.

Missing Elements

No explicit reference to:

- DWS standards.
- Workforce red flags.
- Escalation triggers.
- Workforce risk registers.
- Improvement action tracking.

5. Triangulation of Staffing Decisions

Current Position

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The policy focuses on rostering metrics and fill rates.

Missing Elements

There is little evidence that staffing decisions are routinely triangulated with:

- Patient outcomes.
- Patient experience.
- Safety incidents.
- Complaints.
- Workforce experience data.

6. Use of Modern Workforce Analytics

Current Position

The procedure includes monitoring:

- Fill rates.
- Additional shifts.
- Annual leave.
- EWTD breaches.

Missing Elements

Current best practice would expect reporting on:

- CHPPD.
- Vacancy rates.
- Turnover.
- Sickness.
- Agency usage.
- Red flag events.
- Quality metrics.
- Productivity indicators.

Key Assurance Strengths

- ✓ Clear governance structure
- ✓ Published roster standards

- ✓ Formal approval process
- ✓ Safe staffing provisions
- ✓ Six-monthly audit requirements
- ✓ EWTD compliance monitoring
- ✓ Flexible working process
- ✓ Escalation arrangements for staffing shortfalls

Key Assurance Gaps

- ⚠ Policy has not been fully updated to reflect post-2021 national guidance.
- ⚠ Limited emphasis on workforce wellbeing and fatigue.
- ⚠ No direct linkage to Developing Workforce Safeguards.
- ⚠ Limited patient outcome triangulation.
- ⚠ No reference to CHPPD monitoring.
- ⚠ Limited temporary staffing assurance metrics.
- ⚠ Limited workforce sustainability indicators.

Assurance Statement

The E-Rostering Procedure provides evidence of a mature and embedded rostering governance framework, incorporating roster publication standards, staffing escalation processes, skill mix management, audit arrangements and Board oversight. The procedure aligns with many core safer staffing principles and demonstrates significant assurance regarding rostering governance and operational workforce management. However, the policy would benefit from revision (due 2025) to reflect current NHS England expectations, including Developing Workforce Safeguards, workforce wellbeing and fatigue management, modern workforce analytics, temporary staffing controls and triangulation with patient outcomes.

Overall assurance rating: Significant Assurance (Score 4)

Board of Directors – Meeting held in Public
10 September 2026

Paper title:	NHS England Emergency Preparedness, Resilience & Response (EPRR) Assessment & Declaration	Agenda Item 13
Presented by:	Kelly Barker, Chief Operating Officer (and Accountable Emergency Officer)	
Prepared by:	Emma Hilton, Emergency Planning and Resilience Officer	
Committees where content has been discussed previously		
Purpose of the paper Please check <u>ONE</u> box only:	☒ For approval ☐ For discussion	
	☐ For information	

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

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Purpose of the report

NHS England requires all NHS organisations to annually assess their ability to meet their EPRR statutory obligations. This assurance is sought each autumn, and Trust Boards are to be made aware of the level of preparedness achieved. This report shows the results of our self-assessment for 2026.

Executive Summary

NHS providers are required to provide annual assurance on their readiness to meet their Emergency Preparedness, Resilience & Response (EPRR) statutory obligations in the Civil Contingencies Act 2004, the Health & Social Care Act 2012, the Health Care Act 2022, NHS guidance and the NHS Operating Framework.

A regulated set of core items for all NHS providers is provided to conduct a self-assessment, with all questions to be answered showing the level achieved and actions to be taken to address any which fall below full compliance. BDCFT is assessed at **77.6%** (partially compliant); the same as last year.

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 findings of this report.
- Agree with the assessment of compliance as **PARTIALLY COMPLIANT**

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:

- All

Care Quality Commission domains

Please check **ALL** that apply

- | | |
|--|--|
| ☒ Safe | ☐ Caring |
| ☒ Effective | ☒ Well-Led |
| ☒ Responsive | |

Compliance & regulatory implications

The following compliance and regulatory implications have been identified as a result of the work outlined in this report:

- Emergency Preparedness, Resilience & Response (EPRR) statutory obligations.

Board of Directors – Meeting held in Public

10 September 2026

Comment by Accountable Emergency Officer (AEO)

NHS England requires all providers to conduct an annual self-assessment of EPRR competence against a multitude of exacting Core Standards. Since 2023, the assessment process has been scrutinised and debated by providers and ICBs at local, regional and national level. Due to impending changes at national level, NHS England has recently confirmed the standards remain unchanged for this year, and evidence was to be provided in full for review against each standard. They have also determined that there is no deep dive into a particular topic where a potentially increased risk or gap in appropriate response actions is perceived.

The peer review of self-assessments was not carried out this year as an individual exercise, however throughout the year all plans, policy, training and exercising arrangements, have been discussed with partners to ensure accuracy and consistency between partners. The ICB have advised that whilst a full evidence submission is required in readiness for NHS England dip testing, the ICB themselves will be reviewing evidence against 17 standards across the domains of Duty to Maintain Plans, Response and Business Continuity.

For BDCFT, we have slightly improved our overall compliance rating, increasing our green rating by 3 standards, however we have reduced to amber rating against 2 other standards this year. These areas are specifically as follows:

- Increase to green – LHRP attendance. 75% attendance rate at LHRP meetings by the Trust AEO.
- Increase to green – Trained on Call Staff. The implementation of an EPRR Training Needs Analysis and supporting training packages (where available) for on call staff.
- Increase to green – Responder Training – The launch and utilisation of the CPDme portfolio platform for on call staff.
- Reduce to amber – Mass Casualty and Excess Fatalities – analysis of specific standard guidance identifies the need to have in place planning arrangements for psychosocial support in such instances; a plan is in production to achieve full compliance against both standards.

Last year our self-assessment showed a compliance rate of 77.6%, for 2026 this has increased to 79.3%; keeping the Trust at partially compliant status. BDCFT has fully completed (green rated) 46 out of the 58 standards required, and it is only the green rated items which count towards the competency assessment. Outside of that the Trust is partially compliant (amber rated) in 9 areas and there remain 3 (red rated) items where we have no level of compliance (see diagram below).

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Please select type of organisation:
Click button to format the workbook

Mental Health Providers

Format Workbook

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	9	2	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	10	0	0
Hazmat/CBRN	10	0	7	3
CBRN Support to acute Trusts	0	0	0	0
Total	58	46	9	3

Overall assessment:

Partially compliant

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so.
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 6: In the Action Plan tab, click on the 'Format Action Plan' button.

The areas where BDCFT are less than fully compliant are mostly concerned with Chemical, Biological, Radiological & Nuclear (CBRN) capabilities. Further comment on each of the areas below full compliance is contained in this report.

Mass Casualty and Excess Fatalities. In line with the EPRR assurance assessment guidance, all providers of health must have in place plans to support ongoing patient care and support in response to a Mass Casualty or Excess Fatalities event. Whilst providers of mental health care would not respond in the immediate aftermath of any such incident, there is a need to understand and plan for psychosocial support to those affected by such an event alongside understanding any potential mutual aid requirements across the wider system. Whilst BDCFT respond accordingly to any incident, a plan is now required to frame response arrangements, which will be delivered in the following 12-month period.

Chemical, Biological, Radiological & Nuclear (CBRN). The entire subject of CBRN capability remains a matter of grave concern for all community and mental health provider organisations. This has been raised as an ongoing risk at regional and national level, due to a marked difference between the requirements outlined in the Core Standards and the realistic capabilities of non-acute provider organisations. Unfortunately, Yorkshire Ambulance Services (YAS) were not commissioned to support non acute organisations to suitably assess their CBRN capabilities, as previously reported, leading to the ongoing inability to suitably strengthen internal CBRN arrangements. Across Yorkshire and the Humber, non-acute providers have agreed to move forward with CBRN self-assessment in the next 12 months, enhancing capabilities where possible based on local interpretation of the standards and guidance available to them.

The discrepancy between standards and reality accounts for all 3 of BDCFT's non-compliant (red rated) items, and also 7 partially compliant (amber) areas where we are unable to reach the targets to be achieved. Overall, this equates to 10 out of 13 (76.92%) of the areas where the Trust is less than fully compliant.

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Our current self-assessment accurately depicts the credible and realistic level of response BDCFT could provide in a CBRN incident. That is based on the equipment, facilities and staff training that were established to give immediate care for such casualties who arrive at Trust sites (i.e. dry decontamination), pending the arrival of specialist staff and equipment from the ambulance service's Hazardous Area Response Team (HART) to deliver more appropriate care and an effective decontamination capability. A programme of works will be implemented within BDCFT to strengthen and progress this domain over the next 2 years.

Summary

A good deal of progress has been made in our EPRR work programme to strengthen and implement systems and tools to better support BDCFT achieve its statutory obligations. The change of staffing within the EPRR Team has brought new expertise to the Trust and enabled the roll out of the new EPRR portfolio system and subsequent training to support. Works to assess the effectiveness of this initiative are underway, and initial positive feedback demonstrates the value and need for such a system to be in place.

Our completed assessment return has been compared and peer reviewed with other community and mental health provider organisations across the whole of the Yorkshire and Humber region, and our findings largely reflect their own. BDCFT has comparable levels of compliance with both LYPFT and SWYFT.

We will continue to work collectively with fellow MH and community Trusts, ICB and NHS England EPRR leads and YAS on the areas where improvements can be made to redress areas of non-compliance. Any emerging risks or issues will be communicated up through the appropriate organisation and system structures.

BDCFT retains a realistic level of assurance and compliance against the NHS England framework and remain confident in our ability to maintain effective EPRR measures for any incidents which may affect delivery of our services. This is borne out by the effectiveness of the Trust response to recent events where our contingency measures have been activated. Overall, the Trust Board should be assured that our EPRR systems and processes remain appropriate, realistic and proportionate to provide an effective response to incidents and emergencies.

Kelly Barker

Chief Operating Officer (Accountable Emergency Officer)

Bradford District Care Foundation Trust

10th September 2026

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Board of Directors – Meeting held in Public

10th September 2026

Paper title:	Medical Appraisal and Revalidation Annual Report	Agenda Item 14
Presented by:	Dr Sal Uka	
Prepared by:	Dr Sal Uka, Chief Medical Officer, Caldicott Guardian and Responsible Officer	
Committees where content has been discussed previously	Not applicable	
Purpose of the paper Please check <u>ONE</u> box only:	☒ For approval ☐ For information ☐ 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	
	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	
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 the Board with assurance regarding the Designated Body Annual Board Report and Statement of Compliance, demonstrating Bradford District Care NHS Foundation Trust's compliance with the Medical Profession (Responsible Officers) Regulations 2010 (as amended), and to seek Board approval of the Statement of Compliance prior to submission to NHS England.

Executive Summary

Main Findings

The Trust continues to meet all requirements of the Responsible Officer Regulations and continues to operate effective arrangements for medical appraisal, revalidation, employment checks, professional standards, and clinical governance. All areas of the annual compliance framework were self-assessed as 'compliant'. As part of the quality assurance process progress on quality improvement within 2025/26 is detailed below along with proposed actions for the same in 2026/27.

Key achievements during 2025/26 include:

- Appointment and training of a Deputy Responsible Officer, strengthening leadership capacity and resilience within the revalidation system.
- Establishment of a Medical Compliance Officer function and improved oversight of appraisal and revalidation processes.
- Revision of key governance policies and procedures, including the Medical Appraisal Policy, Responsible Officer Advisory Group (ROAG) Terms of Reference, and improvements to the MHPS policy and process.
- Introduction of a Senior Leadership Development Forum to strengthen medical leadership and governance.
- Strong appraisal and revalidation performance, with 60 of 61 doctors completing appraisal, no missed approved appraisals, five GMC recommendations submitted on time, and no deferrals or non-engagement referrals.

Performance metrics demonstrate robust governance arrangements, including:

- 61 doctors with a prescribed connection to the Trust.
- 60 completed appraisals and zero missed approved appraisals.
- Five positive revalidation recommendations submitted to the GMC with no late recommendations.
- Five concerns managed through professional standards processes, one exclusion/suspension, and one GMC referral during the reporting period.

Areas for Continued Improvement

The report identifies several quality improvement priorities for 2026/27:

- Completion of the Responsible Officer Peer Review and implementation of recommendations.
- Further automation of core data required for appraisal and governance reporting.
- Strengthening arrangements for locum doctors with a prescribed connection to the Trust.

- Development of a standard operating procedure for appraisal non-engagement and revalidation deferment processes.
- Further revision of the MHPS policy, including incorporation of an unconscious bias assessment tool.
- Implementation of recommendations arising from the Aubrey Report, particularly around integrated governance intelligence and reporting.

Summary of Actions for 2026/27

The Trust will focus on a programme of continuous improvement including:

- Completion of GMC Responsible Officer training for the Medical Compliance Officer.
- Automation of appraisal and revalidation reporting processes.
- Completion of the Responsible Officer Peer Review and delivery of a quality improvement action plan.
- Strengthening governance arrangements for locum doctors.
- Revision of MHPS and Medical Appraisal policies.
- Audit of appraisal quality and doctors' full scope of practice.
- Development of SOPs for non-engagement and revalidation processes.
- Enhancement of appraiser support, training and quality assurance.
- Review of medical leadership structures and governance arrangements.
- Monitoring implementation of Aubrey Report recommendations and equality impacts within professional standards processes.

Conclusion

The report concludes that BDCFT has maintained a mature and effective framework for medical appraisal, revalidation and professional standards governance. Significant improvements have been delivered during 2025/26, and the Trust is well positioned to further strengthen assurance, transparency and continuous quality improvement during 2026/27.

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 and assurance provided within the Designated Body Annual Board Report for the period 1 April 2025 to 31 March 2026.
- Confirm its assurance that the Trust remains compliant with the Medical Profession (Responsible Officers) Regulations 2010 (as amended).
- Approve the Statement of Compliance for submission to NHS England through the Higher-Level Responsible Officer.

Links to the Strategic Organisational Risk register (SORR)	n/a
Care Quality Commission domains Please check <u>ALL</u> that apply	☐ Safe ☐ Effective ☐ Responsive ☐ Caring ☒ Well-Led
Compliance & regulatory implications	Trust Designated Body, GMC Responsible Officer, and Medical Revalidation compliance.

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Board of Directors – Meeting held in Public 10th September 2026 **Designated Body Annual Board Report and Statement of Compliance** **Reporting period 1 April 2025 – 31 March 2026**

1 Purpose

This report sets out the information and metrics that a Designated Body (BDCFT) is expected to report upwards, through their Higher-Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 – Summary and conclusion

Section 4 – Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

1A – General

The Board/Executive Management Team of: **Bradford District Care NHS Foundation Trust** can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	The Responsible Officer is the Chief Medical Officer: Dr Sal Uka GMC 4631767
Comments:	A Deputy Responsible Officer has been appointed (Dr Anitha Mukundan Deputy Chief Medical Officer) and has also completed RO training with the GMC.
Action for next year:	It is recommended that the new Medical Compliance Officer (currently out to advert) completes GMC RO training within the first 12-months once in post.

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1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Introduction of Mandatory Training Compliance report for all medical appraisals.
Comments:	Action from last year is complete. In addition, we have introduced a Deputy RO and along with the Medical Compliance Officer who have commenced in-year improvement work to improving reporting processes. Where possible the aim is to automate this as currently this is a manual process.
Action for next year:	Improve and embed automated data for appraisal. RO Peer Review (with Cygnet as an independent sector provider of mental health services) is underway. This will complete in Q3. Recommendations from this will be reviewed and should be considered as part of the quality improvement action plan for 2026/27.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	None
Comments:	The Trust has maintained access to GMC Connect as the portal for revalidation. In addition, the Medical Compliance Officer maintains all licensed medical practitioner with a prescribed connection to BDCFT electronically on L2P which also serves at the medical appraisal platform. There has been an increase in doctors leaving training and requesting BDCT as their designated body. This is being closely monitored.
Action for next year:	Review and embed a process to oversee all locum doctors with a prescribed connection to BDCFT. This should include minimum number of shifts within the trust, supervision (where required), and appraisal (in line with other substantive doctors).

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1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Review of: 1. Medical Appraisal Policy and Handbook 2. MHPS (Maintaining Health Professional Standards) 3. TOR Responsible Officer Advisory Group.
Comments:	1. Medical Appraisal Policy and Handbook – complete. 2. MHPS (Maintaining Health Professional Standards) – partially complete. This policy has been revised in line with high court regarding designation of Case Manager for all Consultants. It has also been strengthened to ensure health and well-being of doctors under investigation. 3. TOR Responsible Officer Advisory Group – complete.
Action for next year	Revise MHPS policy with the addition of an unconscious bias tool. Consider further revision to Medical Appraisal policy regarding guidance on patient multi-source feedback. A trial is underway with Hospital Managers providing written feedback to Responsible Clinicians following attendance at review hearings. This, along with any national guidance may need to be added to the policy.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	Confirm partner and plan review
Comments:	RO Peer Review (with Cygnet as an independent sector provider of mental health services) is underway. This will complete in Q3. Recommendations from this will be reviewed and should be considered as part of the quality improvement action plan for 2026/27.

Action for next year:	Provide assurance that the recommendations of the peer review and considered. Where appropriate these recommendations should be included in the quality improvement action plan for 2026/27.
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1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	Continue to gain feedback from locum doctors for continuous improvement.
Comments:	We provide appraisal data for all locum doctors who have worked in the trust for 5 months or longer.
Action for next year	Review and embed a process to oversee all locum doctors with a prescribed connection to BDCFT. This should include minimum number of shifts within the trust, supervision (where required), and appraisal (in line with other substantive doctors).

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	None
Comments:	Data to support appraisal is uploaded on L2P including any concerns that should prompt reflection as part of the appraisal process.
Action for next year:	Audit appraisal to ensure that the doctor's full scope of work is being reviewed including any work carried out of the organisation.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	None
Comments:	We have introduced regular RO, Deputy RO, Medical Compliance Officer meetings to discuss and agree actions where there are concerns about non-engagement. We have also introduced formal letters advising doctors about appraisal and revalidation obligations.
Action for next year:	Create a SOP for where there are concerns about non-engagement and revalidation recommendations including deferment.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	None
Comments:	The policy is currently has been revised to include more information about MSF and RC Psychiatry requirements.
Action for next year:	Consider further revision to Medical Appraisal policy regarding guidance on patient multi-source feedback. A trial is underway with Hospital Managers providing written feedback to Responsible Clinicians following attendance at review hearings. This, along with any national guidance may need to be added to the policy.

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
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¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	Review quality of appraisals.
Comments:	We currently have 17 active appraisers for 76 doctors. The Appraisal Lead and Medical Compliance Officer work closely to ensure training is up to date and undertake quarterly Appraisal Peer Review meetings as well as auditing appraiser feedback. We also offer mentoring for new appraisers to ensure best practice is learnt and applied to all appraisals.
Action for next year:	Review how/if Appraisers are remunerated as this is not currently specified within job plans. Review allocation of Appraiser to Appraisee process.

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Yes
Action from last year:	Continue to hold 4 Appraiser Peer Support meetings a year and organise refresher training.
Comments:	This year we have also introduced best practice training sessions as part of the CPD activity at the trust.
Action for next year:	Continue to drive improvement through mentoring, Appraiser Peer Support meetings and best practice sessions.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	None

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Comments:	All appraisals are audited by the Medical Compliance Officer when they are sent to the appraisal team for approval. Escalation of concerns is to ROAG, Deputy RO and RO.
Action for next year:	Medical Compliance Officer audit of appraisals prior to sending to the RO by acting on recommendations from the appraisal peer review and using the ASPAT tool.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None.
Comments:	RO recommendations are made in a timely manner. The process is overseen and supported by the Medical Compliance Officer. Letters are issued to all doctors following the recommendation including those where there is a recommendation to defer or non-engagement. These letters what corrective actions are needed and in what time scale to ensure a future recommendation to revalidate.
Action for next year:	Create a SOP for where there are concerns about non-engagement and revalidation recommendations including deferment.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None
Comments:	Letters are issued to all doctors following the recommendation including those where there is a recommendation to defer or non-engagement. These letters what corrective actions are needed and in what time scale to ensure a future recommendation to revalidate.

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Action for next year:	Create a SOP for where there are concerns about non-engagement and revalidation recommendations including deferment.
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1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	None
Comments:	A new CMO Office is being established which includes the development of a Deputy RO (also Deputy CMO) and a new Medical Director of Operations. The latter is an entirely new role which will need further refinement as the year progresses. A Senior Leadership Development Forum (SLDF) has been established for all doctors in a leadership role.
Action for next year:	Review of Clinical Director structure, roles and responsibilities, supervision and support. Include MHPS for all medical leaders within future SLDF sessions.

1D(ii) Effective **systems** are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Embedding activity, demand and capacity into job planning process.
Comments:	Responsible Officer Advisory Group (ROAG) has re-established with a revised TOR meeting every two-months. Minutes includes a confidential log of concerns relating to either conduct or capability of all doctors working in the trust. MHPS policy has been reviewed and revised. There is a plan to revise further with the addition of an unconscious bias tool.

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	All CMO direct reports have undergone Case Manage training.
Action for next year:	MHPS policy review. MHPS training for all medical leaders at SLDF. Review of Case Investigator training and maintaining competence of those already trained.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	None
Comments:	Appraisal data reports are collated and uploaded to Appraisals by the Medical Compliance Officer. The Aubrey Report recommends integrated reporting of incidents and complaints, and we are looking into the best way to implement this.
Action for next year:	Consider Aubrey Report recommendations by automating relevant data for appraisal.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	None
Comments:	MHPS policy has been reviewed and revised in this context. This is fit for purpose.
Action for next year:	None

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1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	None
Comments:	The Responsible Officer Advisory Group oversees and confidentially records all concerns relating to doctors. At present this does not report to Board and/or a designated sub-committee. MHPS policy includes allocation of a Designated Board Member for formal investigation. This ensures Board oversight for the most serious cases.
Action for next year:	Maintain a log of concerns through ROAG and MHPS investigations.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	None
Comments:	MPIT forms are completed and shared as required.
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	None
Comments:	MHPS policy has been strengthened with this regard although there are plans to introduce an unconscious bias tool. Medical Leaders at the SLDF have undergone Active By-stander Training which included preventing and managing discrimination.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	None
Comments:	Recommendations from the Aubrey Report have been reviewed. There is an exec lead for each high-priority recommendation. It has been proposed that these recommendations are managed by Corporate Governance as part of the existing Well-Led Action Plan.
Action for next year:	Review and report on progress of the high-priority recommendations within the Aubrey report.

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Y/N	Yes
Action from last year:	None
Comments:	Trust-wide policies are in place aligned to MHPS for doctors and dentists.
Action for next year:	None

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	None
Comments:	Pre-employment checks are led by the Medical Staffing team.
Action for next year:	None

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1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	None
Comments:	The new Senior Leaders Development Forum brings medical leaders into face-to-face sessions with the CMO monthly. This fosters the culture of support, challenge and sharing of good practice. The Trust strategy refresh continues to reinforce the values and behaviours expected of all colleagues. This is reinforced through Leading Better Lives sessions where leaders from all areas of the trust meet quarterly to discuss a range of topics. The Trust has also completed a review and refresh of the Clinical Professions Strategy with plans to oversee the implementation of this through a revised Clinical Board.
Action for next year:	None

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	The Trust strategy refresh continues to reinforce the values and behaviours expected of all colleagues. All colleagues undertake mandatory training on EDI. In addition, additional and targeted EDI training is available.
Action for next year:	None

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	The Trust employs a Freedom to Speak Up Guardian supported by a deputy FTSUG and ambassadors. The FTSUG reports regularly to Quality and Safety Committee and directly to the Board.
Action for next year:	Review medical FTSUG ambassador roles

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaint procedure).

Y/N	Yes
Action from last year:	None
Comments:	All complaints relating to and/or involving a doctor are shared with the appropriate line manager (usually the Clinical Director) and the Head of Medical Workforce. Where there is learning and/or reflection the Trust routinely shares action plans with the relevant clinical and operational leadership for implementation. The Medical Compliance Officer also provides a report for appraisal that includes any complaints and/or concerns.
Action for next year:	Review 'letter of complaints and/or concerns' issued to all doctors for appraisal.

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1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	None
Comments:	This can be monitored through ROAG data.
Action for next year:	Review pattern of concerns for doctors with protected characteristics and/or who are International Medical Graduates.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	None
Comments:	The RO, Deputy RO, Medical Appraisal Lead, Medical Staffing and Education Lead and Medical Compliance Officer where possible attend regional and national network events and/or workshops.
Action for next year:	None

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	61
Total number of appraisals completed	60
Total number of appraisals approved missed	0
Total number of unapproved missed	1
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	5
Total number of late recommendations	0
Total number of positive recommendations	5
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	5 (plus bank investigators as required)
Total number of trained case managers	3
Total number of concerns received by the Responsible Officer ²	5
Total number of concerns processes completed	4
Longest duration of concerns process of those open on 31 March (working days)	176
Median duration of concerns processes closed (working days) ³	42
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	1
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	6
Total number of new employment checks completed before commencement of employment	6
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

General review of actions since last Board report

The Trust has made good progress in strengthening its medical revalidation and appraisal arrangements during 2025/26. Key achievements include the appointment and training of a Deputy Responsible Officer, the establishment of a Medical Compliance Officer function, implementation of mandatory training compliance reporting for appraisals, revision of the Medical Appraisal Policy and Responsible Officer Advisory Group Terms of Reference and further strengthening of the MHPS process. Regular meetings between the Responsible Officer, Deputy Responsible Officer and Medical Compliance Officer have improved oversight of appraisal, revalidation and doctor engagement. A Senior Leadership Development Forum has also been established to support medical leadership development and governance. The appraisal system continues to perform strongly, with 60 of 61 doctors completing appraisal and no missed approved appraisals.

Actions still outstanding

Several improvement initiatives remain in progress. The Responsible Officer Peer Review with Cygnet is underway and due to complete in Q3. Further automation of appraisal reporting and integration of governance data is required. The MHPS policy requires a further review to incorporate an unconscious bias assessment tool. Work is also ongoing to strengthen arrangements for locum doctors with a prescribed connection to the Trust and to consider recommendations arising from the Aubrey Report regarding integrated reporting of incidents, complaints and concerns.

Current issues

The Trust has seen an increase in doctors leaving training programmes and seeking a prescribed connection with BDCFT, requiring continued monitoring and support. Manual data collection and reporting processes remain resource intensive. There is also a need to strengthen arrangements relating to locum doctors, appraisal quality assurance, management of non-engagement with appraisal and revalidation, and ensuring consistent oversight of medical concerns through ROAG and MHPS processes. During the reporting year there were five concerns managed through professional standards processes, one exclusion/suspension and one referral to the GMC, highlighting the need for continued vigilance and robust governance arrangements.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

1. Ensure the newly appointed Medical Compliance Officer completes GMC Responsible Officer training within 12 months of appointment.
2. Implement and embed automated appraisal and revalidation reporting processes, including consideration of Aubrey Report recommendations on integrated governance data.
3. Complete the Responsible Officer Peer Review and develop a quality improvement action plan to implement agreed recommendations.
4. Develop and implement a formal policy and oversight process for locum doctors with a prescribed connection to the Trust, including requirements for induction, supervision, appraisal and minimum service thresholds.

5. Revise the MHPS policy to incorporate an unconscious bias assessment tool and further strengthen fairness and inclusivity within investigations.
6. Review and update the Medical Appraisal Policy to incorporate guidance on patient and service-user multi-source feedback and evidence from the Hospital Manager feedback pilot.
7. Audit appraisal documentation to ensure doctors' full scope of practice, including work undertaken outside the organisation, is consistently reviewed.
8. Develop a standard operating procedure for managing appraisal non-engagement, deferments and revalidation recommendations.
9. Review appraiser remuneration arrangements and the appraiser allocation process to ensure sustainability and equity.
10. Continue appraiser development through mentoring, peer support meetings, calibration events and best-practice training.
11. Strengthen appraisal quality assurance by implementing ASPAT and acting on peer review recommendations.
12. Review the Clinical Director structure, roles, supervision arrangements and support mechanisms within the developing CMO Office.
13. Deliver MHPS training for medical leaders and review capability and capacity of trained case investigators.
14. Maintain and analyse ROAG and MHPS concern logs to improve organisational learning and governance reporting.
15. Monitor and report progress against high-priority Aubrey Report recommendations.
16. Review medical Freedom to Speak Up ambassador arrangements and strengthen engagement with doctors.
17. Review and improve communication to doctors regarding complaints, concerns and appraisal-related reflections.
18. Undertake an equality review of concerns and disciplinary processes, including analysis by protected characteristic and International Medical Graduate status.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

BDCFT remains compliant with the Responsible Officer Regulations and continues to demonstrate a mature and effective system for medical appraisal, revalidation and professional standards governance. Significant improvements have been delivered during 2025/26, including enhanced Responsible Officer capacity, stronger governance

arrangements, policy development and leadership engagement. The organisation has achieved high appraisal completion rates and timely GMC recommendations, supporting safe and effective patient care. The focus for 2026/27 will be on embedding continuous quality improvement, implementing peer review recommendations, strengthening governance intelligence through automation, enhancing support for locum doctors and ensuring that medical professional standards processes remain fair, transparent and inclusive. These improvements will further strengthen assurance to the Board and support the Trust's ambition to deliver outstanding clinical leadership and governance.

Close, Holly
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Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	
---------------------------------------	--

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Dr Sat Uka, Chief Medical Officer
28th August 2026

Close, Holly
04/09/2025 14:12:13

Trust Board

10th September 2026

Paper title:	Trust Board - Finance Report (Month 03 – June 2026)	Agenda Item 15
Presented by:	Mike Woodhead, Chief Finance Officer	
Prepared by:	Claire Risdon, Operational Director of Finance	
Committees where content has been discussed previously	Finance & Performance Committee	
Purpose of the paper Please check <u>ONE</u> box only:	☒ For approval ☐ For information ☐ 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	✓

Close: Holly
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Purpose of the report

The purpose of this report is to share the current financial position, key messages, risks and mitigations.

Executive Summary

The Trust remains technically on plan and forecasting a breakeven position, but delivery of the year-end financial target is becoming increasingly dependent on mitigating a significant Cost Improvement Programme (CIP) shortfall and addressing a residual financial risk of £4.5 million.

Financial Position

- The Trust continues to forecast breakeven, however this assumes successful delivery of recovery actions and management of identified risks.
- A £4.1m forecast CIP shortfall has been recognised within the reported position, with non-recurrent mitigations identified to maintain financial balance.

Key Risks

The principal risk remains delivery of the efficiency programme, with potential further deterioration estimated between £2.4m (best case) and £7.3m (worst case). Additional emerging risks include:

- Fair Deal for Nurses review, with a potential financial impact of £0.9m to £4.0m.
- Deteriorating financial performance across West Yorkshire Provider Collaboratives.
- Uncertainty regarding pay award funding for the 0-19 contract
- General cost pressures and run-rate risks.

The overall likely-case financial risk has reduced from £5.1m in Month 3 to £4.5m in Month 4, reflecting some improvement but still requiring substantial further action.

NHS England Oversight

The Trust has been placed by NHS England Enhanced Intervention Framework into the "Watch: Targeted Support" category due to concerns over deliverability of the financial plan rather than current financial distress. This will result in increased scrutiny of:

- Financial recovery planning.
- CIP delivery.
- Workforce and pay expenditure management.
- Spending controls.
- Governance and risk management arrangements.

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Workforce and Staffing

- Agency expenditure remains within planned levels, although the Trust is forecasting a £0.2m breach of the agency cap, driven by an exceptional package of care, fully offset by income.
- The bank staffing cap is forecast to be breached by £1.2m, primarily due to vacancies, sickness absence and patient acuity. This is offset by forecast substantive staffing underspends of £1.6m.

Recovery Actions

The Trust has strengthened financial oversight through:

- Weekly executive financial performance reviews.
- Enhanced programme management and escalation arrangements.
- Targeted actions to reduce out-of-area placements and improve operational efficiency.
- Additional workforce, non-pay and estates controls.
- Identification of further savings opportunities and difficult service/infrastructure decisions where necessary.

Overall Assessment

The Trust remains compliant with its planned financial position but faces a high-risk delivery challenge. Success depends on accelerating CIP delivery, maintaining strengthened financial controls, and securing further mitigations to close the remaining £4.5m risk gap. While NHS England's placement of the Trust in the Watch category increases external scrutiny, it also provides additional support to strengthen delivery confidence and financial recovery.

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 Trust Board is asked to:

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

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Trust Board

10th September 2026

Item 15 - Finance Report – Month 4 (July 2026)

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Financial Performance – Key Messages & Risks

The Trust remains technically on plan and forecasting breakeven, but delivery of the financial position is increasingly dependent on managing a substantial CIP shortfall and mitigating a £4.5m residual risk. NHS England's decision to place the Trust in the 'Watch category' reflects concern over deliverability rather than current financial failure, and there is heightened scrutiny on recovery planning, CIP delivery, workforce costs and governance.

Financial Risk assessment

The main risks continue to arise from the delivery risk on the CIP programme. A forecast £4.1m CIP shortfall is reported in the financial position at Month 4, with non recurrent mitigation plans identified to cover the risk. The risk of further deterioration has been assessed between **£2.4m to £7.3m**.

In addition to the CIP risks there are a number of further risks that have arisen during the year, these include:

- The fair deal for nurses
- Deteriorating financial position for the West Yorkshire Provider Collaboratives
- Securing pay award funding from BMDC for the 0-19 contract
- General run rate risks and additional cost pressures

The risk assessment at Month 4, taking account of the upside and downside risks, highlights that a **further £4.5m of actions are needed to fully de-risk the position**. This is a decrease in the overall risk assessment from Month 3 of £0.6m (likely risk at month 3 was £5.1m).

Management actions

In response to the emerging risks, and in addition to the extra-ordinary FPC in August, the Executive Management Team have stood up a weekly 'report out' for more regular oversight of the financial position and the key metrics agreed as part of the additional management actions/ controls. The key risks that will impact delivery of the financial plan are robustly challenged through these governance arrangements, with the Executives held to account for their respective programmes.

Financial Performance – Key Messages & Risks

Bradford District Care
NHS Foundation Trust

Reporting breaches

- At Month 4, the Trust is **within it's planned Agency costs for both year to date and forecast**. However, the Agency cap has been breached by £0.2m forecast, due to the lead provider arrangements for the exceptional package of care (EPoC) for a service user on the Naturally Centre. The forecast costs of the EPoC are £0.2m and are offset by income.
- The Bank cap has been **breached by £0.6m YTD** and **forecast to breach by £1.2m at the year end**. This is driven by vacancies, sickness and patient acuity.
 - Substantive staffing underspends are mitigating the bank cap breach (YTD underspend £1.4m and forecast underspend £1.6m).
 - The Enhanced Therapeutic and Observations of Care (ETOC) programme is underway and ward based leadership briefing sessions have started in June 2026 to support developing improvement plans.

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NHS England enhanced intervention framework

Bradford District Care
NHS Foundation Trust

NHS England North East & Yorkshire's has introduced a strengthened approach to financial recovery, performance improvement and quality oversight for 2026/27. A risk stratification model will determine the level of support and intervention from NHS England as follows:

Risk Category	Meaning
On Track	Full autonomy retained
Watch	Recovery required with targeted support
At Risk	Active regional intervention
Mandated	Intensive turnaround and regulatory oversight

Bradford District Care NHS Foundation Trust has been placed in the **"Watch: Targeted Support"** category due to concerns about delivery risk.

Additional oversight includes:

- More frequent NHS England engagement
- Deep dives into risk areas
- Monitoring of finance, workforce and CIP delivery
- Reviews of spending controls
- Peer and NED support
- Greater provider and commissioner alignment.

The Trust is not currently considered in financial distress, but NHS England is signalling concern about its ability to deliver plan without additional scrutiny and support. For the Board and Executive Team, the practical expectations are:

- Stronger financial recovery planning
- Demonstrable CIP delivery
- Better alignment between workforce reductions and pay expenditure
- Increased assurance around governance and oversight
- Improved transparency of risks and mitigating actions
- Participation in regional support and peer-learning programmes.

Trust Financial Overview

Statement of Comprehensive Income

Financial Position by Care Group/Directorate						
£000's	YTD Budget	YTD Actual	Revised YTD Variance	Annual Budget	FOT Actual	Revised FOT Variance
Mental Health Care Group	33,148	34,238	1,090	96,135	99,255	3,120
Adults and Children's Comm. Care Group	21,652	21,912	260	64,242	65,072	830
Medical Directorate	6,453	6,567	114	18,900	18,909	9
Central Reserves & Developments	4,228	2,629	(1,599)	11,121	6,186	(4,935)
Contract Income	(76,336)	(75,850)	486	(228,508)	(228,045)	463
Estates & Facilities	4,091	3,964	(127)	12,030	12,365	335
Finance	916	909	(7)	2,698	2,699	1
Trust General Management	992	918	(74)	2,958	2,896	(62)
Nursing, Quality and Gov	2,376	2,320	(56)	7,121	7,028	(93)
People Matters	1,741	1,710	(31)	5,112	5,179	67
Digital Services	1,789	1,870	81	5,311	5,766	455
Transformation	949	805	(144)	2,880	2,690	(190)
(Surplus)/Deficit	1,999	1,992	(7)	0	0	0

Statement of Financial Position

Statement of Financial Position £000's	Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
Non-Current Assets	78,963	59,657	(19,306)	91,994	90,548	(1,446)
Current Assets	21,724	27,791	6,066	22,203	22,203	0
Current Liabilities	(29,560)	(25,166)	4,394	(8,157)	(8,157)	0
Non-Current Liabilities	(6,405)	(7,107)	(702)	(4,192)	(4,192)	0
Total Assets Employed	64,723	55,175	(9,548)	101,848	100,402	(1,446)
Public dividend capital	52,123	49,399	(2,724)	88,590	87,144	(1,446)
Income and expenditure reserve	(1,597)	(6,997)	(5,400)	403	403	0
Revaluation Reserve	4,000	2,578	(1,422)	2,659	2,659	0
Miscellaneous Other Reserves	10,197	10,195	(2)	10,196	10,196	0
Total Taxpayers' and Others' Equity	64,723	55,175	(9,548)	101,848	100,402	(1,446)

Efficiency Programme – Included in Position

The Month 4 position includes under delivery on the efficiency programme of £527k YTD and £4.2m 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.

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
1. Temporary Staffing	KB	344	77	267	1,032	444	588	High
1. LOS/Out of Area Placements	KB	572	0	572	3,610	1,892	1,719	High
1. P & P Adult & Community Pathway Total		916	77	839	4,642	2,335	2,307	
2. Medical Staffing	SU	174	153	21	447	328	119	Medium
3. Continence Service review	KB	233	0	233	349	0	349	High
4. Enteral Feeding consumables	KB	57	57	0	85	85	0	Low
5. CYP Leadership restructure	KB	80	80	0	80	80	0	Low
6. Clinical Admin Review	KB	86	72	14	257	216	41	Low
7. Corporate Service Review	EMT	344	582	(£238)	928	761	167	High
8. Difficult Decisions CAMHS Neuro	KB	93	33	60	278	95	183	High
8. Difficult Decisions BANDS	KB	86	8	78	257	24	233	High
9. LMH Development	MW	102	102	0	305	305	0	Low
10. Bracken Ward	KB	103	0	103	309	0	309	High
10. Low Secure	KB	132	86	46	396	383	13	Low
11. TrustWide Efficiency	EMT	462	946	(£484)	4,159	4,172	(£13)	High
12. Technical efficiencies	MW	189	189	0	535	535	0	Low
13. Place Corporate efficiencies	TP	0	275	(£275)	300	300	0	Low
14. Transformation target	FR	89	0	89	800	800	0	High
Grand Total		3,144	2,659	485	14,127	10,419	3,708	

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	Delivery Risk
2. Medical Staffing	SU	78	78	0	233	233	0	Medium
3. Continence service review	KB	116	116	0	349	18	331	High
7. Corporate Services review	EMT	90	48	42	271	145	126	High
15. Vacancy Factor	KB	1,018	1,018	0	3,054	3,054	0	Low
Total		1,303	1,260	42	3,908	3,450	457	

OVERALL CIP PERFORMANCE	4,447	3,920	527	18,035	13,870	4,165
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Efficiency Programme – Risk Assessment

The Month 4 position includes under delivery on the efficiency programme of £0.5m YTD and £4.1m forecast. In addition, the CIP programme has been risk assessed to determine the further risk of under delivery to inform the Trusts net risk position. At Month 4 further risks range from **£2.4m best case to £7.3m worse case**.

Efficiency Plan	SRO	BEST	LIKELY	WORST
1. Temporary Staffing	KB	-31	212	622
1. LOS/Out of Area Placements	KB	833	2,341	3,075
1. P & P Adult & Community Pathway Total		803	2,554	3,698
2. Medical Staffing	SU	168	336	672
8. Difficult Decisions CAMHS Neuro	KB	0	0	95
8. Difficult Decisions BANDS	KB	0	0	24
11. TrustWide Efficiency MHCG	KB	640	1,281	1,537
11. TrustWide Efficiency A&CCG	KB	217	434	521
11. TrustWide Efficiency Estates	MW	6	11	22
14. Transformation target	FR	560	640	720
Risk Assessment		2,394	5,256	7,289

Following the assessment of the likely case financial risk at Month 3, the Trusts Executive held an extra-ordinary and extended OSPB session in July, to provide dedicated time to focus on the Trust's sustainability and recovery position and the actions required.

The agenda was designed around the key areas where we need greater grip, focus and decision-making, including cost improvement delivery, financial recovery, grip and control measures, and prioritisation. The focus was on identifying where we need to go further and faster, addressing delivery barriers, making difficult decisions where required, and agreeing practical actions that will strengthen our trajectory and delivery confidence.

The key outputs from this session include:

- Sprint activities for the Adult Mental Health Strategic Programme to target reductions in out of area placements:
 - Extended cover for 'clinical decision makers' – 8am to 8pm 7 days a week
 - Early identification of service users likely to experience Trauma: early intervention to avoid admissions
 - Enhanced PMO cadence: rapid escalations and actions
- By end of August - Improve the robustness of plans that are scheduled to deliver from Q2 onwards
- Identify opportunities to go further to deliver additional savings: e.g. Community Clozapine
- Additional management controls – including: Workforce/ Non Pay/ Estates
- Difficult decisions – e.g. performance compliance/ stop services not adequately commissioned/ cease outsourcing/ rationalise infrastructure etc

Quantification of these additional actions will take place during August and will inform a revised risk assessment in Month 5.

Headlines:

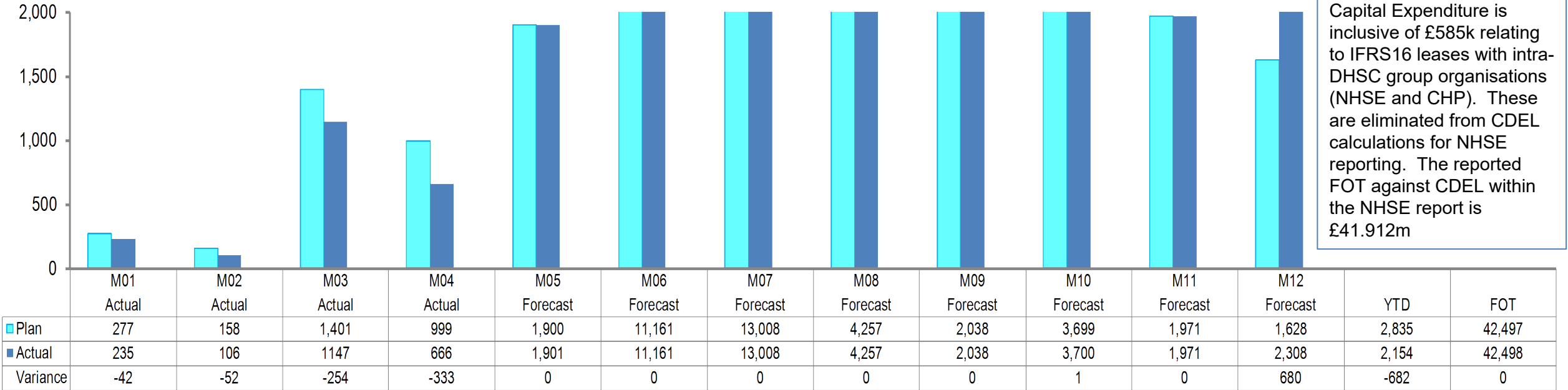
The likely case risk assessment at Month 4, taking account of the upside and downside risks in the table below, highlight that a **further £4.5m of actions are needed to fully de-risk the position**. This is a decrease of the overall risk assessment from Month 3 of £651k (risk at month 3 was £5.1m).

The main risks continue to arise from the delivery risk on the CIP programme. £4.2m CIP shortfall is reported in the financial position at Month 4, and the risk of **further deterioration** has been assessed between £2.4m to £7.3m.

The **fair deal for nurses** review poses a significant financial risk, ranging from £0.9m to £4m. Work will commence in September to evaluate job descriptions; the national timescale for completion of this work is October 2028.

	Description	Best	Likely	Worse
Upside 1	Risk Contingency	£0	£0	£0
Upside 2	Cost pressure review - target further reductions	£44	£44	£44
Upside 3	Non recurrent opportunities that arise during the year/ budget underspends	£1,278	£1,274	£1,274
Upside 4	Non recurrent income	£1,216	£1,216	£1,216
Upside 5	Continence funding from ICB	£500	£300	£0
Upside 6	Secure 0-19 pay uplift funding for 26/27	£162	£162	£162
Sub-total Upsides		£3,200	£2,996	£2,696
Downside 1	CIP delivery risk	(£2,394)	(£5,256)	(£7,289)
Downside 2	Adult Secure PC financial risk	(£178)	(£238)	(£301)
Downside 3	Additional Cost pressures	(£247)	(£371)	(£500)
Downside 4	General Run Rate Risks	(£207)	(£290)	(£414)
Downside 5	0-19 Pay uplift for 26/27	(£344)	(£344)	(£344)
Downside 6	Fair deal for nurses (national JD reviews)	(£872)	(£996)	(£3,954)
Net Risk		(£1,042)	(£4,498)	(£10,106)

Capital Expenditure Plan vs Actual/Forecast



The capital position in July is underspent by £0.68m with a YTD spend of £2.1m. The Trust is confident that it will spend their full capital allocation for Operational Capital and additional PDC.

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

Self certification

1. Declaration of review of submitted data

The board is satisfied that adequate governance measures are in place to ensure the accuracy of data entered in this submission.

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.

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.

Approved on behalf of the board of directors (normally by CFO and CEO):

The PFR must be signed off by the Provider CFO and CEO or Chair in their absence. In signing off the PFR the Provider CFO and CEO are providing assurance that the key information contained within the return is a true and accurate reflection of the Provider financial position.

2. Is the return consistent with the board report?

Please confirm that the financial data reported in this monthly monitoring return is/will be consistent with the information reported to and published in the board report

Date of board report (please note that this can be a future date)

3. 2026-27 Dissolution

Has the trust dissolved in the financial year?

Number of months as a trust

4. 2026-27 Capital Envelope Allocations

The capital plan included in this template has been agreed with The Board, any additional funding requirements assumed are in line with priorities, and the Trust's 26/27 capital plan is affordable within the overall provider operational capital allocation.

5. 2026-27 Capital Delegated Limit

All NHS trusts and Foundation trusts have a capital delegated limit. These have been increased for all Trusts and are linked to the NHS Oversight Framework (NOF). NHS Trusts and NHS Foundation Trusts in NOF 1 and 2 benefit from greater autonomy with higher capital delegated limits.

NHS trust and Foundation trusts should refer to NHSE Capital Guidance 2026/27-2029/30 for details on capital delegated limits. Further detailed guidance will be published in an addendum to the capital investment business case approval guidance.

Please confirm your NHS Oversight Framework segment (1 to 5)

7. Advanced Foundation Trust

Have you been approved as an Advanced FT?

Flexibilities approved for deployment in current financial year

8. Provider key metrics

Adjusted financial performance surplus/(deficit) - Year to Date

Adjusted financial performance surplus/(deficit) - Forecast

NOF combined finance score

NOF financial override applies?

Trust YTD spend on agency as proportion of Trust YTD total paybill

Trust YTD spend on bank as proportion of Trust YTD total paybill

Compliance with agency cap

Compliance with bank cap

00ACTYTD
Self-cert declarations
Actual
31/07/2026
YTD
DROP-DOWN

Confirmed

CFO
Name
Mike Woodhead
Email address
Mike.Woodhead@bdct.nhs.uk
Job title
Chief Finance Officer
Date
14/08/2026

CEO or Chair
Name
Therese Patten
Email address
Therese.Patten@bdct.nhs.uk
Job title
Chief Executive Officer
Date
14/08/2026

Yes

10/09/2026

No
12

Yes

2

No	Authorisation data as at 28/07/2026
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(1,992)
0
1
No
1.9%
7.2%
No
No

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04/09/2025

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;
- Note the enhanced interventions framework introduced by NHS England, with BDCFT being placed in the 'watch' category; and
- Highlight any further assurances required.

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04/09/2026 14:22:13

Sent by email

Sarah Jones
Chair

Therese Patten
Chief Executive

Bradford District Care NHS Foundation Trust

North East and Yorkshire
7 and 8 Wellington Place
Leeds
West Yorkshire
LS1 4AP

23 July 2026
Ref: 055_SA_RD

Dear Sarah and Therese,

We would like to begin by thanking you for all the work you are doing to stabilise performance and deliver on the ambitions set out in your 2026/27 plans. It is clear we are operating in a very different financial environment to previous years where there is no expectation of additional in-year funding, and pressures on the public finances remain significant. This means we must operate on the basis that what we have in our agreed funding allocations and plans to deliver our performance and quality ambitions against.

Quality

High quality care is delivered across the region every day, but recent reviews and outcome data shows a mixed picture of quality care.

It is vital that the 3 key areas of quality - patient safety, patient experience and clinical effectiveness - are triangulated and that the Board, through a robust quality management system, has sight of its outcomes for patients.

The National Quality Strategy published in July 2026, sets out the enablers for quality care and focuses on the need for accountability at every level of the organisation. Boards should set clear quality priorities, using data to manage quality and inform decision making and increasing transparency on care quality metrics.

Reviewing our outcome data there are priorities. Infection prevention and control measures continue to be off plan and highlights concern about key elements of the fundamentals of care. Delay in emergency and planned care is happening across all care settings. There needs to be a continuing focus on Mental Health outcomes and on Maternity and Neonatal delivery standards. Patient experience outcomes will be a focus for all organisations in line with the Patient Experience Framework.

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The regional team is working closely with the ICBs to ensure quality oversight is clear and duplication does not take place. We recognise we have more to do together to get this right. The National Quality Board guidance will be followed to ensure support is offered when required to improve patient quality outcomes.

Regional finance and workforce position

As discussed in the recent CEO event, the Quarter 1 position reinforces the need for immediate grip and recovery action across the region. At month 3 the region reported a £152.7m deficit (excluding the impact of deficit support funding), against a planned £119m deficit, resulting in a £33.7m adverse variance to plan. This adverse variance has been driven predominantly by under delivery of cost improvement plans and residual industrial actions costs from month 1 still requiring mitigation. Thirteen of the 33 providers in the region reported an adverse variance to plan at month 3, with ICBs reporting on plan.

Across the region, cost improvement plans were behind plan at month 3 by £35m. This is a deterioration from month 2 where cost improvement plans were behind plan by c£24m. We know plans are phased with CIP increases expected at Q2, Q3 and Q4 and it is therefore more concerning we have under delivery in some areas at month 3. All organisations continue to forecast delivery of the full year £1.6bn efficiency plan for the region with £287m delivered at month 3, leaving 82% of the full year plan to be delivered over the remaining 9 months of the year.

Workforce plans across showed WTEs were 0.8% below plan at M3 however this doesn't align with the pay overspend position at M3 (£28.4m). The workforce plans also show above plan for 12-month rolling sickness absence rates and bank spend. It is essential that the triangulation of plans is being considered and realistic workforce reduction plans are in place for the level of efficiency set. As a region, we have now completed several workforce plan reviews with organisations and will be sharing the learning and best practice from these reviews. Cumbria, Northumberland, Tyne and Wear NHS FT and Sheffield Teaching NHS FT were highlighted as organisations where positive action is taking place. Work is underway across the regions CPO network focusing on health and wellbeing with consideration of potential for greater join up on staff Mental Health, and scaled occupational health services supported by the Social Partnership Forum. Three providers (RDASH, YAS and Leeds Community) have been put forward for a national sickness reduction programme and we will look to spread learning across the region from this programme.

While some pressure and risk at this stage of the year is not unexpected, this level of variance to plans and delivery phasing highlights the importance of taking early and sustained action now to avoid positions becoming embedded. Where organisations are not delivering to plan, it is expected that a strengthened and immediate response is being undertaken to support delivery of mitigations. As a region, we have developed a principle-based approach to in year financial delivery which includes risk stratification to identify the organisations where delivery is a concern. This

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approach includes the expected actions which should be taking place, the improvement support available and the assurance reporting required to provide confidence both internally and externally that delivery is back on track. Further details of this approach are included in Appendix 1 and has been discussed with Directors of Finance. We will be asking for support from organisations to spread learning or areas of best practice to support wider recovery.

Expectations of organisations most at risk include, but are not limited to:

- A board-approved risk adjusted recovery plan with quantified actions
- Clear executive stewardship and accountability
- Evidence that all opportunities have been fully explored
- Ongoing and frequent board oversight of delivery and impact with considerations on course corrective actions where necessary
- Turnaround support identified early where required to ensure delivery both in year and to maintain progress with medium term plan trajectories

Your organisation has been assessed regionally as “Watch: Targeted support”. We will now work with you on the support, actions and intervention which will support and ensure plan delivery within the framework shown at Appendix 1. We will keep you informed of any change in risk assessment.

Performance delivery and productivity

Alongside financial performance, there are emerging pressures in the region in relation to key operational priorities, including RTT, Cancer and Urgent and Emergency Care, and wider access and standards in Mental Health, Learning Disabilities and Autism. At our meeting on Friday, we talked about the leadership and recovery challenges across the service whilst delivering the commitments we have made in this year’s plan. We also talked about the importance of transparency, and of sharing and learning from each other.

Performance information for all organisations in England is available [NHS England public data gateway](#). For those organisations significantly off plan at Q1 our team has already been in contact to discuss recovery plans and to co-ordinate support more widely.

For all Trusts, you will of course want to ensure that you and your Board remain focused on ensuring that:

- Recovery trajectories are pro-actively monitored to ensure course correction at the earliest opportunity
- Operational, workforce and financial plans remain aligned and credible
- Productivity opportunities are identified and delivered where performance is off plan

On Friday we also discussed how we might develop some shared priorities across the region both in terms of improving access and transforming services for our

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population. We began to discuss how we might work together on the “big shifts” that need to be made in UEC, Electives and Neighbourhood Health along with Cancer, Mental Health, and Maternity. We committed to following up on this conversation and hearing more from you about the approach we might take, including how we might best share and spread learning and good practice.

On a more tactical level, the regional team has already started work to support all organisations with key productivity improvements that should enable step change in performance and access for patients over time. Programmes of work are already in place to:

- Improve theatre utilisation and throughput
- Optimise new to follow-up ratios
- Reduce patient length of stay and Out of Area Placements in mental health, learning disabilities and autism
- Address unwarranted variation across pathways including primary care
- Further improve of ambulance handover times & reduce conveyance to hospital.

If your organisation would like to learn more about these workstreams please don't hesitate to get in touch as we are happy to facilitate an “adopt and adapt” approach to learning from others.

We know how incredibly hard your teams are working across all aspects of delivery and we are committed to supporting organisations to achieve our joint ambitions. Thank you for your continued leadership.

Yours sincerely,



Bill McCarthy

Chair

NHS England – North East & Yorkshire



Samantha Allen CBE

Interim Regional Director

NHS England – North East & Yorkshire

CC: David Purdue, Regional Chief Nurse, NHSE NE&Y

Leaf Mobbs, Interim Regional Chief Operating Officer, NHSE NE&Y

Tarryn Lake, Regional Director of Finance, NHSE NE&Y

Close/Holly
04/09/2026 14:22:17

Board of Directors – Meeting Held in Public

10th September 2026

Paper title:	Integrated Strategic Performance and Quality Report – August 2026	Agenda Item 17.0
Presented by:	Phil Hubbard - Director of Nursing, Professions & Care Standards Fran Stead - Trust Secretary	
Prepared by:	Kelly Barker - Chief Operating Officer Cliff Springthorpe - Head of Business Support Catherine Sunter – Deputy Director Performance, Planning and Insight	
Committees where content has been discussed previously	Quality and Safety Committee Mental Health Legislation Committee People and Culture Committee Finance and Performance Committee Audit Committee	
Purpose of the paper Please check <u>ONE</u> box only:	☒ For approval ☐ For information ☐ For discussion	

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

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Good governance	Governance, accountability & oversight	x
Purpose of the report		
The purpose of this report is to present the Board with the Trust's Integrated Strategic Performance and Quality Report for August 2026, providing an integrated view of performance, quality, workforce, finance, productivity and strategic assurance. The report brings together key metrics, risks, mitigations and committee assurance to support Board oversight and enable triangulated discussion on areas of strong performance and areas requiring further improvement.		

Executive Summary
Overall Position The Trust remains operationally stable and continues to deliver strong performance across a number of strategic priorities. The latest published NHS Oversight Framework (NOF) position remains Sector 2, reflecting sustained improvement over the last 12 months and demonstrating the organisation's ability to maintain quality, access and financial performance despite continued system pressures. The Trust continues to perform particularly strongly in community waiting times, urgent crisis response standards, mandated 0-19 public health contacts, workforce vacancy levels, temporary staffing controls and a range of patient safety indicators. The report also highlights a number of emerging NOF measures where underlying data quality, recording practices and system-wide factors currently influence reported performance. Whilst these measures require improvement, the majority form part of an established Data Quality Improvement Programme with defined recovery trajectories during 2026/27.
Key Areas of Strong Performance The Board can take assurance from: - Continued elimination of community 52-week waits, maintaining NOF 1 performance. - Sustained delivery of crisis access standards, with over 94% of service users receiving face-to-face assessment within 24 hours. - Delivery of all five mandated 0-19 Health Visiting contacts above contractual and national expectations. - Continued reduction in vacancy rates alongside low agency utilisation. - Stable patient safety indicators with no evidence of special cause deterioration across key harm measures. - Improvement in CMHT access performance despite increasing referral demand. - Delivery of the financial plan at Month 4 and retention of a forecast breakeven position.
Principal Areas Requiring Continued Board Oversight

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Whilst overall performance is stable, four areas continue to require focused executive and Board oversight:

Access and Flow

The most significant operational challenge remains inpatient flow through adult mental health services. Although delayed occupancy remains below target, length of stay, discharge complexity and system barriers continue to generate Out of Area Placement (OAP) expenditure above trajectory. July delivered 869 OAP bed days against a planned trajectory of 709. Recovery activity is now being accelerated through the Trust-wide Purposeful and Productive Flow Command Sprint.

Community Dental Services continue to perform below the national RTT standard, although the service has demonstrated recovery over recent months and remains affected by longstanding workforce and General Anaesthetic theatre capacity constraints that are recognised across West Yorkshire.

Outcomes and Data Quality

The introduction of new NHS Oversight Framework indicators has highlighted areas where reported performance is significantly influenced by data quality and clinical recording practice. This is particularly evident within CYP 104-week waits, paired outcome measures and adult admissions without prior contact with mental health services (ICB Measure). Dedicated delivery groups are in place to resolve these issues through system configuration, staff training and retrospective validation work. Significant improvement is anticipated during the second half of 2026/27

Workforce

Sickness absence remains the most significant workforce challenge at 7.21%, substantially above the national benchmark. While labour turnover, vacancy rates, appraisal compliance, clinical supervision and mandatory training all remain favourable, deteriorating performance relating to time to fill vacancies, return-to-work interviews and employee relations cases requires continued oversight. Workforce wellbeing and leadership support, capacity and capability therefore remain priority areas for improvement.

Financial Sustainability and Productivity

The Trust remains forecast to achieve a breakeven position; however, delivery of the Cost Improvement Programme remains the principal financial risk. Current forecasts indicate a £4.1m CIP shortfall which is presently mitigated through non-recurrent actions. Additional executive controls, weekly oversight arrangements and productivity improvement programmes are now in place to reduce financial risk and support sustainable delivery of the financial plan.

Risk	Current Mitigation
Delivery of the CIP programme and underlying recurrent efficiency position	strengthened financial controls, productivity programme oversight, accelerated delivery plans and identification of further mitigations

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Adult mental health flow, inpatient length of stay and Out of Area Placement utilisation.	Purposeful and Productive Flow Command Sprint, Summer Sprint in CMHT, system escalation processes, discharge optimisation and repatriation oversight.
Data quality and performance on newly introduced NOF indicators.	Trust-wide Data Quality Improvement Programme, targeted task-and-finish groups, clinical system changes, staff training and enhanced performance governance.
Workforce sickness absence and wellbeing	Attendance improvement programme strengthened management capability, policy review, wellbeing interventions and focused support for high absence areas.
Community Dental Service RTT performance	West Yorkshire Collaborative recovery programme, active waiting list management and ongoing review of GA theatre capacity with provider partners

Progress against these actions will continue to be monitored through Care Group Accountability Meetings, Operational and Strategic Programme Boards, Executive Management Team and relevant Board Committees.

Assurance Levels

The Strategic Assurance Framework, previously part of the ISPR, is to become a separate more detailed report from September 2026 onwards. The Committees have reviewed performance against the relevant Board Assurance Framework risks. The ISPQR supports the following assurance conclusions:

The levels of assurance of this month using the historical framework are as follows:

Being the Best Place to Work

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

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- Confirmed assurance level by delegated Committee – **High**

Delivering Best Quality Services

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

Making Best use of resources

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

Best partner – measures & metrics to be agreed

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

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

Whilst performance remains mixed across a small number of operational, workforce and financial indicators, the assessment is that the organisation remains stable, well-governed and supported by credible recovery plans. Areas currently rated as limited or low assurance are well understood, subject to active executive oversight and have identified mitigation plans in place. The Board can therefore take reasonable assurance regarding the overall delivery of the Trust Strategy whilst maintaining focused oversight of access, flow, workforce wellbeing, data quality and financial sustainability

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**

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Recommendation(s)
The Board is asked to: • Take assurance from the Trust's overall performance, quality, workforce and financial position. • Note the Trust's NHS Oversight Framework position and committee assurance ratings. • Endorse the principal risks and mitigations identified within the ISPQR. • Support continued executive focus on: ○ Adult mental health flow and Out of Area Placements. ○ CYP waiting time recovery and data quality improvements. ○ Mental health outcomes improvement. ○ Workforce sickness reduction and wellbeing. ○ Delivery of the CIP, productivity and financial recovery programmes. • Agree continued Board oversight of these areas through the remainder of 2026/27.

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 – IP Bed Capacity • 2815 – Access to ILS ad BLS training • 2672 – Lynfield Mount Redevelopment • 2654 – Medicines Shortages • 2896 – Bank Workers
Care Quality Commission domains Please check <u>ALL</u> that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • 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

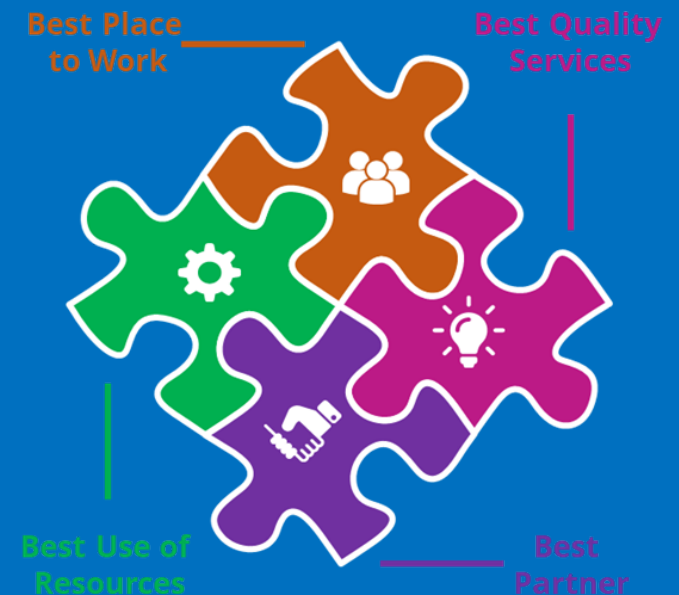
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	potential issues and prompt further investigation of support needs and align with the five national themes of the NHS oversight framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.
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Integrated Strategic Performance And Quality Report

August 2026 (July Data)



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Introduction

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

The Trust's strategic priorities are informed by nationally defined objectives for providers - the NHS Constitution, the NHS 10 Year Plan, the National Oversight Framework, Adult Social Care Outcomes Framework, Integrated Care Systems (ICS), and the Insightful Board as well as local contracting and partnership arrangements.

This report is set out in the following sections:

- Executive summary of performance against a range of measures
- A more in-depth view of performance against metrics in our six domains: Access to Services, Quality and Patient Safety, Effectiveness of Care, People and Finance and Productivity
- A heat map of indicators by care group
- An appendix that contains further detail on overall performance against NoF metrics, performance against each metric along with narrative and annual measures

The content of this report will be reviewed on a regular basis to ensure indicators are current and relevant reflecting areas of highest priority for the Trust.

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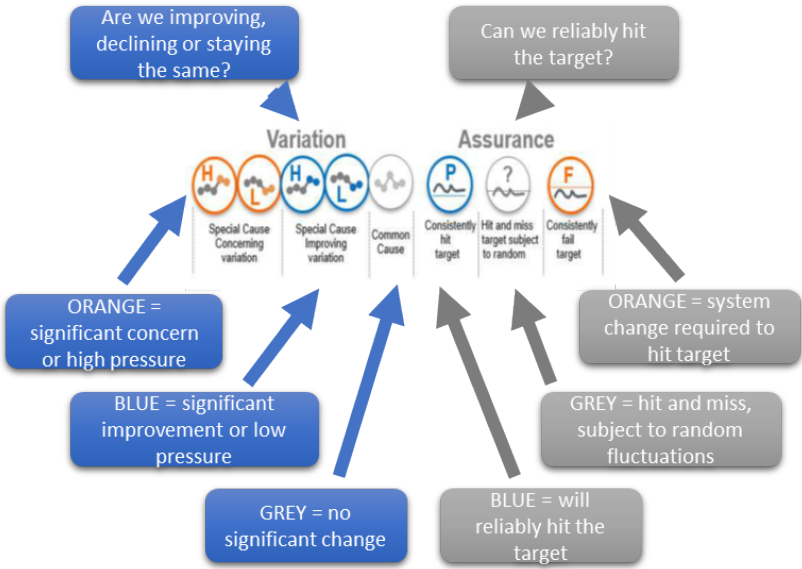
Definitions

SPC Definitions

Within this data pack there has been a 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 in this graphic.



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Executive Summary – KPI Assurance Grid (General, Excluding NOF Indicators)

The following matrix shows how each indicator is performing its target or objective, at a high level. It also includes which sector the indicator was in previously.

Under Target / Consistently Under Target	Domain	Last Report	Achieving / Consistently Achieving	Domain	Last Report	Achieving / Consistently Achieving	Domain	Last Report
Consultant-led waiting times - Community Dental Services	ATS		0-19 - Antenatal Contact	ATS		No Force first - Prone Restraint	QPS	
Inappropriate OAP bed days	EXC		0-19 - New Birth Visit	ATS		No force first – Seclusion	QPS	
Time to fill a vacancy	P		0-19 - 6 to 8 Week Contact	ATS		No force first – Segregation	QPS	
Number of employee relations cases	P		0-19 - 12 Month Review	ATS		Pressure ulcers: Total	QPS	
Return to work interview after sickness absence	P		0-19 - 2 to 2.5 Year Review	ATS		Falls – Total reported	QPS	
Forecast Performance Against CIP Plan	FP		% of Ward occupancy delayed for Acute Wards	EXC		Pressure ulcers: ulcers moderate or above with omissions	QPS	
Financial risk assessment of delivering the Plan	FP		Labour Turnover	P		% Red Shifts	QPS	
Forecast Performance against bank cap limit	FP		Level of Bank Staffing	P		Safer Staffing - % of hours utilised for enhanced obs.	QPS	
Proportion open CYP MH related waits over 104 weeks	ATC		Level of Agency Staffing	P		Medication Incidents	QPS	New
% of people accessing MH services with 2 or more contacts and a paired outcome	ATS		Vacancy Rate	P		Forecast outturn against plan	FP	
Variable Performance	Domain	Last Report	Forecast outturn against plan	FP		Cash Ratio	FP	
No amber this period			Variation from budgeted establishment	P		Performance against agency cap limit	FP	
			Clinical supervision	P		Capital Performance YTD	FP	
			Mandatory training	P		Capital Performance Forecast	FP	

Red indicators have been under target for 3 or more periods. Those that have dipped under target for one or two periods will remain Amber.

Domain Key:

ATS = access to services, **QPS** = quality and patient safety, **EFC** = effectiveness of care, **EXC** = experience of care, **P** = people, **FP** = finance and productivity

Executive Summary – KPI Assurance Grid (National Oversight Framework)

The following matrix shows how each NOF indicator is performing its target or objective, at a high level. It also includes which sector the indicator was in previously.

NOF Reporting Period = **Quarter 4 2025/26 (Latest Published Quarter)**

NOF Score 4 Latest Quarter	Domain	Last Quarter Score	NOF Score 3 Latest Quarter	Domain	Last Quarter Score	NOF Score 2 Latest Quarter	Domain	Last Quarter Score	NOF Score 1 Latest Quarter	Domain	Last Quarter Score
Sickness Absence	People and Workforce	3 	% Change in no. of CYP (under 18) Accessing NHS funded Services	Access to Services	3 	CQC Community MH Satisfaction Score	Experience of Care	2 	Percent waiting 52 weeks for community services	Access to services	2 
			Variance YTD to Finance Plan	Finance and Prod.	1 	% of IP with >60 Day LoS at discharge (Quarter)	Experience of Care	2 	% Patients in Crisis F2F Within 24 hrs	Patient Safety	3 
						Urgent Community Response	Experience of Care	2 	Planned Surplus / Deficit	Finance and Prod.	1 
						NHS Staff Survey – Raising Concern Score	Patient Safety	2 			
						MNHS Staff Survey Engagement Score	People and Workforce	2 			
						Relative Difference in Costs	Finance and Prod.	2 			

Note: Scoring indicators only. Excludes contextual measures and new indicators for 2026/27 – these will be added once formally confirmed

Strategic Indicators – Access to Services – overview of KPI's / Indicators

Service / Area	NOF / Planning / Other	KPI / Indicator	Latest Month / Period	Measure And RAG Rating	Target	Variation to Target	Data Quality Confidence (Low/Med/High)
PH Community	NOF	Percentage of patients waiting over 52 weeks for community services Link to Slide	Quarter 4 25/26	0 NOF 1	0 (NOF 1)	On Target	Data quality confidence to be added next time
MH CYP	NOF & Planning	Proportion of total open CYP MH related waits that are over 104 weeks Link to Slide	June 26	48%	<5% (NOF1) 0 by Mar 27 (planning)	43%	
MH Community	-	Community Mental Health - % of people seen within 4 weeks Link to Slide	July 2026	CMHT – 33.7%	No set target	-	
MH CYP	NOF (Yes 25/26, Out for 26/27)	% change in no. of under 18s supported through NHS funded MH with at least 1 contact in a rolling 12m period Link to Slide	Quarter 4 25/26	3.2% reduction NOF 3	25/26 – NOF ranking 1 26/27 - No Target	3.2% or more to show increased access	
MH CYP & Adults	NOF 27/27	Percentage of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages) (new measure) Link to Slide	April 26	CYP – 10% Adult – 5%	CYP >= 28% Adult >= 12% (NOF 1)	CYP – 18% Adult – 7% (NOF 1)	
Dental	-	Consultant-led waiting times - Community Dental Services - % waiting over 18 weeks Link to Slide	July 2026	58.3%	92%	33.7%	
PH 0-19	-	0-19 Mandated Contacts - Antenatal Contact Link to Slide	Q1 2026/27	81.9%	55.0%	26.9% above target	
PH 0-19	-	0-19 Mandated Contacts - New Birth Visit Link to Slide	Q1 2026/27	97.6%	90.0%	7.6% above target	
PH 0-19	-	0-19 Mandated Contacts - 6 to 8 Week Contact Link to Slide	Q1 2026/27	97.8%	90.0%	7.8% above target	
PH 0-19	-	0-19 Mandated Contacts - 12 Month Review Link to Slide	Q1 2026/27	97.2%	90.0%	7.2% above target	
PH 0-19	-	0-19 Mandated Contacts - 2 to 2.5 Year Review Link to Slide	Q1 2026/27	95.6%	85.0%	10.6% above target	

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Strategic Indicators – Quality and Patient Safety – overview of KPI's / Indicators

Service / Area	NOF / Planning / Other	KPI / Indicator	Latest Month / Period	Measure And RAG Rating	Target	Variation	Data Quality Confidence (Low/Med/High)
All	NOF	NHS Staff Survey raising concerns sub-score (MHPRV) Link to Slide	2025 Staff Survey	6.80 NOF 2	See narrative	N/A	Data quality confidence to be added next time
MH Crisis	NOF	Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours (3m rolling) - safety (3.25) Link to Slide	May 2026	94.4%	80%+ (NOF 1)	14.4%	
All	-	Sexual Safety (no slide yet)	New Standard - Reporting To Be Developed				
All	-	No Force first - Prone Restraint Link to Slide	July 2026	0	No Set Target (See Note)	N/A	
All	-	No force first – Seclusion Link to Slide	July 2026	2	No Set Target (See Note)	N/A	
All	-	No force first – Segregation Link to Slide	July 2026	0	No Set Target (See Note)	N/A	
All	-	Medication Incidents Link to Slide	Quarter 1 (2026-2027)	243	No Set Target	N/A	
All	-	Avoidable Harm - pressure ulcers: Total Link to Slide	July 2026	13	No Set Target (See Note)	N/A	
All	-	Falls – Total reported Link to Slide	July 2026	28	No Set Target (See Note)	N/A	
PH Community	-	Avoidable Harm - pressure ulcers: ulcers moderate or above with omissions Link to Slide	July 2026	3	No Set Target (See Note)	N/A	
All	-	Safer staffing - % of hours utilised for enhanced observations (no slide yet)			No Set Target (See Note)		
All	-	% red Shifts (Mental Health Inpatients) (no slide yet)	July 2026	0	No Set Target (See Note)	N/A	
All	-	% Black shifts Opel Rating (Physical Health services) (no slide vet)	New Standard – Reporting To Be Developed				

Note: RAG rating for Quality Indicators is based on SPC chart interquartile ranges. Those below the upper quartile range are Green, those within the upper quartile range are Amber, anything above the upper limit is Red.

Summary Points

- NHS Staff Survey raising concerns sub-score – NOF score is determined by ranking all provider scores. BDCFT are in the second-best quarter of responses so have scored a NOF 2.

Strategic Indicators – Effectiveness of Care – overview of KPI's / Indicators

Service / Area	NOF / Planning / Other	KPI / Indicator	Latest Month / Period	Measure And RAG Rating	Target	Variation	Data Quality Confidence (Low/Med/High)
Inpatients	NOF – ICB Metric	Adult acute admissions with no contact with mental health services in the prior year (new measure) Link to Slide	April 2026	17% (would be NOF 4)	5% and Lower (NOF 1)	12% (to NOF 1)	Data quality confidence to be added next time
MH	NOF	% of acute adult discharges followed up within 72 hours (new measure) Link to Slide	May 2026	80.0%	80% (NOF 1)	0.0%	
Talking Therapies	NOF	Percentage of NHS talking therapies patients completing a course of treatment and achieving reliable recovery (new measure) Link to Slide	May 2026	50.0%	51% March 2027 (NOF1)	-1.0%	

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Strategic Indicators – Experience of Care - overview of KPI's / Indicators

Service / Area	NOF / Planning / Other	KPI / Indicator	Latest Month / Period	Measure And RAG Rating	Target	Variation	Data Quality Confidence (Low/Med/High)
Inpatients	Planning	Inappropriate OAP bed days (our spot continuity number and all OAP bed days) Link to Slide	July 2026	78 Spot 791 Block 869 Total	On / under Trajectory (709 July)	160	Data quality confidence to be added next time
Inpatients	-	% of ward occupancy delayed for Acute Wards Link to Slide	July 2026	7.5%	10% and under	0.8%	
Inpatients	NOF	Mean length of stay for adult acute and psychiatric intensive care unit (PICU) patients (new measure) Link to Slide	June 2026	48 (June Only)	51 March 2027 – Planning (<=40 for NOF 1)	8	
Inpatients	NOF	Mean length of stay for older adult acute discharges (new measure) Link to Slide	June 2026	89 (June Only)	76 March 2027 – Planning (<=73 for NOF 1)	13	
PH Community	NOF	% of Urgent Community Responses within 2 hours Link to Slide	Quarter 4 25/26	73.8% NOF 2	70% (NOF 1 26/27) *	3.8%	
MH All	NOF	CQC community mental health service satisfaction rate Link to Slide	Quarter 4 25/26	As Expected NOF 2	Based on rank – TBC	Based on Rank	

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Strategic Indicators – People - Overview of KPI's / Indicators

Service / Area	NOF / Planning / Other	KPI / Indicator	Latest Month / Period	Measure And RAG Rating	Target	Variation	Data Quality Confidence (Low/Med/High)
All	NOF	NHS Staff Survey Engagement sub score - pulse survey becomes the narrative Link to Slide	July 2026	7.06	7.4+ (NOF 1)	0.34 below target	Data quality confidence to be added next time
All	NOF	Sickness absence rate (3m rolling) - add long term and short term as a narrative Link to Slide	July 2026	7.21%	4% (NOF 1)	3.21% above target	
All	-	Labour Turnover Link to Slide	July 2026	9.95%	10%	0.05% below target	
All	-	Level of bank staffing (slide to be developed)	July 2026	22.43%	20-25%	Within target range	
All	-	Level of agency staffing (slide to be developed)	July 2026	0.58%	2%	1.42% below target	
All	-	Time to fill a vacancy (slide to be developed)	July 2026	12 Weeks	8 Weeks (as set by NHS England)	4 weeks above target	
All	-	Number of employee relations cases (open cases at a point in time) Link to Slide	July 2026	42	30	12 cases above target	
All	-	Vacancy Rate Link to Slide	July 2026	5.26%	10%	4.74% below target	
All	-	Variation from budgeted establishment Link to Slide	July 2026	173.59	350	176.41 below target	
All	-	Appraisal compliance Link to Slide	July 2026	80.89%	80%	0.89% above target	
All	-	Clinical supervision Link to Slide	July 2026	84.32%	80%	4.32% above target	
All	-	Mandatory training Link to Slide	July 2026	91.17%	80%	11.17% above target	
All	-	Return to work interview after sickness absence Link to Slide	July 2026	50.79%	95%	44.21% below target	

Summary Points

- The low vacancy rate whilst positive in terms of performance, is contributing to a reported above plan workforce position and the financial position of the Trust at M4. A review to strengthen the workforce controls is taking place, with a key focus on demand into services, experiences of patients and service users, safer staffing requirements, health and wellbeing of colleagues and Equality and Quality Impacts. Temporary staffing usage is performing ahead of the workforce plan and lower than expected.
- Active support continues into the management of sickness absence across the Trust, including improving return to work rates and quality of support for colleagues, including signposting to the Health and Wellbeing offer. A statistically significant improvement in the number formal employee relations cases has taken place since January 2026, following the implementation of the avoidable harm initiative. Further development of the time to fill a vacancy metric will also take place ahead of the next reporting period.
- Strong, consistent performance continues in relation to labour turnover, appraisal completion, clinical supervision and mandatory training.

Strategic Indicators – Finance and Productivity - overview of KPI's / Indicators

better lives, together

Service / Area	NOF / Planning / Other	KPI / Indicator	Latest Month / Period	Measure And RAG Rating	Target	Variation	Data Quality Confidence (Low/Med/High)
All	NOF	Forecast outturn against plan Link to Slide	July 2026	Breakeven	On or better than plan (NOF1)	-	High
All	-	Forecast Performance Against CIP Plan (no slide yet)	July 2026	CIP delivery is forecast to be offtrack by £4.1m (non recurrently mitigated)	On or better than plan	£4.1m	High
ALL	-	Financial risk assessment of delivering the Plan	July 2026	Best Case Risk £1.0m Likely Case Risk £4.5m Worse Case Risk £10.1m	Risks fully mitigated	£4.5m	High
All	-	Performance against agency cap limit (no slide yet)	July 2026	Forecast Achievement of planned agency expenditure	On or better than plan	-	High
All	-	Performance against bank cap limit (no slide yet)	July 2026	Forecast breach by £1.1m	On or better than plan	£1.1m	High
All	-	Cash ratio (no slide yet)	July 2026	Forecast = 1.62	Ratio of 1 or more	+0.62	High
All	-	Capital Performance YTD (no slide yet)	July 2026	Underspent against plan by £0.68m	Achievement of Plan	£0.68m	High
All	-	Capital Performance Forecast (no slide yet)	July 2026	Forecast Achievement of Plan	Achievement of Plan	-	High
All	NOF	Relative difference to cost Link to Slide	Proposed NOF indicator for 26/27		TBC	-	TBC

Note: current financial RAG rating (excluding NOF) is set as Green if achieving and Red if off plan. A more comprehensive RAG rating is being developed to include an Amber rating for those just off plan.

Summary Points

Reported Position

- We are reporting slightly better than plan at Month 4 by £7k and continuing to forecast a breakeven position.

Financial Risk Assessment

- The main risks continue to arise from the delivery risk on the CIP programme. A forecast £4.1m CIP shortfall is reported in the financial position at Month 4, with non-recurrent mitigation plans identified to cover the risk. The risk of further deterioration has been assessed between £2.4m to £7.3m.
- In addition to the CIP risks there are a number of further risks that have arisen during the year, these include:
 - The fair deal for nurses
 - Deteriorating financial position for the West Yorkshire Provider Collaboratives
 - Securing pay award funding from BMDC for the 0-19 contract
 - General run rate risks and additional cost pressures
- The risk assessment at Month 4, taking account of the upside and downside risks highlight that a further £4.5m of actions are needed to fully de-risk the position (£3.5m before the fair deal for nurses' impact). This is a decrease in the overall risk assessment from Month 3 of £0.6m (likely risk at month 3 was £5.1m).

Management Actions

- In response to the emerging risks, and in addition to the extra-ordinary FPC in August, the Executive Management Team have stood up a weekly 'report out' for more regular oversight of the financial position and the key metrics agreed as part of the additional management actions/ controls. The key risks that will impact delivery of the financial plan are robustly challenged through these governance arrangements, with the Executives held to account for their respective programmes.

Reporting Breaches

- At Month 4, the Trust is within its planned Agency costs for both year-to-date and forecast. However, the Agency cap has been breached by £0.2m forecast, due to the lead provider arrangements for the exceptional package of care (EPoC) for a service user on the Naturally Centre. The forecast costs of the EPoC are £0.2m and are offset by income.
- The Bank cap has been breached by £0.6m YTD and forecast to by £1.2m at the year end. This is driven by vacancies, sickness and patient acuity.
- Substantive staffing underspends are mitigating the bank cap breach (YTD underspend £1.4m and forecast underspend £1.6m).
- The Enhanced Therapeutic and Observations of Care (ETOC) programme is underway and ward-based leadership briefing sessions have started in June 2026 to support developing improvement plans.

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Mental Health Care Group – Service Area Heat Map

Service Area Heat Map

Service Area	Criteria									
	Sickness Absence	Labour Turnover	Temporary Staffing (% B&A)	% of Red Shifts	IREs Relating to Patient Safety	Number of Grievances	Staff Survey Engagement Score	Variance to Financial Plan	Performance Against CIP	Productivity
Data Period	July 2026	July 2026	July 2026	July 2026	N/A	July 2026	2025 Survey	July 2026	July 2026	N/A
Inpatients	9.24%	11.94%	A – 75 B – 1658	0%	Reporting under development	0	6.59 (average)	£3,050k	£588k	Measures to be confirmed
CMHT / Adult Community	4.26%	10.10%	A – 14 B – 35	N/A		0	6.82	-£1,340k	£0k	
OPMH	8.45%	7.48%	A – 11 B – 259	N/A		0	6.82		£0k	
Learning Disabilities	13.18%	10.93%	A – 0 B – 342	N/A		0	7.26	-£88k	£0k	
Acute Community Services	5.52%	10.95%	A – 0 B – 164	N/A		0	TBC	-£73k	£0k	
Talking Therapies	10.72%	6.48%	A – 0 B – 15	N/A		0	6.42	-£165k	£0k	
CAMHS	6.86%	11.08%	A – 0 B – 23	N/A		0	7.11	-£114k	£0k	

Financial RAG ratings:

- FOT Against Plan – Red = 2% or more worse than plan, Amber = up to 2% worse than plan, Green = on plan or better
- FOT Against CIP Position - Red = 10% or more worse than plan, Amber = up to 10% worse than plan, Green = on plan or better

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Physical Health Care Group – Service Area Heat Map

Service Area Heat Map

Service Area	Criteria									
	Sickness Absence	Labour Turnover	Temporary Staffing (% B&A)	% of Black Shifts	IREs Relating to Patient Safety	Number of Grievances	Staff Survey Engagement Score	Variance to Financial Plan	Performance Against CIP	Productivity
Data Period	July 2026	July 2026	July 2026	N/A	N/A	July 2026	2025 Survey	July 2026	July 2026	N/A
Community Nursing - Planned	6.78%	7.18%	A – 0 B – 460	Reporting under development	Reporting under development	1	7.37	£1,603k	£680k	Measures to be confirmed
Community Nursing - Unplanned	7.39%	5.19%	A – 0 B – 144			0	6.39			
End of Life Care	10.22%	4.49%	A – 0 B – 29			1	6.77	£35k	£0k	
AHPs – Podiatry	2.00%	7.39%	A – 0 B – 0			0	6.49	-£233k	£0k	
AHPs – Speech and Language	1.72%	5.91%	A – 0 B – 525			0	7.36			
Public Health Nursing	12.66%	8.06%	A – 0 B – 152			0	6.32	-£60k	£0k	
Specialist - LAC / YOT / Safeguarding	2.39%	8.97%	A – 0 B – 11			0	7.52	-£17k	£0k	
WYVIC – Vaccination and Immunisation	3.84%	9.64%	A – 0 B – 0			0	7.63	-£4k	£0k	
Community Dental Services	6.84%	10.31%	A – 0 B – 6			0	6.38	-£375k	£0k	

Financial RAG ratings:

- FOT Against Plan – Red = 2% or more worse than plan, Amber = up to 2% worse than plan, Green = on plan or better
- FOT Against CIP Position - Red = 10% or more worse than plan, Amber = up to 10% worse than plan, Green = on plan or better

Corporate Services – Service Area Heat Map

Service Area Heat Map

Service Area	Sickness Absence	Labour Turnover	Temporary Staffing (% B&A)	Number of Grievances	Staff Survey Engagement Score	Variance to Financial Plan	Performance Against CIP	Productivity
Data Period	July 2026	July 2026	July 2026	July 2026	2025 Survey	July 2026	July 2026	N/A
People Directorate	4.76%	14.36%	A – 0 B – 4	0	6.93	£67k	£73k	Measures to be confirmed
Finance	0.00%	11.78%	A – 0 B – 0	0	7.52	£1k	-£10k	
Estates and Facilities	9.02%	9.93%	A – 0 B – 205	0	7.18	£335k	£0k	
Transformation Directorate	4.77%	7.21%	A – 0 B – 0	0	6.83	-£191k	-£122k	
Digital	5.04%	7.70%	A – 0 B – 0	0	5.72	£456k	£488k	
Nursing, Professions and Care Standards (Quality and Governance)	4.01%	3.79%	A – 0 B – 18	2	7.40	-£67k	-£136k	

Financial RAG ratings:

- FOT Against Plan – Red = 2% or more worse than plan, Amber = up to 2% worse than plan, Green = on plan or better
- FOT Against CIP Position - Red = 10% or more worse than plan, Amber = up to 10% worse than plan, Green = on plan or better

Average score

2.23

Lower by 0.36 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics). Scores range from 1.00 (high performing) to 4.00 (low performing).

[How has average score been calculated?](#)

Trust in financial deficit?

No

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

[How is financial deficit applied?](#)

Segment

2 - Above average

Previous quarter's segment: 3

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

[How has segment been calculated?](#)

Trust rank

27 out of 61

Previous quarter's rank: 44 out of 61

Trusts are ranked first on their segment and then their average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 61 (segment four trust with the highest average score).

[How has rank been calculated?](#)

Performance domains ?

Access to services

Finance and productivity

Effectiveness and experience

Patient safety

People and workforce

2 - Above average

2 - Above average

3 - Below average

1 - High performing

3 - Below average

Average score by trust rank placement

Segment 1 2 3 4 Selected trust

Trust Rank	Average Score	Segment
1	1.5	1
10	2.0	1
15	2.1	2
20	2.2	2
25	2.3	2
27	2.23	2 (Selected)
30	2.4	2
35	2.5	2
40	2.6	2
45	2.7	2
50	2.8	2
55	2.9	2
60	3.0	2
61	3.1	2

[View full league table](#)

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NOF Performance Summary 2025/26 – Scoring Indicators Only

Metric Description	2025/26							
	Q1		Q2		Q3		Q4	
	Raw measure	Score Derived	Raw measure	Score Derived	Raw measure	Score Derived	Raw measure	Score Derived
ACCESS TO SERVICES								
Percentage of patients waiting over 52 weeks for community services (end of quarter snapshot)	0.25%	2.15	1.12% ↑	2.66 ↑	0.07% ↓	2.15 ↓	0.00% ↓	1.00 ↓
% change in no. of under 18s supported through NHS funded MH with at least 1 contact in a rolling 12m period	-0.43%	3.55	-2.96% ↓	3.43 ↓	-4.86% ↓	3.57 ↑	-3.20% ↑	3.43 ↓
DOMAIN SCORE		2.85 (3)		3.05 (4) ↑		2.86 (3) ↓		2.22 (2) ↓
EFFECTIVENESS AND EXPERIENCE OF CARE								
National CQC community mental health survey overall experience rating	As expected	2.00	As expected	2.00 ↔	As expected	2.00 ↔	As expected	2.00 ↔
Urgent Community Response % achieving 2hr standard	79.04%	2.62	77.12% ↓	2.71 ↑	79.54% ↑	2.59 ↓	73.84% ↓	2.90 ↑
Percentage of adult discharges with a length of stay above 60 days (3m rolling)	33.33%	3.87	26.32% ↓	3.04 ↓	23.24% ↓	2.47 ↓	23.40% ↑	2.28 ↓
DOMAIN SCORE		2.83 (4)		2.58 (4) ↓		2.35 (3) ↓		2.39 (3) ↑
PATIENT SAFETY								
NHS Staff Survey raising concerns sub-score (MHPRV)	6.83	2.35	6.83 ↔	2.35 ↔	6.83 ↔	2.35 ↔	6.80 ↓	2.1 ↓
Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours (3m rolling)	28.08%	3.93	35.27% ↑	3.88 ↓	57.73% ↑	3.25 ↓	88.30 ↑	1.13 ↓
DOMAIN SCORE		3.14 (4)		3.11 (4) ↓		2.80 (3) ↓		1.62 (1) ↓

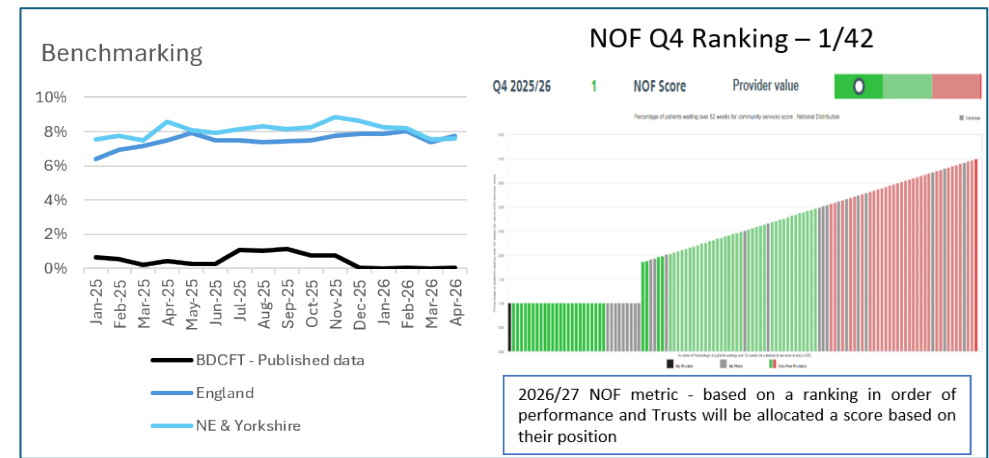
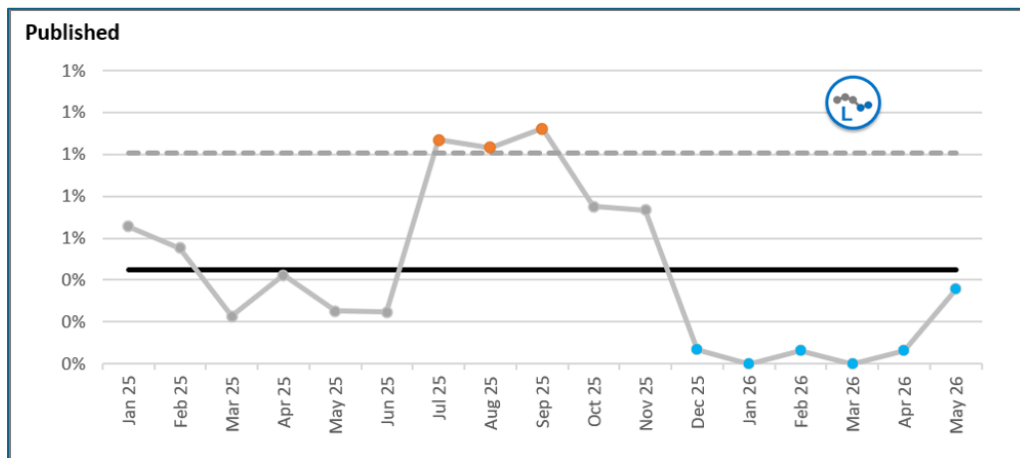
NOF Performance Summary 2025/26 – Scoring Indicators Only

Metric Description	2025/26							
	Q1		Q2		Q3		Q4	
	Raw measure	Score Derived	Raw measure	Score Derived	Raw measure	Score Derived	Raw measure	Score Derived
PEOPLE AND WORKFORCE								
Sickness absence rate (3m rolling)	6.95%	3.85	6.30 ↓	3.78 ↓	6.84% ↑	3.78 ↔	7.36% ↑	3.68 ↓
NHS Staff Survey engagement sub-score (MHPRV)	7.08	2.50	7.08 ↔	2.50 ↔	7.08 ↔	2.50 ↔	7.06 ↓	2.25 ↓
DOMAIN SCORE		3.18 (4)		3.14 (4) ↓		3.14 (4) ↔		2.96 (3) ↓
FINANCE AND PRODUCTIVITY								
Planned surplus / deficit	0.0% (not published)	1.00	0.86% ↑	1.00 ↔	0.86% ↔	1.00 ↔	0.86% ↔	1.00 ↔
Variance YTD to financial plan	0.0% (not published)	1.00	0.12 ↑	1.00 ↔	0.03 ↓	1.00 ↔	0.01 ↓	1.00 ↔
Combined finance score		1.00		1.00 ↔		1.00 ↔		1.00 ↔
Relative difference in costs	113.4	3.43	106.45 ↓	2.8 ↓	106.45 ↔	2.8 ↔	106.45 ↔	2.8 ↔
DOMAIN SCORE		2.22 (3)		1.90 (2) ↓		1.90 (2) ↔		1.90 (2) ↔
Overall Average Score/Final Segmentation	2.84	4	2.74 ↓	4 ↔	2.59 ↓	3 ↓	2.23 ↓	2 ↓

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Appendix 2 – Detailed Description of Performance

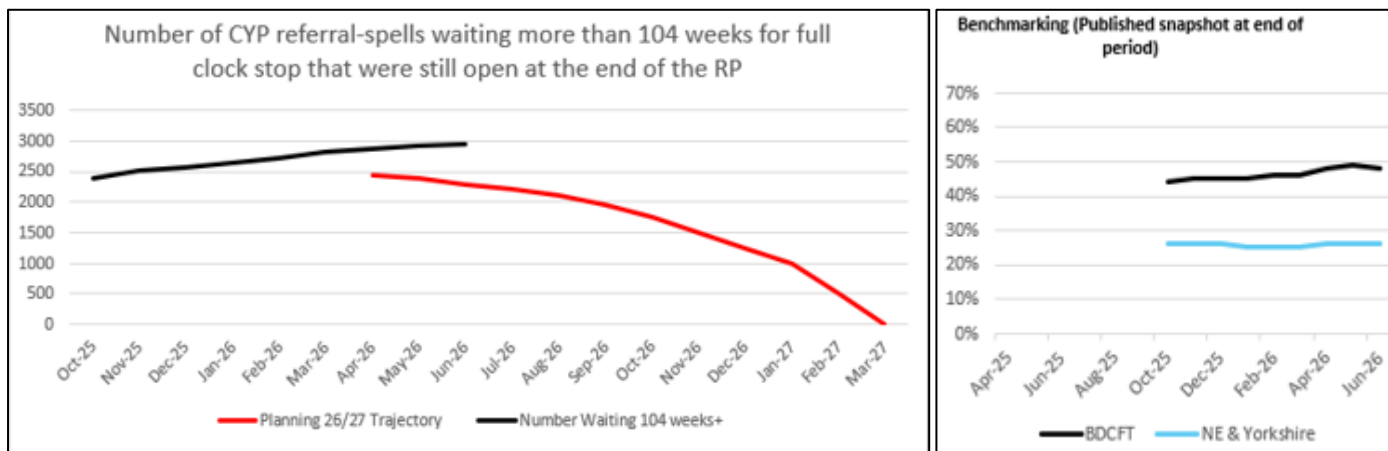
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Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a National Outcome Framework indicator that helps us track our longest waiters for community based physical health services.	We are currently on track. There was a slight increase in ling waiters in May 2026, however these were all seen during June. June data indicates there was only 1 person waiting 52 weeks who was booked to be seen.	Service leads are activity monitoring wating lists and focusing on those areas where we are more likely to get longer waits, for example in Dysphagia where specialist availability can be a challenge.	An agreement is in place with Leeds Teaching Hospital for the regular provision of a Dysphagia specialist and longer waits are being mitigated though active list management.

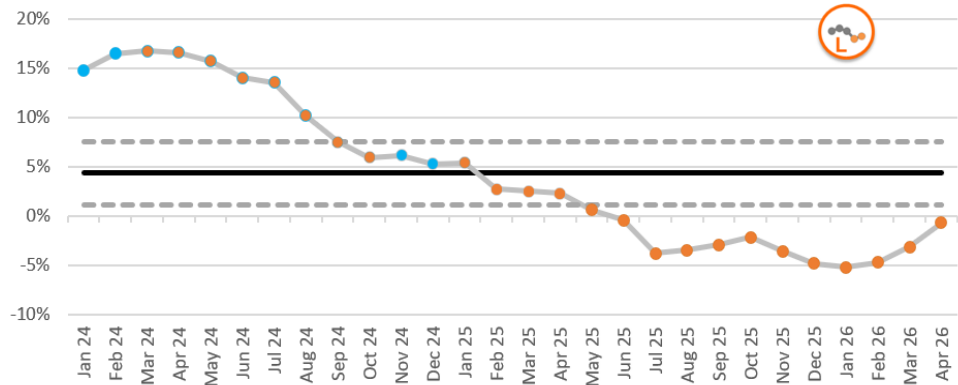
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Measure: Number/proportion of CYP referral-spells waiting more than 104 weeks for full clock stop that were still open at the end of the RP					
Domain:	Access to Services	NOF:	Yes	Accountable Exec:	Kelly Barker
Target:	0% by March 27	Actual:	48%	Data Period	June 2026
				Author:	DQ Assessment
				Angela Bethel TBD	

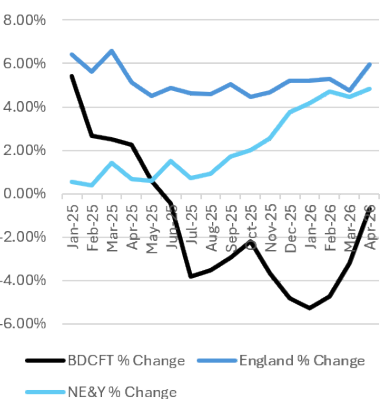


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This National Oversight Framework measure identifies children and young people experiencing the longest waits for meaningful CAMHS intervention. It provides an important line of sight on access, equity and potential clinical risk, and enables the Board to assess whether operational recovery is translating into a sustained reduction in excessive waits.	There are currently no children and young people waiting 104 weeks to access a meaningful intervention through CAMHS. However, the clinical record system has not historically enabled the appropriate information to be captured and reported to evidence the “clock stop” for referrals. This includes an “outcomed” appointment, a SNOMED code to describe the intervention and a patient reported outcome measure. This has resulted in an under-reporting of performance against this measure.	Changes have been made to the clinical record system to enable the recording of the SNOMED codes and the Outcome Measures. Training has been provided across the service on the new functionality, purpose and clinical benefits, alongside further training on booking and outcoming appointments. From August, all completed appointments will have a SNOMED code and Outcome measure recorded which will stop the clock and reduce the number of Children and Young People recorded as waiting more than 104 weeks to commence a meaningful intervention.	The principal risks are inconsistent adoption of the revised recording process, insufficient capacity to validate historic records, and a risk that data improvement initially increases the reported backlog before recovery becomes visible. These are mitigated through targeted training, BI-supported validation, exception reporting, long-wait list oversight and escalation through performance governance.

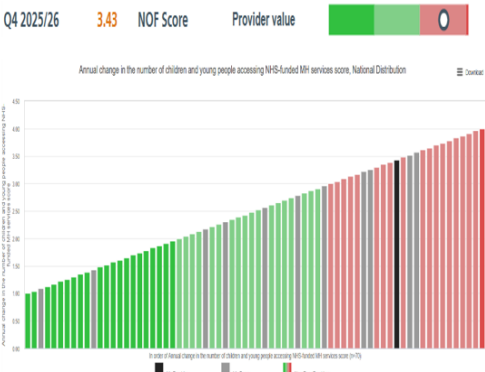
BDCFT (published performance)



Benchmarking



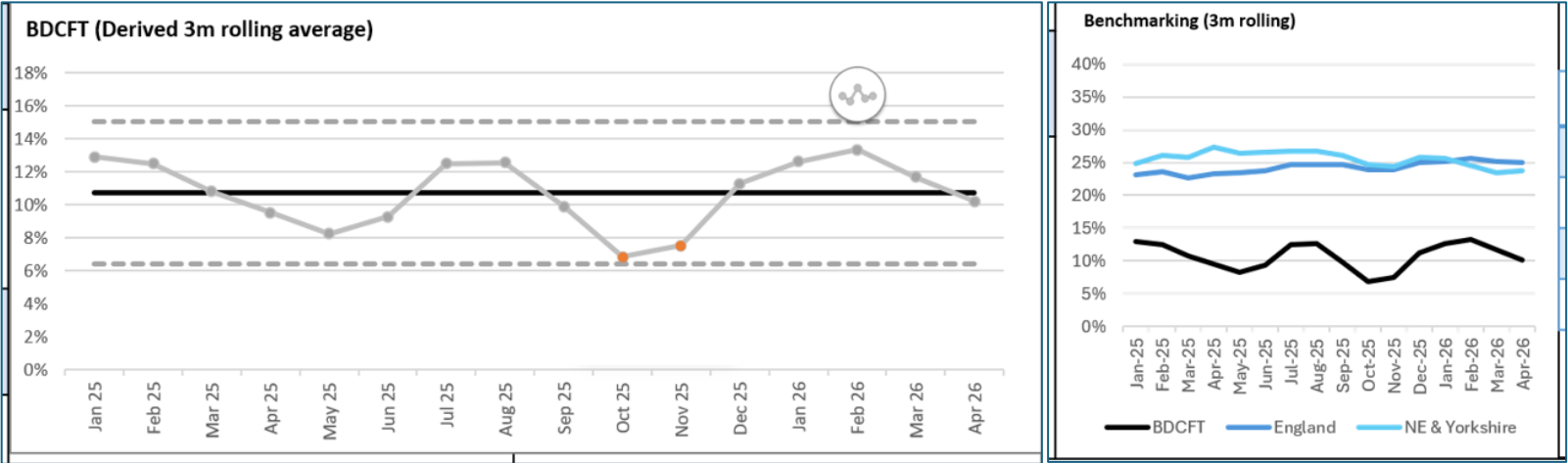
NOF Q4 Ranking – 43/50



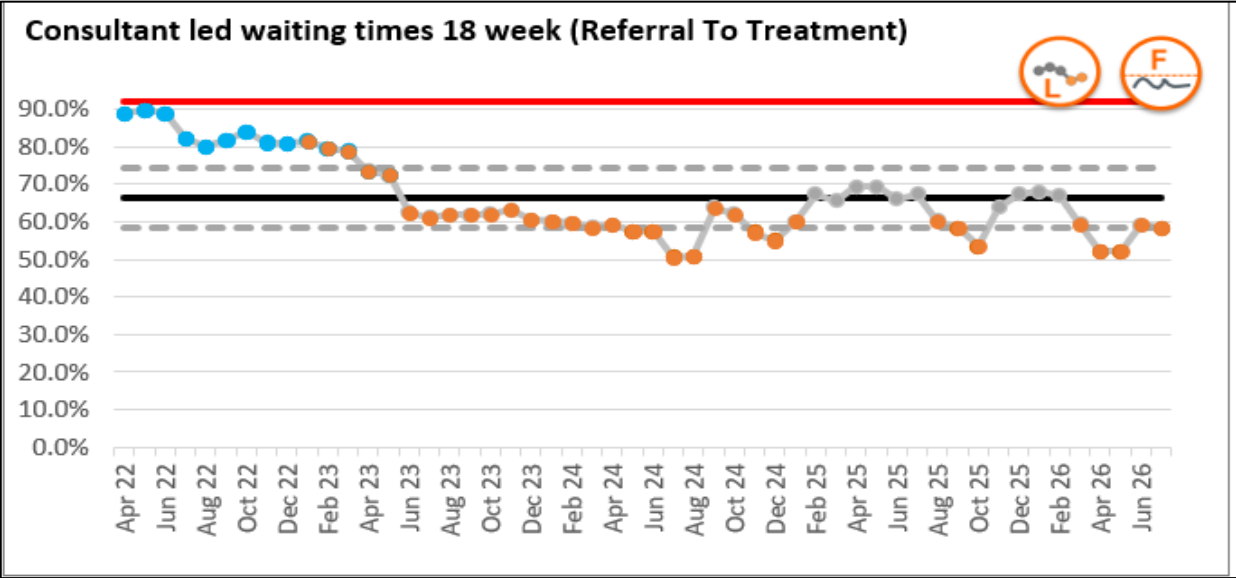
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a Current NOF indicator, but it is expected to be removed once the Q1 2026/27 data is published	Currently below the previous year's performance but an upwards trend since the turn of the year is being highlighted.	Currently on track but predicted to be removed as NOF indicator within next 4-5 weeks. This will continue to be monitored locally within service.	No current risks identified. This will be removed as a NOF indicator in coming weeks but be monitored within service.

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Measure: Percentage of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages) (new measure)							
Domain:	Experience of Care	NOF:	Yes – 25/26	Accountable Exec:	Kelly Barker	Author:	Bernard Hughes
Target:	28% children (NOF 1), 12% adults (NOF1)	Actual:	10% children (NOF 4), 5% adults (NOF 3)	Data Period	Q4 25/26	DQ Assessment	TBD



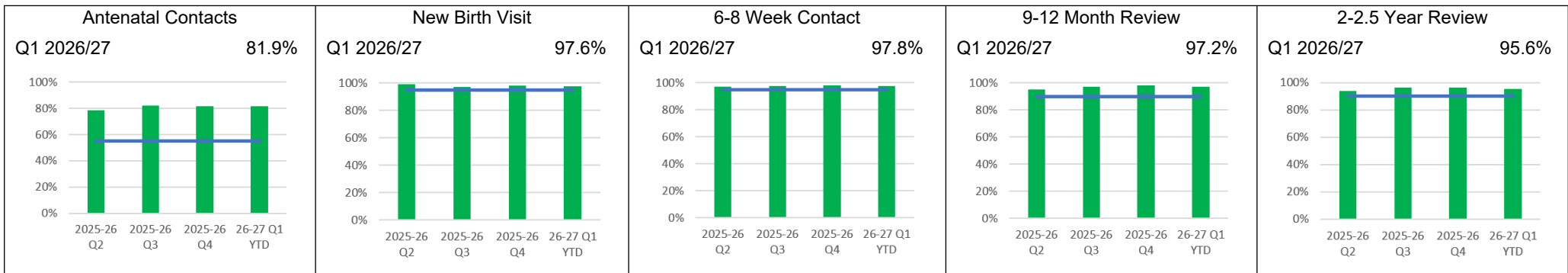
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This new National Oversight Framework measure tests whether access to mental health services results in sufficient clinical engagement and measurable change, rather than activity alone. Two contacts and a paired patient-reported outcome provide a clearer line of sight on the impact of care for individuals and populations. For Board assurance, performance should be considered alongside access, completed treatment, clinical outcomes, service-user experience, equity, workforce capacity and the completeness of outcome recording.	Off track in both cohorts. At Q4 2025/26, 10% of children and young people had at least two contacts and a paired outcome score against the 28% threshold, giving an indicative NOF score of 4. Adult performance was 5% against the 12% threshold, giving an indicative score of 3; the combined indicative score is 4. Benchmarking also places the Trust below regional and national levels. The gap reflects variation in service delivery and how activity is recorded, so current assurance is limited until data completeness and operational practice are validated together.	A Trust-wide 'Understanding Our Patient Population and Outcomes' programme is being established to accelerate delivery. Each applicable service will confirm its baseline, validate denominator and paired-score recording, map workflow and agree a trajectory to the relevant threshold. Training, system configuration and routine team-level oversight will support consistent use of outcome measures at the right points in care. Progress will be tracked through performance governance and this report, triangulating paired outcomes with contacts, caseload, pathway completion, experience and clinical improvement so that increased recording represents meaningful care rather than compliance alone.	The principal risks are inconsistent system functionality, variable staff confidence and workflow adoption, limited capacity to complete paired measures, and incomplete recording that obscures the true clinical position. There is also a risk of focusing on the metric without improving patient benefit, or of widening variation between services and population groups. Mitigations include service-by-service mapping, system and data-quality fixes, targeted training, named operational ownership, equality analysis, exception reporting and monthly oversight against agreed trajectories. Overall assurance is limited: the performance gap is clear and a recovery programme is being mobilised.



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
BDCFT are the lead provider for the West Yorkshire Community Dental Service. All community providers should be meeting the 18-week referral to treatment (RTT) standard.	We are currently below the 18-week standard. There has period of performance heavily impacted by industrial action, sickness and availability of General Anaesthetic theatres, all impacting waiting times. The end of 2025 and start of 2026 saw a period of recovery. Following a dip in the last reporting period we are now seeing an improvement.	This is being addressed through joint working in the BDCFT led West Yorkshire Collaborative, including a review of General Anaesthetic services. Active waiting list management is also in place	There is an ongoing risk around GA theatre availability which is being picked up with the acute providers, who provide the theatres and support staff, including anaesthetists. At the start of the West Yorkshire Lead Provider contract commissioners acknowledge historical challenges with meeting the 18-week target. A 3-year grace period to reach 18 weeks was granted for all providers. This runs to March 2028.

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Measure: 0 – 19 metrics	NOF: No	Accountable Exec: Kelly Barker	Author:	Richard Holmes
Domain: Access to Services	Actual: Various	Data Period: Q1 2026/27	DQ Assessment	High
Target: Various				



Why is this measure important?	Are we on track or off track? Why?	If we are off track, what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
These indicators are important because they measure compliance against national and local targets for the delivery of mandated health visitor contacts. This is reported to the Local Authority commissioner. The overarching trend is one of continued success in meeting these targets.	The Trust is on track and currently meeting and/or exceeding compliance against all five targets for the delivery of mandated health visitor contacts. Delivery of mandated contacts is considered 'core business' and are prioritised where possible. Efficiently designed templates on SystemOne, coupled with weekly performance reports, support delivery teams to meet targets.	Weekly monitoring reports are produced and shared with delivery teams to ensure the continued achievement of these targets. Where there are in quarter areas of underperformance, recovery actions are put in place.	The main risk to the 0-19 service is the "Living Well Public Health Nursing" tender, and potential impacts to the service, depending on the outcome. A competitive tender has been submitted, and the Trust awaits the decision of the contract award by the Local Authority – due late September 2026. No re-escalation to board required – already aware.

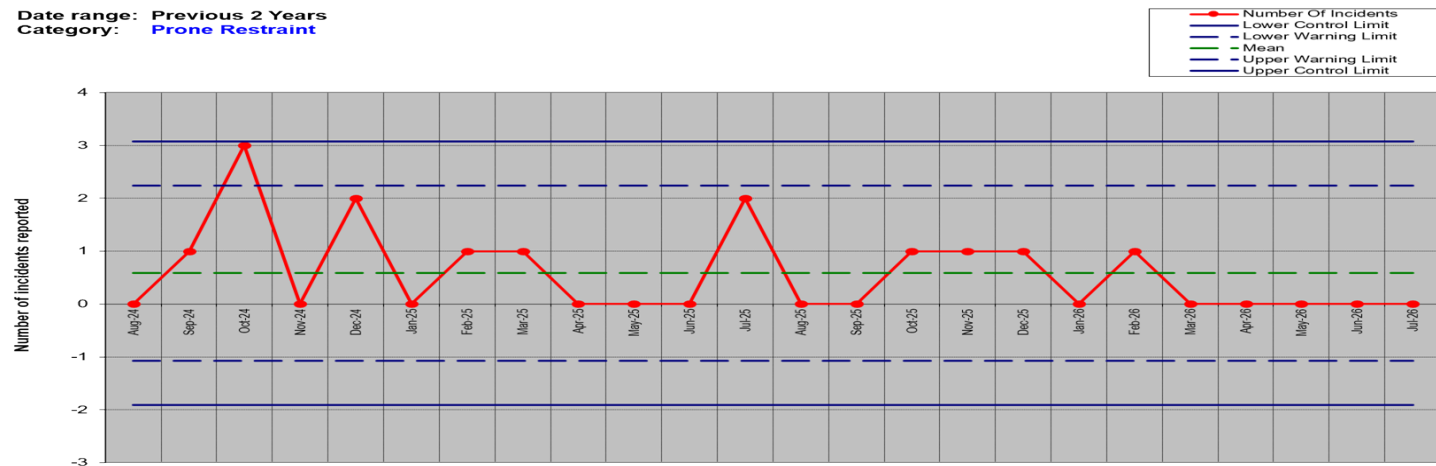
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Measure: Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours (3m Rolling)						
Domain:	Quality and Patient Safety	NOF: Yes	Accountable Exec:	Kelly Barker	Author:	Pete Garland
Target:	80% (NOF 1)	Actual:94.4%	Data Period:	May 26	DQ Assessment	TBD

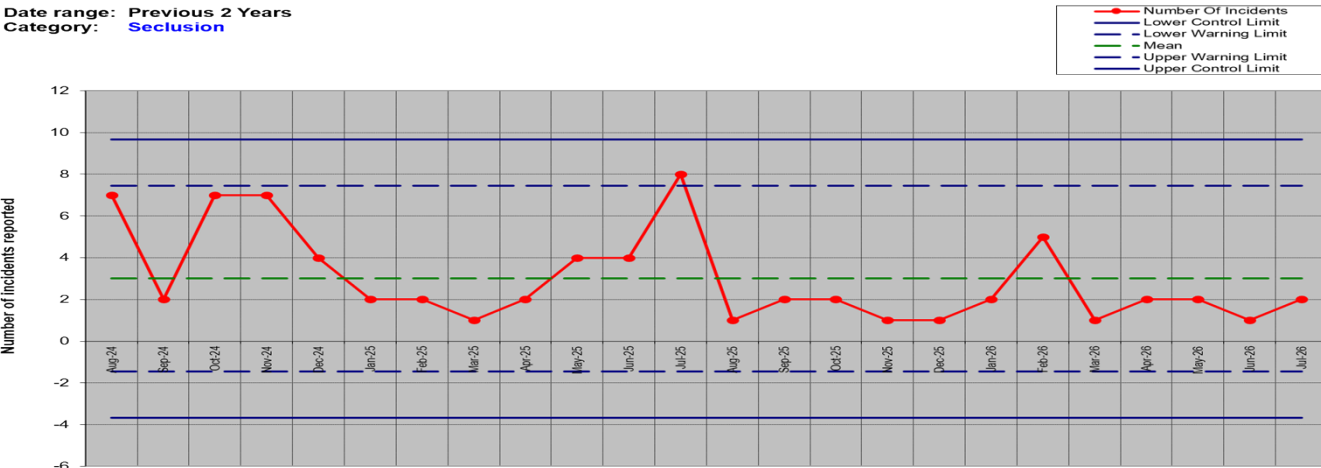


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Crisis Care Services support individuals experiencing acute mental health need and risk. Timely face-to-face assessment is a key indicator of responsiveness and clinical safety, ensuring that service users receive prompt intervention, risk assessment and appropriate care planning. Delivery of this standard supports improved patient experience, effective risk management and compliance with national expectations for urgent mental health care.	On track. Performance for July 2026 was 92.2%, exceeding the national target of 80%. Bradford District Care NHS Foundation Trust has historically invested in a responsive crisis care model, including the development of the First Response Service (FRS). Recent changes to Electronic Patient Record (EPR) configuration have enabled more accurate reporting of face-to-face response times and have aligned reported performance more closely with operational practice. While work continues to further strengthen data quality assurance processes, current reporting provides increased confidence in the accuracy of the measure and demonstrates sustained performance above target.	The service continues to monitor performance closely through daily operational oversight and regular review of all exceptions to the standard. Weekly meetings with the Performance Team remain in place to further strengthen data quality and reporting arrangements. Continued focus on timely assessment, operational responsiveness and robust recording processes will support sustained delivery of the target.	The principal risks relate to service users not being available or willing to engage within the required timescale, together with occasional operational or recording issues that may impact performance reporting. To mitigate these risks, all referrals that do not receive face-to-face contact within 24 hours are reviewed to identify the reason for the delay and any associated risks. Where required, alternative risk management arrangements are implemented and monitored. Exceptions are reported and reviewed through established Daily Lean Management processes, providing organisational oversight and supporting timely corrective action where necessary.

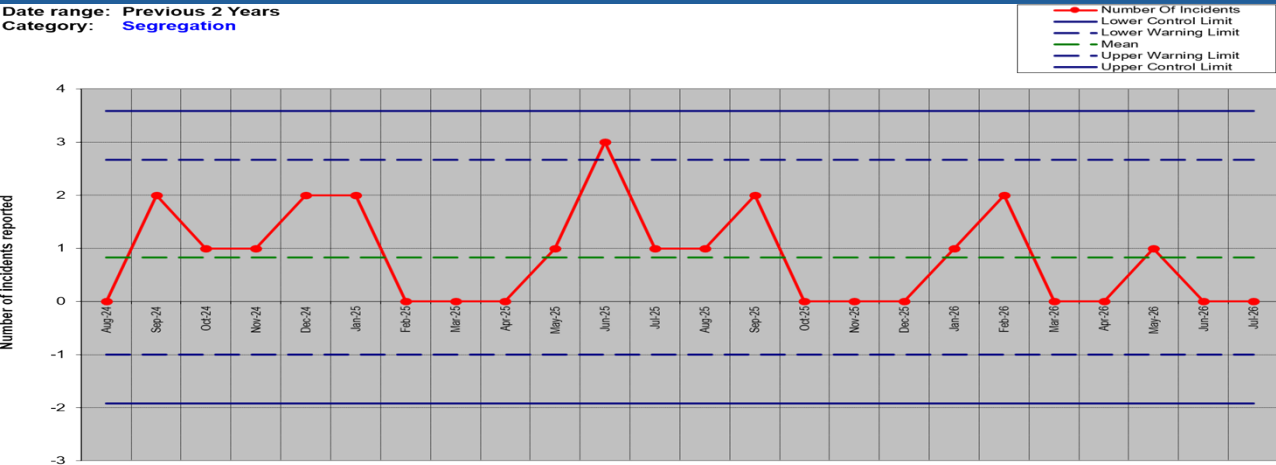
Measure: No Force first - Prone Restraint					
Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Prone restraint is a key quality and patient safety measure because it represents one of the most restrictive interventions used in mental health and learning disability settings. It is associated with significant physical and psychological risk and should only be used as a last resort, for the shortest possible duration, and where less restrictive alternatives have been ineffective or unsafe. Monitoring this measure supports delivery of the Trust's restrictive practice reduction ambitions, strengthens assurance against No Force First principles, and enables ward teams to identify variation, learning and opportunities to improve prevention, de-escalation, care planning and post-incident review. The team have recently undergone reaccreditation for No Force First	There is no set numerical target for this indicator; therefore, the measure should be interpreted through the direction of travel shown in the graph, the level of month-to-month variation and triangulation with incident review, patient acuity and ward context. Based on the need for continued oversight and the absence of a formal target, this should be treated as a monitored quality indicator rather than a simple pass/fail measure. Where the graph shows sustained low use or reduction over time, this indicates positive progress and should be maintained. Where the graph shows increases, clusters or unexplained variation, this should be treated as off track for improvement purposes and subject to local review.	Continued improvement will be supported through ward-level scrutiny of all prone restraint incidents, including review of antecedents, duration, staff response, care plan quality, patient voice and evidence of post-incident debrief. Where increases or clusters are identified, immediate actions should include targeted review by ward leadership and the Management of Violence and Aggression lead, reinforcement of least restrictive practice and de-escalation approaches, review of personalised safety plans, and escalation through the Positive and Proactive Care governance route. Where the measure remains low or reducing, the focus should be on sustaining practice through routine incident learning, sharing good practice between wards, monitoring training compliance, and maintaining visibility of restrictive practice data in ward safety huddles and governance meetings.	Key risks include increased acuity and complexity on inpatient wards, workforce capacity pressures, inconsistent application of de-escalation and least restrictive practice, variable quality of personalised care plans, and data quality issues that may affect interpretation of restraint activity. These risks are mitigated through senior nursing and operational oversight, ongoing ward leadership engagement, targeted support from the Management of Violence and Aggression lead, triangulation with incident reviews and patient safety learning, continued monitoring through quality governance routes, and reinforcement of learning through supervision, safety huddles and training compliance reporting.

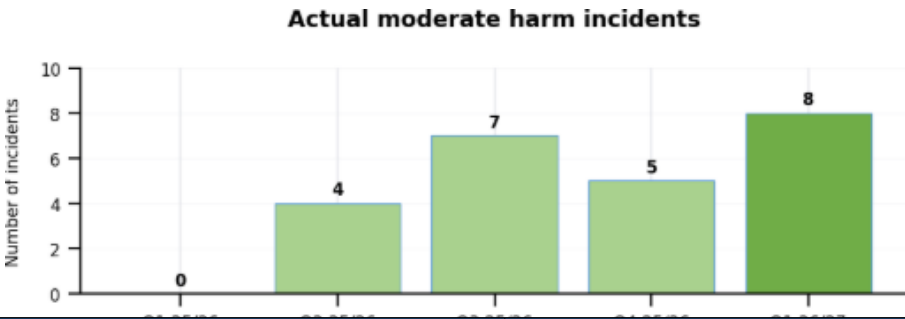
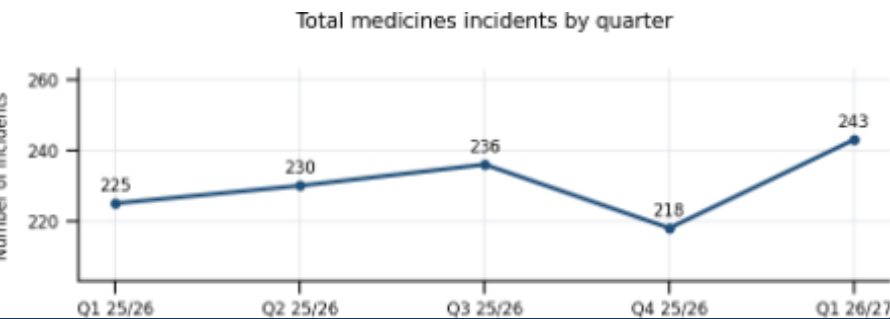


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Seclusion is a key quality and patient safety measure because it is one of the most restrictive interventions used within mental health inpatient settings. It has significant implications for patient experience, dignity, human rights, therapeutic relationships and safety. Monitoring seclusion supports the Trust's No Force First and restrictive practice reduction ambitions, enables oversight of variation between wards, and helps ensure seclusion is used only when clinically necessary, proportionate, legally compliant and for the shortest possible time.	Performance should be assessed through the direction of travel shown in the graph, the level of month-to-month variation, and triangulation with acuity, incident themes, staffing context and ward level practice. Where the graph shows sustained low use or reduction over time, this can be considered on track in relation to the Trust's restrictive practice reduction aims. Where the graph shows increases, clusters, repeated use, longer durations or unexplained variation, this should be treated as off track for improvement purposes and escalated for local review and learning.	Where the measure is off track, actions should include ward-level review of all seclusion episodes, with a focus on antecedents, duration, care planning, patient debrief, staff debrief, observation quality, MDT decision-making and evidence that alternatives to seclusion were considered. Themes should be reviewed through ward governance and Positive and Proactive Care routes, with targeted support from senior nursing, operational leadership and the Management of Violence and Aggression lead where variation or repeated use is identified. Where the measure remains low or reducing, this should be sustained through routine review of restrictive practice data, shared learning across wards, ongoing reinforcement of least restrictive practice, patient-centred safety planning, and continued monitoring of training compliance and supervision.	Key risks to delivery include increased inpatient acuity and complexity, workforce capacity pressures, environmental constraints, inconsistent application of least restrictive practice, variation in quality of personalised care planning, and data quality limitations that may affect interpretation of seclusion activity. These risks are mitigated through senior clinical and operational oversight, timely review of seclusion episodes, governance through Positive and Proactive Care and quality forums, targeted support to wards with higher use or variation, reinforcement of de-escalation and trauma-informed practice, and continued monitoring of incident themes, training compliance and post-incident learning.



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Segregation is a key quality, safety and human rights measure because it represents a highly restrictive intervention that can significantly affect patient experience, dignity, therapeutic engagement and recovery. Its use should be exceptional, clinically justified, proportionate, legally compliant and subject to robust multidisciplinary oversight. Monitoring segregation supports the Trust's No Force First and restrictive practice reduction ambitions, enables visibility of variation across inpatient areas, and provides assurance that least restrictive alternatives, personalised care planning and regular review arrangements are being applied consistently.	Performance is interpreted through the direction of travel shown in the graph, the level of month-to-month variation, duration of segregation episodes, repeated use, and triangulation with acuity, incident themes, staffing context and environmental constraints. Where the graph shows sustained low use, reduction over time or limited exceptional use with clear review arrangements, this can be considered on track in relation to restrictive practice reduction aims. Where the graph shows increases, clusters, prolonged episodes, repeated use or unexplained variation, this should be treated as off track for improvement purposes and subject to enhanced local review and escalation.	Where the measure is off track, actions should include immediate ward-level and senior clinical review of all segregation episodes, with scrutiny of antecedents, rationale, duration, observation arrangements, MDT decision-making, patient voice, care plan quality, debrief arrangements and evidence that less restrictive options were considered. Episodes and emerging themes should be reviewed through local governance, Positive and Proactive Care routes and senior operational oversight, with targeted input from the Management of Violence and Aggression lead where variation or sustained use is identified. Where the measure remains low or reducing, this should be sustained through regular monitoring of restrictive practice data, continued reinforcement of least restrictive and trauma-informed practice, shared learning across inpatient wards, supervision and review of personalised safety and support plans.	Key risks to delivery include increased acuity and complexity within inpatient services, workforce capacity pressures, environmental limitations, delayed discharge pathways, inconsistent application of least restrictive principles, variable quality of personalised care planning, and data quality limitations that may affect interpretation of segregation activity. These risks are mitigated through senior nursing, medical and operational oversight, timely review of each segregation episode, escalation through restrictive practice governance routes, targeted ward support where variation is identified, reinforcement of de-escalation and trauma-informed practice, continued monitoring of training compliance, and triangulation with incident reviews, patient safety learning and ward-level quality improvement activity.

Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Sal Uka	Author:	Prabhdeep Sidhu
Target:	N/A	Actual:243	Data Period: Quarter 1 April 2026 – June 2026		DQ Assessment	TBD



Why is this measure important?	Are we on track or off track? Why?	If off track, what are the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Medicines incidents are a key patient safety indicator, providing assurance on patient harm, emerging risks and recurring themes requiring improvement.	On track. Q1 reporting remained stable (243 incidents vs 242 in Q4), indicating a consistent reporting culture. Moderate harm incidents remain within expected variation and are monitored through medicines governance. Increases in treatment delays around medications, medicine supply issues, and incidents involving clozapine and morphine sulphate have been identified and are being actively managed.	Of the eight incidents resulting in actual moderate harm, five related to intentional overdoses in community settings, with no common medication theme identified. Targeted reviews of moderate harm and significant medicines incidents are identifying learning and driving improvement. Current actions focus on reducing treatment delays, addressing supply issues, improving administration processes, and strengthening safety controls for high-risk medicines, including clozapine and insulin.	Risks - Rising treatment delays, medicine supply issues, and incidents involving high-risk medicines could increase the risk of patient harm. Mitigations - Ongoing incident surveillance, review of moderate incidents, dissemination of learning, and oversight through medicines management governance groups. Escalations to board - No immediate escalation required. Trends will continue to be monitored through Q2, with particular focus on medication delays, supply issues and clozapine-related incidents.

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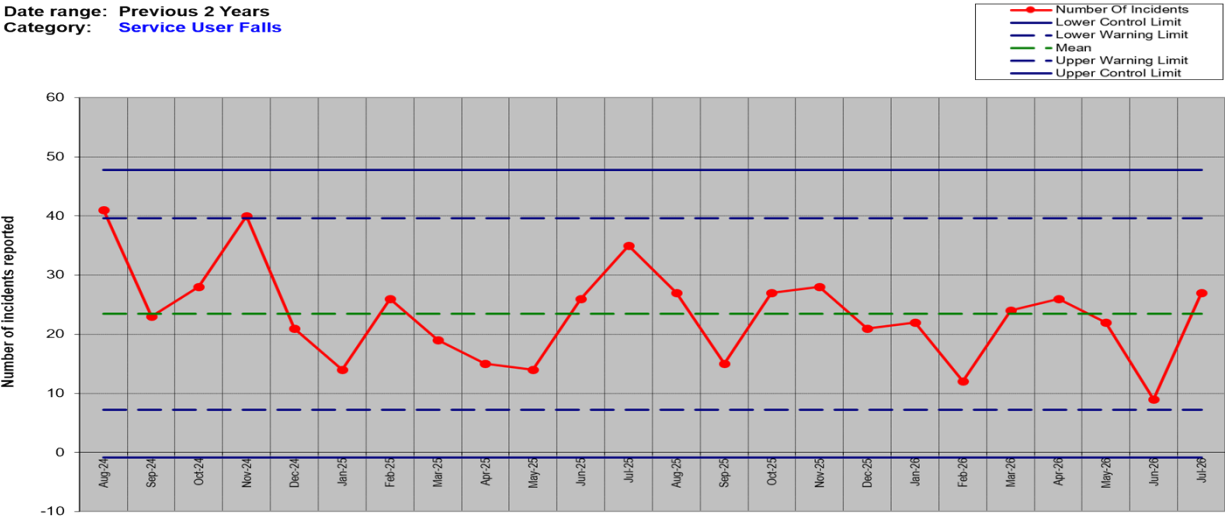
Measure: Falls – number and severity
Domain: Quality and Patient Safety
Target:

NOF: No
Actual: 28

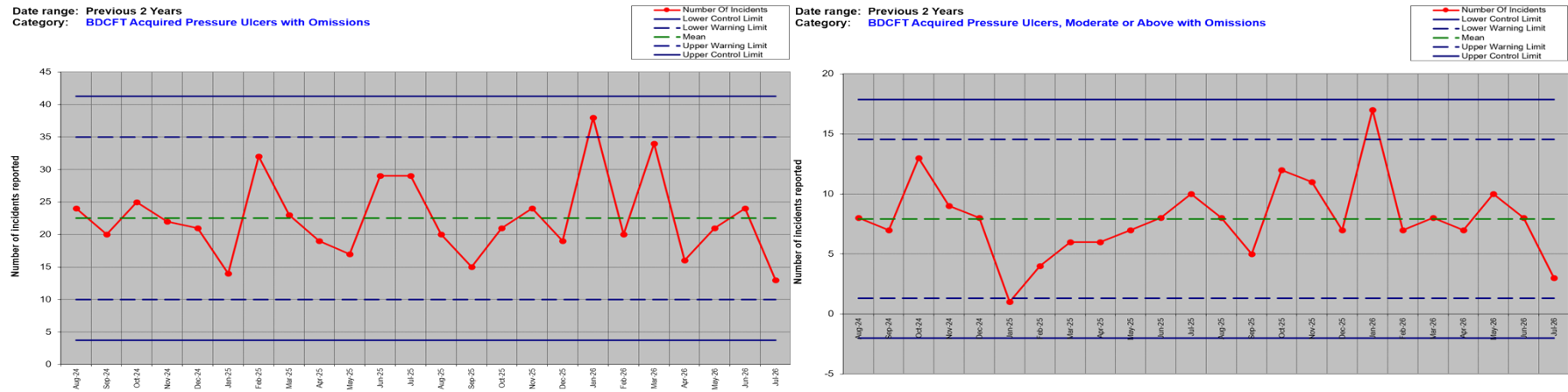
Accountable Exec: Phil Hubbard
Data Period: July 2026

Author: Chris Dixon
DQ Assessment TBD

Date range: Previous 2 Years
Category: Service User Falls



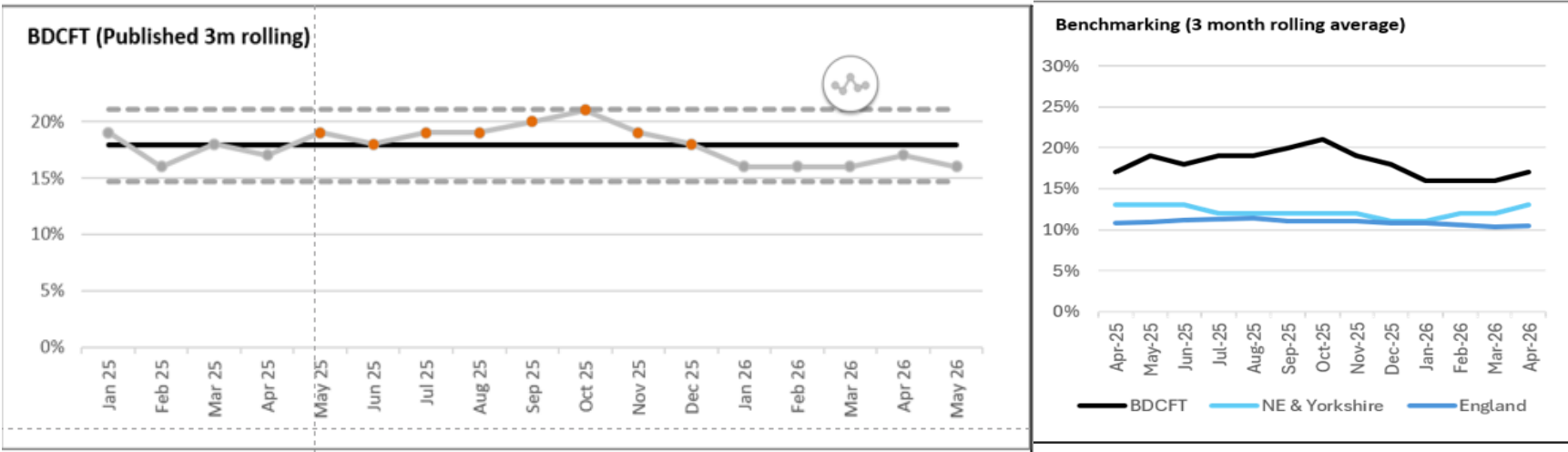
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Falls involving service users are a key quality and patient safety measure because they can result in physical harm, loss of confidence, reduced independence, increased length of stay and avoidable deterioration. Monitoring reported falls supports early identification of themes, variation and learning across services, including the impact of acuity, mobility needs, medication, environmental factors and observation levels. The measure also provides assurance that falls prevention, risk assessment, care planning and post-falls review processes are being applied consistently to reduce avoidable harm.	Performance is interpreted through the trend shown in the graph, the level of month-to-month variation, incident severity, repeated falls and triangulation with service context. Where the graph shows stable or reducing levels of reported falls, with no increase in moderate or above harm, this can be considered on track in relation to harm reduction and quality improvement. Where the graph shows increases, clusters, repeated incidents for individual service users, or an increase in falls resulting in harm, this should be treated as off track for improvement purposes and reviewed through local safety governance.	Where the variance is off track, actions should include timely review of all falls incidents, identification of themes and contributory factors, and targeted review of falls risk assessments, care plans, observation arrangements, medication, mobility aids, footwear, environmental risks and post falls management. Ward and service leadership teams should ensure learning is shared through safety huddles, supervision, quality meetings and patient safety governance routes. Where the measure remains stable or reducing, this should be sustained through continued focus on falls prevention, consistent completion and review of risk assessments, proactive multidisciplinary input, environmental checks, patient and carer involvement, and regular monitoring of falls data and learning.	Key risks to delivery include increased patient acuity and frailty, cognitive impairment, mobility deterioration, medication side effects, staffing pressures, inconsistent completion or review of falls risk assessments, environmental hazards and data quality limitations. These risks are mitigated through senior clinical oversight, multidisciplinary review of high-risk service users, targeted support for areas with increased falls activity, timely post-falls review, environmental safety checks, medicines review where indicated, reinforcement of falls prevention practice, and triangulation of falls data with incident themes, harm levels, complaints, staffing context and quality improvement activity



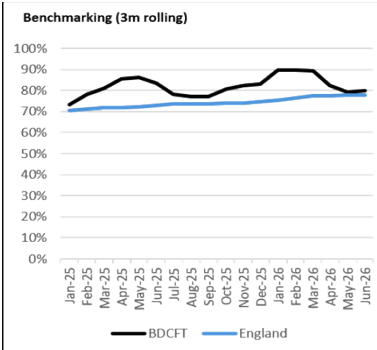
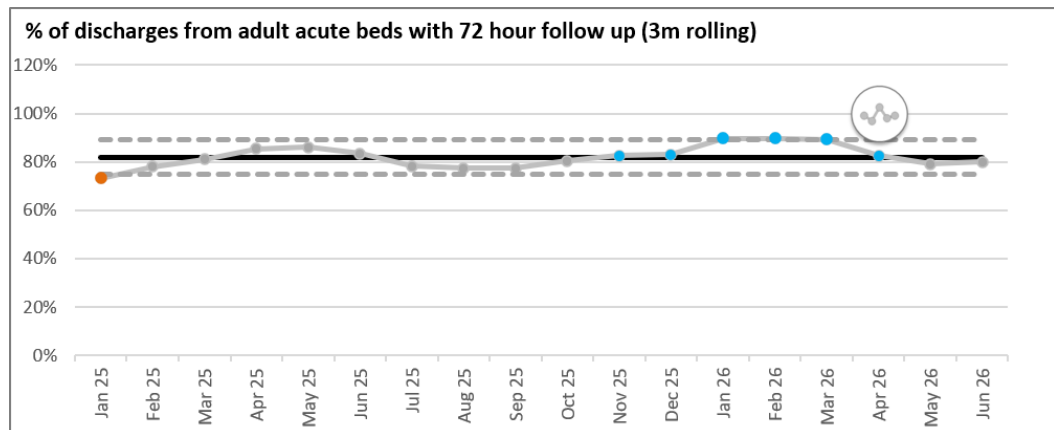
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
BDCFT-acquired pressure ulcers with omissions indicate potentially avoidable harm and gaps in delivery or recording of planned preventative care. • The moderate-or-above measure gives additional focus to incidents with greater potential impact and supports proportionate review, learning and assurance. • Across both charts, results fluctuate around the mean and remain within the control limits.	Statistically, both measures appear stable and in control: there are no data points outside the control limits and no clear prolonged run on one side of the mean. • Performance is therefore broadly on track from an SPC-control perspective, but not yet on track for a sustained reduction because common-cause variation continues and periodic peaks remain. • The latest month is lower than the preceding month and below the mean for both measures, this could be as a result of not completing IRE managers actions in a timely manner.	• Review each omission-related pressure ulcer, prioritising moderate-or-above harm, to identify recurring themes in assessment, care planning, repositioning, equipment, escalation, documentation and handover. • Validate the latest low figures for completeness and reporting timeliness before concluding that improvement has been achieved. • Share learning and targeted feedback with relevant teams, to test whether planned preventative care is reliably delivered. • Continue monthly SPC review. Escalate any point outside a control limit, an emerging sustained shift, or repeated peaks. • Aim for several consecutive months below the current mean; if improvement is sustained, recalculate the SPC limits to reflect the new baseline.	• Risk: under-reporting or inconsistent classification. Mitigation: routine data-quality checks, clear definitions and audit of incident records against clinical documentation. • Risk: recurring common causes continue to generate avoidable harm. Mitigation: thematic review, named action owners, deadlines and evidence of impact. • Risk: operational pressures affect reliable prevention. Mitigation: monitor staffing, workload, access to pressure-relieving equipment and timeliness of assessment/escalation. • Board escalation: any special-cause deterioration, repeated moderate-or-above harm, overdue high-risk actions, or barriers requiring executive support.

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Domain:	Effectiveness of Care	NOF: Yes – but ICB measure	Accountable Exec:	Kelly Barker	Author:	Bernard Hughes, Laura Frost , Pete Garland
Target:		Actual: 17%	Data Period	May 26	DQ Assessment	TBD



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a NoF measure that sits with the ICB but BDCT have significant influence over. The measure is important as it demonstrates if the right infrastructure is in place across the health and care system to identify and support people in keeping mentally healthy before they reach crisis point and admission. Metric is based on 3-month rolling admissions for clients with no contact in the previous 12 months. Benchmarking shows BDCFT above NHSE and regional levels.	We are above national and regional averages at present.	Through the DQ working group a task and finish group will be set up to identify contributing factors and ensure appropriate monitoring of system and BDCFT data.	Risks and mitigations will be determined as part of the Data Quality talk and finish group.



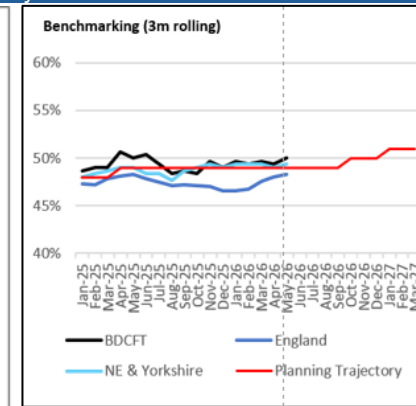
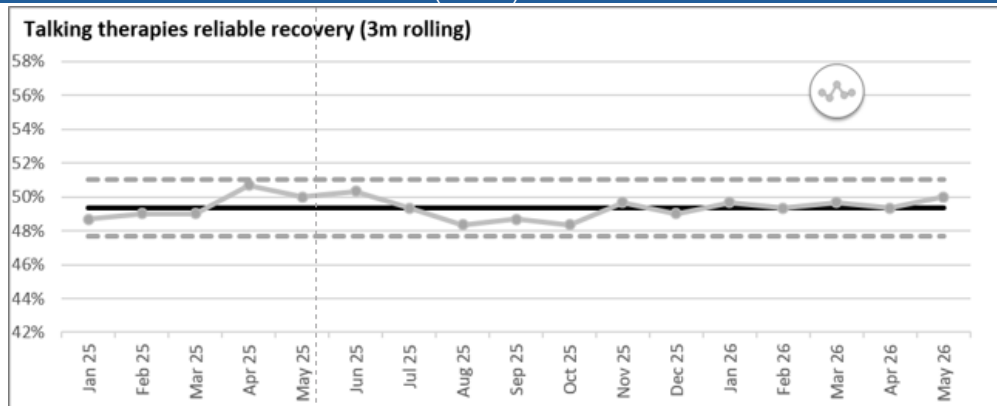
Proposed 2026/27 Thresholds		
Score	Threshold	Jun-26
Score 1	≥ 80%	80%
Score 2	71 - 79%	
Score 3	63 - 70%	
Score 4	≤ 62%	

Measure: % of acute adult discharges followed up within 72 hours (new measure)			Accountable Exec:	Kelly Barker	Author: Pete Garland
Domain:	Effectiveness of Care	NOF:	Yes	Data Period	June 26
Target:	80%	Actual:	80% (NOF 1)	DQ Assessment	TBD

Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
The period immediately following discharge from acute mental health inpatient care is associated with an increased risk of adverse outcomes, including suicide. Timely follow up within 72 hours provides an opportunity for a mental health professional to review the individual's wellbeing, confirm that discharge arrangements remain effective, identify emerging risks, and intervene promptly where required. Delivery of this standard is recognised nationally as an important component of safe and effective discharge planning and continuity of care.	On track. Performance for April 2026 was 82.5%, exceeding the national target of 80%. Performance has improved through sustained work to strengthen the accuracy and consistency of appointment recording and follow up documentation. Administrative support processes and routine managerial oversight have reduced historical data quality issues, providing greater confidence that reported performance reflects operational delivery. Whilst performance is currently above target, achievement remains sensitive to a relatively small number of exceptions and therefore requires continued monitoring.	The service will maintain its focus on robust discharge follow up processes, ongoing data quality assurance, and regular review of exceptions. Team leaders continue to monitor compliance throughout the month and support timely corrective action where gaps are identified.	The principal risk to sustained delivery is the challenge of engaging some service users within the required timeframe following discharge. This is a recognised challenge across crisis and acute care pathways and can result in a small number of unavoidable exceptions. Mitigating actions include continued focus on discharge planning, strengthening engagement approaches, working with system partners to support continuity of care, and ongoing monitoring of follow up activity. Data quality oversight remains in place to ensure reported performance accurately reflects service delivery, although final validated performance is typically confirmed 7-10 days after month end.

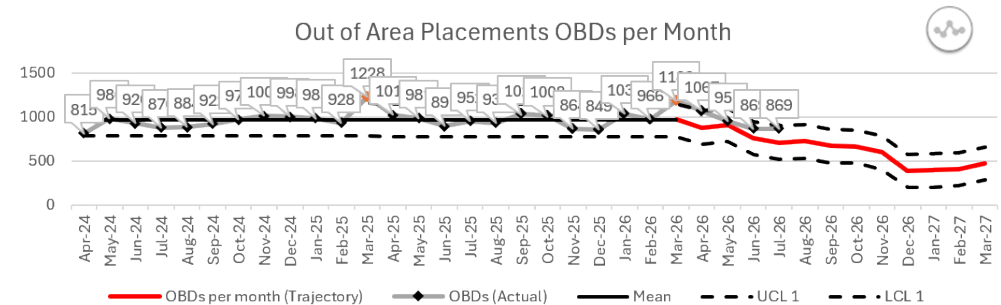
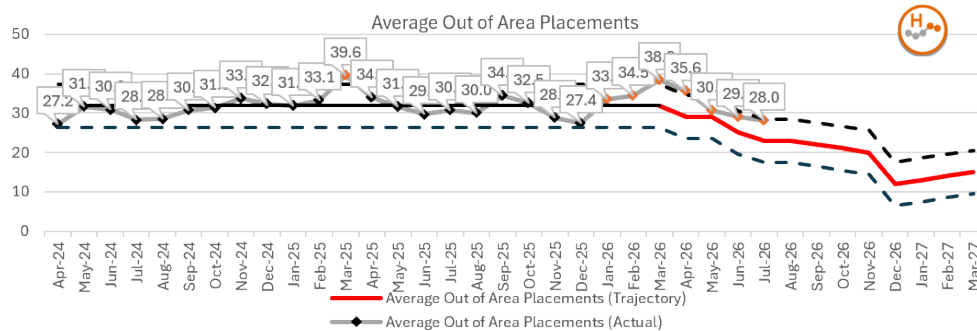
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Measure: Percentage of NHS talking therapies patients completing a course of treatment and achieving reliable recovery (new measure)							
Domain:	Effectiveness of Care	NOF:	Yes	Accountable Exec:	Kelly Barker	Author: Naomi Holdsworth	
Target:	51%	Actual:	49.3% (NOF 2)	Data Period	May 26	DQ Assessment	TBD



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Reliable Recovery is a key quality indicator for NHS Talking Therapies services, measuring the proportion of patients who achieve a clinically meaningful and statistically reliable improvement in their mental health. Performance against this target demonstrates the effectiveness of treatment and evidences the service's contribution to improving patient wellbeing. Maintaining strong reliable recovery outcomes is essential for ensuring high-quality care and supporting better long-term health outcomes for local populations.	The reliable recovery target for 25/26 was 50% it has since increased to 51% for 26/27. For the rolling 3-month average of March – May the service achieved 50% average, which falls 1% below target for the NOF however is in line with National targets at the time. Local data on PCMIS is showing that more recent data (July) indicates that the service is at a 3-month rolling average of 51% which is on track for the NOF and national Talking Therapies target.	Since this data has been published the service has undertaken training with the service on how to improve reliable recovery. Focused conversations are happening within staff management 1-1's. Looking at individual staff's reliable recovery for a rolling 3- and 12-month period. For staff repeatedly underperforming performance plans are put in place.	Reliable Recovery performance continues to be impacted by the increasing complexity. A growing proportion of referrals present with multiple long-term mental and physical health conditions, social adversity, risk factors, and higher baseline symptom severity, all of which can require longer treatment episodes and may reduce the likelihood of achieving recovery within standard treatment pathways. In addition, the service continues to receive inappropriate referrals where patients' needs are outside the scope of NHS Talking Therapies, including those requiring secondary care support. These referrals can result in delays to patients accessing the most appropriate care and can impact overall service performance through assessment activity that does not subsequently progress to treatment To mitigate this, the service is working to improve the use of LIMBIC to screen out inappropriate referrals and a pilot on an introduction of a triage pathway prior to be offering an assessment.

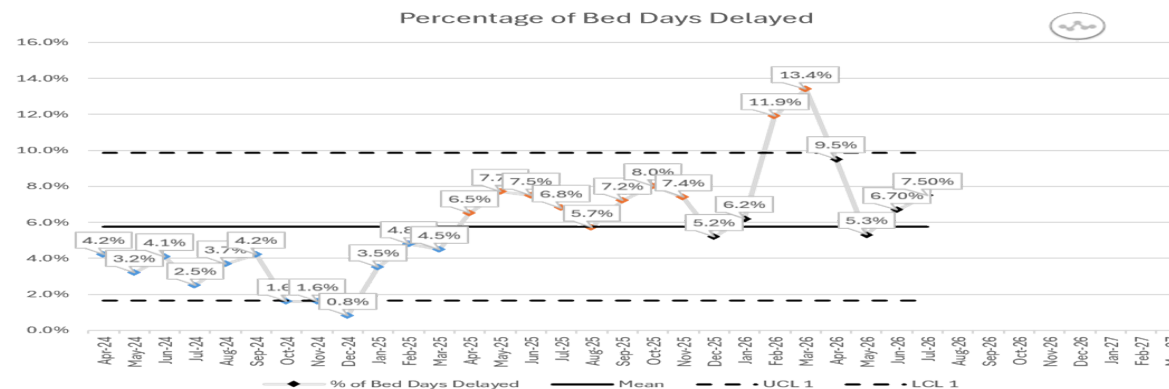
Measure: Inappropriate OAP bed days (our spot continuity number and all OAP bed days)							
Domain:	Experience of Care	NOF: No	Accountable Exec:	Kelly Barker	Author:	Laura Frost	
Target:	On/under trajectory aim for 0	Actual:	78 Spot, 791 Block, 869 Total	Data Period	July 2026	DQ Assessment	TBD



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Out of Area Placements (OAPs) are a key indicator of pressure across the whole mental health system. They can impact patient experience, continuity of care, family involvement, clinical outcomes and cost. Reducing OAP use remains a strategic priority for the Trust and system partners. The overarching trend demonstrates sustained improvement from the peak position experienced during 2025/26; however, performance remains above trajectory and the pace of improvement needs to accelerate to achieve the March 2027 ambition. OAP bed days remain primarily driven by challenges within inpatient flow, delayed progression through pathways and demand exceeding available local capacity.	We are currently off trajectory. July delivered 869 OAP bed days against a planned trajectory of 709, a variance of 160 bed days. Average OAP occupancy has continued to reduce and remains significantly below historic levels; however, reductions are not yet being achieved at the pace required. Whilst delayed occupancy has improved and remains below the Trust threshold, length of stay across adult acute pathways continues to create pressure within bed capacity. Demand for inpatient admission remains high and a small cohort of individuals with complex discharge, housing, care package or system-related barriers continue to occupy beds for longer than clinically required.	A dedicated Flow Command Sprint has been established to accelerate reductions in OAP use through a whole-system focus on admission avoidance, active inpatient flow management and discharge optimisation. Actions include: - Daily review of all OAP patients and opportunities for repatriation. - Executive oversight of long-stay patients and discharge barriers. - Strengthened multidisciplinary review of patients exceeding expected length of stay. - Enhanced partnership working with Local Authority, ICB and housing providers. - Continued implementation of admission avoidance and community alternatives. - Weekly monitoring against reduction trajectories. Patient feedback consistently highlights the importance of receiving care closer to home and maintaining contact with families and support networks. Learning from recent repatriations demonstrates that early system escalation and executive-led coordination can significantly reduce unnecessary delays. We expect the trajectory to continue improving through the remainder of 2026/27 but recognise that further reductions will depend upon sustained improvements in length of stay and discharge processes.	Mitigations - Flow Command Sprint governance. - P&P PMO Sprint - Daily and weekly executive review. - System escalation routes with Local Authority and ICB partners. - Enhanced discharge planning and repatriation oversight. - Monitoring of long-stay cohorts and delayed discharge reasons.

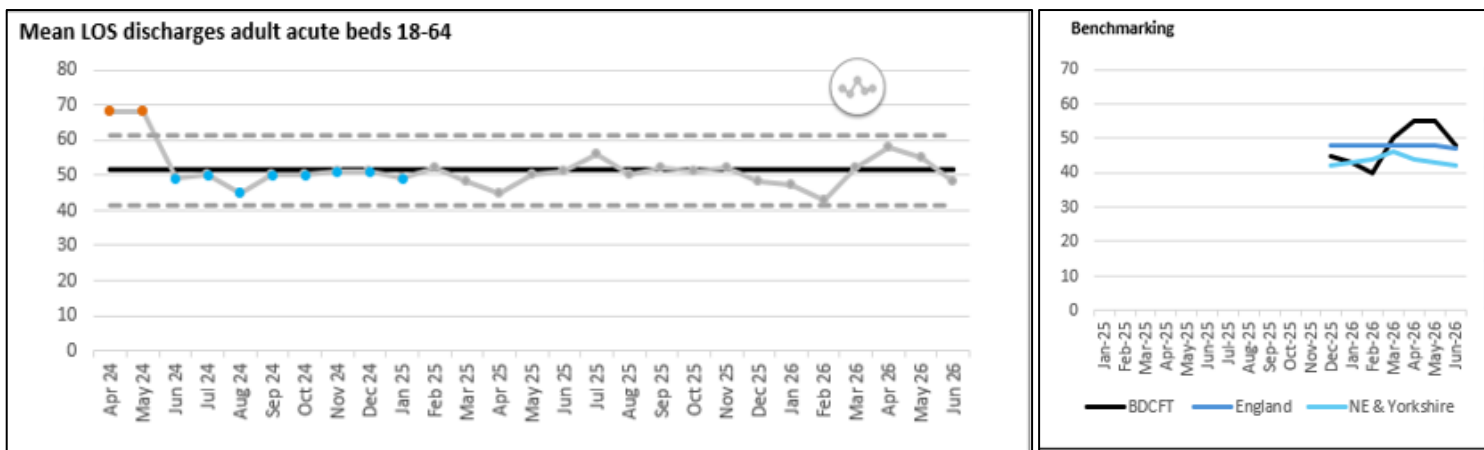
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Measure: % of Ward Occupancy Delayed for Acute Wards						
Domain:	Experience of Care	NOF: No	Accountable Exec:	Kelly Barker	Author:	Laura Frost
Target:	10% or under	Actual: 7.5%	Data Period: July 26		DQ Assessment	TBD

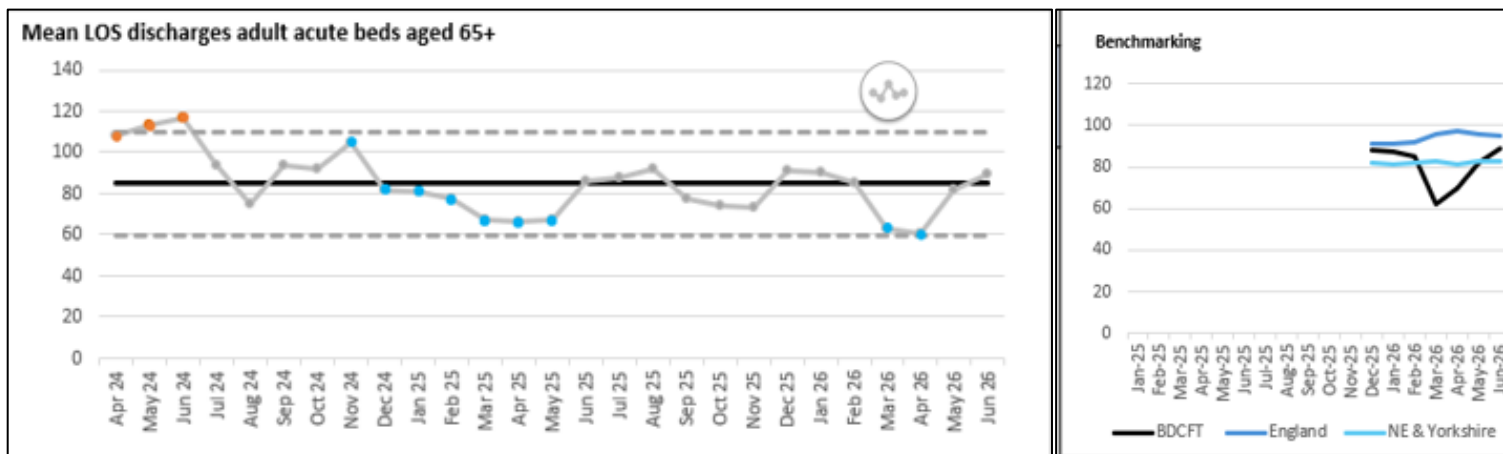


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Delayed occupancy provides an indication of how effectively patients move through inpatient services once they are clinically ready for discharge. Improving delayed occupancy supports patient experience, increases bed availability, reduces inpatient length of stay and directly contributes towards reducing Out of Area Placements. The long-term trend shows some variation, with deterioration seen earlier in 2026 followed by sustained improvement over recent months.	We are currently on track. July performance was 7.5%, below the Trust threshold of 10%. Following a period of increased delays between February and April 2026, performance has improved and has now returned below target. Although this position is positive, delayed occupancy remains a contributing factor to pressures within overall inpatient flow. Analysis shows that while discharge delays are reducing, length of stay remains above desired levels for several cohorts, meaning flow improvements have not yet translated fully into the reductions in OAP trajectory required.	As per OOA report Current actions are focused on maintaining the progress achieved: - Daily review of all delayed discharges. - Clear escalation routes for housing, social care and care package delays. - Weekly review of patients approaching anticipated discharge dates. - Integration with Flow Command arrangements and OAP reduction programme. Learning from recent improvement demonstrates that early executive visibility of discharge barriers significantly improves system responsiveness. If these actions are sustained, delayed occupancy is expected to remain below target throughout the remainder of 2026/27	Mitigations - Flow Command Sprint governance. - P&P PMO Sprint - Daily and weekly executive review. - System escalation routes with Local Authority and ICB partners. - Enhanced discharge planning and repatriation oversight. - Monitoring of long-stay cohorts and delayed discharge reasons.

Measure: Mean length of stay for adult acute and PICU discharges (3m rolling)						
Domain:	Experience of Care	NOF: Yes	Accountable Exec:	Kelly Barker	Author:	Laura Frost

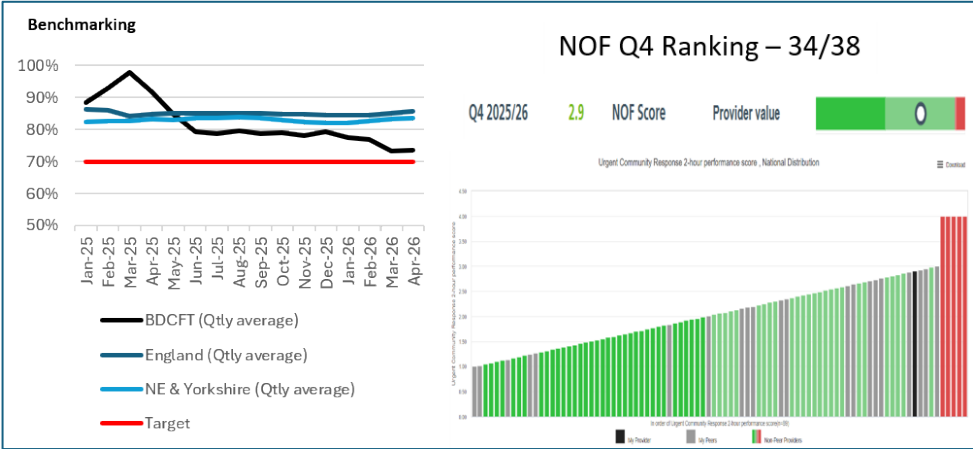
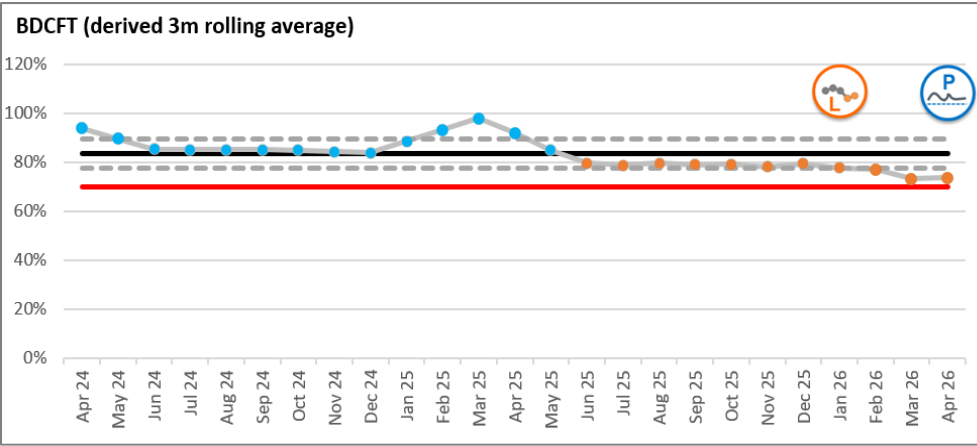


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Length of stay is an important monitor of inpatient flow and bed availability. Maintaining an optimal length of stay ensures that people receive care for the shortest period consistent with recovery, maximises bed capacity and supports reduction of Out of Area Placements. The overall trend remains relatively stable over the last 18 months. Recent improvement has reversed earlier deterioration and performance is now within the Trust's planning trajectory.	Performance is currently on track against the Trust planning trajectory but not yet achieving the NOF benchmark position. The current mean length of stay is 48 days. This is below the local planning target of 51 days but remains above the NOF benchmark of 40 days. Length of stay has remained broadly stable over the last twelve months. Whilst delays are not being driven solely by discharge processes, a small number of patients with highly complex presentations and discharge requirements continue to significantly influence overall averages. Benchmarking indicates BDCFT remains above England and regional averages and therefore further improvement is required.	Actions include: - Weekly review of all long-stay patients. - Strengthened expected discharge date processes. - Enhanced discharge planning from admission. - Increased scrutiny of patients exceeding 60 and 90 days. - Flow Command work to improve whole-system flow. - Focus on reducing unwarranted variation between wards. Patient and staff feedback continues to reinforce the importance of clear discharge planning, earlier MDT decision-making and stronger partnership working with community services. We anticipate a gradual reduction in length of stay during 2026/27 which should support delivery of both OAP reduction trajectories and improved patient flow.	Whilst performance remains within local planning assumptions, improvement is required to reach NOF benchmark levels. This remains a key component of the Trust's OAP reduction strategy and should continue to receive Board oversight.



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Length of stay is an important monitor of inpatient flow and bed availability. Maintaining an optimal length of stay ensures that people receive care for the shortest period consistent with recovery, maximises bed capacity and supports flow. The overall trend has been reducing over the last 18 months. Recent performance shows a small level of deterioration following a significant reduction in length of stay in March and April.	Performance is currently in line with expectations and is below the England benchmark. Performance over the last 18 months has been broadly better than Northeast and Yorkshire peers following a significant improvement in the first half of 2024 which coincided with the appointment of the permanent consultant psychiatrist under the functional model following a move from the continuity of care model.	We continue to monitor average length of stay at discharge as well as current length of stay for those on the ward. The Discharge Co-ordinator works in collaboration with the Local Authorities to ensure early identification of barriers to discharge.	With the expected rise in the older adult population there is a risk that inpatient capacity in the future will be insufficient to deal with significant increased demand. Maintaining a focus on flow and minimising length of stay will support with managing increased demand.

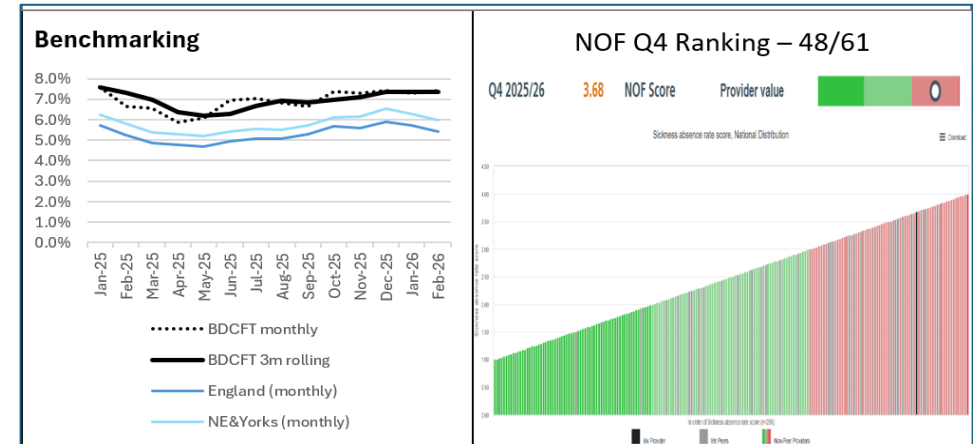
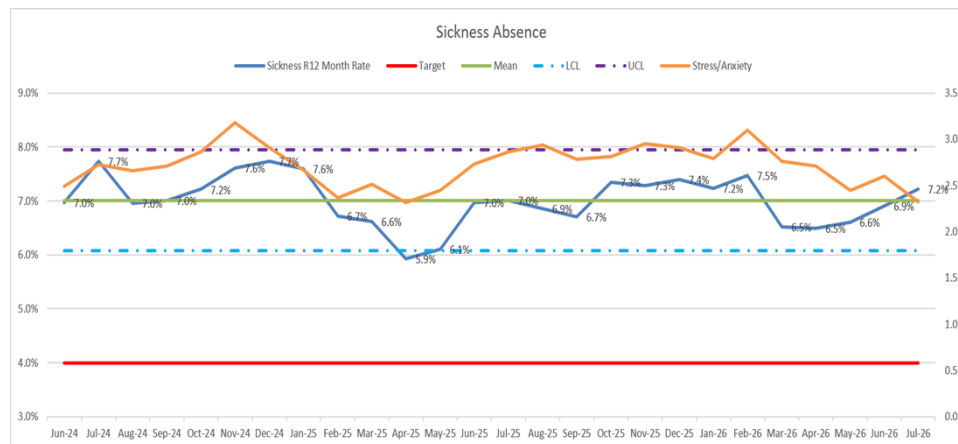
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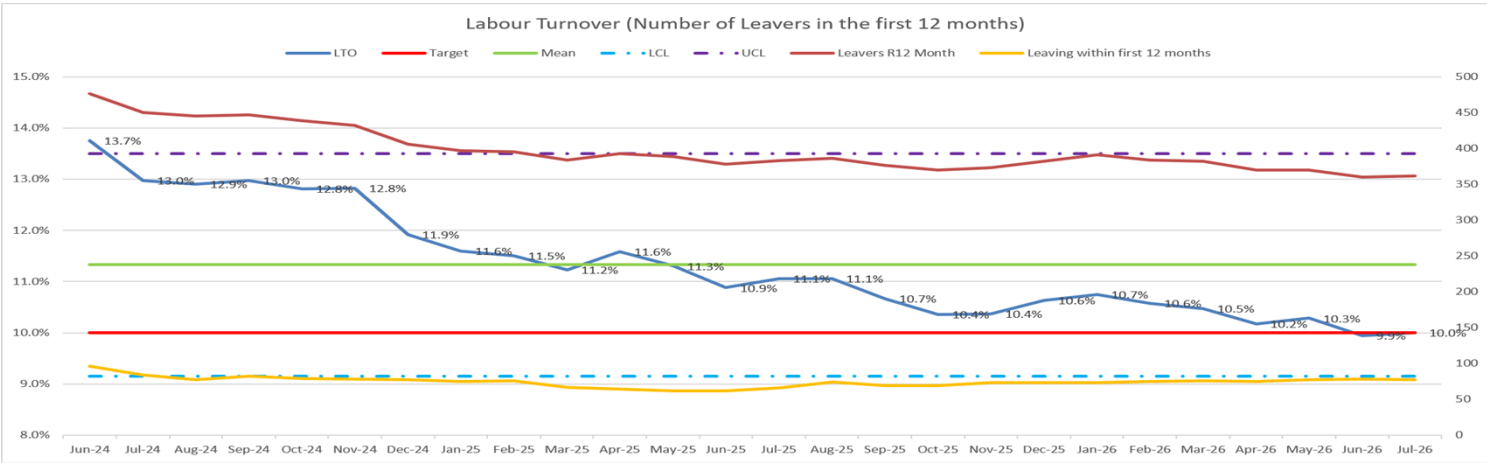
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Urgent Community Response (UCR) performance measures the effectiveness of the unplanned community nursing service in responding to patient within escalating needs that may otherwise lead to a hospital attendance or unnecessary suffering. UCR is a NOF target. Despite activity numbers more than doubling in the last 12 months, performance continues to be over the 70% national target.	We continue to be on track and above national target, although performance has reduced slightly due to increased numbers accessing.	We are currently on track but are reviewing data and processes to make sure it is accurate and timely. A working group has been established to standardise reporting practice through a new SOP, deliver individual staff training and accessible performance reporting.	Noting sustained attainment over the reporting period there are no current risks identified. It is noted however that operational pressures can impact on performance. Lower performance over the last 12 month reflects higher absence rates and increased service access.

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Measure: Sickness absence rate (3m rolling)					
Domain: People	NOF: Yes	Accountable Exec: Jo Harrison	Author: Claire Ingle		
Target: 4%	Actual: 7.36% (NOF4) (7.2% July)	Data Period: Q4 205/26	DQ Assessment		TBD

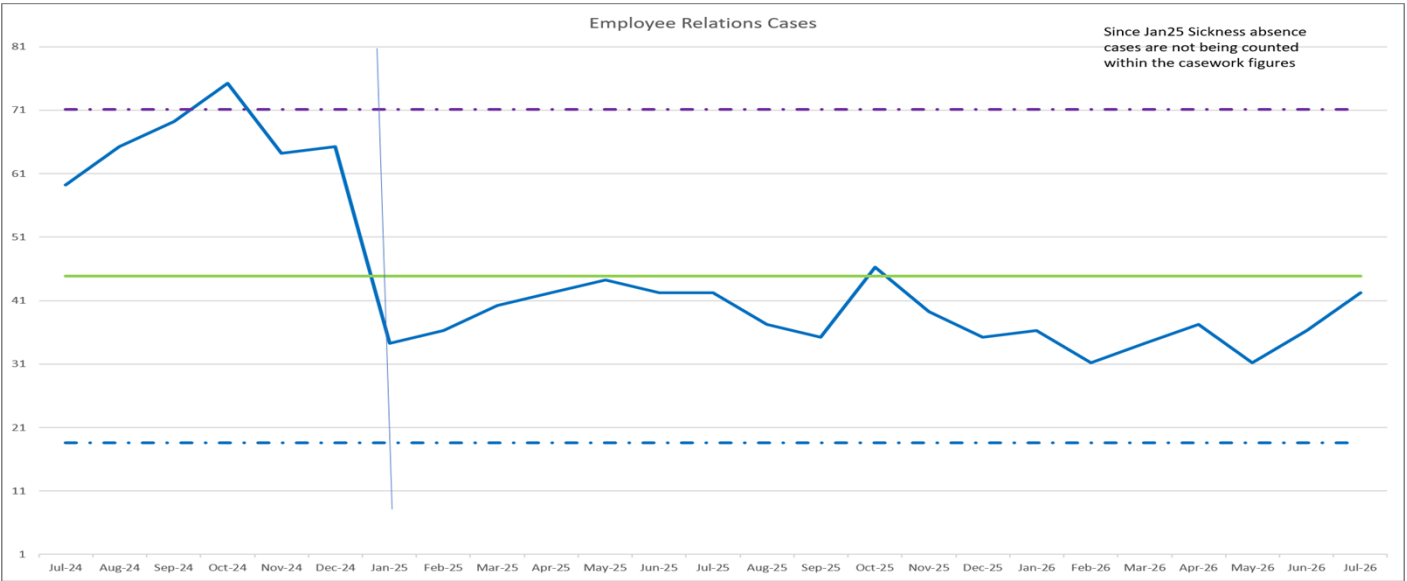


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring sickness absence levels in the NHS is important because it has a direct impact on patient care, workforce wellbeing, service delivery, and organisational costs. The SPC chart shows a fluctuating trend since Jun24 with a gradual increase since Mar26. Most data points fall within the control limits with some falling below average. The graph above represents the latest available NoF data although it should be noted that performance for July is at 7.21%.	The SPC shows sickness absence data since Jun24 monitored against the Trust target of 4%. Currently sickness absence stands at 7.21% 3.21% above target. Sickness absence has consistently been above 4% since Jun24. The management of sickness absence in some areas lacks consistency and rigour with policy not always applied robustly at the early stages. This, alongside with broader workforce resilience pressures is contributing to this remaining above target.	We have a live transformational plan currently in place that is supporting strengthening management capability and streamlining tasks via automation. We are fully reviewing the attendance policy and making changes to support a more robust application and management of absences including a strengthening of managing patternable absences.	None to report



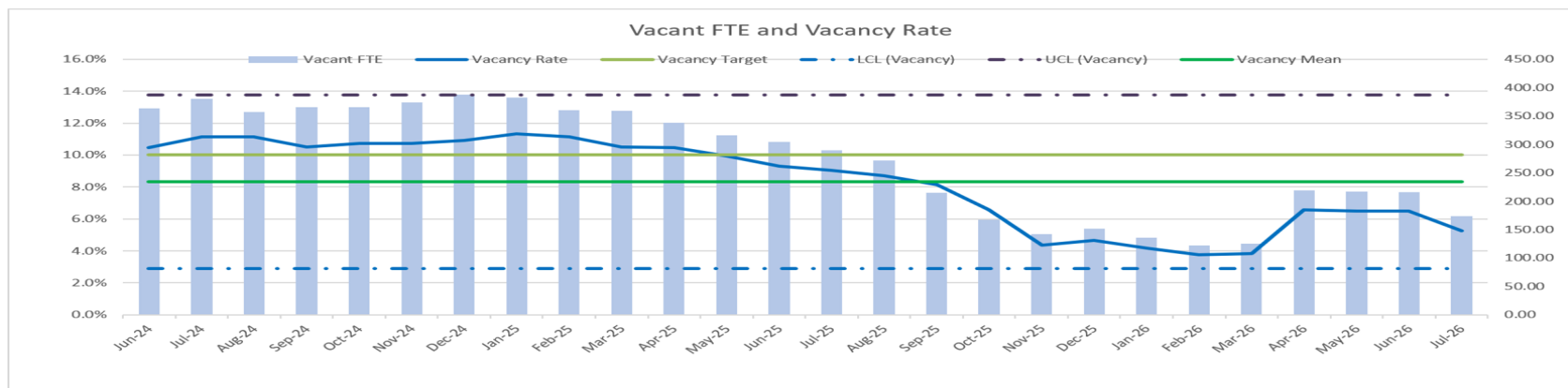
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring labour turnover is important in the NHS because it provides insight into workforce stability, organisational health, and the ability to deliver safe and effective patient care. The SPC chart shows a gradual reduction in LTO since Jun24. With current levels falling below target and well below the average. Most data points are within the control limits, with levels reducing closer to the lower control limit.	The SPC shows LTO data since Jun24 monitored against the Trust target of 10%. Currently LTO stands at 9.99% 0.01% below target. More uncertainty in the wider NHS system as well as the disbanding of ICB's and NHSE is translating as less opportunities across the piece meaning there is less movement.	We have a comprehensive induction process and a system by which new starters are routinely contacted to ensure optimum engagement and to make sure that any employment issues are resolved early on to mitigate people leaving the trust. There is an evolving piece of work form the People Services team to review all management training to ensure things are dealt with correctly first time and early on to support colleagues in work. With current climate it is expected that LTO will stay within the target for the foreseeable future.	None to report

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Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring the number of Employee Relations cases in the NHS is important because it provides insight into workforce issues, organisational culture, and potential risks that could affect staff wellbeing and service delivery. Since Jan25 the volume of ER cases has fluctuated, it peaked in October 25 with 46 cases, steadily declined, but is now showing an increase. Most data points are falling within the control limits.	There is a target of 30 for ongoing active ER cases at any one-time, current levels are above that target, reporting 46 cases in July 2026, 16 cases above target. Case volumes remain above the target of 30 due to ongoing workforce pressures, organisational change activity and the complexity of ER issues. We have seen an increase of grievances, especially in relation to other processes (such as Org change and Flexible working).	To address this, regular case reviews are taking place, managers are being supported through HR advice and coaching, and key themes are being monitored to enable earlier intervention and reduce escalation. Learning from recent cases indicates that proactive management and early resolution approaches are effective in reducing case duration and preventing further escalation. While case numbers are expected to remain above target in the short term, they are anticipated to stabilise as these actions take effect. The main risks are the impact of sustained high case volumes on staff wellbeing, management capacity and service delivery.	Mitigations include enhanced HR support, manager development, regular monitoring of case trends and focused interventions where themes emerge. No board escalation is required at present, although performance will continue to be monitored closely.

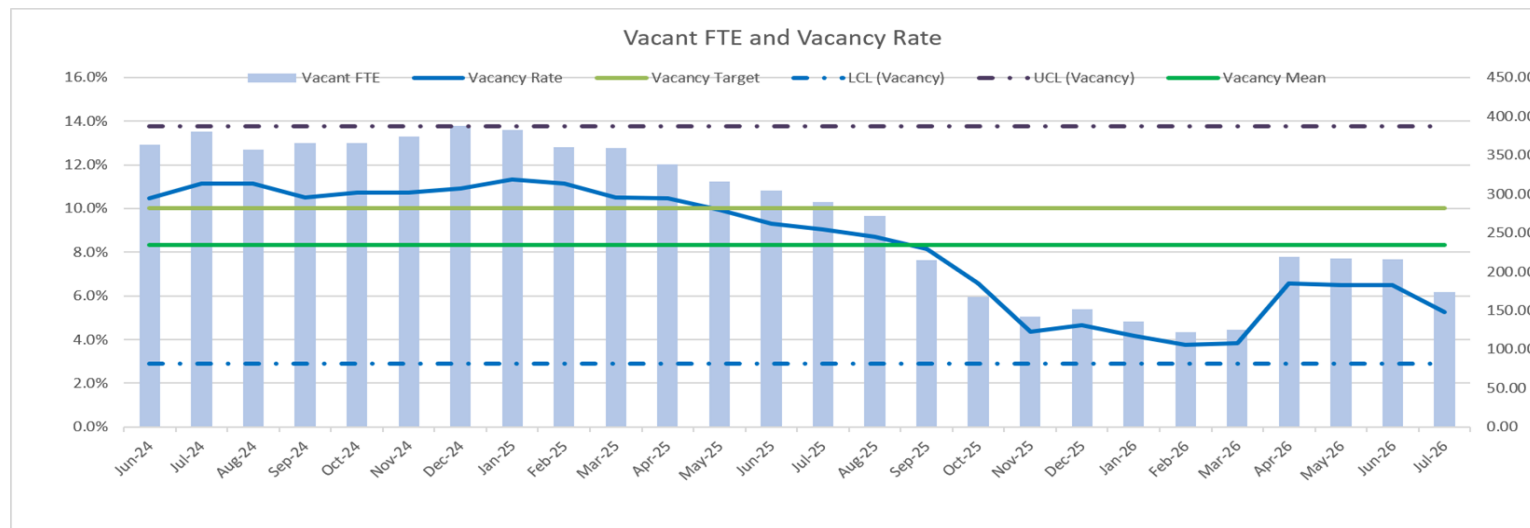
Measure: Vacancy Rate	NOF: No	Accountable Exec:	Jo Harrison	Author: Claire Ingle	
Domain: People	Actual:	Data Period	July 26	DQ Assessment	TBD
Target: 10%	5.26%				



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track how do we stay on track?	What are the risks to delivery and mitigations
Monitoring vacancy rates in the NHS is critical because vacancies directly affect workforce capacity, service delivery, financial performance, and patient care. Vacancy rates are one of the most important workforce metrics for understanding whether an organisation has sufficient staff to meet demand. The SPC chart shows a gradual reduction in vacancy rates since June 24. With current levels falling below target and well below the average. All data points fall within the control limits.	The SPC shows Vacancy data since June 24 monitored against the Trust target of 10%. Currently the vacancy rate stands at 5.33% 4.74% below target. A number of factors are likely contributing to this: Strong recruitment performance, with recruitment timelines consistently outperforming KPI targets. Recent reporting shows advert-to-unconditional offer times of around 25 days against a 65-day target Improved retention and reduced labour turnover (LTO). Vacancy scrutiny and approval processes, including recruitment freeze controls. Post redesign and CIP activity, where vacancies have been reviewed to identify opportunities for different skill mixes, restructures or efficiency savings before recruitment proceeds.	Retention has improved and is now receiving at least as much attention nationally as recruitment. NHS England's People Promise programme has been heavily focused on reducing turnover through flexible working, wellbeing support, career development and better rostering practices. Continued focus on this from BDCT will undoubtedly support this measure staying on track.	If Labour turnover increases could quickly impact vacancy levels if resignations rise Longer term recruitment freeze restrictions may limit the ability to recruit proactively into some vacancies. Recruitment and retention challenges for Band HCSW 3 roles may be exacerbated by changes to immigration and sponsorship requirements. Planned changes to sponsorship eligibility are expected to remove Band 3 HCSWs from sponsorship routes altogether from December 2026. Workforce Shortages - Delays in adopting the national Band 3 HCSW profile also present a risk, particularly as neighbouring NHS organisations have already implemented the profile, potentially affecting the Trust's competitiveness in the labour market.

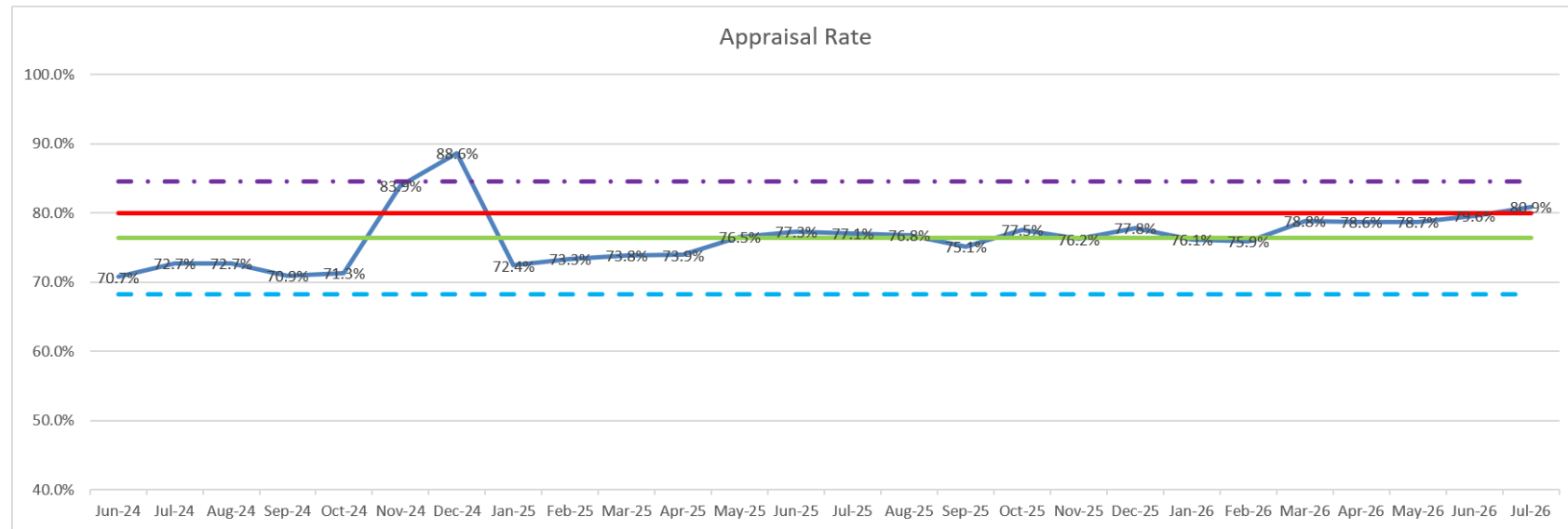
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Measure: Variation from budgeted establishment					Accountable Exec: Jo Harrison	Author: Danielle Stephenson	
Domain: People	NOF: No				Data Period	July 26	DQ Assessment
Target: 350	Actual: 173.59						TBD



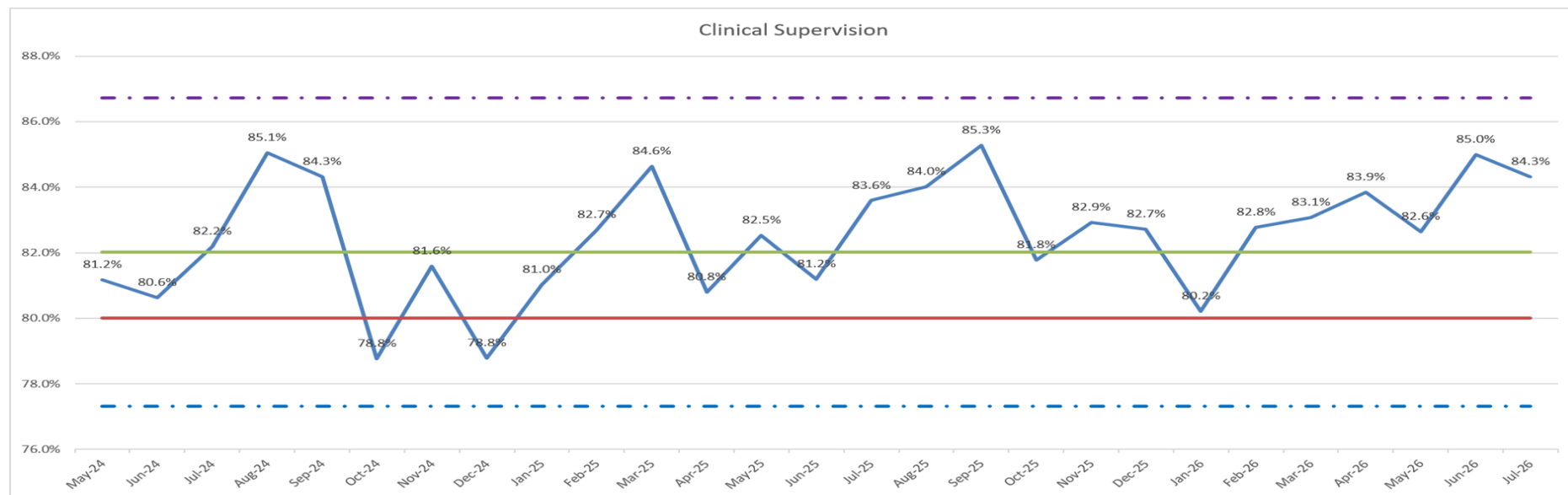
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring variation from budgeted establishment in the NHS is important because it shows whether the actual workforce is aligned to the staffing levels and costs that have been planned and funded. It is a key measure of workforce efficiency, financial control, and service capacity. The SPC chart shows a gradual reduction in vacant FTE since Jun24. With current levels falling below target and well below the average.	The SPC shows vacant FTE data since Jun24 monitored against the Trust target of 350. Currently the vacant FTE stands at 173.59, which is 176.41 below target.	To stay on track, we need to continue monitoring the Trust's overall vacancy rate to ensure it stays below 10%. We now have two dashboards to support this so we can identify which services may be outside this target area to support further discussions to improve recruitment or look at why they are over established to make more informed decisions. We expect the trend to continue going down as tighter controls are introduced to support with workforce planning triangulated with finance and activity.	We have two directorates to monitor closely as individually July data is showing they are over the 10% vacancy target (by most 1.3%) and two directorates over established (by most 4.66%). Recommended mitigations – to understand which services within these directorates are most impacted by over / under establishment and what plans they have in place to mitigate this.

Measure: Appraisal compliance	NOF: No	Accountable Exec:	Jo Harrison	Author: Naomi Fernandez	
Domain: People				DQ Assessment	TBD
Target: 80%	Actual: 80.89%	Data Period	July 26		



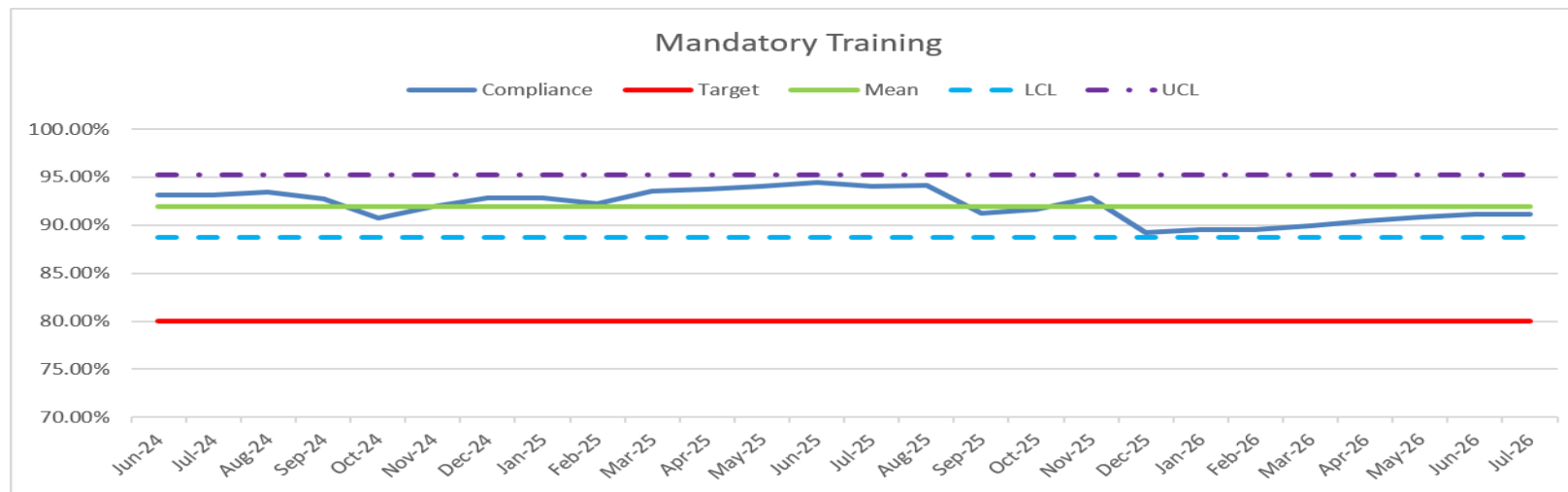
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring appraisal compliance in the NHS is important because appraisals are a key mechanism for supporting staff performance, development, engagement, and ultimately the delivery of high-quality patient care. The SPC chart shows a gradual increase in appraisal compliance rates since Jan25, with levels falling within the control limits, and climbing above average and finally achieving the target.	The SPC shows appraisal compliance rates since Jun24 monitored against the Trust target of 80%. Currently the appraisal compliance rate stands at 80.89%, 0.89% above target. There is no set appraisal date per annum, % rate for compliance can fluctuate. May be low points in the year due to service pressures, changes in service that may impact completion of appraisal in a timely manner.	ESR provides compliance/ due date notifications for managers/staff. Reports on low compliance target support for services and teams. Appraisal rates & quality monitored through annual internal audits. Staff survey monitors appraisal results to questions and staff comments on quality and effectiveness of objective setting. Feeds into induction journey & training to develop staff & managers. To embed shared responsibility, support employee life cycle that improves staff experience.	Risk - service pressures at points in the year may show low compliance of completion of appraisal. Risk - completion of appraisal yet not quality appraisal and objectives

Measure: Clinical supervision	NOF: No	Accountable Exec:	Jo Harrison	Author: Naomi Fernandez	
Domain: People				DQ Assessment	TBD
Target: 80%	Actual: 84.32 %	Data Period	July 26		



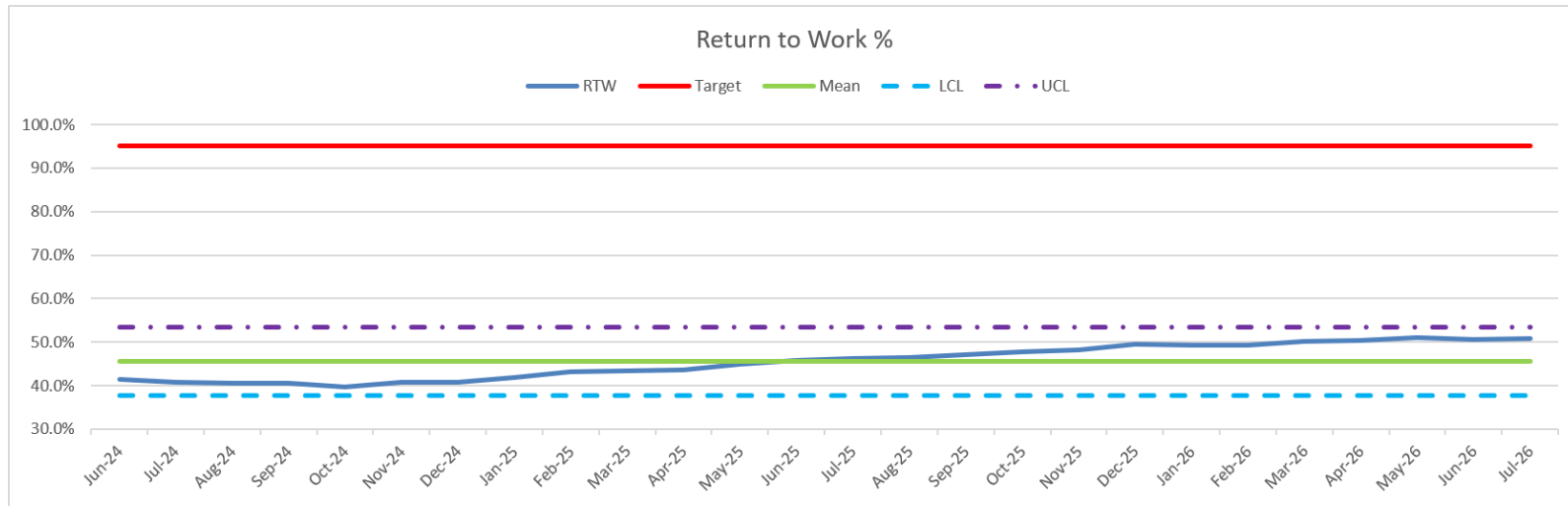
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring clinical supervision compliance in the NHS is important because clinical supervision is a key safeguard that supports professional practice, staff wellbeing, patient safety, and the delivery of high-quality care. The SPC chart shows fluctuating clinical supervision compliance rates since Jun24, with all data points falling within the control limits, and consistently being above average and achieving the target.	The SPC shows clinical supervision compliance rates since Jun24 monitored against the Trust target of 80%. Currently the clinical supervision compliance rate stands at 84.32%, 4.32% above target. There is consistency in this being met and compliance maintained through professional clinical good practice and adherence to meeting professional standards in practice.	Effective processes in place for clinical governance, training & procedures to support clinical colleagues with clinical supervision. The preceptorship programme further supports / promotes clinical supervision. Further work is underway to support digital recording and notification systems to support clinical supervision infrastructure.	None to report.

Measure: Mandatory Training Compliance	NOF: No	Accountable Exec: Jo Harrison	Author: Naomi Fernandez
Domain: People	Actual: 91.17%	Data Period: July 26	DQ Assessment
Target: 80%			TBD



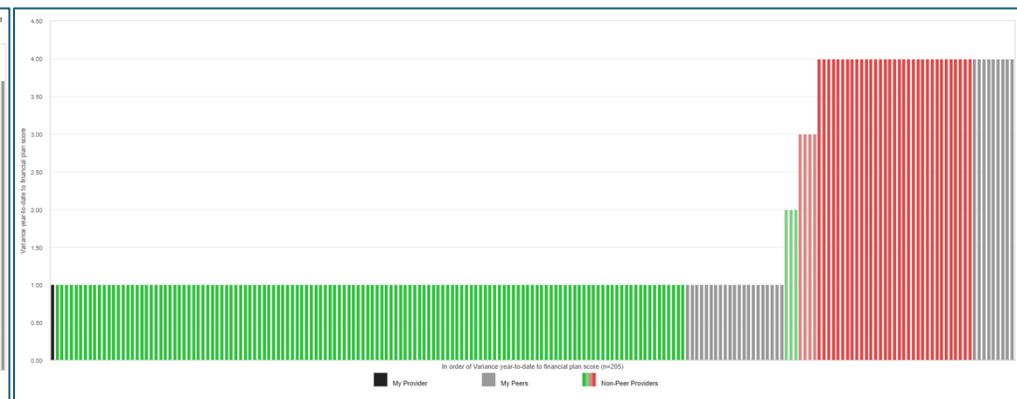
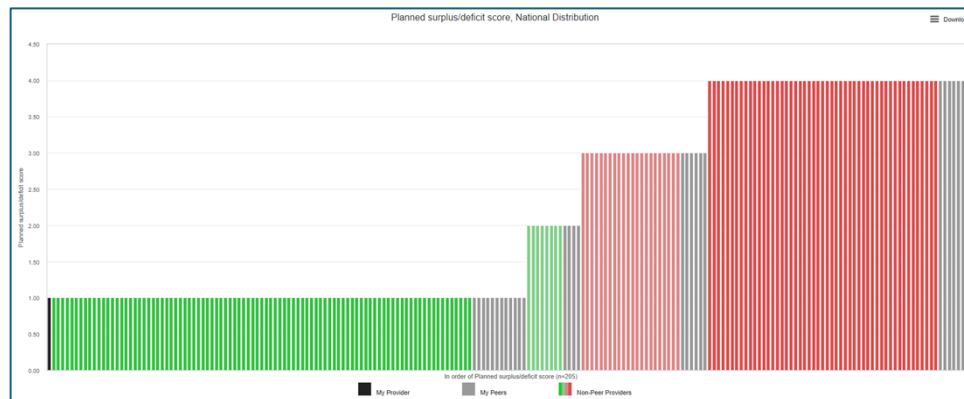
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring mandatory training compliance in the NHS is important: mandatory training ensures that staff have the essential knowledge, skills, and awareness required to work safely, meet legal and regulatory requirements, protect patients from harm, and deliver high-quality care. The SPC chart shows compliance rates which have varied since Jun24, with all data points falling within the control limits, and consistently being above average and achieving the target.	The SPC shows mandatory training compliance rates since Jun24 monitored against the Trust target of 80%. Currently the compliance rate stands at 91.17%, 11.17% above target. The compliance rat remains consistent and there is an established understanding across the Trust of the mandatory and compliance training requirements.	ESR provides compliance/ due date notifications for managers/staff. Reports on low compliance target support for services and teams. Reports are produced & distributed on compliance of statutory / mandatory training - shared with service leads to support continuation of compliance, identify areas of low compliance. Reports used by SME's to predict training compliance & capacity for future workforce training requirements.	Continued support and funding for Oliver McGowan and increasing compliance in these mandatory areas. NHSE New Core skills framework and changes for SME's in implementing new framework and requirements for training, learning and development.

Measure: Return To Work Interview Complete							
Domain:	People	NOF:	No	Accountable Exec:	Jo Harrison	Author:	Naomi Fernandez
Target:	95%	Actual:	50.8%	Data Period	July 26	DQ Assessment	TBD



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring return to work interviews following sickness absence in the NHS is important because these interviews provide a structured opportunity to support employee wellbeing, confirm fitness to return, identify any ongoing health concerns, and ensure appropriate workplace adjustments are in place. The SPC chart shows RTW rates which have steadily increased since Jun24, with all data points falling within the control limits, however consistently below average and not achieving the target.	The SPC shows RW rates since Jun24 monitored against the Trust target of 80%. Currently the completion rate stands at 50.8%, 44.2% below target. We are still experiencing challenges such as: Entering of absences retrospectively into HeRo (Health Roster) - this has now been rectified. Time pressures that managers are reporting to complete RTW's.	Included additional functionality into HeRo so retro RTW's can be added Issued further guidance including video demos for managers. Stood up drop-in session on how to record RTW's in HeRo Comms via E connect-, MHAG and CAG	Failure to understand causes of absence mean we are unable to look at preventative action to reduce absences. Missed opportunities for early intervention More frequent repeated absences Equality risks regarding reasonable adjustments.

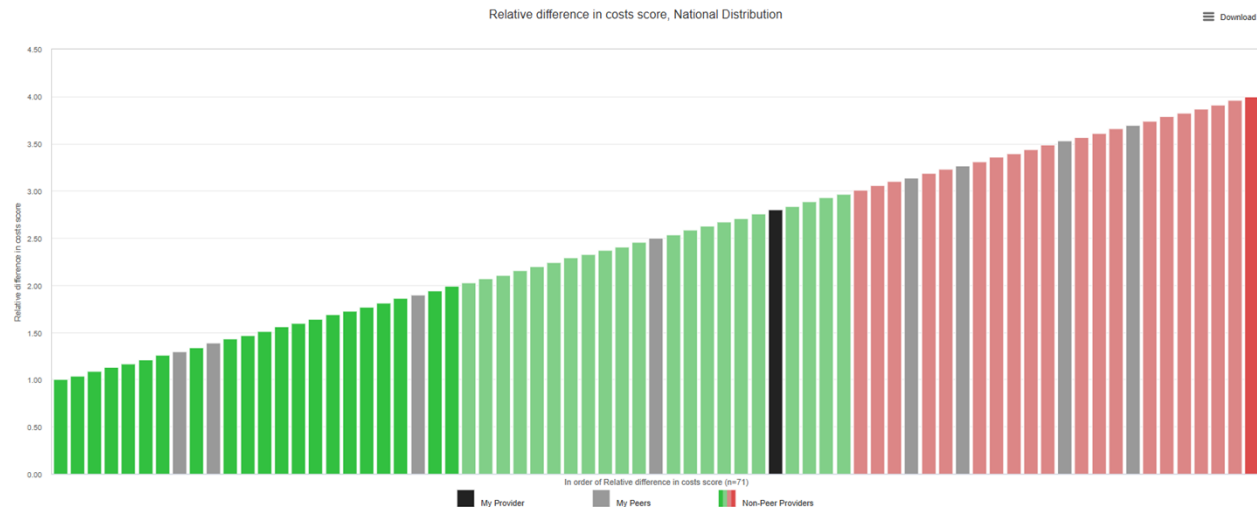
Measure:	Planned surplus / deficit / Variance year to date financial plan			Accountable Exec:	Mike Woodhead	Author:	Anne-Marie Dewhirst
Domain:	Finance and Productivity	NOF:	Yes				TBD
Target:	Achieve Plan for both	Actual:	0.86% (NOF1) / 0.01 (NOF1)	Data Period	Q4 25/26	DQ Assessment	



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This measure reflects the financial performance for the Trust and confidence that the Trust will deliver its plan.	We are reporting slightly better than plan at Month 4 by £7k and continuing to forecast a breakeven position. The main risks continue to arise from the delivery risk on the CIP programme. A forecast £4.1m CIP shortfall is reported in the financial position at Month 4, with non recurrent mitigation plans identified to cover the risk. The risk of further deterioration has been assessed between £2.4m to £7.3m.	- Sprint activities for the Adult Mental Health Strategic Programme to target reductions in out of area placements - By end of August - Improve the robustness of plans that are scheduled to deliver from Q2 onwards - Identify opportunities to go further to deliver additional savings: e.g. Community Clozapine - Additional management controls – including: Workforce/ Non Pay/ Estates - Difficult decisions – e.g. performance compliance/ stop services not adequately commissioned/ cease outsourcing/ rationalise infrastructure etc	The main risk is that the actions that we are taking do not deliver improvements to the run rate at the pace needed to ensure delivery of the Trusts break-even financial plan. Weekly EMT oversight has been stood up to monitor delivery of actions. There is a risk that NHS England intervention will be instigated and distract the Trust from taking the action needed to ensure financial sustainability.

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Measure: Relative difference in costs						
Domain: Finance and Productivity	NOF: Yes	Accountable Exec: Mike Woodhead	Author: Anne-Marie Dewhirst			
Target: Based on ranking	Actual: 2.8 (NOF 2)	Data Period	DQ Assessment			TBD

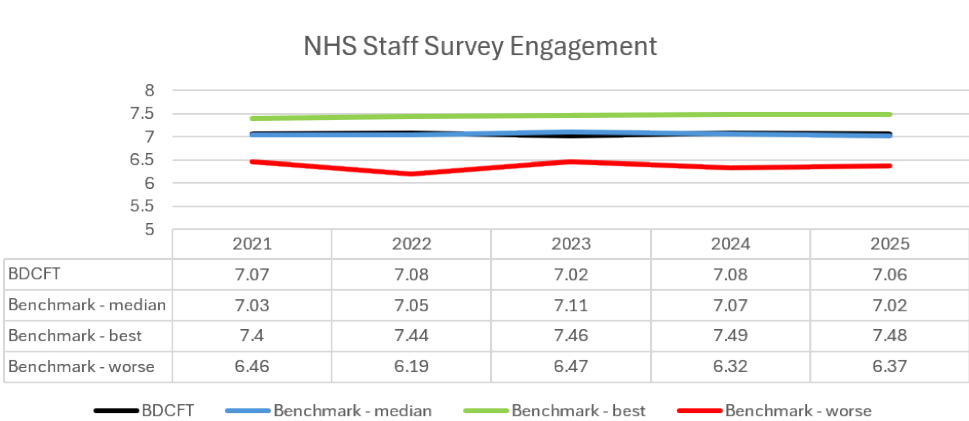
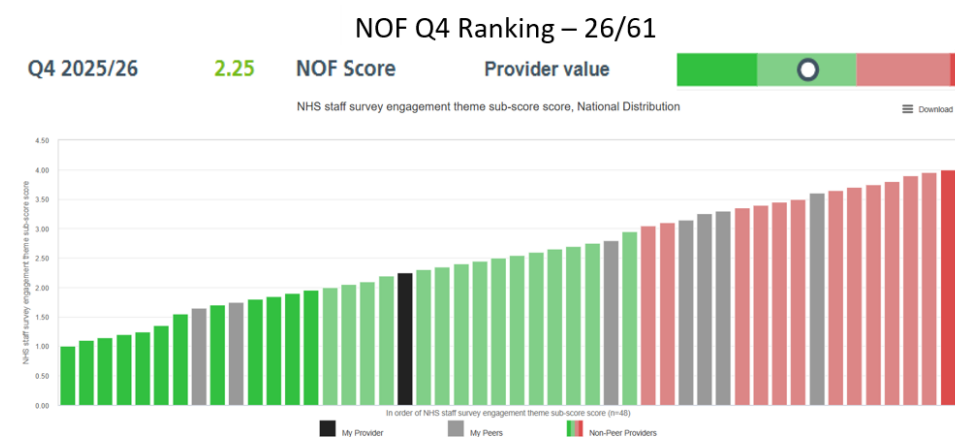


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
The measure is important because it is a measure of the Trust's costs against national average costs. This is an annual return submitted in July each year following the financial year. An index of over 100 shows that the Trusts costs are in excess of national average. The currencies used for this submission form the basis of the Deconstructing the Block (DtB) exercise.	Based on 24/25 data submitted, the Trust is at 107 (where 100 is the average). This is broken down into Mental Health 119 and Community 82. Data quality and capture are issues that affect performance as well as different service models. The accurate use of national currencies is a risk due to missing data to enable appropriate classification. The Trust has currently 31% of activity in unclassified or other categories.	The Data Quality Group is focusing on priority areas to improve data quality/ capture and to understand warranted differences to the national averages. We are developing Activity Based Budgeting to ensure that we can demonstrate that the resources are allocated fairly and align to service delivery. Delivery of the Trusts CIP programme is fundamental to ensure that costs are reduced to bring costs in line with national averages.	In 2027/28 it is expected that Mental Health & Community Trusts will move towards an activity-based funding model. The current assessment indicates that the Trust will lose c£26m of income. A regional approach is being taken to ensure that issues with the DtB exercise are consistently understood, and actions can be taken to remedy. Focus remains on improving data quality to ensure that the Trust is paid adequately for the services it delivers.

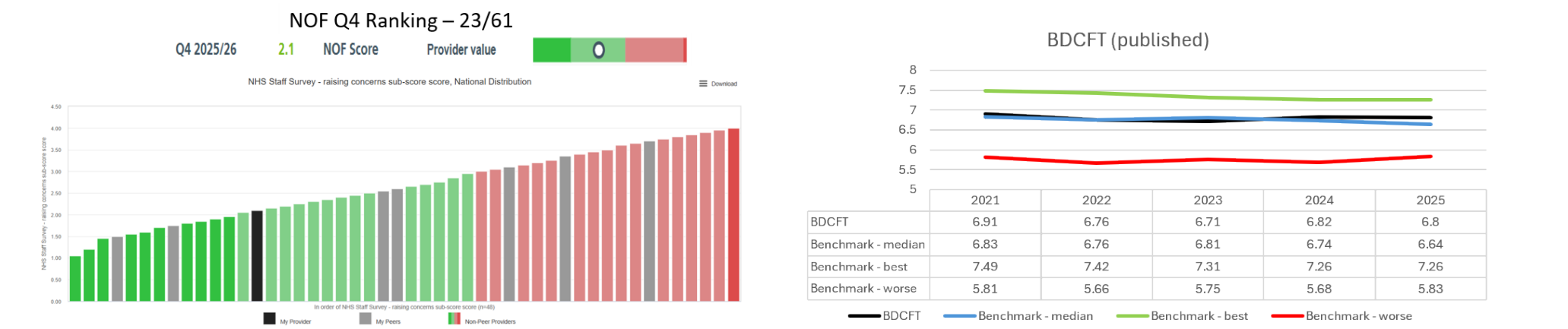
Appendix 3 – Annual Measures

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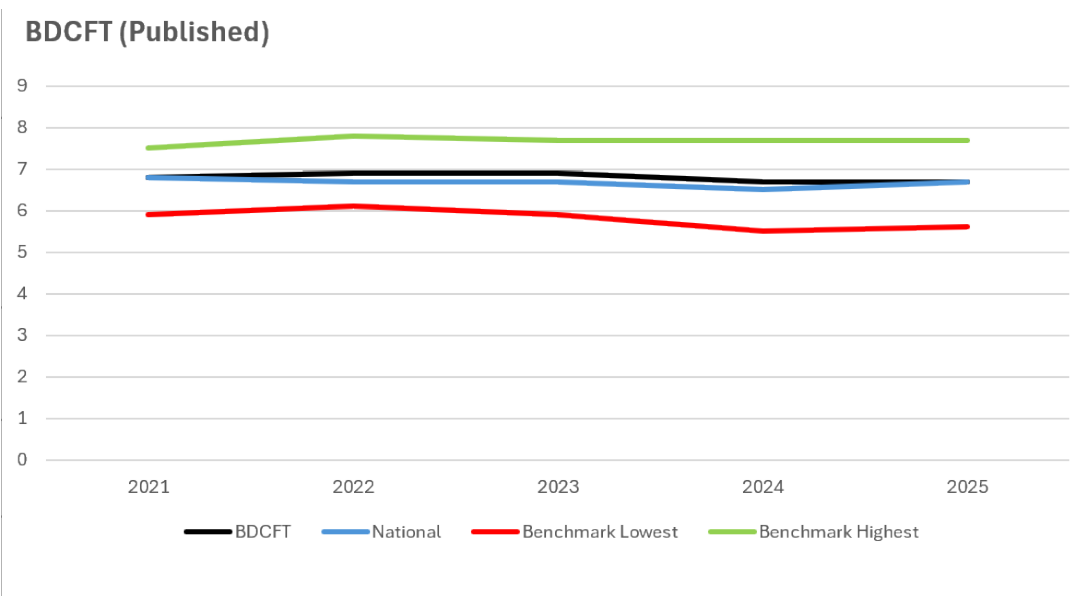
Measure: NHS Staff Survey Engagement Sub Score	Accountable Exec: Jo Harrison	Author: Naomi Fernandez
Domain: People	NOF: Yes	DQ Assessment
Target:	Actual: 7.06	TBD
Data Period: 2025		



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
The Staff Engagement Score - Staff Survey provides a vital measure of staff experience, which is known to be crucial to service-user outcomes and high-quality care. The score forms an essential element in our quarterly NOF rating; and other staff survey elements will contribute to the upcoming NHS Staff Standards scoring. The Staff Engagement score is calculated from answers to 9 questions around motivation, involvement and advocacy. The 2025 Staff Engagement Score demonstrate a consistent performance over the last 5 years, and an above benchmark median score in 4 of the 5 years, including 2024 and 2025. The scores also contribute to an improving and above benchmark NOF rating for this quarter.	Ensuring all staff have a voice that count remains a key priority in our People Strategy. Providing inclusive and compassionate workplace culture and leadership remain central to our People, Management and Development, and Belonging (EDI) Strategies. The recent Better Lives Strategy refresh consultation demonstrates commitment to effective engagement. The upcoming 2026 NHS annual Staff Survey will provide an updated measure of staff engagement score. In addition, quarterly pulse surveys provide anecdotal evidence that scores remain on track.	Continue with plans to engage with all staff and continue work with managers and teams across the Trust. Ensure we continue to show we are listening to staff voice and actioning improvements to drive change in areas they raise. To continue with the staff survey world cafes introduced in 2026 to provide managers and teams with their personalised team reports on their team staff survey results. Provide space and opportunity to get accessible reports and analysis – to listen, reflect and intentionally plan improvements at team level.	Effective engagement and commitment to staff voice and experience requires commitment at all levels of the Trust. Outside factors such as national policies and pressures effect staff motivation and advocacy, alongside internal issues such as staffing levels. The Trust must continue to optimise listening, action and feedback in relation to staff voice; and all managers should avail of learning opportunities to increase leadership competencies in this area.



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Supporting narrative under development			



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Supporting narrative under development			

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Board of Directors – Meeting held in Public

10 September 2026

Paper title:	Board Assurance Framework	Agenda Item 17.1
Presented by:	Phil Hubbard - Director of Nursing, Professions & Care Standards Fran Stead - Trust Secretary	
Prepared by:	Holly Close, Senior Corporate Governance Officer	
Committees where content has been discussed previously	Quality and Safety Committee Mental Health Legislation Committee People and Culture Committee Finance and Performance Committee Audit Committee Executive Management Team	
Purpose of the paper Please check ONE box only:	☒ For approval ☐ For information ☐ For discussion	

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

Good governance	Governance, accountability & oversight	X
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Purpose of the report (50 words)

The purpose of this report is to present and provide an update on the Board Assurance Framework (BAF). The BAF is a Board-owned tool which provides assurance regarding the delivery of the Trust's strategic priorities and supports effective decision-making and strategic risk management. The BAF supports a proactive approach to identifying risks and opportunities, promotes a "no surprises" culture, and helps to inform agenda planning by focusing discussion on areas of greatest strategic importance and value.

Executive Summary (100 words)

Following the redesign of the Integrated Strategic Performance Report into the Integrated Strategic Performance and Quality Report, a review of the Board Assurance Framework (BAF) was undertaken to strengthen the Trust's strategic assurance arrangements and align the framework to the Strategic Risk Register and Better Lives Together strategy. The review identified opportunities to improve assurance processes, governance arrangements, reporting and accountability. As a result, the BAF will be reported separately to the Board on a quarterly basis. Further quality improvement work is planned, with progress monitored through a development plan and reported regularly to the Board and Audit Committee.

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:

- Approve and be assured the refreshed Board Assurance Framework reporting arrangements.
- Note the current assurance position, as presented to the Board Committees aligned to the current Standard Operating Procedure.
- Support the continued development of the Board Assurance Framework and Strategic Risk Register through the proposed improvement programme and action plan.
- Note that the agreed improvement actions will continue to take place to add value and remove waste from the Board Assurance Framework process.

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:

- N/A

Care Quality Commission domains Please check <u>ALL</u> that apply	☒ Safe ☒ Effective ☒ Responsive ☒ Caring ☒ Well-Led
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

10 September 2026

Board Assurance Framework

1 Purpose

The purpose of this report is to provide an update on the Board Assurance Framework (BAF). The BAF is a Board-owned tool which provides assurance regarding the delivery of the Trust's strategic priorities and supports effective decision-making and strategic risk management. The BAF supports a proactive approach to identifying risks and opportunities, promotes a "no surprises" culture, and helps to inform agenda planning by focusing discussion on areas of greatest strategic importance and value.

2 Background

In 2022 the Board agreed that the Board Assurance Framework would form part of the Integrated Strategic Performance Report (ISPR) to support integrated strategic thinking. In Spring 2025, an external Well Led Development Review took place, which suggested consideration be given to positioning and linkages of the Board Assurance Framework. Noting how it is connected to the 'Strategic Risk' process.

At the Board Development Session on 30 April, a discussion took place on the ISPR, the report was redesigned as the Integrated Strategic Performance and Quality Report (ISPQR), bringing together performance, quality, workforce, finance and productivity metrics into a single reporting framework. It was also agreed by the Board that the BAF would be removed from the ISPQR. This is version 1 of the new reporting arrangements, which will be an iterative process in support of quality improvement. Ongoing developments will continue to be reported.

3 Quality improvement: BAF review 2026, adding value and removing waste

Following the review and redesign of the Integrated Strategic Performance Report (ISPR) into the Integrated Strategic Performance and Quality Report (ISPQR), it was recognised that further opportunities existed to strengthen the Trust's strategic assurance arrangements. As part of this work, the Board Assurance Framework (BAF) was reviewed to ensure it remained aligned to the Trust's strategic priorities, Strategic Risk Register (SRR), and emerging Better Lives Together strategy, whilst supporting effective Board oversight and decision-making. In addition, the BAF has been separated from the ISPQR and will now be reported to the Board on a quarterly basis, enabling greater focus on strategic assurance, risk and governance matters.

The review was delivered through a two-stage approach.

Stage 1: Existing Process Review

The first stage focused on understanding the effectiveness of the existing arrangements and identifying opportunities for improvement. This included:

- Discussions with colleagues involved in the current BAF process.
- Discussion at a Board Development Session regarding the development of the ISPQR and BAF reporting arrangements.
- Benchmarking against approaches adopted by other organisations.
- Discussions and analysis with Internal Audit.

The review identified a number of opportunities for improvement, including:

- Standardised application of assurance ratings.
- Development of new process to support 'stand alone' reporting arrangements (not in ISPQR).
- Alignment of the BAF with the Strategic Risk Register (SRR).
- Alignment with the Better Lives Together strategy refresh.
- Corporate Governance support process delivery (standardisation and independence).
- Confirmation of reporting arrangements to Corporate Governance meetings.
- Confirmation of executive ownership for strategic areas for assurance (accountable officers).

Stage 2: Quality Improvement of the BAF Framework

As an improvement organisation, the Trust recognises that assurance processes should continually evolve to reflect best practice and changing organisational needs. In line with the principle that "better never stops", a programme of ongoing quality improvement has been established to further strengthen the effectiveness of the BAF and wider strategic assurance arrangements.

Priority areas of focus include:

- Undertaking an effectiveness review informed by national guidance and best practice.
- Completing further benchmarking activity through Internal Audit.
- Continuing the standardisation of assurance processes and assurance rating application.
- Strengthening the use of the BAF to inform Board and Committee agenda planning.
- Reviewing and updating Committee work plans.
- Supporting the continued development of Audit Committee oversight arrangements.
- Refreshing the BAF and SRR Standard Operating Procedure.
- Reviewing guidance and supporting documentation to align with the Trust's ambition to be a high-performing organisation.
- Considering whole-system and partnership assurance arrangements.
- Developing an improvement plan for the BAF and SRR to monitor and track further enhancements through Audit Committee oversight.
- Using quality improvement methodology to support co-production of agreed improvements.

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The improvement activity will continue throughout 2026/27 and the Board will continue to receive quarterly updates on progress. A development and action plan will be developed to support the changes to the Board Assurance Framework arrangements.

4 Board Assurance Levels – September 2026

The assurance levels below represent the assessment under the existing BAF methodology and the current Standard Operating Procedure. The level highlights areas of strong assurance across organisational culture, governance and workforce priorities, whilst lower assurance levels continue to be reported in relation to access and flow, financial sustainability and estate-related priorities. These themes will be subject to ongoing monitoring through the refreshed BAF arrangements.

Being the Best Place to Work

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

Delivering Best Quality Services

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

Making Best use of resources

- Theme 1 – Financial Sustainability
 - o Confirmed assurance level by delegated Committee – **Low**

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

Best partner – measures & metrics to be agreed

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

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

5 Recommendation

The Board of Directors is asked to:

- Approve the refreshed Board Assurance Framework reporting arrangements.
- Note the current assurance position.
- Support the continued development of the Board Assurance Framework and Strategic Risk Register through the proposed improvement programme and action plan.
- Note that the agreed improvement actions will continue to take place to add value and remove waste from the Board Assurance Framework process.

Holly Close – Senior Corporate Governance Officer and Executive Support Team Manager

Fran Stead – Trust Secretary

September 2026

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Board of Directors – Meeting held in Public

10th September 2026

Paper title:	Better Lives Together Strategy Refresh 2026 - 31	Agenda Item 18.0
Presented by:	Farhan Rafiq, Director of Transformation, Improvement and Productivity	
Prepared by:	Catherine Sunter, Deputy Director of Performance, Planning and Insight Fran Stead - Trust Secretary	
Committees where content has been discussed previously	Board of Directors Executive Management Team Strategy Refresh Group	
Purpose of the paper Please check <u>ONE</u> box only:	☒ For approval ☐ For information ☐ For discussion	

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

Purpose of the report

The purpose of this report is to share with the Board the final draft refreshed Better Lives Together Strategy 2026 – 31 and Better Lives Together: Supporting Delivery Framework 2026 – 2031 for sign off by the board ahead of final sign off at the Annual Members meeting on Thursday 24th September.

Executive Summary

The Board holds legal responsibility and authority for setting the Trust strategy and the associated culture. In response to Better Lives Together (2023-2026) reaching its natural end point, work was established to support the development of a programme which was agreed as a strategy refresh. This has involved several colleagues from across the Trust, over a two-stage process. Strategy Refresh Group; Strategy Reference Group. On behalf of the Board, I would like to thank all colleagues who have been involved. The work has culminated in two things: creation of the Better Lives, Together (2026-2031) strategy document; creation of a supporting delivery framework for the same period. Both of which are presented as an update on progress to the Board, to provide assurance on refresh delivery, and for approval. The Board should note that this work is part of the Quality and Performance Management System, facilitated by the Care Trust Way. Consideration is being given to creating a model to learn about how the strategy is being delivered, impact and peoples experience. Which can be linked to external celebrations, such as NHS quality improvement week, and internal events taking place in associated periods.

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 content of this report and be assured on the refreshed delivery process
- Sign off the refreshed Better Lives Together Strategy 2026 – 31
- Endorse the proposed implementation approach
- Note the connection to the new Quality and Performance Management System and the Board endorsed mobilisation plan/actions
- Support the formal launch of the strategy at the Annual Members' Meeting 2026 and future plans to celebrate quality improvement and strategy delivery
- Be assured that following approval, work will take place across the Trust to update reference to the new strategic framework

- Be assured on the pre-agreed improvement work taking place on Alert, Advise, Assure and Decision reports; Strategic Risk reporting; and Board Assurance Framework reporting in support of adding further value and removing waste

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: • N/A	
Care Quality Commission domains Please check <u>ALL</u> that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led
Compliance & regulatory implications	The following compliance and regulatory implications have been identified as a result of the work outlined in this report: • Insightful Board • Trust Constitution • Well Led • Provider License • NHS Act 2006 • Health and Social Care Act 2012 • Health and Care Act 2022	

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Board of Directors – Meeting held in Public

10th September 2026

Better Lives Together Strategy Refresh 2026 - 31

1 Purpose

The purpose of this paper is to request sign off from the Board for the refreshed Better Lives Together Strategy 2026 – 2031. This is following an intense period of strategy development that commenced in April 2026 that has included engagement with staff members, partners, service users and several development sessions with the Board.

The overarching strategy is made up of two documents that Board members have received:

1 – Better Lives together Strategy Document that sets out our shared direction for the next five years. It describes the needs of our population, what our colleagues, communities and partners have told us, the choices we have made and the difference we want people to experience by 2031.

2 – Better Lives Together: Supporting Delivery Framework 2026 – 2031 that explains how Bradford District Care NHS Foundation Trust will translate the ambitions and priorities in Better Lives Together: Our Strategy 2026–2031 into delivery. It provides the next level of detail, including our Values and Behaviour Compact, strategic delivery priorities, breakthrough programme outcomes, foundations for delivery, connected strategies, and the arrangements through which progress will be planned, measured, assured and reviewed.

These documents should be read alongside each other.

2 Background

The refresh of the Better Lives Together Strategy was driven by the significant changes in the environment in which BDCFT now operates. Rising demand, financial pressures, workforce challenges and ongoing NHS reform mean that traditional service delivery approaches are no longer sufficient to meet the needs of our communities. At the same time, our role within the Bradford District and Craven system has evolved, with greater expectations for collaboration, system leadership and collective impact. The refresh provided an opportunity to build on the strengths of our existing strategy while responding to lessons learned from the previous strategy which included, sharpening our focus on the outcomes that matter most, and ensuring our limited resources are directed where they can have the greatest benefit for our population, our people and our partners. By aligning our strategic priorities more explicitly with the Care Trust Way, the aim was to strengthen our delivery, accountability and continuous improvement approaches ensuring we can understand if the strategy is having an impact and why.

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The strategy is grounded in the outputs from engagement with over 500 staff, service users, their families and carers. Specific engagement was also undertaken with our partners. Outcomes from this engagement was taken, synthesised and played back to over 100 staff who validated our proposed revised approach. Feedback from Board sessions that were held May, June and July have also significantly contributed to the approach that has been taken. The work has been overseen by a Strategy Refresh Group, bringing together subject matter experts across clinical, corporate services, including communications and engagement and quality improvement. A Strategy Reference Group was also formed to support delivery, capitalising on professional expertise and experience of a broader group of colleagues, with a focus on co-producing this work and ensuring connectivity to the supporting strategies.

Through engagement with colleagues, people using our services, carers, partners and the Board, a consistent message emerged. People wanted fewer priorities, greater clarity, stronger follow-through and clearer evidence that change is making a difference. We have also looked to understand those things that have perhaps held our strategies back from being as impactful as they could have been in the past and agreed ways in which those things can be addressed.

Therefore, the refreshed strategy makes several deliberate choices:

- Focusing on fewer priorities and concentrating our effort where it will have the greatest impact.
- Becoming clearer about what we will do less of, creating capacity for what matters most.
- Focusing on outcomes, experience, impact and how things 'feel' for our colleagues and people using our services, not simply activity and performance.
- Aligning delivery through our organisational improvement methodology the 'Care Trust Way', creating a single approach to planning, improvement, performance and accountability.
- Concentrating leadership attention and investment on a small number of breakthrough programmes that address our most significant opportunities and risks.
- Committing to listen, learn and adapt continuously, ensuring the strategy remains relevant as circumstances change.
- Focussed on our people owning the strategy and feeling empowered to make the ambitions a reality.

The Care Trust Way will be used to embed continuous improvement, co-production and learning in everything we do. Above all, this strategy is designed to help us turn ambition into action and demonstrate visible improvements for our people, our communities and our partners.

Insight continues to feature strongly within the Trust, with intentional ways of gather experience taking place throughout the development. Consideration of future engagement and involvement will be considered as part of the mobilisation of the Quality and Performance Management System.

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This is what it means to one individual who was part of the consultation process for the strategy:

“Meaningful involvement is about more than being given a voice, it is about knowing that voice has been heard, valued and has the power to influence change. Involvement has shown me that good healthcare is not only about what we can do for people, it is about what becomes possible when we are courageous enough to listen to them”.

Assurance and oversight

The Alert, Advise, Assure and Decision framework, the Board Assurance Framework, and the Strategic Risk framework will continue to be utilised as key tools for the Board and wider organisation. As an improvement and learning organisation, review of existing processes will continue to take place to ensure effectiveness, creating opportunities to add value and remove waste. The Corporate Governance Team are leading this review, which will be co-produced using improvement methodology. Further updates on the improvements within these areas will be presented to the Board. Key metrics from the strategy will be embedded into the ISPQR (Integrated Strategic Performance Report)

Launching the Strategy

Following on from the engagement period the steering group have continued to communicate regularly across the Trust to feedback on what was heard and how we are responding to this. This activity will continue and will form the developing Quality and Performance Management Systems.

In discussion with the Trust Secretary, Chief Executive, and Chair, it has been agreed that the refreshed strategy is officially launched as part of the Annual Members Meeting 2026.

The next step in terms of implementation will be to hold an engagement session at the Leading Better Lives Together workshop in September to co design the approach to development of annual plans and embedding strategic priorities into team objectives and appraisals with the aim of ensuring everyone in the organisation understands the important role that they can play in successfully implementing the strategy.

Future Celebrations

As a learning and improvement organisation, culturally, it is important to ensure purposeful opportunity to review, reflect and recognise impact and peoples experience. To support this, discussion has begun to scope out opportunity for regular celebration events, building on existing arrangements. This will consider alignment to national celebrations, such as the NHS annual quality improvement week (14 – 18 September 2026), how the Trust could have an annual celebration event to learn from others on how the strategy has been delivered, improvement activity and peoples experience. We will consider how this could be aligned to existing events, such as the Annual Members’ Meeting. Further information, including ways Board members can be involved, will be shared.

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3 Ask of the board

The Board of Directors is asked to:

- Note the content of this report and be assured on the refreshed delivery process
- Sign off the refreshed Better Lives Together Strategy 2026 – 31
- Endorse the proposed implementation approach
- Note the connection to the new Quality and Performance Management System and the Board endorsed mobilisation plan/actions
- Support the formal launch of the strategy at the Annual Members' Meeting 2026 and future plans to celebrate quality improvement and strategy delivery
- Be assured that following approval, work will take place across the Trust to update reference to the new strategic framework
- Be assured on the pre-agreed improvement work taking place on Alert, Advise, Assure and Decision reports; Strategic Risk reporting; and Board Assurance Framework reporting in support of adding further value and removing waste

Catherine Sunter – Deputy Director of Performance, Planning and Insight

Fran Stead - Trust Secretary

27/08/2026

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Better Lives, Together:

Our Strategy 2026–2031

Our shared direction for
improving health, reducing
inequalities and creating better lives
across Bradford District and Craven.



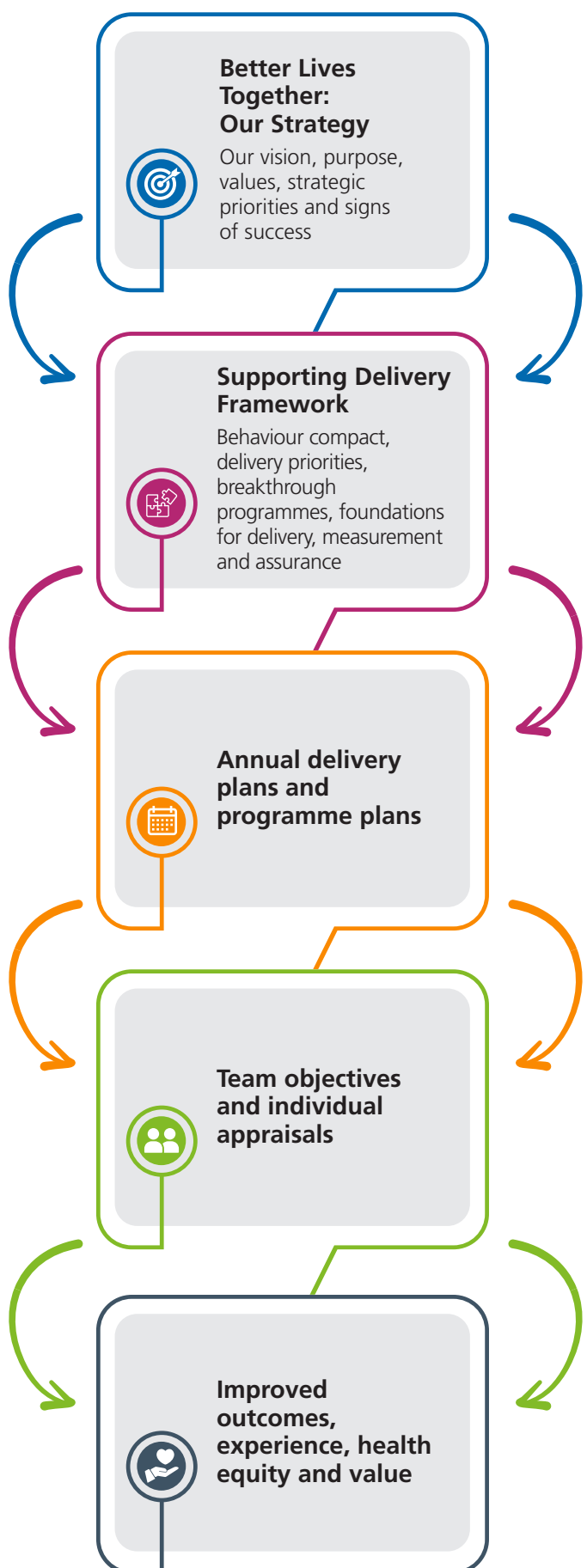
Better Lives Together: Our Strategy 2026–2031 sets out our shared direction for the next five years. It describes the needs of our population, what our colleagues, communities and partners have told us, the choices we have made and the difference we want people to experience by 2031.

This strategy should be read alongside Better Lives Together: Supporting Delivery Framework 2026–2031. The Framework provides the next level of detail, including our values and behaviour compact, strategic delivery priorities, breakthrough programme outcomes, foundations for delivery, connected strategies, and the arrangements through which progress will be planned, measured, assured and reviewed.

The two documents have distinct but connected purposes:

- ✓ Our Strategy sets the direction and defines success.
- ✓ The Supporting Delivery Framework translates that direction into delivery.
- ✓ Annual delivery plans, programme plans and team objectives will set out the actions, ownership, milestones and measures required each year.

Together, they create a clear golden thread from our vision and strategic priorities to the everyday work of teams and the experiences and outcomes of the people and communities we serve.



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1. Foreword from the Chief Executive and Chair

At Bradford District Care NHS Foundation Trust (BDCFT), we are proud to serve the people and communities of Bradford District and Craven (BDC). Every day, our colleagues, volunteers and partners make a difference through compassionate care, support and early intervention, helping people live healthier and more independent lives.

Better Lives Together remains the right long-term ambition for our Trust, but the context in which we deliver it continues to evolve. People's needs are becoming more complex, health inequalities remain significant, demand is growing and resources are under increasing pressure. At the same time, people rightly expect care that is easier to access, more joined-up and centred on what matters most to them.

This strategy refresh has been shaped by what our communities, colleagues and partners have told us. The people who use our services, carers and families, have also contributed, particularly on access, communication, coordination and support on 'waiting well'. While there is strong support for our direction of travel, there is a clear expectation that we focus on what matters most, demonstrate visible progress and show how change is improving people's lives. As a result, this strategy is more focused, more measurable and more explicit about the choices we need to make. We cannot do everything. We must concentrate our effort where it will have the greatest impact, create more time for care, make the best use of our resources and strengthen partnership working across BDC.

Reducing health inequalities is the golden thread that runs throughout this strategy. Alongside this, we remain committed to supporting our workforce, improving access and experience, delivering high-quality care and using our resources responsibly to achieve the greatest benefit for our communities.

Most importantly, this strategy is as much about how we will deliver change as it is about what we want to achieve. Our accompanying Supporting Delivery Framework explains how our priorities, breakthrough programmes, annual planning and measures will work together. Through the Care Trust Way and our Quality Performance and Management System, we will create a clear line of sight between our ambitions, the work of our teams and the outcomes experienced by the people we serve.

Success will not be measured by this document, but by the difference it makes: whether people experience more responsive and coordinated care; whether colleagues feel supported, valued and able to thrive; and whether, together with our partners, we improve health and reduce inequalities across our communities.

Better Lives Together is more than a strategy. It is our commitment to deliver better health, reduce inequalities and create lasting benefits for the people and communities we serve.



Sarah Jones,
Chair



Therese Patten,
Chief Executive



2. About us

2.1 Who we are

At BDCFT, we are proud to support people across our communities at every stage of life, from before birth to end of life. We provide a wide range of services, including mental health, learning disability, community and specialist dental services, alongside children's public health services for people of all ages across Bradford, Airedale, Wharfedale and Craven.

Supporting the health and wellbeing of our communities is a privilege. Every day, we have the opportunity to make a meaningful difference by helping people stay well for longer and providing high-quality care and treatment when it is needed most.

We are committed to designing services that are accessible, inclusive and responsive to the diverse needs of our communities. This means working closely with partners across health and care, understanding the wider factors that influence health and wellbeing, and providing joined-up, person-centred care. Co-production is central to this approach, ensuring people using our services help shape design and improvement.

Our colleagues are at the heart of everything we do. More than 3,000 clinical and non-clinical colleagues bring dedication, compassion and expertise to the services we provide every day. Together, we are united by a shared purpose: to care for, support and improve the lives of the people and communities we serve.

We oppose racism and all forms of discrimination. As a mental health and community provider, we recognise our responsibility to tackle structural inequalities, create a culture where everyone can bring their whole selves to work, and provide the conditions our colleagues need to deliver safe, high-quality care.





2.2 Our colleagues at the Trust

Our colleagues are our most important asset. Their skill, compassion and commitment enable us to care for

our communities every day and deliver our ambition to improve health and wellbeing across BDC.

Our workforce at a glance:



Together, our colleagues make the difference.



2.3 Our population

We serve a population of more than 647,000 people across Bradford, Airedale, Wharfedale and Craven, covering 595 square miles of vibrant urban and rural communities. Our population is one of the most diverse in the country, with more than 100 languages spoken. This diversity is a strength, but it also requires services to be accessible, inclusive and responsive to different needs. We provide over 1,000 hours of interpreting support each month to help people access our services.



Our population at a glance*

Headline figures*

647,000+ people served

595 square miles

100+ languages spoken

1,000+ interpreting hours every month

Changing population

27% increase in people aged 65+ by 2040

53% increase in people aged 85+ by 2040

Greatest growth in Shipley, Keighley and Craven

Health profile

51% relatively healthy

38% living with long-term conditions

30% of ill health linked to lifestyle factors

1 in 3 people living in poverty

*Bradford District and Craven Health and Care Partnership strategy, Our plans for health care and wellbeing in Bradford District and Craven, published September 2025.



2.4 Our partnerships

The future health and wellbeing needs of BDC cannot be met by any organisation acting alone. Delivering better outcomes, reducing inequalities and improving the experience of care requires stronger partnership working across health, care, communities and the voluntary sector.

As a mental health, community, learning disability and children's services provider, we play a unique role in connecting services, supporting prevention and helping people access coordinated support closer to home.

Through this next phase of our Better Lives, Together Strategy, we will strengthen how we work with communities, carers, local authorities, primary care, NHS providers and Voluntary Community and Social Enterprises (VCSE) partners to design services around people rather than organisations. This will help create simpler pathways, smoother transitions and more joined-up care.

People told us they want stronger collaboration, more community-based support and clearer evidence that partnerships deliver real improvements. This strategy responds directly to that feedback.

2.4.1 Joint strategic ambition

In 2026, Airedale NHS Foundation Trust, BDCFT and Bradford Teaching Hospitals NHS Foundation Trust agreed a shared strategic ambition for BDC. This represents a commitment to work more closely together to improve outcomes, reduce inequalities and use public resources more effectively for the benefit of our population.

Over the last decade, we have worked on joint clinical pathways, shared improvement initiatives and collaborative programmes to integrate services and demonstrate what we can achieve to improve value and outcomes for our patients when we act as one system.

We are proud of this progress and are committed to building on it and going further. This commitment is underpinned by a shared set of values across our three organisations, including a focus on improving outcomes for our population, reducing health inequalities, working collaboratively, and using public resources responsibly.

These shared principles provide the foundation for how we lead, make decisions and work together as a system. This strategic ambition is therefore a commitment to deepen our organisational collaboration and integration that will help inform each of our respective corporate strategies for the next five years.

Our ambition is also aligned to the UK's 10-Year Health Plan for England, which calls for care to move closer to communities, greater use of digital technology and a stronger focus on prevention. Together, these shifts reinforce the direction we are already taking across BDC.

Our shared approach across BDC reflects these national priorities, translating them into practical, place-based action that improves outcomes, experience and sustainability for our population. Over time, this direction of travel also aligns with emerging national thinking on more integrated delivery models, such as Integrated Health Organisations, while recognising that BDC is at an early stage of this journey.

Over the next five years, we will strengthen our collaboration by aligning our priorities, coordinating our services more effectively, and removing duplication where it exists. This will include sharing expertise, data, and innovation to improve outcomes and experiences for the people and communities we serve.

Through changes to the local NHS commissioning arrangements, we also have the opportunity to work together to lead the local health and care system, overseeing key operational and improvement work, role modelling behaviours, and speaking a unique voice with other strategic partners so we can more effectively meet the collective challenges ahead.

2.4.2 Bradford District and Craven health, care and wellbeing strategy

In 2025, the Bradford District and Craven Health and Care Partnership launched its Health, Care and Wellbeing Strategy, setting out the shared ambitions of partners to improve health and wellbeing and reduce inequalities across our communities.

As national arrangements continue to evolve, Place Provider Partnerships (PPP) are expected to play an increasingly important role in coordinating delivery of this ambition from 2027 onwards. Delivery of the Health, Care and Wellbeing Strategy at place level will depend on organisations aligning their strategies and delivery plans, working collectively and holding one another to account for progress. Strong partnership with primary care, local authorities, communities and the voluntary, community and social enterprise sector will be essential, particularly in supporting prevention, early intervention and tackling inequalities.

Through existing partnership arrangements, organisations across Bradford District and Craven are already working together on a number of shared priority programmes that support delivery of the Health, Care and Wellbeing Strategy. These programmes provide a practical foundation for strengthening collaboration now whilst helping shape the future development of place-based partnership arrangement.



2.4.3 Building on what we are already doing

Across Bradford District and Craven, partners are already working together on a number of shared priority programmes that support delivery of the Health, Care and Wellbeing Strategy. These programmes bring organisations together around common challenges and opportunities, focusing collective effort on areas where collaboration can have the greatest impact on outcomes, experience, health inequalities and the long-term sustainability of health and care services.

Cross-partnership strategic delivery groups are established for each priority programme, bringing together expertise from across partner organisations to coordinate activity, support delivery and drive improvement. These programmes will continue to evolve as partnership working develops and will help provide a strong foundation for emerging Place Provider Partnership arrangements from 2027 onwards.



Airedale and Bradford Collaboration of Acute Services (ABCAS)

Acute care and hospital sustainability



Integrated Neighbourhood Health Care (INH)

Closer to home



Corporate Services Review (CSR)

Efficiency and sustainability



Children & Young People (CYP)

Earlier intervention and better outcomes



Healthy Minds (HM)

Mental wellbeing and prevention



Together, these programmes demonstrate how partnership is already being translated into practical action. Through collaboration across NHS organisations, primary care, local authorities, VCSE partners and local communities, they provide a practical mechanism for delivering shared priorities and improving outcomes for the people of Bradford District and Craven. As Place Provider Partnerships develop, these programmes will continue to play an important role in turning shared ambition into measurable improvement for our population.

Workstream	Purpose	Why it matters
Airedale and Bradford Collaboration of Acute Services (ABCAS)	Integrating acute services across Bradford and Airedale, improving hospital performance, sustainability and planning for the future Airedale Hospital.	Supports better patient flow, improved access to acute care and the long-term sustainability of local hospital services.
Integrated Neighbourhood Health (INH)	Bringing together primary care, community services, mental health, social care and VCSE partners to deliver coordinated neighbourhood-based care.	Helps people receive more proactive, joined-up care closer to home whilst reducing inequalities and avoidable hospital use.
Corporate Services Review (CSR)	Reviewing corporate and support services across organisations to reduce duplication and improve efficiency.	Releases resources for frontline care and supports the long-term financial sustainability of the health and care system.
Children and Young People (CYP)	Aligning services across organisations to improve outcomes, strengthen prevention and provide more joined-up support for children and families.	Improves lifelong outcomes, tackles inequalities early and reduces future demand on health and care services.
Healthy Minds (HM)	Improving mental health and wellbeing through prevention, early intervention and integrated support across NHS, local authority and VCSE partners.	Supports earlier access to mental health support, reduces crisis presentations and improves wellbeing across communities.

Together, these programmes demonstrate how partnership is already being translated into practical action. Through collaboration across NHS organisations, primary care, local authorities, VCSE partners and local communities, they provide a practical mechanism for delivering shared priorities and improving outcomes for the people of Bradford District and Craven.

As Place Provider Partnerships develop, these programmes will continue to play an important role in turning shared ambition into measurable improvement for our population.

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2.4.4 Place Provider Partnerships

As part of the changes to the commissioning landscape, by April 2027, all local areas in England, covering populations of around 500,000 are being urged to form PPPs. These partnerships will take on some of the commissioning, governance and leadership responsibilities that were once held by NHS Integrated Care Boards. The PPP will work alongside primary care, local authorities, VCSE and a range of healthcare support organisations as key partners in delivering integrated, preventative and communitybased care, particularly through Integrated Neighbourhood Health, and Children and Young People pathways.

The PPPs matter because they will offer NHS organisations a practical way to lead change at the scale where people experience care. They are a forum where providers can align their decisions, pool their strengths, and act with a single purpose for a defined population. The PPP will give organisations a structured way to respond to these pressures collectively, rather than individually absorbing risk and cost.

While NHS providers will play a central leadership role within PPP, success will depend equally on strong collaboration with primary care, local authorities, VCSEs organisations, and the communities we serve. The most sustainable improvements in health and wellbeing will come from collective action across all partners, bringing together clinical expertise, community insight and local assets to improve outcomes and reduce inequalities.

That shift - from organisations working side by side to providers shaping a shared system of care - opens opportunities that individual organisations cannot unlock alone.

Some of these opportunities include:

- Shared data and insight.
- Joint engagement and co-production.
- Shared workforce solutions.
- Estates and digital infrastructure.
- Efficient use of resources.
- Innovation at scale.

Partnership outcomes by 2031

- More care closer to home.
- Reduced inequalities.
- A more sustainable NHS.
- Organisations planning and innovating together.
- Stronger place-based leadership.

This matters because partnership is not simply about meetings, structures or shared intentions. It will shape how we plan services, how we make decisions, how we use our people and resources, and how we work with others to improve care.

Ultimately, partnership is how we will deliver Better Lives Together. It is how we will improve health, tackle inequalities and create a more sustainable future for our communities. Over the life of this strategy, we will expect services to think beyond organisational boundaries, focus on what matters most to people, and demonstrate how working with partners is making care easier to access, better coordinated and more responsive.

Our success will not be measured by the strength of our relationships alone, but by the difference those relationships make to the lives of the people we serve.

This reflects what our people, population and partners told us throughout the strategy refresh: a desire for clearer links between ambition and delivery, visible follow-through, and practical improvements in access, coordination and responsiveness.

2.5 Our why – reducing health inequality

Reducing health inequality is the golden thread that runs throughout everything we do.

Health inequalities are unfair and avoidable differences in people's health, access to services, experience of care and outcomes. Identifying and addressing these inequalities is essential if we are to improve health and wellbeing across BDC.



The challenge

- 8 years difference in female life expectancy.
- 10 years difference in male life expectancy.
- 23 years difference in female healthy life expectancy.
- 20 years difference in male healthy life expectancy.



What drives inequality?

- Housing.
- Education.
- Income and poverty.
- Environment.
- Access to services.



Our response

- Equity in access, experience and outcomes.
- Inclusive service design and co-production.
- Prevention and early intervention.
- Partnership working on wider determinants.
- Data, evidence and insight-driven improvement.

2.5.1 Delivering social value

Delivering social value also supports in reducing health inequality.

As a major local employer, partner and anchor institution, we have a wider responsibility to understand and increase the social value we create for BDC. This means looking beyond the direct delivery of services and being clearer about the broader benefit created through how we employ, procure, use our estate, support volunteering, work with the VCSE sector, reduce our environmental impact and strengthen local communities.

Over the life of this strategy, we will strengthen how we define, measure and report social value, building on existing work to develop a Trust-wide position. This will help ensure that social value is not treated as an additional activity, but as part of how we make decisions, use our resources and demonstrate the wider impact we create for our communities.

'Meaningful involvement is about more than being given a voice; it is about knowing that voice has been heard, valued and has the power to influence change. Involvement has shown me that good healthcare is not only about what we can do for people; it is about what becomes possible when we are courageous enough to listen to them.'

Involvement partner

3.0. Why refresh our strategy and what will be different?

3.1 Why refresh our strategy



Our Trust has a strong foundation, shaped by our purpose, values and commitment set out in Better Lives, Together. Since its launch, we have achieved a great deal. However, the needs of our communities, workforce and the wider health and care system continue to evolve, alongside changes in the national context, including the introduction of the 10 Year Health Plan.

Refreshing our strategy provides an opportunity to build on what is working, learn from experience and set a clear direction for the next five years. In a period of increasing demand and finite resources, we must focus our effort where it will have the greatest impact.

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Why refresh now?

National drivers

- 10 Year Health Plan.
- National quality strategy.
- Financial pressures.

What our communities told us

- Improve access.
- Better coordination.
- Visible delivery.

What our colleagues told us

- More time for care.
- Better workforce support.
- Less duplication.

What we need

- Greater focus.
- Clear priorities.
- Stronger accountability.

This refresh responds to these challenges whilst building on the strengths that already exist across our organisation and partnerships.

3.2 What makes this strategy different?

Whilst this strategy builds on the strengths of Better Lives Together, it is designed to be more focused, more deliverable and more accountable than previous strategies.

We have listened carefully to the views of colleagues, people using our services, carers, partners and our Board. A consistent message emerged: people wanted fewer priorities, greater clarity, stronger follow-through and clearer evidence that change is making a difference. We have also looked to understand those things that have perhaps held our strategies back from being as impactful as they could have been in the past and agreed ways in which those things can be addressed.



This strategy therefore makes several deliberate choices:

- We are focusing on fewer priorities and concentrating our effort where it will have the greatest impact.
- We are becoming clearer about what we will do less of, creating capacity for what matters most.
- We are focusing on outcomes, experience, impact and how things ‘feel’ for our colleagues and people using our services, not simply activity and performance.
- We are aligning delivery through our organisational improvement methodology the Care Trust Way (CTW), creating a single approach to planning, improvement, performance and accountability.
- We are concentrating leadership attention and investment on a small number of breakthrough programmes that address our most significant opportunities and risks.
- We are committing to listen, learn and adapt continuously, ensuring the strategy remains relevant as circumstances change.
- We are focussed on our people owning the strategy and feeling empowered to make the ambitions a reality.

We need to use the CTW to embed continuous improvement, co-production and learning in everything we do. Above all, this strategy is designed to help us turn ambition into action and demonstrate visible improvements for our people, our communities and our partners.



3.3 The journey we have been on to refresh our strategy

To be able to build on what is working and learn from our experiences it was essential that our colleagues and our service users, their carers and families along with our delivery partners and stakeholders were at the heart of our strategy refresh.

All elements of the strategy in this section have been developed using feedback from surveys, engagement sessions, drop-in sessions and meeting with teams to hear their thoughts on:

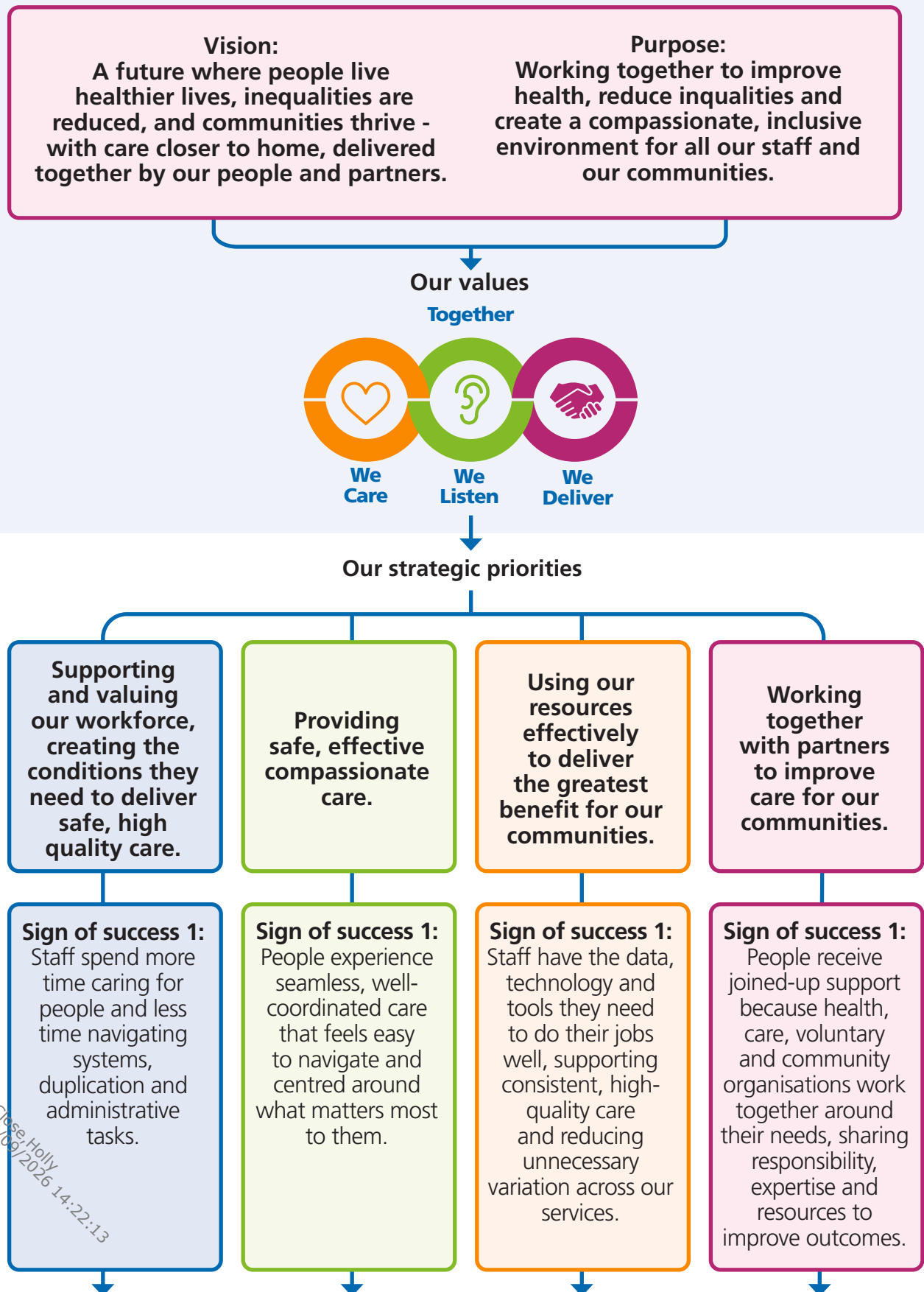
- Our vision and purpose.
- Our values and behaviour framework.
- Our strategic priorities.

Throughout this participative strategy engagement, a number of common themes emerged. The table following highlights the key things we heard and how they have been reflected in our strategy.

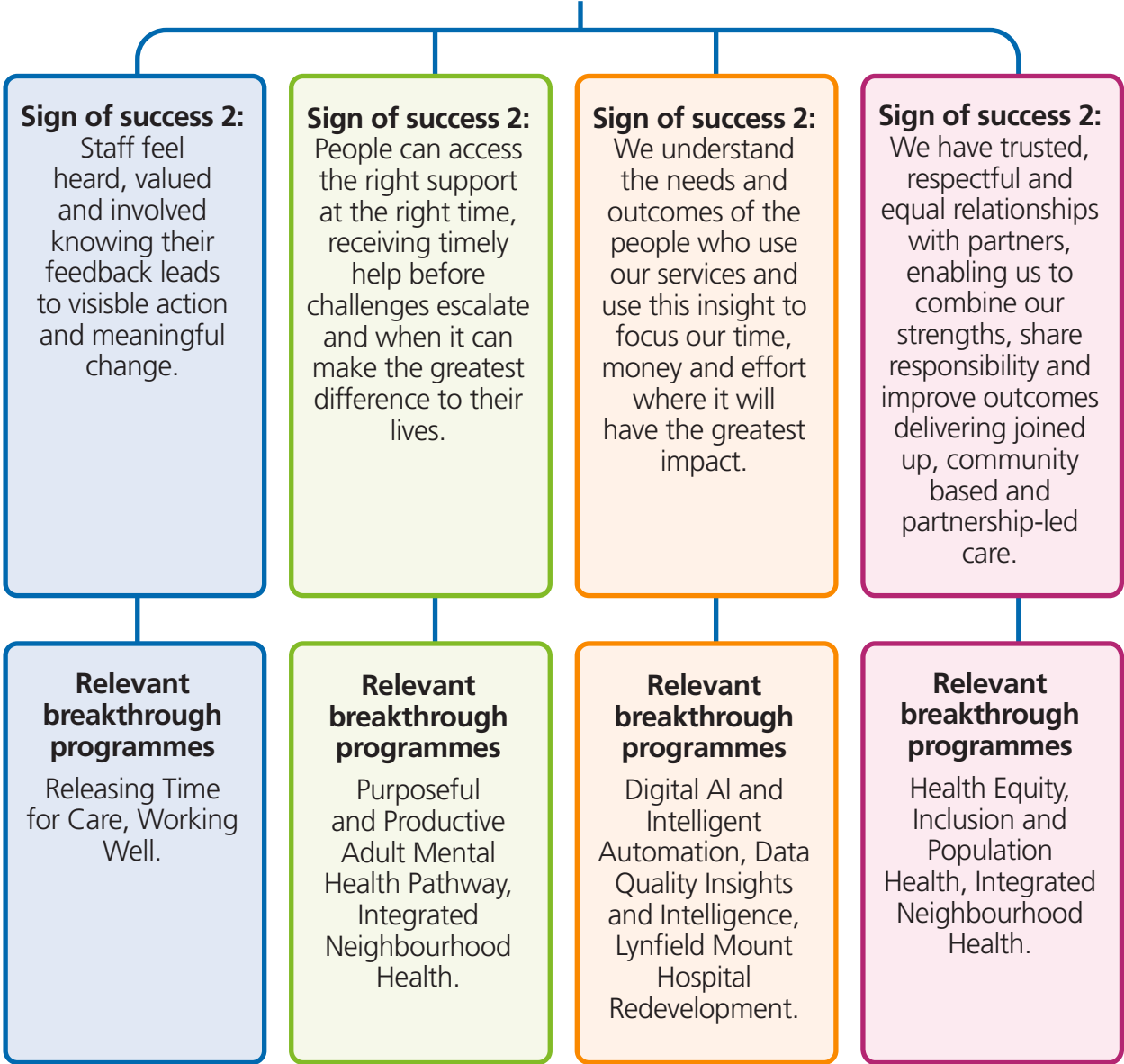
What we heard	What has changed
The strategy must be deliverable. 'How does the 'Better Lives Together' strategy translate into everyday experiences for both colleagues and service users?' Engagement session with colleagues	There are fewer priorities in this strategy and a focus on how delivery plans will be developed.
Workforce support is essential to successful delivery. 'A supported staff member will always provide a better service, a supported manager will always have a happier more productive workforce.' Colleague survey	Better supporting the workforce is our number one strategic priority.
Access, coordination and responsiveness are the biggest experience risks. 'All too often we are responding in crisis as needs have escalated.' Delivery partner survey	Addressing this challenge is the focus of our second strategic priority.
Listening is valued - but follow-through is inconsistent. 'We don't then always act on what we have heard.' Colleague survey	Our staff feeling listened to and heard through new mechanisms we are proposing along with existing mechanisms is one of our 'signs of success' that effectiveness of the strategy will be judged on.
Integration is a shared ambition - but not consistently experienced. 'I feel that the current system is fragmented and not particularly person-centred.' Engagement session with colleagues	Enhancing our work in partnership working is our fourth strategic priority.

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4.0. The core of our strategy



Our strategic priorities (continued)



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It sets out our:

- Vision and purpose.
- Our values.
- Our strategic priorities.
- Our signs of success that will tell us if we are making progress.
- Our breakthrough programmes of work – our vehicles for driving change.

Each of these elements are covered in this section.

4.1 Vision and purpose

Vision

A future where people live healthier lives, inequalities are reduced, and communities thrive, with care closer to home, delivered together by our people and partners.

Purpose

Working together to improve health, reduce inequalities and create a compassionate, inclusive environment for our colleagues and our communities.

Our vision and purpose provide a clear and shared direction for the future. They reflect the outcomes we want to achieve together: better health, reduced inequalities, stronger communities, care closer to home, effective partnerships, and a compassionate, inclusive environment where our colleagues can thrive. These themes will guide our decisions, shape our priorities, and help ensure we focus our energy and resources on what matters most to our colleagues and the people and communities who use our services.

4.2 Our values

Our values describe how we work every day and the behaviours people can expect from us.

They matter because they shape people's experiences of care and of working here, and they are essential to building trust and improving health outcomes. Feedback from colleagues, partners and the people using our services shows that while our values are widely understood, they are not always consistently experienced in practice, particularly when it comes to listening, acting on feedback and delivering real change.

The behaviour compact developed for each of our values sets out clearly what this means in practice including the actions all colleagues, leaders and the organisation will take to bring our values to life. Our behaviour compact is summarised below. The detail can be found in our Better Lives Together Strategy Delivery Framework.





4.2.1 We care

We show compassion by responding to need early, create a sense of belonging where people feel safe to be themselves, and consistently treat everyone with dignity and respect. Our behaviour compact sets out how we bring the areas below to life in our every day work:

Compassion:

We notice and respond to need early.

Belonging:

We create environments where people feel and are safe to be themselves.

Respect:

We treat everyone consistently with dignity.



4.2.2 We listen

We listen to understand, act on what we hear, and provide clear feedback so people know what has changed and why. Our behaviour compact sets out how we bring the areas below to life in our every day work:

Hear:

We listen to understand

Act:

We use feedback to make change and learn

Feedback:

We demonstrate what has changed and why



4.2.3 We deliver

We take ownership for what matters most, working collaboratively, simplifying how work gets done, and continuously improve outcomes through learning, evidence and action. Our behaviour compact sets out how we bring the areas below to life in our every day work:

Own:

We take responsibility, work collaboratively and follow through on what matters.

Simplify:

We value each other's expertise and together remove unnecessary complexity making work easier to do well.

Improve:

We continuously learn together, adapt and make things better for people and in a way that delivers improved outcomes.

4.3 Our strategic priorities

Our strategic priorities describe the four areas in which we need to make the greatest difference. Each priority is supported by a consistent set of measures:

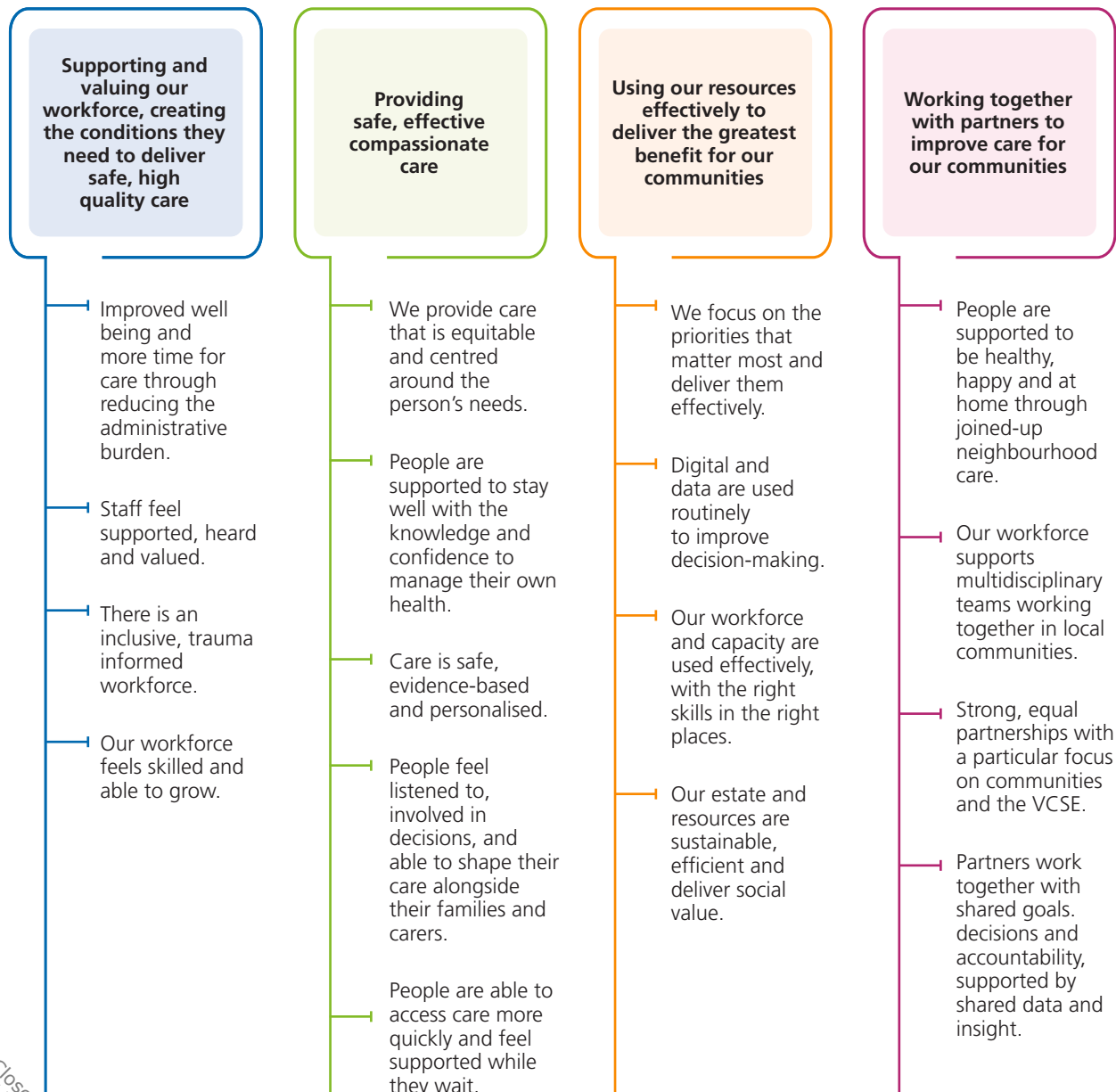
- Signs of success describe the difference that people have told us matters most and help us understand whether change is being experienced in practice.
- Overarching measures provide a high-level indication of progress against each strategic priority.

- Health equity measures help us understand whether improvement is being experienced fairly across different communities and population groups.
- Breakthrough programme measures, set out in the Supporting Delivery Framework, track whether our major programmes are delivering their intended outcomes and benefits.
- Annual delivery measures translate the strategy into specific milestones and improvement expectations for each year.

Together, these measures will give us a rounded view of progress, combining performance information with experience, outcomes, equity, qualitative insight and learning.

The detailed delivery priorities, linked breakthrough programmes and supporting measures for each strategic priority are set out in the Better Lives Together Supporting Delivery Framework. These will be translated into accountable actions, milestones and measures through annual delivery and programme planning.

Our new strategic priorities and delivery outcomes



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4.3.1 Strategic priority one:

Supporting and valuing our workforce, creating the conditions they need to deliver safe, high quality care.

We cannot deliver high quality care without a supported and engaged workforce. Evidence consistently links colleagues' wellbeing, capacity and feeling valued to better care, stronger teams and improved experience for people. This priority recognises that workforce support is not separate from strategy delivery – it is what enables it. This is our first priority as it is the foundation required to achieve success in our other priority areas.

In line with the NHS 'staff' standards we believe all our employees should:

- **Expect us to provide** supportive, fair, developmental and compassionate line management, helping staff to perform well, feel valued and fulfil their potential.
- **Expect us to support** their wellbeing, prevent work-related ill health, and ensure they feel safe, cared for and able to perform at their best.
- **Expect us to take sustained and meaningful action** to prevent and eliminate racism and all forms of discrimination in the workplace.
- **Expect us to create** a 'flexible first' culture where flexibility is the norm rather than the exception.
- **Expect us to ensure** they feel safe and supported at work by taking meaningful action to prevent violence, aggression, intimidation discrimination and abuse in any form.
- **Expect us to take clear and consistent action** to prevent sexual misconduct and harassment, and to promote a culture of openness and transparency where concerns are reported and acted upon promptly and appropriately.

We will act in all these areas and regularly assess the difference it is making. We will do this not only through measures and indicators, but by listening to colleagues and understanding their lived experiences of working here.

The four outcomes we are looking to achieve through this strategic priority are:

- Improved wellbeing and more time for care through reducing the administrative burden.
- Colleagues feel supported, heard and valued.
- There is an inclusive, trauma-informed workforce.
- Our workforce feels skilled and able to grow.

From strategy to delivery

The detailed delivery priorities, linked breakthrough programmes and supporting measures for this priority are set out in the Better Lives Together Supporting Delivery Framework. These will be translated into accountable actions, milestones and measures through annual delivery and programme planning.



Signs of success for this priority

Our first sign of success will be:



Colleagues spend more time caring for people and less time navigating systems, duplication and unnecessary administrative tasks.

For staff who are not frontline facing, colleagues 'spend more time delivering on objectives that directly impact on patient care and less time navigating systems, duplication and unnecessary administrative tasks' - staff quote.

'There is a strong emphasis on data collection, yet the IT systems supporting this are insufficient. This combination increases staff stress and limits our ability to provide services as effectively as we could' - colleague survey.

To understand whether we are making progress against this sign of success, we will regularly ask colleagues:

- To what extent do administrative tasks and processes get in the way of your ability to provide patient care?
- What single change would make the biggest difference to releasing more time for care?
- Are you usually able to finish work on time? If not, what is preventing this?

Our second sign of success will be:



Colleagues feel heard, valued and involved, knowing their feedback leads to visible action and meaningful change.

'Staff voices prioritised so they feel it's worth saying something when they need to' – colleague survey.

To understand whether we are making progress against this sign of success, we will regularly ask colleagues:

- Do you feel listened to and heard?
- Have you had opportunities to influence decisions that affect your work?
- If you have provided feedback recently has this resulted in positive change?

Our overarching measure of success for this priority will be the annual NHS staff survey staff satisfaction score. By reducing unnecessary administrative burden and ensuring colleagues feel listened to and involved in decisions, we aim to create a workplace where people feel valued, supported and empowered to deliver safe, high-quality care. We expect this to be reflected in improving colleague experience, wellbeing and satisfaction over time.

From a health equity perspective, we want our workforce to reflect the diversity of the communities we serve. A workforce that better reflects our population is more likely to understand different needs, perspectives and experiences, helping us design and deliver services that are responsive to our communities.

4.3.2 Strategic priority two:

Providing safe, effective
compassionate care

Delivering high quality, equitable, safe care is at the heart of our strategy because it is fundamental to the experience and outcomes of our service users. We know that quality is experienced through timely access, clear communication, joined-up care, and feeling listened to, respected and supported. We also know that pressures such as demand, staffing and fragmented pathways can lead to delays and inconsistent care and unwarranted variation.

This priority focuses on improving access, flow, responsiveness and person-centred care and reducing unwarranted variation so that high quality, safe care is experienced consistently in everyday practice.

The five outcomes we are looking to achieve are:

- We provide care that is equitable, consistent and centred around the person's needs.
- People are supported to stay well with the knowledge and confidence to manage their own health.
- Care is safe, evidence-based and personalised.
- People feel listened to, involved in decisions, and able to shape their care alongside their families and carers.
- People can access care more quickly and feel supported while they wait.

From strategy to delivery

The detailed delivery priorities, linked breakthrough programmes and supporting measures for this priority are set out in the Better Lives Together Supporting Delivery Framework. These will be translated into accountable actions, milestones and measures through annual delivery and programme planning.

Signs of success for this priority

Our first sign of success will be:



People experience seamless, well-coordinated care that feels easy to navigate and centred around what matters most to them.

'If we did this people would not be passed between services or have to repeat their story' – staff survey.

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To understand whether we are making progress against this sign of success, we will regularly ask people using our services, their families and carers:

- Did you feel the different people and services involved in your care worked well together?
- To what extent did your care feel joined-up and centred around what mattered most to you?

Our second sign of success will be:



People can access the right support at the right time, receiving timely help before challenges escalate and when it can make the greatest difference to their lives.

'People would be referred to the right place sooner and not sent to the wrong place. People would be waiting less for things they don't need' – patient, carer and family survey.

To understand whether we are making progress against this sign of success, we will regularly ask people using our services, their families and carers:

- Did you receive the right support at the right time for your needs?
- If you had to wait, did you feel supported and informed while you were waiting?



Our overarching measure of success for this priority will be whether our colleagues would recommend our services to their family and friends.

This question is included within the annual NHS Staff Survey, and we will seek to understand this more regularly throughout the year. We believe our colleagues are one of the most reliable indicators of whether people are receiving safe, effective and compassionate care.

If our colleagues would confidently recommend our services to those closest to them, we can be reassured that we are making progress towards delivering the quality of care we aim to provide.

This will be considered alongside feedback from people using services, carers and families, including differences between population groups.

From a health equity perspective, we want to understand whether people living in communities experiencing the greatest health inequalities are accessing our preventative community services. This will help us ensure that support is reaching the people who are most likely to benefit from it and that access to our services is fair and equitable.

4.3.3 Strategic priority three:

Using our resources effectively to deliver the greatest benefit for our communities

Using our resources effectively is essential to delivering sustainable, high-quality care. Resources include not only funding, but also our people, time, buildings, technology and wider system capacity. When these are not used well, duplication, inefficient processes and fragmented systems reduce capacity, increase pressure on colleagues and take time away from direct care. By simplifying how work gets done, reducing unnecessary burden, making better use of digital and focusing our effort where it adds the greatest value, we can create capacity for prevention, earlier intervention and more community-based support.

Financial sustainability is a critical part of this approach: with demand continuing to grow faster than available resources, we must make deliberate choices about how we use our resources, improve productivity, reduce waste and duplication, and be prepared to stop

activities that are important but deliver less value when resources are stretched. We will maximise the value of every pound entrusted to us, strengthen our long-term sustainability and improve outcomes for the people and communities we serve.

Our aim is not simply to spend less, but to create more value - improving outcomes, experience and equity from every pound, every hour and every asset available to us.

The four outcomes we are looking to achieve are:

- We focus on the priorities that matter most and deliver them effectively.
- Digital and data are used routinely to improve decision making, productivity and care.
- Our workforce and capacity are used effectively, with the right skills in the right places.
- Our estate and resources are sustainable and efficient and deliver social value.

From strategy to delivery

The detailed delivery priorities, linked breakthrough programmes and supporting measures for this priority are set out in the Better Lives Together Supporting Delivery Framework. These will be translated into accountable actions, milestones and measures through annual delivery and programme planning.

Signs of success for this priority

Our first sign of success will be:



Colleagues have the data, technology and tools they need to do their jobs well, supporting consistent, high-quality care and reducing unnecessary variation across our services.

'It would be helpful to have statistics showing measurable service improvements backed up by feedback from users' – colleague survey.

To understand whether we are making progress against this sign of success, we will regularly ask our colleagues:

- Do you have the technology and digital tools you need to do your job effectively?
- Do you have access to the information and data you need to make informed decisions about the people you support and the service you provide?

This sign of success is equally important to the people using our services, although the sign of success is framed slightly differently:



People receive a consistent and high-quality experience across the teams involved in their care, supported by shared approaches, reliable information and joined-up technology.

'I do not get text reminders for my CMHT appointments and often forget about them when I am having a bad mental health and physical health day. Some services remind you' – service user, carer and family survey.

To understand whether we are making progress against this sign of success, we will regularly ask people using our services, their families and carers:

- Did the people involved in your care have the information they needed to support you effectively?
- Did you have to repeat your story or information unnecessarily?
- Did you receive a consistent approach from the different teams involved in your care?

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Our second sign of success will be:



We understand the needs and outcomes of the people using our services and use this insight to focus our time, funding and effort where it will have the greatest impact.

'Resources focused on the right areas – preventative – rather than corrective actions' – colleague survey.

To understand whether we are making progress, we will regularly ask our colleagues:

- Do you have access to meaningful information that helps you understand whether your service is making an equitable difference for the diverse population you support?
- Do you feel time, funding and effort are focused on the areas where they can make the biggest difference?

Our overarching measure of success for this priority will be productivity. By reducing unnecessary administrative burden, reducing waste, improving health equity, reducing variation, simplifying pathways, improving the quality of information available to colleagues and enabling better decision-making, we expect to release more time and resources for activities that improve outcomes for people using our services. Our aim is not simply to do more with the same, but to work in a way that creates more value - improving outcomes, experience and equity from every pound, every hour and every asset available to us.

As a balancing measure, we will work towards every service having an agreed outcomes framework that helps teams understand the impact of the care they provide. Over time, we expect to see evidence that decisions about service delivery, investment and improvement are increasingly informed by the outcomes achieved for the people and communities we serve.

From a health equity perspective, once outcomes frameworks are embedded, we want to understand whether people living in our most deprived communities experience outcomes that are as good as those experienced by the wider population. This will help us identify and address inequalities in outcomes.

4.3.4 Strategic priority four:

Working together with partners to improve care for our communities

Our focus is to translate partnership into measurable improvements in outcomes, experience and equity for our communities.

Building on our joint strategic ambition and place partnerships, we will work alongside others to improve access, strengthen prevention, coordinate care and make better use of collective resources.

The four outcomes we are looking to achieve are:

- People are supported to be healthy, happy and at home through joined-up neighbourhood care.
- Our workforce supports multi-disciplinary teams (MDTs) working together in local communities.
- Strong, equal partnerships with a particular focus on communities and the VCSE.
- Partners work together with shared goals, decisions and accountability supported by shared data and insight.

From strategy to delivery

The detailed delivery priorities, linked breakthrough programmes and supporting measures for this priority are set out in the Better Lives Together Supporting Delivery Framework. These will be translated into accountable actions, milestones and measures through annual delivery and programme planning.

Signs of success for this priority

Our first sign of success will be:



We have trusted, respectful and equal relationships with partners, enabling us to combine our strengths, share responsibility and improve outcomes delivering joined-up, community based and partnership-led care.

‘There is clear energy and determination of people across the organisation to make a positive difference – you just need to find a way to give them the space to collectively drive forward whilst still being accountable or responsible for service delivery and coherence’
– partner survey.

To understand whether we are making progress, we will regularly ask our partners and our colleagues:

- What is working well through collaboration in our neighbourhoods, and what could work better?
- Does it feel as though there is shared trust, ownership and accountability across partner organisations?
- To what extent do partners feel valued as equal contributors to improving outcomes for our communities?

Our second sign of success will be:



More people can stay well, independent and connected to their communities through earlier support, prevention and joined-up support.

‘People would experience care earlier, closer to home, and in ways that feel easier to access, less fragmented, and more joined-up’ – staff survey.

To understand whether we are making progress, we will regularly ask people using our services, their families and carers:

- Did the different organisations involved in your care and support work well together?
- Do you have the support you need within your community to help you stay well and independent?

From a health equity perspective, we want to understand whether the people benefiting from more care and support closer to home, and therefore avoiding unplanned care, are representative of the population we serve. This will help us identify whether any communities or population groups are benefiting less from our neighbourhood approach and where additional action may be needed to reduce inequalities and achieve fairer outcomes.

4.4. Continuing to listen, learn and adapt

This strategy is about delivering genuine change and making a meaningful difference to the people using our services and communities we serve. It has been shaped by what our colleagues, people using our services, their families, carers and our partners have told us matters most. These things that matter most have shaped our signs of success that we will be relentlessly focused on delivering and understanding the progress we are making against them.

As an organisation, we already have many measures and performance indicators. While these remain important, we also want to understand whether the changes we are making are being felt by people now, rather than waiting for this to appear in performance reports months later.

To achieve this, we will continue to ask our colleagues, people using our services, their families, carers and our partners about their experiences. This will provide us with real-time insight into what is working well, where we need to improve, and where we need to adjust our approach before challenges become more significant.

By listening more frequently, we can make better decisions about where to focus our time, attention and resources. We can also identify positive change earlier, helping us learn from success and celebrate the difference people are making every day. These listening strategies will support our co-production approach.



Below outlines the strategies we plan to deploy to do this.

How we will listen more frequently

For our colleagues	For service users, their carers and families	For our partners
• We will check in more regularly to understand how things are going and gather real-time feedback about working at BDCFT. • More emphasis on our quarterly pulse survey which will focus on the things you have told us are most important to you, our signs of success. • We will provide more regular ‘you said, we did’ updates so our colleagues can see how feedback is influencing change and what the impact has been. • We will share the changes made in response to feedback and seek views on whether those changes have made a difference.	• We will create more opportunities for people to share their experiences and tell us what matters most to them. • We will hold more frequent listening sessions in our communities to understand people’s experiences and priorities. • We will introduce simpler, more accessible ways for people to provide feedback, helping us understand experiences and use insights to improve services. This may include real-time feedback mechanisms, digital tools and other approaches that make it easier for people to share their views. We’ll also provide accessible ‘you said, we did, we learned’ updates to show what’s changed as a result.	• We will engage with partner organisations more regularly to understand how effectively we are working together and how we can strengthen our relationships. • We will create more opportunities for partners working alongside us in multidisciplinary and neighbourhood teams to provide feedback on how we are working together. • We will use partner feedback to identify opportunities to improve collaboration, reduce barriers and strengthen our collective impact for local communities.

5.0. What does this mean in 2031 – our picture of success

Our strategic priorities are clear. We know what our measures of success are and our breakthrough programmes are aligned. But what does this mean in practice? What will be different in 2031?

5.1 What will be different for our colleagues?

If we deliver our strategic priorities well, our colleagues will work in an environment that enables them to spend more time providing care and less time navigating unnecessary administration. Simplified processes, effective use of digital tools and stronger partnership working will support a connected ‘team of teams’ focused on improving lives and reducing inequalities.

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Colleagues will feel heard, valued and supported, with opportunities to develop, grow and contribute their best. Clear expectations, meaningful performance information and timely feedback will help teams focus on what matters most and understand the difference they make.

Ultimately, colleagues will feel empowered to spend their time where it adds the greatest value: caring for people, improving outcomes and supporting healthier communities.

If we are getting it right, our colleagues will say:

- I have more time to care.
- I understand what matters most and how my work contributes.
- Work is simpler – unnecessary duplication and bureaucracy have been removed.
- My voice is heard and leads to visible action.
- I feel safe, supported and able to speak up.
- I have fair opportunities to learn, grow and progress.
- I have the data, technology and tools I need to do my job well.
- I work seamlessly with colleagues and partners to provide joined-up care around each person.
- I feel proud of the difference I make.

5.2 What will be different for the people using our services?

If we deliver our strategic priorities well, people will experience care that feels joined-up, responsive and centred around what matters most to them. Services will work more seamlessly across health, care, community and voluntary sector partners, with clearer pathways, better coordinated support and smoother transitions between teams. People will feel listened to, involved and respected, with care shaped around their goals and priorities and lived experience helping to drive improvement.

A stronger focus on prevention, early intervention and waiting well support will help people access the right support at the right time, while our commitment to tackling inequalities will ensure care is fair, inclusive and accessible for all communities.

Ultimately, people will experience personalised, coordinated care that helps them live healthier, more independent lives and achieve the outcomes that matter most to them.

If we are getting it right, people using our services will say:

- I know where to go when I need help.
- I do not have to keep repeating my story.



- The people supporting me work well together.
- I feel informed, supported and safe while I wait for care.
- I have access to advice and support that helps me manage my health and wellbeing.
- My care reflects what matters to me and the people who support me.
- Services understand my circumstances, community and individual needs.
- I get help early enough to prevent problems from becoming a crisis.
- Care feels joined-up and easy to navigate.

5.3 What will be different for carers and family members of people using our services?

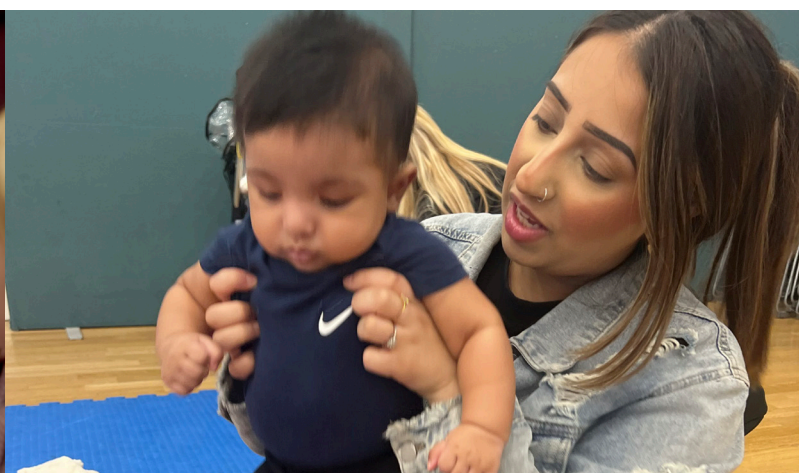
If we deliver our strategic priorities well, carers, families and friends will feel recognised, informed and supported in the important role they play. Services will be easier to navigate, with clearer pathways, better coordination and more joined-up support across organisations, reducing the effort needed to access help and advocate for those they care for. Where appropriate and agreed, carers and families will be involved in decisions and recognised as valued partners in wellbeing and recovery, with access to clear

information, advice and practical support. Greater use of technology and flexible ways of accessing care will make it easier to stay involved and connected.

Ultimately, carers, families and friends will feel valued, included and confident that they are working alongside services to help the people they care about live well and achieve the outcomes that matter most to them.

If we are getting it right, carers, families and friends of people who use our services will say:

- I know where to go for help and advice.
- I am recognised and valued for the role I play.
- I feel listened to and involved when it is appropriate to do so.
- I have the information and support I need to help myself and the person I care for.
- My contribution to helping someone stay well is reflected in their care and support plan.
- I am kept informed and know who to contact if I have concerns.
- I can access support without unnecessary travel or effort.
- People work together to support the person I care for.



- The person I support gets help early enough to prevent problems becoming a crisis.

5.4 What will be different for our partners?

If we deliver our strategic priorities well, our partners will experience BDCFT as a trusted, collaborative and delivery-focused organisation, working alongside them to improve outcomes, reduce inequalities and make the best use of our collective resources. We will be clear about our priorities, open in our decision-making and focused on turning shared ambition into practical action, using data, insight and lived experience to make better decisions, target resources where they can have the greatest impact and support more joined-up care across organisational boundaries.

Strong relationships, shared accountability and collective ownership will help us improve outcomes, experience and sustainability across BDC.

Ultimately, our partners will feel that working together enables us to make the best use of our collective resources and achieve better results than working alone, creating lasting improvements in the health and wellbeing of local people and communities.

If we are getting it right, our partners will say:

- We have a shared understanding of what we are trying to achieve.
- We are involved in decisions that affect our communities.
- We work together to solve problems and improve outcomes.
- Information, insight and expertise are shared openly and constructively.
- We make the best use of our collective resources.
- We trust each other to do what we say we will do.
- Partnership working is making support more joined-up, preventative and effective.
- Together, we are reducing inequalities and improving outcomes for local people.
- Together, we are making a measurable difference to the lives of our communities.

5.5 What are the principles we will need to adopt to achieve this picture?

There are a number of guiding principles to support and guide consistent decision making that will help make our picture of success a reality.

These principles will guide how we make decisions, prioritise resources and deliver improvement. They reflect our commitment to focus on what matters most and to create the greatest possible benefit for the people and communities we serve.

Principles



In detail

Principle	What it means we will do	What it means we will not do
Focus on what matters most	• Be data led - prioritising our time, resources and improvement effort on the things that make the greatest difference to outcomes, experience and equity. • Have the courage to stop, simplify or reduce activities that do not clearly contribute to our strategic goals or add sufficient value.	• Focus on things that we cannot demonstrate will make a difference through a data led approach. • Continue with everything we are currently doing; we are going to need to prioritise if we are going to make progress against our signs of success. • Deliver in pockets. If an initiative improves health outcomes in one area, it is likely to deliver improved outcomes in another. So wherever possible we will look to deliver across our organisation.

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Start with people

- Design services, pathways and decisions around what matters most to our colleagues, people using our services, their carers and family members and communities.
- Listen, involve and work alongside people to shape care and support that is personalised, accessible and responsive to their needs.
- Develop and deliver change programmes without co-producing / involving the people using our services.

Work together as one team

- Work across teams, organisations and communities to improve population outcomes rather than organisational performance alone.
- Break down barriers, share responsibility and build strong partnerships that make it easier for people to receive joined-up support.
- Solve challenges alone. Instead, we will reach out to other teams and partners for their learning and advice.
- Operate as a silo. Instead, we will always understand where we fit on the internal and system pathway and how we can adjust our services to work better together and deliver the best value collectively.

Act early and reduce inequalities

- Focus on prevention, early intervention and proactive support wherever possible.
- Use evidence, data, insight and lived experience to understand need, reduce inequalities and improve equity in access, experience and outcomes.
- Presume a one size fits all approach works for the people using our services. Through considering data, evidence and insight, services might have to be delivered differently in different geographies or with different populations so people can benefit from the same outcomes.

Make it easy to do the right thing

- Simplify processes, reduce duplication and administrative burden, and make the best use of digital, data and technology removing barriers that take away time to care.
- Create the conditions for our colleagues and partners to do their best work.
- See manual, paper based and fragmented ways of working as being OK.
- Make small changes to small parts of the pathway. To deliver our strategy we need to be bold focusing on things that will make the biggest difference.

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Deliver value and continuously improve

- Act as responsible stewards of the resources entrusted to us. Recognising that resources are finite, we cannot always provide everything to everyone, nor always deliver the most intensive or 'gold-plated' solution. Instead, we will focus on delivering the best possible outcomes, experience and value from the resources available.
- Focus on outcomes not outputs, continuously use evidence, data, insight and lived experience to understand what is making the greatest difference and where improvement is needed. This may sometimes mean redirecting resources to the areas where they will have the greatest impact for people, communities and our colleagues.
- Focus on inputs and not outcomes.
- Try and deliver multiple competing priorities that dilute focus and slow delivery.
- Protect those things we have always done. Change will be needed if we are to make a difference against the things that will have the biggest impact.
- Be reactive rather than proactive. We will therefore focus on the plans and changes that will make the biggest difference.



5.6 Our ten breakthrough programmes - how change will be delivered?

Achieving our picture of success for 2031 requires more than incremental change. Growing demand, health inequalities, workforce pressures, financial constraints and increasing expectations mean we must focus our effort on a small number of breakthrough programmes capable of delivering meaningful and lasting improvement.

We cannot do everything.

Our ten breakthrough programmes are the principal mechanisms through which we will deliver our strategy.

The breakthrough programmes are not intended to cover every delivery priority though. They represent areas where concentrated organisational transformation focus, investment and change are most likely to accelerate delivery of the strategy and address our most significant opportunities and risks.

They are summarised here to show the connection between our ambition and the major programmes of change. The full programme descriptions, intended 2031 outcomes, and proposed measures are set out in section four of the Better Lives Together Supporting Delivery Framework. Each programme will also have an approved programme plan setting out scope, leadership, milestones, dependencies, risks, benefits and delivery arrangements.

① Releasing time for care

Strategic priority linked to: Supporting and valuing our workforce, creating the conditions they need to deliver safe, high quality care.

Purpose: Improve colleague experience and satisfaction by removing unnecessary burden and making the best use of our resources, creating more time to deliver high-quality care and improve outcomes.

② Working well

Strategic priority linked to: Supporting and valuing our workforce, creating the conditions they need to deliver safe, high quality care.

Purpose: Improve colleague experience and satisfaction by creating an environment where people feel valued, supported and able to thrive, enabling them to deliver high-quality care and improve outcomes.

③ Purposeful and productive adult mental health pathway (mental health flow, recovery and service transformation)

Strategic priority linked to: Providing safe, effective compassionate care.

Purpose: Improve people's experience and outcomes by creating a more responsive and sustainable mental health system that makes the best use of our collective resources.

④ Health equity, inclusion and population health

Strategic priority linked to: Providing safe, effective compassionate care.

Purpose: Improve health outcomes for people and reduce health inequality by working with communities to remove barriers, improve inclusion and create opportunities for everyone to live healthier lives.

⑤ Data quality, insight and intelligence

Strategic priority linked to: Using our resources effectively to deliver the greatest benefit for our communities.

Purpose: Improve outcomes, decision-making and productivity by ensuring high-quality information is used to make the best use of our resources and drive continuous improvement.

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6 Digital, Artificial Intelligence (AI) and intelligent automation

Strategic priority linked to: Using our resources effectively to deliver the greatest benefit for our communities.

Purpose: Improve colleague and patient experience, productivity and sustainability by using digital, AI and automation to make the best use of our resources, improve services and create more time for care.

7 Lynfield Mount Hospital redevelopment and mental health campus transformation

Strategic priority linked to: Using our resources effectively to deliver the greatest benefit for our communities.

Purpose: Improve the experience, health outcomes and recovery of the people who use our in-patient services by creating therapeutic, modern and sustainable environments that support high-quality mental health care.

8 Smarter spaces

Strategic priority linked to: Using our resources effectively to deliver the greatest benefit for our communities.

Purpose: Improve colleague and patient experience, productivity and sustainability by making the best use of our estate to create modern, flexible environments that support high-quality care and new ways of working.

9 Integrated Neighbourhood Health

Strategic priority linked to: Working together with partners to improve care for our communities

Purpose: Improve the health outcomes and reduce the health inequalities of our population by organising care around neighbourhoods, bringing services together to provide joined-up support closer to home.

10 Place Partnership and Integrated Provider leadership

Strategic priority linked to: Working together with partners to improve care for our communities.

Purpose: This programme provides the leadership, governance and delivery arrangements required to translate our joint strategic ambition and emerging Place Provider Partnership arrangements into measurable improvements for our population.

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6. Foundations for delivery

Our six foundations for delivery describe the capabilities and ways of working that will support every strategic priority and breakthrough programme. They are not separate initiatives. They work together as one delivery approach, with the Care Trust Way describing how we work and the Quality Performance and Management

System (QPMS) providing the routines through which we plan, measure, assure, learn and improve.

This section provides a concise overview. Further detail on how each foundation will operate is set out in section five of the Better Lives Together Supporting Delivery Framework.



Better Lives Together Strategy - foundations for delivery

6.1 How we work – The Care Trust Way

The Care Trust Way is how we work together to deliver Better Lives Together. It brings together our values, leadership behaviours, quality management approach, improvement methods, performance arrangements and daily ways of working into a single approach that helps us focus on what matters most, continuously improve and achieve better outcomes. By combining clear priorities, meaningful measures, co-production and continuous learning, it helps turn ambition into action and ensures everyone understands the part they play in improving the lives of the people and communities we serve.

our strategic priorities into clear objectives, actions and accountabilities for teams and individuals across the Trust, creating a golden thread from organisational ambition to everyday practice. While the priorities are shared, teams will have the flexibility to develop plans that reflect their local context, challenges and opportunities, recognising that those closest to the work are best placed to identify where improvements are needed and how change can be delivered. This helps ensure everyone understands their contribution to delivering Better Lives Together while empowering teams to lead improvement in ways that will make the greatest difference for the people and communities they serve.

6.2 What will enable delivery?

6.2.1 Annual delivery planning – how we translate strategy into action

Annual delivery plans are how we translate strategy into action. They turn

6.2.2 Innovation, research and continuous improvement - how we learn and improve

Research, innovation and continuous improvement are how we learn and improve. Research helps us generate new knowledge, understand what works and



ensure our decisions, services and models of care are informed by the best available evidence. Building on this foundation, innovation and continuous improvement create the conditions for colleagues, people using our services, carers, families, communities and partners to identify opportunities, test ideas, evaluate impact and share learning. By combining research, innovation, improvement, digital and data, we will develop, spread and embed approaches that improve outcomes, reduce inequalities, release time for care and create value for the people and communities we serve

6.2.3 Co-production – how we ensure change is shaped by the people who experience it

Co-production is how we ensure change is shaped by the people who experience it. It involves working in partnership with people using our services, carers, families, communities and colleagues to plan, deliver and improve services. We will place particular emphasis on engaging and involving those who experience the greatest inequalities, poorest outcomes and barriers to accessing care, ensuring their voices help shape decisions, priorities and improvements. By valuing

lived experience, promoting shared decision-making and making involvement inclusive, meaningful and representative of the diverse communities we serve, co-production helps us design better services, reduce inequalities and improve outcomes, experience and quality for the people and communities we support.

6.2.4 Digital enabled care and service delivery

Digital is how we enable delivery. It helps people access care more easily, communicate with services in ways that work for them, and receive more joined-up, responsive support. For colleagues, it reduces administrative burden, simplifies processes, improves information access and creates more time for care. Investing in modern digital tools, systems and infrastructure, will support safer, more coordinated care, improve operational flow, strengthen productivity and make the best use of resources. Digital underpins every strategic priority within Better Lives, Together. It helps us improve outcomes, experience and long-term sustainability for the communities we serve, whilst also considering digital inclusion, accessibility and privacy, with non-digital options and human support where required.



6.3 How we manage and measure delivery - Quality Performance and Management System (QPMS)

The Quality Performance and Management System (QPMS) is the management system that supports delivery of the Care Trust Way. It sets out how we manage and measure our performance. It brings together planning, performance management, quality improvement, assurance, accountability and organisational learning into a single approach that helps us understand whether we are making progress, where improvement is needed and how we will respond. By providing clear objectives, meaningful measures, consistent review processes and a clear golden thread from Board priorities to frontline teams, the QPMS helps ensure we remain focused on improving outcomes, reducing inequalities, supporting our workforce and making the best possible use of our resources.



7.0 Other critical connected strategies

Better Lives, Together provides the overarching strategic direction for the Trust. It does not replace our clinical, workforce, quality, equality, sustainability, research, risk or enabling strategies. These connected strategies provide specialist direction and detail in their respective areas, while contributing to our common vision, priorities and signs of success.

The relationship is two-way. Better Lives, Together shapes the priorities and outcomes of connected strategies, while those strategies provide the specialist plans, standards and actions needed to deliver Better Lives Together. As each connected strategy is updated and developed from 2026 onwards, it will explicitly demonstrate how it contributes to one or more Better Lives, Together strategic priorities, signs of success, breakthrough programmes and delivery outcomes.

Further information on the purpose of each connected strategy and how it contributes to our priorities is provided in section six of the Better Lives, Together Supporting Delivery Framework.

The diagram below sets out some of these key connected strategies, their focus and their role in delivering this refreshed Better lives, Together Strategy. Further detail on these strategies can be found in our Better Lives, Together Strategy Delivery Framework.



● Health Equity Strategy.

How they connect: Link to our vision and purpose each of which talks about 'inequalities reducing and communities thriving'. Links throughout but particularly providing safe, effective compassionate care - we provide care that is equitable and centred around the person's needs.

● The Belonging and Inclusion Plan.

How they connect: Link to our vision and purpose each of which talks about 'inequalities reducing and communities thriving'. Links throughout but particularly providing safe, effective compassionate care - we provide care that is equitable and centred around the person's needs.

● The Clinical and Professional Strategy.

How they connect: Strong connection with each of our four strategic priorities as this strategy sets out how they will be achieved through the lens of clinical professions.

● The Patient Safety Strategy.

How they connect – Clear links to 'Providing safe, effective compassionate care', with a strong link to 'care is safe, evidence based and personalised'.

● **The Green Plan.** How they connect: Using our resources effectively to deliver the greatest benefit for our communities, with a particular link to 'our estate and resources are sustainable, efficient and deliver social value'.

● **The Research and Knowledge Strategy.** How they connect: Creates the conditions for colleagues to deliver safe, high-quality care through access to evidence that improves care delivery and service transformation. Develops research careers, strengthens collaboration with academic institutions and partners, and increases research participation among underserved communities.



● **Social Value / Anchor Institution Framework.** How they connect: Links directly to using our resources effectively, reducing inequalities, partnership working, sustainability and community wealth. It will support the Trust to agree, measure and report social value commitments, ensuring that wider community benefit is planned, visible and evidenced over time.

● **Risk Management Strategy.** How they connect - Clear links to 'providing safe, effective compassionate care', with a strong link to 'care is safe, evidence based and personalised'.

8.0 Looking forward

Better Lives, Together is more than a strategy. It is a commitment to the people and communities we serve, to our colleagues and volunteers, and to the partners with whom we work every day.

The challenges ahead are significant. Demand is increasing, resources remain constrained and expectations continue to evolve. Yet throughout the development of this strategy, we have been reminded of something equally important — the commitment, compassion and capability that already exists across BDCFT and our partners.

By focusing on what matters most, listening to those we serve, supporting

our workforce, embracing innovation and working together across organisational boundaries focusing on our signs of success, we believe we can create meaningful and lasting improvements in people's lives.

This strategy will not be judged by the document itself. It will be judged by the difference it makes.

By 2031, we want people to experience services that are easier to access, more joined-up and more responsive to their needs. We want our colleagues to feel valued, supported and able to spend more time doing what they do best. We want our partners to see us as trusted, collaborative and delivery focused. Most importantly, we want our communities to experience better health, reduced inequalities and improved opportunities to live healthier, more fulfilling lives.

Delivery will be taken forward through our Supporting Delivery Framework, annual delivery plans and breakthrough programmes. We will report openly on progress, listen to people's experiences, learn from what is and is not working, and adapt our plans while remaining focused on the outcomes and signs of success set out in this strategy.

**Together, we will create
better lives, together**

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September 2026



Bradford District Care
NHS Foundation Trust

Better Lives, Together:

Supporting Delivery Framework 2026–2031

How we will translate our strategy into priorities,
programmes, plans, measures and action





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1. Purpose and status of this framework

Better Lives, Together: Supporting Delivery Framework 2026–2031 explains how Bradford District Care NHS Foundation Trust will translate the ambitions and priorities in Better Lives, Together: Our Strategy 2026–2031 into delivery.

1.1 Purpose

The strategy sets out where we are going, why change is needed and what success will look like. This framework provides the next level of detail. It brings together:

- Our values and behaviour compact.
- The delivery priorities supporting each strategic priority.
- The ten breakthrough programmes through which we will focus major organisational change.
- The foundations that enable delivery.
- The relationship with other strategies and plans across our Trust.
- The measures and arrangements through which progress will be monitored, assured, learned from and reported.

This framework is not a separate strategy. It is the principal companion document to Better Lives, Together and should be read alongside it.

1.2 How the documents work together

Better Lives, Together is delivered through a connected hierarchy:

- Our strategy defines our vision, purpose, strategic priorities, signs of success and intended picture of success for 2031.
- This Supporting Delivery Framework defines the behaviours, delivery priorities, breakthrough programmes, enabling arrangements and measurement approach.
- Annual delivery plans identify the organisation's priorities, actions, accountable leads, milestones and measures for each year.
- Breakthrough programme and service plans translate these commitments into coordinated delivery at programme and operational level.
- Team objectives and individual appraisals enable every colleague to understand and contribute to the strategy through their role.

This creates a golden thread from Board-approved ambition to everyday practice and from everyday experience back to organisational learning and decision-making.



1.3 How this framework will be used

This framework will support:

- Annual planning and prioritisation.
- Development and review of breakthrough programme plans.
- Alignment of corporate, clinical and enabling strategies.
- Service and team planning.
- Objective setting and appraisals.
- Performance, quality and programme assurance.
- Assessment of benefits, outcomes and health equity.
- Communication with colleagues, communities and partners about progress.

It is intended to provide sufficient consistency for Trust-wide alignment while allowing services and teams to respond to their local context, population needs and improvement opportunities.

1.4 Keeping the framework current

The strategic direction and priorities are set for the period to 2031. The actions, milestones and delivery assumptions needed to achieve them will evolve. This Framework will therefore be reviewed through the annual planning cycle and updated where necessary to reflect learning, evidence, changing needs, national requirements and delivery progress.

Any material change to the vision, purpose, strategic priorities or signs of success will be considered through the Trust's established governance arrangements. Changes to annual actions, milestones and delivery methods will be managed through annual planning and programme governance.





2. Our values and behaviours compact

Our Strategy describes our three values: We Care, We Listen and We Deliver. This section translates those values into observable commitments for colleagues, leaders and the organisation.

The behaviour compact is an integral part of delivery. It describes the culture and behaviours required to turn strategic intent into everyday experience. It should inform leadership practice, appraisal, team development, decision making, improvement activity and the way we work with people using our services, carers, communities and partners.

The compact should be applied alongside professional standards, employment policies and role-specific responsibilities. It does not replace them. They matter because they shape people's experiences of care and of working here, and they are essential to building trust and improving outcomes. Feedback from colleagues, partners and the people using our services shows that while our values are widely understood, they are not always consistently experienced in practice, particularly when it comes to listening, acting on feedback and delivering real change.

The behaviour compact developed for each of our values sets out clearly what this means in practice including the actions all colleagues, leaders and the organisation will take to bring our values to life. It moves us from intent to action, with a focus on being compassionate and inclusive; listening and acting on what matters; working together across boundaries; and delivering what matters most by focusing on fewer priorities and doing them well. This ensures our values are visible in everyday behaviours, decision making and delivery, not just words on a page.



We care

We show compassion by responding to need early, create a sense of belonging where people feel safe to be themselves, and consistently treat everyone with dignity and respect.



Compassion:
We notice and respond to need early.

Belonging:
We create environments where people feel and are safe to be themselves.

Respect:
We treat everyone consistently with dignity.

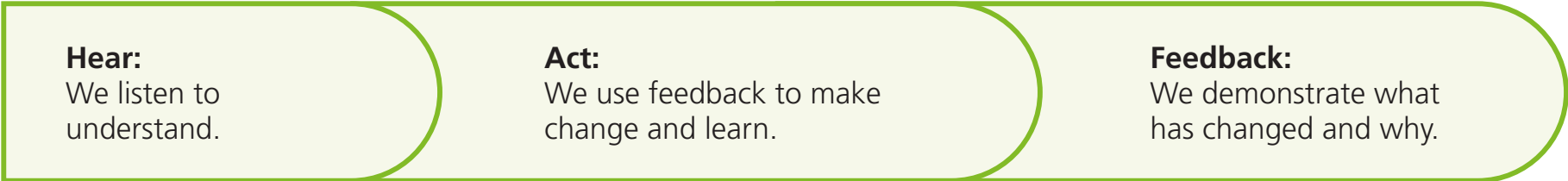
We care behaviour compact: compassion, respect, psychological safety, person centred

We treat people with kindness and respect, support each other, and make care feel safe, inclusive and consistent for everyone.

All colleagues – I will	Leaders will	Organisation – we will
• Treat everyone with kindness, dignity and respect, even when under pressure. • Adapt my approach to people’s individual needs, experiences and circumstances. • Create a safe, inclusive environment where people feel able to be themselves and ask for help, speaking up if I am in a situation I feel care or wellbeing may be impacted. • Support colleagues as well as service users, recognising the impact we have on each other.	• Model inclusive, compassionate behaviour and set clear expectations for how we treat each other, being visible, approachable and present. • Create psychologically safe teams where people feel valued, supported, heard and able to speak up. • Support teams to take a trauma-informed, person-centred approach in all interactions. • Recognise and celebrate good work and effort consistently.	• Care for and support our workforce, recognising that colleagues’ wellbeing, development and belonging are essential to safe, compassionate care. • Embed a trauma-informed approach across the organisation, with clear expectations, support and measures to reduce avoidable harm. • Create an inclusive culture where every person is valued, recognising difference and delivering on our belonging and inclusion commitments. • Recognise, celebrate and learn from the compassion and care shown by our people, making it visible and valued in everyday practice.

We listen

We listen to understand, act on what we hear, and provide clear feedback so people know what has changed and why.



We listen behaviour compact: hear, act, feedback

We listen to understand, seek out all voices, and respond – showing clearly what changes as a result.

All colleagues – I will	Leaders will	Organisation - we will
• Listen to understand what matters to each person. • Treat every view with respect and curiosity, taking time to understand different experiences and perspectives. • Actively seek out views, especially from those less likely to be heard, using feedback to improve what I do and continuously learn. • Explain what I have heard and what happens next. • Use my own views and lived experience to support continuous improvements and delivery of this strategy.	• Create a team culture where people feel safe to speak up, every voice is heard and valued and learning is encouraged. • Model curiosity, openness and willingness to be challenged. • Involve colleagues, service users and partners in shaping decisions and approaches. • Respond clearly to feedback, explaining what will change and what cannot and why, taking a 'you said, we did' approach. • Act as a role model and spokesperson for belonging and inclusion.	• Embed listening as an ongoing, everyday practice, with regular, joined-up opportunities to hear from colleagues, service users and partners. • Create a culture where speaking up is safe, valued and expected, with no negative consequences for raising concerns and learning is shared and celebrated. • Be responsive to feedback, acting where we can and being clear and transparent where we cannot close the loop consistently, showing 'you said, we did' and how feedback leads to visible change.

We deliver

We take ownership for what matters most, working collaboratively, simplifying how work gets done, and continuously improve outcomes through learning, evidence and action.



Own:

We take responsibility, work collaboratively and follow through on what matters.

Simplify:

We value each other's expertise and together remove unnecessary complexity making work easier to do well.

Improve:

We continuously learn together, adapt and make things better for people and in a way that delivers improved outcomes.

We deliver behaviour compact: ownership, simplification, improvement, accountability

We work together across teams, organisations and communities, focusing on what matters most to provide joined-up, person-centred care and continuously improve.

All colleagues – I will

- Involve people, families and carers in decisions, and see the person, not just their needs.
- Work with others, share information and help people get joined-up care.
- Do what I say I will do, take responsibility and speak up early when things are not going to plan.
- Focus on what matters most and use what I learn to keep improving.
- Engage in continuous professional development to enable me to stay informed, knowledgeable and confident.

Leaders will

- Set clear priorities so teams can focus on what matters most, based on data, evidence and insight.
- Work collaboratively across teams, organisations and communities to provide joined-up care.
- Create a culture where teams learn, improve and adapt together.
- Value every contribution and support teams to work flexibly across pathways to meet people's needs.

Organisation - we will

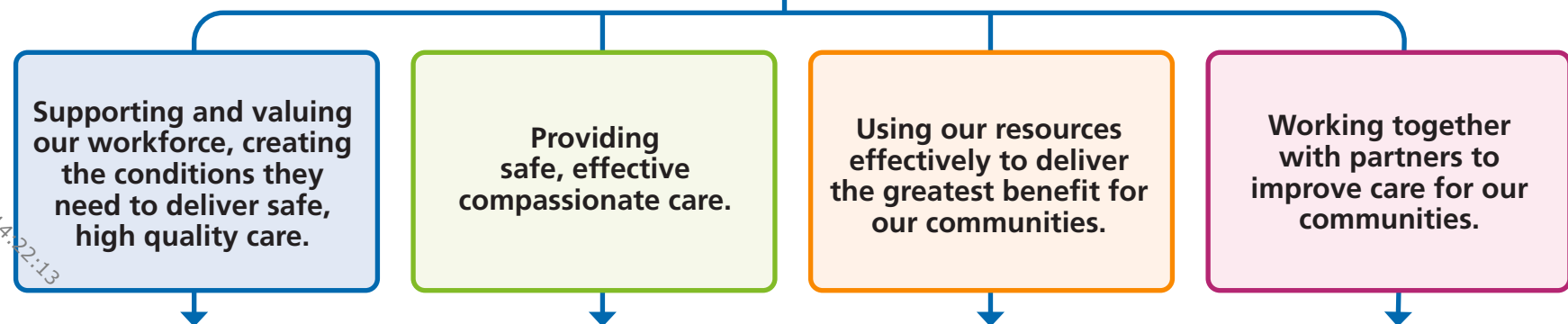
- Build strong partnerships across health, care, voluntary and community services, recognising that we achieve more together than any organisation can alone.
- Work with people, families, carers and communities to design and deliver joined-up care that is easy to navigate and centred around people's lives.
- Create the conditions for collaboration, learning and continuous improvement, using feedback, evidence and insight to drive positive change.
- Prioritise delivery based on evidence of need, focusing on what matters most, with clear priorities, visible progress and a commitment to learn and improve.



Our values
Together

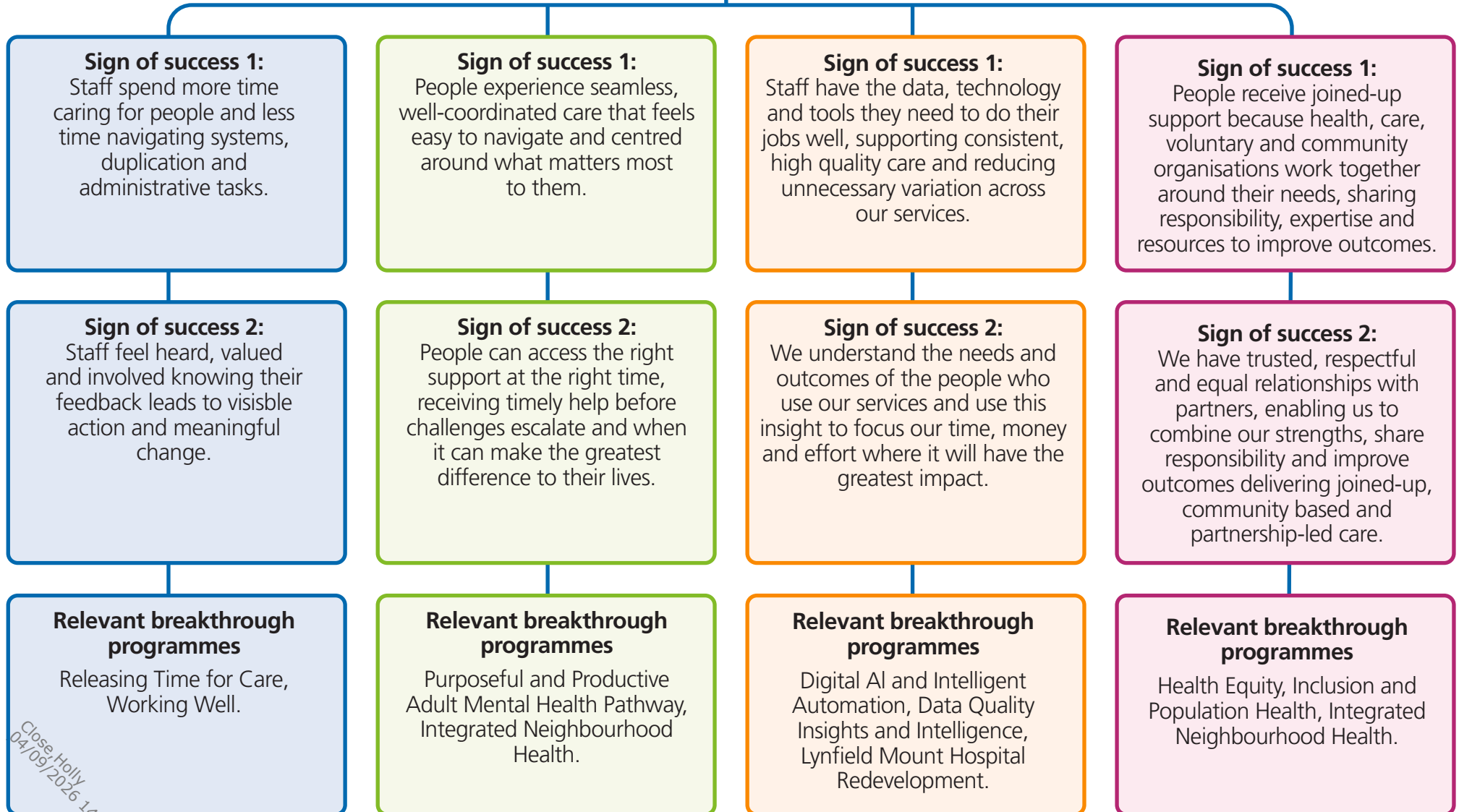


Our strategic priorities



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Our strategic priorities (continued)



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3. Strategic priority delivery areas

Our Better Lives, Together strategy document describes these strategic priorities in greater detail along with our 'signs of success' for each of them. The key areas of delivery for each priority can be found in the tables below. These have all been shaped and informed through engagement with colleagues, people who use our services, their carers and families, and our partners.

Strategic priority one: Supporting and valuing our workforce, creating the conditions they need to deliver safe, high quality care

Intended outcomes

Improved wellbeing and more time for care through reducing the administrative burden.

Colleagues feel supported, heard and valued.

There is an inclusive, trauma-informed workforce.

Our workforce feels skilled and able to grow.

Delivery priorities

- | | | | |
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| <ul style="list-style-type: none">• Reduce administrative burden and duplication, focusing on what matters most to colleagues.• Simplify and standardise core processes to make work easier and more efficient. | <ul style="list-style-type: none">• Embed regular high quality supervision and wellbeing conversations across all teams ensuring colleagues feel they have what the need to perform well, feel valued and fulfil their potential. | <ul style="list-style-type: none">• Develop the representation of our workforce so it reflects the communities we serve through ensuring all colleagues feel valued for the unique experience they bring, delivering on the promises as set out in the belonging and inclusion plan. | <ul style="list-style-type: none">• Establish transparent, inclusive progression routes from entry level through to advanced practice for career paths throughout the Trust. |
|--|---|--|--|



- Use digital tools and technology to support safe, effective ways of working.
- Make progress visible, showing how colleagues' feedback has led to time being released.
- Listen to and act on colleague feedback through clear 'you said, we did' communication, via identified routes demonstrating how colleague feedback leads to meaningful change at Trust, service and team level.
- Expand equality networks and give them formal involvement in policy design and quality improvement (QI) activity.
- Strengthen the 'speak up, listen up' culture ensuring staff feel psychologically safe, confident and supported to raise concerns, without detriment.
- Prioritise staff wellbeing doing what we can to prevent ill health associated with work and ensuring staff feel safe and cared for.
- Create a flexible first culture where requests will be considered objectively and if they cannot be granted alternatives will be explored.
- Embed anti racism commitments through a clear action plan and introduce cultural competency workshops supported through the patient carer race equality network delivered by lived experience leaders and VCS partners.
- Roll out trauma-informed practice to all colleagues through Bradford's trauma-informed leadership model.
- Ensure staff feel safe in work and we take action to prevent violence, aggression intimidation or abuse in any form, including championing sexual safety.
- Ensure there is a clear, fair and equitable training offer led through teams.

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Strategic priority two:

Providing safe, effective compassionate care delivery priorities

Intended outcomes

We provide care that is equitable, consistent and centred around the person's needs.

People are supported to stay well with the knowledge and confidence to manage their own health.

Care is safe, evidence based and personalised.

People feel listened to, involved in decisions, and able to shape their care alongside their families and carers.

People can access care more quickly and feel supported while they wait.

Delivery priorities

- | | | | | |
|--|---|---|--|---|
| <ul style="list-style-type: none"> • Demonstrate strong, visible leadership on health equity and anti racism, aligning priorities, removing barriers and driving joined-up action starting at Board level. • Embed equity, diversity and inclusion into everything we do, ensuring it is reflected in decision making, operational practice and care, and supporting staff at all levels to take action. | <ul style="list-style-type: none"> • Embed prevention and early intervention in services and pathways, reducing avoidable harm, crisis and future demand. • Strengthen early intervention across mental health, children and young people (CYP), frailty and dementia, with proactive outreach in neighbourhoods. | <ul style="list-style-type: none"> • Use better data on who we see, what we do and the outcomes we achieve to improve the quality, safety and value of our services through our understanding our patient population and outcomes programme. • Ensure care plans are clear, consistent and centred on 'what matters to me', with strong ownership across teams. | <ul style="list-style-type: none"> • We will embed automated reminders to all services as a standard approach to reminding people of their appointment, looking to roll out patient engagement solution. • We will co-produce communications relating to services with people with lived experience. | <ul style="list-style-type: none"> • We will work to support colleagues to re-design pathways, taking away the 'stones in their shoes' that get in the way of maximising patient facing time through our 'releasing time for care' programme. • Work as one team around the person, improving handovers, discharge and transitions. |
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- Use data and insight to reduce inequalities in access, experience and outcomes, focusing effort where need is greatest and supporting measurable improvement.
- Embed our health equity delivery model in practice.
- Strengthen partnerships in schools, public health and family services to support earlier identification and joined-up support for children and families.
- Support people to manage their own health (self-management) wherever possible, increasing access to tools and digital support where appropriate.
- Embed evidence based, standardised care pathways, co-designed with people who use services and carers.
- Strengthen research and development ensuring all clinical practices and pathways are evidence-based, fully embedding patient safety and incident response framework (PSIRF) and using evidence to improve practice.
- Place people, families, carers and communities at the centre of care, strengthening involvement, making involvement accessible through multiple engagement routes.
- We will demonstrate how lived experience insight leads to tangible service improvement through 'you said, we did' feedback loops.
- Improve access, flow and responsiveness, ensuring people receive the right care, in the right place, at the right time through stronger system working, expanded community alternatives and closer partnership with acute services.
- We will ensure all people who have to wait to access services receive 'waiting well' support.

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Strategic priority three:

Using our resources effectively to deliver the greatest benefit for our communities' delivery priorities

Intended outcomes**We focus on the priorities that matter most and deliver them effectively.****Digital and data are used routinely to improve decision making, productivity and care.****Our workforce and capacity are used effectively, with the right skills in the right places.****Our estate and resources are sustainable, efficient and deliver social value.****Delivery priorities**

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| <ul style="list-style-type: none"> • Use a consistent approach to performance and insight to focus resources on the priorities with greatest impact. • Limit the number of priorities and stop or pause lower value or duplicate activity. • Prioritise initiatives that deliver benefit across the whole organisation. • Empower colleagues to identify and implement changes that reduce cost and improve equity and outcomes. | <ul style="list-style-type: none"> • Reprocore and optimise our electronic patient record (EPR) system to reduce administrative burden, improve workflows and enable information to be captured once and used effectively. • Strengthen data foundations and automate data collection, ensuring consistent recording and better information to support service improvement. • Provide a 'single version of the truth', with automated dashboards so teams can understand performance and identify opportunities from ward to board. • Safe use of artificial intelligence (AI) tools to improve triage, processes and clinical documentation. | <ul style="list-style-type: none"> • Improve how we plan and deploy our workforce, using better rostering, caseload management and skill mix to understand and reduce variation across teams. • Set clear job plans and activity expectations, tailored to each team and the population they serve. • Share regular productivity and performance information, so teams understand how they are performing and where they can improve. • Provide accessible, up to date workforce data, giving managers the insight and tools to deploy staff where they will have the greatest impact. | <ul style="list-style-type: none"> • Rationalise and improve use of our estate, creating smarter, shared spaces and multi agency hubs to support co-located neighbourhood services. • Deliver our green plan, reducing our environmental impact through energy efficiency, lower carbon estates, sustainable transport and waste reduction. • Embed social value and sustainable procurement, ensuring our spending benefits our communities, environment and local economy. • Strengthen estate resilience, using climate risk planning to protect services, infrastructure, staff and patients. |
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Strategic priority four:

Working together with partners to improve care for our communities' delivery priorities

Intended outcomes			
People are supported to be healthy, happy and at home through joined-up neighbourhood care.	Our workforce supports multi-disciplinary teams working together in local communities.	Strong, equal partnerships with a particular focus on communities and the VCSE.	Partners work together with shared goals, decisions and accountability, supported by shared data and insight.
Delivery priorities			
• Develop neighbourhood hubs with partners and communities, working as a 'team of teams' to support priority groups locally. • Integrate services within each locality, including mental health, learning disabilities and autism, community nursing, diagnostics, prevention and social prescribing. • Improve discharge and coordination, helping people leave hospital sooner with the right community support. • Create a single, clear point of access, making neighbourhood care easier to navigate.	• Create time for teams to build strong relationships with partners, enabling effective neighbourhood multi-disciplinary team (MDT) working. • Develop a flexible system workforce, through rotation roles and local training pathways with education partners. • Maintain and strengthen management capability for staff working in neighbourhoods, through consistent appraisal, supervision and development. • Align workforce planning to neighbourhoods, improving continuity of care and reducing reliance on agency staff.	• We will enhance our communities by working with partners in service design decisions on the use of our resource. • We will organise services around neighbourhoods wherever possible, creating seamless pathways instead of multiple separate services and referral rules. • We will work alongside our community partnerships focusing on how we can support prevention, reducing inequalities and wider determinants of health across the whole population. • We will develop a more formalised and structured approach to working in partnership and prioritise the development of collaborative models of care.	• Agree on shared goals to guide improvements and service delivery with measurable outcomes. • Collaborate to develop our collective system approach to governance, accountability and shared financial planning. • Create place-wide shared dashboards for flow, inequalities, prevention and outcomes, looking to understand impact through shared 'linked' data sets allowing us to evaluate our collective impact on the patient journey. We will use predictive analytics for proactive care identification. • Promote system wide shared learning, collaborative working and consistent standards when we work across BDC and the West Yorkshire (WY) collaborative.

4. Breakthrough programmes

In the Better Lives, Together strategy document our ten breakthrough programmes are described. These have been selected because they address our most significant challenges and provide the greatest opportunity to improve outcomes, support our workforce, reduce inequalities and ensure long-term sustainability. They are not separate from our strategy; they are the primary mechanisms through which we will deliver it.

Equally though, the breakthrough programmes are not intended to cover every delivery priority.

They represent areas where concentrated organisational transformation focus, investment and change are most likely to accelerate delivery of the strategy and address our most significant opportunities and risks.

Further detail on each of these programmes can be found below.

1 Releasing time for care	
Strategic priority linked to: Supporting and valuing our workforce, creating the conditions they need to deliver safe, high quality care. Brief description: Colleagues consistently tell us that unnecessary administration, duplication and cumbersome processes reduce the time available for care. Releasing time for care will systematically remove these barriers, simplifying how work is done through improvement, standardisation and digital enablement. This programme directly supports workforce wellbeing, productivity, patient access, responsiveness and quality whilst helping mitigate workforce capacity pressures. It is central to our ambition to deliver more care, with the same or fewer resources, without compromising quality.	
By 2031 we will: Have fundamentally redesigned how work is done across the Trust, increasing patient-facing time and enabling our colleagues to focus on care, improvement and prevention rather than administration.	Key outcome measures • Staff survey score relating to ability to deliver high quality care. • Percentage of our colleagues reporting unnecessary administrative burden. • Patient-facing contact time. • Productivity improvement achieved through pathway redesign. • Improved health and workforce equity.

② Working well

Strategic priority linked to: Supporting and valuing our workforce, creating the conditions they need to deliver safe, high quality care.

Brief description: The quality of care we provide is directly linked to the experience of the people delivering it. Workforce sustainability, management capability, wellbeing, inclusion and engagement feature prominently within the Trust's strategic risks.

Working well will bring together our efforts to improve wellbeing, belonging, leadership, attendance, retention, psychological safety and career development into a single organisational programme focused on creating the best possible environment for our colleagues to thrive.

By 2031 we will:

Be recognised as one of the best NHS organisations to work for, with a resilient, engaged, healthy and inclusive workforce that reflects the communities we serve.

Key outcome measures

- NHS staff survey engagement score.
- Sickness absence rate.
- Turnover rate.
- Percentage of our colleagues recommending BDCFT as a place to work.

③ Purposeful and productive adult mental health pathway (mental health flow, recovery and service transformation)

Strategic priority linked to: Providing safe, effective compassionate care.

Brief description: Access and flow represent some of the most significant strategic challenges facing the Trust. Out-of-area placements, delayed discharge, lengthy inpatient stays, workforce pressures and increasing demand all impact on patient experience, outcomes, productivity and financial sustainability. This programme will redesign mental health pathways from crisis through to recovery, bringing together inpatient flow, community alternatives, discharge, crisis care, bed management, productivity and neighbourhood-based support. The focus is not simply on improving performance, but on creating a more responsive and sustainable mental health system.

By 2031 we will:

Deliver a mental health system where people receive timely care closer to home, out-of-area placements have become the exception, and pathways consistently support recovery, independence and flow.

Key outcome measures

- Out-of-area placement bed days.
- Average inpatient length of stay.
- Percentage of people receiving care within agreed access standards.
- Number of people supported through community alternatives to admission.
- Improved mental health equity.

④ Health equity, inclusion and population health

Strategic priority linked to: Providing safe, effective compassionate care.

Brief description: The greatest opportunities to improve outcomes often lie with the people who currently experience the greatest barriers. Persistent inequalities in access, experience and outcomes remain a significant challenge across our communities. This programme brings together the health equity strategy, patient and carer race equality framework, inclusion, anti-racism, population health management and community engagement into a single organisational commitment to reducing avoidable inequality.

By 2031 we will:

Demonstrate measurable reductions in health inequalities, ensuring our services consistently improve access, experience and outcomes for the communities that need us most.

Key outcome measures

- Reduction in inequality gaps in access, patient experience and health outcomes for agreed priority populations.
- Completeness of protected characteristics data.
- Access equity indicators by service.
- Patient experience scores for underserved communities.

⑤ Data quality, insight and intelligence

Strategic priority linked to: Using our resources effectively to deliver the greatest benefit for our communities.

Brief description: High quality information underpins every strategic decision we make. Without accurate data, the Trust cannot effectively improve quality, understand inequalities, optimise productivity, benchmark performance or plan services. This programme responds directly to the Trust's data quality strategic risk and will strengthen how data is collected, interpreted and used to drive improvement. It will support better operational, clinical, workforce and financial decision making from ward to Board.

By 2031 we will:

Be recognised as a data-driven organisation where decisions are routinely informed by high quality intelligence, predictive insight and measurable outcomes.

Key outcome measures

- Data quality compliance across key data sets.
- Performance improvement.
- Percentage of key decisions supported by real-time dashboards.
- Benchmarking performance against peer organisations.

6 Digital, Artificial Intelligence (AI) and intelligent automation

Strategic priority linked to: Using our resources effectively to deliver the greatest benefit for our communities.

Brief description: Using digital, AI and automation to release workforce capacity, improve patient access, strengthen operational flow, support joined-up care and improve organisational productivity. This will be structured around five strategic domains: workforce productivity and capacity optimisation, digital access and patient engagement, operational flow and performance improvement, connected and coordinated care and digital resilience and assurance. It is explicitly intended to release clinical capacity, reduce administrative burden, improve service flow and strengthen financial sustainability.

By 2031 we will:

Have transformed how services are delivered through digital, AI and intelligent automation, enabling our colleagues to spend more time caring, people to access services more easily, and leaders to make decisions using timely, trusted intelligence.

Key outcome measures

- Hours of workforce capacity released through digital and automation.
- Patient digital engagement rates.
- Reduction in paper-based and manual processes.

7 Lynfield Mount Hospital redevelopment and mental health campus transformation

Strategic priority linked to: Using our resources effectively to deliver the greatest benefit for our communities.

Brief description: This goes far beyond replacing buildings. Lynfield Mount represents a once-in-a-generation opportunity to redesign inpatient mental health care, therapeutic environments, workforce experience, clinical pathways and recovery-focused care. The redevelopment directly supports strategic priorities around quality, experience, safety, workforce and sustainability.

By 2031 we will:

Provide modern therapeutic environments that support recovery, improve colleague and patient experience, and enable new models of mental health care.

Key outcome measures

- Inpatient patient experience.
- Restrictive practice indicators.
- Colleague experience within inpatient services.
- Estate condition and utilisation measures.
- Increase in staff satisfaction and workforce retention.

8 Smarter spaces

Strategic priority linked to: Using our resources effectively to deliver the greatest benefit for our communities.

Brief description: Our estate is one of the Trust's most valuable assets and must evolve to support modern healthcare delivery. Changes in clinical practice, flexible working, digital technology and integrated models of care require us to rethink how our buildings support services. This programme is already underway and is seeking to create modern, flexible and sustainable environments that improve care, colleague experience and productivity. Through a hub-and-spoke approach, smarter use of space and closer partnership working, we will ensure our estate supports future models of care, makes best use of public resources and meets the needs of our communities.

By 2031 we will:

Have a modern, flexible and sustainable estate that supports integrated care, enables our workforce to thrive, makes best use of public resources and provides high quality environments for the people and communities we serve.

Key outcome measures

- Estate utilisation and occupancy rates.
- Reduction in estate running costs and backlog maintenance liabilities.
- Colleague satisfaction with working environments.
- Carbon reduction and environmental sustainability measures.

9 Integrated Neighbourhood Health

Strategic priority linked to: Working together with partners to improve care for our communities.

Brief description: Demand cannot be met through hospital based models alone. Future success depends upon stronger prevention, early intervention and care organised around neighbourhoods rather than organisational structures. This programme will bring together community health, mental health, primary care, social care, VCSE partners and local communities to provide more coordinated support closer to home.

By 2031 we will:

Operate mature neighbourhood-based models of care that help people stay healthier, independent and connected to their communities for longer.

Key outcome measures

- Percentage of care delivered in neighbourhood settings.
- Avoidable hospital attendance/admission rates.
- Multi-disciplinary team participation and integration indicators.
- Patient experience of coordinated care.



10 Place partnership and integrated provider leadership

Strategic priority linked to: Working together with partners to improve care for our communities.

Brief description: This programme provides the leadership, governance and delivery arrangements required to translate our joint strategic ambition and emerging Place Provider Partnership arrangements into measurable improvements for our population.

By 2031 we will:

Be recognised as a leading partner in an integrated place-based system that consistently improves outcomes, reduces inequalities and makes better use of collective public resources.

Key outcome measures

- Shared system outcomes delivered.
- Joint programmes successfully implemented.
- Reduction in duplication across organisations.
- Population-level health and wellbeing indicators.
- Agreed social value commitments and supporting measures.

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5. Foundations for delivery

Our strategy has six inter-connected foundations for delivery as set out in our diagram below. Further detail on each our foundations are also set out in further detail.



The Care Trust Way – how we work

Throughout the strategy refresh, our colleagues, people using our services, carers, families and partners told us something important. They agreed with the direction of travel but wanted greater confidence that this strategy would lead to visible change in everyday practice. They wanted to understand not only what we will do, but how we will deliver it.

The Care Trust Way is our response to that challenge.

The Care Trust Way is how we translate strategy into action. It brings together our values, leadership behaviours, quality management

approach, improvement methods, performance arrangements and daily ways of working into a single delivery system, that helps us focus on what matters most and continuously improve outcomes for the people we serve.

It creates a clear line of sight between the ambitions set out within this strategy and the work undertaken every day by teams across the Trust. By providing clear priorities, meaningful measures, visible leadership and a shared approach to improvement, the Care Trust Way supports individuals, teams and services to understand their contribution, solve problems, remove barriers and improve the quality of care they provide.



The Care Trust Way is built on the belief that everybody improves. We also believe that the best improvements are developed with the people who experience our services. Through co-production, we will work alongside people using our services, carers, families, volunteers, communities and partners to shape decisions, redesign pathways and improve services. We will move beyond simply gathering feedback to involving people in identifying priorities, developing solutions and evaluating whether changes have made a difference. In doing so, we will ensure that lived experience remains central to how we deliver Better Lives, Together.

Whether we are providing care directly, supporting services behind the scenes or working with partners across the system, every colleague has a role to play in delivering Better Lives, Together. It supports our commitment to listening, acting on what we hear, and demonstrating how feedback leads to improvement. In this way, it helps us move from aspiration to delivery and from engagement to action.

The Care Trust Way is not a programme, a project or a separate initiative. It is the way we will work together to deliver this strategy. It provides the foundation upon which our breakthrough programmes, digital transformation, partnerships and service improvements will be delivered. By creating a

stronger culture of learning, accountability and continuous improvement, it will help us turn our vision for Better Lives, Together into meaningful and lasting improvements for the people and communities we serve.

Annual delivery planning – how we translate strategy into action

The Care Trust Way will provide the framework for turning this strategy into action. Through annual planning, it will create a clear golden thread from our strategic priorities to the work of teams and individuals across the Trust.

Our strategy will only succeed if it is owned by everyone. The engagement process highlighted both the scale of the challenges we face and the commitment of our colleagues, people who use services, carers and partners, to improve things. By building on the strengths that already exist across our organisation, we can turn ambition into meaningful change.

This strategy sets out what matters most. Delivering it will depend on the decisions we make, how we work together, and the actions we take every day. Everyone has a role to play, and leaders at every level have a responsibility to create the conditions in which people can thrive, innovate and improve.

As individuals, we should regularly ask ourselves:

- What does this strategy mean for my role?
- What could I do differently?
- How can I contribute to our strategic priorities?

The answers will be different for each of us, but all of us can contribute. Our contribution as a team will be documented within our annual plans. Our contribution as an individual will be in our appraisals.

Examples of the types of actions teams and individuals can consider are in the table below:

Strategic priority	Examples of actions
Supporting and valuing our workforce, creating the conditions they need to deliver safe, high quality care.	Develop new skills, share knowledge, support colleagues and create inclusive teams where people feel valued and able to thrive.
Providing safe, effective compassionate care.	Use data and feedback to improve services, personalise care, monitor outcomes and focus improvement on what matters most to people and communities.
Using our resources effectively to deliver the greatest benefit for our communities.	Identify duplication, reduce waste, simplify processes and make the best use of available resources.
Working together with partners to improve care for our communities.	Work with other services and organisations to improve outcomes, strengthen relationships and develop more joined-up pathways.

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If we succeed, people across the Trust will be able to say with confidence:

‘We knew what mattered most. We played our part. We made a difference. We achieved it together’.



Better Lives, Together sets a consistent direction to 2031, but delivery will take place in a changing environment. Annual planning will provide the mechanism for reviewing progress, agreeing priorities and sequencing delivery for the year ahead.

Each annual planning cycle will:

- Review progress against the strategic priorities, signs of success and programme outcomes.
- Consider changes in population need, evidence, national policy, resources, risks and partnership arrangements.
- Identify the limited number of actions and milestones requiring particular organisational focus.
- Confirm accountable leadership, delivery capacity and resource implications.
- Agree measures, expected benefits and health equity considerations.
- Identify dependencies between programmes, services and partners.
- Translate agreed priorities into directorate, service, team and individual objectives.

Learning from delivery will be used to adapt actions and methods while protecting the overall direction and intent of the strategy. This will help us remain responsive without losing focus.

Annual planning will translate our strategic priorities into measurable objectives at every level of the organisation. This will help ensure everyone understands their contribution, what they are accountable for, and how progress will be measured.

Using the Care Trust Way, teams will be supported to identify problems, test improvements, measure impact and share learning. By taking this approach consistently across the organisation, we will turn strategic intent into practical action.

We will celebrate progress and recognise the contribution that individuals, teams and services make towards our shared ambition for 2031. While this strategy describes a journey rather than a destination, every improvement brings us closer to achieving our vision.



Innovation, research and continuous improvement – how we learn and improve

For us, innovation is not simply about adopting new technology. It is about creating a culture where people are encouraged to identify problems, test ideas, learn quickly and improve continuously. Innovation can come from anywhere – from frontline teams, people using our services, carers, partners, volunteers, communities, researchers and industry. Our role is to create the conditions where good ideas can be developed, evaluated and scaled when they demonstrate value.

A key catalyst for innovation and improvement is 'Better Lives' the official NHS charity for BDCFT. Acting as enabler, the charity supports innovation and activity that cannot be covered by core NHS budgets, transforming the everyday experiences of patients, service users, carers, volunteers and staff. The charity secures charitable donations through fundraising and charitable grants, and spends these guided by its charitable aims and charity strategy 2025-28.

Innovation at BDCFT will be supported through a connected improvement and innovation ecosystem that brings together frontline improvement, research, digital transformation, data and analytics, artificial intelligence (AI), knowledge sharing and external partnerships. By creating stronger links between these capabilities, we will accelerate the identification, testing, spread and adoption of ideas that improve outcomes, reduce inequalities, release time for care and create value for our communities.

We will take a disciplined approach to innovation, using the Care Trust Way to ensure new ideas are grounded in evidence, aligned to strategic priorities and focused on improving outcomes, experience, productivity and value.

Co-production – how we ensure change is shaped by the people who experience it

Our ambition is to ensure the Trust involves service users, patients, carers and communities in the planning, delivery and continuous quality improvement of services. We will support co-production and shared decision making in service design and quality improvement, to actively contribute to improved quality, safety, and patient outcomes and experience.

Our future strategy will align to NHS England's statutory guidance 'Working in Partnership with People and Communities' and the new Quality Strategy published July 2026.

We'll seek to promote meaningful partnerships with our colleagues, service users, carers and communities, and to embed inclusive, accessible involvement approaches that reflect the diversity of the population we serve.

It will be our aim to contribute to reducing health inequalities by actively involving yet-to-reach communities and those who may be under-represented or experience poorer access to services.

We will ensure all involvement activity aligns with national duties, best practice and regulatory expectations. There will be an emphasis on the importance of clear roles and responsibilities that support safe, meaningful, and consistent involvement across the Trust. This will be underpinned by demonstrating transparency and accountability by providing feedback on how involvement has influenced decisions.

Our work to apply the Patient and Carer Race Equality Framework (PCREF) to strengthen culturally competent, ethical involvement will continue, to support the wider Trust ambition to improve the experience, access, and participation of racialised communities.

We will support staff to undertake involvement activity that is respectful, purposeful and grounded in lived experience.

Digital – how we enable delivery

Digital is not a separate strategy or a standalone programme of work. It is one of the key enablers through which we will deliver Better Lives, Together.

The challenges facing health and care cannot be addressed through additional effort alone. Growing demand, workforce pressures, financial constraints and rising expectations require us to work differently. Digital, data, AI, and automation will help us create capacity, improve productivity, strengthen decision making and make it easier for people to access care and support. Digital therefore has a role to play in every strategic priority within this strategy.

Our approach is focused on delivering measurable improvements in outcomes, experience and value. We will prioritise digital investment where it helps release time for care, reduce administrative burden, improve service flow, strengthen communication with patients and carers, improve access to services, support operational decision making and contribute to long term financial sustainability.



To support this, our digital portfolio is organised around five connected domains:

- Optimised workforce.
- Enhanced digital experience.
- Improvement in operational flow.
- Streamlined, connected care.
- Effective resilience.

These domains reflect the areas where digital can make the greatest contribution to the ambitions set out within this strategy.

For our workforce, digital will help create more time for care through simplifying processes, reducing duplication and automating routine tasks. Technologies such as Generative Artificial Intelligence (GenAI), ambient voice technology, workflow automation and optimisation of clinical systems will support colleagues to spend less time on administration and more time delivering care, improvement and prevention across all care settings.

For people using our services, digital will support easier access, better communication and more convenient ways of interacting with services. This includes expanding on multichannel communications, a digital front door centred on patient preferences and personalised digital services that help people access support at the right time and in the way that best meets their health.

For operational efficiencies, digital will improve visibility of demand, capacity, flow and outcomes. Better data quality, real-time reporting, operational dashboards and advanced analytics will help teams identify unwarranted variation, improve productivity, support service improvement and make more informed decisions from ward to Board.

Digital will also help to strengthen joined-up care. Through improved interoperability, information sharing and connected systems, colleagues and partners will have access to the information they need to deliver safer, more streamlined care. This will help reduce duplication, improve transitions between services and support neighbourhood based models of care.

Productivity improvement is a particularly important focus over the life of this strategy. Digital on its own does not create value; value is realised when technology is combined with pathway redesign, new ways of working and continuous improvement. We will therefore focus on using digital to release capacity, reduce waste and enable colleagues to work at the top of their licence, ensuring that productivity gains are translated into improvements in access, quality, outcomes and financial sustainability.

Finally, strong digital foundations are essential. Cyber security, digital infrastructure, information governance, resilience and modern clinical systems are critical to maintaining safe and reliable services. Over the next five years we will continue to invest in these foundations, including the future electronic patient record, ensuring that our technology estate is secure, resilient and capable of supporting future models of care.



Quality Performance and Management System (QPMS) – how we manage and measure delivery

The Quality Performance and Management System (QPMS) is the management system that supports delivery of the Care Trust Way. It sets out how we manage and measure our performance. The QPMS brings together annual planning, performance management, quality improvement, assurance, accountability and organisational learning into a single delivery system. It provides the structures, standards, measures and routines that enable delivery at every level of the organisation, ensuring that strategic priorities are translated into annual objectives, service plans, improvement activity, performance management and day-to-day decision making. In doing so, it creates a clear golden thread from Board priorities through to frontline teams, helping everyone understand what matters most, how success will be measured and how they contribute to delivering Better Lives, Together.

Through the Care Trust Way and QPMS, we will use data, research, insight, lived experience and equality impact assessments to guide decision making, identify opportunities for improvement and monitor progress against our signs of success, overarching measures and health equity measures.

This will help ensure we remain focused on improving outcomes, reducing inequalities, supporting our workforce and making the best possible use of our resources.

6. Connected strategies and plans

Our refreshed Better Lives, Together strategy will be an enabler for other key Trust strategies outlined below. The strategy is high level with much of the detail being developed within specific strategies and action plans. The ambitions, strategic priorities and signs of success as set out in this strategy will also shape the content of related strategies going forward, making sure that they are clearly linked. Many of these strategies and their role in delivering this refreshed Better Lives, Together strategy is shown in the graphic that follows.

Each connected strategy will explicitly demonstrate how it contributes to one or more Better Lives, Together strategic priorities, signs of success, breakthrough programmes and delivery outcomes. When strategies are refreshed, they will clearly articulate those links and describe how delivery will be aligned through annual planning and the QPMS.



7.2 From measures to action

Through QPMS, progress will be reviewed at the appropriate level of the organisation.

Reviews will consider:

- Whether agreed actions and milestones are on track.
- Whether outcomes and experience are improving.
- Whether benefits are being realised.
- Whether inequalities are reducing or widening.
- Whether risks, constraints or unintended consequences require action.
- What has been learned and what needs to change.

Where progress is not on track, the focus will be on understanding the causes, agreeing corrective action, removing barriers and escalating issues that cannot be resolved at the level at which they arise.

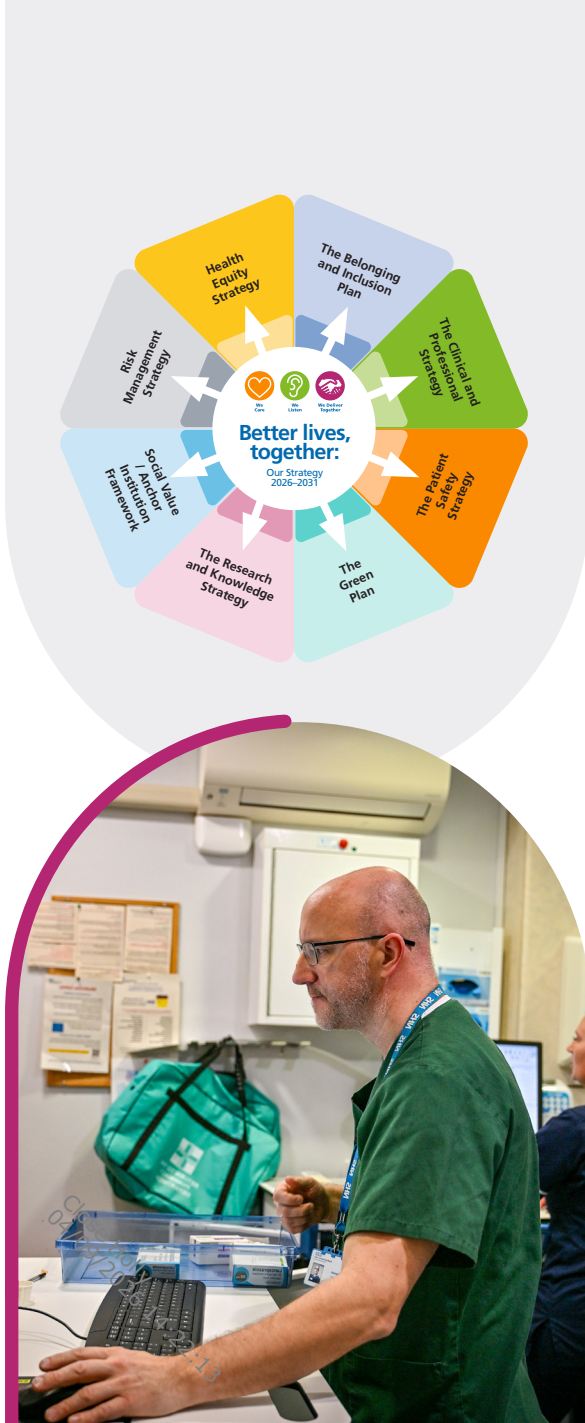
7. Measuring, assuring and reporting progress

7.1 Our measurement approach

We will use a balanced set of information to understand whether Better Lives, Together is making a difference. No single measure can provide a complete picture. Our approach will combine:

- The signs of success identified through engagement.
- Overarching measures for each strategic priority.
- Health equity measures.
- Breakthrough programme outcome and benefit measures.
- Quality, safety, workforce, operational and financial information.
- Feedback and lived experience from colleagues, people using services, carers, families and partners.
- Research, evaluation and improvement learning.

Measures will be used to support learning and action, not merely to report activity. We will seek to understand what is changing, for whom, where variation exists and whether improvement is being experienced fairly.





7.3 Reporting and assurance

Reporting will be proportionate and designed around existing governance wherever possible. It will provide clear line of sight from breakthrough programmes and annual delivery plans to the strategic priorities and signs of success considered by the Board.

Public and colleague-facing updates will describe not only what has been delivered, but the difference it has made. We will use clear 'you said, we did, we learned' communication to show how feedback and evidence have influenced action.

7.4 Benefits realisation

Each breakthrough programme will identify its intended benefits, the people or groups expected to benefit, how those benefits will be measured, and how they will be sustained. Benefits will include relevant improvements in outcomes, experience, equity, quality, workforce capacity, productivity, sustainability and use of resources.

Benefits will not be treated as achieved solely because an activity or milestone has been completed. We will seek evidence that change has produced a meaningful and sustainable improvement.

This is especially important given the strategy's strong emphasis on outcomes rather than output and on creating value from every pound, hour and asset.

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8. Glossary and references

Glossary

Term	Definition
Annual delivery plans	Annual delivery plans identify the organisation’s priorities, actions, accountable leads, milestones and measures for each year.
Better Lives, Together	Better Lives, Together: Our Strategy 2026–2031 sets out our shared direction for the next five years. It describes the needs of our population, what our colleagues, communities and partners have told us, the choices we have made and the difference we want people to experience by 2031.
Breakthrough programmes	Our ten breakthrough programmes are vehicles through which we will focus major organisational change. They translate commitments in the strategy into coordinated delivery at programme and operational level.
Care Trust Way	The Care Trust Way is how we translate strategy into action. It brings together our values, leadership behaviours, quality management approach, improvement methods, performance arrangements and daily ways of working into a single delivery system that helps us focus on what matters most and continuously improve outcomes for the people we serve.
Co-production	Co-production is how we involve service users, patients, carers and communities in the planning, delivery and continuous quality improvement of services.
Health equity	Health equity means that everyone has a fair and just chance to be as healthy as possible. It removes unfair barriers like poverty, discrimination, and lack of care. This goal means giving extra help to groups who face more obstacles so everyone can reach good health.

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Quality Performance and Management System (QPMS)	Our QPMS is the management system that supports delivery of the Care Trust Way. It sets out how we manage and measure our performance. The QPMS brings together annual planning, performance management, quality improvement, assurance, accountability and organisational learning into a single delivery system.
Population health	Population health is an approach to health that aims to improve the physical and mental wellbeing of an entire group or community while reducing health inequalities.
Signs of success	Our signs of success, developed through engagement, describe the difference that people have told us matter most and help us understand whether change is being experienced in practice.
Social value	Social value is how BDCFT will maximise the wider social, economic and environmental value it creates for Bradford District and Craven through its role as an employer, purchaser, partner, estate owner and community organisation.
Strategic priorities	Our strategic priorities set out the broad areas for change, and our delivery outcomes set out what will be different because of that.
Supporting delivery framework	The Supporting Delivery Framework provides the next level of detail down from our Better Lives, Together strategy document, including our values and behaviour compact, strategic delivery priorities, breakthrough programme outcomes, foundations for delivery, connected strategies, and the arrangements through which progress will be planned, measured, assured and reviewed.

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Abbreviations

Abbreviation	Definition
AI	Artificial intelligence (AI) is computer software or a machine built to do tasks that normally require human thinking, such as learning, reasoning, and solving problems.
BDC	Bradford District and Craven. The geographical area that covers the communities we serve.
BDCFT	Bradford District Care NHS Foundation Trust. Our organisation.
EPR	Electronic Patient Record. This is a digital software system that contains a person's medical history, test results and other information in relation to their care.
INH	Integrated Neighbourhood Health. A programme that looks at bringing together primary care, community services, mental health, social care and VCSE partners to deliver coordinated neighbourhood-based care.
MDT	Multi-disciplinary teams. Teams working together in a local area to address a person's health and care needs.
PCREF	The Patient and Carer Race Equality Framework designed to illuminate racial inequalities in services.
PPP	Place Provider Partnership. These partnerships will take on some of the commissioning, governance and leadership responsibilities that were once held by NHS Integrated Care Boards. The PPP will work alongside primary care, local authorities, VCSE and range of healthcare support organisations as key partners in delivering integrated, preventative and community based care, particularly through Integrated Neighbourhood Health and Children and Young People pathways.
QPMS	Quality Performance and Management System (QPMS). Our QPMS is the management system that supports delivery of the Care Trust Way. It sets out how we manage and measure our performance.
VCSE	Voluntary, Community and Social Enterprises. Organisations whose reach into communities is critical to support prevention, early intervention and tackling inequalities.

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September 2026

Board of Directors – meeting held in public

10 September 2026

Paper title:	Bradford District and Craven – Strategic Partnering Agreement (2026 update and approval)	Agenda Item
Presented by:	Fran Stead, Trust Secretary	19.0
Prepared by:	Place Governance – Bradford District and Craven	
Committees where content has been discussed previously	Board of Directors	
Purpose of the paper Please check <u>ONE</u> box only:	☒ For approval ☒ For information ☐ For discussion	
Link to Trust Strategic Vision Please check <u>ALL</u> that apply	☐ Providing excellent quality services & seamless access ☐ Creating the best place to work ☐ Supporting people to live to their fullest potential ☐ Financial sustainability, growth & innovation ☒ Governance & well-led	
Care Quality Commission domains Please check <u>ALL</u> that apply	☐ Safe ☐ Caring ☐ Effective ☒ Well-Led ☐ Responsive	

Purpose of the report
To provide an update on the process to continually refresh the Strategic Partnering Agreement for the Bradford District and Craven Place, including the current version, presented or approval at all partner organisations.

Executive Summary
The current operating context is informed by three areas: firstly, 10-Year Health Plan: Fit for the Future, published in July 2025. Secondly, Bradford District and Craven Health and Care Partnership developed its Health, Care and Wellbeing Strategy in September 2025 and implementation is underway. Thirdly, undertaking due diligence and developing Partnership Governance arrangements in 2026/27 to support emerging Place Provider Partnerships as they form in each of the five Places within the West Yorkshire System. The Strategic Partnering Agreement (SPA) sets out the key terms that the Partners have agreed to work together on and aims of the Partnership to work in a collaborative and integrated way on a Best for Bradford District and Craven basis. It describes an approach to shared decision making and how resources are committed. The most recent refresh of the SPA was approved in May 2025

by the Bradford District and Craven Health and Care Partnership Board. This SPA refresh sets out arrangements established to enable delivery of the Strategy and takes account of the operating context. This full review of the SPA and Governance Handbook supports arrangements through this 2026/27, and changes include:

- alignment of with the Health, Care and Wellbeing Strategy (September 2025) of the vision, objectives and principles, the Health and Wellbeing Strategies and the BMDC District Plan;
- refresh of the Governance clauses and schedule to reflect the emergent Provider Partnership Governance arrangements;
- inclusion of a new schedule outlining compliance with Health Overview and Scrutiny;
- outlined Integrated Neighbourhood Health as a key policy driver for services change; and
- Hill Dickinson review of the SPA including boiler plate clauses to enable and support the development of the Place Provider Partnership, Partnership Governance arrangements. Further work underway to draft an updated Information sharing and Conflicts of Interest (clause 13).

During 2026/27 decision making will continue to be discharged through ICB delegation from NHS West Yorkshire ICB Board to Bradford district and Craven place via the Bradford District and Craven Health and Care Partnerships Board (a Committee of the ICB). Therefore, the governance arrangements set out in the SPA are aligned to governance framework of the ICB and should be read alongside the [NHS West Yorkshire Integrated Care Board's Constitution](#) and associated documents including the Scheme of Reservation and Delegation (SoRD), the Financial Scheme of Delegation (FSOD), and the Standing Financial Instructions (SFIs).

Following agreement of the SPA by partners, the [Bradford District and Craven Governance Handbook](#) and finalisation of the ICB staffing structure changes, the Governance Handbook will be refreshed and re-published on the Partnership's Act as One website.

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 updated SPA; and
- authorise the Chief Executive to sign the SPA as the Trust's representative.

Links to the Strategic Organisational Risk register (SORR)

N/A

Care Quality Commission domains

Please check **ALL** that apply

- | | |
|-------------------------------------|--|
| ☐ Safe | ☐ Caring |
| ☐ Effective | ☒ Well-Led |
| ☐ 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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DATE 1 APRIL 2026

1. NHS WEST YORKSHIRE INTEGRATED CARE BOARD (BRADFORD DISTRICT AND CRAVEN PLACE)
2. AIREDALE NHS FOUNDATION TRUST
3. BRADFORD DISTRICT CARE NHS FOUNDATION TRUST
4. BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
5. CITY OF BRADFORD METROPOLITAN DISTRICT COUNCIL
6. BRADFORD CHILDREN AND FAMILIES TRUST
7. NORTH YORKSHIRE COUNCIL
8. BRADFORD CARE ALLIANCE COMMUNITY INTEREST COMPANY
9. BRADFORD VCS ALLIANCE LIMITED
10. LOCAL CARE DIRECT
11. MODALITY PARTNERSHIP
12. WHARFEDALE, AIREDALE AND CRAVEN ALLIANCE
13. BRADFORD CARE ASSOCIATION LIMITED
14. AFFINITY CARE

STRATEGIC PARTNERING AGREEMENT

FOR THE TRANSFORMATION AND BETTER INTEGRATION OF HEALTH AND
CARE SERVICES FOR THE POPULATION OF BRADFORD DISTRICT AND
CRAVEN

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Date: 1 APRIL 2026

2026/27

This Strategic Partnering Agreement (“SPA”) is made between:

1. **NHS WEST YORKSHIRE INTEGRATED CARE BOARD (BRADFORD DISTRICT AND CRAVEN PLACE)** of White Rose House, West Parade, Wakefield WF1 1LT (“ICB”)
2. **AIREDALE NHS FOUNDATION TRUST** of Airedale General Hospital, Skipton Road, Steeton, Keighley BD20 6TD
3. **BRADFORD DISTRICT CARE NHS FOUNDATION TRUST** of New Mill, Victoria Road, Saltaire BD18 3LD
4. **BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST** of Duckworth Lane, Bradford BD9 6RJ
5. **CITY OF BRADFORD METROPOLITAN DISTRICT COUNCIL** of Bradford City Park, City Hall, Centenary Square, Bradford BD1 1HY (“BMDC”)
6. **NORTH YORKSHIRE COUNCIL** of County Hall, Northallerton, DL7 8AD (“Council”)
7. **BRADFORD CHILDREN AND FAMILIES TRUST** of 4 Manchester Road, Bradford, BD5 0QL
8. **BRADFORD CARE ALLIANCE COMMUNITY INTEREST COMPANY** (Registered Company number 10083487) of The Ridge Medical Centre, Cousen Road, Bradford BD7 3JX
9. **BRADFORD VCS ALLIANCE LIMITED** (Registered Company number 10597133) of Perkin House, Grattan Road, Bradford BD1 2LU
10. **LOCAL CARE DIRECT** (Registered Company number IP29766R) of Sheridan Teal House, Unit 2 Longbow Close, Pennine Business Park, Bradley, Huddersfield HD2 1GQ
11. **MODALITY PARTNERSHIP** of Orsborn House, 55 Terrace Road, Handsworth, Birmingham B19 1BP
12. **WHARFEDALE, AIREDALE AND CRAVEN ALLIANCE** of Ling House Medical Centre, 49 Scott Street, Keighley, BD21 2JH
13. **BRADFORD CARE ASSOCIATION LIMITED** (Registered Company number 11911880) of 68 Kirkgate, Shipley BD18 3EL
14. **AFFINITY CARE** of The Westcliffe Building, Westcliffe Road, Shipley BD18 3EE

together referred to in this SPA as the “Partners” and each individually a “Partner”.

BMDC and NYC are collectively referred to in this SPA as the “Councils”. Those Partners that are NHS organisations are referred to as the “**NHS Partners**”.

The ICB and the Councils (to the extent that either or both of the Councils are acting as commissioners and not providers of social care and/or public health services) are together referred to in this SPA as the “**Commissioners**”.

The other Partners, excluding the Commissioners but including the Councils (where either or both of them are acting as a provider of social care and/or public health services), are together referred to in this SPA as the “**Providers**”.

RECITALS

1. The Partners have operated under a Strategic Partnering Agreement (“SPA”) since 2019 through which they have established a place-based partnership for Bradford District and Craven through their ‘Act as One’ approach (the “**Bradford, District and Craven Provider Partnership**” or the “**Provider Partnership**”). In line with the principle of subsidiarity, the ICB has delegated certain of its functions to be exercised on its behalf by the Provider Partnership through the governance arrangements set out in this SPA.
2. This SPA sets out the operating framework (as of 1 April 2026), values, principles and shared ambition of the Partners in supporting work towards the transformation of health and care and better health and wellbeing outcomes for the people who live in Bradford District and Craven through the Provider Partnership model.
3. The Partners recognise that from the Commencement Date they will need to continue with their programme of work through the governance arrangements set out in this SPA to further develop the Provider Partnership to achieve its Vision and the Objectives. During the term of this SPA, the Partners will be embarking on a programme of work to develop a provider partnership for Bradford District and Craven. This programme of work is set out, in outline terms, in the SPA Work Plan in Schedule 8

Health Overview and Scrutiny Arrangements

1. Health Overview and Scrutiny Committees (HOSCs) play a key role in holding the health system to account on behalf of local people. They proactively seek, test, and challenge information about the performance, planning and operation of local health services, using a range of evidence and intelligence.
2. A HOSC’s function is to provide effective scrutiny in order to help improve

outcomes for communities:

- 2.1 enabling local people and elected members to influence health priorities;
 - 2.2 giving communities a voice on quality, safety, access and effectiveness of services;
 - 2.3 providing assurance that services are safe, effective and tackling health inequalities; and
 - 2.4 supporting commissioners and providers to better understand local needs and develop improved services and care pathways.
3. At the local level, **Calderdale, Kirklees, Leeds, Bradford District and Craven** and **Wakefield**, has its own established statutory HOSC, in Calderdale Council currently considers health matters through its Overview and Scrutiny Committee. These committees scrutinise NHS planning, delivery and finances and form an important part of system-wide accountability.
 4. At a **West Yorkshire** level, the West Yorkshire Joint Health Overview and Scrutiny Committee (WY JHOSC with North Yorkshire participating as an interested party for Craven) operates on a discretionary basis. It works in partnership with NHS West Yorkshire ICB and has an informal role in scrutinising substantial service change across West Yorkshire.
 5. At a **North Yorkshire** level, the North Yorkshire Scrutiny of Health Committee scrutinises any matter relating to the planning, provision and operation of health services in the County (which includes Craven), including the policies of the Health and Care Partnerships

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Schedule 9

Act as One Provider Partnership Protocol for Information Sharing

1. INTRODUCTION

- 1.1 The Bradford District and Craven (BD&C) Provider Partnership Strategic Partnering Agreement (the **SPA**) sets out the operating framework for how health and care system partners in BD&C who are signatories to the SPA (the **Partners**) will work together in a collaborative and integrated way on a Best for Bradford District and Craven basis. To this end, the Partners have agreed to share information with each other in an honest, open and timely manner.
- 1.2 As referenced in Clause 13.1 of the SPA, this Protocol sets out arrangements to manage the sharing of information between the Partners to support collaboration and joint working.
- 1.3 This Protocol forms part of the governance arrangements for the BD&C Provider Partnership as set out in the SPA and should be considered in conjunction with the SPA and the terms of reference of the BD&C Partnership Board, Act as One Committee and other governance groups as referenced in the SPA (referred to in this Protocol as the **Governance Groups**).

2. DEFINITIONS

In this Protocol defined terms have the meaning set out in the SPA with the exception of the terms defined in Appendix 1.

3. SCOPE

This Protocol applies to each of the Partners and its representatives, and each Partner will ensure that its representatives who are members of the BDC Act as One system governance group(s) or who are involved in strategy delivery groups pursuant to the SPA are aware of, and comply with, this Protocol when sharing information for the purposes of the SPA.

4. CONFIDENTIAL INFORMATION

- 4.1 The Partners have agreed under the SPA to share information in an honest, open and timely manner to support the achievement of the SPA objectives, subject to compliance with Law and their obligations of confidentiality in the SPA.

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- 4.2 Each Partner must maintain clear records of all Confidential Information disclosed or received.
- 4.3 Where it is agreed between any of the Partners that the sharing of personal data is necessary for the purposes of the SPA, the relevant Partners must ensure that a data protection impact assessment (DPIA) is produced and, if the data sharing is not already covered by existing data sharing agreements, enter into appropriate data sharing agreements in accordance with the requirements of the GDPR.

5. COMPETITION SENSITIVE INFORMATION

- 5.1 The Partners must not disclose to each other any Competition Sensitive Information.
- 5.2 Information is not Competition Sensitive Information if:
 - 5.2.1 it relates to activities or markets in which the Partners do not currently compete against other organisations and where there is no realistic prospect that they will in future compete;
 - 5.2.2 subject to paragraph 5.3 of this Protocol, if it relates to any arrangements involving information exchange and collaboration (including for the purpose of joint projects contemplated or being implemented by the Partners) which were put in place prior to the date of the SPA for the purpose of Business as Usual activities; and
 - 5.2.3 it relates to activities or markets in which the Partners are actual or potential competitors and disclosure of the relevant information would not affect the Partners' commercial strategy or decisions; this may apply if, for example:
 - (a) the information is historical, Aggregated (as defined below) and/or anonymised; or
 - (b) the information is freely available in the public domain other than as a direct or indirect result of the information being disclosed in breach of this Protocol or the SPA or of any other undertaking of confidentiality addressed to the Partner to whom the information relates (except that any compilation of otherwise public information in a form not publicly known shall nevertheless be treated as Competition Sensitive Information).

- 5.3 The following principles should be considered in relation to any information disclosed from one Partner to another:

5.3.1 Business as Usual

- (a) The Partners must continue to act, make bids and try to win new business as appropriate in exactly the same way that each would have done in the absence of the development of closer collaboration and joint working.
- (b) The Partners will remain separate to other organisations in the area and should continue to make decisions on matters such as bidding strategies and entry into new contracts independently.

5.3.2 Document Creation

- (a) Documents created by any Partner for the development of closer collaboration and joint working as part of the Provider Partnership may be disclosable under the Freedom of Information Act 2000.
- (b) Due care and attention should be taken when creating documents (including emails and handwritten notes) to avoid the use of language that could be misinterpreted.
- (c) If any Partner or their staff are asked by their external legal advisors to provide Data, any documents should be clearly marked "Privileged and confidential: prepared at the request of our external legal advisers".

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APPENDIX A - DEFINITIONS

- 1 **Aggregated** means that the price, cost and volume of individual services or contracts for the provision of services, the subject matter of which forms or could form the basis of competition between any of the Partners, cannot be determined from the Data.
- 2 **Commercially Sensitive Information:** Confidential Information which is of a commercially sensitive nature relating to a Partner, its intellectual property rights or its business or which a Partner has indicated would cause that Partner significant commercial disadvantage or material financial loss.
- 3 **Competition Sensitive Information:** Confidential Information (as defined in the SPA) which is owned, produced and marked as Competition Sensitive Information by one of the Partners and which that Partner properly considers is of such a nature that it cannot be exchanged with the other Partners without a breach or potential breach of Competition Law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Partner, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions.
- 4 **Data:** information, data and material recorded in any form and shared between any or all of the Partners including Confidential Information and Commercially Sensitive Information.

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4. Schedule 10 to this SPA.
5. The Commissioners are the statutory bodies responsible for planning, organising and buying social care, NHS-funded healthcare, support and community services for people who live in Bradford District and Craven. The Providers are providers of social care, NHS funded healthcare, support and community services to the population across Bradford District and Craven.
6. The Councils have a role within the Provider Partnership and this SPA as both commissioners of public health and social care services but also as providers of social care services either through direct delivery or through various subcontracts. In their respective roles as commissioners of social care services, the Councils shall be Commissioners and in their respective roles as providers of social care services they shall be Providers. The Councils recognise the need to ensure that any potential internal or external conflicts of interest are appropriately identified and managed.
7. Specific new services and initiatives may be added by agreement and inserted into this SPA as required to further the collaborative work of the Partners.
8. This SPA has been drafted to work alongside:
 - (a) the Services Contracts between the Commissioners and the Providers for the delivery of the Services; and
 - (b) the Section 75 Agreements between the ICB and each of the Councils.
9. This SPA replaces the previous SPA entered into by certain of the Partners dated 1 April 2025 which is terminated with effect from the Commencement Date.

IT IS AGREED AS FOLLOWS:

1. DEFINITIONS AND INTERPRETATION

- 1.1 In this SPA, capitalised words and expressions shall have the meanings given to them in Schedule 1, in addition to any definitions set out elsewhere in this SPA.
- 1.2 In this SPA, unless the context requires otherwise, the following rules of construction shall apply:
 - 1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

- 1.2.2 a reference to a “Partner”, “Provider” or “Commissioner” includes its personal representatives, successors or permitted assigns;
- 1.2.3 a reference to statute or a statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to statute or a statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;
- 1.2.4 any phrase introduced by the terms “including”, “include”, “in particular” or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms;
- 1.2.5 documents in “agreed form” are documents in the form agreed by the Providers and identified as such (whether electronically or otherwise) and annexed to this SPA; and
- 1.2.6 a reference to writing or written includes e-mails.

2. STATUS AND PURPOSE OF THIS SPA

- 2.1 The Partners have together formed the Provider Partnership on the terms set out in this SPA in order to deliver better health outcomes for the population of Bradford District and Craven.
- 2.2 This SPA sets out the key terms that the Partners have agreed in how the Commissioners and Providers will work together in a collaborative and integrated way on a Best for Bradford District and Craven basis to develop and implement the Provider Partnership from 1 April 2027.
- 2.3 The Services Contracts set out how the Partners provide Services to Bradford District and Craven. This SPA is not intended to conflict with or take precedence over the terms of the Services Contracts unless expressly agreed in writing by the Partners to the respective Services Contract.
- 2.4 Notwithstanding the good faith consideration that each Partner has afforded the terms set out in this SPA, the Partners agree that save as provided in Clause 2.5 below, this SPA shall not be legally binding. The Partners enter into this SPA intending to honour all their obligations.
- 2.5 This Clause 2.4 and Clauses 3 (Information Sharing and Conflicts of Interest), 9 (Liability), 2 (Assignment and Novation), 23 (Confidentiality and Freedom of Information), 24 (Intellectual Property), 29 (Counterparts) and 32 (Governing Law and Jurisdiction) shall come into force from the

date of this SPA and shall give rise to legally binding commitments between the Partners.

- 2.6 Each of the Providers either have entered or will enter into individual Services Contracts (or where appropriate combined Services Contracts) with one or more of the Commissioners. The Commissioners may also enter into certain contracts with each other such as agreements for the pooling of funds or resources between the Commissioners. This SPA is intended to provide an overarching collaborative framework for such arrangements, without amending or overriding any Services Contract except where expressly agreed in writing.

3. ACTIONS TAKEN PRIOR TO AND POST THE COMMENCEMENT DATE

- 3.1 Each Partner shall provide to each of the other Partners on or prior to the Commencement Date confirmation that it has approved entry into this SPA.

4. DURATION AND REVIEW

- 4.1 This SPA shall take effect on the Commencement Date and will continue in full force and effect and will expire on 31 March 2027 (the “**Initial Term**”), unless and until terminated in accordance with the terms of this SPA.
- 4.2 The Partners may by mutual agreement in writing extend the Initial Term of the SPA by a further additional period of up to three (3) years (the “**Extended Term**”).
- 4.3 The Partners will review the terms of this SPA and progress made against the SPA Work Plan throughout the Initial Term and Extended Term (if applicable) at six monthly intervals from the Commencement Date or as otherwise agreed between the Partners. Following any such review, the Partners may agree to vary the SPA to reflect developments as appropriate in accordance with Clause 21 (*Variations*).

SECTION A: SCOPE, VISION, OBJECTIVES AND PRINCIPLES

5. BRADFORD DISTRICT AND CRAVEN PROVIDER PARTNERSHIP IN-SCOPE SERVICES

The Partners have agreed that the Services set in in Schedule 3 are within the scope of the Provider Partnership during the Shadow Period.

6. PROVIDER PARTNERSHIP VISION

6.1 The Partners have agreed to work towards a common vision that:

6.1.1 People will live in good health, with equitable access to high-quality, culturally appropriate care, informed by population health insight and the wider determinants of health.

6.1.2 People will be supported to stay Happy, Healthy at Home through neighbourhood-based, integrated teams delivering proactive, personalised care.

6.1.3 Reducing health inequalities is central to our purpose, applying proportionate universalism and targeting the greatest effort where need is greatest.

6.1.4 Care will increasingly shift from hospital to community, supported by digital innovation, shared care records, and integrated multidisciplinary teams.

6.1.5 Communities will be active partners in shaping services, with power devolved closer to people and neighbourhoods (“inverting the power to act”)

In short... Happy, Healthy at Home – delivered through prevention, neighbourhood care, digital innovation, and equity.

7. PROVIDER PARTNERSHIP OBJECTIVES

7.1 The Partners wish to deliver improved population health through integrated health, care and support. The Partners have agreed a collective way of working – “Act as One” – which they will use to achieve the following Objectives:

7.1.1 deliver the Health, Care and Wellbeing Strategy aligned with the Joint Strategic Needs Assessments and Wellbeing Strategies;

a) embed the Government’s “3 Big Shifts”: analogue to digital; hospital to community; and treatment to prevention; and

b) shift resources and activity into prevention and neighbourhood care, including early intervention and proactive care.

7.1.2 Develop advanced population health management capability using segmentation, predictive modelling, and citizen insight

a) reduce health inequalities through equity-led decision-making and proportionate universalism;

- b) strengthen citizen activation and co-production, ensuring communities shape decisions and service design;
- c) support and develop the workforce to operate in integrated neighbourhood teams with digital capability;
- d) ensure financial sustainability through value-based, population-level resource allocation; and
- e) deliver integrated, digitally enabled care with interoperable systems and digital inclusion.

8. THE PRINCIPLES

- 8.1 These Principles underpin the delivery of the Partners' obligations under this SPA and set out the values, behaviours and ways of working required to achieve the Vision and Objectives. These Principles reflect the commitments set out in the Bradford District and Craven Health, Care and Wellbeing Plan (2025), including the shift towards prevention, neighbourhood-based care, digital innovation, population health management, and the reduction of health inequalities.
- 8.2 The Partners acknowledge that the successful delivery of the Provider Partnership depends on their ability to coordinate and combine their expertise, resources, and influence to deliver a whole-system, population-focussed approach to health, care, and wellbeing.
- 8.3 The Partners therefore agree to work together in good faith and, unless the provisions in this SPA state otherwise, will behave consistently as leaders in ways that model and promote the following shared Principles:

Acting as one system the Partners will

- 8.4 act as one team, pursuing one shared purpose:
 - 8.4.1 to improve population health outcomes and reduce inequalities across Bradford District and Craven;
 - 8.4.2 to prioritise decisions that are "Best for Bradford District and Craven", even where this requires compromise or change within individual organisations;
 - 8.4.3 to adopt a distributive leadership model, taking collective responsibility for outcomes, resources, and risks;

Choosing equity

- 8.4.4 The Partners will place equity at the heart of all decisions, recognising that reducing inequalities is a moral, statutory, and financial imperative.
- 8.4.5 Partners will apply the principle of proportionate universalism, ensuring support for all while directing the greatest effort and resource to those with the greatest need.
- 8.4.6 Partners will use data, insight, and lived experience to identify and address unwarranted variation in access, experience, and outcomes.

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Prevention and Early Intervention

- 8.4.7 The Partners will prioritise prevention across the life course, shifting activity and investment from reactive care to proactive, preventive, and anticipatory support.
- 8.4.8 Partners will embed prevention into all pathways, services and neighbourhood models, recognising that up to 80% of health outcomes are shaped by non-medical factors.
- 8.4.9 Partners will work together to slow the progression of long-term conditions, reduce avoidable hospital admissions, and support people to remain independent at home.

Neighbourhood-Based, Integrated Care

- 8.4.10 The Partners will organise care around neighbourhoods and communities, applying subsidiarity so that decisions are taken as close to local people as possible.
- 8.4.11 Partners will support the development and maturity of Integrated Neighbourhood Teams, ensuring multidisciplinary, joined-up working across health, care, VCSE, and community assets.
- 8.4.12 Partners will design services around the needs of people and communities, not organisational boundaries.

Population Health Management and Shared Insight

- 8.4.13 The Partners will use population health management approaches, including segmentation, predictive modelling, and real-time data, to target interventions and resources.
- 8.4.14 Partners will share data, intelligence, and insight to understand population needs, service use, and outcomes.
- 8.4.15 Partners will use evidence of people's experiences to inform co-production and continuous improvement.

Workforce as One

- 8.4.16 The Partners recognise the workforce as a shared system asset and will support its development, wellbeing, and sustainability.
- 8.4.17 Partners will promote a culture of civility, kindness, belonging, and mutual respect across all organisations and teams.

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- 8.4.18 Partners will support new roles, new ways of working and cross-organisational collaboration, particularly within neighbourhood teams.

Stewardship and Social Value

- 8.4.19 The Partners will act as stewards of the health and care system on behalf of current and future generations.
- 8.4.20 Partners will recognise the wider social, economic, and environmental impact of their decisions, contributing to social value, good employment, local prosperity, and sustainability.
- 8.4.21 Partners will work with local authorities, VCSE organisations, education providers, and communities to address the wider determinants of health.

Efficiency, Simplicity and Avoiding Duplication

- 8.4.22 The Partners will “do the work once”, reducing duplication of systems, processes, and effort.
- 8.4.23 Partners will streamline governance, decision-making, and operational processes to maximise value and reduce waste.
- 8.4.24 Partners will undertake shared analysis of problems and opportunities as the basis for collective action.

Recognising Diversity of Communities

- 8.4.25 The Partners will recognise and respond to the different needs of different communities, whether geographical (urban, rural), demographic, cultural, or communities of interest.
- 8.4.26 Partners will tailor approaches to ensure services are culturally competent, accessible, and responsive.
- 8.4.27 Partners will work with trusted community organisations to reach underserved groups.
- 8.5 (these principles, together with the Financial Principles (Schedule 5), Workforce Principles (Schedule 6) and Quality Principles (Schedule 7) are the “**Principles**”).

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SECTION B: DELIVERY OF THE VISION AND OBJECTIVES

9. PROBLEM RESOLUTION AND ESCALATION

- 9.1 The Partners agree to adopt a systematic approach to problem resolution that recognises the Vision, Objectives and the Principles of the SPA set out in Clauses 7, 7 and 8 above.
- 9.2 If a problem, issue, concern or complaint comes to the attention of a Partner which relates to any matter in this SPA and is appropriate for resolution between the Partners, such Partner shall notify the other Partners and the Partners each acknowledge and confirm.
- 9.3 The Partners shall then seek to resolve the issue by a process of discussion within 20 Operational Days of such matter being notified.
- 9.4 A Dispute arising between the Partners which is not resolved under Clause 9.2 and 9.3 above will be resolved in accordance with Schedule 4 (Dispute Resolution Procedure).
- 9.5 If any Partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this SPA (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000 relating to this SPA) the receiving Partner will liaise with the Act as One Committee as to the contents of any response before a response is issued.

10. OBLIGATIONS AND ROLES OF THE PARTNERS

General obligations of the Partners and mutual accountability

- 10.1 Each of the Partners will co-operate in good faith with the others to facilitate the proper performance of this SPA and in particular will:
 - 10.1.1 use all reasonable endeavours to avoid unnecessary Disputes and claims against any other Partner;
 - 10.1.2 not interfere with, hinder, prevent or wilfully impede the rights or the performance of any other Partner or its servants, agents, representatives, contractors or sub-contractors (of any tier) obligations under this SPA, having regard always to the interactive nature of the activities of the Partners, the Services and the statutory functions of the Partners;

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- 10.1.3 subject to Clause 10.3, assist the other Partners (and their agents, representatives, or sub-contractors (of any tier)) in performing those obligations so far as is reasonably practicable.
- 10.2 Each Partner severally undertakes that it shall:
- 10.2.1 work collaboratively with the other Partners in accordance with the Principles;
- 10.2.2 focus on the delivery of key actions that have been agreed by the Partners through the Provider Partnership governance structure and agreement on areas where they require support from the wider group of Partners to ensure the effective management of financial and delivery risk; and
- 10.2.3 co-operate with the other Partners in providing a system wide approach and response to national regulatory bodies (including DoHSC, NHS England and the CQC) from the Bradford District and Craven system through the Provider Partnership governance on regulatory issues which impact upon the Services or the ability of the Partners to deliver the Vision and Objectives.
- 10.3 The Partners must comply with local authority statutory health overview and scrutiny (HOSC) arrangements actively and transparently, including with joint health overview and scrutiny (JHOSC), when there is a substantive service change that crosses local authority's boundaries. This will include timely access to relevant information and data (including performance, quality, and system impact), attendance of appropriately senior decision-makers when requested, to the local authority HOSC or CKW JHOSC, early engagement on proposed service developments or changes, and a timely written response to recommendations made by scrutiny bodies, in accordance with statutory guidance. (schedule 8: Scrutiny)
- 10.4 Nothing in this Clause 10 shall:
- 10.4.1 interfere with the Health and Wellbeing Boards' respective statutory roles as the vehicles for joint local system leadership for health and care or other statutory roles of the Partners;
- 10.4.2 interfere with the right of each Partner to arrange its affairs in whatever manner it considers fit in order to perform its obligations under this SPA in the manner in which it considers to be the most effective and efficient; or

10.4.3 oblige any Partner to incur any additional cost or expense or suffer any loss in excess of that required by its proper performance of its obligations under this SPA.

SECTION C: GOVERNANCE ARRANGEMENTS

11. GOVERNANCE

11.1 The governance structure for the Provider Partnership is set out in the diagram in Schedule 2 and includes the following:

11.1.1 the Partnership Board;

11.1.2 the Act as One Committee;

11.1.3 the partnership forums (being the Finance, Performance & Quality Forum);

11.1.4 the Clinical Executive Group and the Citizens Voice Forum;

11.1.5 Collaboration Programme Executive Group, strategy delivery groups: Integrated Acute Services; Integrated Neighbourhood Health & Care; Integrated Corporate Support & Difficult Decisions; and Integrated Children, Young People and Families Services; and

11.1.6 Enablers: Planning and Commissioning Forum; Reducing Inequalities Alliance; Living Well; Digital, Data, Insight & Intelligence; and Estates.

Partnership Board

11.2 The Partnership Board is the ICB Committee for Bradford District and Craven. The Partnership Board is established as a committee of the ICB Board, in accordance with the ICB's Constitution. The Partnership Board has delegated authority from the ICB Board to make decisions about the use of ICB resources in Bradford District and Craven in line with its remit, and to otherwise support the ICB as set out in its terms of reference. The decisions reached by the Partnership Board are decisions of the ICB, in line with the ICB's Scheme of Reservation and Delegation. This work is referred to as "**ICB Business**". Members of the Partnership Board must comply with ICB policies and procedures and the ICB Committee terms of reference.

11.3 The terms of reference for the Partnership Board, as may be updated from time to time by agreement of the Partners during the term, are set out in the Provider Partnership's Governance Handbook.

- 11.4 For ICB Business, the aim will be to ensure that decisions reflect applicable national and local strategies and are taken in accordance with the Vision, Objectives and Principles for the Provider Partnership.
- 11.5 The Partners acknowledge that their employees may be appointed as members of the Partnership Board. The Partners agree to support their employees in doing so in line with the aims and objectives of the Partnership Board. The Partners acknowledge that any individual who is nominated as a member of the Partnership Board understands and agrees to bring knowledge and perspective from their sector but not be a delegate or carry agreed mandates from that sector or from their Partner organisation.

Act as One Committee

- 11.6 During the Shadow Period 2026/27 the Act as One Committee will make recommendations to the Partnership Board and Partner organisations, and its terms of reference are set out in the Provider Partnership's Governance Handbook. The Act as One Committee shall not be a committee of any Partner or any combination of Partners and will operate as a management forum during 2026/27.
- 11.7 The Act as One Committee has responsibility for aligning decisions on strategic policy matters made by Partners that are relevant to the Provider Partnership. The Act as One Committee may also make recommendations on matters that it has been asked to consider by a Partner in the Provider Partnership. Where the Act as One Committee has been asked to consider matters on behalf of a Partner, that Partner remains responsible for the exercise of its functions and nothing that the Act as One Committee does or recommends shall restrict or undermine that responsibility. This work is referred to as "**Partnership Business**";
- 11.8 The Act as One Committee will report to Partner organisations and is the group responsible for:
- 11.8.1 overseeing the Provider Partnership arrangements under this SPA;
 - 11.8.2 reporting to the Health and Wellbeing Boards on progress against the Objectives; and
 - 11.8.3 liaising where appropriate with the Health and Wellbeing Boards and national stakeholders (including DHSC and NHS England), to communicate the views of the Provider Partnership on matters relating to integrated care in Bradford District and Craven Place.

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- 11.9 The Act as One Committee is supported by the Provider Partnership groups and forums.
- 11.10 The Provider Partnership groups and forums are established by the Act as One Committee and are responsible for developing a system-wide approach in their respective areas of focus. They will provide advice, insight and assurance to the Act as One Committee in their areas of focus and play a key role in driving improvement across the Provider Partnership. They report to the Act as One Committee, and their terms of reference are set out in the Provider Partnership's Governance Handbook. They shall not be a committee of any Partner or any combination of Partners, and each group or forum shall operate as a management forum.

Planning and Commissioning Forum

- 11.1 The Planning and Commissioning Forum is formed by the ICB and BMDC to exercise functions of the ICB and BMDC in respect of the Section 75 Agreement. The Planning and Commissioning Forum will report to the Partnership Leadership Executive and the BMDC Health and Wellbeing Board, and its terms of reference are set out in the Place Partnership Governance Handbook. The Planning and Commissioning Forum shall not be a committee of any Partner or any combination of Partners and will operate as a management forum.

Adults Social Care Joint Commissioning Group

- 11.2 The Adults Social Care Joint Commissioning Group is formed by NHS Humber and North Yorkshire ICB and NHS West Yorkshire ICB and North Yorkshire Council (NYC) to exercise functions of the ICBs and NYC in respect of the section 75 agreement between Humber and NHS North Yorkshire ICB, NHS West Yorkshire ICB and NYC. The Adults Social Care Joint Commissioning Group will update the Act as One Committee on relevant matters, and report to the NYC Health and Wellbeing Board, and its terms of reference are set out in the Provider Partnership Governance Handbook. The Adults Social Care Joint Commissioning Group shall not be a committee of any Partner or any combination of Partners and will operate as a management forum.

Integrated Neighbourhood Health Model

- 11.3 Our Integrated Neighbourhood Health Model is the core approach for delivering care differently across Bradford District and Craven Place.

Neighbourhood footprints of 25,000 to 80,000 people build on existing Primary Care Networks (PCNs) and Community Partnerships (CPs), providing a practical foundation without creating new structures. Fourteen integrated neighbourhoods align closely to PCN and Community Partnership geographies, with limited variation to reflect local context. This balance enables consistent scaling while remaining responsive to place.

- 11.4 Neighbourhoods bring services together through multi-disciplinary teams (MDTs) that target cohorts identified through population health data and local insight. Our initial focus is on people with complex needs and high use of urgent and emergency care. The model aims to identify risk earlier, intervene sooner, and coordinate support more effectively. Professionals across health, social care, and the voluntary sector operate as a team of teams, not a new organisational unit. Delivery will vary - some neighbourhoods co-locate staff, others coordinate virtually - but the organising principle is consistent: integrated care around the individual.
- 11.5 Our CPs connect services with communities and address wider determinants of health. Their informal structure enables flexible, locally driven action. Thirteen CPs, largely aligned to PCNs, focus on prevention, reducing inequalities, and strengthening community resilience and complementing our MDTs. While MDTs support individuals with complex needs, CPs focus on population-level prevention, targeted interventions, and programmes such as Core20PLUS5.
- 11.6 Together, our Integrated Neighbourhoods, MDTs, and CPs shift the system from activity to outcomes, from organisations to populations, and from reactive services to prevention. The model is intentionally evolving, but the direction is clear, care will increasingly be planned and delivered at neighbourhood level, shaped by local need, and enabled by stronger collaboration.

Place Lead role / Director of Integration (BDC)

- 11.7 Following a nomination from the Provider Partnership, the ICB has appointed a 'Place Lead' who has responsibility as the 'convenor' of the Provider Partnership, bringing Partners together and leading collaborative work and integration across the Provider Partnership. The Place Lead is a member of the Partnership Board and the Act as One Committee.
- 11.8 The role of the Place Lead will cease by 1 September 2026 and when the ICB new staffing structure will be mobilised and Director of Integration (BDC) will have been appointed.

Distributed Leadership

- 11.9 The Partners will uphold equal partnership by cooperating and contributing in accordance with Distributed Leadership.

12. RESERVED POWERS

- 12.1 The Partners agree and acknowledge that nothing in this SPA shall operate as to require them to make any decision or act in any way which shall place any Partner in breach of:

12.1.1 Law;

12.1.2 any Services Contract or any Section 75 Agreement;

12.1.3 any specific Department of Health and Social Care or NHS England policies;

12.1.4 if applicable, its constitution, any terms of its NHS provider licence or its registration with the CQC;

12.1.5 the terms of reference of the Partnership Board;

12.1.6 any legislative requirements including the NHS Act 2006 and the NHS Health and Care Act 2022; or

12.1.7 any term of a non-NHS Partner's legal constitution or other legally binding agreement or governance document of which specific written notice has been given to the Partners prior to the date of this SPA, and the Act as One Committee and the Partnership Board will not make a final recommendation which requires any Partner to act as such.

13. INFORMATION SHARING AND CONFLICTS OF INTEREST

- 13.1 Subject to compliance with Law (including without limitation Competition Law) and contractual obligations of confidentiality, in order to meet the Vision, Objectives and Principles the Partners agree to share all information relevant to the provision of the Services in an honest, open and timely manner. The Partners Agree to comply with the Information Sharing Protocol in discharging their obligations under this SPA (Schedule 9).

13.2 The Partners will:

- 13.2.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this SPA or the

operation of the Partnership Board, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the performance of this SPA;

13.2.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this SPA (without the prior consent of the other Partners) before they participate in any decision in respect of that matter; and

13.2.3 use best endeavours to ensure that their representatives on the Act as One Committee and other Governance Groups for the Provider Partnership also comply with the requirements of this Clause 13 when acting in connection with this SPA.

13.3 If there is:

13.3.1 any uncertainty or a lack of consensus between the Partners regarding the existence of a conflict of interest under Clause 13.2.1 or 13.2.2; or

13.3.2 any query or Dispute as to whether any Partner is put in a position (or will be) of conflict under Clause 13.2.2, which cannot be resolved with recourse to the protocol referred to in Clause 13.4, any Partner may refer the matter for resolution under Clause 9 (Problem Resolution and Escalation).

13.4 The Partners will each comply with the ICB conflicts of interest policy when the Partnership Board or any other Governance Group is undertaking ICB Business. When the Act as One Committee is undertaking Partnership Business, each member of the Act as One Committee will comply with the conflicts of interest policy and procedures of its individual organisation. A register of interested will be supported and maintained by the Act as One Committee secretariat.

13.5 The ICB and the Provider Partnership have planned to manage any actual and potential conflicts of interest to ensure that decisions made by the Partnership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

13.6 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the ICB website.

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- 13.7 The Partners shall ensure that all Partnership Board members nominated by them comply with the ICB policy on conflicts of interest in line with their terms of office. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.
- 13.8 The Partners shall ensure that all Partnership Board members comply with the ICB Standards of Business Conduct policy.

SECTION D: FINANCIAL, WORKFORCE AND QUALITY FRAMEWORK, LIABILITY, ADMISSION AND EXCLUSION

14. FINANCIAL AND RISK MANAGEMENT PRINCIPLES

- 14.1 The Partners will act in accordance with the Financial and Risk Management Principles set out in Schedule 5 to this SPA to facilitate greater transparency and collaborative working to achieve the changes required to deliver financial sustainability for Bradford District and Craven.
- 14.2 Whilst the Partners will be paid in accordance with the mechanism set out in the Services Contracts in respect of their Services, they also acknowledge that they are ready to work together, manage risk together, and support each other when required to deliver the changes required to achieve financial sustainability and live within the resources of Bradford District and Craven.

15. WORKFORCE PRINCIPLES

- 15.1 The Partners will act in accordance with the Workforce Principles set out in Schedule 6 to this SPA to maximise the collective resources of the Partners to achieve the changes required to deliver the Vision and Objectives for Bradford District and Craven.

16. QUALITY PRINCIPLES

- 16.1 The Partners will act in accordance with the Quality Principles set out in Schedule 7 to this SPA to achieve the changes required to deliver the Vision and Objectives for Bradford District and Craven.

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17. WITHDRAWAL, EXCLUSION AND TERMINATION

17.1 Without affecting any other right or remedy available to it, a Partner may withdraw from this SPA on giving not less than 6 months' written notice to the Act as One Committee.

17.2 A Partner may be excluded from this SPA immediately on notice from the remaining Partners (acting in consensus) in the event of:

17.2.1 the Partner's relevant Services Contract (including an NHS Standard Contract or Primary Care Contract) is terminated or expires; or

17.2.2 the Partner becomes Insolvent; or

17.2.3 the Partner commits a material or persistent breach of the SPA which is not remedied following written notice; or

17.2.4 the Partner loses the regulatory, statutory, or organisational status required to participate in the Partnership; or

17.2.5 there is a serious failure of quality, governance, engagement, or conflict of interest management which, in the reasonable opinion of the remaining Partners, is incompatible with continued participation.

17.3 A Partner may be excluded from the SPA if the Partner in question has materially breached the terms of this SPA by a resolution passed at a meeting of the Act as One Committee of not less than 75% of the Partners voting at that meeting. The Partner which is the subject of the resolution shall be entitled to make representations at the Act as One Committee meeting at which the resolution is being proposed prior to any vote being taken.

Consequences of withdrawal / termination / exclusion

17.4 Where a Partner is excluded from this SPA, or withdraws from it, the Partners agree to work together in good faith to agree necessary changes so that the SPA continues to operate effectively on a Best for Bradford District and Craven basis. Any departing Partner (whether exiting or excluded) shall procure that all data and other material belonging to any other Partner under this SPA shall be delivered back to the relevant Partner, deleted or destroyed as soon as reasonably practicable and confirm to the remaining Partners when this has been completed. The departing Partner shall also on exit grant a new licence to the remaining Partners to continue to use any of its existing or new Intellectual Property under the terms of Clause 24 to the extent that it remains required for the

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sole purpose of the fulfilment of the remaining Partners' obligations under this SPA.

18. INTRODUCING NEW PARTIES

- 18.1 Subject to complying with applicable Law, if appropriate to achieve the Objectives, the Partners at the Act as One Committee may agree to admit additional parties. If the Act as One Committee agrees on such a course, the new parties will become parties to this SPA on such terms as the current Partners shall jointly agree subject to any notification under Clause 9.2 (Problem Resolution and Escalation) in the event of any disagreement.
- 18.2 The Partners each commit to the Vision, Principles and the Objectives and ownership of the system success/failure as set out in this SPA.

19. LIABILITY

- 19.1 The Partners' respective responsibilities and liabilities in the event that things go wrong with the Services will be allocated under their respective Services Contracts and not this SPA.

SECTION E: FUTURE DEVELOPMENT OF THE PROVIDER PARTNERSHIP FOR BRADFORD DISTRICT AND CRAVEN

20. WORK PLAN

- 20.1 The Partners have agreed to work together to further develop, and implement, the SPA Work Plan, the initial draft of which is set out in 10 (SPA Work Plan). The areas for development set out in the SPA Work Plan have been identified by the Partners as priorities for the 2026/27 financial years. The SPA Work Plan will form part of a wider programme of work to be undertaken to develop the Provider Partnership during 2026/27. The Partners will keep the SPA Work Plan under review through the governance structures set out in this SPA and may agree to amend the SPA Work Plan as required during the Initial Term in accordance with Clause 20 (Variations), in line with policy direction and legislative developments.

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SECTION F: GENERAL PROVISIONS

21. VARIATIONS

21.1 Save as set out in Clause 22, any amendment, waiver or variation of this SPA will not be binding unless set out in writing, expressed to amend, waiver or vary this SPA and signed by or on behalf of each of the Partners.

22. ASSIGNMENT AND NOVATION

22.1 Unless the Partners agree otherwise in writing, none of the Partners will novate, assign, delegate, sub-contract, transfer, charge or otherwise dispose of all or any of their rights and responsibilities under this SPA.

23. CONFIDENTIALITY AND FREEDOM OF INFORMATION

23.1 Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner to this SPA except to the extent that such Confidential Information is required by Law (including any regulatory authority having jurisdiction over the relevant Partner) to be disclosed, is already in the public domain, comes into the public domain otherwise than through an unauthorised disclosure by a Partner to this SPA, or is disclosed on a confidential basis to that Partner's professional advisers or insurers for the Purpose.

23.2 Each Partner shall be entitled to use another Partner's Confidential Information in order to:

23.2.1 comply with its obligations under this SPA;

23.2.2 comply with its obligations under any Services Contract it is a party to;
and

23.2.3 work to achieve the Vision and Objectives in accordance with the Principles
(the **Purpose**).

23.3 No Partner shall use or disclose any Confidential Information received under this SPA for any reason other than the Purpose, including, without limitation, for its own commercial gain or to inform any competitive bid in relation to any part of the Services without the express written permission of the disclosing Partner.

- 23.4 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights that a Partner may have in respect of such Confidential Information.
- 23.5 The Partners agree to procure, as far as is reasonably practicable, that the terms of this Clause 23.3 are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this SPA and this Clause will survive the expiry or the termination of this SPA for a period of 5 years.
- 23.6 Nothing in this Clause 23 will affect any of the Partners' regulatory or statutory obligations, including but not limited to Competition Law, and any disclosure made pursuant to such obligations shall be deemed a disclosure required by Law for the purposes of Clause 23.1.
- 23.7 If any Partner receives a request for information relating to this SPA or the Services under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004, it shall (as soon as reasonably practicable and in any event within seven (7) days from receipt of the request) consult with the other Partners before responding to such request and, in particular, shall have due regard to any claim by any other Partner to this SPA that the exemptions relating to commercial confidence and/or confidentiality apply to the information sought.

24. INTELLECTUAL PROPERTY

- 24.1 In order to meet the Vision and the Objectives each Partner grants each of the other Partners a fully paid up non-exclusive licence to use its existing Intellectual Property (being Intellectual Property owned or controlled by that Partner as at the date of this SPA **or** developed independently of the Services) related to the Services but only insofar as it is reasonably required for the sole purpose of the fulfilment of that Partner's obligations under this SPA including use by that Partner's employees, professional advisers and subcontractors engaged in connection with such obligations. Such licence shall subsist for the duration of this SPA and for so long thereafter as required to give effect to any surviving obligations

New Intellectual Property

- 24.2 If any Partner creates any new Intellectual Property through the development of the Services between the Partners, the Partner which creates the new Intellectual Property shall own such new Intellectual Property and shall grant to the other Partners a fully paid up non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Partner's obligations under this SPA.

25. NOTICES

- 25.1 Any notice or other communication given to a Partner under or in connection with this SPA shall only be valid when sent in writing, addressed to that Partner at its principal place of business or such other address as that Partner may have specified to the other Partner in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery, commercial courier or email.
- 25.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 25.1; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed; or, if sent by email, one (1) Operational Day after transmission.

26. SEVERANCE

- 26.1 If any court or competent authority finds that any provision of the SPA (or part of any provision) is invalid, illegal or unenforceable, that provision or part-provision shall, to the extent required, be deemed to be deleted, and the validity and enforceability of the other provisions of the SPA shall not be affected.
- 26.2 If any invalid, unenforceable or illegal provision of the SPA would be valid, enforceable and legal if some part of it were deleted, the provision shall apply with the minimum modification necessary to make it legal, valid and enforceable.

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27. WAIVER

27.1 A waiver of any right or remedy under the SPA is only effective if given in writing and shall not be deemed a waiver of any subsequent breach or default. No failure or delay by a Partner to exercise any right or remedy provided under the SPA or by law shall constitute a waiver of that or any other right or remedy, nor shall it preclude or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall preclude or restrict the further exercise of that or any other right or remedy.

28. NO PARTNERSHIP

28.1 Nothing in this SPA is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this SPA.

29. COUNTERPARTS

29.1 This SPA may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this SPA, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this SPA transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each party has executed at least one counterpart.

30. THIRD PARTY RIGHTS

30.1 A person who is not a party to this SPA shall not have any rights under or in connection with it.

31. ENTIRE AGREEMENT

31.1 This SPA and the Services Contracts constitute the entire agreement between the Partners and supersedes all prior discussions, correspondence, negotiations, arrangements, representations,

understandings or agreements between them, whether written or oral, relating to its subject matter.

32. GOVERNING LAW AND JURISDICTION

- 32.1 This SPA, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English Law, and where applicable, the Partners irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

This SPA for Bradford District and Craven Provider Partnership has been entered into on the date stated at the beginning of it.

Signed by Therese Patten (Place Lead) for and on behalf of NHS WEST YORKSHIRE INTEGRATED CARE BOARD – BRADFORD DISTRICT AND CRAVEN (PLACE)	.....
Signed by Foluke Ajayi (Chief Executive) for and on behalf of AIREDALE NHS FOUNDATION TRUST	.....
Signed by Therese Patten (Chief Executive) for and on behalf of BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	.....
Signed by Mel Pickup (Chief Executive) for and on behalf of BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	.....
Signed by Lorraine O'Donnell (Chief Executive) for and on behalf of CITY OF BRADFORD METROPOLITAN DISTRICT COUNCIL	.....
Signed by Charlotte Ramsden (Chief Executive) for and on behalf of BRADFORD CHILDREN AND	.....

FAMILIES TRUST	
Signed by Richard Flinton (Chief Executive) For and on behalf of NORTH YORKSHIRE COUNCIL	
Signed by Richard Haddad (Chair) for and on behalf of BRADFORD CARE ALLIANCE COMMUNITY INTEREST COMPANY	.....
Signed by Sam Keighley (Chief Executive) for and on behalf of BRADFORD VCS ALLIANCE LIMITED	.....
Signed by Helen Carr (Chief Executive) for and on behalf of LOCAL CARE DIRECT	.....
Signed by Brendan Kennedy (Executive Partner) for and on behalf of MODALITY PARTNERSHIP	.....
Signed by Laura Molyneux (Clinical Director) for and on behalf of WHARFEDALE, AIREDALE AND CRAVEN ALLIANCE	.....
Signed by Louise Bestwick (Chief Executive) for and on behalf of BRADFORD CARE ASSOCIATION LIMITED	.....
Signed by Nick Hayward (Clinical Director) for and on behalf of AFFINITY CARE	

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Schedule 1

Definitions and Interpretation

2 The following words and phrases have the following meanings:

Phrase	Meaning
Act as One Committee	Bradford District and Craven Provider Partnership's Act as One Committee, as set out in paragraphs 11.6 to 11.10
Best for Bradford District and Craven	best for the achievement of the Vision and Objectives for Bradford District and Craven on the basis of the Principles
Bradford District and Craven	the population covered by BMDC and Craven District of North Yorkshire Council
Citizen Activation	enabling people to understand, manage and influence their own health, with support to build confidence, skills, and motivation to take an active role in decisions and care planning
Commencement Date	1 April 2026
Communities of Interest	groups of people connected by a shared identity, experience, or characteristic, used in health and care to tailor engagement, insight, and targeted interventions
Community Partnerships	the Community Partnerships as referred to in Clause 11
Competition Law	the Competition Act 1998 and the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013
Confidential Information	means a) any information which is marked or otherwise designated as confidential, private, proprietary or similar, and b) all information which is not publicly available (in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this SPA

Phrase	Meaning
Core20PLUS5	NHS England's national approach to reducing inequalities: • Core20 – the most deprived 20% of the population • PLUS – locally identified high-risk groups • 5 – five clinical priorities (maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, hypertension case-finding)
Culturally Competent	providing care that is respectful of and responsive to cultural beliefs, language, values, and practices, ensuring services work effectively for diverse communities
Digital inclusion	ensuring everyone has access, skills, confidence, and support to use digital tools for health and care, so that digital transformation does not widen inequalities
Dispute	any dispute arising between two or more of the Partners in connection with this SPA or their respective rights and obligations under it
Dispute Resolution Procedure	the procedure set out in Schedule 4 for the resolution of disputes which are not capable of resolution under Clause 9
Distributed Leadership	leadership in accordance with the following principles: • our leadership spirit offers autonomy, empowerment, and responsibility at all levels. • our leadership practice means seeing others' perspectives, developing supportive relationships, and bringing people together. • our people have permission to contribute the best of their knowledge, their skills, and their ideas. • by offering equal partnership, we foster innovation, collaboration, and agility. • it's how we do things around here.

Phrase	Meaning
	#ActAsOne
Governance Group	any group referred to in this SPA or set up pursuant to the various terms of reference referred to in this SPA to further the work of the Provider Partnership
Guidance	has the meaning set out in the NHS Standard Contract
Health and Wellbeing Boards	the Bradford District Health and Wellbeing Board and the North Yorkshire Health and Wellbeing Board
Initial Term	the initial term of this SPA as set out in Clause 4.1
ICB Business	has the meaning set out in Clause 11.2
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Insolvency	any of the following events or circumstances (as may be applicable to each Partner): a) where a Partner suspends, or threatens to suspend, payment of its debts (whether principal or interest) or is deemed to be unable to pay its debts within the meaning of Section 123(1) of the Insolvency Act 1986; b) where a Partner calls a meeting, gives a notice, passes a resolution or files a petition, or an order is made, in connection with the winding up of that Partner (save for the sole purpose of a solvent voluntary reconstruction or amalgamation); c) where a Partner has an application to appoint

Phrase	Meaning
	an administrator made or a notice of intention to appoint an administrator filed or an administrator is appointed in respect of it or all or any part of its assets; d) where a Partner has a receiver or administrative receiver appointed over all or any part of its assets or a person becomes entitled to appoint a receiver or administrative receiver over such assets; e) where a Partner takes any steps in connection with proposing a company voluntary arrangement or a company voluntary arrangement is passed in relation to it, or it commences negotiations with all or any of its creditors with a view to rescheduling any of its debts; or f) where a Partner has any steps taken by a secured lender to obtain possession of the property on which it has security or otherwise to enforce its security; or g) where a Partner has any distress, execution or sequestration or other such process levied or enforced on any of its assets which is not discharged within 14 Operational Days of it being levied; h) where a Partner has any proceeding taken, with respect to it in any jurisdiction to which it is subject, or any event happens in such jurisdiction that has an effect equivalent or similar to any of the events listed above; and/or i) where a Partner substantially or materially ceases to operate, is dissolved, or is de-authorised as an NHS trust or NHS foundation trust; j) where a Partner is clinically and/or financially unsustainable as a result of any clinical or financial intervention or sanction by the regulator responsible for the independent

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Phrase	Meaning
	regulation of NHS trusts or NHS foundation trusts or the Secretary of State and which has a material adverse effect on the delivery of the Services; k) a trust special administrator is appointed over a Partner under the National Health Service Act 2006, or a future analogous event occurs; or l) if a Partner suffers any event analogous to the events set out in a) to k) of this definition in any jurisdiction in which it is incorporated or resident
Interoperable System	a health and care system where IT systems can securely share and use information across organisations, enabling coordinated, safe, and efficient care
Inverting the Power to Act	shifting decision-making closer to people and communities, giving frontline teams and local partners greater autonomy to design solutions based on local insight rather than top-down instruction
Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; c) Guidance (as defined in the NHS Standard Contract); d) National Standards (as defined in the NHS Standard Contract); and e) any applicable code
NHS Standard Contract	the NHS Standard Contract as published by NHS England from time to time

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Phrase	Meaning
Objectives	the objectives of the Partners set out in Clause 7
Operational Day(s)	a day other than a Saturday, Sunday or bank holiday in England
Partnership Board	the Partnership Board as referred to in Clause 11
Proportionate universalism	providing services for everyone, but with greater intensity and more tailored support for people and communities who face the greatest barriers to good health, so outcomes improve fairly across the whole population
Provider Partnership	Bradford District and Craven Provider Partnership.
Provider Partnership's Governance Handbook	Underpins the SPA by providing easy access to key governance information and describes how the partnership governance arrangements operate. The updated version can be accessed on how we make decisions section of the Act as One Website
Principles	has the meaning set out in Clause 8.5
Purpose	has the meaning set out in Clause 23.2
Section 75 Agreements	means the three agreements between the following parties (1. the ICB and the BMDC dated 1 April 2020; 2. BDCFT and the BMDC dated 1 April 2024; and 3. NYC and HNY ICB*) and any subsequent agreement entered into by the Commissioners under section 75 of the National Health Service Act 2006 to commission elements of the Services *Note WYICB are not a party to NYC section 75 agreement, however, is a key partner and takes an active role as an attendee on the Adults Social Care Joint Commissioning Group
Services	the services commissioned to be provided by the Providers by the Commissioners for Bradford District and Craven as set out in Schedule 3 (Services)
Services Contract	a contract entered into by one of the Commissioners and a Provider for the provision of elements of the Services as set out in Schedule 3, and references to a Services Contract include all or any one of those

Phrase	Meaning
	contracts as the context requires
Shadow Period	1 April 2026 to 31 March 2027
SPA	this agreement incorporating the Schedules
SPA Work Plan	the SPA work plan set out in Schedule 8 Health Overview and Scrutiny Arrangements 1. Health Overview and Scrutiny Committees (HOSCs) play a key role in holding the health system to account on behalf of local people. They proactively seek, test, and challenge information about the performance, planning and operation of local health services, using a range of evidence and intelligence. 2. A HOSC's function is to provide effective scrutiny in order to help improve outcomes for communities: 2.1 enabling local people and elected members to influence health priorities; 2.2 giving communities a voice on quality, safety, access and effectiveness of services; 2.3 providing assurance that services are safe, effective and tackling health inequalities; and 2.4 supporting commissioners and providers to better understand local needs and develop improved services and care pathways. 3. At the local level, Calderdale, Kirklees, Leeds, Bradford District and Craven and Wakefield, has its own established statutory HOSC, in Calderdale Council currently considers health matters through its Overview and Scrutiny Committee. These committees scrutinise NHS planning, delivery and finances and form an

Phrase	Meaning
	important part of system-wide accountability. 4. At a West Yorkshire level, the West Yorkshire Joint Health Overview and Scrutiny Committee (WY JHOSC with North Yorkshire participating as an interested party for Craven) operates on a discretionary basis. It works in partnership with NHS West Yorkshire ICB and has an informal role in scrutinising substantial service change across West Yorkshire. 5. At a North Yorkshire level, the North Yorkshire Scrutiny of Health Committee scrutinises any matter relating to the planning, provision and operation of health services in the County (which includes Craven), including the policies of the Health and Care Partnerships Schedule 9 Act as One Provider Partnership Protocol for Information Sharing 6. INTRODUCTION 6.1 The Bradford District and Craven (BD&C) Provider Partnership Strategic Partnering Agreement (the SPA) sets out the operating framework for how health and care system partners in BD&C who are signatories to the SPA (the Partners) will work together in a collaborative and integrated way on a Best for Bradford District and Craven basis. To this end, the Partners have agreed to share information with each other in an honest, open and timely manner. 6.2 As referenced in Clause 13.1 of the SPA, this Protocol sets out arrangements to manage the

Phrase	Meaning
	sharing of information between the Partners to support collaboration and joint working.
	6.3 This Protocol forms part of the governance arrangements for the BD&C Provider Partnership as set out in the SPA and should be considered in conjunction with the SPA and the terms of reference of the BD&C Partnership Board, Act as One Committee and other governance groups as referenced in the SPA (referred to in this Protocol as the Governance Groups).
	7. DEFINITIONS In this Protocol defined terms have the meaning set out in the SPA with the exception of the terms defined in Appendix 1.
	8. SCOPE This Protocol applies to each of the Partners and its representatives, and each Partner will ensure that its representatives who are members of the BDC Act as One system governance group(s) or who are involved in strategy delivery groups pursuant to the SPA are aware of, and comply with, this Protocol when sharing information for the purposes of the SPA.
	9. CONFIDENTIAL INFORMATION 9.1 The Partners have agreed under the SPA to share information in an honest, open and timely manner to support the achievement of the SPA objectives, subject to compliance with Law and their obligations of confidentiality in the SPA. 9.2 Each Partner must maintain clear records of all Confidential Information disclosed or received. 9.3 Where it is agreed between any of the Partners that the sharing of personal data is necessary for

Phrase	Meaning
	the purposes of the SPA, the relevant Partners must ensure that a data protection impact assessment (DPIA) is produced and, if the data sharing is not already covered by existing data sharing agreements, enter into appropriate data sharing agreements in accordance with the requirements of the GDPR. 10. COMPETITION SENSITIVE INFORMATION 10.1 The Partners must not disclose to each other any Competition Sensitive Information. 10.2 Information is not Competition Sensitive Information if: 10.2.1 it relates to activities or markets in which the Partners do not currently compete against other organisations and where there is no realistic prospect that they will in future compete; 10.2.2 subject to paragraph 5.3 of this Protocol, if it relates to any arrangements involving information exchange and collaboration (including for the purpose of joint projects contemplated or being implemented by the Partners) which were put in place prior to the date of the SPA for the purpose of Business as Usual activities; and 10.2.3 it relates to activities or markets in which the Partners are actual or potential competitors and disclosure of the relevant information would not affect the Partners' commercial strategy or decisions; this may apply if, for example: (a) the information is historical, Aggregated (as defined below) and/or anonymised; or (b) the information is freely available in the public domain other than as a direct or indirect result of the information being

Phrase	Meaning
	disclosed in breach of this Protocol or the SPA or of any other undertaking of confidentiality addressed to the Partner to whom the information relates (except that any compilation of otherwise public information in a form not publicly known shall nevertheless be treated as Competition Sensitive Information). 10.3 The following principles should be considered in relation to any information disclosed from one Partner to another: 10.3.1 Business as Usual (a) The Partners must continue to act, make bids and try to win new business as appropriate in exactly the same way that each would have done in the absence of the development of closer collaboration and joint working. (b) The Partners will remain separate to other organisations in the area and should continue to make decisions on matters such as bidding strategies and entry into new contracts independently. 10.3.2 Document Creation (a) Documents created by any Partner for the development of closer collaboration and joint working as part of the Provider Partnership may be disclosable under the Freedom of Information Act 2000. (b) Due care and attention should be taken when creating documents (including emails and handwritten notes) to avoid the

Phrase	Meaning
	use of language that could be misinterpreted. (c) If any Partner or their staff are asked by their external legal advisors to provide Data, any documents should be clearly marked “Privileged and confidential: prepared at the request of our external legal advisers”. APPENDIX A - DEFINITIONS 5 Aggregated means that the price, cost and volume of individual services or contracts for the provision of services, the subject matter of which forms or could form the basis of competition between any of the Partners, cannot be determined from the Data. 6 Commercially Sensitive Information: Confidential Information which is of a commercially sensitive nature relating to a Partner, its intellectual property rights or its business or which a Partner has indicated would cause that Partner significant commercial disadvantage or material financial loss. 7 Competition Sensitive Information: Confidential Information (as defined in the SPA) which is owned, produced and marked as Competition Sensitive Information by one of the Partners and which that Partner properly considers is of such a nature that it cannot be exchanged with the other Partners without a breach or potential breach of Competition Law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation,

Phrase	Meaning
	information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Partner, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions. 8 Data: information, data and material recorded in any form and shared between any or all of the Partners including Confidential Information and Commercially Sensitive Information. Schedule 10
Value Based, Population-Level, Resource Allocation	allocating resources based on population need and expected outcomes, directing investment to interventions that deliver the greatest health value per pound across a whole population rather than individual services
Vision	the vision of the Partners for the Provider Partnership as set out in Clause 6.1
Workforce Principles	the workforce principles set out in Schedule 6 (Workforce Principles)

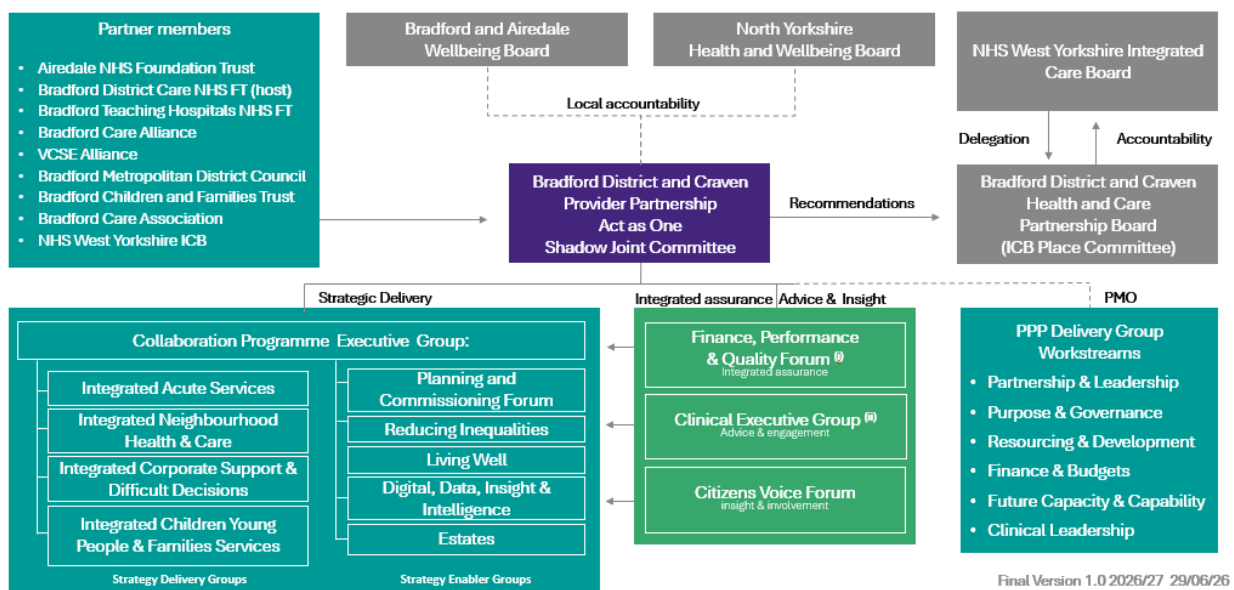
Schedule 2

Governance Arrangements

1. Governance structure

1.1 The diagram below summarises the Provider Partnership governance structure which the Partners have agreed to establish and operate from the Commencement Date for the transitional year 2026/27. This governance structure provides oversight of the development and implementation of the Provider Partnership approach and the arrangements under this SPA.

Diagram 1: Governance structure v1 2026/27 29/06/26.



1.2 Groups and Forums

1.2.1 Collaboration Programme Executive Group (CPEG) is responsible for the oversight and assurance of programme delivery. The work is structured through four Provider Partnership Strategy Delivery Groups:

- Integrated Acute Services;
- Integrated Neighbourhood Health & Care;
- Integrated Corporate Support & Difficult Decisions; and
- Integrated Children Young People & Families Services.

The work is also supported through five enablers of the strategy:

- Planning and Commissioning Forum;
- Reducing Inequalities;
- Living Well;
- Digital, Data, Insight & Intelligence; and
- Estates.

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The CPEG receives regular updates on each strategy delivery group in line with key milestones set out within the strategy delivery plans. The CPEG identifies and where possible, seeks to mitigate any programme delivery risks and issues. The CPEG also agrees key themes for communication within each Partner organisation, across the BDC place, and with partners across WY. The CPEG will report, agree any key decisions, and matters for escalation to the Act as One Joint Committee.

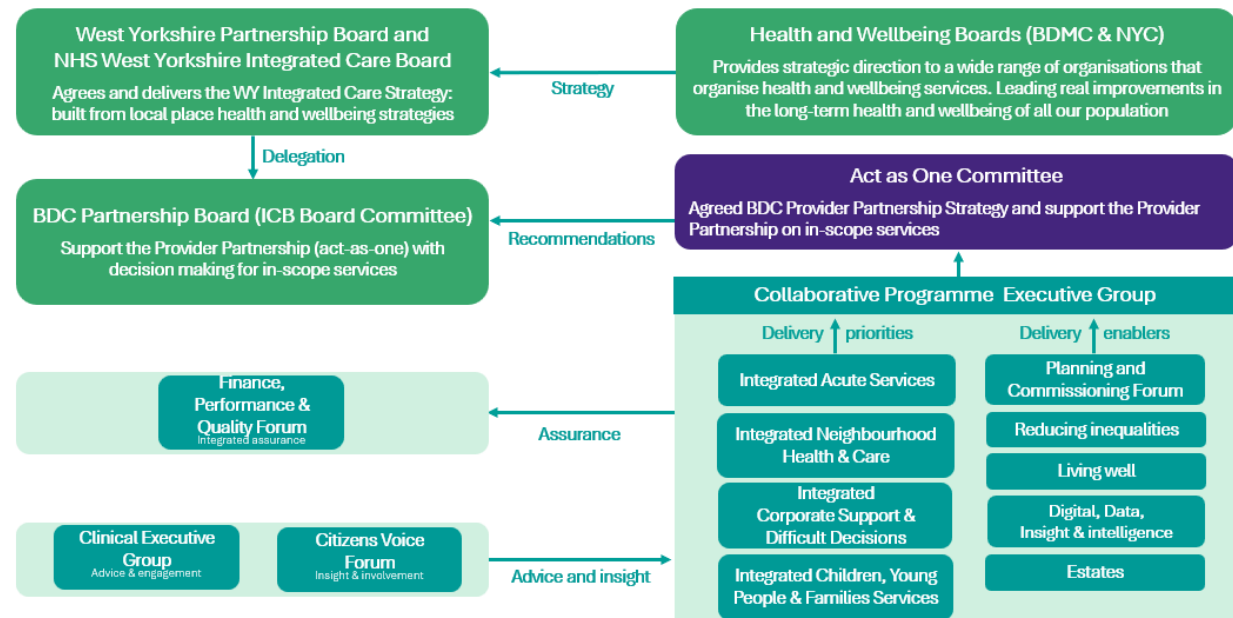
- 1.2.2 Finance, Performance and Quality Forum: is an informal group to support the ICB and providers to hold collaborative discussions on issues that may impact across the system. Provides forum for check and challenge of one another and provide mutual aid (informally) as required
- 1.2.3 Clinical Executive Group: acts as a high level multi-professional leadership group that provides clinical oversight for system-wide transformation programmes, ensuring plans across Strategic Delivery Groups (SDGs) are coordinated, clinically sound and governed at system level. The Group serves as the collective clinical voice guiding our SDGs, aligned with our objectives of improved outcomes, equity, and efficiency, and making sure that front-line clinical perspectives shape all major decisions.
- 1.2.4 Citizens Voice Forum / Citizens Voice and Influence Group: to be established

2. NHS West Yorkshire Integrated Care Board Delegation, through the ICB's Scheme of Reservation and Delegation (below outlines the flow of decision making for Bradford District and Craven Health and Care Partnership)

- 2.1 The ICB constitution and Scheme of Reservation and Delegation ("SORD") create the framework for the ICB to delegate much decision-making authority and resources to committees of the ICB in West Yorkshire places – **Bradford District and Craven**, Calderdale, Kirklees, Leeds and Wakefield. The diagram describes this delegation for Bradford District and Craven Health and Care Partnership (the Partnership Board).
- 2.2 All decisions and responsibilities set out in NHS West Yorkshire ICB SORD will be carried out with regard to **ICB function 9**:
 - 2.2.1 Through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensure that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability. (Guidance on the functions and governance of the ICB, August 2021 (updated March 2022)).
- 2.3 The diagram below describes how NHS West Yorkshire ICB SORD will operate

within Bradford District and Craven.

Diagram 2: illustration of the Flow of decision making (Final v1 2026/27 29/06/26)



- 2.4 During 2026/27 transitional year there are two decision making management fora, the Partnership Board and the Provider Partnership Act as One Committee. The terms of reference for each of these groups, together with the Partnership Groups and Forums, are set out in the Provider Partnership's Governance Handbook.

3. Building recommendations and making decisions during the transitional year

- 3.1 The Act as One Committee will meet to develop recommendations for the population and communities across Bradford District and Craven. With recommendation made by the Act as One Committee to be taken through the Partnership Board as referred to in Clause 11 (Governance).
- 3.2 The Partnership Board, established by the ICB, has delegated authority to make decisions in accordance with the Scheme of Reservation and Delegation (SoRD), Operational Scheme of Delegation (OSoD), Financial Scheme of Delegation (FSoD), and Standing Financial Instructions (SFIs).
- 3.3 The Partners acknowledge that the Partnership Board will continue to operate until 31 March 2027.

- 3.4 During the Shadow Period, the Partners agree to participate in the Partnership Board and the Act as One Committee in accordance with this SPA. The terms of reference for the Partnership Board and the Act as One Committee will form part

of the Provider Partnership's Governance Handbook. The Act as One Committee will make recommendations on in-scope services to the Partnership Board during the Shadow Period.

- 3.5 From 1 April 2027, the Partners intend that the Act as One Committee will have the ability to begin making decisions subject to agreement of appropriate terms of reference.

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Schedule 3

Services

The Services that will be within the scope of the SPA will be:

- (1) The following in-scope health and care services commissioned by the ICB for the Bradford District and Craven population:
 - [add list of in-scope services here]

The services listed above have an approximate value of [£###m].

- (2) All adult social care, children's social care and public health services commissioned by the Council.

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Schedule 4

Dispute Resolution Procedure

1 Avoiding and Solving Disputes

- 1.1 The Partners commit to working cooperatively to identify and resolve issues to the Partners mutual satisfaction to avoid all forms of dispute or conflict in performing their obligations under this SPA. Accordingly, the Partners will look to collaborate and resolve differences under Clause 9 of the SPA prior to commencing this procedure.
- 1.2 The Partners believe that by focusing on their agreed Vision, Objectives and Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the provision of the Services to Bradford District and Craven.
- 1.3 The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this SPA or the operation of the Services (each a '**Dispute**') when it arises.
- 1.4 In the first instance, the relevant Partners' representatives shall meet with the aim of resolving the Dispute to the mutual satisfaction of the Partners. If the Dispute cannot be resolved by the relevant Partners' representatives within 10 Operational Days of the Dispute being referred to it, the Dispute shall be referred to senior officers of the relevant Partners, such senior officers not to have had direct day-to-day involvement in the matter and having the authority to settle the Dispute. The senior officers shall deal proactively with any Dispute on a Best for Bradford District and Craven basis in accordance with this SPA so as to seek to reach a unanimous decision.
- 1.5 The Partners agree that the senior officers may, on a Best for Bradford District and Craven basis, determine whatever action they believe is necessary including the following:
 - (a) If the senior officers cannot resolve a Dispute, they may agree by consensus to select an independent facilitator to assist with resolving the Dispute; and
 - (b) The independent facilitator shall:
 - (i) be provided with any information they request about the Dispute;

- (ii) assist the senior officers to work towards a consensus decision in respect of the Dispute;
 - (iii) regulate their own procedure;
 - (iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed or such longer period as may be agreed between the Partners in Dispute; and
 - (v) have any costs and disbursements met by the Partners in dispute equally; and
- (c) If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 4 and only after such further consideration again fails to resolve the Dispute, the Partners may decide to:
- (i) terminate this SPA; or
 - (ii) agree that the Dispute need not be resolved.

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Schedule 5

Financial and Risk Management Principles

1. As overriding financial principles, the Partners will:

- a) aim to live within their means, i.e. work to the level of resources which are available to their organisation to provide the Services;
- b) work together to make the best use of their collective resources to minimise duplication and waste, and look to re-direct their resources to support the Partnership priorities;
- c) develop and shape the strategic capital and estates plans across Bradford District and Craven together, looking to maximise all possible funding sources and ensuring that these plans support the delivery of the Vision and the Objectives; and
- d) work together to ensure that they have the best possible information, data, and intelligence with which to inform the decisions that they take.

2. Supporting Processes

The Partners agree that:

- a) There will be a rigorous Quality Impact and Equality Impact Assessment process for both transformational and in-year changes in order to support financial decisions being made under the SPA on a Best for Bradford District and Craven basis;
- b) Future financial investment into Bradford District and Craven should be determined as a result of partnership oversight and agreement on commissioning intentions and should fit with the Partnership's clinical, quality and safety priorities. The Partners' investment decisions should also start to address health inequalities and be aligned with the Bradford District and Craven priorities each year (following the process for investments decisions beyond baseline budgets set out in financial governance (section 5 below);
- c) Dis-investment from services within Bradford District and Craven by any individual organisation or collective organisations should follow the same process as investment decisions and should have oversight by the Partnership (Act as One Committee and/or Partnership Board). The Partners agree that services are kept safe but accept that there may be a compromise on quality to live within the collective resource.

- d) The Partners acknowledge that some priority programmes (or their constituent projects) will have the potential to disproportionately benefit some participating Partners at the expense of others. A Strategic Outline Case will be prepared to set out the potential impact of the implementation of a programme or project and will describe the 'risk/reward' model between the relevant Partners affected by the programme or project, to support the selection of the preferred option in the subsequent Outline Business Case.

This risk/reward model will be tailored to each programme or project and will be developed on the basis that:

- transactional costs between the Partners should be minimised;
- there will be cost transparency between the Partners (subject to compliance with Competition Law (where applicable), the need to ensure non-disclosure of commercially sensitive information and having regard to the information sharing protocol);
- definitions of costs will be agreed by all Partners in advance;
- value for money must be demonstrated across Bradford District and Craven; and
- no Partner shall derive unreasonable advantage or suffer unreasonable disadvantage.

3. NHS Finance principles

In respect of the management and allocation of NHS finances, the Partners agree that:

- There is a need to agree and utilise one set of activity and finance data for the purposes of planning, managing transformational changes, managing disinvestment and agreeing any related risk/reward mechanisms;
- They will commit to managing NHS expenditure in Bradford District and Craven in aggregate across the system, including joint management of stranded costs (focussing on costs and expenditure, not tariff or funding);
- The implications of any changes which result in a net NHS deficit will be considered a failure of all the NHS Partners under the SPA. If longer term planning timeframes are established and cash positions allow, a short term system deficit may be considered by the Partners if initial investment is required by the system to recover greater return in future years (any such approach would be dependent on the ICB and Bradford District and Craven Health and Care Partnership's system financial framework being

able to accommodate such an approach – e.g. by a surplus offsetting the deficit in another Provider Partnership);

The financial focus for decision making by the NHS Partners will be to balance service delivery, quality and safety, and actual cost/expenditure rather than tariff or funding; and

- A transition mechanism process will be agreed by the NHS Partners to support the impact of transformative service changes (including disinvestment). This may include approaches to managing and mitigating losses and gains, double running costs, and unintended financial consequences. Annex 1 to this Schedule 5 sets out the proposed financial framework for future investment/disinvestment decisions which incorporates an integrated approach to development/reduction/cessation of services and ensuring that material decisions are made within the available resources for Bradford District and Craven.

4. Planning Principles

- a) Initially, NHSE published planning guidance will be used for financial planning, but this will be aligned to the Partnership strategy, objectives and priorities for that year and future years. The Partners agree that the future investment decision making process for Bradford District and Craven should explore options and develop plans for the most effective use of available resources in an integrated way across the Partners.
- b) Any growth funding within overall allocations can be used flexibly with agreement from Partners (following the governance in Annex 1). This includes the alignment of growth to the strategic priorities; funding the investment decisions made and aiding disinvestment decisions for longer term gain.
- c) The baseline/underlying financial position for Bradford District and Craven needs to be clearly understood by the Partners to determine the viability of additional investment or disinvestment that impacts on the run rate. Any such proposal for investment or disinvestment will require an appropriate business case with clearly articulated benefits, financial impact and measurable Key Performance Indicators (KPIs). The designated programme lead will present the business case to the Business Case Approvals Panel, following the principles outlined in those terms of reference.

5. Financial Governance

- a) The Partners acknowledge that whilst it is expected that each individual

organisation will have their own governance procedures, if they are to work collectively as a Partnership, they need to ensure that there is a framework that enables assurance on the delivery of Bradford District and Craven system plans and priorities.

- b) Annex 1 sets out the financial governance framework for developing the plans and the process for recommendations through the System Finance, Performance & Quality Forum to the Act as One Committee then to the Partnership Board for approval of investment plans. In-line with the ICB's Financial Scheme of Delegation, and Closing the Gap Mandate, the Closing the Gap Programme Board will make recommendations to the Act as One Committee on Business Cases reviewed by the Business Case Appraisal Panel.
- c) The Partners will, where agreed, give delegated responsibility to lead Directors from their organisation who will form the membership of the System Finance, Performance & Quality Forum and be responsible in giving assurance on recommendations to the Act as One Committee then on to the Partnership Board for future developments that align with the Bradford District and Craven Health and Care Partnership priorities.

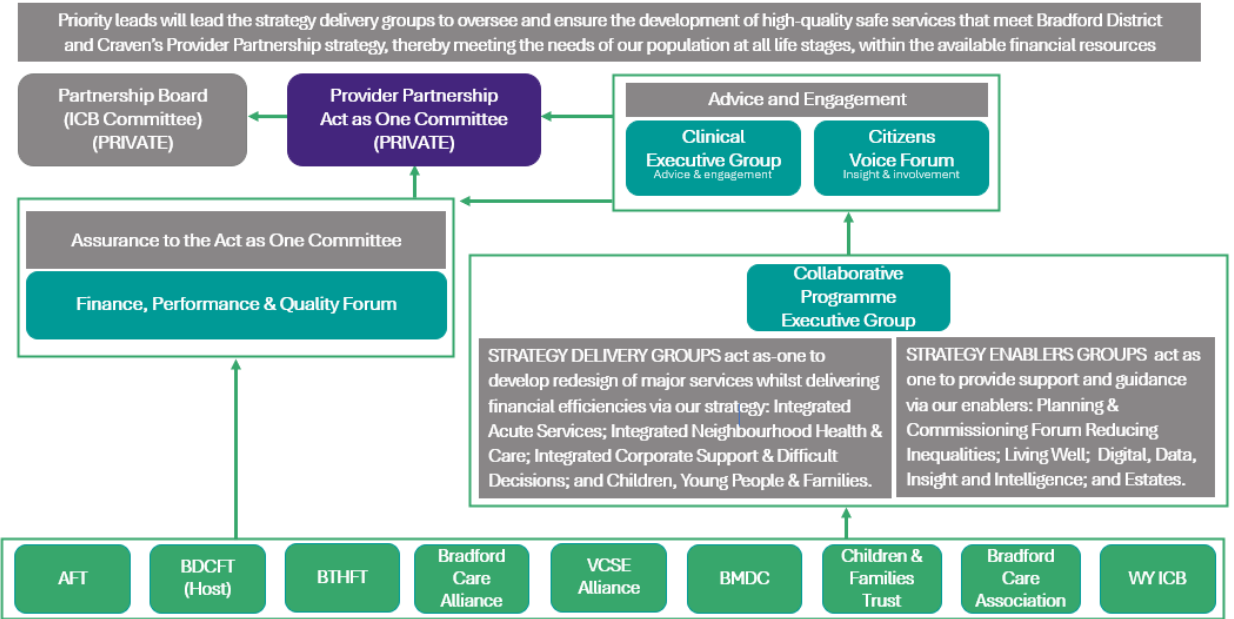
6. Agreed Clinical & Quality Priorities

- a) Bradford District and Craven Health and Care Partnership will agree its main priorities in each year to form the "Act of One Transformational priorities and enablers" which are the focus of the activity of the partnership.
- b) The decision making process will also be done in conjunction with the System Finance, Performance & Quality Forum to ensure investment decisions are also evaluated to understand the impact on quality standards.

(See also the terms of reference for the role of the System Finance, Performance & Quality Forum in the Provider Partnership's Governance Handbook).

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Annex 1 – Financial Governance Framework (Final v1 2026/27 29/06/26)



Final Version 1.0 2026/27 29/06/26

Schedule 6

Workforce Principles

The workforce principles agreed by the Partners are:

Our shared workforce values are:

- Mutual respect, trust and understanding
- Willingness to learn together
- Commitment to work together
- People in control of their own lives
- Everybody matters
- Openness to share

ID	Workforce Principles
A	Acting with compassion and ensuring we keep the person at the center of everything we do; striving to ensure no decision is taken in isolation of the wider health and care system and taking collective ownership of the key workforce challenges within the partnership as they present.
B	Embed an ethos of 'Act as One' and working for our health and care partnership rather than an organisation or sector; demonstrating our values in our everyday actions and behaviors through the development of a shared set of core competencies.
C	Put difficult workforce issues on the table, with a high support and high challenge coaching approach; surfacing the early warning signs of things not working by encouraging a learning culture.
D	Work with colleagues in our Integrated Care System (ICS), health and care partnership and on a sector footprint to strategically plan our workforce; aiming to secure the best people by being inclusive, striving to ensure our workforce is representative of the communities we serve and by working in ways to make employment opportunities and careers across our health and care partnership attractive to all including those with lived experience.
E	Optimise the knowledge, experience, skills and strengths of our shared workforce by developing our people together; providing local mentoring schemes, talent management and succession planning pipelines whilst ensuring connectivity and alignment across the ICS where appropriate to maximise our collective resources.

Our shared workforce values are:

- Mutual respect, trust and understanding
- Willingness to learn together
- Commitment to work together
- People in control of their own lives
- Everybody matters
- Openness to share

ID	Workforce Principles
F	Proactively engage with and support the careers progression of colleagues who are under-represented across all the protected characteristics, so their needs are understood in a way that enables them to bring their whole selves to work and achieve a sense of belonging within our partnership.
G	Involve the right people, at the right time to enable workforce transformation; enabling movement around the partnership to provide the right care and best experience for our local people.
H	Develop our workforce in response to current and emerging local population needs; including equipping people for working across new and emerging care pathways and ensuring digital capability.
I	Create formal and informal opportunities for our leaders to develop together as system leaders using evidence-based approaches and our 'Act as One' ethos.
J	Take collective responsibility for proactively supporting the health and wellbeing of our workforce; retaining staff by being good employers and offering flexible working and career opportunities across the partnership.
K	Work collectively to develop agreements to retain talent within the partnership; retraining people and supporting them to transition to new roles, in particular during times of organisational change (whilst recognising and working within employers' statutory responsibilities).

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Schedule 7

Quality Principles

The quality principles agreed by the Partners are:

How we work across the Place – our Quality Principles Points to consider ... think Health and Care	
	Quality Principles
1	What contribution is the programme making to help reduce health inequalities?
2	Does the programme promote quality and safety and mitigate any risks, are these risks shared at place and are there appropriate metrics to determine the impact on quality of service provision and patient safety?
3	Are there concerns from a regulatory perspective and if so, how are they being addressed and measured and how are they being shared at Place?
4	What are the key outcomes for the priority area? How will the programme measure whether it is making a demonstrable difference to outcomes – clinical and non-clinical?
5	What role is there for citizens and patient voices in the programme and how do you know that you are improving their experiences?
6	Have Quality and Equality Impact Assessments (QEIA) been completed and are there plans to review them throughout the programme life span?
7	Does the programme utilise known best practice and how far is it evidence based?
8	Does the programme encourage training and development of the workforce?
9	How will the programme impact on and support 'recovery' and 'reset' requirements?
10	How will the programme be evaluated and to what extent will this be independent of programme governance?

Schedule 8

Health Overview and Scrutiny Arrangements

6. Health Overview and Scrutiny Committees (HOSCs) play a key role in holding the health system to account on behalf of local people. They proactively seek, test, and challenge information about the performance, planning and operation of local health services, using a range of evidence and intelligence.
7. A HOSC's function is to provide effective scrutiny in order to help improve outcomes for communities:
 - 7.1 enabling local people and elected members to influence health priorities;
 - 7.2 giving communities a voice on quality, safety, access and effectiveness of services;
 - 7.3 providing assurance that services are safe, effective and tackling health inequalities; and
 - 7.4 supporting commissioners and providers to better understand local needs and develop improved services and care pathways.
8. At the local level, **Calderdale, Kirklees, Leeds, Bradford District and Craven** and **Wakefield**, has its own established statutory HOSC, in Calderdale Council currently considers health matters through its Overview and Scrutiny Committee. These committees scrutinise NHS planning, delivery and finances and form an important part of system-wide accountability.
9. At a **West Yorkshire** level, the West Yorkshire Joint Health Overview and Scrutiny Committee (WY JHOSC with North Yorkshire participating as an interested party for Craven) operates on a discretionary basis. It works in partnership with NHS West Yorkshire ICB and has an informal role in scrutinising substantial service change across West Yorkshire.
10. At a **North Yorkshire** level, the North Yorkshire Scrutiny of Health Committee scrutinises any matter relating to the planning, provision and operation of health services in the County (which includes Craven), including the policies of the Health and Care Partnerships

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Schedule 9

Act as One Provider Partnership Protocol for Information Sharing

11. INTRODUCTION

- 11.1 The Bradford District and Craven (BD&C) Provider Partnership Strategic Partnering Agreement (the **SPA**) sets out the operating framework for how health and care system partners in BD&C who are signatories to the SPA (the **Partners**) will work together in a collaborative and integrated way on a Best for Bradford District and Craven basis. To this end, the Partners have agreed to share information with each other in an honest, open and timely manner.
- 11.2 As referenced in Clause 13.1 of the SPA, this Protocol sets out arrangements to manage the sharing of information between the Partners to support collaboration and joint working.
- 11.3 This Protocol forms part of the governance arrangements for the BD&C Provider Partnership as set out in the SPA and should be considered in conjunction with the SPA and the terms of reference of the BD&C Partnership Board, Act as One Committee and other governance groups as referenced in the SPA (referred to in this Protocol as the **Governance Groups**).

12. DEFINITIONS

In this Protocol defined terms have the meaning set out in the SPA with the exception of the terms defined in Appendix 1.

13. SCOPE

This Protocol applies to each of the Partners and its representatives, and each Partner will ensure that its representatives who are members of the BDC Act as One system governance group(s) or who are involved in strategy delivery groups pursuant to the SPA are aware of, and comply with, this Protocol when sharing information for the purposes of the SPA.

14. CONFIDENTIAL INFORMATION

- 14.1 The Partners have agreed under the SPA to share information in an honest, open and timely manner to support the achievement of the SPA objectives, subject to compliance with Law and their obligations of confidentiality in the SPA.

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- 14.2 Each Partner must maintain clear records of all Confidential Information disclosed or received.
- 14.3 Where it is agreed between any of the Partners that the sharing of personal data is necessary for the purposes of the SPA, the relevant Partners must ensure that a data protection impact assessment (DPIA) is produced and, if the data sharing is not already covered by existing data sharing agreements, enter into appropriate data sharing agreements in accordance with the requirements of the GDPR.

15. COMPETITION SENSITIVE INFORMATION

- 15.1 The Partners must not disclose to each other any Competition Sensitive Information.
- 15.2 Information is not Competition Sensitive Information if:
- 15.2.1 it relates to activities or markets in which the Partners do not currently compete against other organisations and where there is no realistic prospect that they will in future compete;
- 15.2.2 subject to paragraph 5.3 of this Protocol, if it relates to any arrangements involving information exchange and collaboration (including for the purpose of joint projects contemplated or being implemented by the Partners) which were put in place prior to the date of the SPA for the purpose of Business as Usual activities; and
- 15.2.3 it relates to activities or markets in which the Partners are actual or potential competitors and disclosure of the relevant information would not affect the Partners' commercial strategy or decisions; this may apply if, for example:
- (a) the information is historical, Aggregated (as defined below) and/or anonymised; or
 - (b) the information is freely available in the public domain other than as a direct or indirect result of the information being disclosed in breach of this Protocol or the SPA or of any other undertaking of confidentiality addressed to the Partner to whom the information relates (except that any compilation of otherwise public information in a form not publicly known shall nevertheless be treated as Competition Sensitive Information).

- 15.3 The following principles should be considered in relation to any information disclosed from one Partner to another:

15.3.1 Business as Usual

- (a) The Partners must continue to act, make bids and try to win new business as appropriate in exactly the same way that each would have done in the absence of the development of closer collaboration and joint working.
- (b) The Partners will remain separate to other organisations in the area and should continue to make decisions on matters such as bidding strategies and entry into new contracts independently.

15.3.2 Document Creation

- (a) Documents created by any Partner for the development of closer collaboration and joint working as part of the Provider Partnership may be disclosable under the Freedom of Information Act 2000.
- (b) Due care and attention should be taken when creating documents (including emails and handwritten notes) to avoid the use of language that could be misinterpreted.
- (c) If any Partner or their staff are asked by their external legal advisors to provide Data, any documents should be clearly marked "Privileged and confidential: prepared at the request of our external legal advisers".

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APPENDIX A - DEFINITIONS

- 9 Aggregated** means that the price, cost and volume of individual services or contracts for the provision of services, the subject matter of which forms or could form the basis of competition between any of the Partners, cannot be determined from the Data.
- 10 Commercially Sensitive Information:** Confidential Information which is of a commercially sensitive nature relating to a Partner, its intellectual property rights or its business or which a Partner has indicated would cause that Partner significant commercial disadvantage or material financial loss.
- 11 Competition Sensitive Information:** Confidential Information (as defined in the SPA) which is owned, produced and marked as Competition Sensitive Information by one of the Partners and which that Partner properly considers is of such a nature that it cannot be exchanged with the other Partners without a breach or potential breach of Competition Law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Partner, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions.
- 12 Data:** information, data and material recorded in any form and shared between any or all of the Partners including Confidential Information and Commercially Sensitive Information.

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Schedule 10

SPA Work Plan

This SPA Work Plan sets out the Partners agreed areas of focus for the further development of the SPA from April 2026/27 and will form part of a wider programme of work to develop the Provider Partnership during this period.

Areas for development will include:

	Area for development	Proposed focus
1	Establish Bradford District and Craven Provider Partnership	Deliver strategic priorities overseen by the Act as Once Joint Committee (JC). The JC will work to formal establishment from 1 April 2027 by demonstrating achievement of a 'mature' self-assessment of readiness. (Note: the self-assessment framework's requirements to demonstrate readiness forms the basis of ICB's readiness checklist for go live from 1 April 2027)
2	Place Health, Care and Wellbeing Strategy Priority 1 Priority 2 Priority 3	Prevention and Early Intervention • Increase uptake of prevention programmes. • Implement neighbourhood-level prevention hubs. • Develop multi-morbidity pathways integrating physical and mental health. Neighbourhood Integrated Care • Establish fully functioning Integrated Neighbourhood Teams (INTs) in all localities. • Standardise multidisciplinary team (MDT) models. • Expand community diagnostics and home-based care. Digital and Data • Implement shared care record enhancements. • Expand digital inclusion programmes.

	Area for development	Proposed focus
	Priority 4 Priority 5 Priority 6 Priority 7	• Deploy predictive modelling tools for population health management. Reducing Inequalities • Apply proportionate universalism to all programmes. • Target inclusion health groups with tailored interventions. • Reduce unwarranted variation across Community Partnerships. Citizen Activation and Co-Production • Expand Listen In and deliberative engagement. • Develop community-led service design frameworks. • Embed our personas into pathway redesign. • Strengthen recruitment and retention in underserved areas. Workforce Transformation • Develop neighbourhood-based workforce models. • Implement cross-organisational training on population health and digital skills. Financial Sustainability • Deliver the Closing the Gap programme. • Shift investment from acute to community settings. • Implement value-based resource allocation.
2	Contracting & Procurement (Finance, Performance & Quality Forum)	1) Develop a clear contracting model between the ICB and the BDC Provider Partnership, in line with the Provider Selection Regime. 2) Review of all section 75 and section 256 agreements, to support and enable the Provider Partnership from 1 April 2027 onwards
3	Further develop governance arrangements for 1 April 2027 onwards	1) Further development of this Strategic Partnering Agreement (SPA) to form the BDC Provider Partnership Alliance Agreement developed in alignment with the contracting process from 1 October 2026 to 31 March 2027

	Area for development	Proposed focus
	(Act as One Joint Committee and partnership governance arrangements)	2) Establish the BDC Provider Partnership Joint Committee with delegation from Partners into this Joint Committee which will make binding majority decisions 3) Annually, by the end of March each year undertake an annual effectiveness review of the Provider Partnership governance arrangements, with independent review every 3 years

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Board of Directors – meeting held in public

10 September 2026

Paper title:	Governance Report	Agenda Item 20.0
Presented by:	Fran Stead, Trust Secretary/Rachel Trawally Corporate Governance Manager and Deputy Trust Secretary	
Prepared by:	Holly Close, Senior Corporate Governance Officer & Executive Support Manager	
Committees where content has been discussed previously		
Purpose of the paper Please check <u>ONE</u> box only:	☒ For approval ☐ For information ☐ For discussion	
Link to Trust Strategic Vision Please check <u>ALL</u> that apply	☐ Providing excellent quality services & seamless access ☐ Creating the best place to work ☐ Supporting people to live to their fullest potential ☐ Financial sustainability, growth & innovation ☒ Governance & well-led	
Care Quality Commission domains Please check <u>ALL</u> that apply	☐ Safe ☐ Caring ☐ Effective ☒ Well-Led ☐ Responsive	

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

Executive Summary
This report provides an overview of key governance developments and updates over the previous two months, alongside highlighting upcoming matters for the Board of Directors' awareness. This report details that the Corporate Governance Team have undertaken a review of the Board Nomination and Remuneration Committee Terms of Reference which has been presented at this meeting for approval. The report also make reference to a number of Council of Governor updates in particular that the Trust is engaging in an election process to fill a number of vacant seats.

Finally, the report documents NHS England's 2026 Provider Capability Assessment process, including the Trust's approach to completing the self-assessment, the timetable for Committee and Board review, and the submission requirements ahead of the national deadline of 2 October 2026.

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)

- Ratify the revised Terms of Reference for the Board Nominations and Remuneration Committee
- Note the emerging collaborative Governor development programme across Bradford District and Craven Place
- Note the commencement of the 2026 Provider Capability Assessment Process

Links to the Strategic Organisational Risk register (SORR)

N/A

Care Quality Commission domains

Please check **ALL** that apply

- | | |
|-------------------------------------|--|
| ☐ Safe | ☐ Caring |
| ☐ Effective | ☒ Well-Led |
| ☐ 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

10 September 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.

Accountability and Governance

Board of Directors Nomination and Remuneration Committee Terms of Reference

Good governance stipulates that there will be an annual review of the Terms of Reference that support group and committees. In-line with this, the Terms of Reference for the Board of Directors Nominations and Remuneration Committee have been reviewed by the Corporate Governance team. A number of proposed amendments to the Committee terms of reference are as follows:

- Committee title updated from 'Remuneration Committee' to 'Nominations and Remuneration Committee' throughout.
- Purpose and objectives expanded to include nominations responsibilities, including Executive Director appointments, succession planning and Board skills, knowledge and experience.
- Section added on nominations and appointments, including recruitment processes, appointment panels and recommendations to the Board.
- Responsibility added for receiving the output of the Fit and Proper Person exercise for Executive Directors.
- Assurance to the Board expanded to include leadership sustainability and succession planning.
- References to national guidance and the NHS Foundation Trust Code of Governance updated.
- Previous appendix on Monitor Code provisions/performance-related schemes removed.
- Reference to Clinical Excellence Awards removed.

The terms of reference were discussed and approved at the Board Nominations and Remuneration Committee on 22 June 2026. They are now being presented to the Board of Directors for formal ratification.

Collaborative working across Bradford District and Craven Place

The Corporate Governance Team has begun working in partnership with other Corporate Governance Teams across Bradford District and Craven Place to facilitate shared learning, promote standardisation, and align approaches to meeting structures and governance practices. The Board will be kept updated on this work, which further builds on existing

partnership practice and is expected to consider a variety of topics across the Corporate Governance function.

Engagement and Involvement

Council of Governors

Appointment and Resignations:

Arshad Ali: Staff Governor: Clinical has resigned from the Council of Governors. On behalf of the Trust, the Council thanked them for their commitment and hard work.

The Board of Directors should also be made aware that the Council of Governors has also welcomed Councillor Jayne Morgan who took up the post of Appointed Governor: Bradford Council on 17 July 2026.

Elections:

In accordance with Schedule 7 of the NHS Act 2006 and the Trust Constitution and on behalf of the Council of Governors the Corporate Governance team will be commencing the election process for vacant Public and Staff Governor seats with nominations opening on 10 September 2026. The following seven seats will be up for election:

Constituency	Number of seats available	Comments
Public – Bradford South	1 Seat	
Public - Craven	1 Seat	
Public - Keighley	1 Seat	
Public - Shipley	2 Seats	
Public – Bradford West	1 Seat	This seat has been included to fill the remainder of an unexpired term of office in accordance with the Trust's Constitution.
Staff - Clinical	1 Seat	

The nomination period will close on Friday 2 October 2026. Should any constituency be contested, a ballot will open on 21 October 2026 and close on Wednesday 11 November 2026. Board members will be invited to support the promotion of the vacancies through their networks to encourage strong engagement from Trust members and the wider community. Further updates and information will be provided throughout the election process.

Governor Partnership working

The Board of Directors is advised that Governors from Bradford District Care NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust and Airedale NHS Foundation Trust met on 10 August 2026 at Airedale NHS Foundation Trust to begin exploring the implications of the NHS Ten Year Health Plan, including the Governments proposals to remove the statutory requirement for NHS Foundation Trusts to maintain a Council of Governors, and how any future changes may operate across the Bradford District

and Craven place. The Trust recognises and values the importance of representation, involvement and engagement.

The session also included a tour of the Airedale estate to view the impact of Reinforced Autoclaved Aerated Concrete (RAAC). Further joint Governor development sessions are planned, including a session to be hosted by Bradford District Care NHS Foundation Trust in the autumn. The Board of Directors will be updated as this work progresses.

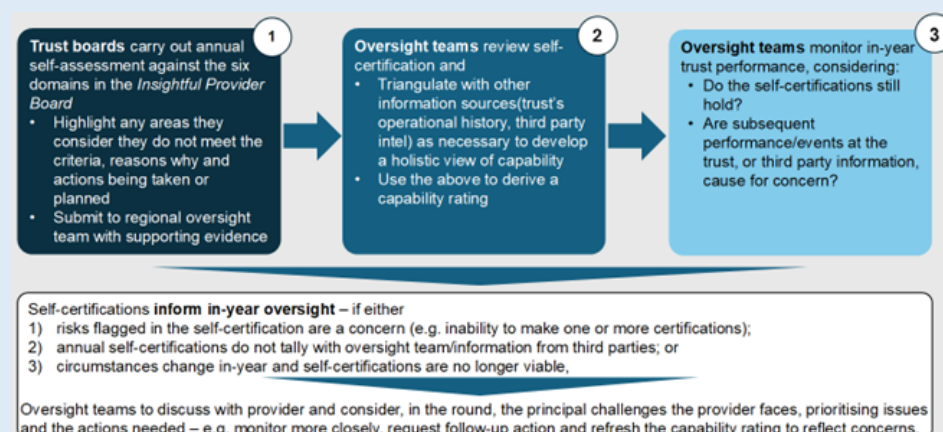
Health Modernisation Bill

The Trust continues to monitor the progress of the NHS Modernisation Bill and its potential implications for NHS Foundation Trust governance arrangements, including proposals relating to membership and Councils of Governors. As part of this, the Corporate Governance Team has engaged with national forums including a joint session ran by the NHS Alliance and NHS England on the 'Future of Council of Governors'. This session provided an opportunity to share learning, consider national developments and discuss potential implications for Governor and member engagement. Further national guidance is anticipated in the Autumn, and the Board will continue to receive updates as developments emerge

Compliance

Provider Capability Assessment

NHS England has commenced the 2026 Provider Capability Assessment (PCA) process, building on the approach introduced in 2025. The PCA requires NHS trust boards to undertake a self-assessment against capability statements aligned to the six domains set out in The Insightful Provider Board. Minor amendments have been made to the framework this year, including strengthened consideration of board oversight of cybersecurity, digital maturity and staff wellbeing. The assessment is intended to support robust board assurance, promote openness and transparency between providers and regional teams, and inform the level of regulatory oversight applied to organisations.



The overall process remains largely unchanged. Boards are required to assess their capability across the six domains, supported by evidence and identification of any areas for development. Unlike last year, self-assessments will be completed using the same Green, Amber-

Green, Amber-Red and Red rating scale applied to the final assessment. Trusts are required to submit their completed self-assessment, supporting evidence and Board or Committee approval papers to NHS England by **5.00pm on Friday 2 October 2026**. Regional teams will review and triangulate the submission against their knowledge of the organisation, third-party

information and the Board's recent track record before recommending a final rating. Ratings will then be subject to moderation and ratification through NHS England's national processes, with final outcomes expected to be published by December 2026.

Following discussion at Executive Management Team, it was agreed that the Trust's 2025 PCA submission and supporting evidence would be used as the baseline for the 2026 assessment. The approach, endorsed by the Chair, is to refresh and update the existing submission to reflect progress, developments and assurance gained since the previous assessment. The draft PCA will be reviewed through the relevant Committees during September before being presented to the Board of Directors for approval on 1 October 2026.

Annual Report 2025/26

The Annual Report and Accounts has been updated to reflect a small number of minor amendments. The updated document is expected to be laid before Parliament in early September in line with the required timetable.

People Matters

Chief Medical Officer Recruitment

Work is progressing with the Executive Support Team and Recruitment Team to support the delivery of a robust recruitment campaign for the substantive position of the Chief Medical Officer. The advert for the role went live on 17 August with a closing date of 6 September. Shortlisting is due to take place on 7 September with interviews across 22 and 23 September 2026. Further updates will be provided as the recruitment process progresses and concludes.

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Board of Directors **Nominations and** Remuneration Committee

Terms of Reference

Document details:	Terms of Reference for the Board of Directors Nominations and Remuneration Committee
Version:	<u>7</u>
Approved by:	Board Nominations and Remuneration Committee
Date approved:	<u>22 June 2026</u>
Ratified by:	Trust Board <u>of Directors held in Public</u>
Date ratified:	
Title of originator / author:	Corporate Governance Team
Title of responsible Director:	Trust Chair
Date issued:	
Review date:	
Frequency of review:	Annual
Where is previous copy archived: (if applicable)	Available from Corporate Governance Team
Amendment Summary (changes highlighted in red):	<u>Update the references to the title of the committee throughout and update to reflection the nominations requirements part of the committee relating to appointment, succession planning and skills</u>

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Terms of Reference for the Board of Directors Nominations and Remuneration Committee

A. Overall aim or purpose:

The Board hereby resolves to establish a Committee of the Board to be known as the Nominations and Remuneration Committee. The overall and prime aim of the Nominations and Remuneration Committee is:

To decide appropriate remuneration and terms of service for the Chief Executive and Executive Directors including all aspects of salary, provision for other benefits including pensions and cars, arrangements for termination of employment including redundancy and other contractual terms.

The Nominations and Remuneration Committee also has responsibility for:

- overseeing the appointment of Executive Directors
- leading succession planning for the Chief Executive and Executive Directors
- ensuring the Board has the appropriate balance of skills, knowledge and experience
- receiving the output of the Fit and Proper Person exercise for all Executive Directors, in accordance with NHS England guidance and CQC regulatory activities.

The Nominations and Remuneration Committee also has a key role in:

Reviewing pay, terms and conditions for the most senior staff below executive director level

The applicability of any national agreements for staff on local terms and conditions or pay arrangements that are not determined nationally

Receiving information on the outcome of Clinical Excellence Awards Rounds and any new proposals

Commented [FS1]: Removed as this doesn't go to Board NRC anymore - think it got moved to EMT

Reviewing and approving all redundancy business cases and any proposed payments to staff that do not fall within contractual entitlements e.g. settlement agreements.

Reviewing Trust strategies and proposals around pay and reward including Foundation Trust freedoms, flexibilities and options.

A1 The level and components of remuneration:

Main principle

Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with the skills and experience required to lead the NHS foundation

trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.

B. Key objectives:

The Nominations and Remuneration Committee's key objectives are to:

- Determine the remuneration and terms of service of Directors and the Chief Executive to ensure they are fairly rewarded for their individual contribution to the Trust having proper regard to the Trust's circumstances and performance and to the provisions of any national agreements for such staff where appropriate. The Committee will report to the Board the decisions taken at the Committee
- Agree contractual arrangements for such staff and to approve and have oversight of the proper calculation and scrutiny of payments including those upon termination of employment with the Trust taking into account guidelines issued by the Department of Health and the Treasury, as appropriate
- Approved payments and strategies linked to its other roles including redundancy payments, non-contractual settlements and pay and reward proposals.
- Review the structure, size and composition of the Board and make recommendations where changes are required
- Ensure robust and transparent processes are in place for the appointment of Executive Directors
- Lead succession planning to support the long-term sustainability of the Trust
- receiving the output of the Fit and Proper Person exercise for all Executive Directors, in accordance with NHS England guidance and CQC regulatory activities.

The Nominations and Remuneration Committee will report to the Board on decisions taken and provide assurance on leadership capacity and capability.

B1 Supporting principles

B1.1 Any performance-related elements of executive directors' remuneration should be stretching and designed to promote the long-term sustainability of the NHS foundation trust. They should also take as a baseline for performance any competencies required and specified within the job description for the post.

B1.2 The Nominations and reRemuneration committee should decide if a proportion of executive director's remuneration should be structured so as to link reward to corporate and individual performance. The Nominations and Remuneration committee should judge where to position its NHS foundation trust relative to other NHS foundation trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration levels with no corresponding improvement in performance.

B1.3 The Nominations and Remuneration committee should also be sensitive to pay and employment conditions elsewhere in the NHS foundation trust, especially when determining annual salary increases.

~~Attached at Appendix 1 are the Monitor Code provisions on performance related schemes, increases in basic salary, release of a director to service elsewhere and compensation commitment considerations in the event of early termination. The Committee will operate in line within relevant national guidance and best practice and in line with the NHS Foundation Trust Code of Governance and oversee remuneration arrangements that are fair, transparent and aligned to performance and organisational objectives."~~

C. Specific areas of responsibility:

The Nominations and Remuneration Committee's significant role is to ensure that the Chief Executive and Executive Directors are appropriately remunerated and employed upon appropriate terms and conditions of service.

C1 Main principle

C1.1 There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration.

Supporting principle

C1.2 The nominations and remuneration committee should consult the chairperson and/or chief executive about its proposals relating to the remuneration of other executive directors.

C1.3 The nominations and remuneration committee should also be responsible for appointing any independent consultants in respect of executive director remuneration.

C1.4 Where executive directors or senior management are involved in advising or supporting the nominations and remuneration committee, care should be taken to recognise and avoid conflicts of interest.

C2 Nominations and appointments

The Nominations and Remuneration Committee will:

- Identify and nominate candidates for appointment as Executive Directors
- Agree role descriptions and person specifications for Executive Director posts
- Oversee recruitment processes, including establishing appointment panels
- Make recommendations to the Board (and Council of Governors where required) regarding appointments
- Keep under review succession plans for Executive Directors

The Nominations and Remuneration Committee will:

- Advise the Board about appropriate remuneration and terms of service for the Chief Executive and Directors
- Advise the Board on all aspects of salary including; annual pay uplifts, - and any performance related elements and bonuses
- Advise the Board about provisions for other benefits including pensions and cars
- Advise on appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.
- Have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose should be determined by the board, but should normally include the first layer of management below board level.
- Will make available its terms of reference, explaining its role and the authority delegated to it by the board of directors.

The Nominations and Committee will have the power to make recommendations to the Board regarding relevant matters.

It will have the power to include other parties, not members of the Committee, in order to address specific issues.

The Nominations and Remuneration Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of external individuals with relevant experience and expertise if it considers this necessary in furtherance of its duties. Where remuneration consultants are appointed, a statement should be made available through the annual report as to whether they have any other connection with the NHS Foundation Trust.

The Nominations and Committee will request and receive relevant minutes and reports where appropriate.

D. Chair:

The Nominations and Remuneration Committee shall be chaired by the Trust Chair and in his/her absence, by the Deputy Chair.

E. Membership

The Nominations and Remuneration Committee shall be appointed by the Board from amongst the Non Executive Directors of the Trust and shall consist of not less than three members, including the Chair.

The Trust's Chief Executive and any other appropriate Director will attend by invitation to provide appropriate advice.

Other advisers may be invited to attend if necessary, in particular with regard to the Chief Executive.

F. Accountable to:

The Nominations and Remuneration Committee is accountable to the Board from whom it has delegated authority for decision making for those areas within its remit. The minutes of the Committee meetings shall be formally recorded and submitted to the private section of the Board. The Board Committee report will include a submission from the Nominations and Remuneration Committee reflecting the items that were discussed.

The Nominations and Remuneration Committee will provide assurance to the Board on:

- remuneration governance
- leadership sustainability and succession planning

G. Accountable for:

There are no formal lines of accountability between the Nominations and Remuneration Committee and other Trust Committees. The Nominations and Remuneration Committee interacts with other Trust Committees through cross attendance.

H. Roles

Minutes and administration of the meetings is undertaken through the Corporate Governance Team office.

I. Frequency of Meetings:

Meetings will be held at least once a year. The Trust Chair may request a meeting if they consider that one is necessary.

J. Frequency of Attendance:

All Committee members will be expected to attend at least one meeting a year.

K. Quorum:

A quorum shall be two Non- Executive Directors - one of whom must be the Chair (or Deputy Chair).

L. Record Keeping:

Archives of minutes and papers relating to the Nominations and Remuneration Committee are maintained by the Corporate Governance Team.

M. Lifespan of meeting:

The Nominations and Remuneration Committee is a standing committee of the Trust Board. It will continue to meet in accordance with these Terms of Reference until the Trust Board determines otherwise.

N. Other matters: attendance

The Chief Executive, Director of Human Resources and Organisation Development and other Directors or members of staff will be invited to attend where appropriate.

The Nominations and Remuneration Committee may choose to invite external organisations and individuals to present issues and reports from time to time.

O. Terms of Reference review

The Nominations and Remuneration Committee will review its Terms of Reference at least annually.

Code Provisions on Performance-related schemes and other payments

- Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions:
 - i) The remuneration committee should consider whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.
 - ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in key indicators, and the taking of independent and expert advice where appropriate.
 - iii) Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed.
 - iv) The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.
- Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.
- The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.

Escalation and Assurance Report (AAA)

Report from the: West Yorkshire Community Health Services Provider Collaborative (WYCHS) - Quarterly Chairs and Executives Leads meeting.

Date of meeting: 7th July 2026

Agenda
Item

XX

Key escalation and discussion points from the meeting			
Alert	Action (to be taken)	By Whom	Target Date
WYCHS Governance Arrangements Agreed Partners have agreed a revised operating model for the WYCHS Provider Collaborative, reflecting a more focused and proportionate approach to collaborative working. Key changes include: - Quarterly WYCHS Chief Executive and Chair meetings will cease. - A bi-monthly Executive Leads forum will become the primary governance mechanism. - Standing director forums will be replaced by task-and-finish groups established as required. - Community providers will continue to collaborate where there is clear value, including: - NHS England requirements. - ICB commissioning asks.	Each organisation is requested to: - Confirm or reconfirm its nominated Executive Lead for WYCHS. - Ensure appropriate reporting and feedback arrangements into both: - The organisation's executive structures. - Relevant Place Provider Partnerships (PPPs).	Each member organisation	September 2026

Close, Holly
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West Yorkshire-wide priorities requiring scale. This represents a shift from formal governance structures towards a more agile, delivery-focused model.			
Advise:			
Urgent Community Pathways Discussion focused on opportunities to maximise urgent community pathways and reduce unnecessary acute demand. A proposal was agreed to strengthen engagement between Yorkshire Ambulance Service (YAS) and Urgent Community Response (UCR) services across West Yorkshire. Calderdale, Airedale and Kirklees have volunteered to support the initial engagement work with Yorkshire Ambulance Service to explore opportunities for improving integration with UCR services.			
Assure:			
The principal outcome from the meeting was agreement to move WYCHS to a lighter-touch collaborative model led through Executive Leads rather than quarterly CX/Chair meetings. Collaboration will continue around key strategic priorities, with community providers retaining a collective voice in West Yorkshire system governance. Organisations are asked to confirm Executive Lead representation, with revised arrangements commencing immediately and subject to review in January 2027. Continued WYCHS Strategic Collaboration Despite the reduction in formal governance arrangements, partners reaffirmed commitment to collaboration around the four existing strategic priorities: - West Yorkshire Core Community Offer. - System Transformation and Strategic Commissioning. - West Yorkshire-wide Community Service Models. - Community Waits Recovery. Particular emphasis will be placed on: - Speech and Language Therapy (SaLT). - Data and analytics. Maintaining System Influence The revised Executive Leads forum will continue to provide community provider representation into key West Yorkshire system structures, including:			

- West Yorkshire Integrated Neighbourhood Board.
- West Yorkshire System Leadership Executive – Strategic Commissioning and System Development Group.

This should maintain the collective community provider voice at system level despite the governance simplification.

Review Arrangements

The impact and effectiveness of the revised operating model will be formally reviewed by Chief Executives and Chairs on **12 January 2027**.

Report completed by:

Becca Spavin

Programme Director: West Yorkshire Community Healthcare Provider Collaborative

9.7.26

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

Executive Lead Nomination Required

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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

			Date	Date	Date	Date	Date		Date
Category	Agenda item	Paper author	02.04.26	04.06.26	23.07.26	10.09.26	5.11.26	14.01.27	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

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