Board held in Public

Thursday 5 November 2026, 09:30 - 12:15

Horton Park Centre, 99 Horton Park Avenue Bradford BD7 3EG

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 Horton Park (details of how to express your interest in joining this meeting can be found at the end of the agenda).

Agenda

09:30 - 09:32
2 min

1. Welcome and apologies for absence (verbal)

Information *Sarah Jones*

Item 01.0 - Board of Directors Agenda - held in public - 5 November 2026 v4.pdf (4 pages)

09:32 - 09:33
1 min

2. Declaration of any conflicts of interest (enclosure)

Information *Sarah Jones*

Item 02.0 - Declarations of Interest - Board of Directors - October 2026 V1.1.pdf (1 pages)

09:33 - 09:33
0 min

3. Trust Risk Appetite Matrix (enclosure)

Information *Fran Stead*

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

09:33 - 09:33
0 min

4. Questions received (verbal)

Discussion *Sarah Jones*

09:33 - 09:35
2 min

5. Minutes of the previous meetings held on 23 July 2026 and 10 September 2026 (enclosures)

Decision *Sarah Jones*

Item 05.0.0 - Public Board minute 23 July 2026 Chair approved.pdf (15 pages)
Item 05.0.1 - Public Board minutes 10 September 2026 -Chair approved.pdf (13 pages)

09:35 - 09:35
0 min

6. Matters arising (verbal)

Information *Sarah Jones*

Close Holly 29/10/2026 15:09:24

09:35 - 09:40
5 min

7. Action log (enclosure)

Sarah Jones

Item 07.0 - Public Board of Directors - Action Log - for 5 November 2026.pdf (3 pages)

09:40 - 10:00 (20 min)

8. Board story - Mental Health Services experiences (presentation)

Discussion *Suzanne Hala and CB/SB*

10:00 - 10:05 (5 min)

9. Chair's Report (enclosure)

Sarah Jones

Item 09.0.0 - Chair's Report - 5 November 2026 (Final)_.pdf (4 pages)

10:05 - 10:15 (10 min)

10. Chief Executive's Report (enclosure)

Discussion *Phillipa Hubbard*

Item 10.0 - CE Report Public - November 2026.pdf (7 pages)

Quality and Safety

10:15 - 10:20 (5 min)

11. Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held 17 September 2026 (enclosure)

Discussion *Warren Brown*

Item 11.0 - AAAD - Effective Oversight Escalation and Assurance - MHLC 17 Sept 2026 CHAIR EXEC APP.pdf (3 pages)

10:20 - 10:25 (5 min)

12. Alert, Advise, Assure and Decision Report: Quality and Safety Committee held 16 September and 21 October 2026 (enclosure)

Discussion *Alyson McGregor*

Item 12.0.0 - AAAD - Effective Oversight Escalation and Assurance - QSC Sept 2026 - Final - Chair Approved.pdf (4 pages)

Item 12.0 - AAD - Effective Oversight Escalation and Assurance - QSC October 2026 - Chair Approved.pdf (3 pages)

10:25 - 10:35 (10 min)

13. Freedom to Speak up thematic report (enclosure)

Decision *Christopher Dixon*

Item 13.0.0 - Freedom to Speak Up Guardian Bi-Annual Activity Report - Nov 2026.pdf (11 pages)

10:35 - 10:40 (5 min)

Break (10.35 – 10.40)

Finance and Sustainability

10:40 - 10:45 (5 min)

14. Finance Report (enclosure)

Discussion *Mike Woodhead*

Item 14.0.0 - Finance Report Board (Cover paper).pdf (3 pages)

Item 14.0.1 - Trust Board - Finance Report (Month 6 - September 2026).pdf (9 pages)

Close Holly 29/10/2026 15:09:2

10:45 - 10:50 (5 min)

15. AAAD Extraordinary Finance and Performance Committee held on 23 September 26 (enclosure)

Discussion *Mark Rawcliffe*

Item 15.0 - AAAD - Effective Oversight Escalation and Assurance - FPC 23 Sept 2026 CHAIR EXEC APP.pdf (3 pages)

10:50 - 10:55
5 min

16. NHS quarterly submission (enclosure)

Decision *Mike Woodhead*

Item 16.0.0 - NHS England Quarterly Submission (Trust Board) Q2 26_27.pdf (4 pages)

10:55 - 11:05
10 min

17. LMH Redevelopment programme derogations

Decision *Mike Woodhead/ John Neeson*

Item 17.0.0 - TB Derogations Cover Paper v1 DRAFT.pdf (5 pages)
Item 17.0.1 - Appendix A - LMH Stage 5 Design Derogations Oct 26_FINAL.pdf (1 pages)

Strategy and partnerships

11:05 - 11:20
15 min

18. Integrated Strategic Performance and Quality Report (enclosure)

Discussion *Kelly Barker & Chris Dixon*

Item 18.0.0 - ISPQR - October 2026 - Trust Board Cover Paper FINAL.pdf (6 pages)
Item 18.0.1 - ISPQR - October 2026 (September Data) FINAL.pdf (65 pages)

18.1. Board Assurance Framework (enclosure)

Fran Stead

Item 18.1.0 - Board Assurance Framework - Public Board - 5 November 2026 - Final.pdf (8 pages)

18.2. Strategic Risk Report (enclosure)

Fran Stead

Item 18.2.0 - Strategic Risk Assurance Report - Board - November 2026 - v.0.1.pdf (15 pages)
Item 18.2.1 - Appendix 1 - 2026.09 - Strategic Risk Assurance Report WHOLE - Public Board.xlsx (25 pages)

11:20 - 11:35
15 min

19. Quality and Performance Management System (enclosure)

Chris Hunt

Item 19.0.0 -BDCFT Public Board Meeting - QPMS - 5-11-26 - V2.pdf (9 pages)

11:35 - 11:45
10 min

20. BDCT Social Value activity (enclosure)

Discussion *Farhan Rafiq*

Item 20.0.0 - BDCFT Social Value activity Board Paper.pdf (9 pages)

People & Culture

11:45 - 11:50
5 min

21. Alert, Advise, Assure and Decision Report: People and Culture Committee held 17 September and 22 October 2026 (enclosures) • PCREF report • Menopause update

Cleared by
29/10/2026 15:09:2

Discussion *Joanne Harrison*

Item 21.0.0 - AAAD - Effective Oversight Escalation and Assurance - PCC 17 Sept 2026 CHAIR EXEC APP.pdf (3 pages)

- Item 21.0.1 -AAAD - Effective Oversight Escalation and Assurance - PCC Oct 2026 CHAIR EXEC APP.pdf (3 pages)
- Item 21.0.2 - Menopause at Work Update 2026.pdf (8 pages)
- Item 21.0.3 - Appendix 1 Pay Gap and Menopause Action Plan 2026 - 2028.pdf (3 pages)
- Item 21.0.4 - Appendix 2 Feedback from Colleagues about Menopause at Work.pdf (2 pages)
- Item 21.0.5 - Public Sector Equality Duty Report 2026 Cover Paper.pdf (3 pages)
- Item 21.0.6 - PSED REPORT 2026 - 2027.pdf (35 pages)

Governance and well led

11:50 - 11:55
5 min

22. Alert, Advise, Assure and Decision Report: Audit Committee held 23 September 2026 (enclosure)

Discussion *Warren Brown*

- Item 22.0.0 - AAAD - Effective Oversight Escalation and Assurance - Audit Committee 23.09.2026 - Chair Approved.pdf (3 pages)

11:55 - 12:00
5 min

23. Alert, Advise, Assure and Decision Report: Charity Funds Committee held 29 October 2026 (enclosure)

Discussion *Sally Napper*

- Item 23.0 - AAAD - Effective Oversight Escalation and Assurance CFC 29 October 2026 - Chair Approved.pdf (3 pages)

12:00 - 12:05
5 min

24. Well Led Development Plan (enclosure)

Discussion *Fran Stead*

- Item 24.0 -2026.11 - Well Led Development Plan - Board - Final.pdf (19 pages)

12:05 - 12:10
5 min

25. Governance report (enclosure) • Committee schedule • PCA update • Elections • AMM

Discussion *Fran Stead*

- Item 25.0.0 - Governance report- final.pdf (6 pages)
- Item 25.0.1 - Board COG and Sub-Comm dates final 2027-28.pdf (2 pages)

12:10 - 12:10
0 min

26. Partnership reports (enclosure)

Information

None received

- Item 26.0.0 - PRIVATE_WYMHSC Committees in Common_AAA Report_14.10.2026.pdf (2 pages)

12:10 - 12:10
0 min

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

Information *Sarah Jones*

- Item 27.0.0 - Work Plan - Board 202627 DRAFT.pdf (2 pages)

12:10 - 12:13
3 min

28. Any other business (verbal)

Discussion *Sarah Jones*

Clerk Holly 29/10/2026 15:09:24

12:13 - 12:15
2 min

29. Meeting evaluation (verbal)

Discussion *Sarah Jones*

Was the meeting conducted in line with the Trust values?

Date of next meeting: 14 January 2027– final details to be confirmed by Corporate Governance Team

Close Holly 29/10/2026 15:09:24

Board of Directors – held in public

Date: Thursday 5 November 2026

Time: 9.30 until 12.15

Venue: Meeting to be held in person, Horton Park PACT room S18

Together
We care We listen We deliver

AGENDA

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

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

This meeting will be held in person at Horton Park (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 23 July 2026 and 10 September 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 –Mental Health Services experiences** (presentation)	CD/ CB & SB	For discussion	9.40
All	9	**Chair's Report** (enclosure)	SJ	For discussion	10.00
	10	**Chief Executive's Report** (enclosure)	PH	For discussion	10.05

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Quality and Safety

BQS	11	**Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held 17 September 2026** (enclosure)	**WB**	**For discussion**	**10.15**
	12	**Alert, Advise, Assure and Decision Report: Quality and Safety Committee held 16 September and 21 October 2026** (enclosures)	**AM**	**For discussion**	**10.20**
	13	**Freedom to Speak up thematic report** (enclosure)	**CD**	**For discussion**	**10.25**
		Break 10.35-10.40			

Finance and Sustainability

BUOR	14	**Finance Report** (enclosure)	**MW**	**For discussion**	**10.40**
	15	**Alert, Advise, Assure and Decision Report: Finance and Performance Committee held 23 September 2026** (enclosure)	**MR**	**For discussion**	**10.45**
	16	**NHS quarterly submission** (enclosure)	**MW**	**For decision**	**10.50**
	17	**LMH Redevelopment programme derogations** (enclosure)	**MW/ John Neeson**	**For decision**	**10.55**

Strategy and partnerships

All	18	**Integrated Strategic Performance and Quality Report** (enclosure) **18.1 – Board Assurance Framework** (enclosure) **18.2 – Strategic Risk Report** (enclosure)	**CD/ KB** **FS** **FS**	**For discussion**	**11.05**
All	19	**Quality and Performance Management System** (enclosure)	**FR/ C Hunt**	**For discussion**	**11.20**
	20	**BDCFT Social value activity** (enclosure)	**E Clarke/ FR**	**For discussion**	**11.35**

People and Culture

BPTW	21	**Alert, Advise, Assure and Decision Report: People and Culture Committee held 17 September and 22 October 2026** (enclosures) • **PCREF report** • **Menopause update**	**JH** **JH**	**For discussion**	**11.45**

Close Holly 29/10/2026 15:09:24

Governance and well led

GG	22	**Alert, Advise, Assure and Decision Report: Audit Committee held 23 September 2026** (enclosure)	**WB**	**For discussion**	**11.50**
	23	**Alert, Advise, Assure and Decision Report: Charity Funds Committee held 29 October 2026** (enclosure)	**SN**	**For discussion**	**11.55**
	24	**Well Led Development Plan** (enclosure)	**FS**	**For discussion**	**12.00**
GG	25	**Governance report** (enclosure) • **Committee schedule** • **PCA update** • **Elections** • **AMM**	**RT**	**For decision**	**12.05**
	26	**Partnership reports** (enclosure) • WYMHSC Committees in Common AAA Report – 14.10.2026	**-**	**For information**	**-**
	27	**Board of Directors public meeting work plan 2026-27** (enclosure)	**-**	**For information**	**-**
	28	**Any other business** (verbal)	**SJ**	**For discussion**	**12.10**
	29	**Meeting evaluation** (verbal) **Was the meeting conducted in line with the Trust values?** (verbal)	**SJ**	**For discussion**	**-**

Date of the Next Meeting: 14 January 2027, to be held online on teams– 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**

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	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**

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Name	Directorships, including Non-Executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	Position of authority in a charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited...	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	Meeting Attendance
Executive Directors									
Kelly Barker	No	No	No	No	No	No	No	Spouse employed at BDCFT	
Joanne Harrison	1. BDC Corporate Target Operating Model - Shared SRO for the programme commenced in Sept 2025 2. PPP Development SRO for the Partnership and Leadership workstream and the Communications and engagement workstreams since Jan 2026 3. Joint People Office BDCFT/Airedale	No	No	No	Chief People Officer Co-Chair of the North East and Yorkshire CPO network, hosted by NHS Employers.	No	No	No	
Phillipa Hubbard	Director of Nursing and Quality within WY ICB working into Bradford District and Craven	Langtry-Langton Architects	None	None	None	None	None	None	
Farhan Rafiq	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	
Tim Rycroft	NA	NA	NA	NA	NA	NA	NA	NA	
Sal Uka	Nil	Nil	Nil	Trustee Overgate Hospice in Halifax	Nil	Nil	Nil	Nil	
Mike Woodhead	none	none	none	none	none	none	none	Close associate (Elite Consulting and Training Ltd) is providing service to BDCT	
Non Executive Directors									
Warren Brown	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Spouse is a member of Ilkley Town Council	
Cleveland Henry	None	None	None	None	None	None	Employed at EMIS Health/Optum UK (Software supplying to NHS) Director of Leeds Digital Bali CIC	Spouse works at Leeds Teaching Hospital Trust NHS	
Sarah Jones	Trust Chair at Airedale NHS FT	None	None	None	None	None	None	None	
Chrisopher Malish	Bradford College	N/A	N/A	Outside my Non-exec role - none	No	No	No	None	
Alyson McGregor	None	None	None	None	Altogether Better (NHS hosted organisation): Director *(declared 06/03/24) Health Foundation Common Ambition Programme Advisory Group: Expert Advisor (declared 06/03/24)*	None	None	None	
Sally Napper	None	None	None	None	None	None	None	None	
Mark Rawcliffe	Horse and Jockey Horbury Bridge Limited Park Tavern Ossett Limited Dark Industries Limited	As above 50% holding	N/a	N/a	N/a	N/a	N/a	N/a	

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Risk Appetite Matrix

NHS
Bradford District Care
NHS Foundation Trust

	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.

Closed fully
29/10/2026 15:09:24

Bradford District Care
NHS Foundation Trust

Agenda Item 04.0

Board of Directors - held in Public
Thursday 23 July 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
	Warren Brown	Non-Executive Director
	Jo Harrison	Joint 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
	Sally Napper	Non-Executive Director and Senior Independent Director
	Farhan Rafiq	Director of Transformation, Improvement and Productivity
	Tim Rycroft	Chief Information Officer
	Mike Woodhead	Chief Finance Officer
In attendance in person:	AM	Involvement Partner, Board Story (agenda item 8)
	Anitha Mukundan	Consultant Psychiatrist (representing S Uka)
	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):	-	
Apologies:	Kelly Barker	Chief Operating Officer
	Alyson McGregor	Non-Executive Director
	Mark Rawcliffe	Non-Executive Director and Deputy Chair
	Dr Sal Uka	Chief Medical Officer

Close Holly 29/10/2026 15:09:24

MINUTES

Item	Discussion	Action
58	**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 A Mukundan, in the absence of S Uka and C Risdon, in the absence of M Woodhead. Apologies for absence were noted, and the meeting was confirmed as quorate.	
59	**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.	
60	**Trust Risk Appetite Matrix** (agenda item 3) The Trust Risk Appetite Matrix was received for information.	
61	**Questions received** (agenda item 4) No questions were received.	
62	**Minutes of the previous meeting held on 4 June 2026** (agenda item 5) Following the move to in-person meetings, work was being undertaken to review the use of Copilot to effectively support the production of minutes, while ensuring minutes accurately captured discussion, challenge and assurance. The minutes of the Board of Directors held in Public on 4 June 2026 would be circulated for approval once finalised.	
63	**Matters arising** (agenda item 6) No matters arising had been received.	
64	**Action log** (agenda item 7) The Chair presented the action log. The Board noted that four actions had been presented as complete. **The Board of Directors:** • **noted the contents of the action log;**	

Close Holly 29/10/2026 15:09:24

Item	Discussion	Action
	• **agreed to close the actions listed as complete; and** • **noted that no further actions were required on any actions listed.**	
65	**Board Story presentation – Inspired to Make a Difference** (agenda item 8) P Hubbard, Director of Nursing, Professions and Care Standards and Deputy Chief Executive, introduced AM, Involvement Partner, who shared their personal story of living with complex physical and mental health conditions and reflected on the importance of compassionate, person-centred care. AM explained that their experience of healthcare had been shaped not only by their diagnoses, but by the care, kindness and compassion shown by professionals throughout their journey. They described being diagnosed with Crohn's disease as a child after earlier symptoms and reflected on the significant impact of not initially being believed, highlighting the importance of listening to patients and treating them without judgement. They described the effect of bullying, anxiety, depression and obsessive-compulsive disorder during their teenage years, and explained how support from Child and Adolescent Mental Health Services had provided tools that continued to help them manage their wellbeing. They emphasised the importance of being listened to, being seen as a whole person and receiving timely mental health support alongside physical healthcare. They noted that their ongoing physical health conditions and treatment continued to affect their mental health, education, relationships, confidence and sense of identity. They reflected that consistent care, dignity and support from consultants, nurses, his GP and other healthcare professionals had helped them to persevere and maintain hope. They described how becoming an Involvement Partner had helped them find meaning and purpose in their experiences and strengthened their ambition to pursue a career in medicine. They highlighted the importance of valuing lived experience alongside professional expertise and continuing to build services where people were seen before their conditions. Board members thanked AM for sharing their powerful story. S Jones, Chair, highlighted the phrase "empathy is medicine" and noted that it strongly captured the importance of compassion, dignity, non-judgemental listening and person-centred care. AM commented that improving an individual's experience of care could also influence families and wider communities, including through conversations, understanding and reduced stigma. Board members noted the wider impact of compassionate care and the importance of patient and community involvement in shaping services.	

Close Holly 29/10/2026 15:09:24

Item	Discussion	Action
	It was commented that the language, themes and outcomes described within the story were powerful and suggested there may be an opportunity to reflect these within the Trust's strategic narrative. It was agreed that the reflections from the story should be held in mind during the rest of the meeting. The Board noted the powerful reflections shared through the Board Story and the importance of continuing to embed compassion, dignity, hope and lived experience in the Trust's approach to care. **The Board welcomed the presentation and were assured by the update.**	
66	**Chair's Report** (agenda item 9) The Chair presented the report, highlighting key updates since the previous reporting period. **The Board of Directors noted the report and the continued engagement with external partners, the Trust and the Council of Governors.**	
67	**Chief Executive's Report** (agenda item 10) T Patten, Chief Executive, presented the report and highlighted recent national guidance, including concerns about inappropriate access to patient records and the need to reinforce information governance responsibilities. T Rycroft, Chief Information Officer provided assurance that controls were in place to manage access to patient records, including role-based smartcard access, privacy alerts, monitoring by Information Asset Owners and oversight through the Information Governance Group. It was noted that previous inappropriate access incidents had been managed in line with reporting obligations, including referral to the Information Commissioner's Office where required, with no further action required. A Trust communications campaign had commenced and would continue throughout the year. P Hubbard, Director of Nursing, Professions and Care Standards, and Deputy Chief Executive advised that clinical records management would be strengthened in response to the national letter, supported by staff training on record keeping, legal obligations and professional accountability. T Patten highlighted the NHS staff standards and leadership management framework, which would need to be reflected and rolled out through appraisals, personal development reviews, training and development. J Harrison, Chief People Officer welcomed the framework as supporting consistent leadership and management standards across health and care. The Leadership College was noted, although the Chair highlighted that a	

Close Holly 29/10/2026 15:24:24

Item	Discussion	Action
	clear Board-level offer had not yet been published. The importance of creating "time to think" was highlighted, which aligned with local leadership development and existing Care Trust Way work. P Hubbard also noted that once ready the Quality Strategy would be brought to a future meeting. **Action:** to circulate guidance on the Leadership and Management framework **The Board of Directors noted the contents of the paper and sought any further clarification as appropriate.**	**CGteam**
68	**Alert, Advise, Assure and Decision Report: Mental Health Legislation Committee held 16 July 2026** (agenda item 11) W Brown, Non-Executive Director, presented the update from the Mental Health Legislation Committee held on 16 July 2026. The Board was advised that a recent Supreme Court ruling on deprivation of liberty under the Mental Capacity Act had changed previous assumptions and guidance, creating uncertainty while national guidance was awaited. The Committee had also received an update on Community Treatment Orders, which were expected to be strengthened through the Mental Health Act 2025, although implementation guidance was still awaited. The Board noted that the Trust had achieved a 36% reduction in physical restraint and a 55% reduction in seclusion over four years, and discussed the opportunity to share this learning more widely as good practice. The Board was assured that reports had been received on ligature detection systems and monitoring, including actions taken in response to the relevant National Patient Safety Alert, and that compliance with Mental Health Act and Mental Capacity Act training remained strong. P Hubbard confirmed a Board Story was scheduled to be presented to a future meeting. The Board noted the resignation of one Involvement Parter due to health reasons and discussed the value of involvement partners and lived experience in providing insight and challenge, and noted work to strengthen involvement and engagement processes. A question was raised about triangulating reductions in restraint and seclusion with health and safety reporting, including incidents involving harm to staff, and assurance was provided that incidents were reviewed through appropriate governance routes. **The Board noted the update and was assured by the work being undertaken.**	

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Item	Discussion	Action
69	**Alert, Advise, Assure and Decision Report: Quality and Safety Committee held 17 June 2026 and 16 July 2026** (agenda item 12) C Henry, Non-Executive Director, presented the update from the Quality and Safety Committee meetings held in June and July. The Board noted recurrent areas of alert, including data quality and reporting issues linked to SNOMED coding, safety risks in inpatient services relating to self-harm and patient flow, workforce capacity pressures in community nursing, and wider patient access and flow challenges across a number of services. The Board discussed whether recurrent alerts were receiving sufficient visibility and rigour across committees, particularly where issues had continued over time. It was noted that community nursing pressures had also been considered by Finance and Performance Committee and would be picked up through the community services review. The Board noted the planned work to strengthen the Board Assurance Framework, which would support improved agenda planning and assurance. **Action:** To consider if a joint committee deep dive would be relevant relating to Community Nursing. **The Board of Directors were assured by the update.**	**PH**
70	**Safer staffing annual report** (agenda item 13) P Hubbard presented the Safer Staffing Annual Report, noting that the statutory reporting requirement related to inpatient services, with additional appendices provided on children and young people's services and community nursing. The Board was advised that there had been no red shifts during the reporting period and that there continued to be daily oversight of safe and effective staffing**.** It was noted that ward acuity and complexity had increased, with enhanced therapeutic observations supporting a more therapeutic and individualised approach to patient care. The Board noted that sickness absence remained relatively high and that work was ongoing with clinical and ward managers to address temporary staffing, bank usage and vacancies. It was reported that there was currently one registered mental health nurse vacancy across inpatient wards, although turnover and the transition of newly qualified nurses into roles continued to require careful management. The Trust had also completed an external safer staffing review with NHS England, which concluded that the Trust was compliant overall and met national workforce safeguards. J Harrison, commented that while actual care hours per patient day were slightly above plan, further work was needed to review rostering practice, particularly in relation to overnight temporary staffing and unregistered vacancies. It was noted that this would be taken forward through People and Culture Committee, and potentially Quality and Safety Committee if required.	

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Item	Discussion	Action
	C Henry, Non-Executive Director raised a question regarding differences in bank staff training compliance ratings, and it was clarified that different training areas had different compliance thresholds. The Board discussed the position in adult community nursing, where a safer staffing tool had identified a gap of approximately 30 full-time equivalent posts, reflecting rising demand and activity. It was noted that this required further work in the context of integrated neighbourhood health and future community service demand. The Board discussed vacancies, sickness absence, maternity cover, vacancy factor assumptions and opportunities to review workforce models, digital innovation and releasing time to care. Further questions were raised about whether community nursing staffing had reduced over recent years. It was confirmed that the staffing establishment had not been reduced, but that long-standing vacancies, sickness absence and increased demand had affected capacity. The Board also discussed the increasing complexity of patients being supported in the community, the need to benchmark community service models elsewhere, and the potential role of partners, care homes and voluntary sector organisations in supporting future workforce models. The Board welcomed the improvement in clinical supervision and highlighted the positive impact of preceptorship support for students and newly qualified staff. It was suggested that the scope of reporting could be widened to include community mental health services in future. The Board also noted the benefits of assessment centre recruitment and the need to monitor its impact on recruitment and retention. **The Board noted the report and was assured by the oversight provided.**	
71	**Complaints annual report** (agenda item 14) P Hubbard presented the Patient Advice and Complaints Annual Report, which had been reviewed by the Quality and Safety Committee. The Board noted the significant progress made with regulatory compliance, including strengthened processes for managing concerns and complaints and improved consent arrangements. S Napper, Non-Executive Director, asked about support for staff working in the complaints service, recognising the emotional impact of dealing regularly with difficult and negative experiences. It was confirmed that psychological safety support was available to the team through the Assistant Director for Psychological Therapies, with a trauma-informed approach in place. The Board also noted that a policy had been developed to support the management of frequent and complex complaints, ensuring individuals continued to be taken seriously while supporting staff to manage these cases appropriately.	

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Item	Discussion	Action
	The Board approved the content of the report and its publication.	
72	**Alert, Advise, Assure and Decision Report: People and Culture Committee held 18 June 2026** (agenda item 15) C Henry, Non-Executive Director, provided an update from the People and Culture Committee on behalf of the Chair of the Committee, M Rawcliffe. It was advised that the meeting had been positive, with no issues to alert to the Board. The Committee had received updates on reciprocal mentoring, including the value achieved and plans for continuation and expansion, and positive quality metrics from the LGBTQ+ team. The Board also noted positive workforce trends, including improved stability, reduced vacancy rates, stabilising sickness absence and improvements in workforce data quality. The Board noted the continued organisational focus on workforce metrics, including the need to triangulate data across services and understand the impact of agency use, temporary staffing, sickness absence, turnover, retention and recruitment. It was also noted that employment relations activity had reduced, following work by clinical and non-clinical teams to apply learning and an avoidable harm approach, which had improved staff experience and reduced the number of formal cases being managed. **The Board of Directors were assured by the update.**	
73	**Alert, Advise, Assure and Decision Report: Finance and Performance Committee held 22 July 2026** (agenda item 16) C Henry, Non-Executive Director, presented an update from the Finance and Performance Committee held on 22 July 2026. The Board noted the strong assurance of robust Health, Safety, and Fire Safety arrangements supported by high compliance and external accreditation. The Board also recognised the progress demonstrated in performance measures related to delayed discharges and patient flow, alongside the maintained strong performance in Community Services and Talking Therapies, as well as the NHS Oversight Framework position. The Board was alerted to the increase in financial risk, particularly associated with the delivery of Cost Improvement Programmes. The Board noted the additional grip and control measures, which included a scheduled Executive Team meeting to review difficult decisions in detail, in order to mitigate the risk. The Board was advised of the agreement to hold an extraordinary Finance and Performance Committee meeting in August to understand the outputs from the Executive Team session and seek further assurance on the financial plans.	

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Item	Discussion	Action
	The Board noted the update and recognised the alerts from the Committee. It was suggested that any key findings or escalations from the extraordinary Finance and Performance Committee meeting in August be communicated before the next Board meeting. **The Board of Directors were assured by the update.**	
74	**Health, Safety and Security Annual report (agenda item 17)** M Woodhead, Chief Finance Officer, presented the Annual Report for Health, Safety and Security. The Board noted the positive external recognition and accreditation, as well as the report on incidents and outcomes which the Board recognised as demonstrating improvement. The Board was assured that the Finance and Performance Committee reviewed the report on 22 July 2026 and recommended approval. **The Board of Directors approved the content of the report and its publication.**	
75	**Fire Safety Annual report (agenda item 18)** Mike Woodhead presented the Annual Report for Fire Safety. The Board noted the compliance with statutory requirements and healthcare fire safety guidance, and heard the positive engagement with West Yorkshire Fire Service. The Board noted the report on incidents and the update on the Fire Safety Strategy key objectives. The Board was assured that the Finance and Performance Committee reviewed the report on 22 July 2026 and recommended approval. P Hubbard, Director of Nursing, Professions and Care Standards, and Deputy Chief Executive, advised the Board that Fire Safety reviews had continued on a fortnightly basis following an incident on an Inpatient Ward at Airedale Centre for Mental Health in 2024, which had resulted in an enforcement notice from West Yorkshire Fire Service. The Board heard that West Yorkshire Fire Service commended the work that had been undertaken, and recorded thanks to those involved in the work and ongoing Fire Safety improvement. **The Board of Directors approved the content of the report and its publication.**	
76	**Senior Information Risk Owner annual report (agenda item 19)** Tim Rycroft, Chief Information Officer, presented the Senior Information Risk Owners Annual Report, and highlighted the external assurance received through the compliance of the Data Security Protection Toolkit and Cyber Security Framework, alongside an internal audit that reflected low overall risk and high overall confidence.	

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Item	Discussion	Action
	The Board heard recognition for the multi-disciplinary approach to Information Governance Risks which spanned across directorates, including the Cyber Security Team, Information Governance Team, Quality, and Emergency Planning. The Board acknowledged the scale and challenge of the protection of the Trust's digital and data assets, and recorded thanks to those involved. The Board was informed of a reportable incident to the Information Commissioners Office. The Board was assured that the Information Commissioners Office were satisfied with the response from the Trust and did not result in any further action. J Harrison, Joint Chief People Officer, commented on the information requests that were outside of the deadline and asked if there was any further support required. T Rycroft advised of the exploration into a level of automation support the fluidity of information flow, though acknowledged the complexity of the recent requests. The Board heard that communication was maintained with requesters to provide updates on the position of the information request when the deadline had passed. F Rafiq, Director of Transformation, Improvement and Productivity, advised the Board of the appetite to develop a publication scheme with regular themes of requested information. **The Board of Directors were assured by the update and approved the report.**	
77	**Finance Report (agenda item 20)** M Woodhead presented the month three finance report. The Board noted that the reported position to NHS England was on track with the financial plan, though that the net risk had increased from month two to month three as a result of out of area placements which remained above trajectory, lowered confidence in cost improvement and transformational targets, and emerging risks which included the "fair deal for nurses" review. The Board heard that the North East and Yorkshire region of the NHS accounted for fifty percent of the national financial challenge, which had resulted in an emerging financial framework which ranked NHS organisations into categories, which dictated the level of intervention. The Chair advised the Board of the message from the interim North East and Yorkshire Regional Director at NHS England was centred around an existing poor financial position and a run rate that projected significant deterioration. S Napper, Non-Executive Director, queried if the regional financial challenge related to historic underfunding or previous interventions. M Woodhead responded that the West Yorkshire system had a positive reputation for financial delivery. M Woodhead advised the Board of the Organisational Sustainability Programme Board meeting scheduled for 24 July 2026 to review the grip and	

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Item	Discussion	Action
	control measures, difficult decisions, and ensuring optimal delivery of existing schemes. J Harrison assured the Board of some of the learning that was being shared from Airedale NHS Foundation Trust, as well as the challenging decisions were being explored. The Board discussed the challenges associated with vacancy controls and the impact on organisational productivity, and the clarity on prioritisation of patient safety. The Board noted that a further update following this meeting would be presented at the extraordinary Finance and Performance Committee meeting in August. **The Board of Directors:** • **Noted the challenging financial position, and the actions being taken to deliver the agreed financial position and** • **Noted the level of risks and actions being taken to mitigate**	
78	**NHS England quarterly submission (agenda item 21)** M Woodhead presented the submission to NHS England of the Quarter One Financial Return and asked for retrospective approval, following endorsement by the Finance and Performance Committee. **The Board retrospectively approved the submission and declaration.**	
79	**Alert, Advise, Assure and Decision Report: Charity Funds Committee held on 25 June 2026 (agenda item 22)** S Napper, Non-Executive Director and Chair of the Charity Funds Committee presented the update following the Charitable Funds Committee meeting on 25 June 2026. The Board was assured on the increase in charitable funds income, alongside an increase in funding applications, and noted the intention to develop a formal reserves policy. The Board was alerted to the concerns related to value for money of the proposal to launch a Charity Appeal to secure the match funding for the Hospital Rooms programme at Lynfield Mount proposal and noted the approach to seek further assurance. The Board discussed the benefits of the proposal, the ability to demonstrate social value and engage communities, and the impact on capital funding. **The Board of Directors were assured by the update.**	
80	**Integrated Strategic Performance and Quality Report** (agenda item 23) P Hubbard presented the Integrated Strategic Assurance Report, noting the broadly stable position and highlighting the priority areas which required continued oversight. The Board noted the reduction in length of stay, and were informed of ongoing risks related to waitlists, workforce wellbeing, and financial metrics. The additional measures that would be considered as part	

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Item	Discussion	Action
	of the National Oversight Framework were noted, and reiterated the progress made to date by the Trust having moved from segment 4 to segment 2 since its introduction. F Rafiq advised the Board that the new format of the report reflected the previous feedback, and welcomed any further suggestions to improve the report. **The Board of Directors:** • **Noted the overall performance, quality, workforce and financial position** • **Noted the improvement in the Trust's NHS Oversight Framework Position** • **Endorsed the principal risks identified within the report** • **Supported the continued executive focus on priority areas** • **Approved the Integrated Strategic Performance and Quality Report as the Trust's primary integrated assurance reporting for Board oversight**	
81	**Better Lives Together Strategy Refresh 2026-31 (agenda item 24.1)** F Rafiq, Director of Transformation, Improvement and Productivity, provided an update on the progress of the Better Lives, Together Strategy Refresh. The Board noted that the full strategy would be presented for approval at the September meeting. The Board noted the work undertaken on the measures of success, the process of engagement with colleagues, service users, families and partners, and the breakthrough programmes as delivery vehicles. The Board was assured that the rollout of the strategy would be aligned to the business planning process later in the year. **The Board of Directors noted the content of the report.**	
82	**Quality & Performance Management System update and 12 month plan (agenda item 24.2)** F Rafiq presented the report as an output of a development session held on the Quality & Performance Management System. The Board noted the four domains of the Quality Management System, and the work within each domain that formed the priorities for the year ahead. The Board heard how the priorities would be deployed alongside the strategy refresh, and the proposal for measuring the success. The Board discussed work undertaken to connect the strategy and the Quality & Performance Management System into services, and the action from the Well Led Action Plan that was considered in the development of the strategy. **The Board of Directors:**	

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Item	Discussion	Action
	• **Noted the progress made in developing the Quality & Performance Management System** • **Supported the adoption of the term Quality & Performance Management System** • **Endorsed the proposed approach** • **Agreed to receive a further update on implementation progress and organisational maturity**	
83	**NHS Oversight Framework update (agenda item 25)** F Rafiq presented the update on the NHS Oversight Framework and highlighted the improvement of twenty-six places amongst non-acute NHS Providers. The Board noted that the measures that improved performance were around data validation and flows for the crisis response, and the improvement in patients waiting greater than 52 weeks. The Board was advised of the increase in the number of assessed metrics for the 26/27 financial year and the work undertaken through the Data Quality Working Group to provide early visibility, timely monitoring, and identification of Data Quality issues. The Board noted that the Executive Team were responding to a national consultation on the NHS Oversight Framework. F Rafiq suggested that the NHS Oversight Framework Update form part of the Integrated Strategic Performance and Quality Report. The Board celebrated the improvement in the NHS Oversight Framework ranking and recorded thanks for teams across the Trust. **The Board noted the content of the report.**	
84	**Alert, Advise, Assure and Decision Report: Audit Committee held 18 June 2026** (agenda item 26) C Malish, Non-Executive Director, presented the Audit Committee AAAD report, highlighting the risk identified from external auditors on the capital development, and noted the main focus of the meeting around the accounts and audit opinion. The Board was assured on the continued oversight, and the significant assurance opinions presented in the report. C Malish informed the Board on the matters that the Audit Committee provided advice on, and the monitoring of the Well Led Development Plan. **The Board of Directors were assured by the update.**	
85	**Well-led development plan update** (agenda item 27)	

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Item	Discussion	Action
	F Stead presented the Well-led Development Plan update, noting that actions continued to be reported through the relevant Board committees and an update would be presented in September. The Board heard an update on the process improvement work and noted the learning that had been identified as outputs from benchmarking, annual effectiveness reviews, and stakeholder engagement, which had resulted in two new actions added to the plan. F Stead advised the Board that an additional step had been identified to support the prioritisation of agreed improvement activity, along with a process to standardise the approach to the assurance ratings. F Stead informed the Board of the discussions within the Executive Team on how improvement activity and findings from policy changes, national guidance, or good governance can be integrated into the Well Led Development Plan to provide a monitoring forum. **The Board of Directors were assured by the update.**	
86	**Governance report** (agenda item 28) R Trawally, Corporate Governance Manager and Deputy Trust Secretary, presented the Governance report, noting the staged constitution review and the proposed changes to roles and governor composition, subject to the endorsement from the Council of Governors and Members. F Stead advised the Board on the process for amendments to the constitution. P Hubbard confirmed that the changes to Board members had also been logged with the CQC. The Board was assured by the completion of the annual processes, including the Fit and Proper Person assessments, the Annual Governance Statement, Annual Report, Annual Accounts, Board Appraisal processes, and the Annual Compliance Statements. The Board heard an update on the Council of Governor elections, and the latest announcement on the future role of Governor's based on the NHS Modernisation Bill. **The Board of Directors:** • **Noted the updates;** • **Approved the proposed amendments to the constitution subject to consideration by the Council of Governors and Members;** • **Were assured from the completion of the annual processes; and** • **Noted the implications of the NHS Modernisation Bill.**	
87	**Partnership reports** (agenda item 29) None	

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Item	Discussion	Action
88	**Board of Directors public meeting work plan 2026-27** (agenda item 30) **The Board of Directors noted the report which was received for information.**	
89	**Any Other Business** (agenda item 31) No other business was raised.	
90	**Comments from public observers** (agenda item 27) None	
91	**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 a rich discussion with well-presented papers and updates. **The meeting was closed at 12.25**	

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

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Agenda Item 04.0

Board of Directors - held in Public
Thursday 10 September 2026 at 09:30
Meeting held in person in Room 4.03 at New Mill and on MS Teams

Members present in person:	Sarah Jones	Chair in Common
	Therese Patten	Chief Executive Officer
	Kelly Barker	Chief Operating Officer
	Warren Brown	Non-Executive Director
	Joanne Harrison	Joint Chief People Officer
	Cleveland Henry	Non-Executive Director
	Chris Malish	Non-Executive Director
	Farhan Rafiq	Director of Transformation, Improvement and Productivity
	Tim Rycroft	Chief Information Officer
	Dr Sal Uka	Chief Medical Officer
	Mark Woodhead	Chief Finance Officer
In attendance in person:	Holly Close	Senior Corporate Governance Officer and Executive Support Manager (Secretariat)
	Chris Dixon	Deputy Director of Nursing and Professions (Representing P Hubbard)
	Prabhdeep Sidhu	Deputy Clinical Director of Pharmacy (agenda item 08.0)
	Fran Stead	Trust Secretary
Observer(s):	Mike Lodge	Public Governor: Rest of England and Lead Governor
	Victoria Wadsworth	Member of Public
Apologies:	Phil Hubbard	Director of Nursing, Professions and Care Standards, Deputy Chief Executive
	Sally Napper	Non-Executive Director and Senior Independent Director
	Alyson McGregor	Non-Executive Director
	Mark Rawcliffe	Non-Executive Director and Deputy Chair
	Rachel Trawally	Corporate Governance Manager and Deputy Trust Secretary

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MINUTES

Item	Discussion	Action
92	**Welcome and Apologies for Absence** (agenda item 1) The Chair, S Jones opened the Board of Directors meeting held in Public. Apologies for absence were noted, and the meeting was confirmed as quorate.	
93	**Declarations of interest** (agenda item 2) J Harrison, Joint Chief People Officer declared joint directorship at Airedale NHS Foundation Trust. **Action:** It was agreed that J Harrison and F Stead, Trust Secretary would update the Declarations of Interest Form. No other declarations of interest were made.	**JH / FS**
94	**Trust Risk Appetite Matrix** (agenda item 3) The Trust Risk Appetite Matrix was received for information.	
95	**Questions received** (agenda item 4) No questions were received.	
96	**Minutes of the previous meeting held on 4 June 2026 and 23 July 2026** (agenda item 5) The minutes of the Board of Directors held in Public on 4 June 2026 were approved as a true and accurate record.	
97	**Matters arising** (agenda item 6) No matters arising had been received.	
98	**Action log** (agenda item 7) F Stead, Trust Secretary provided an update on the action log. **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.**	
99	**Board Story presentation: Critical Medicines Initiative** (agenda item 8)	

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Item	Discussion	Action
	The Board received a presentation from P Sidhu, Deputy Clinical Director of Pharmacy on the Time Critical Medications Quality Improvement Project, which had been undertaken as part of a national collaborative led by the Specialist Pharmacy Service. The Trust had been one of only 15 organisations selected nationally to participate. P Sidhu explained that the project had been launched in response to incidents involving delayed or missed doses of critical medications related to long term conditions outside of the care they are receiving from the Trust. It had been identified that many colleagues were unaware of which of these medicines were classed as time critical, resulting in delays and avoidable risks to service users. Examples, such as insulin, were provided to demonstrate the potential impact, including deterioration in physical health, prolonged admissions, patient complaints and, in some cases, transfer to an acute trust. The Board heard that insulin had been selected as the pilot medication. The project aimed to ensure that 80 per cent of insulin doses were administered within one hour of their prescribed time. Whilst the national collaborative had established two measures, the Trust had focused on reporting the proportion of doses administered within one hour of the prescribed time, as the longer length of stay within mental health services made the other measure less meaningful. A whole-system approach had been adopted involving Pharmacy, Nursing, Medical teams, Quality Improvement and Business Intelligence colleagues. Improvement initiatives included simplified guidance, enhanced electronic identification of time critical medications, staff training, strengthened handovers and improved stock management arrangements. The Board noted that performance had improved significantly, increasing from 24 per cent to a peak of 94 per cent of insulin doses being administered within the required timeframe. Performance had remained sustained at 86 per cent, exceeding the project target. Nursing knowledge of time critical medications had also improved, increasing from 27 per cent to 96 per cent following the interventions. P Sidhu outlined the next steps, which included the development of a diabetes policy, implementation of an Electronic Prescribing and Medicines Administration (EPMA) dashboard, ongoing nurse education and the introduction of automated dispensing cabinets to improve medication availability and stock visibility. Future work would focus on other time critical medications, including antimicrobials. S Uka, Chief Medical Officer commended P Sidhu's leadership of the project and noted that the business case for automated dispensing cabinets had been	

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Item	Discussion	Action
	approved and welcomed the anticipated benefits for medication availability, stock management and patient safety. During discussion, W Brown, Non-Executive Director sought assurance regarding the remaining delays in medication administration and queried whether a higher performance target should be adopted. P Sidhu advised that a proportion of apparent delays related to service users being on leave, transferred to another organisation or clinically appropriate delays, such as insulin administration being linked to mealtimes. It was noted that these factors were being reviewed to improve the accuracy of reporting. The Chair also asked how colleagues had responded to the project. P Sidhu reported that engagement had grown throughout the programme, with colleagues demonstrating greater understanding of the importance of time critical medications and becoming more proactive in preventing delays. T Patten, Chief Executive Officer welcomed the approval of the automated dispensing cabinets and requested a future update on implementation plans and the anticipated benefits for service user safety. **Action:** Discussion to be planned on the implementation of the automated dispensing cabinets. **The Board of Directors welcomed the presentation and were assured by the update.**	**SU**
100	**Chair's Report** (agenda item 9) The Chair presented the report, highlighting key updates since the previous reporting period. It was highlighted that there was ongoing work to prepare for forthcoming legislative changes to NHS foundation trust governance. The Board heard that the proposed legislation, expected to take effect in April 2027, would remove the statutory role of Governors and members whilst requiring organisations to demonstrate meaningful dynamic engagement with their communities. To support this transition, it was proposed that a joint Board and Governor Development Session be held in February 2027 to review existing engagement arrangements and identify opportunities to strengthen community involvement under the new legislative framework. **Action:** joint board session to be organised. It was noted that the Trust was working with the other provider trusts across the place to develop a consistent approach and avoid creating confusion for local communities. During discussion, M Lodge, Public Governor: Rest of England and Lead Governor emphasised the continued importance of maintaining strong lay and public voices within the organisation regardless of any changes to formal	**FS**

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Item	Discussion	Action
	governance structures. T Patten also shared that national discussions regarding the future of Healthwatch arrangements were continuing and may influence future engagement approaches. **The Board of Directors noted the report and the continued engagement with external partners, the Trust and the Council of Governors.**	
101	**Chief Executive's Report** (agenda item 10) T Patten presented the report and highlighted key areas of progress. The Board noted the national recognition received by the Trust's Individual Placement and Support (IPS) service, including its contribution to national guidance. The Board was also made aware of the findings emerging from the Southport Inquiry and national maternity reviews. Whilst the Trust does not provide maternity services, it was recognised that there were important wider lessons for the organisation, which would be explored through future Board development sessions. **Action:** Findings from the inquires to be added to the Board Development List S Uka provided an update on the General Medical Council National Training Survey. It was demonstrated that previously identified areas of decline had improved and that the Trust remained a positive outlier in key domains relating to doctors in training, including overall satisfaction and the quality of training provided. The Board also received an update from J Harrison on the annual Staff Survey, which was due to open later in the month. It was noted that increasing participation would be a key priority to ensure the views and experiences of a broader range of staff informed future improvement activity. The value of the Trust's World Café events was highlighted and the Chair reflected on the potential contribution they had made to positive engagement outcomes. It was noted that, if demonstrated to be effective, the approach could be shared more widely as an example of good practice. The Board also heard from F Rafiq, Director of Transformation, Improvement and Productivity, who outlined early discussions regarding the potential use of the ImproveWell platform to complement existing engagement initiatives and support targeted wellbeing and staff engagement activity in areas requiring additional focus. **The Board of Directors the contents of the paper and sought any further clarification as appropriate.**	**HC**
102	**Bradford and District Safe Staffing Assurance Report** (agenda item 11)	

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Item	Discussion	Action
	C Dixon, Deputy Director of Nursing and Professions presented the annual Safe Staffing Review and outlined the NHS England assurance process, which included a self-assessment, submission of supporting evidence and a face-to-face assurance meeting. The Board heard that the Trust had received a high level of assurance, with NHS England recognising its mature and well-established approach to workforce planning, establishment setting, colleague deployment and escalation processes. Opportunities for further development included strengthening the triangulation of workforce, quality and patient impact data within Board and Committee reporting. J Harrison welcomed the positive assurance outcome and shared the ongoing work to maximise the use of workforce rostering data and technology, strengthen oversight of enhanced staffing requirements and support the Therapeutic Observations Collaborative. W Brown sought assurance regarding alignment between NHS England and CQC expectations. C Dixon explained that assurance was derived from workforce data, professional judgement, colleague feedback and inspection findings, with colleague experience remaining a key indicator of safe staffing. The importance of ensuring colleagues felt safe, alongside maintaining robust staffing governance arrangements, was emphasised by K Barker, Chief Operating Officer. **The Board of Directors:** • **Received and noted the Bradford District Care Safe Staffing Assurance Report 2026.** • **Noted the overall High, Level 4 Assurance position and the conclusion that no significant unmanaged workforce risks were identified during the assurance review.** • **Noted the strengths identified and the areas for continued development, which will be progressed through existing governance and assurance arrangements.**	
103	**Winter plans** (agenda item 12) K Barker presented the Winter Plan for approval. The Board heard that the plan had been developed in line with NHS England requirements and would be tested through a regional preparedness exercise later in September, with any resulting learning incorporated as required. Assurance was provided that winter planning formed part of the Trust's year-round risk and resilience arrangements and drew on learning from previous winters, current service pressures and identified risks, including workforce resilience and the potential impact of flooding. The Board heard that targeted work was underway to increase flu vaccination uptake amongst colleagues and vulnerable service users, including	

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Item	Discussion	Action
	engagement with local communities and the use of community champions to support key public health messages. **Action:** Arrange for a flu vaccination clinic to be available at the next Board meeting to support uptake amongst Board members. The Board approved the Winter Plan and delegated authority to the Chair and Chief Executive Officer to approve any amendments arising from the regional preparedness exercise and sign the final Board Assurance Statement on behalf of the Board. **The Board of Directors:** • **noted the Trust's preparedness and the contribution of the Purposeful & Productive summer sprint to winter readiness;** • **endorsed the proposed operational control, escalation and assurance framework;** • **noted the evidence still required from regional testing and gap closure; and** • **delegated final confirmation of the BAS to the Chair and Chief Executive following review of the stress-test outcome and completion of outstanding assurance actions**	**PH**
104	**Medical appraisal and revalidation annual report** (agenda item 13) S Uka presented the Medical Appraisals and Revalidation Annual Report and advised that the Trust remained fully compliant with its statutory responsibilities as a designated body and with the requirements of the Responsible Officer role. No significant risks or concerns were identified, although opportunities for ongoing quality improvement had been highlighted. The Board approved the Annual Report and its submission to NHS England. **The Board of Directors:** • **Noted the contents and assurance provided within the Designated Body Annual Board Report for the period 1 April 2025 to 31 March 2026.** • **Confirmed its assurance that the Trust remains compliant with the Medical Profession (Responsible Officers) Regulations 2010 (as amended).** • **Approved the Statement of Compliance for submission to NHS England through the Higher-Level Responsible Officer.**	
105	**Finance Report** (agenda item 14)	

Close Holly 29/1/2026 15:09:24

Item	Discussion	Action
	M Woodhead, Chief Finance Officer presented the monthly Finance Report. The Board heard that the Trust's financial risk had reduced slightly from the previous month but remained significant, primarily due to challenges in delivering savings targets and emerging cost pressures, including national pay awards. The Board received an update on the actions implemented since July, including focused improvement work to reduce out of area placements and temporary staffing costs. Early indications were encouraging, although it was acknowledged that the impact of these measures would become clearer later in the year. M Woodhead advised that NHS England continued to monitor the Trust's financial position and had placed the Trust within the second-best oversight category. Whilst recognising the financial challenges facing the organisation, the categorisation attracted only a limited level of enhanced reporting and assurance requirements. W Brown shared feedback from a recent meeting of NHS England Finance Committee Chairs, where the significant financial challenges facing the NHS were discussed. The importance of delivering improvement plans, reducing reliance on savings anticipated later in the financial year and maintaining a clear focus on financial recovery was emphasised. Also demonstrated was the role of Boards in supporting transformation and improvement activity whilst maintaining appropriate governance and oversight. **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** • **Highlighted any further assurances required.**	
106	**AAAD Extraordinary Finance and Performance Committee held on 20 August 2026** (agenda item 15) C Henry, Non-Executive Director presented the item to the Board. It was described as a single agenda item to look at risks that had been identified in July 2026. The session was described as a brilliant and robust session which detailed work around grip and control. **The Board of Directors were assured by the update**	
107	**Integrated Strategic Performance and Quality Report** (agenda item 16) K Barker presented the Integrated Strategic Performance, Quality and Risk Report (ISPQR) and highlighted that the Trust remained operationally stable and continued to deliver strong performance across a number of key priorities. Members heard that the Trust had maintained its current NOF rating despite changes to the framework and that work continued to strengthen data quality	

Close Holly 29/10/2026 10:09:24

Item	Discussion	Action

	and reporting arrangements for emerging measures. Positive performance was highlighted in relation to the elimination of 52-week waits and the achievement of over 94% of crisis contacts within 24 hours.
	
	The Board heard that continued focus was required in relation to access and flow across the mental health pathway, community dental services, outcomes reporting, data quality, workforce wellbeing and financial sustainability. Assurance was provided that these areas were subject to executive oversight and were being monitored through existing governance arrangements.
	
	In discussion, T Patten queried the measure relating to inpatient admissions where there had been no previous contact with mental health services. It was explained that, whilst not a Trust performance measure, understanding the data could provide valuable insight into local population needs and inform future service planning.
	
	C Malish, Non-Executive Director sought clarification on recruitment performance indicators and received assurance by J Harrison that further work was underway to refine reporting and improve visibility of recruitment process measures.
	
	W Brown queried the reported position for children and young people's waiting times and the variance against the planned trajectory. The Board heard that this reflected known data quality issues rather than service performance concerns, and that work was underway to improve reporting accuracy.
	
	S Uka highlighted that the revised ISPQR had been presented to the Board before completing the usual Committee cycle. Future reports would be subject to detailed scrutiny by Committees, with key themes and assurances escalated to the Board through the AAAD reports.
	
	J Harrison then shared that there had been significant reduction in formal employee relations cases, reflecting the positive impact of work undertaken to promote early intervention and reduce avoidable harm associated with formal processes.
	
	The Board of Directors:
	• **Took assurance from the Trust's overall performance, quality, workforce and financial position.**
	• **Noted the Trust's NHS Oversight Framework position and committee assurance ratings.**
	• **Endorsed the principal risks and mitigations identified within the ISPQR.**
	• **Supported continued executive focus on:**
	  • **Adult mental health flow and Out of Area Placements.**
	  • **CYP waiting time recovery and data quality improvements.**	

Close Holly 29/10/2026 15:09:24

Item	Discussion	Action
	• **Mental health outcomes improvement.** • **Workforce sickness reduction and wellbeing.** • **Delivery of the CIP, productivity and financial recovery programmes.** • **Agreed continued Board oversight of these areas through the remainder of 2026/27.**	
108	**Board Assurance Framework** (agenda item 16.1) F Stead, Trust Secretary presented the revised Board Assurance Framework (BAF) reporting approach, which had been developed following learning from the Well-Led Review and Board development discussions. The Board heard that assurance ratings would now be reported separately from the ISPQR to provide clearer alignment between assurance, risk and performance reporting. Whilst the new process was currently being aligned with the Strategic Risk Report cycle, no changes had been made to the underlying assurance ratings. T Patten sought clarification regarding the alignment of measures and metrics with the emerging Trust Strategy. Assurance was provided that a review of associated reporting would be undertaken following approval of the Strategy to ensure consistency across reporting frameworks. The Board approved the revised Board Assurance Framework reporting approach. **The Board of Directors:** • **Approved and were assured the refreshed Board Assurance Framework reporting arrangements.** • **Noted the current assurance position, as presented to the Board Committees aligned to the current Standard Operating Procedure.** • **Supported the continued development of the Board Assurance Framework and Strategic Risk Register through the proposed improvement programme and action plan.** • **Noted that the agreed improvement actions will continue to take place to add value and remove waste from the Board Assurance Framework process.**	
109	**Better Lives Together Strategy Refresh 2026-31** (agenda item 17) F Rafiq presented the refreshed Better Lives Together Strategy 2026-2031 and accompanying Delivery Framework for approval. It was demonstrated that the documents reflected extensive engagement and consultation undertaken over the previous five months with the Board, colleagues, partners, communities and stakeholders. The refreshed strategy had been developed in response to changing organisational and system challenges,	

Close Holly 29/10/2026 10:24

Item	Discussion	Action
	including increasing demand, workforce pressures, financial constraints and NHS reforms. The Board heard that the strategy provided greater clarity of focus, with four strategic objectives centred on supporting and valuing the workforce, providing safe and compassionate care, using resources effectively and working in partnership, underpinned by a focus on reducing health inequalities. A key change was the move towards measuring outcomes and "signs of success" rather than activity, supported by a delivery framework designed to align strategic ambitions with annual planning, improvement activity, team objectives and individual contributions. F Rafiq advised the Board that the strategy would be formally launched at the Annual Members' Meeting taking place on 24 September 2026 and embedded through a structured deployment process. An annual review process would also be introduced to assess progress against the strategy and incorporate learning into future planning cycles. T Patten thanked F Rafiq and F Stead for their executive leadership in developing the strategy and recognised the significant contribution made by colleagues, partners and stakeholders throughout the engagement process. The Chair welcomed the introduction of an annual strategy refresh and suggested that a similar approach could be adopted more widely, including by Airedale NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust, to support greater alignment of strategic priorities. C Henry particularly welcomed the annual review process, reflecting on the importance of being able to demonstrate what had been achieved against the strategy and how progress would be assessed year-on-year. Building on this, S Uka highlighted the opportunity to use the annual review not only to measure delivery but also to celebrate success, recognise achievements and share learning across the organisation. The Board commended all those involved in developing the strategy and approved the Better Lives Together Strategy 2026-2031 and accompanying Delivery Framework. **The Board of Directors:** • **Noted the content of this report and be assured on the refreshed delivery process** • **Signed off the refreshed Better Lives Together Strategy 2026 – 31** • **Endorsed the proposed implementation approach** • **Noted the connection to the new Quality and Performance Management System and the Board endorsed mobilisation plan/actions**	

Close Holly 29/10/2026 15:09:24

Item	Discussion	Action
	• **Supported the formal launch of the strategy at the Annual Members' Meeting 2026 and future plans to celebrate quality improvement and strategy delivery** • **Were assured that following approval, work will take place across the Trust to update reference to the new strategic framework** • **Were 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**	
110	**SPA signing** (agenda item 19) F Stead presented updates to the Strategic Partnership Agreement (SPA) and sought delegated authority for the Chief Executive Officer to sign the document on behalf of the Trust. The Board heard that the proposed amendments reflected changes to the scope and focus of the partnership and wider policy developments. It was recognised that the SPA would continue to evolve as partnership arrangements developed further. In discussion, T Patten highlighted that the agreement should be viewed as a living document and acknowledged that further revisions were likely as system arrangements matured. No concerns were raised regarding the proposed changes. **The Board of Directors:** • **Approved the updated SPA; and** • **Authorised the Chief Executive to sign the SPA as the Trust's representative.**	
111	**Governance report** (agenda item 18) H Close, Senior Corporate Governance Officer and Executive Support Manager presented the Governance Report and highlighted a number of matters for approval and assurance. The Board was asked to formally ratify the revised Terms of Reference for the Board Nominations and Remuneration Committee, following their annual review and prior approval by the Committee. The Board noted changes to the Council of Governors, including the resignation of a Staff Governor and the appointment of a new Bradford Council Governor. The Board was also advised that the election process for seven vacant Governor seats had commenced and would conclude later in November 2026. Board members were encouraged to support promotion of the elections through their networks.	

Close Holly 29/10/2026 15:09:24

Item	Discussion	Action
	An update was provided on the 2026 Provider Capability Assessment (PCA). The Chair emphasised the importance of the submission and reminded the Board that it should be regarded as a robust self-assessment rather than a compliance exercise. The Board were encouraged to review the assessment carefully and contribute evidence and challenge through the relevant Committee process ahead of Board approval in October. The Board also received assurance that the Trust's Annual Report and Accounts had been formally laid before Parliament on 8 September 2026. **The Board of Directors:** • **Ratified the revised Terms of Reference for the Board Nominations and Remuneration Committee** • **Noted the emerging collaborative Governor development programme across Bradford District and Craven Place** • **Noted the commencement of the 2026 Provider Capability Assessment Process.**	
112	**Partnership reports** (agenda item 19) The West Yorkshire Community Health Services Provider Collaborative (WYCHS) - Quarterly Chairs and Executives Leads meeting held on 7 July 2026 **were presented and noted for information.**	
113	**Board of Directors public meeting work plan 2026-27** (agenda item 20) **The Board of Directors noted the report which was received for information.**	
114	**Any Other Business** (agenda item 21) No other business was raised.	
115	**Meeting evaluation** (agenda item 22) 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 11.26.**	

Close Holly 29/10/2026 Version 1.0

These minutes were prepared with the assistance of AI tools and reviewed by the Senior Corporate Governance Officer and Executive Support Manager and the Chair for accuracy and completeness

Action Log for the Public Board of Directors' Meeting – 5 November 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**
2. 10/09/2026	Critical Medicines Initiative Discussion to be planned on the implementation of the automated dispensing cabinets.	**SU**	TBC 2027	**The Board is asked to consider this action closed:** Update provided below.
3. 10/09/2026	Chair's Report Joint board session between Board and Governors to be organised.	**FS**	February 2027	**Ongoing:** not due yet
4. 10/09/2026	Chief Executive's Report Findings from the inquires to be added to the Board Development List	**HC**	November 2026	**The Board is asked to consider this action closed:** Item has been added to the Board Development Plan

Closed Publicly 29/07/2026 15:09:24

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**
5. 10/09/2026	Winter Plans Arrange for a flu vaccination clinic to be available at the next Board meeting to support uptake amongst Board members.	**PH**	November 2026	**The Board is asked to consider this action closed:** this was held on 1 October 2026
67 23/07/2026	Chief Executive's Report to circulate guidance on the Leadership and Management framework	**CG team**	September 2026	**The Board is asked to consider this action closed:** This was circulated via email to Board members
Actions closed at the last meeting				
15. 23/07/2026	AAAD People and Culture Committee QMS quarterly report to be presented at alternative Board meetings held in public	**RT**	October 2026	**The Board is asked to consider this action closed:** Item has been added to the public work plan.
12. 23/07/2026	AAAD Quality and Safety Committee 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.

Closed Holly 29/10/2026 15:09:24

Update provided regarding action 2. 10/09/2026: The Automated Dispensing Cabinets are secure, electronically controlled medicines storage cabinets which will replace the traditional ward medicines cupboard model. They provide controlled access and a full audit trail, automate stock management and replenishment, improve expiry management and strengthen medicines security and accountability. The key anticipated benefits are improved medicines safety, fewer missed or delayed doses and selection errors, reduced medicines waste and stock holding, greater control around controlled drugs/diversion, and releasing nursing and pharmacy time back to patient care.
Implementation will commence from April 2027, when the dedicated project team is due to start. This will include installation across all 14 inpatient wards and an electronic controlled drug cabinet within the inpatient dispensary, with integration into CMM.
We are still working through the most appropriate ongoing governance and reporting arrangements, and once agreed Board will be advised on any relevant future updates.

Prabhdeep Sidhu, Deputy Clinical Director of Pharmacy, Trust Medicines Safety Officer (MSO), Patient Safety Specialist

Close Holly
29/10/2026 15:09:24

NHS
Bradford District Care
NHS Foundation Trust

Board of Directors – Meeting held in Public

5 November 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 **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	
	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.

Rose Hall
29/10/2026 15:09:24

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 **ALL** 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

Close Holly 29/10/2026 15:09:24

Board of Directors – Meeting held in Public
5 November
Chair of the Trust Report

Board visits

It is really pleasing that we have managed to bring the Board out on to Horton Park site for our November meeting and I am grateful to all those colleagues who have arranged the logistics to make this happen. I am planning that we shall rotate round our other operational sites over coming months as it gives us a chance to meet colleagues and be visible, as well as giving us additional opportunities to visit services.

Executive Directors

The communications regarding Therese Patten's secondment for 12 months has gone smoothly with colleagues and all key stakeholders. Phil Hubbard has taken up the position as our Acting CEO and appointments to Acting Deputy CEO and Acting Chief Nurse positions have been made following interviews. These will be announced shortly once ratified by Remuneration Committee.

Review of Chair in Common

In line with the agreed process, a review has been conducted by our Trust Secretary, SID and Lead Governor in conjunction with those of Airedale, to assess if the role of a shared Chair in Common is working effectively. The joint finding was that both Trusts are benefiting positively.

NED Mid-Year Reviews

Mid-Year reviews with Non-Executive Directors are taking place through October and November. Any issues arising will be feedback to our Council of Governors November meeting.

Annual Members Meeting

The Annual Members Meeting was held on Thursday 24 September. The event was attended by the Board, colleagues from across the Trust, Governors, and members of the public advertised locally, it provided an opportunity for attendees to network before receiving an update on the business from the Board. This year, the Trust Strategy Refresh was presented. This core strategy document sets out our direction for the next five years and is supported by a five-year delivery framework outlining how we will achieve our objectives

Confidential
29/10/2026 15:09:24

ICB Chairman visit to Lynfield Mount Hospital

The redevelopment of LMH is continuing at pace. The Chair of the ICB Mark Chamberlain, was hosted on a visit last month and I am hoping to arrange a visit for the Regional Chair Bill McCarthy shortly.

It is really impressive to see this significant investment into Mental Health care provision coming to life. Once the building work is finished, we are working with a Charity called Hospital Rooms who develop art installations to improve the caring environment. This project will specifically focus on improvements to the retained estate at LMH to give it a fresh new feel

Hospital Managers Hearings

As part of our ongoing development, all NEDs have committed to observing at least two Hospital Managers Hearings per year. Feedback from those already conducted has been shared with the CMO.

CQC Readiness

To support us as we prepare for a possible CQC Well Led review, the Board will be undertaking some specific development actions. I am hoping that we can arrange these before the New Year. This forms part of our ongoing Development Programme of activities aimed at ensuring we are a strongly performing and ambitious Board.

Sarah Jones
Chair in Common
November 2026

Close Holly
29/10/2026 15:09:24

NHS
Bradford District Care
NHS Foundation Trust

Board of Directors – Meeting held in Public

5 November 2026

Paper title:	Chief Executive's Report	**Agenda Item 10.0**
Presented by:	Phillipa Hubbard, Chief Executive	
Prepared by:	Phillipa Hubbard, Chief Executive	
Committees where content has been discussed previously	N/A	
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	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.

Closed only 20/10/2025 15:09:24

Executive Summary	
The areas covered in this report include: ▪ Trust News ▪ Awards and Recognition ▪ Supporting our People ▪ CQC Notifiable Incidents, Regulatory Matters and Visits ▪ Patient Safety Incidents and Never Events ▪ Place/System/National news	
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

Close Holly 29/10/2026 15:09:24

Board of Directors – Meeting held in Public
5 November 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

Learning from the Aubrey Report
Following discussion at the regional Chief Executives and Chairs network, NHS trusts have been encouraged to consider the learning arising from the Aubrey Report. The Trust has already completed a self-assessment against the recommendations, identifying areas of existing assurance alongside opportunities for further strengthening. Relevant actions will be incorporated within our existing Well Led improvement work and monitored through the appropriate governance arrangements. Learning from the Thirlwall Inquiry has previously been considered through Board Development

Recognition following NHS England Board Visit
We were pleased to receive such positive feedback following the NHS England Board visit on 2 October, which included time with our Vocational Rehabilitation and IPS teams. The visitors recognised the quality of the services, the commitment of colleagues and the positive difference being made to people's lives. They also highlighted the constructive and collaborative culture within the Trust and identified learning from our services that could help inform national policy and government priorities

The Cellar Trust
The Cellar Trust Impact Report 2026 highlights the significant impact of integrated working and the strong partnership developed between The Cellar Trust and Bradford District Care NHS Foundation Trust over a number of years. It provides a positive reflection on what can be achieved through integrated services and the opportunities to sustain and scale this approach across partner organisations. The report also looks ahead to the next chapter for The Cellar Trust, including the Phase 2 development of its Farfield site in Shipley. Kim Shutler, who will be leaving The Cellar Trust later this year, is recognised for her leadership and commitment to partnership working across local communities.

3 Awards and Recognition

Reward, Recognition update January to August 2026
The Recognition activity remains strong, with 102 **Thanks a Bunch** nominations' and 46 **Living Our Values** nominations received between January 2026 and August 2026, demonstrating continued colleague appreciation and celebration of Trust values.

Close Your
13/11/2026 15:09:24

Key highlights

- 102 Thanks a Bunch nominations received with 67 vouchers of £25 awarded
- 46 Living Our Values nominations received with 24 living our values Awards announced.

Looking forward we have opportunity to review the reward and recognition schemes in line with the launch of the refreshed Trust Strategy. This will support us to ensure that any recognition supports our refreshed values 'together' and our new leadership and staff behaviours compact.

4 Supporting our People

The Resourcing Service has continued to deliver strongly against both operational and strategic priorities over the last quarter, supporting the Trust's workforce ambitions through successful recruitment, workforce modernisation and reduced reliance on agency staffing.

A number of significant senior appointments have been secured, strengthening leadership capacity across the organisation.

Recent notable hires include:

- Alison Davies, Consultant Clinical Psychologist and Non-Medical Clinical Lead (Band 8c), who commenced in October 2026;
- Louise Beevers, currently in pre-employment checks, appointed as Programme Director for Integrated Neighbourhood Health and Care (Band 8c)
- Rashmi Sudhir, also in pre-employment checks, appointed as Senior Healthy Minds Manager for Pathways and Integration (Band 8b);
- Sal Uka, who commenced his substantive role as Chief Medical Officer in October 2026 following a comprehensive three-stage recruitment process.

Workforce planning activity linked to the Lynfield Mount redevelopment programme has continued to mature. Dedicated workforce governance arrangements are now in place, with engagement underway with hiring managers to align recruitment timelines, develop attraction strategies and proactively identify backfill requirements arising from internal appointments. This early planning is designed to support workforce continuity throughout the redevelopment programme.

The Trust continues to play an active role as an early adopter of the NHS People Portal (NHSPP). Over recent months, the Resourcing Team has worked closely with the system developers to review existing recruitment processes, identify critical functionality within Trac and provide detailed feedback to help shape future system design. Particular focus has been given to the Talent Acquisition module, which aims to improve the candidate experience, simplify internal movement between roles and enhance workforce data quality.

Finally, the Trust has welcomed back the Bob Champion in a temporary, part-time capacity through a shared appointment with Airedale NHS Foundation Trust. The role will focus on reviewing and assessing the Trust's Band 5 Nursing job profiles against the national profiles developed by NHS England, helping to ensure local roles remain aligned with national standards and support wider workforce attraction, recruitment and retention objectives across the nursing workforce.

Clare Mary 09/12/2025 15:09:24

5 CQC Notifiable Incidents, Regulatory Matters and Visits

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

Mental Health Act (MHA) visits

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

- DAU had an unannounced visit on 11th August 2026
- Fern ward had an unannounced visit on 6th October 2026

Unannounced inspections
There were no unannounced inspections during this reporting period.

CQC Notifiable incidents
There were 3 notifiable incidents during this reporting period.

- 1 AWOL from Baildon. The service user was returned by the police.
- 2 Young Person emergency admissions to Oakburn ward

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 & Safety Committee.

Inquests:

8 inquests were concluded during this period in which BDCFT had provided some level of evidence to the coroner. Of these, staff were called by the coroner in three 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:
Narrative x 3
Suicide x 3
Drug related x 2

6 Patient Safety Incidents and Never Events

Since the last report **0 Never Event** was reported. In addition, there were:

Two (2) new Patient Safety Incident Investigations (PSIIs) reported since the last report
2 suspected suicides
There are **five (5)** open PSIIs, currently.
There are **three** (**3)** SJRs ongoing.
There are **ten (10)** LLRs on-going currently.

Classification
29/07/2026 15:09:24

7 Media Coverage

Media and news highlights since the last Board meeting.

Area / dates	Details
Nominations open for Care Trust Governor elections - 9 September	Bradford District Care NHS Foundation Trust is encouraging local people from Bradford, Airedale, Wharfedale and Craven to nominate themselves in their Governor elections. The Trust is seeking nomination for six seats from five constituencies across the district, with two in Shipley and one each in Bradford South, Bradford West, Craven and Keighley.
Could your medications increase your risk of falls? - 16 September	People taking four or more medications are invited to find out whether they could be at increased risk of a fall by bringing their medications list for friendly, helpful advice from Bradford District Care NHS Foundation Trust's Falls Prevention team during Falls Awareness Week (Monday 21 to Sunday 27 September 2026).
Adult learners gain valuable construction experience at hospital redevelopment site - 23 September	Four students from Bradford College recently undertook a two-week placement on the Lynfield Mount Hospital site to gain valuable insight into the delivery of a live construction project. The students, who are enrolled on the Adult Construction Skills course, were welcomed to the Bradford District Care NHS Foundation Trust site which is currently undergoing a £65 million phased investment to improve the facilities for people who use the Trust's services and colleagues working on site.
Chief Executive Officer for Bradford District Care NHS Foundation Trust - 30 September	From 6 October, Bradford District Care NHS Foundation Trust's Director of Nursing, Professions and Care Standards and Deputy Chief Executive, Phillipa Hubbard, will step in as the Acting Chief Executive Officer (CEO) for the organisation. Phillipa is taking on the role to enable the substantive CEO Therese Patten to accept a 12-month secondment as interim Chief Executive for Northern Lincolnshire and Goole NHS Foundation Trust (NLaG).
Care Trust celebrates shining stars at awards ceremony – 2 October	A team who have literally walked over fire to support the people they care for scooped two awards at this year's Bradford District Care NHS Foundation Trust's You're a Star Awards 2026, which took place at the Midland Hotel, Bradford on Thursday 1 October.

Close Holly 29/10/2026 15:09:24

Trust shares expertise and experience in supporting homeless people – 19 October	Bradford District Care NHS Foundation Trust has shared its experience and expertise in care for the homeless during a visit by the Chief Executive of the Queen's Institute for Community Nursing (QICN) Stephanie Lawrence and Deputy Chief Public Health Nurse Jamie Waterall to the Horton Park Medical Centre.

8 Place/System/National news

National and system developments continue to reinforce the strategic importance of strong, integrated community services. The Queen's Institute of Community Nursing Strategic Plan 2026–30 aligns its priorities to the national shifts from hospital to community, analogue to digital and sickness to prevention, with a particular focus on neighbourhood care, workforce, leadership, evidence and innovation.

This is particularly pertinent following the recent visit by Stephanie Lawrence, Chief Executive of the Queen's Institute of Community Nursing, and Jamie Waterall, Deputy Chief Public Health Nurse, to the Trust's Homeless and New Arrivals Health team, where the Trust showcased its person-centred approach to inclusion health, proactive care and tackling health inequalities.

This direction is reinforced by the CQC State of Care 2025/26, which highlights a 34% increase in people in contact with community mental health services over the last three years, continuing challenges with timely access, crisis care, discharge and restrictive practice, and the need for stronger system working across health and social care.

These developments provide a clear national context for the Trust's continued focus on strengthening community and neighbourhood models, addressing health inequalities, mental health Sprint approach improving access and flow, supporting safe and sustainable community nursing, and working with partners to deliver more preventative, integrated care closer to home.

Phillipa Hubbard
Chief Executive
26 October 2026

Close Holly 29/10/2026 15:09:24

Effective Oversight: Escalation and Assurance

NHS
Bradford District Care
NHS Foundation Trust

Report to:	**Board held in Public**	**Meeting date:**	**TBC**
Report from:	**Mental Health Legislation Committee**	**Meeting date:**	**17/09/2026**
Quorate?	**Yes ☒ No ☐**		
Members present	Warren Brown (NED/Chair), Alyson McGregor (NED), Sarah Jones (Chair in common), Phillipa Hubbard		
In attendance	Alix Jeavons, Christopher Dixon, Jess Greenwood-Owens, Karan Essien, Joanne Tiler, Marilyn Bryan, Baljit Kaur Nota, Teresa Okeefe, Karan Essien, Richard Cliff, Tricia George, Fran Stead, Phalaksh Walishetty		
Observers	Lee Wakefield, Leanne Sobaratee		
Apologies	Therese Patten, Thabani Songo, Anita Brewin, Dr Gail Harrison, Dr Sal Uka, Kelly Barker		

Best Quality Services	**Theme** 1 – Access and Flow	**BQS:T1**
	Theme 2 – Learning for improvement	**BQS:T2**
	Theme 3 – Improving the experience of people using our services	**BQS:T3**

Agenda items	• Learning from your Experience – AWOL • Mental Health Act 2025 Update • Feedback from Involvement Partner • Strategic Narrative Report .1 Strategic Performance Report • Associate Hospital Manager's Report • Mental Capacity Act update including (where applicable): Liberty Protection Safeguarding, Action Plan updates, Mental Capacity Act Annual Report, Audit Results • Restrictive Practice Annual Report • CQC Mental Health Act monitoring review visits • Section 117 - Audit • AAAD Positive & Proactive Group • Well Led Implementation Plan • Provider capability • Board Assurance Framework • Strategic Risk Report • Confirmation of Escalation Reporting including: • Mental Health Legislation Committee: Annual Work Plan
Alert items agreed by Committee	• The Committee noted the ongoing implementation risks associated with significant legislative and regulatory changes, including the forthcoming Mental Health Act reforms and the implications of the Supreme court judgement in relation to the reference made by the Attorney General for Northern Ireland (AGNI) as to the lawfulness of the Deprivation of Liberty safeguards in the mental capacity act. Members discussed the potential for increased variation in

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	professional judgement, the need for clear guidance and training, and the risk of inconsistencies in application across services while national guidance continued to develop. • The Committee also noted areas requiring continued improvement, including Section 117 care planning compliance, data quality relating to restrictive interventions, and ensuring effective feedback mechanisms following Hospital Managers' hearings. • The Committee welcomed that an additional 4 Associate Hospital Managers were recruited in July meaning that there should be no issues around filling panels. Sarah Jones advised that NEDs would be encouraged to attend panels as observers.
Advise items agreed by Committee	• Progress against key programmes of work, including implementation planning for the Mental Health Act reforms, Mental Capacity Act governance, restrictive practice reduction, CQC Mental Health Act monitoring activity, and the Well-Led and Provider Capability Assessment frameworks. Members discussed the importance of workforce development, strengthening care planning processes, learning from audit findings, and continuing collaborative working with partners including local authorities, police services and acute providers. • The Committee highlighted the value of frontline staff perspectives in understanding the impact of absent without leave (AWOL) incidents and the importance of supporting staff through robust governance, leadership oversight and organisational learning • Feedback from Associate Hospital Managers on the quality of reports presented to Hospital Manager hearings would be shared with relevant staff to support learning and development.
Assure items agreed by Committee	• Governance arrangements remained in place to oversee compliance with mental health and mental capacity legislation and to monitor delivery of associated improvement programmes. Positive assurance was received regarding continued reductions in restrictive interventions, improvements in hospital manager capacity and recruitment, strengthened Mental Capacity Act resources and governance, and progress against Well-Led and Provider Capability Assessment actions. • Members were assured that action plans had been established to address audit findings, that oversight mechanisms remained effective, and that regular reporting would continue through established governance routes to ensure sustained progress and ongoing scrutiny.
Decisions made by Committee Close Holly 29/10/2026 15:09:24	The Committee approved: • Minutes of the previous meeting & AAAD • Action Log • Associate Hospital Manager's Report • Provider capability • Board Assurance Framework • Strategic Risk Report

New risks identified by Committee	• There were no new risks identified.		
Items to be considered by other Committees/Groups	• Board Development Session to receive a presentation on restrictive practice reduction and benchmarking. • Hospital Managers Group to receive the AWOL staff experience presentation. • Ongoing consideration of Mental Capacity Act, Mental Health Act implementation, Section 117 compliance and restrictive intervention governance through the Quality and Safety Committee.		
Feedback following discussion at 'parent' meeting	TBC		
Report completed by	Jess Greenwood-Owens **Corporate Governance Officer**	**Date**	21/09/2026
On Behalf of Chair	Warren Brown		

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AAAD: Effective Oversight: Escalation and Assurance

Report to:	**Public Board**	**Meeting date:**	**XXX**
Report from:	**Quality and Safety Committee (QSC)**	**Meeting date:**	**16.09.2026**
Quorate?	**Yes ☒ No ☐**		
Members present	Alyson McGregor, Chris Malish, Sally Napper, Phillipa Hubbard		
In attendance	Kelly Barker, Anita Brewin, Fran Stead, Jaspreet Sohal, Michelle Holgate, Nazmeen Khan, Prabhdeep Sidhu, Rebecca Jowett, Rebecca Le-Hair, , Tricia George, Sayma Mirza.		
Observers			
Apologies	Chris Dixon, Joanne Harrison, Carla Smith, Catherine Scohfield, Rachel Trawally, Sal Uka		

Best Quality Services	**Theme** 1 – Access and Flow	**BQS:T1**
	Theme 2 – Learning for improvement	**BQS:T2**
	Theme 3 – Improving the experience of people using our services	**BQS:T3**

Agenda items

- Integrated Strategic Performance and Quality Report (ISPQR)
- Strategic Risk Summary
- Board Assurance Framework (BAF)
  Well Led Development plan update
- Provider Capability Assessment (PCA)
- Learning from Deaths Annual Report
- Clinical Audit Annual Report
- Quality Assurance Framework Update
- CQC quarterly report: engagement and activity
- PCREF Update
- Risk Management Annual Report Update
- Staying safe From Suicide Annual Report
- Infection Prevention & Control Annual Report (IPC)
- National Infection Prevention and Control Board Assurance Framework
- Sexual Safety Bi-annual report
- Resilience Policy
- Pandemics Plan
- Trust wide Evacuation and Shelter plan
- Winter Plan Update
- Annual NHS CPD submission plan 2026/27
- NHS England Education Quality Report Provider Statement
- AAAD report: Clinical Board
- AAAD report: Senior Leadership Team Quality, Safety, Governance
- AAAD Report: Senior Leadership Team – Care Group Assurance Meeting (CGAM)

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	• AAAD Report Staying safe From Suicide
Alert items agreed by Committee	•
Advise items agreed by Committee	• ISPQR – The Committee was advised that work is ongoing to further develop health equity reporting and PCREF metrics. Consideration is also being given to how this information can be incorporated into routine performance reporting and Committee assurance processes. • PCA - Members were advised that actions to address identified gaps and strengthen organisational capability are being progressed through existing governance arrangements, including the Well-Led Development Plan and related improvement programmes. • Members requested that future reports include information on audits that have been delayed, reprioritised or carried forward to improve transparency and accountability. • IPC - Areas requiring continued focus include isolation arrangements, ventilation governance, and fit testing compliance. • Staying Safe from Suicide (formerly Suicide Prevention) – Members noted ongoing work to strengthen workforce training, clinical systems and organisational learning arrangements in line with NHS England guidance. • Winter preparedness, pandemic planning and emergency resilience arrangements continue to be reviewed in line with national requirements. • Work is progressing to review the role of Clinical Board and develop strengthened clinical effectiveness governance arrangements. An update is expected at a future Committee meeting following consultation.
Assure items agreed by Committee	• The Committee received assurance that the Integrated Strategic Performance, Quality and Risk Report (ISPQR) continues to mature as the Trust's principal integrated assurance report. It brings together quality, safety, performance, workforce and health equity indicators to support oversight and the early identification of risks. Members noted that reporting arrangements continue to evolve to strengthen assurance on outcomes, inequalities and the impact of improvement activity. • Strategic risks continue to be actively monitored, with mitigating actions progressing through established governance arrangements. • Board Assurance Framework (BAF) – The Committee received assurance that controls remain in place to manage quality and safety risks. Assurance mechanisms continue to strengthen, particularly through the Patient Safety Learning Group and integrated assurance reporting. The Committee supported the current BAF ratings and assurance position

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- Provider Compliance Assessment (PCA) – The Committee received assurance that improvement actions are being monitored through established governance arrangements and that evidence continues to be developed to demonstrate progress against PCA requirements.
- Well-Led Development – Members noted that planned actions continue to progress and are contributing to stronger governance, leadership, quality assurance and Board oversight arrangements.
- The Committee noted the establishment of revised patient safety governance arrangements, including the Patient Safety Learning Group, to strengthen organisational learning and oversight of action plans
- Assurance was provided that the Trust remains compliant with National Clinical Audit requirements. Work is underway to strengthen governance arrangements and improve oversight of audit actions through clinical effectiveness structures and the Safeguard action plan module.
- The Committee received assurance that 324 deaths were reviewed through established mortality governance arrangements and that learning continues to inform trust-wide quality and safety improvement activity. Internal audit of PSIRF implementation provided significant assurance.
- Risk Management Annual Report – Further assurance was received regarding the Trust's risk management framework, risk oversight arrangements, management of strategic and operational risks, and the continued development of a positive risk management culture across the organisation.
- The Committee noted ongoing engagement with the regulator and forthcoming feedback from Mental Health Act monitoring visits and a Dementia Assessment Unit visit.
- Assurance was received that IPC performance remains strong, statutory requirements are met and national assurance criteria show no areas of non-compliance.
- Staying Safe From Suicide (formerly known as Suicide Prevention) Assurance was provided that governance arrangements have been refreshed and that surveillance, learning and improvement mechanisms are being strengthened.
- Sexual Safety - Assurance was received that robust governance, safeguarding and learning arrangements are in place and supported by independent audit assurance.
- Resilience plan, Pandemic plan, and Trust Wide Evacuation plan are up to date and compliant with Emergency Preparedness, Resilience and Response standards.
- CPD allocation had been planned against identified workforce development needs.

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Decisions made by Committee	Item 04.0 – AAAD & Minutes Item 08.0 - Strategic Risk Assurance Report - September 2026 - Quality & Safety Committee Item 08.1 – Board Assurance Framework Item 09.0 – Well Led Development Plan update Item 09.1 – Provider Capability Assessment Item 10.0 – Learning from Deaths Annual Report Item 11.0 – Clinical Audit Annual Report Item 13.0 - CQC quarterly report: engagement and activity Item 15.0 – Risk Management Annual Report Item 16.0 – Staying Safe from Suicide Annual Report Item 17.0 – Infection Prevention & Control Annual Report Item 19.0 - Resilience Policy Item 19.1 - Pandemics Plan Item 19.2 - Trust wide Evacuation and Shelter plan		
New risks identified by Committee	No new risks identified		
Items to be considered by other Committees/Groups			
Feedback following discussion at 'parent' meeting			
Report completed by	Nazmeen Khan Corporate Governance Officer	**Date**	16.09.2026
On Behalf of Chair	Ayson McGergor (NED/Chair)		

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AAAD: Effective Oversight: Escalation and Assurance

Report to:	**Public Board**	**Meeting date:**	**XXX**
Report from:	**Quality and Safety Committee (QSC)**	**Meeting date:**	**21.10.2026**
Quorate?	**Yes ☒ No ☐**		
Members present	Alyson McGregor, Chris Dixon, Chris Malish, Sally Napper, Sal Uka		
In attendance	Nazmeen Khan, Rachel Trawally, Rebecca Jowett, Tricia George, Sarah Sheard, Anne Marie Dorrington, James Cooke.		
Observers	None		
Apologies	Anita Brewin, Catherine Scohfield, Fran Stead, Sayma Mirza, Rebecca Le-Hair, Thabani Songo, Kelly Barker		

Best Quality Services	**Theme** 1 – Access and Flow	**BQS:T1**
	Theme 2 – Learning for improvement	**BQS:T2**
	Theme 3 – Improving the experience of people using our services	**BQS:T3**

Agenda items	• Minutes of the previous meeting and AAAD • Learning From Your Experience Memory Assessment and Treatment Service Pathway Update • West Yorkshire Community Dental Service Collaborative - Annual report 2025-2026 • Integrated Quality Planning and Management System (IQPMS). (verbal) • BDCT Safer Staffing Assurance Report • Thirlwall Report - Quality and Patient Safety actions • AAAD report: Clinical Board • AAAD report: Senior Leadership Team Quality, Safety, Governance • AAAD Report: Senior Leadership Team – Care Group Assurance Meeting (CGAM) • AAAD Report – PCREF Accountability Groop
Alert items agreed by Committee	• No new alerts
Advise items agreed by Committee	
Assure items agreed by Committee	• **Learning from Your Experience – Memory Services:** The Committee received an update on the redesigned memory assessment and treatment pathway. Improvements included more standardised pathways, reduced waiting times and greater use of nursing, AHP and advanced practice roles. Discussion focused on further reducing diagnostic waits, support for carers, integrated

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	dementia care and ensuring equitable access for different communities. • **West Yorkshire Community Dental Service Collaborative:** Community Dental Services: The Committee took assurance from the annual report and the progress achieved across the West Yorkshire collaborative, while identifying opportunities to strengthen future quality and assurance reporting. • **Quality Performance Management System:** The Committee discussed developing the Trust's approach around quality planning, control, improvement and assurance, aligned with Better Lives Together and the national quality strategy. Members emphasised the need to demonstrate the impact of learning and improvement, particularly across patient safety, clinical effectiveness and patient experience. A quality summit was proposed to inform development of the Trust's quality strategy, with further work anticipated by the end of Quarter 4. • **BDCT Safer Staffing Assurance Report:** The Committee received significant/high Level 4 external assurance following the NHS England review. Strengths included workforce planning, establishment setting, deployment and escalation arrangements, governance and Board oversight. Further development will focus particularly on strengthening the patient/service-user voice and improving reporting. • **Thirlwall learning Quality and Patient Safety Actions:** The Committee was assured that work was progressing to assess organisational learning, including triangulation of patient safety, workforce, safeguarding and other intelligence. A completed gap analysis and prioritised action plan with executive ownership will be brought forward, with agreed actions incorporated into the Well-Led Development Plan. • **Incident update**: The Committee received assurance regarding the organisational response to a serious assault on a member of staff within community mental health services, including the emergency response, staff support, regulatory engagement and post-incident review arrangements. •
Decisions made by Committee	Item 04.0 – AAAD & Minutes
New risks identified by Committee	No new risks identified
Items to be considered by other Committees/Groups	

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Feedback following discussion at 'parent' meeting			
Report completed by	Nazmeen Khan Corporate Governance Officer	**Date**	21.10.2026
On Behalf of Chair	Ayson McGergor (NED/Chair)		

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Board of Directors – Meeting held in Public

5 November 2026

Paper title:	Freedom to Speak Up Guardian Bi-annual Report (Q1 & 2 2026/27)	**Agenda Item** **13.0**
Presented by:	Rebecca Wixey – Freedom to Speak Up Guardian	
Prepared by:	Rebecca Wixey – Freedom to Speak Up Guardian Emma Greenwood – Deputy Freedom to Speak Up Guardian	
Committees where content has been discussed previously	Not applicable	
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	
	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

Claire Kelly
20/10/2026 15:09:24

Purpose of the report
This paper provides information about Freedom to Speak Up activity for Q1 & Q2, 2026/27. It is presented in a format to comply with the Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts, published by the office of the National Guardian FTSU and NHSE/I in July 2019.

Executive Summary	
The key issues are: 1. A total of 69 cases were reported to the BDCT Guardian team during Q1 & Q2. 2. The number of anonymous concerns received has increased in Q2 but remains below the national average. 3. There were zero cases suffering detriment over the 6-month period. Our average remains below the national average of 2.6%. 4. There has been an increase in concerns coming to the Guardian regarding personal employment matters which would be better addressed through People Services 5. A large number of concerns continue to relate to poor culture/leadership/management behaviours and this is a key issue which underpins many cases 6. Speaking up cases continue to contribute to the broader improvement strategy.	
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ **Yes** (please set out in your paper what action has been taken to address this) ☒ **No**

Recommendation(s)
The Board of Directors is asked to: • Note the contents of this report.

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 **ALL** 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: • n/a	

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Board of Directors – Meeting held in Public

5 November 2026

Freedom to Speak Up Bi-Annual Report (Q1 & Q2, 2026/27)

1 Purpose

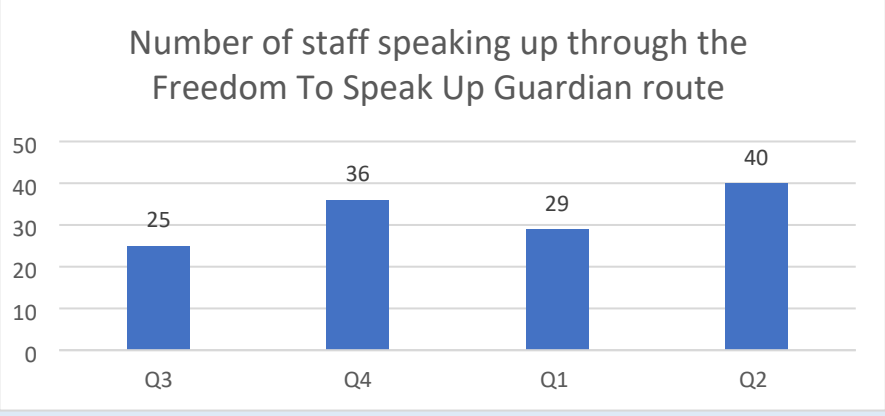
This paper provides information about FTSU activity for the period April to September 2026. The format complies with the 2018 and 2019 publications by the National Guardians Office (NGO) and NHS Improvement published guidance concerning FTSU Guardians Board Reporting.

Section 1 - Assessment of FTSU cases April to September 2026
Section 2 - Themes
Section 3 - Learning and improvement undertaken
Section 4 - Actions taken to improve access to the FTSU Guardian route
Section 5 - Speaking up/listening up culture and actions taken to improve culture
Section 6 - National/regional activities and information
Section 7 - Future actions

Section 1 - Assessment of FTSU cases Q1 & Q2

Figure 1 shows the number of FTSU cases by quarter. There were 69 cases in Q1 & Q2, the same figure as the same period last year. Only cases that involve colleagues directly contacting the Guardian or the Deputy Guardian for advice or support in speaking up can be classified as FTSUG cases.

Figure 1

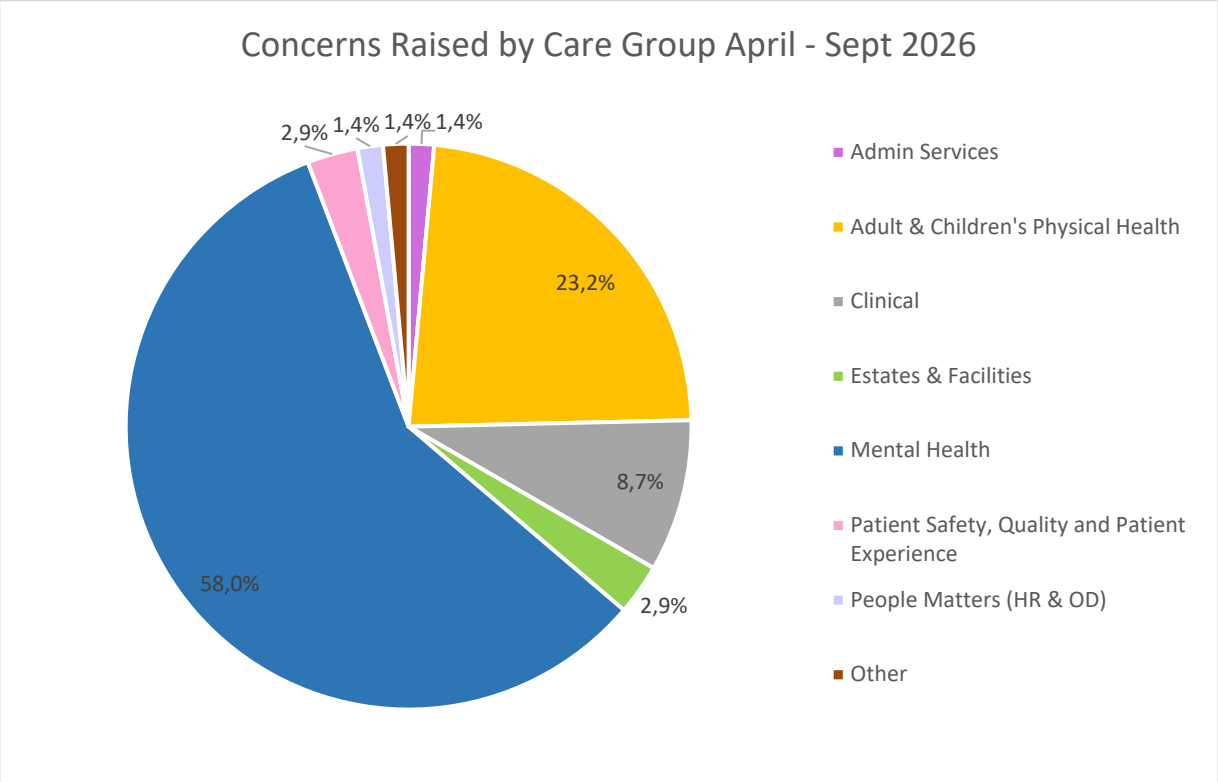


Concerns Raised by Area

Rose Holly
29/10/2026 11:00:04

Figure 2 shows the areas in which concerns were raised. The mental health care group continues to be the biggest reporter and accounted for 58% of activity. Adults and Children's physical health accounted for 23%. Please note that for ease any directorates with zero concerns raised are not included in the chart.

Figure 2



As highlighted previously, having a relatively high number of contacts to the FTSU Guardian in a particular care group or service is not always synonymous with an increased presence of cultural or systemic issues. It could be that colleagues in those areas are more aware of the Guardian as a route for speaking up, or it may be that they feel more confident in being able to use this option. Whilst the Trust must be careful not to invalidate individual voices, directorate and service-level data are always best viewed with a more holistic lens through triangulation with other organisational metrics such as incident reporting, attendance, staff turnover, grievance & disciplinary rates, performance management, exit interviews and staff survey responses.

An investigation has been commissioned into one of our mental health services following a series of concerns that were raised regarding culture, bullying and poor behaviours, management, discrimination and reasonable adjustments. Reporters were also given the opportunity to speak with the Director of Nursing & Professions to ensure their concerns were heard at an executive level.

Number of colleagues speaking up by professional group

During Q1 & Q2, nursing colleagues were the highest reporting group, which is in line with previous years.

Claire Holly
27/10/2026 15:09:24

Closure of Concerns

As at 21/10/2026, of the 69 cases raised during Q1 & Q2, 45 have been closed (65%) and 24 remain outstanding. The mean time taken to closure was 24 days (median 20 days), with a range of zero (closed on the same day) to 106.

Section 2 – Themes

Table 1 shows the total number of cases from 1 April to 30 September 2026, broken down into those with an element of patient safety/quality of care, bullying and harassment, worker safety or wellbeing and other inappropriate attitudes or behaviours. These are the thematic elements that we are required to report on to NHS England. Please note that some cases involve multiple different matters, and this is reflected in the figures. The table also shows the numbers of colleagues who wanted to remain anonymous to the Guardian and the numbers who considered they had experienced disadvantageous and/or demeaning treatment because of speaking up.

Table 1

Item	2022/23	2023/24	2024/25	2025/26	Q1 & Q2 2026/27
Total no of cases	76*	69	112	130	**69**
Patient safety and quality of care concerns	20 (26%)	17 (25%)	46 (41%)	40 (31%)	**23 (33%)**
Bullying and harassment concerns	19 (25%)	27 (39%)	43 (38%)	19 (15%)	**16 (23%)**
Worker safety or wellbeing concerns	59 (78%)	54 (78%)	88 (79%)	104 (80%)	**52 (75%)**
Concerns related to other inappropriate attitudes or behaviours	41 (54%)	41 (59%)	72 (64%)	70 (54%)	**31 (45%)**
Colleagues wishing to remain anonymous to Guardian	8 (11%)	14 (20%)	12 (11%)	15 (12%)	**7 (10%)**
Colleagues perceiving an element of disadvantageous and/or demeaning treatment as a result of speaking up	2 (3%)	3 (4%)	6 (5%)	3 (2%)	**0 (0%)**

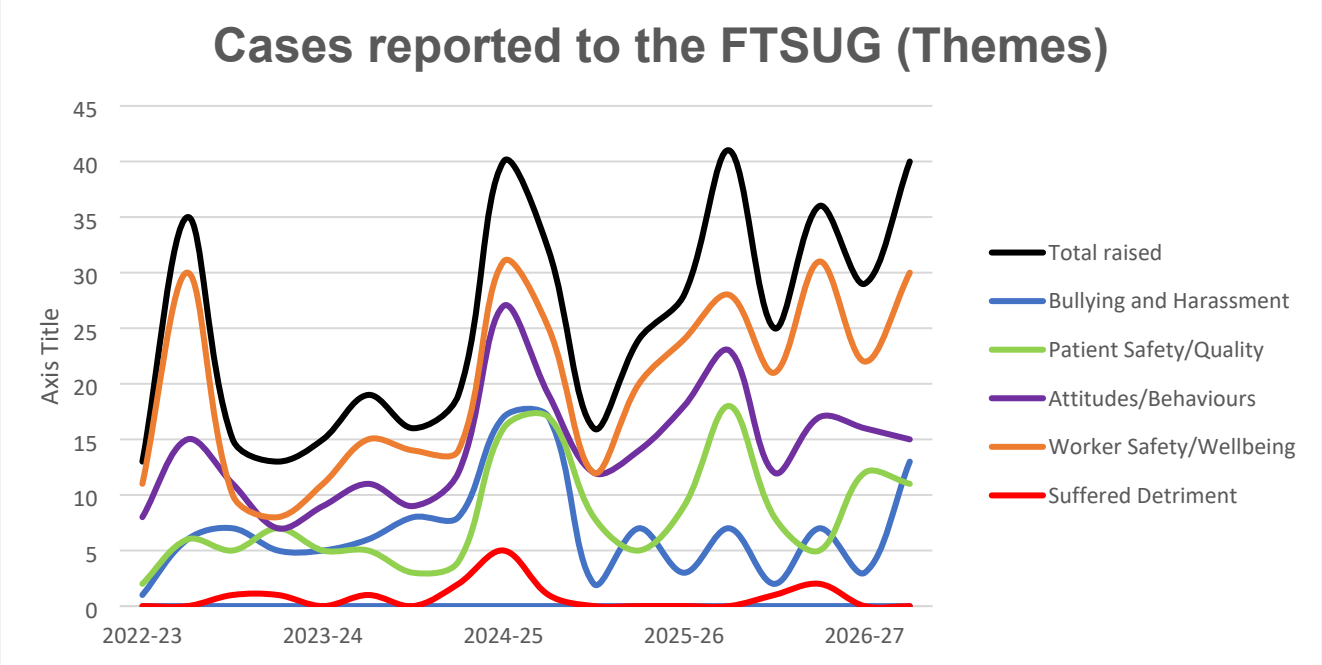
** Corrected figure, originally reported as 75 in the 2022/23 annual report*

Figure 3 provides a longitudinal view of FTSU cases and the frequency in which different themes have appeared since 2022/23. Over the period, more colleagues have spoken up with concerns about worker safety and wellbeing, and attitudes and behaviours, than direct patient safety/quality concerns. However, it should be noted that these types of concerns can still have an indirect impact on patient/service user safety and quality.

In Q1 & 2 the main themes spoken up about were poor culture, leadership and management behaviours. This seems to be an underlying thread that we see running through the vast majority of concerns raised to the Guardian – often being cited as reasons people have felt unable to speak up within their management structure or where concerns have been raised previously but the issue has not been resolved.

Rose Holly
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Figure 3



Staff who fear victimisation by colleagues can speak up anonymously via the FTSU online reporting form. Colleagues can also speak up openly but ask for their information to be kept confidential via the Guardian. We monitor the number of anonymous contacts, with a low number being an indicator of staff's confidence in the system. The percentage of anonymous cases has decreased slightly from last year and is below the national average of 12%. However, we did notice a spike in Q2 and will continue to monitor this and look for any trends.

Concerns with an element of patient safety or quality

On review of the 23 concerns that had an element of patient safety or quality mentioned, and considering the feedback from managers, we do not believe any patients or service users have been harmed as a direct result of these concerns.

Worker safety & wellbeing

For the last 4 years, since the worker safety and wellbeing category was introduced, this has consistently been the theme with the highest number of concerns. The majority of these relate to psychological safety and wellbeing, as opposed to physical safety. To help with organisational understanding, we have done some further analysis on the 52 concerns which recorded an element of this to pick out the main subject(s) within these cases.

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Table 2

Key elements	Count
Leadership & management behaviours	13
Systems and processes	9
Flexible/hybrid working	7
Personal employment issues	7
Lack of psychological safety	5
Team dynamic	5
Culture	4
Reasonable adjustments	3
Bullying	3
Grievances	3

Key elements	Count
Organisational change	2
Burnout	2
Sexual safety	1
Staff incidents	1
Disability discrimination	1
Sexism	1
Lack of support	1
Remuneration	1
Breakdown in professional relationship	1

Personal Employment Issues

There has been a trend of increased reports coming through the Guardian route that relate to issues which would more appropriately be addressed by People Services. During April to September there were 13 cases (19%) which related to individuals who were either already in a formal process, or who were signposted and supported to access their Trade Union or an HR Business Partner for advice. This has been discussed with People Services colleagues at our regular triangulation meetings and the following actions taken to try and address it:

- Additional Trust-wide comms explaining the different routes and when they are appropriate
- Included within briefing at Trust Welcome
- HRBP discussion with staff side reps
- It is hoped the Avoidable Harm workstream will also start to have a positive impact on this.

Equality, Diversity & Inclusion – Protected Characteristics

The information below shows equality monitoring information gathered from staff who have spoken up to the Freedom to Speak Up team. As at 13/10/2026, 28 of the 69 cases (41%) have provided some or all of this information.

Ethnicity	Number
Black or Black British	<5
Asian or Asian British	<5
White British	18
Other ethnic groups	<5
Mixed	<5
Prefer not to answer	<5

Age	Number
21-30	7
31-40	<5
41-50	6
51-60	8
61-71	<5
Not answered	<5

Sexual Orientation	Number
Bisexual	<5
Gay	0
Heterosexual	21
Lesbian	<5
Prefer not to say	<5
Prefer to self-describe	0
Not answered	<5

Gender	Number
Female (including transgender women)	22
Male (including transgender men)	<5
Not answered	<5

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Disability	Number
Yes	8
No	17
Prefer not to say	<5

Section 3 - Learning and improvement

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

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

Actions and improvements made following colleagues speaking up through the FTSU Guardian route in Q1 & 2:

- Importance of clear and timely communication to teams regarding any proposed organisational changes etc.
- EDI working with Smarter Spaces to update Sessional Space Procedure and Venue Handbook with inclusion checklist.
- Action by management to independently review a number of IREs; fact finds undertaken to ensure the incidents were managed appropriately, which it was found they were
- Trust-wide communication issued regarding use of legal and preferred names on Trust systems
- Support plan in place for individual to ensure competency and working with leadership to ensure staff feel safe to speak up and well supported
- Individual reflection on an issue as part of nursing revalidation
- Rationale for annual leave request decisions shared with entire service by management with an offer to hear suggestions for improvement.
- Several colleagues were signposted to the appropriate HR process and supported to access their Trade Union.
- A few colleagues were also supported and empowered to speak to their line manager/other relevant manager directly to achieve local resolution.

Case Studies

The following two case studies give insight into the FTSU process, actions taken and identified learning:

Case Study 1

Claire Holly 27/10/2023 13:39:14

An anonymous form was received raising concerns regarding unfair allocation of shifts in one of our mental health services. The Service Manager and Clinical Manager reviewed the rota and did not identify anything that would suggest unfair allocation of shifts.

However, they also picked up the issue with the Team Leader through management supervision to better understand how the arrangements were being perceived by the team. As this was an anonymous concern it was not possible to feed back to the individual directly, but information and assurance was shared through a future team meeting.

Case Study 2

An anonymous concern was raised regarding the level of support available to a community team when senior support was required. The individual described an incident where staff were unable to access timely support following the activation of a panic alarm, which caused significant anxiety within the team. They also raised wider concerns about accessibility and responsiveness when support was needed.

The concern was shared with relevant management; however, due to the limited information provided, it was not possible to identify which team or service the concern related to. As the concern had been raised anonymously, there was no opportunity to go back to the individual for more information. As a result, managers were unable to consider the issues fully or identify any actions that could be taken.

This case demonstrates the important role anonymous reporting can play in allowing staff to raise concerns when they do not feel comfortable identifying themselves. However, it also highlights some of the limitations. Without sufficient information, it can be difficult to understand concerns fully, provide feedback, or make improvements. Where staff feel able to do so, speaking directly with a FTSU Guardian can often be more effective, as Guardians can explore concerns in greater detail whilst maintaining confidentiality. Also, where appropriate, speaking directly with line managers can allow concerns to be addressed quickly and locally before they escalate.

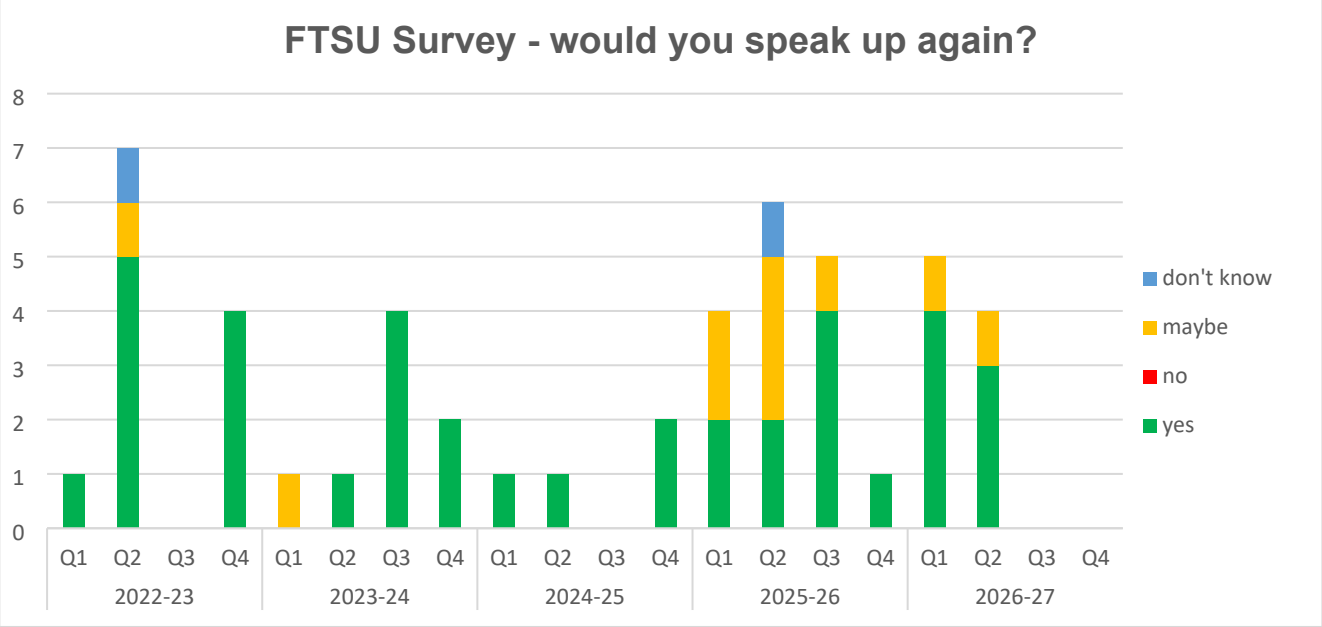
This case reinforces the importance of creating a culture where staff feel psychologically safe to raise concerns openly. When staff trust that concerns will be listened to, taken seriously and addressed appropriately, organisations are better able to learn, improve and make positive changes for both staff and service users.

Feedback about FTSU process

Once a case is closed a survey is sent to the person who spoke up asking questions about their experience of the FTSU process and if they would speak up again. Figure 4 shows the number of people completing the survey and the response to the question “would you speak up again?” Please note cases may be closed in a different quarter to when they were raised, so numbers saying they would speak up do not necessarily relate to cases raised in that quarter.

Close Holly 29/10/2026 15:09:24

Figure 4



Qualitative feedback provided to the team is generally positive, however one person raised that they sadly didn't feel reassured there would be any changes despite there being clear bullying, and felt any further action was discouraged due to the seniority of the person involved. Unfortunately, we cannot identify which case this relates to so we're unable to follow up with the individual concerned.

Very helpful and approachable service, felt totally at ease and able to speak freely

I felt supported to raise a concern and this is very important

Once again big big thankyou for your on going support - I finally feel Listened to and things are being appropriately actioned 🙏

Staff team are brilliant at responding quickly and knowing best steps to take. They respected me and were supportive through the process.

Thank you so much for your support and encouragement ☺

It was a pleasure speaking to you and also thank you for your time today it is very much appreciated

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

- The team's communications plan is now embedded practice, though we review this regularly to ensure it remains fit for purpose and to include any *ad-hoc* items identified.
- In addition to presenting to new staff at Trust Welcome, in this 6-month period we have also attended the Estates & Facilities celebration event, a Falls Team Meeting, the Annual Members' Event and the Nursing celebration event.
- During Q1&2 we ran 9 drop-in sessions as an additional way for staff to access the service

Close Body 29/10/2025 10:09:14

- Our Speak Up Ambassadors also continue to form a crucial part of our network, promoting the 'Speak Up, Listen Up' message and signposting to the Guardian. We currently have 33 active Ambassadors and have been recruiting for our next induction session.

Section 5 – Speaking up/listening up culture

Action taken to improve the 'speak up, listen up, follow up' culture.

- The Trust took the decision to mandate the National Guardian's Office "Speak Up" eLearning in 2021, and completion currently stands at 91%.
- The continuing improvement in the culture (making speaking up business as usual) depends not only on staff having access to the FTSU Guardian arrangements and feeling they can speak up, but much more importantly on the behaviour and response by our managers when they hear concerns, either directly from their team members or via the Guardian.
- Listen Up and Follow Up eLearning is also available on ESR but not mandatory.
- During Q1 & Q2 we ran 1 manager study session and 13 people attended.

Section 6 - National/Regional activities and information

- The first quarterly data submission has been provided to NHS England on the new submission platform.
- Regular regional network meetings and peer support sessions remain in place and provide a helpful forum for sharing good practice and learning.
- The Thirlwall Inquiry report into the events at the Countess of Chester Hospital from 2015 to 2018 was published in September. This serves as a cautionary tale for Boards regarding culture and the importance of directors taking speaking up matters seriously and not attempting to silence colleagues who raise genuine concerns.
- The report also includes a chapter on FTSU Guardians and an associated recommendation: *The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include a. investigating complaints that whistleblowing in the NHS has not been dealt with adequately, and b. assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.*

Section 7 – Future actions

There are no forthcoming actions for the Board to be aware of. Board development session & self-reflection tool to be completed around December 2027, subject to any changes to national requirements from NHSE/DHSC. Strategy & policy in date and reviews not due until 2028.

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2026-10-[illegible]
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Name of author/s: Rebecca Wixey and Emma Greenwood
Title/s: Freedom to Speak Up Guardian and Deputy Guardian
Date paper written: 21 October 2026

NHS
Bradford District Care
NHS Foundation Trust

Trust Board

5th November 2026

Paper title:	Trust Board - Finance Report (Month 06 – September 2026)	**Agenda Item** **14.0**
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 **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	
	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 29/10/2026 15:09:24

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 is forecasting delivery of its agreed breakeven financial position at Month 6. However, financial performance remains increasingly reliant on non-recurrent measures to mitigate a significant CIP shortfall, and there remains a residual financial risk of £3.2m. While the overall risk position has improved since Month 5, delivery of the year-end plan will require continued operational discipline, accelerated transformation activity and successful implementation of recovery actions.

NHS England continues to rate the Trust as "Watch", reflecting concerns regarding the sustainability and deliverability of the recovery programme rather than current in-year performance.

Financial Risk assessment

The principal financial risk remains the delivery of the CIP programme. A forecast CIP shortfall of £4.6m is currently being mitigated through identified non-recurrent actions; however, the risk assessment identifies a further potential deterioration of between £2.0m and £5.1m.

Additional financial risks include unresolved pay-related pressures, deterioration in the financial performance of West Yorkshire Provider Collaboratives, uncertainty regarding funding for the 0-19 contract pay award, and underlying cost pressures across operational services. Collectively these risks continue to place strain on the delivery of the year-end financial position.

Taking account of all identified risks and opportunities, the Trust requires a further £3.2m of mitigation to fully de-risk delivery of the financial plan. Whilst this represents an improvement of £1.1m compared to Month 5, the residual risk remains significant.

Management actions

Recovery actions are focused on strengthening operational grip and control, accelerating transformation and converting identified opportunities into sustainable, cash-releasing savings. The Purposeful & Productive programme is showing early positive operational indicators, while further savings opportunities are being progressed across service transformation, automation, Digital and People Services; immediate priorities are to complete the recovery sprints, close remaining savings gaps, take firm decisions on transformation and corporate opportunities, and demonstrate clear financial benefit against the forecast CIP shortfall.

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Workforce breaches

Workforce expenditure remains under close scrutiny. Agency expenditure remains within the threshold for both plan and NHS England agency cap limits, with forecast spend of **£2.9m**

against a cap of £3.1m. However, bank expenditure exceeds plan by **£1.0m year to date** and is forecast to exceed the annual cap by **£1.3m**, driven by vacancies, sickness and patient acuity. These pressures continue to be mitigated through substantive staffing underspends.

Capital
The capital programme is reporting a **£3.7m underspend** at Month 6, primarily due to reprofiling of expenditure on the Lynfield Mount Redevelopment Scheme. Management remains confident that available operational capital and PDC funding will be fully utilised by year end.

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.

Close Holly 29/10/2026 15:09:24

Bradford District Care
NHS Foundation Trust

Trust Board

5th November2026

Close, Holly
29/10/2026 15:09:24

Item xx - Finance Report – Month 6 (September 2026)

Financial Performance – Key Messages & Risks

Bradford District Care
NHS Foundation Trust

The Trust is forecasting delivery of its agreed breakeven financial position at Month 6. However, financial performance remains increasingly reliant on non-recurrent measures to mitigate a significant CIP shortfall, and there remains a residual financial risk of £3.2m. While the overall risk position has improved since Month 5, delivery of the year-end plan will require continued operational discipline, accelerated transformation activity and successful implementation of recovery actions.

NHS England continues to rate the Trust as "Watch", reflecting concerns regarding the sustainability and deliverability of the recovery programme rather than current in-year performance.

Financial Risk assessment

The main risks continue to arise from the delivery risk on the CIP programme. A forecast £4.6m CIP shortfall is reported in the financial position at Month 6, with non recurrent mitigation plans identified to cover the risk. The risk of further deterioration has been assessed between **£2m to £5.1m**.

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 6, taking account of the upside and downside risks highlight that a **further £3.2m of actions are needed to fully de-risk the position**. This is a decrease in the overall risk assessment from Month 5 of £1.1m (likely risk at month 5 was £4.3m).

Close, Holly
29/10/2026 15:09:24

Financial Performance – Key Messages & Risks

Bradford District Care
NHS Foundation Trust

Management actions

Recovery actions are focused on strengthening operational grip and control, accelerating transformation and converting identified opportunities into sustainable, cash-releasing savings. The Purposeful & Productive programme is showing early positive operational indicators, while further savings opportunities are being progressed across service transformation, automation, Digital and People Services; immediate priorities are to complete the recovery sprints, close remaining savings gaps, take firm decisions on transformation and corporate opportunities, and demonstrate clear financial benefit against the forecast CIP shortfall.

Workforce breaches

- At Month 6, the Trust is **within it's planned Agency costs for both year to date and forecast**. The Trust is forecast to be within it's Agency cap of £3.1m.
- The Bank cap has been **breached by £1m YTD** and **forecast to by £1.3m at the year end**. This is driven by vacancies, sickness and patient acuity.
  - Substantive staffing underspends are mitigating the bank cap breach (YTD underspend £1.7m and forecast underspend £2.4m).
  - The Enhanced Therapeutic and Observations of Care (ETOC) programme has produced ward based action plans.

Close, Holly
29/10/2026 15:09:24

Efficiency Programme – Included in Position

The Month 6 position includes under delivery on the efficiency programme of £1.7m YTD and £4.6m 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	516	123	393	1,032	403	629	High
1. LOS/Out of Area Placements	KB	1,125	82	1,043	3,610	1,720	1,891	High
1. P & P Adult & Community Pathway Total		**1,641**	**205**	**1,436**	**4,642**	**2,123**	**2,519**	
2. Medical Staffing	SU	248	116	132	447	447	0	Medium
3. Continence Service review	KB	349	223	126	349	40	309	High
4. Enteral Feeding consumables	KB	85	85	0	85	85	0	Low
5. CYP Leadership restructure	KB	80	80	0	80	80	0	Low
6. Clinical Admin Review	KB	129	129	0	257	257	0	Low
7. Corporate Service Review	EMT	490	934	(444)	928	1,093	(165)	High
8. Difficult Decisions CAMHS Neuro	KB	139	139	0	278	89	189	High
8. Difficult Decisions BANDS	KB	129	9	120	257	22	236	High
9. LMH Development	MW	153	153	0	305	305	0	Low
10. Bracken Ward	KB	154	0	154	309	0	309	High
10. Low Secure	KB	198	178	20	396	396	0	Low
11. TrustWide Efficiency	EMT	1,386	1,360	26	4,159	4,192	(34)	High
12. Technical efficiencies	MW	281	281	0	535	535	0	Low
13. Place Corporate efficiencies	TP	0	300	(300)	300	300	0	Low
14. Transformation target	FR	267	0	267	800	0	800	High
Grand Total		**5,728**	**4,190**	**1,538**	**14,127**	**9,963**	**4,164**	

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	117	117	0	233	233	0	Medium
3. Continence service review	KB	175	0	175	349	0	349	High
7. Corporate Services review	EMT	136	73	63	271	145	126	High
15. Vacancy Factor	KB	1,527	1,527	0	3,054	3,054	0	Low
Total		**1,954**	**1,716**	**238**	**3,908**	**3,432**	**475**	

OVERALL CIP PERFORMANCE		**7,682**	**5,906**	**1,776**	**18,035**	**13,396**	**4,639**	

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Efficiency Programme – Risk Assessment

Bradford District Care
NHS Foundation Trust

The CIP programme has been risk assessed to determine the **further risk** of under delivery to inform the Trusts net risk position. At Month 6 further risks range from **£2m best case to £5.1m worse case**.

Efficiency Plan	SRO	BEST	LIKELY	WORST
1. Temporary Staffing	KB	-23	158	467
1. LOS/Out of Area Placements	KB	758	1,377	2,257
1. P & P Adult & Community Pathway Total		**735**	**1,534**	**2,724**
2. Medical Staffing	SU	112	224	447
8. Difficult Decisions CAMHS Neuro	KB	0	0	89
8. Difficult Decisions BANDS	KB	0	0	22
11. TrustWide Efficiency MHCG	KB	1,156	1,423	1,778
11. TrustWide Efficiency A&CCG	KB	0	0	0
11. TrustWide Efficiency Estates	MW	13	25	50
Risk Assessment		**2,015**	**3,205**	**5,110**

Recovery actions underway

- Purposeful & Productive: 90-day sprint is strengthening operational grip, seven-day working and pathway flow. Early indicators are positive, including 16 avoided admissions, out-of-area costs/bed days returning to trajectory and 8 of 12 key metrics improving. Bank and agency costs remain a key area for action
- Adult, Children & Physical Health 3% savings have been fully identified, albeit mainly through non recurrent measures
- Transformation target: 96 opportunities have been identified across six themes, with three priority automation opportunities progressing to detailed assessment and proof of concept.
- Digital: Benchmarking and contract reviews are progressing, with alternative solutions identified and further work with peers, Gartner and procurement planned to convert opportunities into savings.
- People Services: Benchmarking has identified c£1.5m potential opportunity, although further analysis is required to confirm how much is deliverable locally and to distinguish in-year from recurrent benefit.

Immediate next steps

- Maintain intensive grip and control on the recovery sprints, prioritising transformation capacity on daily/weekly delivery and embedding improved practice.
- Close the remaining 3% savings gap, particularly through Mental Health transformation, with CAMHS recommendations expected in October and Older Adults in December.
- Convert opportunities into quantified savings: firm Q3 decisions on the £800k transformation target, including automation, and on Digital and People Services corporate savings.
- Demonstrate financial impact: move from activity and opportunity identification to evidenced, cash-releasing delivery capable of improving programme confidence and mitigating the forecast CIP shortfall. This is the key executive challenge arising from the current position.

Claire Hyde
27/10/2026 15:09:14

There is evidence that recovery interventions are gaining traction operationally, the priority now is conversion to demonstrable financial benefit. Q3 is therefore critical for completing the sprints, tightening grip and control, and taking firm decisions on the remaining transformation and corporate savings gaps.

Risks and Mitigations

Bradford District Care
NHS Foundation Trust

Headlines:

The likely case risk assessment at Month 6, taking account of the upside and downside risks in the table below, highlight that a **further £3.2m of actions are needed to fully de-risk the position**. This is a decrease of the overall risk assessment from Month 5 of £1.1m (risk at month 5 was £4.3m).

The main risks continue to arise from the delivery risk on the CIP programme. £4.6m CIP shortfall is reported in the financial position at Month 6, and the risk of **further deterioration** has been assessed between £2m to £5.1m.

The **fair deal for nurses** review poses a significant financial risk, ranging from £0.8m to £3.9m. Work will commence in September to evaluate job descriptions; the national timescale for completion of this work is October 2028.

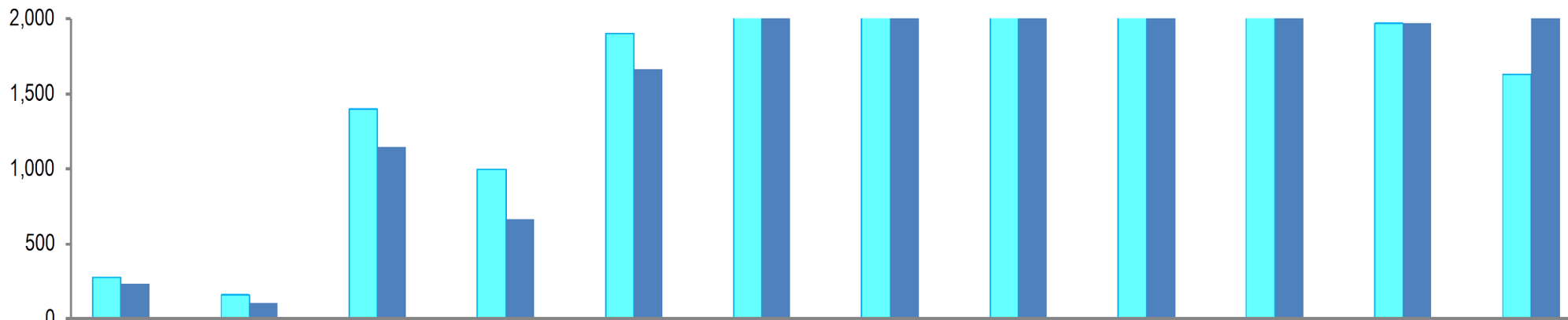
		2026/27			Movement from previous month
	Description	Best	Likely	Worse	- Adverse/ + Favourable
Upside 1	Risk Contingency	£0	£0	£0	£0
Upside 2	Cost pressure review - target further reductions	£44	£44	£44	£0
Upside 3	Non recurrent opportunities that arise during the year/ budget underspends	£1,278	£1,274	£1,274	£0
Upside 4	Non recurrent income	£1,216	£1,216	£1,216	£0
Upside 5	Continence funding from ICB	£500	£300	£0	£0
Upside 6	Secure 0-19 pay uplift funding for 26/27	£162	£162	£0	£0
Sub-total Upsides		**£3,200**	**£2,996**	**£2,534**	**£0**
Downside 1	CIP delivery risk	(£2,015)	(£3,205)	(£5,110)	£1,154
Downside 2	Adult Secure PC financial risk	(£137)	(£304)	(£356)	(£66)
Downside 3	Additional Cost pressures	(£190)	(£390)	(£500)	(£19)
Downside 4	General Run Rate Risks	(£55)	(£153)	(£219)	£125
Downside 5	0-19 Pay uplift for 26/27	£0	(£344)	(£344)	£0
Downside 6	Fair deal for nurses (national JD reviews)	(£804)	(£928)	(£3,886)	£0
Downside 7	CYP Gain Share 25/26	£0	(£552)	(£552)	£0
Downside 8	East Lancs Income Risk ATU	£0	(£369)	(£369)	(£102)
Net Risk		**(£0)**	**(£3,249)**	**(£8,802)**	**£1,092**

Classification: Official
Publication approved: 03-08-24

Capital Expenditure

Bradford District Care
NHS Foundation Trust

Capital Expenditure Plan vs Actual/Forecast



	M01 Actual	M02 Actual	M03 Actual	M04 Actual	M05 Actual	M06 Actual	M07 Forecast	M08 Forecast	M09 Forecast	M10 Forecast	M11 Forecast	M12 Forecast	YTD	FOT
Plan	277	158	1,401	999	1,900	11,161	13,008	4,257	2,038	3,699	1,971	1,628	15,896	42,497
Actual	235	106	1147	666	1,667	8,342	13,008	4,257	2,038	3,700	1,971	4,880	12,163	42,017
Variance	-42	-52	-254	-333	-233	-2,819	0	0	0	1	0	3,252	-3,734	-480

FOT of £42.497m on Capital Expenditure is inclusive of £585k relating to IFRS16 leases with intra-DHSC group organisations (NHSE and CHP). These are eliminated from CDEL calculations for NHSE reporting. The reported FOT against CDEL within the NHSE report is £41.912m

The capital position in September is underspent by £3.7m with a YTD spend of £12.2m. The underspend primarily relates to a revised cashflow on the LMH Redevelopment scheme. The Trust is confident that it will spend the full capital allocation for Operational Capital and additional PDC.

<u>The initial Trust capital plan is allocated as follows:</u>

- 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

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Self-Certification

Self certification		00ACTYTD
		Self-cert declarations Actual 30/09/2026 YTD DROP-DOWN
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.	*i*	Confirmed
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.		
		CFO
Name	**Name**	Mike Woodhead
Email address	**Email address**	Mike.Woodhead@bdct.nhs.uk
Job title	**Job title**	Chief Finance Officer
Date	**Date**	14/10/2026
		CEO or Chair
Name	**Name**	Phillipa Hubbard
Email address	**Email address**	Phillipa.Hubbard@bdct.nhs.uk
Job title	**Job title**	Acting Chief Executive Officer
Date	**Date**	14/10/2026
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	*i*	Yes
Date of board report (please note that this can be a future date)		05/11/2026
In the exceptional event that the forms are not consistent with the board report, please itemise the reasons why it is different		
3. 2026-27 Dissolution		
Has the trust dissolved in the financial year?		No
Number of months as a trust		12
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.		Yes
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)	*i*	2
7. Advanced Foundation Trust		
Have you been approved as an Advanced FT?		No
8. Provider key metrics		
Adjusted financial performance surplus/(deficit) - Year to Date	*i*	(1,691)
Adjusted financial performance surplus/(deficit) - Forecast	*i*	0
NOF combined finance score		1
NOF financial override applies?		No
Trust YTD spend on agency as proportion of Trust YTD total paybill		**1.8%**
Trust YTD spend on bank as proportion of Trust YTD total paybill		**7.3%**
Compliance with agency cap		Yes
Compliance with bank cap		No
Total risks and unidentified mitigations (£m)		3

Close Holly
29/10/2026 15:09:24

Recommendations

Trust Board are asked to:

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

Close, Holly
29/10/2026 15:09:24

Effective Oversight: Escalation and Assurance

Report to:	**Board of Directors held in Public**	**Meeting date:**	**TBC**
Report from:	**Finance & Performance Committee**	**Meeting date:**	**23/09/2026**
Quorate?	**Yes ☒ No ☐**		
Members present	Cleveland Henry (Chair/NED) Mark Rawcliffe (NED), Warren Brown (NED), Mike Woodhead, Tim Rycroft, Farhan Rafiq		
In attendance	Fran Stead, Jess Greenwood-Owens (Secretary), Michelle Holgate, Chris Dixon Timed Business: Alexander Trigg, Catherine Sunter		
Observers	N/A		
Apologies	Philippa Hubbard, Kelly Barker, Jo Harrison, Therese Patten, Dr Sal Uka, Clare Risdon		
Best Quality Services	**Theme 3** – Improving the experience of people using our services		**BQS:T3**
Agenda items	• Trust Risk Appetite Matrix • Minutes of the previous meetings and AAAD report • Matters arising • Action log • Integrated Strategic Performance and Quality Report (including NHS Oversight Framework) • AAAD: Senior Leadership Team Care Group Accountability Meeting • Organisational Sustainability Board (OSPB) Update • Finance Report (including Capital Expenditure) • Deconstructing the Block • Data Quality Update • Activity Based Budgeting • Better Information Better Outcomes Business Case • Green Plan Update (Annual Report and 6-Monthly Report) • Place Provider Partnership Due Diligence • Proposed Sale of Somerset House • Lynfield Mount Hospital Redevelopment • Lynfield Mount Hospital Project Board Minutes • Provider Capability Assessment 2026 • Well-Led Implementation Plan Update • Board Assurance Framework • Strategic Risk Report • Digital Update • Annual Workplan 2026/27		

Close Holly 29/10/2026 15:09:24

	• Confirmation of Escalation Reporting (Strategic Priority Assurance Levels and AAAD Reporting) • Experts at Hand • Meeting Evaluation
Alert items agreed by Committee	• Significant delivery risks remain against the Cost Improvement Programme (CIP), including delivery of recurrent savings, management of out-of-area placement expenditure and achievement of financial targets. Further evidence was required to demonstrate that recovery actions would deliver the planned benefits. • Risks associated with the national deconstructing the block programme were noted, including the potential impact of national productivity assumptions and future funding allocations.
Advise items agreed by Committee	• Continued focus was advised on delivery of the Data Quality Improvement Plan and Better Information, Better Outcomes programme to support productivity, activity-based planning, improved reporting and protection of future income. • Ongoing monitoring of workforce wellbeing was advised as operational recovery actions and improvement programmes continued, recognising the pressures associated with new ways of working and service transformation. • In-principle support was given to progression of the Experts at Hand programme, subject to further development of workforce, financial and sustainability arrangements.
Assure items agreed by Committee	• The Trust remained in Segment 2 of the NHS Oversight Framework, reflecting sustained improvement across a range of performance measures, including crisis access standards, health visiting contacts, vacancy reduction and financial delivery. • Recovery actions overseen through OSPB had begun to demonstrate positive impact, including reductions in out-of-area placements, improved patient flow and strengthened operational oversight. • Governance arrangements for the Data Quality Improvement Plan and associated business case, including strengthened oversight, delivery structures and monitoring arrangements. • The proposed disposal of Somerset House represents value for money, with an offer received above valuation. The Committee recommends to Board that the sale be actioned.
Decisions made by Committee Close Holly 29/10/2026 15:09:24	The Committee approved: • Minutes of the previous meetings and AAAD report • Action log • Finance Report (including Capital Expenditure) • Deconstructing the Block • Proposed Sale of Somerset House

	• Provider Capability Assessment 2026 • Well-Led Implementation Plan Update • Board Assurance Framework • Strategic Risk Report In-Principle Support provided for the item Experts at Hand.		
New risks identified by Committee	No new risks were identified.		
Items to be considered by other Committees/Groups	• Digital deep-dive session to be arranged outside the Committee to report back to FPC.		
Feedback following discussion at 'parent' meeting	TBC		
Report completed by	Corporate Governance Officer	**Date**	28/09/2026
On Behalf of Chair	Cleveland Henry		

Close Holly
29/10/2026 15:09:24

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Trust Board Meeting

5th November 2026

Paper title:	NHS England Quarterly Return Declaration	**Agenda Item** **XX**
Presented by:	Mike Woodhead, Chief Finance Officer	
Prepared by:	Claire Risdon, Operational Director of Finance	
Committees where content has been discussed previously		
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	
	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 29/10/2026 15:09:24

Purpose of the report

The purpose of this report is to share the recommendation from the Finance & Performance Committee that the Trust Board formally approve the Quarter 2 NHS England financial submission.

Executive Summary

The purpose of this report is to request that the Trust Board approve the Quarter 2 NHS England financial submission endorsed by the Finance & Performance Committee.

Key headlines are as follows:

- **Revenue -** Trust performance for the period April 2026 to September 2026 is a deficit of £1.69m which is as planned. The Trust is forecasting a breakeven position.
- **CIP performance** is currently £1.7m adverse to plan year-to-date and is forecast to be £4.6m behind target at year end. This variance is being mitigated through the utilisation of Trust contingency and other non-recurrent measures, maintaining delivery of the overall financial position.
- **Capital -** Total Trust capital YTD expenditure is £12.2m against a plan of £15.9m resulting in a variance of £3.7 YTD. Forecast capital expenditure is as planned.
- Closing **Cash** balance at the end of September 2026 of £41.0m.
- **Agency Expenditure** - YTD agency expenditure is £1.7m which is a favourable variance of £0.5m against plan of £2.2m. Forecast agency expenditure is £2.9m against a plan of £3.7m giving a favourable variance of £0.8m.
- **Bank Expenditure** - YTD bank expenditure is £6.7m which is an adverse variance of £1.0m against plan of £5.7m. Forecast bank expenditure is £12.5m against a plan of £11.2m giving an adverse variance of £1.3m.
- **NHS Oversight Framework rating** – segment 2.

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:

- Approve the quarterly submission made to NHSE on 14th October 2026.

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Trust Board Meeting

5th November 2026

NHS England Quarterly Return and Declaration

1 Background and Context

NHS Foundation Trusts are required to make quarterly submissions to NHS England to confirm their risk rating under the National Performance Assurance Framework rating. From 2025, the National Performance Assurance Framework replaced the NHS Oversight & Assessment Framework. For providers, the segmentation rating reflects a single consolidated rating which informs the level of support and intervention from the regulators.

The Trust is not currently reporting an UoR rating as reporting is suspended.

2 Considerations

The key points are that the Trust has delivered the following financial indicators for quarter 2 of 2026/27:

- **Revenue -** Trust performance for the period April 2026 to September 2026 is a deficit of £1.69m which is as planned. The Trust is forecasting a breakeven position.
- The **Cost Improvement Programme** is on plan YTD and forecast in September 2026. This position has been mitigated by non-recurrent measures.
- **Capital -** Total Trust capital YTD expenditure is £12.2m against a plan of £15.9m resulting in a variance of £3.7 YTD. Forecast capital expenditure is as planned.
- Closing **Cash** balance at the end of September 2026 of £41.0m.
- **Agency Expenditure** - YTD agency expenditure is £1.7m which is a favourable variance of £0.5m against plan of £2.2m. Forecast agency expenditure is £2.9m against a plan of £3.7m giving a favourable variance of £0.8m.
- **Bank Expenditure** - YTD bank expenditure is £6.7m which is an adverse variance of £1.0m against plan of £5.7m. Forecast bank expenditure is £12.5m against a plan of £11.2m giving an adverse variance of £1.3m.
- **NHS Oversight Framework rating** – segment 2.

The Month 6 financial templates were submitted to NHSE on the 14th October 2026 in line with national timescales.

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3 Implications

3.1 Legal and Constitutional

There are no legal or constitutional requirements in relation to this paper.

3.2 Resource

There are no direct financial implications / costs associated with this paper.

3.3 Quality and Compliance

Financial performance is a key measure under the NHS England National Performance Assurance Framework rating. Any cost improvements planned by the Trust are subject to a Quality Impact Assessment process overseen by the Medical Director and the Chief Operating Officer.

4 Communication and Involvement

The Board was sighted on key plan risks and additional scrutiny of key assumptions, risks and mitigation takes place at every Finance & Performance Committee. Key messages are discussed through the Trust's Senior Leadership Team and through the Trust's current command structures.

5 Monitoring and review

The Finance & Performance Committee review and formally recommend the NHS England Quarterly submission to Trust Board following each quarter end.

Name of author/s	Claire Risdon
Title/s	Operational Director of Finance
Date paper written	13th October 2026

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Board of Directors – Meeting held in Public

5 November 2026

Paper title:	LMH Redevelopment Stage 5 Design Derogations	**Agenda Item** **17**
Presented by:	Mike Woodhead, Chief Finance Officer	
Prepared by:	Jonathan Clarkson, Head of Capital Developments & Property	
Committees where content has been discussed previously	LMH Redevelopment Project Delivery Group: 27 October LMH Redevelopment Project Board: 30 October Finance & Performance Committee (Virtual): 30 October	
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	
	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	X
Making Best Use of Resources	Financial sustainability	X
	Our environment and workplace	X
	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 seek Trust Board approval of the LMH Redevelopment Stage 5 Design Derogation Schedule, following review and endorsement through the established project and committee governance process.

Executive Summary	
• As a condition of the Full Business Case approval, any derogations relating to the LMH Redevelopment must be approved by Trust Board. Each derogation must be clearly identified, justified and assessed to confirm that safety, quality, compliance and operational requirements remain appropriately managed. • The Stage 5 Design Derogation Schedule is included as an attachment and provides the agreed record of the derogations, their justification and the controls supporting their acceptance. • Trust Board is asked to approve the Stage 5 Design Derogation Schedule. Approval will confirm the Stage 5 design baseline and provide a clear governance record for the management of the agreed derogations.	
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)
• Trust Board is asked to accept the recommendation of the LMH Redevelopment Project Board and Finance & Performance Committee and approve the LMH Redevelopment Stage 5 Design Derogation Schedule.

Links to the Strategic Organisational Risk register (SORR)	The work contained within this report links to the following corporate risks as identified in the SORR: • N/A	
Care Quality Commission domains	☒ Safe	☒ Caring

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Please check **ALL** that apply	☒ 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 schedule records agreed departures from, or alternative approaches to, relevant Health Building Notes and Health Technical Memoranda. Each derogation has been professionally reviewed and justified to provide assurance that associated safety, quality, compliance and operational risks are identified and appropriately managed.

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Board of Directors – Meeting held in Public

5 November 2026

LMH Redevelopment Stage 5 Design Derogations

1 Purpose

This paper presents the LMH Redevelopment Stage 5 Design Derogation Schedule for approval. A derogation is an agreed departure from, or alternative approach to, the guidance and recommended standards set out in the relevant Health Building Notes (HBNs) and Health Technical Memoranda (HTMs). HBNs provide guidance on healthcare facility planning and design, while HTMs provide technical guidance on the design, installation and operation of healthcare building systems. Each derogation must therefore be clearly identified, justified and assessed to confirm that safety, quality, compliance and operational requirements remain appropriately managed.

2 Proposed Outcome

- Trust Board approves the Stage 5 Design Derogation Schedule, following approval by the LMH Redevelopment Project Delivery Group and Project Board and endorsement by the Finance & Performance Committee.
- Approval provides a clear governance record that each derogation has been identified, justified, technically reviewed and appropriately managed.
- Following Trust Board approval, the schedule will form the agreed baseline for Stage 5 delivery, will be retained with the project assurance documentation Agreement that **Appendix A** as attached, can be submitted to NHSE/DHSC to facilitate closure of an outstanding Full Business Case submission.

3 Options

- **Option 1 – Approve the Appendix A schedule** (recommended): approves the reviewed derogations as the agreed basis for delivery, following endorsement by the Finance & Performance Committee, and satisfies the Full Business Case governance requirement.
- **Option 2 – Defer approval:** seek further information or assurance before a decision. This may delay confirmation of the Stage 5 design baseline and subsequent delivery activity on site.
- **Option 3 – Do not approve:** require the affected design matters to be reconsidered. This could result in redesign, programme delay and additional cost.

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- The LMH Redevelopment project team will remain responsible for maintaining the schedule, evidencing agreed controls and escalating any subsequent changes through the established change-control and governance arrangements.

4 Risk and Implications

- There is a risk that a derogation could introduce a safety, quality, compliance or operational impact if it is not clearly justified, controlled and reflected in the final design and project records.
- This risk has been mitigated through professional review by the Estates and Facilities Team, responses to the comments received, further clarification from McAvoy where required, and confirmation on 16 October 2026 that there were no further comments or objections.
- Approval supports safe and effective delivery by establishing a transparent record of the alternative design approaches and the basis on which they have been accepted.
- No separate resource requirement is requested through this paper. Any cost or programme implications associated with individual derogations will continue to be managed within the approved project controls and change-control process.

5 Results

- The Stage 5 Design Derogation Schedule was issued by McAvoy following completion of the detailed design and circulated to the Estates and Facilities Team on 8 October 2026. Comments received on 12 October 2026 were responded to, with additional clarification sought where required. The Estates and Facilities Team confirmed on 16 October 2026 that there were no further comments or objections.
- **Appendix A** was approved by the LMH Redevelopment Project Delivery Group on 27 October 2026 and is due to be submitted for approval to the LMH Redevelopment Project Board on 30 October 2026. It will also be considered virtually by the Finance & Performance Committee on 30 October 2026, with a recommendation that it be submitted to the Trust Board for final approval. **It should be noted that the above three approvals remain outstanding at the time of submission of this paper. Therefore, a verbal update will be provided at the Trust Board meeting on 5 November 2026.**
- Subject to Trust Board approval, the Stage 5 Design Derogation Schedule will be recorded as the approved Stage 5 baseline and retained within the project assurance records.
- Implementation will be monitored through design coordination, project assurance, inspection and change control. Any new or amended derogation will be reviewed and escalated through the appropriate governance route before acceptance.

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Jonathan Clarkson
Head of Capital Developments and Property
27 October 2026

HTM Title and Year	HTM Paragprah Number	HBN Clause Wording	Description of Derogation/Issue	Derogation Reason / Benefit	Summary
HTM 04-01 A Safe water in healthcare premises - Design, installation and commissioning (2016)	9.11	When separate drinking-water systems have been provided, the policy has normally been to distribute directly from the mains without storage (nor softening), with stored cold water (down service) being used solely for supplies to WCs, wash-hand basins etc. Providing drinking water without storage may not be appropriate in healthcare premises because of the need to have some security of supply. The advantage of separate drinking and cold water services chiefly lies in the possibility of treating the latter (softening or other forms of treatment) without adulterating the drinking, cooking and food preparation supplies. The WSG should define a strategy either for separate supplies or for restricting the extent of softening (see also	Security of supply is a key element for Healthcare premises and as such all domestic water services within the building will be fed via the cold water storage tanks. Any requirement for water treatment to combat hard water be achieved via a non-softened approach. HTM 04-01 part A clause 9.12 & 9.13 and Part B clause 7.30 note 1 suggest that connection to a well-used potable supply is preferable rather than a dedicated drinking water	As all water supplies are from a potable distribution system, drinking water outlets will be connected to that system to avoid duplication of distribution	Improves resilience during a mains water outage because all outlets can continue to be supplied from stored water. However, drinking water will spend longer in storage, increasing reliance on regular tank inspection, cleaning and water quality management. Failure to maintain the system could increase water hygiene risks.
HTM 04-01 A Safe water in healthcare premises - Design, installation and commissioning (2016)	9.2	Cold water pipework runs should be designed and installed to reduce the risk of heat gain and should not be above or near heat sources including ceiling-mounted radiant heating panels. Cold water service mains should be run within a different ceiling space, riser or zone from other heat sources. This includes the hot water service distribution system and steam supply. If not possible, the cold water service and hot water services should be run apart as far as practicable and preferably with the hot water at a higher level	Cold water pipework will not be run in a different zone from heat sources, nor at a different level to hot water pipework within the ceiling zone, as it is not practical to do so. The pipework will be fully insulated and has been sized to reduce low flow in order to reduce the effects of heat gain. The services will be distributed as far as practicable to separate	Not practical to run pipework in different zones.	Cold water temperatures may increase due to heat gain from nearby services. This increases the risk of water temperatures entering the range that can promote bacterial growth, including Legionella. Although insulation and pipe sizing mitigate the risk, additional monitoring and management may be required throughout the building's life.
HTM 03-01 A Specialised ventilation for healthcare premises Part A: The concept, design, specification, installation and acceptance testing of healthcare ventilation systems (2021)	9.131	Rectangular ducting with an aspect ratio of 1:1 is preferred but ratios of up to 3:1 are acceptable where there are space constraints. Circular spiral-wound or flatoval are also acceptable providing they meet the leakage standard when tested (see Note after paragraph 9.136). Flexible ductwork is not suitable for air distribution in healthcare applications. In situations where solid ductwork cannot be used, flexible ductwork may be used to make the final connection to a terminal providing it does not exceed 0.5 m in length, is extended as far as possible and is never	Flexible ductwork will be utilised for the connection to grilles.	Flexible connections to grilles allows for easier coordination.	Simplifies installation but may be less durable and harder to clean than rigid ductwork. Poor installation could reduce ventilation efficiency over time and make maintenance more difficult.
HTM 03-01 A Specialised ventilation for healthcare premises Part A: The concept, design, specification, installation and acceptance testing of healthcare ventilation systems (2021)	9.8	Note: Plantrooms should be provided with a sink so that glass drainage traps may be cleaned out and staff can wash their hands after handling contaminated/dirty filters. A source of domestic hot water (DHW) with a valved hose connection point will also be required so that AHUs can be washed out internally as part of their routine maintenance. Plantrooms at	The roof plantroom is not being served by a dedicated lift as it is not reasonably practical to include in layout.	Not practical to include in layout.	Maintenance staff will need to transport tools, filters and replacement equipment via stairs or alternative routes. This may increase maintenance costs, replacement costs and manual handling risks throughout the life of the facility.
HTM 03-01 A Specialised ventilation for healthcare premises Part A: The concept, design, specification, installation and acceptance testing of healthcare ventilation systems (2021)	9.8	Note: Plantrooms should be provided with a sink so that glass drainage traps may be cleaned out and staff can wash their hands after handling contaminated/dirty filters. A source of domestic hot water (DHW) with a valved hose connection point will also be required so that AHUs can be washed out internally as part of their routine maintenance. Plantrooms at	The roof plantroom has not got a dedicated sink or bib tap.	Plantroom is on roof so no allowance was made at Stage 4.	Maintenance activities such as cleaning AHUs and drainage traps will be more difficult and time-consuming because water will need to be brought from elsewhere in the building. This may increase maintenance costs and reduce compliance with HTM best practice.
HTM 03-01 A Specialised ventilation for healthcare premises Part A: The concept, design, specification, installation and acceptance testing of healthcare ventilation systems (2021)	9.166	Attenuator units with a soundabsorbing in-fill suitable for the quality of air being handled and protected by a perforated sheet metal casing are the preferred option. Absorption of moisture, dirt and corrosive substances into the "infill" and the release of fibrous particles into the airstream should be prevented using a membrane with a declared service life of at least 25 years. If these conditions can be met, the attenuator may be located in the supply ductwork downstream of the final	Manufactures do not offer 25 year life service. Certification for life span will not be provided.	Manufactures do not offer 25 year life service. Certification for life span will not be provided.	There is no assurance that the acoustic attenuator materials will retain their performance for the expected design life. The Trust may face earlier replacement costs if performance deteriorates.
HTM 03-01 A Specialised ventilation for healthcare premises Part A: The concept, design, specification, installation and acceptance testing of healthcare ventilation systems (2021)	9.195	The basic requirements for an automatic control system are as follows: • plant start, run, set-back and stop sequence; • control of the volumetric airflow; • control of the system or room pressure; • temperature control and indication; • humidity control and indication; • devices to monitor and indicate the plant's operating state; • alarms to indicate plant failure, low airflow, and filter state; • the facility to collect data of actual usage and energy consumption. The control functions actually provided will depend on the purpose of the ventilation	The BMS can control pressure or volume but not both. On general systems AHU flow will be controlled to a constant pressure.	BMS cannot control both pressure and volume.	The ventilation system will operate correctly but with reduced control flexibility. This may reduce opportunities to optimise energy efficiency and ventilation performance when building usage changes.
HTM 06-01 Lighting Guide 02		Mental Health - Secion 6 Ensuites need to achieve 500lux Accessible Ensuite need to achieve 500 lux Quiet lounge need to achieve 300kux Assisted bathroom need to achieve 500	In CAD21 environmental drawings ensuite required 150lux Accessible ensuite require 200lux Quiet lounge require 200lux Assisted bathroom require 200lux	From DSSR lighting calculation with same light fittings as CAD21 designed. Ensuite get 277lux Accessible ensuite 200lux Quiet Lounge 287lux Assisted Bathroom 226lux	Several areas will be more dimly lit than recommended guidance levels. This may affect comfort, visibility and certain care activities, and leaves the Trust knowingly accepting lighting levels below current best practice.
HTM -08-02 Lifts		Lift sizes - derogation due to providing 2No. lifts with a weight limit of 1350kg each with a 1000mm opening and 1220mm x2500mm internal dimensions each. This is a betterment to what you had agreed with internal stakeholders but is a derogation to the HTMs,			
HTM 08-01 Acoustics (2013)	2.11	The absorbent treatment will normally be a ceiling. However, floor finishes (for example carpet) or wall panels may also be considered. Acoustically-absorbent materials should have a minimum absorption area equivalent to a Class C absorber (as defined in BS EN ISO 11654:1997) covering at least 80% of the area of the floor, in addition to the absorption that	Category 3 acoustic ceilings were not proposed as part of the Stage 4 design which MCA are working to. This puts the spaces at risk of increased reverberation which is required under HTM.	Category 3 ceilings / materials are not feasible due to the user-group durability requirements. This was noted by P+HS as part of their Stage 4 design, and should have been raised at Stage 4. Mitigation method for reverberation include soft-furnishings and wall-coverings.	

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Board of Directors – Meeting Held in Public

5th November 2026

Paper title:	Integrated Strategic Performance and Quality Report – October 2026	**Agenda Item** **18.0**
Presented by:	Phil Hubbard – Acting Chief Executive 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 **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

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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 October 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 (Quarter 1 of 2026/27) remains as 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 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 and high performance against 18-week waits, maintaining NOF 1 performance for both.
- Sustained delivery of crisis access standards, with over 90% 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.
- Delivery of the financial plan at Month 6 and retention of a forecast breakeven position.

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Principal Areas Requiring Continued Board Oversight

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. September delivered 797 OAP bed days against a planned trajectory of 668; however it should be noted this is lowest number of monthly OAP bed days for over two years. Recovery activity continues to be accelerated through the Trust-wide Purposeful and Productive Flow Command Sprint.

Community Dental Services continue to perform below the national RTT standard. There was a period of recovery over recent months due to longstanding workforce and General Anaesthetic theatre capacity constraints that are recognised across West Yorkshire. The recent drop in performance is mainly due to theatre cancellations because of the ongoing change in Electronic Patients Record systems at the Acute provider.

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. Improvement is noted during quarter 2 and anticipated to improve significantly during the second half of 2026/27.

Workforce

Sickness absence remains the most significant workforce challenge at 7.06%, 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 £4.6m CIP shortfall which is presently mitigated through non-recurrent actions. Additional executive controls, weekly oversight arrangements and productivity improvement programmes are in place to reduce financial risk and support sustainable delivery of the financial plan.

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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
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.

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
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 NHS oversight framework describes how NHS England's oversight of NHS trusts, foundation trusts and integrated care boards operates. Oversight metrics are used to indicate potential issues and prompt further investigation of support needs and align with the five national themes of the NHS oversight framework: quality of care, access and outcomes; preventing ill

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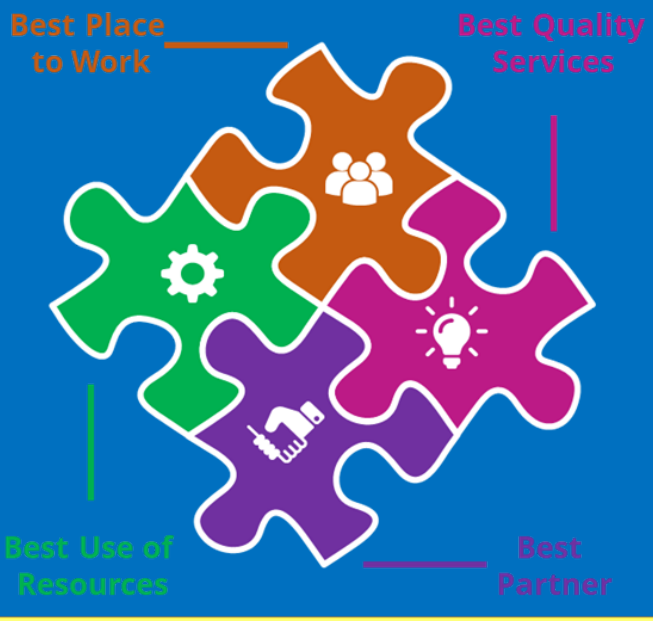
	health and reducing inequalities; people; finance and use of resources; and leadership and capability.

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NHS
Bradford District Care
NHS Foundation Trust

Integrated Strategic Performance And Quality Report

October 2026 (September 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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Themes Observed Within This Report

Overall summary: Overall performance presents a mixed but increasingly clear picture. There are important areas of sustained strength, including crisis responsiveness, community physical health access, 0–19 contacts, safe discharge measures, restrictive practice reduction and overall workforce stability. However, these strengths are offset by interconnected pressures across mental health access and inpatient flow, workforce sickness and financial sustainability. OAP use and length of stay remain challenging, sickness absence is worsening despite otherwise stable workforce indicators, and the breakeven forecast remains dependent on addressing the CIP gap and converting transformation into recurrent savings. Data quality is a cross-cutting assurance issue, particularly across mental health access, outcomes, workforce processes and activity/cost reporting, and strengthening confidence in the data should remain a core Board priority.

Key triangulated themes within this report are:

1 - Workforce pressure appears to be a common factor behind operational and financial pressure

Whilst the vacancy rate is relatively low, and turnover is within target sickness levels are above target. This appears to have translated to bank expenditure being above the gap due to vacancies, sickness and patient acuity. Although substantive staffing underspends provides some mitigation. Mental health inpatient services appear to be an important point where people, operational flow and financial pressures intersect. The bigger workforce risk may therefore be effective workforce availability rather than headline establishment.

2 - Mental health flow is the clearest operational pressure

Post-discharge performance appears comparatively strong, and delayed occupancy is within threshold, yet length of stay and OAP usage remain problematic. That suggests the flow problem cannot be explained solely by formally recorded delayed discharges. Therefore, the challenge appears to be **whole-pathway flow**, from timely community intervention through admission avoidance, inpatient stay and discharge. The Flow Command Sprint therefore provides a sensible unifying improvement response.

3 – Financial balance is being maintained but is not yet sustainable

The headline position is positive: the Trust remains on plan and forecasts breakeven. Agency expenditure is also within cap. However, underneath this is a £4.6m forecast CIP shortfall, currently mitigated non-recurrently, a £3.2m residual risk requiring further action, and a £1.0m YTD bank cap breach. The Trust is also in NHS England's "Watch category" because of concerns about deliverability. Therefore, the financial plan is currently being delivered, but assurance over its sustainability remains constrained by the reliance on non-recurrent mitigation and the need to convert transformation opportunities into recurrent savings

4 – Access performance is polarised

Strong areas include community waits under 18 weeks. 0-19 mandated contacts and urgent community response. However significant pressure exists elsewhere within Community Dental and Community Mental Health. A more in-depth report is being pulled together to support the board in identifying access areas that would benefit from particular focus.

5 – Data quality is a strategic performance risk

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This appears repeatedly across the report:

- CYP 104-week waits are materially affected by historic recording of clock stops, SNOMED codes and outcome measures.
- Paired outcome recording is below threshold in both adults and CYP.
- Community MH four-week reporting still requires final agreement on the definition and SNOMED codes.
- EPR changes have improved confidence in crisis response reporting.
- RTW conversations are reportedly occurring but are not consistently recorded.
- Relative cost performance is affected by activity classification, with 31% of activity reported in unclassified/other categories.

These areas are being picked up through our Data Quality Improvement Working Group (DQIWG) and are central to our Data Quality Improvement Plan.

Good news stories for celebration

Crisis Response - 90.1% of urgent crisis referrals received face-to-face contact within 24 hours against an 80% target, and improved EPR configuration has increased confidence in the measure. One of the three teams remains below target however work is ongoing with this team, indicating potential to continue to improve performance against this measure.

Community Physical Health Access - Performance is particularly **strong: 94.79% are waiting under 18 weeks against the 78% NOF threshold**. The reported community long-wait position also remains very low.

Safe Mantal Health Discharge - Adult acute mental health readmissions within 14 days are 2% against a ≤5% threshold, and 72-hour follow-up is 81.67% against 80%. Together these provide a positive picture around continuity immediately following discharge.

Core Workforce Stability - Despite the sickness challenge, vacancies and turnover remain within target, clinical supervision and mandatory training are above target, temporary staffing usage is reported ahead of workforce plan, and the National Education and Training Survey score is 85.32%, NOF1.

Restrictive Practice - September recorded one prone-restraint incident, one seclusion incident and no segregation episodes**. The wider narrative also reports a 55% reduction in seclusion over the improvement period and recent No Force First reaccreditation**

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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
Community Dental 18 Week Waiting Times	ATS		0-19 - Antenatal Contact	ATS		% of Urgent Community Responses within 2 hours	EXC	
Inappropriate Out of Area Placement bed days	EXC		0-19 - New Birth Visit	ATS		Labour Turnover	P	
Return to work interview after sickness absence	P		0-19 - 6 to 8 Week Contact	ATS		Duty Fulfilment of Bank %	P	New
Time to fill a vacancy	P		0-19 - 12 Month Review	ATS		Duty Fulfilment of Agency %	P	New
Forecast Performance Against CIP Plan	FP		0-19 - 2 to 2.5 Year Review	ATS		Vacancy Rate	P	
Financial risk assessment of delivering the Plan	FP		No Force first - Prone Restraint	QPS		Variation from budgeted establishment	P	
Performance against bank cap limit	FP		No force first – Seclusion	QPS		Appraisal compliance	P	
			No force first – Segregation	QPS		Clinical supervision	P	
			Medication Incidents	QPS		Mandatory training	P	
Variable Performance	Domain	Last Report	Avoidable Harm - Pressure Ulcers: Total	QPS		Performance against agency cap limit	FP	
Number of employee relations cases (Open at a point in time)	P		Avoidable Harm - pressure ulcers: ulcers moderate or above with omissions	QPS		Cash ratio	FP	
			% Red Shifts (Mental Health Inpatients)	QPS		Capital Performance YTD	FP	
			% of Ward Occupancy Delayed for Acute Wards	EXC		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

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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 1 20206/27 (Latest Published Quarter)** **OVERALL TRAST RANKING = NOF 2**

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
% Children and Young People's mental health waits over 104 weeks	Access to Services	New for NOF but Red last report ⇔	Sickness Absence	People and Workforce	4 ⇑	CQC Community MH Satisfaction Score	Experience of Care	2 ⇔	Percent waiting 52 weeks for community services	Access to services	1 ⇔
% of people discharged community MH services with a paired outcome	Access to Services	N/A (New)				Mean LOS for patients discharged from adult acute mental health/PICU	Experience of Care	N/A (New)	Percentage of patients waiting < 18 weeks for community services	Access to services	N/A (New)
Temporary staffing cost relative band	People and Workforce	N/A (New)				NHS staff survey advocacy rate	Experience of Care	N/A (New)	% Patients in Crisis F2F Within 24 hrs	Patient Safety	1 ⇔
% of IP referred to and seen by an in-house tobacco service	Effectiveness of Care and Population Health	N/A (New)				Mean length of stay for patients discharged from older adult acute mental bed	Experience of Care	N/A (New)	% of discharges adult acute MH beds readmitted within 14 days	Effectiveness of Care and Population Health	N/A (New)**
						Adult acute and rehab MH, LD and autism discharges F/Up within 72 hours	Effectiveness of Care and Population Health	N/A (New)	Combined Finance (Planned Surplus / deficit + YTD Variance)	Finance, Productivity, Innovation	1 ⇔
						NHS Staff Survey – Raising Concern Score	Patient Safety	2 ⇔	% of clinical trials set up within 90 days	Finance, Productivity, Innovation	N/A (New)
						Relative Difference in Costs	Finance, Productivity, Innovation	2 ⇔	NET Survey overall experience sub-score	People and Workforce	N/A (New)
						Overall Data Quality Maturity Index score	Finance, Productivity, Innovation	N/A (New)	NHS staff standards sub-score	People and Workforce	N/A (New)
						NHS Staff Survey Engagement Score	People and Workforce	2 ⇔			
						% frontline workers to receive a flu vaccination	People and Workforce	N/A (New)			

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

** BDCFTs readmission figures were suppressed from NOF scoring / published data for Q1 due to low numbers

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	Q1 2026/27	0 (NOF 1)	0 (NOF 1)	-	Data quality confidence to be added next time
PH Community	NOF	Percentage of patients waiting under 18 weeks for community services Link to Slide	Q1 2026/27	94.79% (NOF 1)	>= 78% (NOF 1)	16.79%	
MH CYP	NOF & Planning	Proportion of total open CYP MH related waits that are over 104 weeks Link to Slide	Q1 2026/27	51% (NOF 4)	<5% (NOF1) 0 by Mar 27 (planning)	46%	
MH Community	-	Community Mental Health - % of people seen within 4 weeks Link to Slide	September 2026	27.3%	No set target	-	
MH CYP & Adults	NOF	% of people discharged from community mental health services with a paired outcome score recorded (all ages) Link to Slide	Q1 2026/27	CYP 9.4% (NOF 4) Adult 8% (NOF 2) NOF 4 Overall	CYP >= 28% Adult >= 12% (NOF 1)	CYP 18.6% Adult 4%	
Dental	-	Consultant-led waiting times - Community Dental Services - % waiting over 18 weeks Link to Slide	September 2026	50.1%	92%	-41.9%	
PH 0-19	-	0-19 Mandated Contacts - Antenatal Contact Link to Slide	Q2 2026/27	69.9%	55.0%	14.9% above target	
PH 0-19	-	0-19 Mandated Contacts - New Birth Visit Link to Slide	Q2 2026/27	98.3%	90.0%	8.3% above target	
PH 0-19	-	0-19 Mandated Contacts - 6 to 8 Week Contact Link to Slide	Q2 2026/27	97.5%	90.0%	7.5% above target	
PH 0-19	-	0-19 Mandated Contacts - 12 Month Review Link to Slide	Q2 2026/27	97.0%	90.0%	7.0% above target	
PH 0-19	-	0-19 Mandated Contacts - 2 to 2.5 Year Review Link to Slide	Q2 2026/27	95.1%	85.0%	10.1% 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	6.80 (NOF 2)	See narrative	-	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	Q1 2026/27	90.1%	80%+ (NOF 1)	10.1%	
All	-	Sexual Safety (no slide yet)	New Standard - Reporting To Be Developed				
All	-	No Force first - Prone Restraint Link to Slide	September 2026	1	No Set Target (See Note)	N/A	
All	-	No force first – Seclusion Link to Slide	September 2026	1	No Set Target (See Note)	N/A	
All	-	No force first – Segregation Link to Slide	September 2026	0	No Set Target (See Note)	N/A	
All	-	Medication Incidents Link to Slide	Q1 2026/27	243	No Set Target	N/A	
All	-	Avoidable Harm - pressure ulcers: Total Link to Slide	September 2026	148	No Set Target (See Note)	N/A	
PH Community	-	Avoidable Harm - pressure ulcers: ulcers moderate or above with omissions Link to Slide	September 2026	55	No Set Target (See Note)	N/A	
All	-	Falls – Total reported Link to Slide	September 2026	22	No Set Target (See Note)	N/A	
All	-	Safer staffing - % of hours utilised for enhanced observations (no slide yet)			No Set Target (See Note)	N/A	
All	-	% Red Shifts (Mental Health Inpatients) (no slide yet)	September 2026	0	No Set Target (See Note)	N/A	
All	-	% Black shifts Opel Rating (Physical Health services) (no slide yet)	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.

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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	% of discharges from adult acute mental health beds which were readmitted within 14 days of discharge Link to Slide	Q1 2026/27	2% (NOF 1)	5% and Lower (NOF 1)	3%	Data quality confidence to be added next time
Inpatients	NOF – ICB Metric	% of admissions to acute mental health beds for people who have had no care contacts in 365 days before admission (ICB Scoring Measure) Link to Slide	Q1 2026/27	15% (NOF 3)	5% and Lower (NOF 1)	10%	
MH	NOF	Adult acute and rehab mental health, LD and autism discharges followed up within 72 hours Link to Slide	Q1 2026/27	81.67% (NOF 1)	80% (NOF 1)	1.67%	
Talking Therapies	NOF	Percentage of NHS talking therapies patients completing a course of treatment and achieving reliable recovery Link to Slide	Q1 2026/27	50.0% (NOF 2)	51% March 2027	1%	

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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	September 2026	797	On / under Trajectory (668 September)	129	Data quality confidence to be added next time
Inpatients	-	% of ward occupancy delayed for Acute Wards Link to Slide	September 2026	6.6%	10% and under	-3.4%	
Inpatients	NOF	Mean length of stay for adult acute and psychiatric intensive care unit (PICU) patients (new measure) Link to Slide	Q1 2026/27	56 (NOF 3)	51 March 2027 – Planning (<=40 for NOF 1)	5	
Inpatients	NOF	Mean length of stay for older adult acute discharges (new measure) Link to Slide	Q1 2026/27	81 (NOF 2)	76 March 2027 – Planning (<=73 for NOF 1)	3	
PH Community	Planning	% of Urgent Community Responses within 2 hours Link to Slide	August 2026	72.0%	70%	2%	
MH All	NOF	CQC community mental health service satisfaction rate Link to Slide	Q1 2026/27	As Expected (NOF 2)	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	September 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	Q1 2026/27	7.06%	4% (NOF 1)	3.06% above target	
All	-	Return to work interview after sickness absence Link to Slide	September 2026	51.55%	95%	43.45% below target	
All	-	Labour Turnover Link to Slide	September 2026	9.31%	10%	0.69% within target	
All	-	Duty Fulfilment of Bank % (slide to be developed)	September 2026	22.14%	20-25%	Within target range	
All	-	Duty Fulfilment of Agency % (slide to be developed)	September 2026	0.44%	2%	0.56% within target	
All	-	Time to fill a vacancy (slide to be developed)	September 2026	11	8 Weeks (as set by NHS E)	3 weeks above target	
All	-	Number of employee relations cases (open cases at a point in time) Link to Slide	September 2026	36	30	6 cases above target	
All	-	Vacancy Rate Link to Slide	September 2026	6.81%	10%	3.19% within target	
All	-	Variation from budgeted establishment Link to Slide	September 2026	224.70	350	125.3 within target	
All	-	Appraisal compliance Link to Slide	September 2026	79.55%	80%	0.45% within target	
All	-	Clinical supervision Link to Slide	September 2026	83.36%	80%	3.36% above target	
All	-	Mandatory training Link to Slide	September 2026	91.07%	80%	11.07% above target	
All	NOF	National Education and Training Survey overall experience sub-score - new measure Link to Slide	Q1 2026/27	85.32% (NOF 1)	Based on rank	-	
All	NOF	NHS Staff Standards sub-score (slide to be developed)	Annual	7.97 out of 10 (NOF 1)	Based on rank	-	
All	NOF	Percentage of frontline healthcare workers to receive a flu vaccination (slide to be developed)	Q1 2025/26 (annual)	46% (NOF 2)	Based on rank	-	
All	NOF	Temporary staffing cost relative band (slide to be developed)	Q1 2026/27	NOF 4	TBC	-	

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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 M5. 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.

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Strategic Indicators – Finance and Productivity - 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	Forecast outturn against plan Link to Slide	September 2026	Breakeven	On or better than plan (NOF1)	Breakeven	High
All	-	Forecast Performance Against CIP Plan (no slide yet)	September 2026	CIP delivery is forecast to be offtrack by £4.6m (non recurrently mitigated)	On or better than plan	£4.6m off track	High
ALL	-	Financial risk assessment of delivering the Plan (no slide yet)	September 2026	Best Case Risk £0m Likely Case Risk £3.2m Worse Case Risk £8.8m	Risks fully mitigated	£3.2m mitigations to find	High
All	-	Performance against agency cap limit (no slide yet)	September 2026	Forecast Achievement of planned agency expenditure	On or better than plan	Within Agency cap	High
All	-	Performance against bank cap limit (no slide yet)	September 2026	Breached by £1.0m	On or better than plan	£1.0m breach	High
All	-	Cash ratio (no slide yet)	September 2026	FOT = 1.62	Ratio of 1 or more	1.62	High
All	-	Capital Performance YTD (no slide yet)	September 2026	Underspent against plan by £3.7m	Achievement of Plan	Under by £3.7m	High
All	-	Capital Performance Forecast (no slide yet)	September 2026	Forecast Achievement of Plan	Achievement of Plan	At plan	High
All	NOF	Relative difference to cost Link to Slide	December 2025	106.45 (NOF 2)	NCCI 100 or lower (Annual)	106.45	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.

Reported Position

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 £3.2m 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.

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Financial Risk assessment

The main risks continue to arise from the delivery risk on the CIP programme. A forecast £4.6m CIP shortfall is reported in the financial position at Month 6, with non recurrent mitigation plans identified to cover the risk. The risk of further deterioration has been assessed between £2m to £5.1m.

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 6, taking account of the upside and downside risks highlight that a further £3.2m of actions are needed to fully de-risk the position (£2.3m before the fair deal for nurses' impact). This is a decrease in the overall risk assessment from Month 5 of £1.1m (likely risk at month 5 was £4.3m).

Management actions

Recovery actions are focused on strengthening operational grip and control, accelerating transformation and converting identified opportunities into sustainable, cash-releasing savings. The Purposeful & Productive programme is showing early positive operational indicators, while further savings opportunities are being progressed across service transformation, automation, Digital and People Services; immediate priorities are to complete the recovery sprints, close remaining savings gaps, take firm decisions on transformation and corporate opportunities, and demonstrate clear financial benefit against the forecast CIP shortfall.

Reporting breaches

At Month 6, the Trust is within its planned Agency costs for both year-to-date and forecast. The Trust is forecast to be within its Agency cap of £3.1m.

The Bank cap has been breached by £1m YTD and forecast to by £1.3m at the year end. This is driven by vacancies, sickness and patient acuity. Substantive staffing underspends are mitigating the bank cap breach (YTD underspend £1.7m and forecast underspend £2.4m). The Enhanced Therapeutic and Observations of Care (ETOC) programme has produced ward based action plans.

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Mental Health Care Group – Service Area Heat Map

Service Area Heat Map

	Criteria							
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	September 2026	September 2026	September 2026	September 2026	2025 Survey	September 2026	September 2026	N/A
Inpatients	13.97%	11.19%	B – 2021 A – 62	0	6.59 (average)	£2,770k	£937k	Measures to be confirmed
CMHT / Adult Community	6.82%	10.34%	B – 25 A – 12	0	6.82	£21k	£0k	
OPMH	9.72%	6.29%	B – 273 A – 7	0	6.82	£640k	£0k	
Learning Disabilities	13.63%	9.98%	B – 314 A – 0	0	7.26	-£37k	£0k	
Acute Community Services	6.23%	9.20%	B – 197 A – 0	0	TBC	-£278k	£0k	
Talking Therapies	12.09%	7.98%	B – 14 A – 0	1	6.42	-£227k	£0k	
CAMHS	4.99%	11.51%	B – 58 A – 0	1	7.11	£36k	£189k	

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

Sickness monitoring is being supported by People matters colleagues, to support managers in sickness processes

We are looking at staff survey champions in teams to lead the survey from within the team, this approach has had significant success within physical health.

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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)	Number of Grievances	Staff Survey Engagement Score	Variance to Financial Plan	Performance Against CIP	Productivity
Data Period	September 2026	September 2026	September 2026	September 2026	2025 Survey	September 2026	September 2026	N/A
Community Nursing – Planned	6.94%	6.10%	B – 351 A – 0	0	7.37	£1,375k	£658k	Measures to be confirmed
Community Nursing - Unplanned	12.51%	3.10%	B – 167 A – 0	0	6.39			
End of Life Care	5.07%	5.97%	B – 3 A – 0	0	6.77	£0k	£0k	
AHPs – Podiatry	4.91%	4.96%	B – 0 A – 0	0	6.49	-£80k	£0k	
AHPs – Speech and Language	1.09%	10.28%	B – 210 A – 0	0	7.36	-£83k	£0k	
Public Health Nursing	11.76%	10.11%	B – 133 A – 0	0	6.32	£0k	£0k	
Specialist - LAC / YOT / Safeguarding	11.43%	8.20%	B – 38 A – 0	0	7.52	-£27k	£0k	
WYVIC – Vaccination and Immunisation	14.40%	6.54%	B – 20 A – 0	0	7.63	£0k	£0k	
Community Dental Services	9.33%	7.68%	B – 5 A – 0	0	6.38	-£369k	£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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Corporate Services – Service Area Heat Map

Service Area Heat Map

Service Area	Criteria						
	Sickness Absence	Labour Turnover	Temporary Staffing (% B&A)	Staff Survey Engagement Score	Variance to Financial Plan	Performance Against CIP	Productivity
Data Period	September 2026	September 2026	September 2026	2025 Survey	September 2026	September 2026	N/A
People Directorate	8.13%	9.38%	B – 10 A – 0	6.93	£31k	£0k	Measures to be confirmed
Finance	0.11%	5.89%	B – 0 A – 0	7.52	-£20k	-£5k	
Estates and Facilities	7.46%	9.98%	B – 239 A – 0	7.18	£131k	£0k	
Transformation Directorate	6.95%	3.66%	B – 0 A – 0	6.83	£471k	£393k	
Digital	8.47%	7.79%	B – 22 A – 0	5.72	-£256k	£590k	
Nursing, Professions and Care Standards (Quality and Governance)	3.98%	1.24%	B – 18 A – 0	7.40	-£258k	-£216k	

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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Appendix 1 – NOF Detail Slides

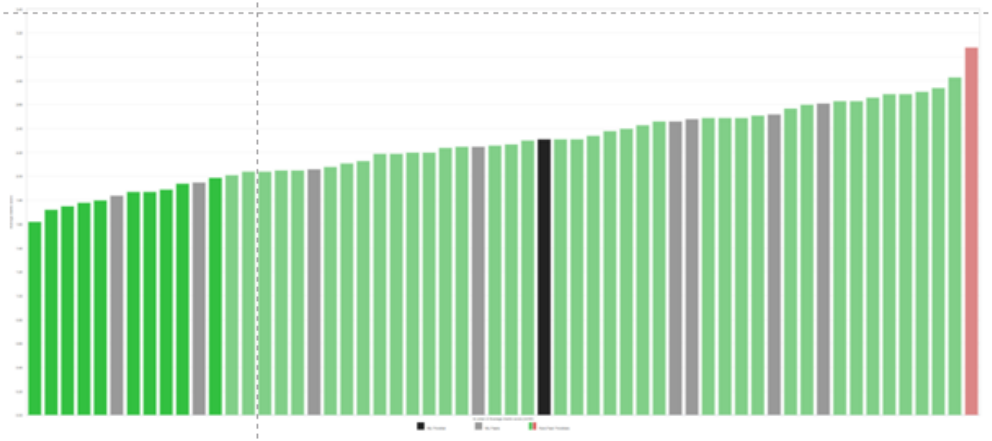
NHS Oversight Framework (NOF) – Non-acute hospital Trusts

NHS
Bradford District Care
NHS Foundation Trust

Overview NOF Q1 2026/27 – Latest Publication

Average score	Financial deficit	Overall segment	Provider rank
2.31	**No**	2	**32**
Above Average		Above average	Out of 58 providers

Access to services	2
Patient safety	1
Finance, productivity & innovation	2
People	3
Experience of care	2
Effectiveness of care & population health	4



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National Oversight Framework - Summary

NHS Bradford District Care NHS Foundation Trust

Metric Description	2026/27							
	Q1		Q2		Q3		Q4	
	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank
DOMAIN 1: Access to Services								
Percentage of patients waiting over 52 weeks for community services (end of quarter snapshot)	0.00%	1 (1/41)						
Percentage of patients waiting less than 18 weeks for community services (end of quarter snapshot)	94.25%	1 (7/41)						
Percentage of total Children and Young People's mental health waits for help that are over 104 weeks.	48.48%	4 (47/49)						
A&B) % of people discharged from community mental health services with a paired outcome score recorded (all ages).		4						
A) % of people discharged from community mental health services with a paired outcome score recorded (CYP).	9.93%	4						
B) % of people discharged from community mental health services with a paired outcome score recorded (Adult & Older adult).	6.78%	3						
DOMAIN SCORE	**2.5**	**2 (26/58)**						

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National Oversight Framework - Summary

NHS Bradford District Care NHS Foundation Trust

Metric Description	2026/27							
	Q1		Q2		Q3		Q4	
	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank
DOMAIN 2: EXPERIENCE OF CARE								
National CQC community mental health survey satisfaction rate		2						
NHS staff survey advocacy rate	7.00	2.32 (26/58)						
Mean LOS for patients discharged from adult acute mental health/PICU beds in the reporting period.	48.00	2 (26/47)						
Mean LOS for patients discharged from older adult acute mental health beds in the reporting period.	89.00	2 (19/48)						
DOMAIN SCORE	2.08	2 (19/58)						
DOMAIN 3: EFFECTIVENESS OF CARE & POPULATION HEALTH								
% of inpatients referred to and seen by an in-house tobacco treatment services who make a supported attempt to stop smoking	0.00%	4						
%of discharges from adult acute MH beds which were readmitted within 14 days of discharge.	Value supressed due to small numbers	Not scored (-/41)						
Adult acute and rehab mental health, LD and autism discharges followed up within 72 hours.	77.29%	2 (40/47)						
DOMAIN SCORE	3	4 (52/54)						

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National Oversight Framework - Summary

NHS Bradford District Care NHS Foundation Trust

Metric Description	2025/26							
	Q1		Q2		Q3		Q4	
	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank
DOMAIN 4: PATIENT SAFETY								
% of urgent/serious referrals to mental health crisis teams receiving their first face-to-face contact within 24 hours.	91.41%	**1 (6/47)**						
NHS staff survey raising concerns sub-score	6.80	**2.11 (22/58)**						
DOMAIN SCORE	1.55	**1 (13/58)**						
DOMAIN 5: FINANCE, PRODUCTIVITY, AND INNOVATION								
A&B) Combined finance score		**1**						
A) Planned surplus / deficit	0.00%	1 (9/58)						
B) Variance YTD to financial plan	0.02	1 (17/58)						
Relative difference in costs	106.45	**2.97 (34/58)**						
% of clinical trials set up within 90days	100.00%	1 (1/45)						
Overall Data Quality Maturity Index score	91.80	**2.89 (38/58)**						
DOMAIN SCORE	1.97	**2 (24/58)**						

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Metric Description	2025/26							
	Q1		Q2		Q3		Q4	
	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank	Raw measure	Score Derived & Rank
DOMAIN 6: PEOPLE								
Sickness absence rate	7.06%	**3.78 (52/58)**						
NHS staff survey engagement theme sub-score	7.06	**2.26 (25/58)**						
National Education and Training Survey overall experience sub-score	85.32	**1.18 (6/58)**						
NHS staff standards sub-score	7.97	**1.37 (8/58)**						
Percentage of frontline healthcare workers to receive a flu vaccination	46.00%	**2.91 (27/58)**						
A&B) Temporary staffing cost relative band		**4**						
A) Temporary staffing bank score		4						
B) Temporary staffing agency score		4						
DOMAIN SCORE	2.58	**3 (35/58)**						
Overall Average Score/Final Segmentation	**2.31**	**2 (32/58)**						

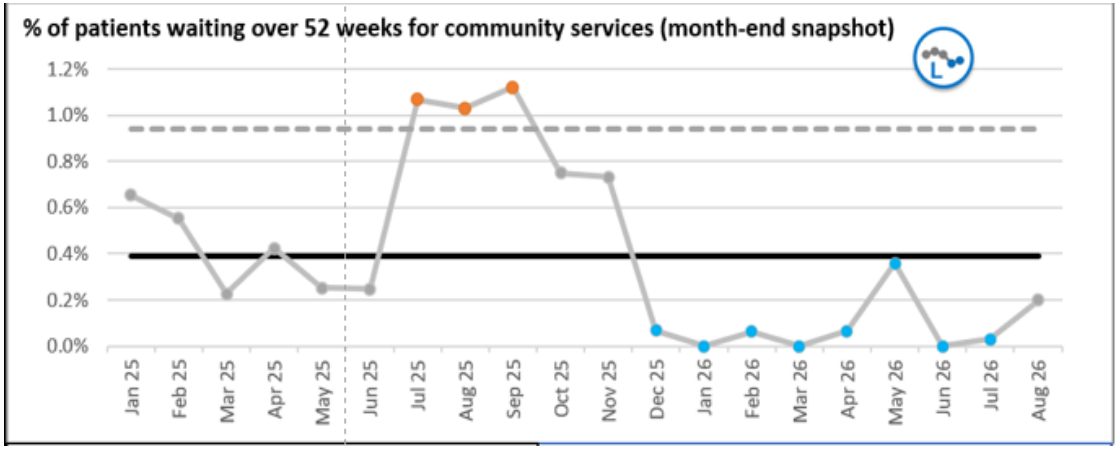
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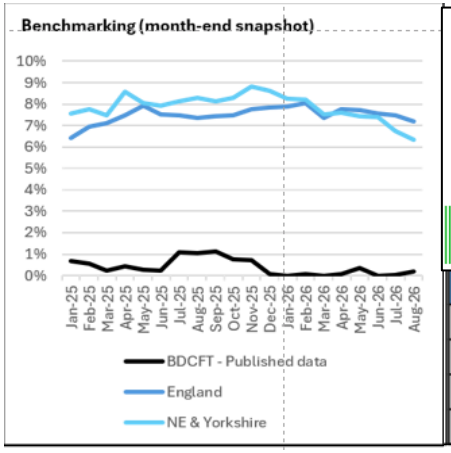
Appendix 2 – Detailed Description of Performance

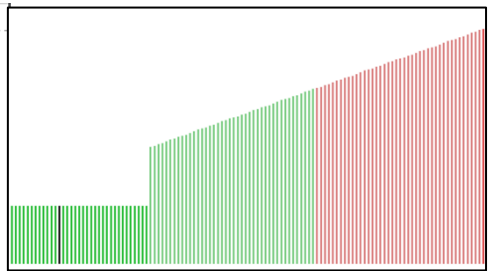
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Measure: Percentage of patients waiting over 52 weeks for community services – month-end snapshot

Domain:	Access to Services	NOF:	Yes	Accountable Exec:	Kelly Barker	Author: Cliff Springthorpe	
Target:	0	Actual:	6 (NOF2)	Data Period	Q2 End of Aug 26/27	DQ Assessment	TBD





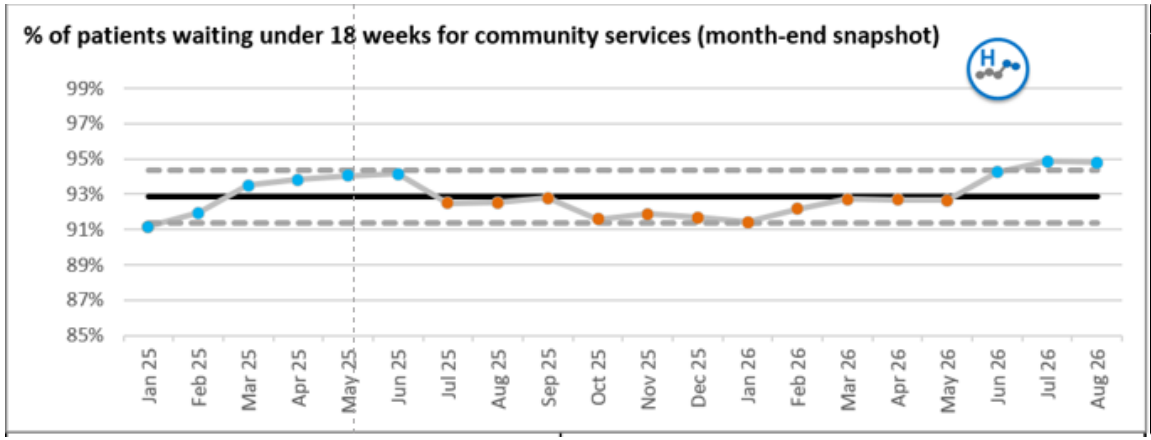


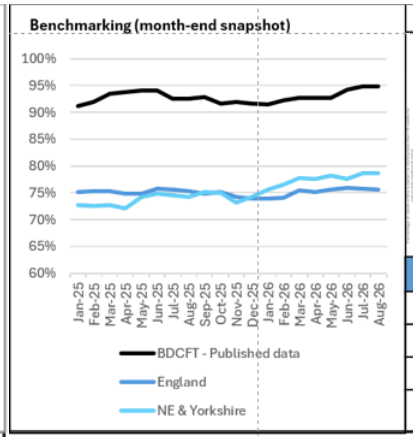
Score	Threshold	Aug-26
1.00	Scores 1-4 will be based on a ranking of all trusts.	
2.00		0.20%
3.00		
4.00		

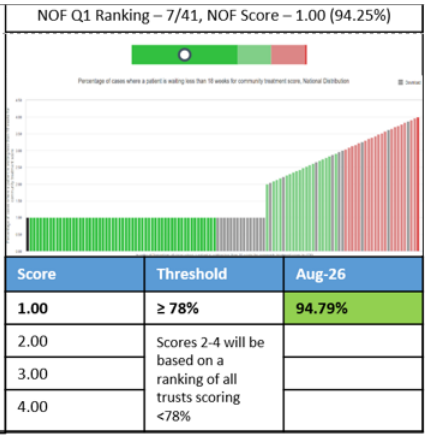
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a National Outcome Framework indicator that helps us track our longest waiters for community based physical health services.	We are currently on track. There was a slight increase in long waiters in May 2026, however these were all seen during June 2026 meaning a NOF score of 1. August data highlights two people currently waiting more than 52 weeks. They have been seen during September, and the figures should be at zero for the next NOF snapshot at the end of September.	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.

Close Holly 29/10/2026 15:09:24

Measure: Percentage of patients waiting under 18 weeks for community services – month-end snapshot							
Domain:	Access to Services	NOF:	Yes	Accountable Exec:	Kelly Barker	Author: Michelle Holgate	
Target:	>=78%	Actual:	94.79%(NOF1)	Data Period	Q2 End of Aug 26/27	DQ Assessment	TBD





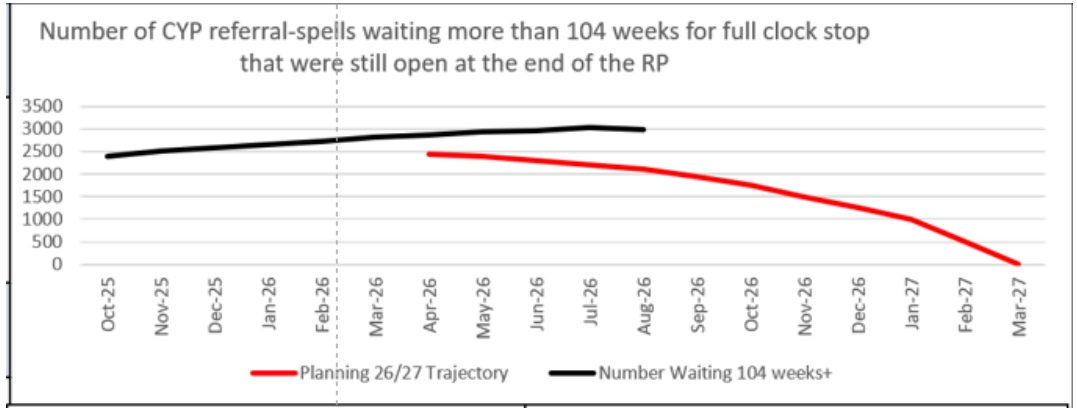


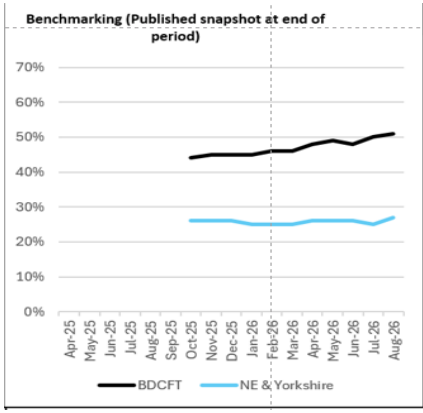
Score	Threshold	Aug-26
1.00	≥ 78%	94.79%
2.00	Scores 2-4 will be based on a ranking of all trusts scoring <78%	
3.00		
4.00		

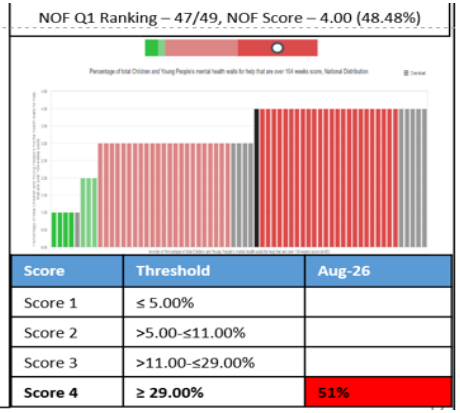
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a National Outcome Framework indicator that helps us track our longest waiters for community based physical health services.	We are currently on track. There has been a gradual improvement in our 18-week wait over the last four months. Trusts are expected to be at 78% or above by Marck 2027, in line with national planning. The Trust position is currently well above that.	As with 52 weeks waits, 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.	Longer waits are being managed through active waiting list management.

Close Holly 29/10/2026 15:09:24

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	Author:	Carla Smith
Target:	0% by March 27	Actual:	51%(NOF4)	Data Period	Aug 2026	DQ Assessment	TBD





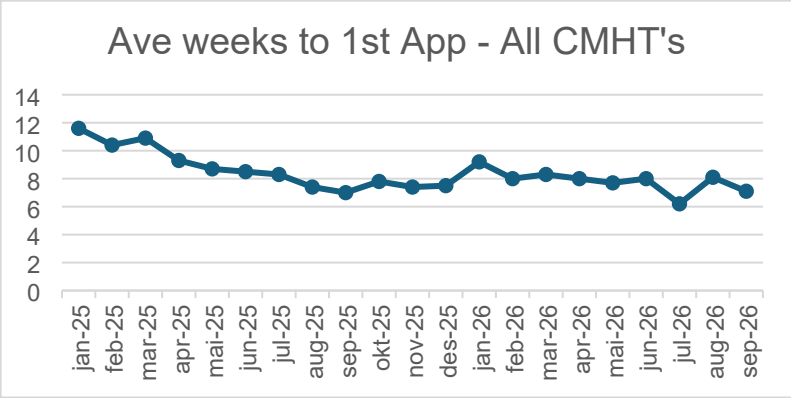


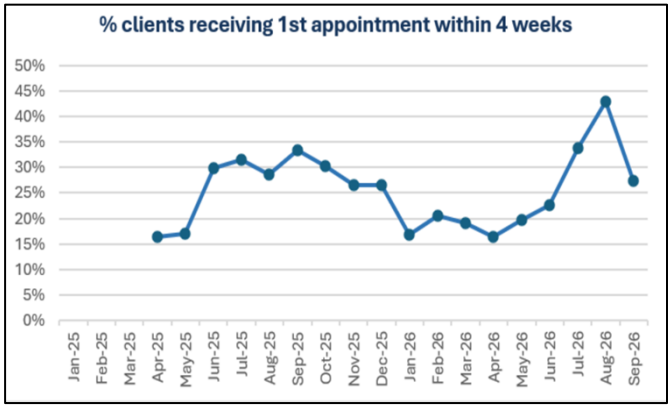
Score	Threshold	Aug-26
Score 1	≤ 5.00%	
Score 2	>5.00-≤11.00%	
Score 3	>11.00-≤29.00%	
Score 4	**≥ 29.00%**	**51%**

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. Close Holly 29/10/2026 15:09:24	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. Data from September shows that 55.8% of appointments have a SNOMED code, from 4.8% in July.

Measure: Community Mental Health - % of people seen within 4 weeks

Domain:	Access to Services	NOF: No		Accountable Exec:	Kelly Barker	Author: Maulbrey Mugani	
Target:	TBC	Actual:	CMHT –27%	Data Period Sep 26		DQ Assessment	TBD



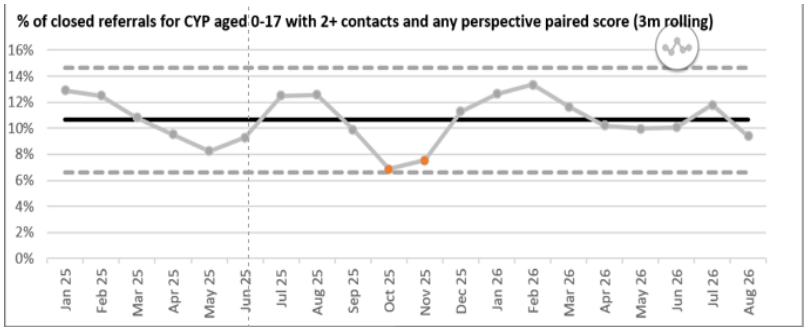


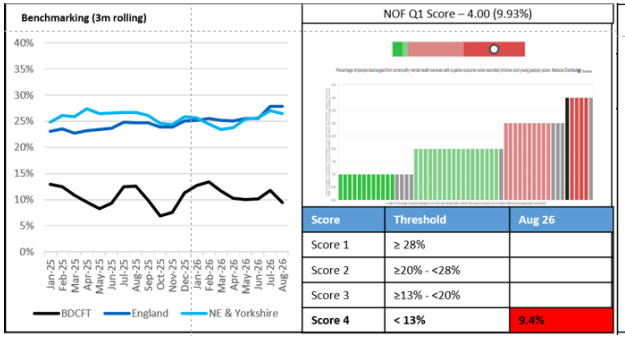
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Timely access to Community Mental Health Teams is a critical indicator of pathway responsiveness and clinical effectiveness. Earlier assessment and intervention can reduce deterioration, crisis presentation and avoidable admission, while improving experience and supporting recovery. For assurance, this measure must be considered alongside referral demand, triage times, appointment activity, DNA rates, clinical outcomes and the acuity of people waiting.	Improving, but not yet consistently meeting the four-week ambition. In July 2026, 33.7% of people were seen within four weeks, while average waits reduced from 11.6 weeks in January 2025 to 6.5 weeks and triage is now completed within four days. Increased activity is supporting improvement but rising referrals and DNA rates above 30% continue to constrain recovery. Assurance remains partial, with positive progress but performance still below the required level. Final agreement of the measure and applicable SNOMED codes is needed to ensure consistent reporting and may change the reported position.	Recovery actions focus on the main operational constraints. Text reminders have reduced assessment DNAs, with further targeted action planned to address rates above 30%. The revised e-referral process will improve referral quality, reduce avoidable demand and accelerate triage. Waiting lists and capacity are under active review, with performance monitored through operational governance. Board assurance will be supported by monthly reporting of access, waits, demand, activity, DNAs, data quality and pathway impact. The AVT pilot has also successfully reduced administration time within the assessment team.	Key risks are rising demand, high DNA rates, limited capacity for historic data quality work, and constrained medic capacity in S&W and City CMHT, where routine waits are up to three months. These pressures could slow recovery or shift delays elsewhere in the pathway. Mitigations include targeted DNA work, implementation and evaluation of e-referrals, clinically prioritised waiting-list management, capacity and demand review, resource mapping for data quality, and maximising medical capacity across services. Overall assurance remains partial: access and triage are improving, but sustained delivery against the four-week ambition, alongside evidence that delays are not being transferred elsewhere, is required for full assurance. Pressures will continue to be monitored and escalated through operational governance.

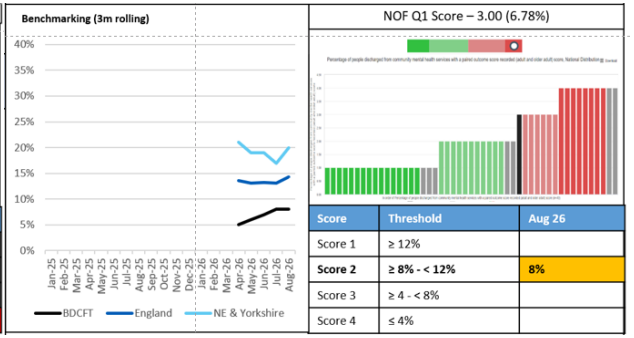
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Measure: % of people discharged from community mental health services with a paired outcome score recorded (all ages)

Domain:	Access to Service	NOF:	Yes – 25/26	Accountable Exec:	Kelly Barker	Author:	Maulbrey Mugani
Target:	28% children (NOF 1), 12% adults (NOF1)	Actual:	9.4% children (NOF 4), 8% adults (NOF 3)	Data Period	Aug 26 (3 M Rolling)	DQ Assessment	TBD



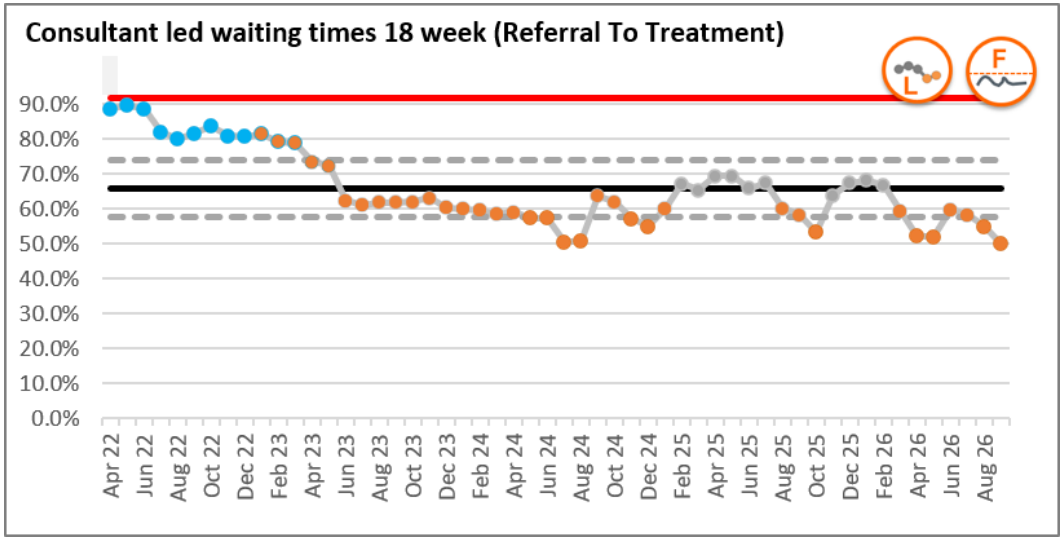




Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This new National Oversight Framework measure tests whether access to mental health services results 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 Q1 2026/27, 9.4% 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 8% against the 12% threshold, giving an indicative score of 2; the combined indicative score is 3. 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.

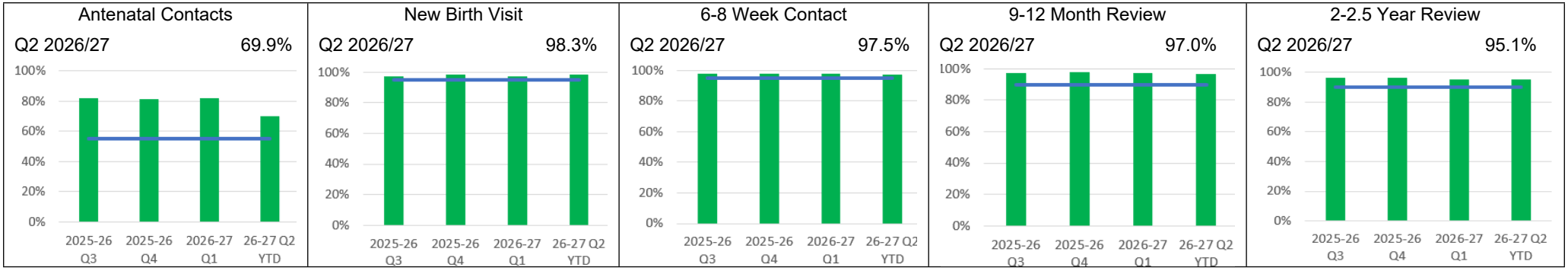
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Measure: Consultant-led waiting times - Community Dental Services						
Domain:	Access to Services	NOF: No	Accountable Exec:	Kelly Barker	Author: James Cooke	
Target:	92%	Actual: 50.1%	Data Period	Sept 2026	DQ Assessment	TBD



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
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. Close Holly 29/10/2026 15:09:24	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. Most recently a number of sessions have been cancelled by AGH due to the move of their EPR from SystmOne to Cerner.	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. Any issues regarding the Cerner transfer will be closely monitored over the coming months as it is made live. Outside of the GA and Cerner issues, the service has reduced the overall waiting list size and the number of recalls required.	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.

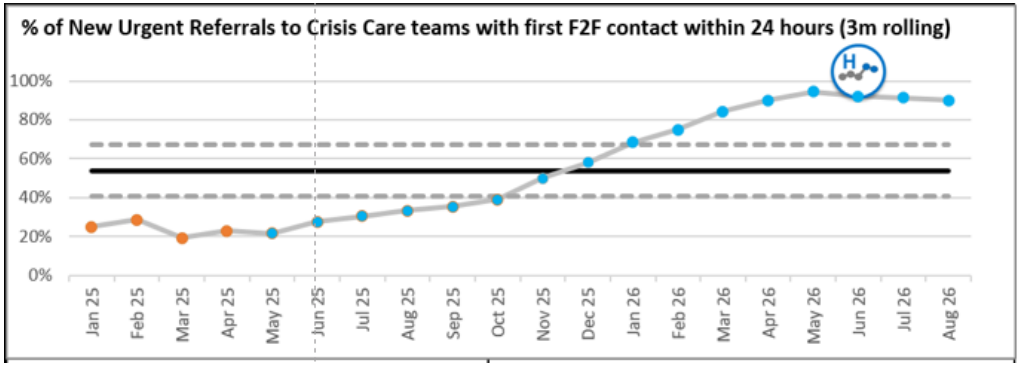
Measure: 0 – 19 metrics					
Domain:	Access to Services	NOF: No	Accountable Exec: Kelly Barker	Author:	Richard Holmes
Target:	Various	Actual: Various	Data Period: Q1 2026/27	DQ Assessment	TBC

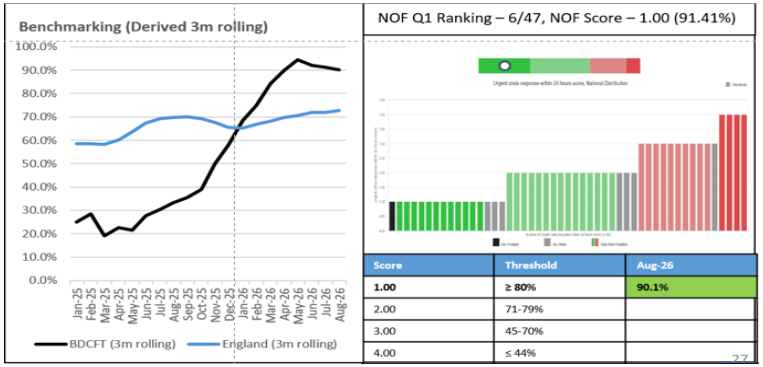


Why is this measure important?	Are we on track or off track? Why?	If we are off track, what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
These indicators are important because they measure compliance against national and local targets 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 SystmOne, 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.	Following a competitive tender process, the Trust is waiting on formal notification of who will deliver the 0-19 "Living Well Public Health Nursing" service from April 2027 onwards. Formal notification is due Early November 2026.

Close Holly 29/10/2026 15:09:24

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:	Maulbrey Mugani
Target:	80% (NOF 1)	Actual: 90.1%(NOF1)	Data Period:	Aug 26 (3 M Rolling)	DQ Assessment	TBD

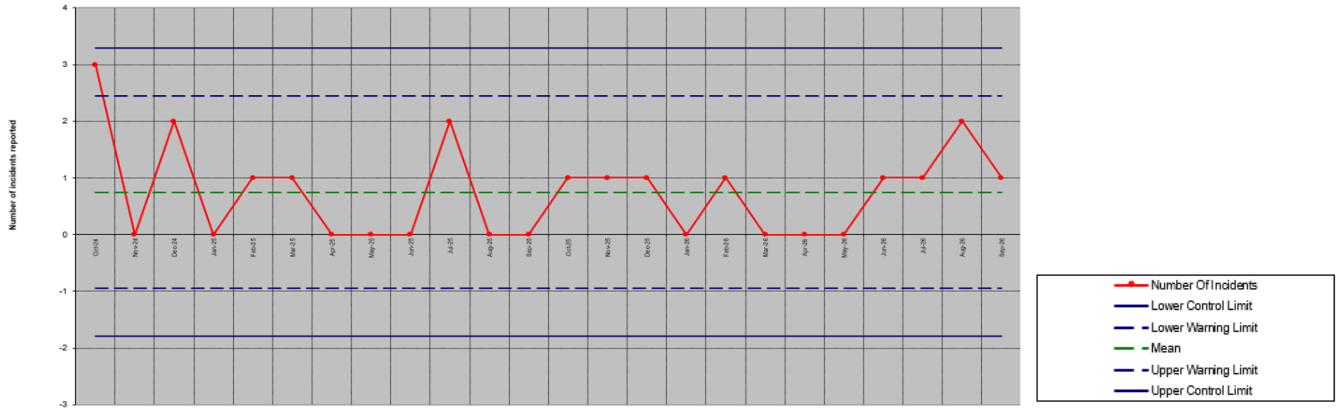




Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Crisis Care Services support individuals experiencing acute mental health need and risk. Timely 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 June–August 2026 was 90.1%, above the national target of 80%, although one of the three teams remains below target. The Trust's established responsive crisis care model, including FRS, supports delivery. Recent EPR changes have improved the accuracy of face-to-face response-time reporting and alignment with operational practice. Further data quality assurance work continues, but there is increased confidence in the measure and 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. For the team which is not hitting the target these checks show that primarily non engagement is the key cause of the target not being met, team systems and demand are being reviewed for potential solutions. 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.

Close Holly 29/10/2026 15:09:24

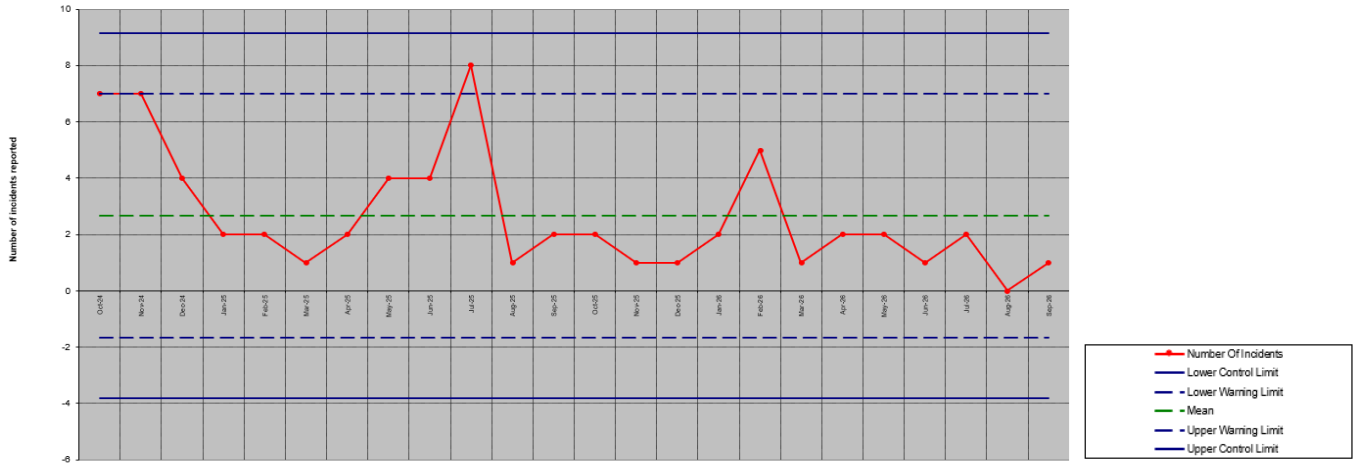
Measure: No Force first - Prone Restraint					
Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon
Target:	No set target	Actual: 1	Data Period: September 2026		DQ Assessment TBD



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
Prone restraint is a key quality and patient safety measure due to the physical and psychological risks associated with this highly restrictive intervention. It should only be used as a last resort, for the shortest possible time, when less restrictive alternatives are ineffective or unsafe. Monitoring supports the Trust's restrictive practice reduction ambitions and No Force First principles, helping teams identify variation and opportunities to strengthen prevention, de-escalation, care planning and post-incident learning. The team has recently completed No Force First reaccreditation.	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. There was one reported prone restraint and from review related to the service user placed themself into this position.	Continued improvement will be supported through ward-level review of all prone restraint incidents, considering antecedents, duration, staff response, care plans, patient voice and post-incident debrief. Where increases or clusters occur, ward leadership and the Management of Violence and Aggression lead will undertake targeted review, reinforce least restrictive practice and de-escalation, review personalised safety plans, and escalate through Positive and Proactive Care governance. Where use remains low or reduces, the focus will be on sustaining good practice through incident learning, sharing learning across wards, monitoring training compliance, and maintaining oversight through 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.

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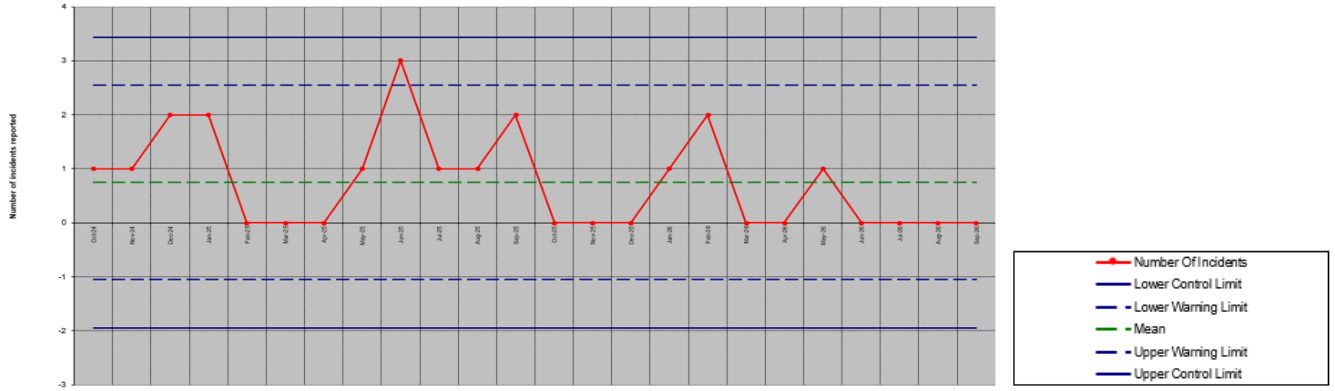
Measure: No Force first - Seclusion					
Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon
Target:		Actual: 1	Data Period September 2026		DQ Assessment TBD



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
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.	Seclusion rates continue to be monitored and below the substantial increase in July 2025.	The trust continues to build on the significant reduction already achieved in the use of seclusion, with a 55% reduction reported across the improvement period. The next phase of work is focused on sustaining this improvement through a whole-system approach to least restrictive practice. This includes strengthening staff clinical judgement and maintaining a high threshold for seclusion; increasing the use of enhanced engagement, sensory and other graded alternatives; embedding flexible seclusion as a structured step-down approach; improving therapeutic observation and MDT review; and using patient and staff debriefing to inform formulation and personalised prevention plans. Bespoke education is being extended across acute inpatient services, alongside greater multidisciplinary and AHP involvement and work to develop an intermediate response between escalating incidents and seclusion.	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.

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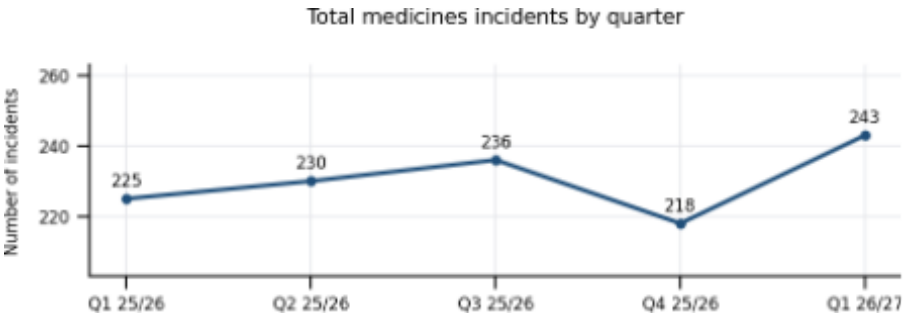
Measure: No Force first - Segregation					
Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon
Target:		Actual: 0	Data Period: September 2026		DQ Assessment TBD

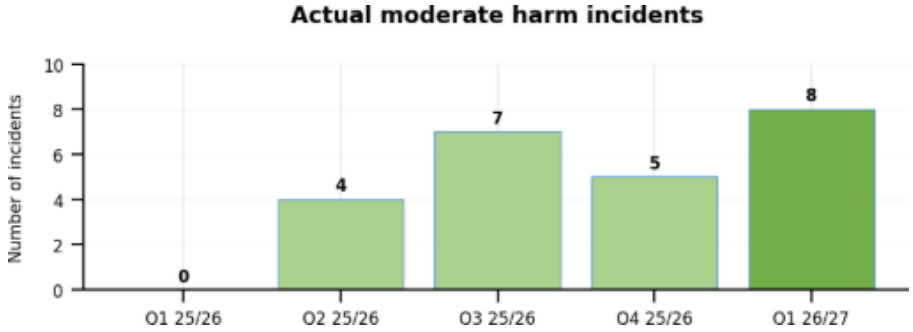


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Segregation is a key quality, safety and human rights measure because it represents a highly restrictive 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.	No Segregation episodes registered for the month of September.	Continued improvement will be supported through ward-level review of all prone restraint incidents, considering antecedents, duration, staff response, care plans, patient voice and post-incident debrief. Where increases or clusters occur, ward leadership and the Management of Violence and Aggression lead will undertake targeted review, reinforce least restrictive practice and de-escalation, review personalised safety plans, and escalate through Positive and Proactive Care governance. Where use remains low or reduces, the focus will be on sustaining good practice through incident learning, sharing learning across wards, monitoring training compliance, and maintaining oversight through safety huddles and governance meetings.	Key risks include increased inpatient acuity and complexity, workforce and environmental pressures, delayed discharge, inconsistent application of least restrictive practice and personalised care planning, and data quality limitations affecting interpretation of segregation activity. Risks are mitigated through senior clinical and operational oversight, timely review and escalation of segregation episodes, targeted ward support, and reinforcement of de-escalation and trauma-informed practice. Assurance is supported through training compliance, incident and patient safety learning, and ward-level quality improvement.

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Measure: Medicine Incidents – Total and Severity					
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

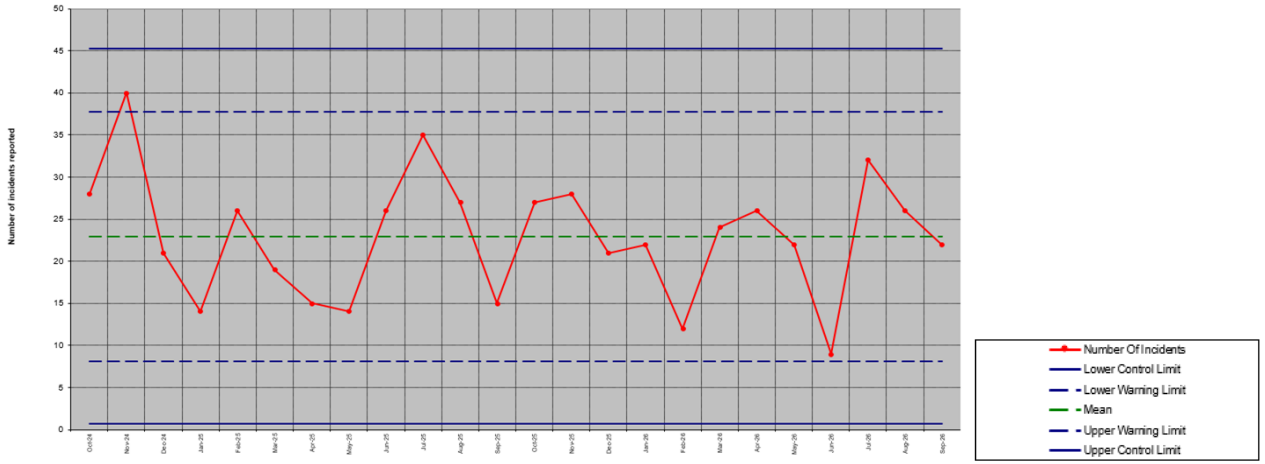




Why is this measure important?	Are we on track or off track? Why?	If off track, what are the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Medicines incidents are a key patient safety indicator, providing assurance on patient harm, emerging 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.

Close Holly 29/10/2026 15:09:24

Measure: Falls – number and severity					
Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon
Target:		Actual: 22	Data Period: September 2026		DQ Assessment TBD

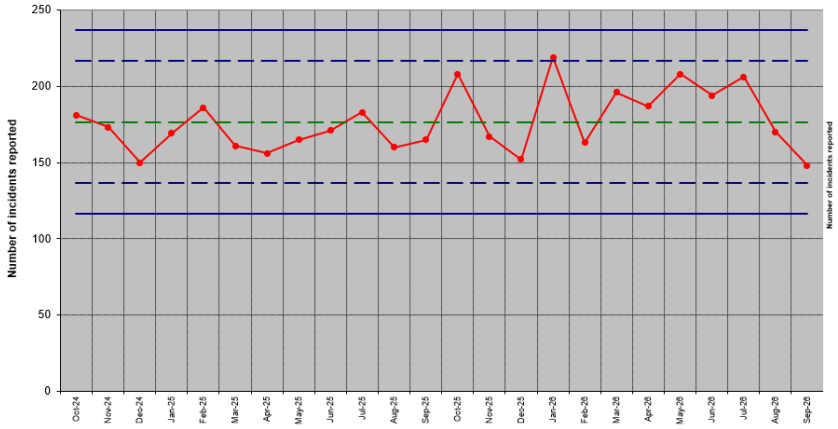


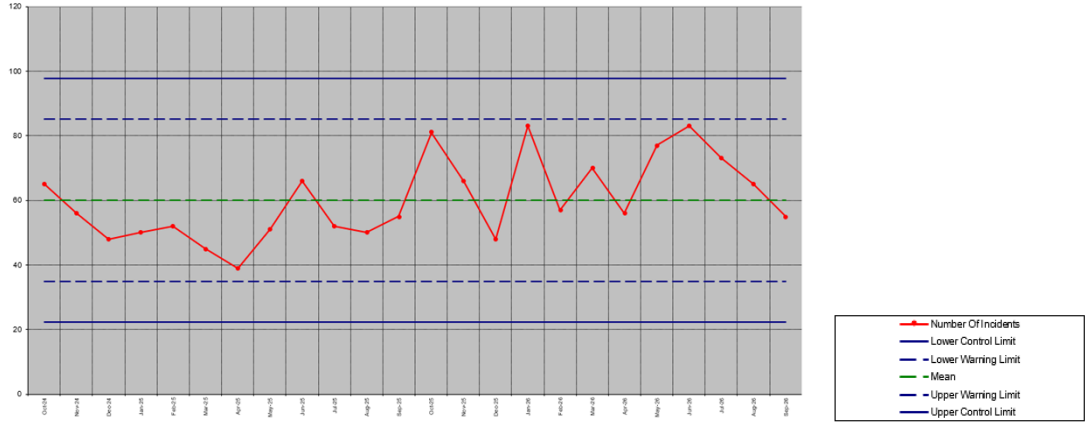
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Falls involving service users are a key quality and patient safety measure because they can result 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.	Falls remain within active organisational oversight, supported by an established Falls Steering Group, care-group arrangements. September data currently reports a reduced number of fall incidents to 22 but fluctuations in reporting is aligned to admission rates in older people's inpatient areas.	Assurance has been received that falls risk assessment within older people's services is being strengthened, with people at increased risk receiving comprehensive assessment and personalised preventative actions. September activity included targeted review of increased falls in the Dementia Assessment Unit and focused learning from Baildon Ward. The Falls Steering Group has agreed further improvements, including consistent risk assessment and care planning, enhanced MDT review of people at highest risk, strengthened medication, bone health and strength-and-balance interventions, and improved post-fall review. A Trust-wide falls dashboard, quarterly thematic analysis and compliance measures will strengthen monitoring and assurance.	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

Oasis 19/10/2026 11:09:24

Measure: Pressure Ulcers – number and severity

Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon
Target:		Actual:148 / 55	Data Period: September 2026		DQ Assessment TBD

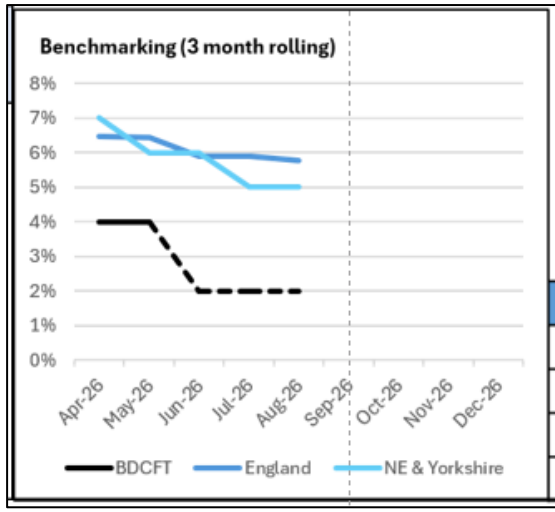




Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Pressure ulcers are an important indicator of harm, quality of care and the effectiveness of prevention. Monitoring the number and severity supports early identification of deterioration, learning from incidents and targeted action to reduce avoidable harm.	On track, with continued oversight required for September 2026. The two SPC charts show the latest plotted points within the upper and lower control limits, with no current special-cause signal visible. The latest point on the first chart is below its mean; the latest point on the second chart is above its mean but remains within control limits.	Maintain the current prevention and surveillance approach: continue monthly SPC review; ensure every pressure ulcer is correctly graded and clinically reviewed; confirm completion of risk assessment, skin inspection, repositioning and equipment actions; and use incident reviews to identify recurring themes. Escalate any point outside control limits, sustained shift or adverse trend through the Quality and Patient Safety governance route.	Risks include inconsistent grading or reporting, delayed recognition of deterioration, gaps in risk assessment or repositioning, and delays in access to pressure-relieving equipment. Mitigate through data-quality validation, routine documentation audit, staff competency updates, timely equipment escalation and focused review of any severe or potentially avoidable harm.

Close Holly 29/10/2026 15:09:24

Measure: % of discharges from adult acute mental health beds which were readmitted within 14 days of discharge						
Domain:	Effectiveness of Care	NOF: Yes	Accountable Exec:	Kelly Barker	Author:	Maulbrey Mugani
Target:	<=5%	Actual: 2% (NOF1)	Data Period	Aug 26(3 M Rolling)	DQ Assessment	TBD

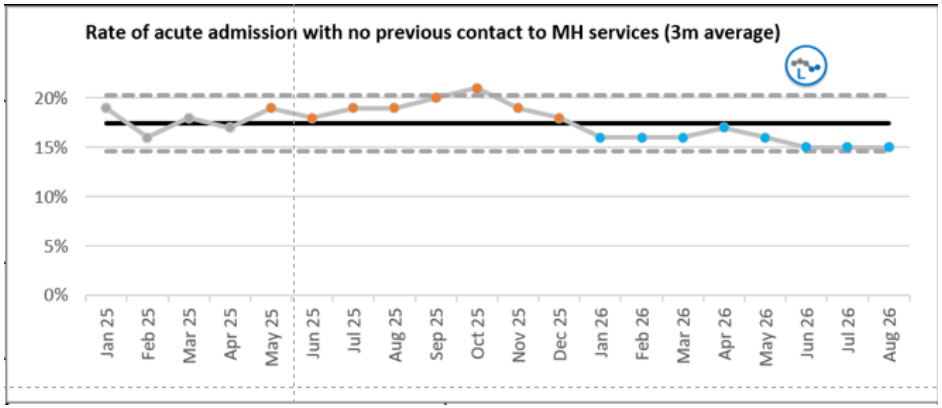


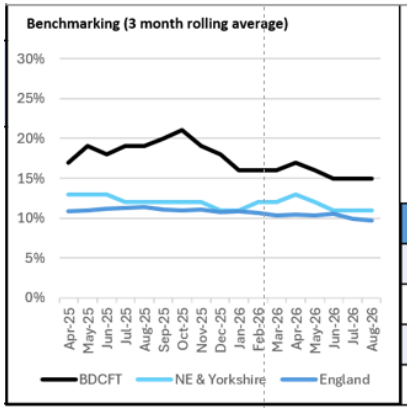
Score	Threshold	Jun-26
1.00	≤ 5%	= 2%
2.00	6 - 10%	
3.00	11 - 17%	
4.00	≥ 18%	

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 (NOF) measure provides an important indicator of the effectiveness and safety of discharge from adult acute mental health inpatient care. Monitoring readmissions within 14 days supports us to identify potentially avoidable early returns to hospital, understand contributory factors and strengthen discharge planning, continuity of care and post-discharge support. It provides an opportunity for systematic learning from readmissions and supports assurance that patients are discharged at the right time, with appropriate community support and risk management arrangements in place.	At present Trust performance is significantly above the national average and aligns with NOF 1.		After Action Reviews are being prioritised for those re-admitted within 14 days in response to an incident action plan. These will provide meaningful insights that clinical and operational teams can respond to.

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29/01/26 15:09:24

Measure: % of admissions to acute mental health beds for people who have had no care contacts in 365 days before admission						
Domain:	Effectiveness of Care	NOF: Yes – but ICB measure	Accountable Exec:	Kelly Barker	Author:	Maulbrey Mugani
Target:	<=5%	Actual: 15% (NOF 3)	Data Period	Aug 26(3 M Rolling)	DQ Assessment	TBD





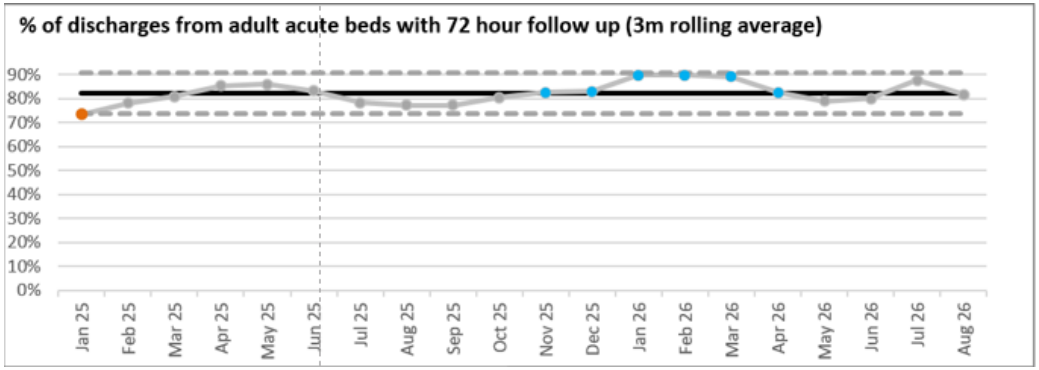
Score	Threshold	Aug-26
1.00	≤ 5.00 %	
2.00	>5.00-≤10.00%	
3.00	**>10.00%-≤15.00%**	**15%**
4.00	> 15.00%	

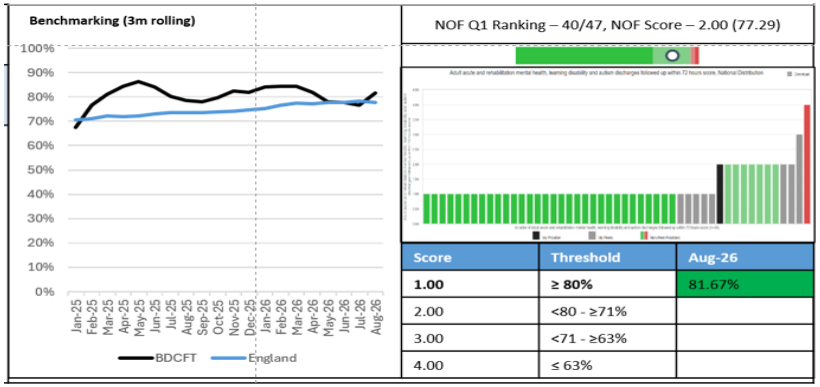
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a NOF measure that sits with the ICB but BDCT have significant influence over. The measure 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 task and finish group.

Close Holly 29/10/2026 15:09:24

Measure: Adult acute and rehab mental health, LD and autism discharges followed up within 72 hours

Domain:	Effectiveness of Care	NOF:	Yes	Accountable Exec:	Kelly Barker	Author: Maulbrey Mugani	
Target:	80%	Actual:	81.67% (NOF 1)	Data Period	Aug 26(3 M Rolling)	DQ Assessment	TBD



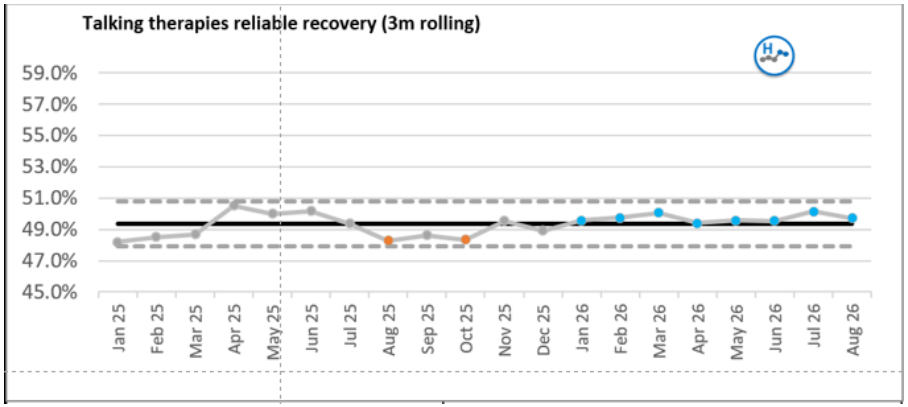


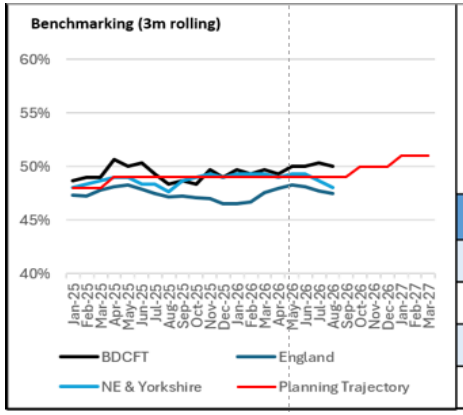
Score	Threshold	Aug-26
1.00	≥ 80%	81.67%
2.00	<80 - ≥71%	
3.00	<71 - ≥63%	
4.00	≤ 63%	

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 and performance for June - Aug'26 was 81.67%, 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.

Close Holly 29/10/2026 15:09:24

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: Carla Smith	
Target:	51%	Actual:	50% (NOF 2)	Data Period	Aug26 (3 M Rolling)	DQ Assessment	TBD



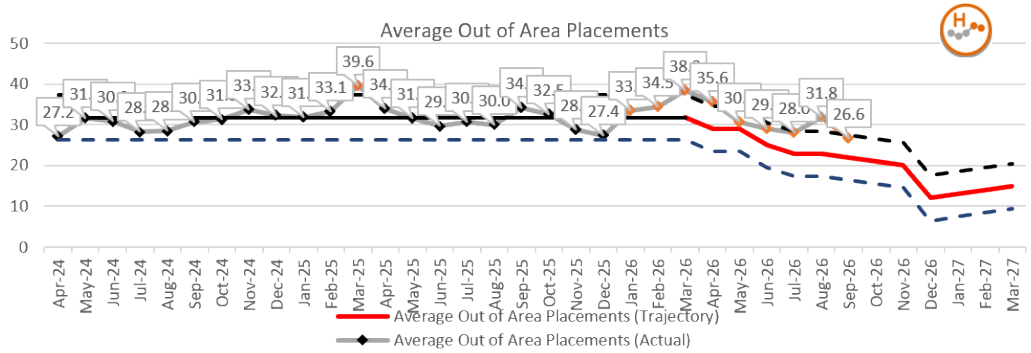


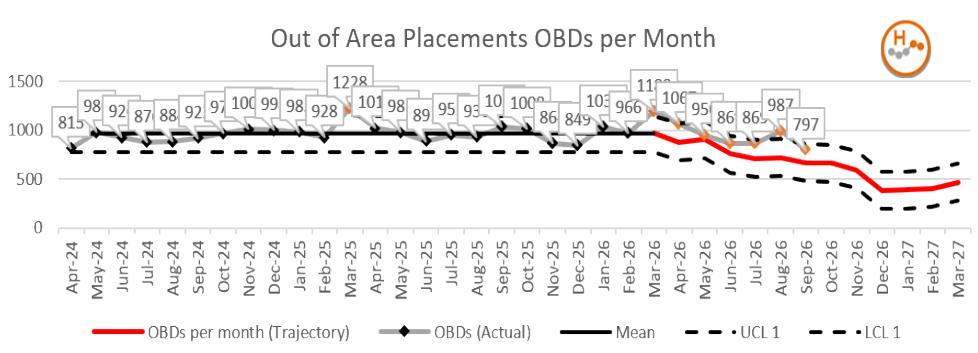
Score	Threshold	Aug-26
Score 1	≥ 52%	
Score 2	**<52% & ≥50%**	**50.0%**
Score 3	<49% & ≥47%	
Score 4	< 47%	

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 26/27 is to achieve 51% by March 2027, based on a 3-month rolling average. For Jun – Aug the rolling average was between 49-51%. Whilst not achieving the national target, BDCT performance is better than the regional and national benchmarks.	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. This equates to approx. 35% of referrals being inappropriate. 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.

Close Holly
29/10/2026 15:09:24

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:	Maulbrey Mugani
Target:	On/under trajectory aim for 0	Actual:	797	Data Period	Sep 2026	DQ Assessment	TBD

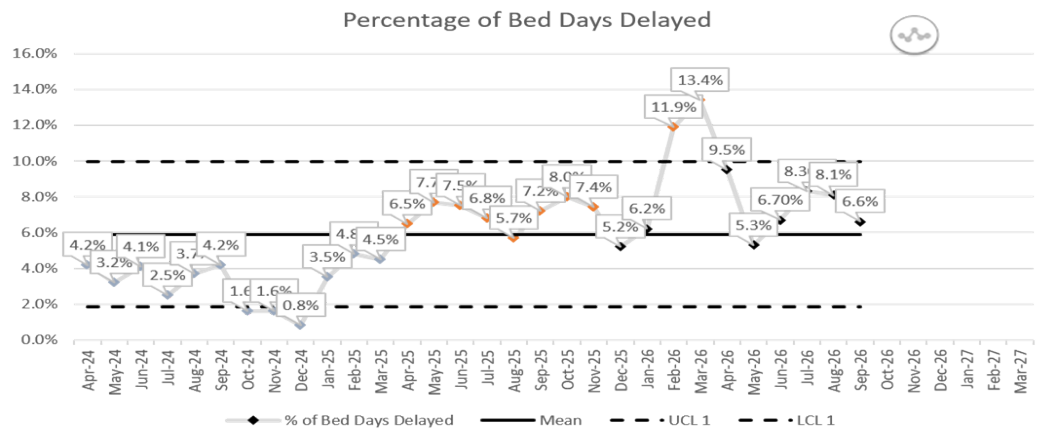




Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Out of Area Placements (OAPs) are a key indicator of pressure across the whole mental health system. 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. Sept'26 delivered 797 OAP bed days against a planned trajectory of 668. 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 **Flow Command Sprint** has been established to accelerate reductions in OAP use, focusing on admission avoidance, inpatient flow and discharge. Actions include daily OAP and repatriation reviews, executive oversight of long stays and discharge barriers, strengthened multidisciplinary review, partnership working and community alternatives, with weekly monitoring against trajectories. Patient feedback reinforces the importance of care closer to home, while recent repatriations demonstrate the value of early escalation and executive coordination. Further improvement is expected through 2026/27 but remains dependent on sustained reductions in length of stay and discharge delays	**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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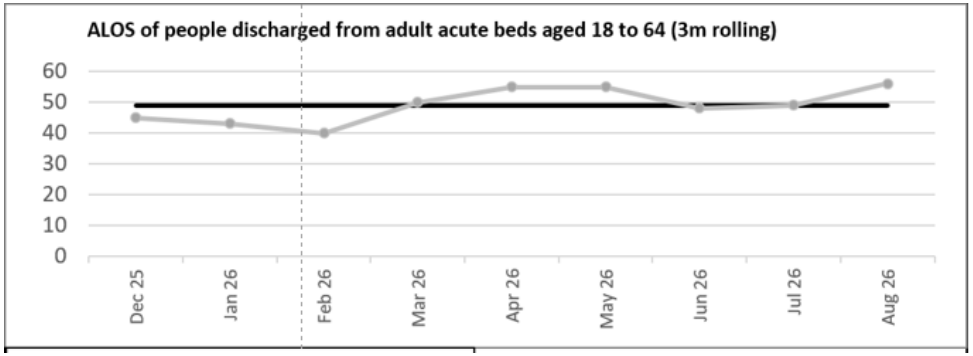
Measure: % of Ward Occupancy Delayed for Acute Wards						
Domain:	Experience of Care	NOF: No	Accountable Exec:	Kelly Barker	Author:	Maulbrey Mugani
Target:	10% or under	Actual: 6.6%	Data Period: Sep 26		DQ Assessment	TBD

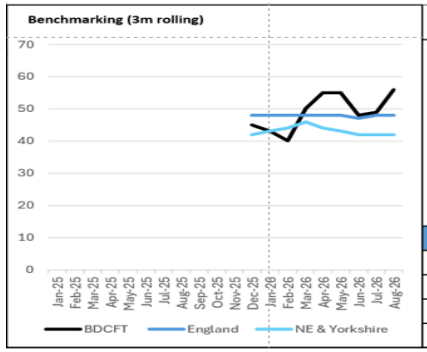


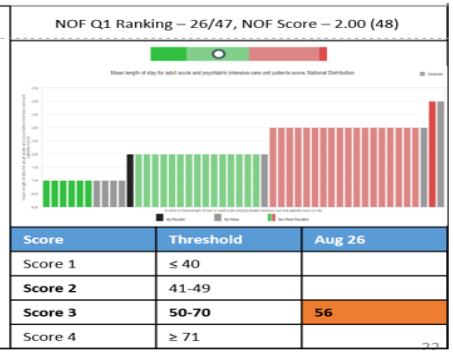
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Delayed occupancy provides an indication of how effectively patients move through inpatient services 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**. September performance was 6.6%, 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.

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Measure: Mean length of stay for adult acute and PICU discharges (3m rolling)							
Domain:	Experience of Care	NOF: Yes		Accountable Exec:	Kelly Barker	Author:	Maulbrey Mugani
Target:	40 or under (NOF 1), 51 Planning	Actual: 56 (NOF3)		Data Period:	Aug 26 (3 M Rolling)	DQ Assessment	TBD







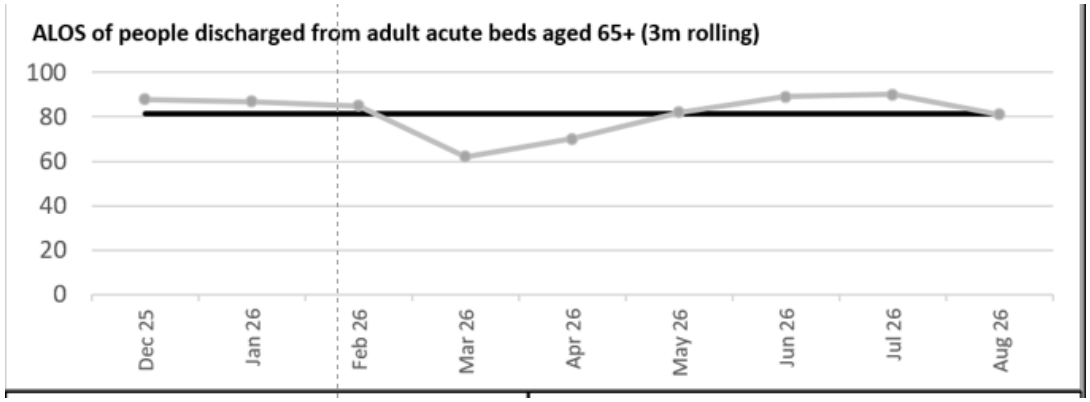
Score	Threshold	Aug 26
Score 1	≤ 40	
Score 2	41-49	
Score 3	50-70	56
Score 4	≥ 71	

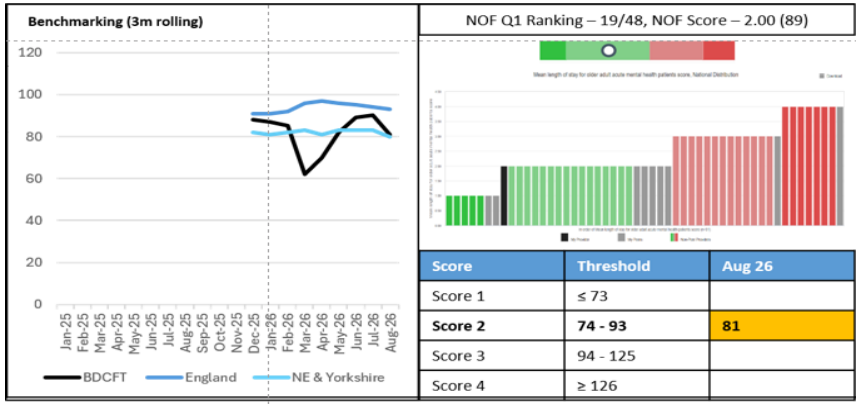
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Length of stay is an important monitor of inpatient flow and bed availability. Maintaining an optimal 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 average length of stay between June-Aug'26 is 56 days. This is above 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.

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Measure: Mean length of stay for older adult acute discharges

Domain:	Experience of Care	NOF:	Yes	Accountable Exec:	Kelly Barker	Author: Carla Smith	
Target:	73 or below	Actual:	81 (NOF 2)	Data Period	Aug 26 (3 M Rolling)	DQ Assessment	TBD



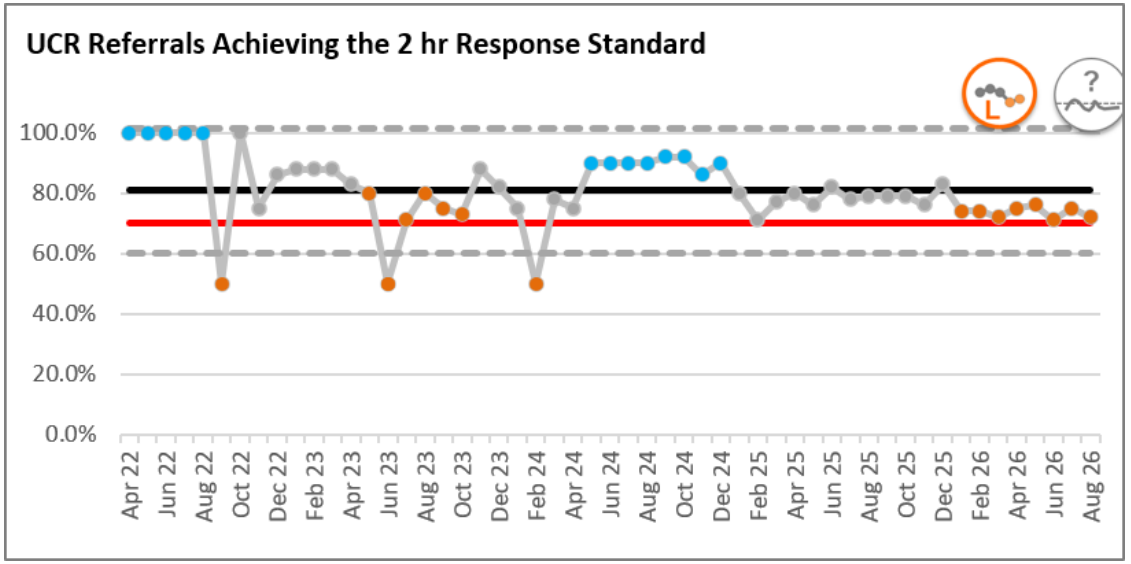


Score	Threshold	Aug 26
Score 1	≤ 73	
Score 2	**74 - 93**	**81**
Score 3	94 - 125	
Score 4	≥ 126	

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 North East 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. The current position for length of stay on Older adult wards reflects that in September 2 patients were clinically ready for discharge and in October 4 patients were CRFD. 8 patients had a LoS >60 days in September, and 12 in October.	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. We are starting to look at a review of services and pathways which will be operationalised in Q1 26/27. Integral to this work is patient pathways, reviews of patients CRFD, Estimated date of discharge and the patient journey to and from acute inpatient care	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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Measure: Urgent Community Response (UCR) Percent Achieving 2hr Standard							
Domain:	Experience of Care	NOF:	No	Accountable Exec:	Kelly Barker	Author: Cliff Springthorpe	
Target:	70%	Actual:	72.0%	Data Period	August 2026	DQ Assessment	TBD



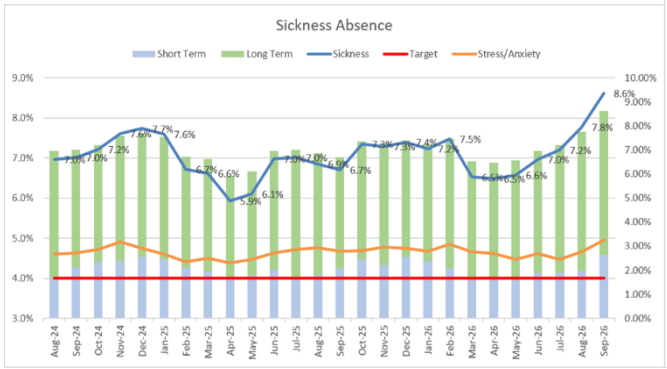
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is no longer a NOF reported indicator but is still a planning requirement for this year. Urgent 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. 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 the service.	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 months reflects higher absence rates and significantly increased service access.

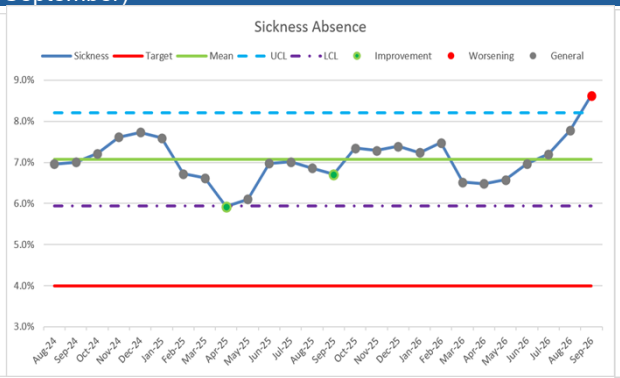
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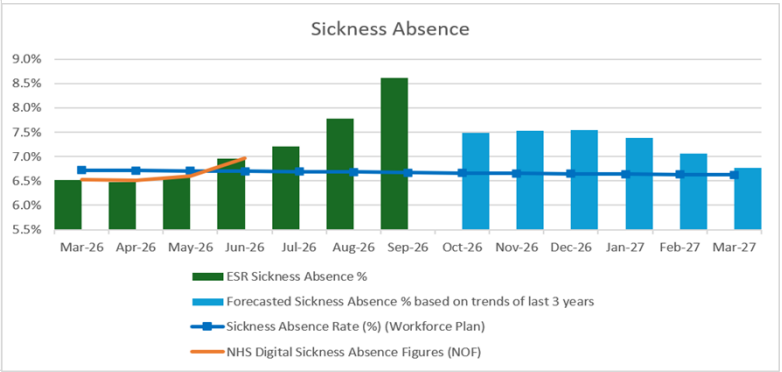
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Measure: Sickness absence rate (3m rolling)							
Domain:	People	NOF:	Yes	Accountable Exec:	Jo Harrison	Author: Claire Ingle	
Target:	4%	Actual:	7.06% (NOF4) (8.6% September)	Data Period	Q1 26/27	DQ Assessment	TBD







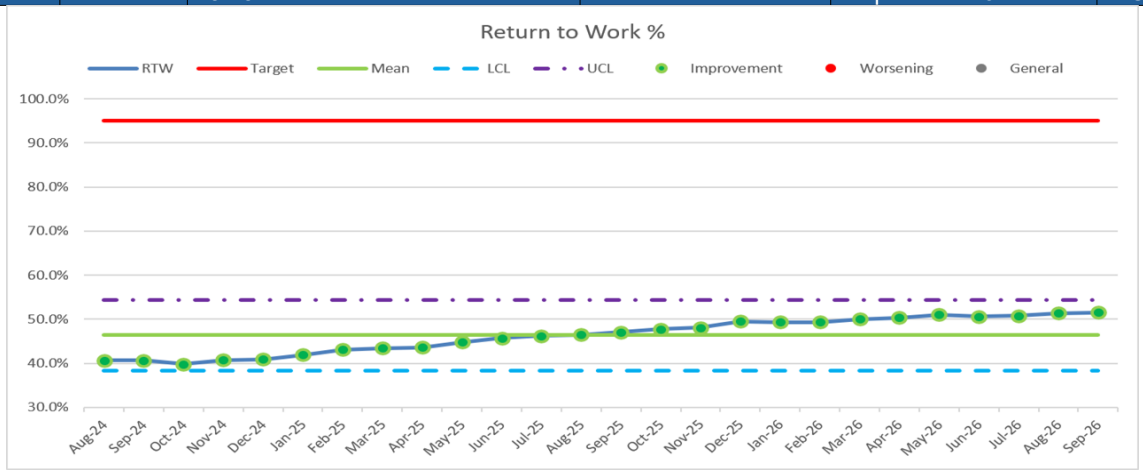
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring sickness absence levels in the NHS is important because it has a direct impact on patient care, workforce wellbeing, service delivery, and organisational costs. **SPC charts use three rules to identify significant change:** • Rule 1 – Outside expected range: A point falls outside the control limits, indicating unusual variation that may need investigation. • Rule 2 – Shift: 8 consecutive points above or below the average, indicating a sustained change. • Rule 3 – Trend: 6 consecutive increases or decreases, indicating a consistent direction of travel.	Sickness absence is **8.62%, 4.62 percentage points above the 4% Trust target**, and has remained consistently above target since August 2024. The SPC indicates a worsening position, with the latest point outside expected variation and six consecutive increases. **Chart 1 shows the split between long- and short-term absence and the proportion attributable to stress/anxiety.** Long-term absence is the main driver of the overall increase, while short-term absence remains relatively stable. Contributing factors include inconsistent application of sickness absence processes, workforce resilience pressures, and increased organisational change and retendering, with associated uncertainty and stress	A live transformation plan is strengthening management capability and streamlining processes through automation. A revised attendance policy is entering a 30-day consultation in October, introducing cumulative absence triggers aligned to the Trust target, earlier intervention and clearer wellbeing checkpoints. The new approach includes structured wellbeing conversations, extended review periods supported by prevention plans, stronger management accountability and fewer formal stages. It also standardises redeployment periods and simplifies return-to-work processes, management reporting and documentation. The approach aligns with other NHS Trusts, NHS Employers guidance and NHS Staff Standards, and is expected to enable earlier management of frequent short-term absence while reducing management burden.	**Risk:** The delay in the new attendance policy has pushed back implementation of the new processes **Mitigation** consistent and transparent engagement with staff side colleagues to ensure they are mobilised for current cases. **Risk:** The policy does focus on ST and repetitive absences yet long term absences remain our biggest driver for the increase **Mitigation** a targeted approach for all LT cases with OH with clear plans will focus on reducing these. **Risk T**hat managers may not apply the new process quickly enough .

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			Mitigation here is the Working well plan that focuses on a clear comms plan and training .

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Measure: Return To Work Interview Complete							
Domain:	People	NOF:	No	Accountable Exec:	Jo Harrison	Author: Claire Ingle	
Target:	95%	Actual:	51.5%	Data Period	September 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. **SPC charts use three rules to identify significant change:** • Rule 1 – Outside expected range: A point falls outside the control limits, indicating unusual variation that may need investigation. • Rule 2 – Shift: 8 consecutive points above or below the average, indicating a sustained change.	The SPC shows RTW rates since Aug24 monitored against the Trust target of 80%. Currently the completion rate stands at 51.5%, 43.45% below target. Based on the SPC chart rules an improving trend can be seen based on both 6 consecutive increases and 8 consecutive data points above the mean. We are still experiencing challenges such as: Entering of absences retrospectively into HeRo (Health Roster) - this has now been rectified from the end of Sept. Time pressures that managers are reporting to complete RTW's.	Improvements to Return to Work (RTW) processes are focused on better recording, stronger manager engagement and simpler processes. HeRo now allows retrospective RTWs to be recorded, improving data quality and reliability. Managers are being supported through guidance, video demonstrations, drop-in sessions and communications, alongside a leadership focus on increasing RTW completion. The revised attendance policy simplifies RTWs by allowing greater flexibility in how and when conversations take place, supported by a shorter template focused on wellbeing, prevention and avoiding recurrence. Further automation is planned for Q4, including pre-population of information and automatic recording and saving of completed RTWs	The main risk is incomplete recording of Return to Work (RTW) conversations, limiting understanding of absence causes and opportunities for early intervention, prevention and reasonable adjustments. Manager feedback indicates that RTW conversations are taking place, but are not always recorded. Mitigations include a simplified RTW process, retrospective recording in HeRo, manager guidance and video demonstrations, and a revised policy allowing RTW conversations to be recorded when a return is agreed rather than requiring a separate meeting. Further automation will streamline recording, supported by monthly SPC monitoring and weekly follow-up in areas of low compliance.

Public Board 25/26 15.10.24

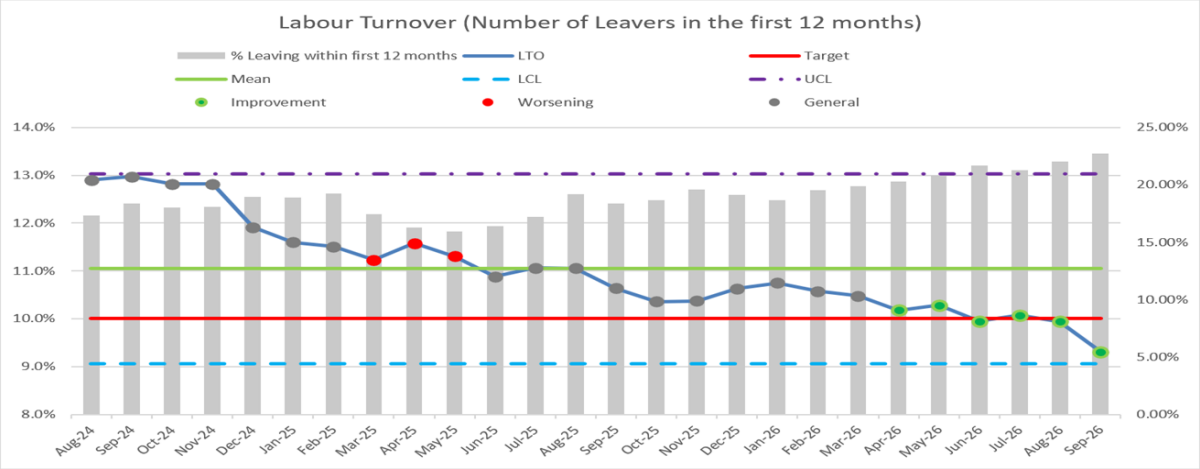
• Rule 3 – Trend: 6 consecutive increases or decreases, indicating a consistent direction of travel.			

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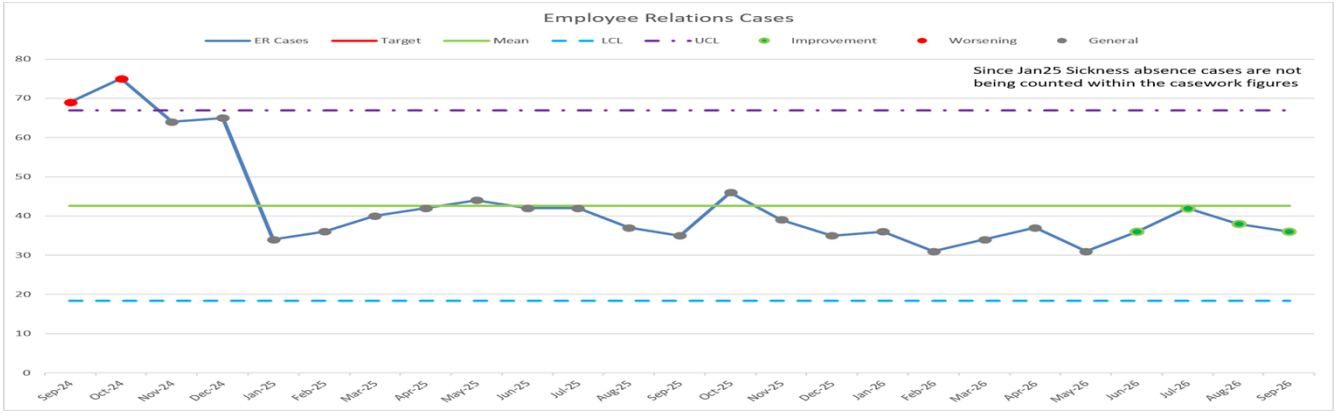
Measure: Labour Turnover						
Domain:	People	NOF: No	Accountable Exec:	Jo Harrison	Author: Claire Ingle	
Target:	10%	Actual:9.3%	Data Period	September 26	DQ Assessment	TBD



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 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. **SPC charts use three rules to identify significant change:** • Rule 1 – Outside expected range: A point falls outside the control limits, indicating unusual variation that may need investigation. • Rule 2 – Shift: 8 consecutive points above or below the average, indicating a sustained change. • Rule 3 – Trend: 6 consecutive increases or decreases, indicating a consistent direction of travel.	Labour turnover is 9.3%, below the 10% target, with the SPC showing an improving trend. However, the proportion of staff leaving within their first 12 months has increased since January 2026. Wider NHS uncertainty and fewer external opportunities may also be contributing to reduced staff movement.	With current climate it is expected that LTO will stay within the target for the foreseeable future. A renewed focus on exit interview completion is being stood up with data being more robustly analysed for trends and areas for focused interventions to prevent people leaving.	**Risk:** Turnover may rise as NHS-wide opportunities increase. **Mitigation:** Monthly monitoring and strengthened retention activity. **Risk:** Early leavers have increased since January 2026. **Mitigation:** Improve the new starter experience and introduce 3- and 6-month stay conversations. **Risk**: 9% of leavers move to other NHS organisations. **Mitigation:** Benchmark and better promote our flexibility and development offer. **Risk:** Career progression is contributing to turnover. **Mitigation:** Strengthen internal career pathways, including through LMH development. **Risk:** Retirement remains a significant driver of turnover. **Mitigation:** Promote retire-and-return and phased working. **Risk:** MH Inpatients has the highest turnover, affecting continuity and agency use. **Mitigation:** Targeted deep dive into exit data, workload and wellbeing.

2988 Board 2024 Item 6 3:09:24

Measure: Number of employee relations cases							
Domain:	People	NOF: No		Accountable Exec:	Jo Harrison	Author: Claire Ingle	
Target:	30	Actual:	36	Data Period	September 26	DQ Assessment	TBD



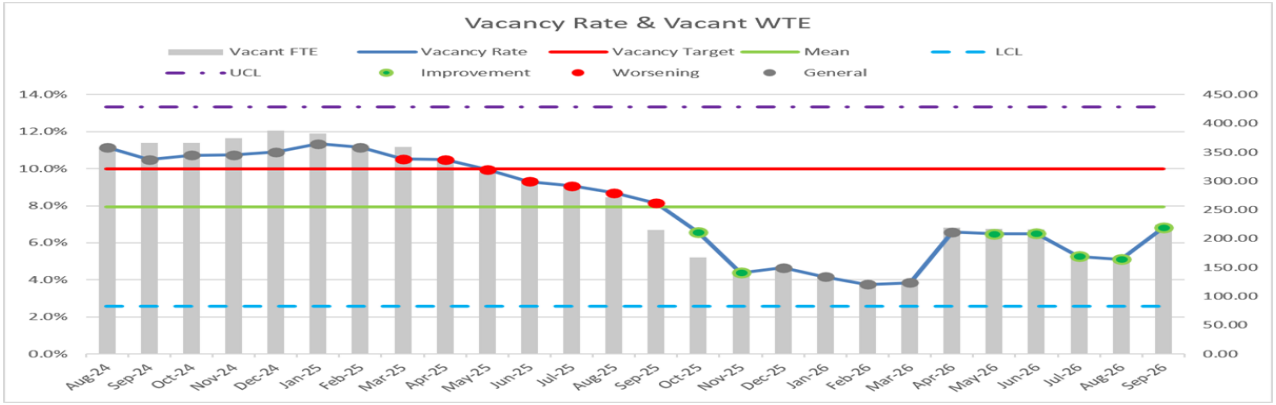
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring the number of Employee Relations cases in the NHS is important because it provides insight into workforce issues, organisational culture, and potential risks that could affect staff wellbeing and service delivery. **SPC charts use three rules to identify significant change:** • Rule 1 – Outside expected range: A point falls outside the control limits, indicating unusual variation that may need investigation. • Rule 2 – Shift: 8 consecutive points above or below the average, indicating a sustained change. • Rule 3 – Trend: 6 consecutive increases or decreases, indicating a consistent direction of travel.	There is a target of 30 for ongoing active ER cases at any one-time, current levels are above that target, reporting 36 cases in September 2026, 6 cases above target. Based on the SPC rules this indicates an improving trend due to 8 consecutive data points being below the mean. Encouragingly, case volumes have reduced since the last submission, although they remain above the target of 30. Wider workforce pressures, organisational change and increasingly complex ER matters continue to influence overall demand. We continue to see increased grievance activity, particularly where concerns are being raised alongside processes such as organisational change and flexible working.	To keep us on track, there is an increasing focus on reducing avoidable employee harm by addressing workplace concerns early and ensuring formal processes are used proportionately. This approach is being embedded within the new disciplinary policy, with greater emphasis on learning, support and alternative approaches where formal action may not be necessary. Alongside this, there has been an increase in informal grievance resolutions, enabling concerns to be addressed earlier through constructive conversations and locally agreed actions. Collectively, these approaches aim to reduce unnecessary escalation, minimise the impact of prolonged formal processes and	No identified risk, however we continue to have strengthened case oversight, earlier intervention, increased use of informal grievance resolution, targeted manager support and the embedding of avoidable employee harm principles within the new disciplinary approach to reduce unnecessary escalation and prolonged formal processes.

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		support a more compassionate, learning-focused culture.	

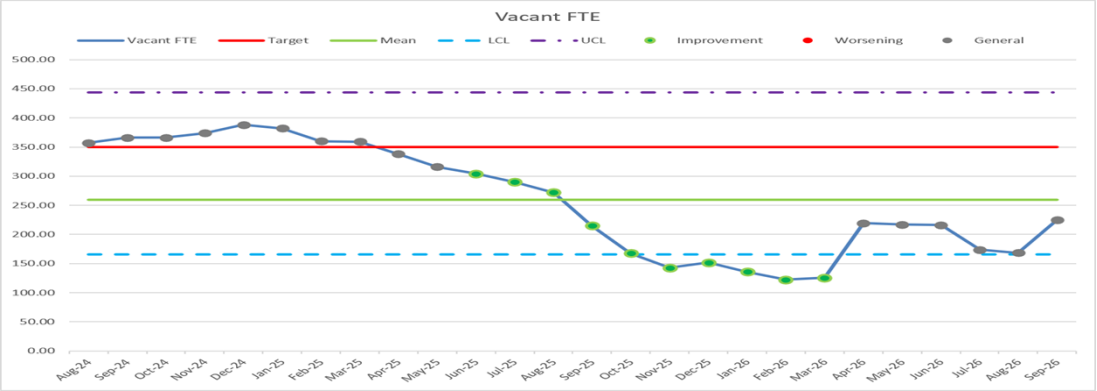
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Measure: Vacancy Rate							
Domain:	People	NOF: No		Accountable Exec:	Jo Harrison	Author: Claire Ingle	
Target:	10%	Actual:	6.81%	Data Period	September 26	DQ Assessment	TBD



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 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. **SPC charts use three rules to identify significant change:** • Rule 1 – Outside expected range: A point falls outside the control limits, indicating unusual variation that may need investigation. • Rule 2 – Shift: 8 consecutive points above or below the average, indicating a sustained change. • Rule 3 – Trend: 6 consecutive increases or decreases, indicating a consistent direction of travel.	The vacancy rate is 6.81%, 3.19 percentage points below the 10% Trust target. The SPC shows an improving position, with eight consecutive points below the mean. Despite a small monthly increase, performance remains strong and broadly aligned with the NHSE rate of 6.7%. This reflects strong recruitment and retention, vacancy controls and establishment reviews, with the recent increase likely due to normal seasonal variation.	The Trust will maintain its focus on recruitment performance, workforce planning, vacancy controls and staff retention. This includes continued investment in wellbeing, flexible working, career development and effective workforce supply strategies, alongside robust establishment reviews to ensure recruitment activity aligns with service need. Sustaining the current position will require continued attention to labour turnover, recruitment market challenges for specialist roles, and the potential impact of national immigration and sponsorship changes on future workforce supply.	**Risks:** Vacancy levels could increase due to rising turnover, national shortages in MH nursing and other registered professions, and continued competition for hard-to-fill roles. Changes to immigration and sponsorship rules, uncertainty around the Band 3 HCSW profile, and wider Band 2 to Band 3 workforce changes may further constrain recruitment. Implementation of the NHS People Platform (NHSPP) may create short-term recruitment pressures during transition, while the Employment Rights Act may affect temporary workforce supply, agency costs and workforce flexibility. **Mitigations:** Continued focus on retention and wellbeing, proactive workforce planning and vacancy scrutiny, targeted attraction for hard-to-fill roles, workforce redesign where appropriate, and monitoring of labour market and legislative changes. Strong programme governance will support NHSPP implementation while maintaining recruitment performance.

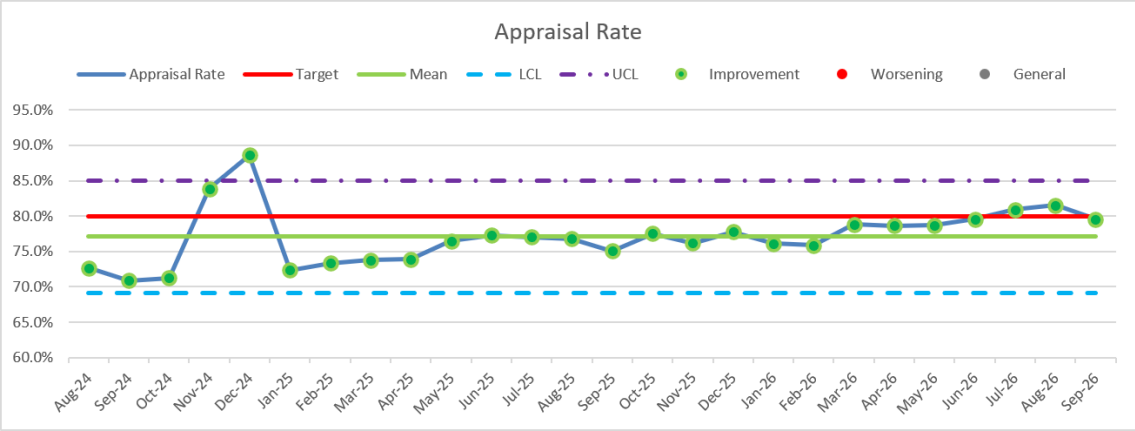
Measure: Variation from budgeted establishment							
Domain:	People	NOF: No		Accountable Exec:	Jo Harrison	Author: Danielle Stephenson	
Target:	350	Actual:	224.70	Data Period	September 26	DQ Assessment	TBD



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 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. **SPC charts use three rules to identify significant change:** • Rule 1 – Outside expected range: A point falls outside the control limits, indicating unusual variation that may need investigation. • Rule 2 – Shift: 8 consecutive points above or below the average, indicating a sustained change. • Rule 3 – Trend: 6 consecutive increases or decreases, indicating a consistent direction of travel.	The SPC shows vacant FTE data since Aug24 monitored against the Trust target of 350. Currently the vacant FTE stands at 224.70, which is 125.3 below target. Based on the SPC rules an improving trend was seen between Jun25 and Mar26 due to both 6 consecutive decreases and 8 consecutive data points below the mean, however data since Apr26 is showing no significant trend.	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 three directorates to monitor closely as individually September data is showing they are over the 10% vacancy target (by most 4.08%) 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.

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Measure: Appraisal compliance							
Domain:	People	NOF: No		Accountable Exec:	Jo Harrison	Author: Naomi Fernandez	
Target:	80%	Actual:	79.5%	Data Period	September 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 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. **SPC charts use three rules to identify significant change:** • Rule 1 – Outside expected range: A point falls outside the control limits, indicating unusual variation that may need investigation. • Rule 2 – Shift: 8 consecutive points above or below the average, indicating a sustained change. • Rule 3 – Trend: 6 consecutive increases or decreases, indicating a consistent direction of travel.	The SPC shows appraisal compliance rates since Aug24 monitored against the Trust target of 80%. Currently the appraisal compliance rate stands at 79.5 %, 0.5% below target. Based on the SPC chart rules all data points are indicating an improving trend, with multiple data points being above the mean. We have appraisal anniversary dates with no set date per annum, % rate for compliance can fluctuate. May be low points in the year due to service pressures, changes in service that may	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 data provides staff experience insight and management support, quality and effectiveness of objective setting. Results feed into induction journey & training to develop staff & managers. To embed shared responsibility, support employee life cycle that improves staff experience. Service areas will be contacted monthly that have low compliance rates below the KPI. Service managers asked to improve appraisal uptake and recording in their area to monitor improvement.	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

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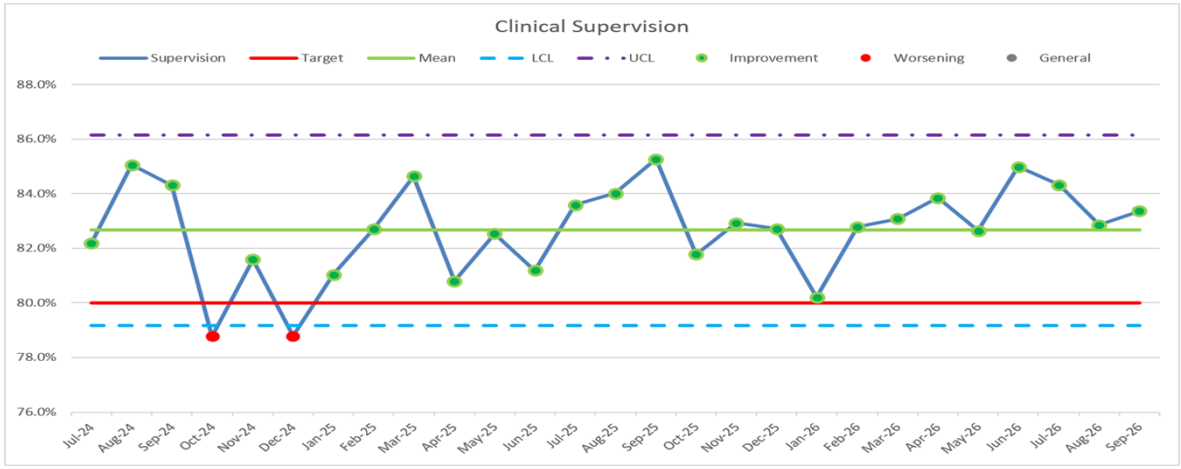
	impact completion of appraisal in a timely manner.		

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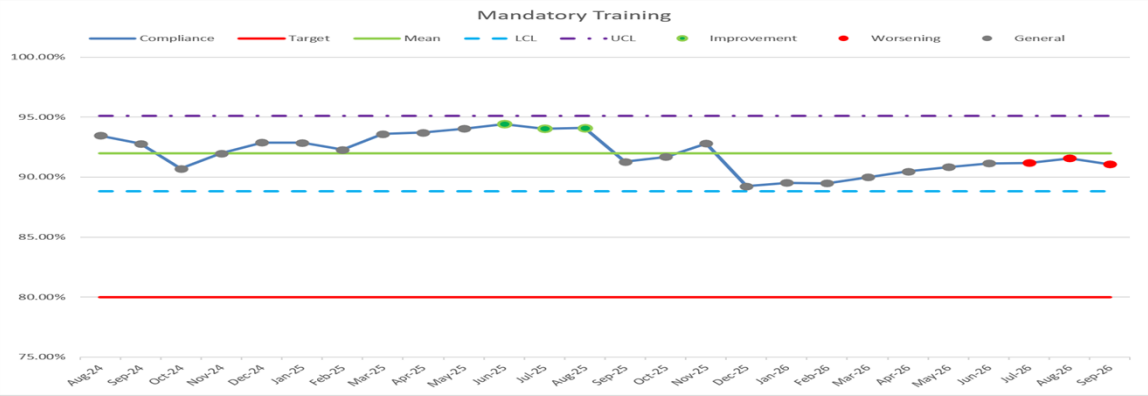
Measure: Clinical supervision							
Domain:	People	NOF: No		Accountable Exec:	Jo Harrison	Author: Naomi Fernandez	
Target:	80%	Actual:	83.3 %	Data Period	September 26	DQ Assessment	TBD



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 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 charts follow 3 rules:** **Rule 1**: Point outside control limits - "A data point has fallen outside the expected range of variation, indicating a potential special cause requiring investigation." **Rule 2**: Shift (8 consecutive points on one side of the mean) - "Eight consecutive data points above or below the average suggest a sustained shift in performance." **Rule 3**: Trend (6 consecutive increases or decreases) - "Six consecutive increases or decreases indicate a consistent upward or downward trend in performance."	The SPC shows clinical supervision compliance rates since Aug24 monitored against the Trust target of 80%. Currently the clinical supervision compliance rate stands at 83.35%, 3.35% above target. Based on the SPC rules most data points are indicting an improving trend due to the consecutive data points above the mean. 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. Inc; NHSE CPD funding investing in external trainers for clinical supervision/supervisor upskilling & refreshing. Available as a half day online offer at points across the year. The preceptorship programme further supports / promotes clinical supervision by mandating a clinical supervisor to be allocated and booking onto (not attending) the clinical supervision training within the first 2 weeks into post. Further work is underway to support digital recording, notifications to support clinical supervision infrastructure.	None to report.

Oct 2026 15:09:24

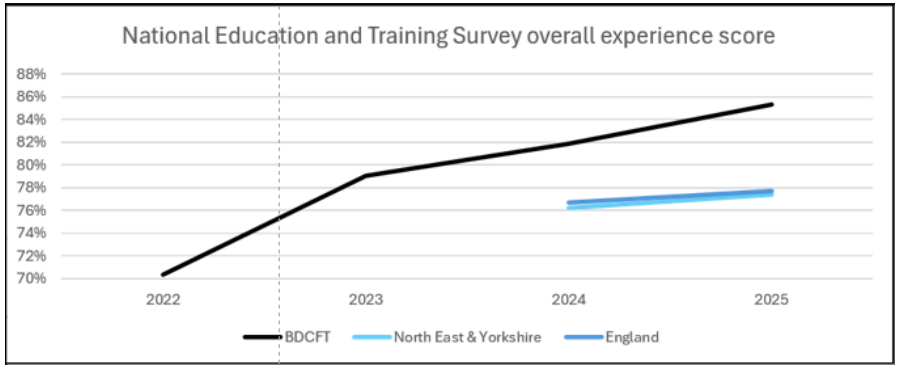
Measure:	Mandatory Training Compliance						
Domain:	People	NOF:	No	Accountable Exec:	Jo Harrison	Author:	Naomi Fernandez
Target:	80%	Actual:	91.07%	Data Period	September 26	DQ Assessment	TBD

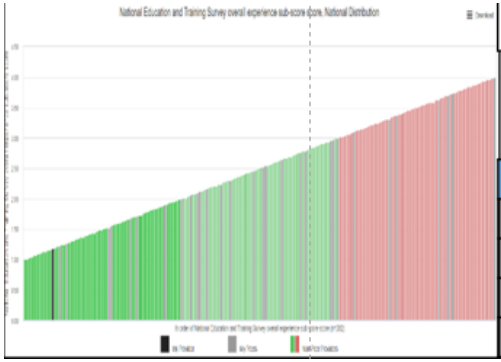


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring mandatory training compliance in the NHS is important: mandatory training ensures that 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 charts follow 3 rules:** **Rule 1**: Point outside control limits - "A data point has fallen outside the expected range of variation, indicating a potential special cause requiring investigation." **Rule 2**: Shift (8 consecutive points on one side of the mean) - "Eight consecutive data points above or below the average suggest a sustained shift in performance." **Rule 3**: Trend (6 consecutive increases or decreases) - "Six consecutive increases or decreases indicate a consistent upward or downward trend in performance."	The SPC shows mandatory training compliance rates since Aug24 monitored against the Trust target of 80%. Currently the compliance rate stands at 91.07%, 11.07% above target. Based on the SPC rules, despite rates increasing, the data is indicating a worsening trend due to 8 consecutive data point being below the mean. The Doctors' Induction is held in August 2026, as this has a significant impact on compliance figures during both August and September. This process is managed by the Medical Workforce Compliance Team, who coordinate mandatory training days to support doctors in achieving and maintaining training compliance. This explains the temporary dip and apparent worsening in compliance, which is consistent with trends observed in previous years (2024 and 2025 respectively).	ESR provides compliance/ due date notifications for managers/staff. Reports on low compliance target support for services and teams. The compliance data we currently receive is primarily competency and SME-driven. We are now working on developing a reporting spreadsheet that focuses on compliance by service areas, enabling teams to identify areas of low compliance more easily and receive targeted support and interventions where required. This will be reported into service monthly to monitor improvements and further target support to areas. Medical staffing setting up a steering group to drive the 10-point plan and improvements which will support improvement in medical staffing and compliance.	Any Mand training application follows a governance process which supports compliance monitoring; however, when introducing a new mandated learning in the Trust that will impact directly the overall compliance-This is the case of Oliver McGowan Training.

Cross-boundary working 15.09.25

Measure: National Education and Training Survey overall experience sub-score - new measure							
Domain:	People	NOF:	Yes	Accountable Exec:	Jo Harrison	Author: Naomi Fernandez	
Target:	-	Actual:	85.32% (NOF 1)	Data Period	2025	DQ Assessment	TBD





NOF Q1 Ranking – 6/58, NOF Score – 1.18 (85.32%)

Score	Threshold	2025
1	Organisations scored between 1.00 and 4.00 based on % positive responses ranked high to low (Higher is better).	85.32%
2		
3		
4		

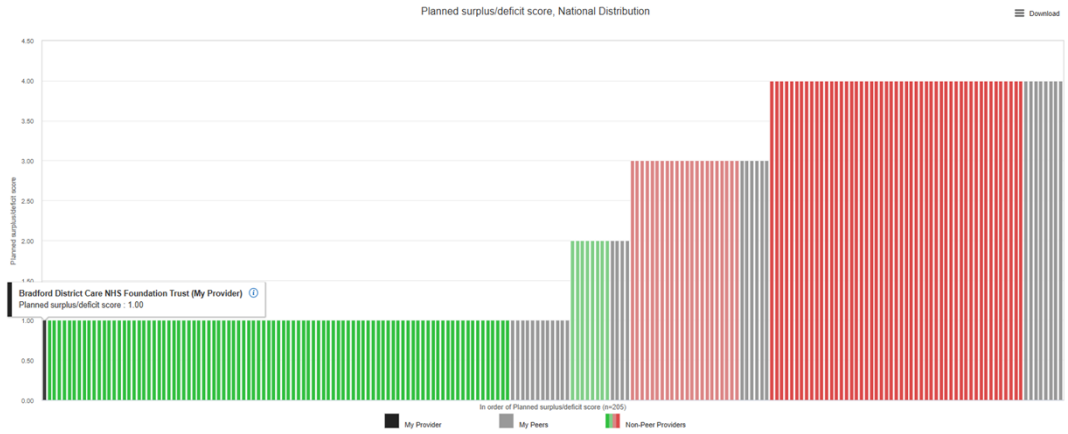
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a newly report NOF indicator for this quarter.	We are on Track, shown year-on-year improvement in our scores and have a current position that is much higher than reginal and national figures.		

Close Holly 29/10/2026 15:09:24

Return to Finance and Productivity Summary

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Measure:	Planned surplus / deficit / Variance year to date financial plan						
Domain:	Finance and Productivity	NOF:	Yes	Accountable Exec:	Mike Woodhead	Author:	Anne-Marie Dewhirst
Target:	Achieve Plan for both	Actual:	0.00% (NOF1) / 0.02 (NOF1)	Data Period	Q1 26/27	DQ Assessment	TBD



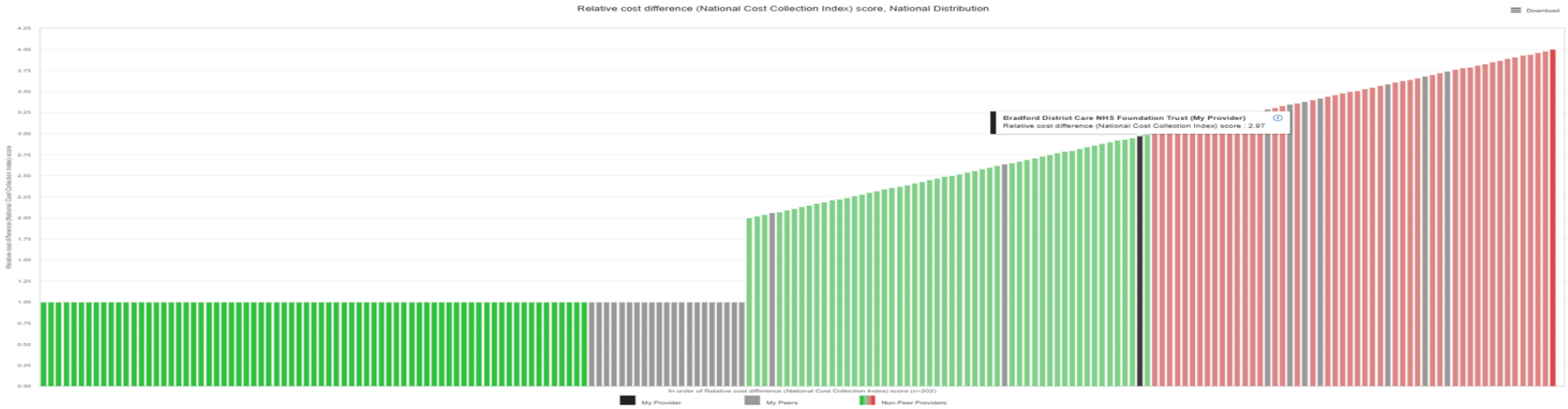
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This measure reflects the financial performance for the Trust and confidence that the Trust will deliver its plan.	We are reporting in line with plan at Month 6 and continuing to forecast a **breakeven position.** The main risks continue to arise from the delivery risk on the CIP programme. A forecast £4.6m CIP shortfall is reported in the financial position at Month 6, with non recurrent mitigation plans identified to cover the risk. The risk of further deterioration has been assessed between £3.2m to £8.8m.	**Recovery actions underway** • 90-day recovery sprint delivering early improvements, with stronger operational grip, seven-day working. • Adult, Children's and Physical Health 3% savings targets identified (non recurrently) • Transformation programme progressing, with 96 opportunities identified and three priority automation schemes advancing to detailed assessment. • Digital reviews underway, with benchmarking and contract analysis identifying potential savings opportunities. • People Services benchmarking underway	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.

Close Holly 29/10/2026 15:09:24

Return to Finance and Productivity Summary

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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:	106.45 (NOF 2)	Data Period	24/25	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.

Olivia Holly
29/10/2026 15:09:24

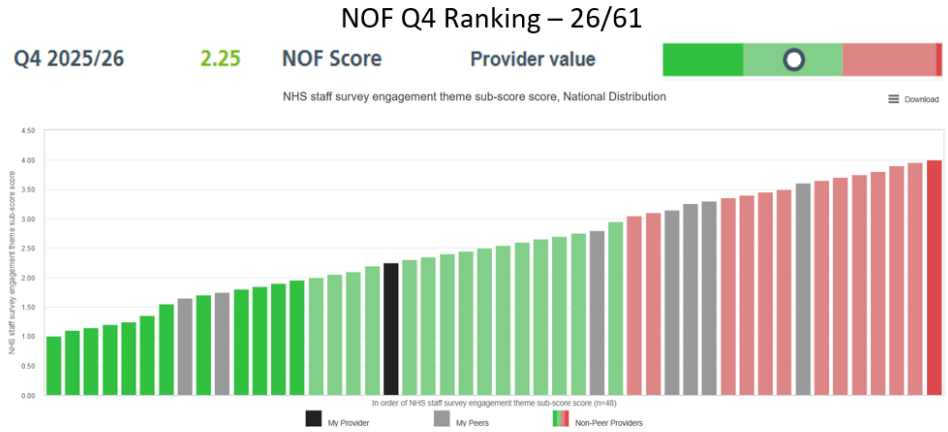
Appendix 3 – Annual Measures

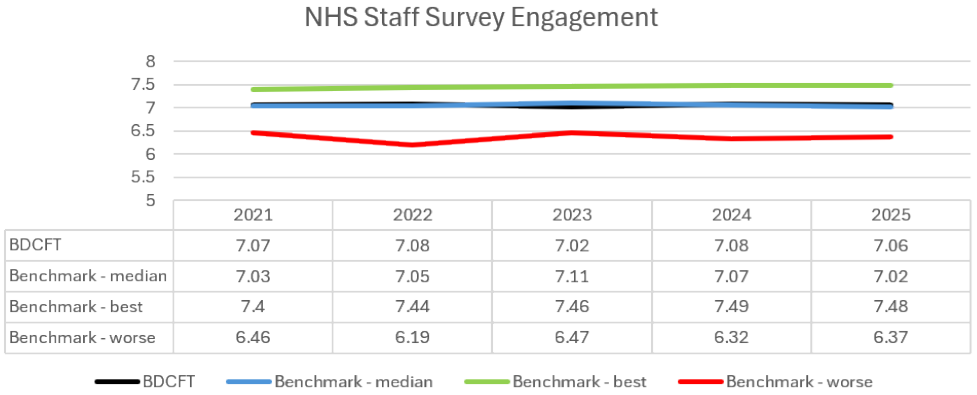
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Return to People Summary Page

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





	2021	2022	2023	2024	2025
BDCFT	7.07	7.08	7.02	7.08	7.06
Benchmark - median	7.03	7.05	7.11	7.07	7.02
Benchmark - best	7.4	7.44	7.46	7.49	7.48
Benchmark - worse	6.46	6.19	6.47	6.32	6.37

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** is a key measure of staff experience and contributes to the quarterly NOF rating and NHS Staff Standards. Based on nine questions covering motivation, involvement and advocacy, performance has remained consistent over the past five years and above the benchmark median in four of five years, including 2024 and 2025. This contributes to the Trust's improving, above-benchmark NOF position.	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.

Agenda 26/04/2026 15:09:24

NHS
Bradford District Care
NHS Foundation Trust

Board of Directors – Meeting held in Public

5 November 2026

Paper title:	Board Assurance Framework	**Agenda Item** **18.1**
Presented by:	Fran Stead - Trust Secretary Chris Dixon – Deputy Director of Nursing and Professions	
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 within 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

Close Holly 29/10/2026 15:09:24

Purpose of the report (50 words)
This report provides an update on the Board Assurance Framework (BAF), a Board-owned tool that supports oversight of strategic priorities, effective decision-making and strategic risk management. It outlines the refreshed reporting arrangements and ongoing improvement work to strengthen assurance, governance and accountability.

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 the refreshed Board Assurance Framework reporting arrangements and take assurance from the proposed approach. • Note the current assurance position, as presented to the Board Committees in accordance with 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 within this report links to the following corporate risks as identified in the SORR: • N/A	
Care Quality Commission domains Please check **ALL** that apply	☒ Safe ☒ Effective ☒ Responsive	☒ Caring ☒ Well-Led

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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

5 November 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 that consideration be given to the positioning of the Board Assurance Framework, its linkages and its connection to the 'Strategic Risk' process.

At the Board Development Session on 30 April 2026, 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. The Board also agreed that the BAF would be removed from the ISPQR. This is version two 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

Claire Holl
13/10/2026 15:09:24

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 a new process to support stand-alone reporting arrangements outside the ISPQR.
- Alignment of the BAF with the Strategic Risk Register (SRR).
- Alignment with the Better Lives Together strategy refresh.
- Corporate Governance support for process delivery, including standardisation and independence.
- Confirmation of reporting arrangements through the relevant 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.

Close Holly
29/10/2025 15:09:24

- Using quality improvement methodology to support co-production of agreed improvements.

The improvement activity will continue throughout 2026/27, supported by the development of an action plan to guide and monitor enhancements to the Board Assurance Framework arrangements.

An initial discussion will take place at the Executive Management Team meeting on 10 November 2026 to begin considering the ongoing quality improvement of the BAF and agree the approach to taking this work forward. Progress will subsequently be reported to the Board through its quarterly updates.

4 Board Assurance Levels – November 2026

The assurance levels below represent the assessment under the existing BAF methodology and current Standard Operating Procedure. Pending the planned workshop with EMT, the assessment remains aligned to the existing strategy and reflects the assurance levels previously reported through the relevant Committees. Following the workshop, the new strategy will be aligned to the appropriate lead SROs and delegated Committees, and this section will be updated in the next iteration of the report to reflect the agreed approach.

The current assessment 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 continue to be monitored and will inform the development of the refreshed BAF arrangements.

Being the Best Place to Work

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

Delivering Best Quality Services

- Theme 1 – Access & Flow
  - Confirmed assurance level by QSC – **Limited**
  - Confirmed assurance level by FPC – **Low**
- Theme 2 – Learning for Improvement

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- 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.

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

October 2026

Close Holly
29/10/2026 15:09:24

Close Holly
29/10/2026 15:09:24

Bradford District Care
NHS Foundation Trust

Board of Directors

5 November 2026

Paper title:	Strategic Risk Assurance Report	**Agenda Item** **18.2**
Presented by:	Fran Stead – Trust Secretary	
Prepared by:	Holly Close, Senior Corporate Governance Officer & Executive Support Manager	
Committees where content has been discussed previously	Mental Health Legislation Committee; Quality and Safety Committee; Finance and Performance Committee; Audit Committee; People and Culture Committee; Board of Directors	
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 within this report contributes to the delivery of the following theme 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

Close Holly
29/10/2026 15:09:24

Purpose of the report

The purpose of this report is to provide an update on the developments of the Strategic Risk Assurance Report as part of the Board Assurance Framework. The update includes the changes to the reporting template and cycle that took place in September 2026.

Executive Summary

The Trust remains committed to regularly reviewing and strengthening its governance and assurance arrangements. Following the Board's decision in 2022 to move from a predominantly risk-based Board Assurance Framework to a more assurance-focused approach, further work has been undertaken to ensure that strategic risk reporting continues to support effective oversight, accountability and delivery of the Trust's strategic priorities.

This report sets out the revised arrangements for managing and reporting the Trust's strategic risks for 2026/27. The strategic risks have been reviewed and aligned with the refreshed *Better Lives, Together* strategy, with risk descriptions updated to improve clarity and consistency. The strategic risks previously assigned to the People and Culture Committee have also been consolidated into a single overarching workforce risk.

Strategic risk reporting will now operate on a quarterly cycle, aligned more closely with Board Committee and Audit Committee meetings. This will provide a clearer route from operational risk management, through focused Committee scrutiny, to Board oversight. The arrangements are supported by the formal adoption of the three lines of defence model, which clarifies responsibility for risk ownership, corporate oversight and independent assurance. A standard data cut-off point will be used wherever possible, with a variation for the October People and Culture Committee cycle to accommodate its earlier reporting timetable.

The report also presents the Trust's strategic risks for 2026/27, their alignment with the strategic priorities, the relevant Executive Leads and assuring Committees, and the arrangements for agreeing and monitoring assurance ratings. It provides an update on the development of the Trust's risk appetite and associated tolerance levels and identifies further work to strengthen alignment between the Strategic Risk Assurance Report, the Board Assurance Framework and the wider governance and assurance structure. The revised arrangements will be reviewed after one year to assess their effectiveness and inform any further improvements.

Overall, the changes are intended to provide a more consistent, transparent and effective approach to strategic risk assurance, maintaining a clear line of sight from risk ownership and management through Committee scrutiny to Board oversight. The Board is asked to note the developments, consider the assurance presented and identify whether any additional action is required.

Do the recommendations in this paper have any impact upon the requirements	☐ **Yes** (please set out in your paper what action has been taken to address this)

Agnes Ikay
29/10/2025 15:09:24

of the protected groups identified by the Equality Act?	☒ **No**

Recommendation(s)
The Board of Directors is asked to: • note the update provided and the next steps as part of the agreed development work for this area • note the changes to the reporting template and cycle • note the assurance-rating approach and agree the assurance rating for the strategic risk for which the Board is the assurance receiver • agree any additional actions required to receive further assurance.

Links to the Strategic Organisational Risk register (SORR)	The work contained within this report links to the following corporate risks identified in the SORR: Not applicable
Care Quality Commission domains Please check **ALL** 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 - Provider Licence - NHS Act 2006 - Health & Care Act 2022 - Trust Constitution - NHS Code of Governance

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Board of Directors – 5 November 2026

Strategic Risk Assurance Report

1 Introduction

As an improvement organisation, the Trust has a strong commitment to regularly reviewing its practices. An example of this occurred in 2022, when the Board agreed to change the Board Assurance Framework model in place at that time. The change was intended to create a process focused on assurance of progress, with accountability for mitigating deviation from plan, rather than a predominantly risk-based approach to oversight and assurance. This resulted in a new process and report for strategic risk.

2 Better Lives Together (BLT)

The Trust strategy describes our role in connecting people to the best-quality care, where and when they need it, and in being a national role model as an employer.



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

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

As part of the 2026–2031 Trust strategy refresh, the following strategic priorities were agreed:

- Supporting and valuing our workforce, creating the conditions they need to deliver safe, high-quality care
- Providing safe, effective and compassionate care
- Using our resources effectively to deliver the greatest benefit for our communities
- Working together with partners to improve care for our communities

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3 Strategic Risk

The Board is asked to note that Strategic Risk reporting across Committees now operates on a quarterly cycle. This change from the previous bi-monthly approach reflects revisions to Committee schedules and aligns reporting more effectively with the Audit Committee cycle, strengthening oversight and assurance.

In addition, the strategic risks assigned to the People and Culture Committee have been consolidated from four risks into a single overarching strategic risk. This change follows a review of the strategic risks to ensure that risks remain strategic in nature and aligned to the Trust's current position and priorities.

As part of the wider review of the Strategic Risk Register, a number of the strategic risk descriptors have also been refreshed to improve consistency and clarity across the register. Risk statements have been aligned to the standard Board-approved format of *"If [cause/event], then [risk], resulting in [impact/consequence]"*.

The Board is reminded that strategic risks are reviewed by the relevant Committees in line with their respective remits, providing focused scrutiny. The Audit Committee receives the Strategic Risk Report following consideration by the relevant Committees, enabling it to review both the risk content and the effectiveness of the assurance framework after Committee-level scrutiny has taken place.

This approach is further strengthened through the formal adoption of the three lines of defence model, which clarifies roles and responsibilities across the organisation:

- First line: Operational management ownership and mitigation of risks;
- Second line: Corporate oversight functions providing challenge, guidance and monitoring of risk management processes;
- Third line: Independent assurance, primarily through Internal Audit and the work of the Audit Committee.

This model supports a more structured and transparent approach to assurance, ensuring that risks are both managed effectively and subject to appropriate levels of independent scrutiny.

Current reporting cycle

- The June Public Board was informed by Committee consideration in May, with Audit review in June.
- The November Public Board will be informed by September Committee cycles, alongside Audit consideration in late September.

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- The January Public Board will be informed by the October People and Culture Committee and the November and December Committee cycles, with Audit Committee review scheduled for December to provide final assurance ahead of the Board meeting.

A small variation is noted for the People and Culture Committee, where it is proposed that the Strategic Risk Report is scheduled for the September, October and March meetings. This approach ensures timely oversight and assurance of strategic people-related risks ahead of each corresponding Audit Committee meeting. Whilst a People and Culture Committee meeting is scheduled in December, it takes place after the December Audit Committee and therefore does not support that assurance cycle. The proposed reporting schedule therefore provides the most effective alignment between the two Committees and ensures that the Audit Committee receives the most recent assurance available.

To support consistency across reporting cycles, the standard data cut-off point will be the last working day of the preceding month wherever possible. An exception applies to the October People and Culture Committee cycle, where the earlier meeting and paper deadlines require an earlier data cut-off point. Whilst this results in a slightly earlier reporting position, it ensures that both the Committee and Audit Committee continue to receive timely assurance within the agreed governance timetable.

Key dates for reference

The table below provides a summary of the key reporting milestones and assurance route for the Strategic Risk Report.

Reporting cycle	Call for data to be provided	Data cut-off point*	Committee Consideration	Audit Committee	Public Board
September 2026	14 August 2026	28 August 2026	September Committee cycle	23 September 2026	November 2026
October 2026**	18 September 2026	2 October 2026	People and Culture Committee - 22 October 2026	10 December 2026	January 2027
November / December 2026	16 October 2026	30 October 2026	November Committee cycle	10 December 2026	January 2027

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March 2027	12 February 2027	26 February 2027	March Committee cycle	25 March 2027	First Board cycle of 2027/28

** As a general principle, data will be extracted as at the last working day of the preceding month to provide a consistent and transparent reporting position across all strategic risks.*

*** Due to the earlier People and Culture Committee timetable, an earlier data cut-off point is required to enable report preparation, quality assurance and paper submission within agreed governance timescales.*

Looking ahead, the March Committee cycle will provide assurance on the closing position for the financial year, with reports informing the first Board cycle of the following year.

An effectiveness review of the revised reporting arrangements and implementation of the three lines of defence model will be undertaken after one year to assess alignment, quality of assurance and overall impact, informing any future refinements.

Overall, the revised timetable maintains a clear line of sight from operational risk management through Committee scrutiny to Board oversight, with the Audit Committee providing independent assurance at key points in the cycle.

3.1 Assurance rating

The strategic risks will be monitored quarterly. They will use the four assurance ratings, which will be tracked throughout the year and included in future iterations of the report. The target assurance ratings remain subject to agreement and have therefore not been populated in the table below.

The Board will consider how the Audit Committee can act as the assurance receiver for the systems and processes overseen by the other Committees, supporting good governance and risk management.



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3.2 Strategic Risks 2026/27

The 2026/27 strategic risks are set out in the table below. The full format is presented to support triangulation across the Board Committees and inform discussion.

2026/27									
Risk Ref	Risk Description	Strategic Priority					Executive Lead	Assuring Committee	Target Assurance Rating
		BPW	BUoR	BQS	BP	CG			
SR01	If pressure on workforce increases, then it could impact on the quality of care to patients resulting in poorer patient experience and outcomes.			✓			Director of Nursing, Professions and Care Standards	Quality & Safety Committee	
SR02	If the Trust does not effectively contribute to delivering health equity across the population it serves, then unwarranted variation in access, experience and outcomes for protected and inclusion health groups will persist or worsen, resulting in negative impacts on people's lives, failure to meet national expectations (including Core20PLUS5 and EDS), misalignment with Trust strategy, reputational damage, and failure to meet the Trust's moral and statutory obligations as an NHS provider to its communities.			✓			Chief Operating Officer	Quality & Safety Committee	

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SR03	If the Trust fails to fully implement the requirements of the Mental Health Act (MHA) and Mental Capacity Act (MCA), then it could result in beaches of statutory and regulatory obligations, potential enforcement action resulting in non-compliance, operational disruption, adverse impacts on quality, safety, reputation, and financial sustainability.			✓			Chief Medical Officer	Mental Health Legislation Committee	
SR04	If the Trust is unable to recruit, train and retain a skilled workforce that is representative of the population we serve, within an improvement and learning culture, the Trust will not be an employer of choice, and will be unable to deliver sustainable, high-quality services, and achieve its strategic priorities.	✓					Chief People Officer	People and Culture Committee	
SR05	If the Trust's data quality is not sufficiently accurate, timely and consistent, then decision making, performance reporting and benchmarking (including NOF, productivity indicators and reference costs) will be compromised, resulting in mis segmentation, reputational risk, inappropriate funding		✓				Director of Transformation, Productivity & Improvement	Finance and Performance Committee	

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	assumptions and reduced ability for the Trust to adapt to changing funding models.							
SR06	If a significant cyber security incident or major digital system failure occurs within the Trust, across system partners, or affecting national NHS infrastructure, then access to critical clinical and corporate systems may be disrupted or unavailable, impacting patient records, care coordination, workforce deployment, statutory reporting, financial processes, and data sharing, resulting in patient harm, regulatory breaches, financial loss, operational disruption, and reputational damage.		✓				Chief Information Officer	Finance and Performance Committee	
SR07	If the Trust fails to deliver its savings target and to control financial pressures during 2026/27, then it will fail to deliver its financial plan. Resulting in: reputational damage, regulatory intervention, financial loss, curbs on financial freedoms and flexibilities, and ultimately a detrimental impact to service delivery, service users and staff.		✓				Chief Finance Officer	Finance and Performance Committee	

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SR08	If the Trust fails to deliver on a credible, robust, compliant medium/long-term plan, then its financial performance will continue to deteriorate. Resulting in: reputational damage, regulatory intervention, financial loss, curbs on financial freedoms and flexibilities, and ultimately a detrimental impact to service delivery, service users and staff.		✓				Chief Finance Officer	Finance and Performance Committee	
SR09	If the Trust does not have robust & effective governance, risk & compliance processes in place, then it will not comply with NHS licencing conditions, CQC, NHSE regulatory & Code of Governance requirements. Resulting in the Trust breaching licence conditions.					✓	Director of Nursing, Professions and Care Standards	Audit Committee	
SR10	If the Trust does not work together with partners strategically, as Lead/Host Provider for relevant services, then opportunities will be lost to maximise improved service delivery for the population, including efficiencies. Resulting in poorer outcomes and experiences for communities, continuation of health				✓		Chief Executive	Board of Directors	

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	inequality, lack of improvement and financial efficiencies, and reputational damage for the Place.							

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3.3 Strategic Risk 2026/27 for the Board of Directors

The 2026/27 strategic risk for which the Board of Directors is the assurance receiver is included as SR10 in the table above.

4 Risk appetite and associated tolerance

The Board uses the Good Governance Institute matrix for risk appetite. A Board Development Session took place in April 2026, facilitated by the Risk Management Team, to enable the Board to agree the appetite for the five domains: financial, regulatory, quality, reputation and people. Version one of the matrix was created, and a follow-up Board Development Session will take place to develop it further.

5 Next steps

Integration with governance and assurance structures

Further consideration will be given to how the Strategic Risk Assurance Report aligns with existing assurance reporting, including the Board Assurance Framework, and how assurance is escalated through Committees to the Board. As part of the Trust's ongoing commitment to effective governance and being a learning and improvement organisation, the BAF process will also be discussed further with the Executive Support Team (EMT) to support a co-produced approach to the BAF and strategic risk management. A workshop is currently being planned to take this forward. This work will reflect feedback from the external Well Led review and support ongoing governance development, with further updates provided as the approach develops.

Ongoing development and review

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

The Board of Directors is asked to:

- note the update provided and the next steps as part of the agreed development work for this area
- note the changes to the reporting template and cycle
- note the assurance-rating approach and agree the assurance rating for the strategic risk for which the Board is the assurance receiver
- agree any additional actions required to receive further assurance.

Cleared by Holly Close 29/01/2026 15:09:24

Holly Close
Senior Corporate Governance Officer & Executive Support Manager
October 2026

Bradford District Care
NHS Foundation Trust

Fran Stead
Trust Secretary
October 2026

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First line – Management

Under the ‘first line role’, management have primary ownership, responsibility and accountability for identifying, assessing and managing risks. Their activities create and/or manage the risks that can facilitate or prevent an organisation’s objectives from being achieved.

The first line ‘own’ the risks and are responsible for execution of the organisation’s response to those risks through executing internal controls on a day-to-day basis and for implementing corrective actions to address deficiencies. Through a cascading responsibility structure, managers design, operate and improve processes, policies, procedures, activities, devices, practices, or other conditions and/or actions that maintain and/or modify risks and supervise effective execution.

Second line– management oversight

The second line role consists of functions and activities that monitor and facilitate the implementation of effective risk management practices and facilitate the reporting of adequate risk related information up and down the organisation. The second line should support management by bringing expertise, process excellence, and monitoring alongside the first line to help ensure that risks are effectively managed.

Third line– Audit and regulators

Internal and External audit is the third line of defence. An effective audit function through a risk-based approach to its work, provides an objective evaluation of how effectively the organisation assesses and manages its risks.

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2026/27									
Risk Ref	Risk Description	Strategic Priority					Executive Lead	Assuring Committee	Target Assurance Rating
		BPW	BUoR	BQS	BP	GG			
SR01	If pressure on workforce increases, then it could impact on the quality of care to patients resulting in poorer patient experience and outcomes.			✓			Director of Nursing, Professions and Care Standards	Quality & Safety Committee	
SR02	If the Trust does not effectively contribute to delivering health equity across the population it serves, then unwarranted variation in access, experience and outcomes for protected and inclusion health groups will persist or worsen, resulting in negative impacts on people's lives, failure to meet national expectations (including Core20PLUS5 and EDS), misalignment with Trust strategy, reputational damage, and failure to meet the Trust's moral and statutory obligations as an NHS provider to its communities.			✓			Chief Operating Officer	Quality & Safety Committee	
SR03	If the Trust fails to fully implement the requirements of the Mental Health Act (MHA) and Mental Capacity Act (MCA), then it could result in beaches of statutory and regulatory obligations, potential enforcement action resulting in non-compliance, operational disruption, adverse impacts on quality, safety, reputation, and financial sustainability.			✓			Chief Medical Officer	Mental Health Legislation Committee	
SR04	If the Trust is unable to recruit, train and retain a skilled workforce that is representative of the population we serve, within an improvement and larning culture, the Trust will not be an employer of choice, and will be unable to deliver sustainable, high-quality services, and acheive its startegic priorities.	✓					Chief People Officer	People and Culture Committee	
SR05	If the Trust's data quality is not sufficiently accurate, timely and consistent, then decision making, performance reporting and benchmarking (including NOF, productivity indicators and reference costs) will be compromised, resulting in mis segmentation, reputational risk, inappropriate funding assumptions and reduced ability for the Trust to adapt to changing funding models.		✓				Director of Transformation, Productivity & Improvement	Finance and Performance Committee	
SR06	If a significant cyber security incident or major digital system failure occurs within the Trust, across system partners, or affecting national NHS infrastructure, then access to critical clinical and corporate systems may be disrupted or unavailable, impacting patient records, care coordination, workforce deployment, statutory reporting, financial processes, and data sharing, resulting in patient harm, regulatory breaches, financial loss, operational disruption, and reputational damage.		✓				Chief Information Officer	Finance and Performance Committee	

Assurance Level	Definition
High (Strong)	High assur ambition is There are e area which
Significant (Good)	Significant this standa areas / revi are infrequ to rapidly a
Limited (Improvement Required)	Limited ass elements o are areas t required st
Low (Weak)	Low assura ambitions a evidence o be undertal

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SR07	If the Trust fails to deliver its savings target and to control financial pressures during 2026/27, then it will fail to deliver its financial plan. Resulting in: reputational damage, regulatory intervention, financial loss, curbs on financial freedoms and flexibilities, and ultimately a detrimental impact to service delivery, service users and staff.		✓				Chief Finance Officer	Finance and Performance Committee	
SR08	If the Trust fails to deliver on a credible, robust, compliant medium/long-term plan, then its financial performance will continue to deteriorate. Resulting in: reputational damage, regulatory intervention, financial loss, curbs on financial freedoms and flexibilities, and ultimately a detrimental impact to service delivery, service users and staff.		✓				Chief Finance Officer	Finance and Performance Committee	
SR09	If the Trust does not have robust & effective governance, risk & compliance processes in place, then it will not comply with NHS licencing conditions, CQC, NHSE regulatory & Code of Governance requirements. Resulting in the Trust breaching licence conditions.					✓	Director of Nursing, Professions and Care Standards	Audit Committee	
SR10	If the Trust does not work together with partners strategically, as Lead/Host Provider for relevant services, then opportunities will be lost to maximise improved service delivery for the population, including efficiencies. Resulting in poorer outcomes and experiences for communities, continuation of health inequality, lack of improvement and financial efficiencies, and reputational damage for the Place.				✓		Chief Executive	Board of Directors	

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rance can be given that there is strong evidence that this s being achieved and is embedded within usual practice. examples of outstanding practice and/or innovation in this n can be evidenced.
assurance can be given that there is good evidence that rd is this ambition is being achieved across the majority of iews undertaken. Whilst there may be some gaps, these ient and there is evidence these are mitigated / responded and appropriately.
surance can be given as whilst there is evidence that some of the ambition are being achieved across some areas, there that require improvement in order to bring them up to the tandard.
ance can be given as there is weak or no evidence that the are being achieved. There are significant gaps with little of effective plans to address and significant works needs to iken to bring these areas up to standard.

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Strategic Objective	1.Best Quality Services	Risk appetite	Quality - Seek
Strategic Risk		Assuring Committee	Quality & Safety Committee
If pressure on workforce increases, then it could impact on the quality of care to patients resulting in poorer patient experience and outcomes.		Executive lead	Phil Hubbard, Director of Nursing, Care Standards & Professions

Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4
	Low	Significant		

Contributory risks from the directorate risk register				Risk Score			
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1	Period 2	Period 3	Period 4
1636	Workforce systems and data integrety/accuracy impacint on service reporting	Joanne Harrsion	Risk and Compliance	6	4		
2509	Demand within community nursing	Kelly Barker	Risk and Compliance	16	16		
1674	demand on band services impacting on service delivery	Kelly Barker	Risk and Compliance	12	12		
3020	demand on coccupational therapy due to long term sickness and maternity leave	Kelly Barker	risk and Compliance	12	12		
3023	unfilled vacancies for band 3 health care support workers	Joanne Harrsion	Risk and Compliance	12	12		

Executive Lead Narrative: Date:	Daily oversight of staffing levels and mitigations in place to support within all settings. A review of current vacancies is currently taking place, and included within the OSPB oversight. A yearly review of safer staffing assessment of systems and process has been undertaken by NHSE and assurance statement at board September 2026. All DD of professions reviewing current assumptions on model roster work to be concluded end Septemebr 2026 - 1.9.2026

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR01.000	•Good compliance with mandatory and essential training •Quality Strategy approved by the Board •Professionals strategy •BDCFT Trust Strategy •NHS England » Patient Safety Incident Response Framework •Being Open Policy •NHSE Safeguarding Assurance Framework Developing-workforce-safeguards •NHS England » National Quality Board guidance on Safe Staffing •Recruitment plan and schedule for newly qualified •nurse, and HCSW Recruitment via recruitment centers •EQIA process and panel •Revised Clinical Governance, Quality and Safety Group •Quality assurance framework	•Safer Staffing Annual and Board Assurance Reports •Quality Board and Quality & Safety Committee reports triangulating staffing, incidents and patient experience •Quality assurance Framework (QAF) reviews and responsive assessments in pressured services •Performance & Intelligence via Daily lean management •Incident trends (PSIRF), •complaints and •Friends & Family Test data •Workforce metrics: vacancies, sickness, turnover, agency usage •Risk Register •IPR •Bi Annual safer staffing paper	

Significant gaps in controls	
Ref	*The main areas of weakness which result in ineffective or absent controls*
SR01.001	Quality strategy due for ratification June 2026
SR01.002	Target for mandatory and statutory not met in month. For monthly review.
SR01.003	BDCFT Trust strategy currently under review

Significant gaps in assurance	
Ref	*The main areas of weakness which result in ineffective or absent assurances*
SR01.004	Compliance NHSE Workforce Safeguards, gap analysis

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SR01.005	Review of patient safety learning process in line with PSIRF implementation

Details of Assurance		
Sources of assurance that demonstrate the controls are effective		
Level 1: Operational Oversight	**Level 2: Reports / Metrics overseen by Board / Committee**	**Level 3: Sources of external oversight / scrutiny**
Daily Lean Management,l review of Incdent	6 monthly reporting of safer staffing, ISPQR reports and deep dives to	NHSE assurance statements yearly review, CNSST and

Mitigating actions underway for controls and assurance:				
Ref	*Actions required to mitigate weaknesses*	*Lead*	*Target Date*	*Progress*
SR01.006	Complete the NHSE Workforce Safeguards gap analysis and deliver the associated action plan, aligned to the forthcoming NHSE safer staffing audit.	Phillipa Hubbard	2.4.2026 - **COMPLETED**	Annual review by NHSE undertaken with assurance on system and processes in place, including governance arrangemenhts, public transparencym workforce data, reporting and triangulation . This has been completed and will be presented to board in September 2026
SR01.007	Progress the Quality Strategy to formal ratification by June 2026 and implement a structured communication and embedding plan across clinical services.	Christopher Dixon and Phillipa Hubbard	**30.6.2026 - COMPLETED**	work with professional councils being undertaken to review the professional strategy and incorpoate performance metrics. Enagement with all professionals and is currently being reviewed within professional councils - 26.8.2026 This has been ratified and awating publication
SR01.008	Ensure the refreshed BDCFT Trust Strategy explicitly reflects workforce sustainability, safer staffing, staff wellbeing and quality impact during periods of increased demand	Phillipa Hubbard	**01/07/2026 - revised to 21 September 2026**	I will be responsible for ensuring clear lines of accountability and metrics within the BDCFT Trust Strategy in reflection of workforce sustaninablity, pipelines and safer staffing including the well being of support services to staff .26.8.2026 - The Trust strategy will be ratified in September 2026 and presented at annual members
SR01.009	Review and strengthen patient safety learning process in line with PSIRF implementation, ensuring learning from incidents related to staffing pressure is consistently captured, shared and acted upon.	Phillipa Hubbard	jun-26	The current ToR for the patient safety and learning group are being updated this will include the refresh of the patient safety strategy which was completed in January 2026 and ensuring there is clear evidence of safer staffing measures which are monitored through daily DLM, Safer staffing group, deep dives and incident monitoring 26.8.2026 - this has been presented at Clinical Board and SLT QSG ratified
SR01.010	Further embed triangulation of workforce metrics (vacancies, sickness, turnover, agency usuage) with patient safety, compliants and experience data though Quality and Safety Committee reporting	Phillipa Hubbard	**01/05/2026 - end of September 2026**	Bi annual review of safer staffing assurance which incorporates, recruitment, management/deployment of staff vacnacies, complaints these are presented to board and quality and safety committee 26.8.26 following 90 day sprint further work is ongoing on strengthening approval process for
SR01.011	Use QAF reviews and responsive assessments to identify services under sustained pressure and implement time limited improvement and workforce support plans.	Phillipa Hubbard	continuous	Annual review of Quality Assurance Framework in line with CQC oversight Framework a plan is developed and adapted dependent on identified risk within services, increase in patient safety incidents/clinical incidentes and staff experience 26.8.2026 quartely reports to Quality and Safety committee continue, currently supporting with a 90 day sprint with acute inpatients which includes review of systems and process and oversight of patient safety and

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Strategic Objective	1.Best Quality Services	Risk appetite	Quality - Seek
Strategic Risk		Assuring Committee	Quality & Safety Committee
If the Trust does not effectively contribute to delivering health equity across the population it serves, then unwarranted variation in access, experience and outcomes for protected and inclusion health groups will persist or worsen, resulting in negative impacts on people's lives, failure to meet national expectations (including Core20PLUS5 and EDS), misalignment with Trust strategy, reputational damage, and failure to meet the Trust's moral and statutory obligations as an NHS provider to its communities.		Executive lead	Kelly Barker, Chief Operating Officer

Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4
	Low	Limited		

Contributory risks from the directorate risk register				Risk Score			
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1	Period 2	Period 3	Period 4
	Data Quallity	Farhan Rafiq	Finanace & Performnace Committee	To be entered and rated during September. This is a stategic risk			

Executive Lead Narrative: Kelly Barker
Date:

Overall assurance remains Limited. The Trust has established a clear strategic direction for health equity, supported by a named Executive Lead, development of the Health Equity Strategy and Delivery Plan, PCREF implementation, community engagement arrangements and improvements to population-level reporting. Work is progressing to align health equity within the refreshed Trust Strategy, the Integrated Performance Report and service-level performance frameworks.

However, these arrangements are not yet fully embedded or consistently translated into measurable changes in access, experience and outcomes across services. There remain gaps in data completeness, analytical capability, service-level ownership, engagement with underserved communities and the alignment of workforce equality actions with patient outcomes. Current assurance is therefore stronger in relation to planned activity and developing infrastructure than demonstrated impact.

The immediate priority is to roll out clear governance and accountability, agree a focused set of health equity measures and outcomes, improve the completeness and use of protected-characteristic data, and strengthen evidence that interventions are reducing unwarranted variation. Assurance should increase once committees and services can demonstrate sustained delivery against agreed measures, supported by lived-experience insight and independent review.

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR02.001	•Developing Health Equity Strategy & Health Equity Ctt/Board •Named Executive for health equity •Development of population health management data (including deprivation, ethnicity, protected characteristics) •Engagement and co-production approaches •Workforce Equality, Diversity and Inclusion (EDI) strategy and Workforce Race Equality Standard (WRES) actions •PCREF Organisational Plan •Clinical audit and quality improvement programmes focused on unwarranted variation •Safeguarding, inclusion health and personalised care policies	1st line: •Health Equity Strategy and Inequalities delivery plan progress reports •IPR & Service-level dashboards showing access, experience and outcome metrics by population group •Quality Improvement projects/programmes updates focused on equity •Community engagement feedback and lived experience insight 2nd line: •Quality Safety Committee reports on health equity and unwarranted variation •People Committee oversight of WRES, WDES and staff inclusion indicators •Internal policy compliance reviews 3rd line: •Internal Audit reviews of health equity governance and data quality •External regulatory feedback (CQC, NHS England) •Benchmarking against peer Trusts	

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Significant gaps in controls	
Ref	*The main areas of weakness which result in ineffective or absent controls*
SR02.002	Inconsistent translation of population data into measurable service
SR02.003	Variable ownership and accountability at service level For monthly review.
SR02.004	Limited capacity and capability in population health data management and analytics to link to health inequalities improvement methodologies and programmes
SR02.005	Inconsistent engagement with underserved communities and groups across pathways
SR02.006	Insufficient alignment between workforce EDI actions and patient equity outcomes

Significant gaps in assurance	
Ref	*The main areas of weakness which result in ineffective or absent assurances*
SR02.007	Variable quality and consistency of data on protected
SR02.008	Validation of tangible impacts – outcomes vs activity
SR02.009	Length of time between interventions and measurable population level outcomes being achieved

Details of Assurance		
Sources of assurance that demonstrate the controls are effective		
Level 1: Operational Oversight	**Level 2: Reports / Metrics overseen by Board / Committee**	**Level 3: Sources of external oversight / scrutiny**
Operational oversight is developing through	The Quality and Safety Committee provides oversight of health equity	External assurance is available through national expectations

Mitigating actions underway for controls and assurance:				
Ref	*Actions required to mitigate weaknesses*	*Lead*	*Target Date*	*Progress*
SR02.010	Set up BDCFT Health Equity Board & Strategy working Group	Kelly Barker	01.07.2026	Aligining into BDCFT Strategy Refresh which is on track for completion July 2026 and will be launched at September LBLT. Plan in place lanuch will commence post LBLT into Q4.
SR02.011	Develop BDCFT wide Health Equity Delivery Plan with clear outcomes and milestones	Kelly Barker	sep-26	Work carried out across 25/26 in relation to developing Health Equity Stratgey and delivery plan completed. Aligning its deployment into BDCFT Strategy Refresh and development of Organisational Governance as noted in SR02.010
SR02.012	Embed health equity metrics within IPR corporate and service-level performance frameworks	Farhan Rafiq	sep-26	IPR develoopment underway. Board development session held in April 2026 looking at refreshed IPR to include specfic focus on health equity. Operational level data now drillable into health equity domains within mental health services, aligned to work of PCREF.
SR02.013	Improve data quality and completeness for protected characteristics	Farhan Rafiq	mar-27	Baselining current data completeness complaince to agree month of month trajectories of imrpvment and associated improvement activiity delivery.
SR02.014	Each Committee to agree one health equity measure & outcome it wants to focus on – understanding the data, Root Cause and achievable action (Do one thing)	Kelly Barker with committee chairs	sep-26	Links to actions 010, 011, 012 - discussion with each committee chair will be tabled alongside the Stratgey refesh and IPR to identify the health equity focus, measure and outcomes.
SR02.015	Build organisational capability in health equity and improvement	Kelly Barker	nov-26	Links to actions 010, 011, 012 - as part of the delivery plan an organisational capability assessment will be completed to understand the development plan needed cross organisation and more targeted where we identify areda if focus through committees.

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Strategic Objective	1.Best Quality Services	Risk appetite	Quality - Seek
Strategic Risk		Assuring Committee	Mental Health Legislation Committee
If the Trust fails to fully implement the requirements of the Mental Health Act (MHA) and Mental Capacity Act (MCA), then it could result in beaches of statutory and regulatory obligations, potential enforcement action resulting in non-compliance, operational disruption, adverse impacts on quality, safety, reputation, and financial sustainability.		Executive lead	Sal Uka, Chief Medical Officer

Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4
	Significant	Limited		

Contributory risks from the directorate risk register				Risk Score			
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1	Period 2	Period 3	Period 4
N/A	N/A	N/A	N/A	N/A			

Executive Lead Narrative: Sal Uka Date:	The assurance rating for this strategic risk has reduced to 'partial' for two main reasons. Purposeful and Productive meetings have not been quorate during Q2 and have been stood down. A review of this meeting in underway and recommendations are expected at QSG SLT in October. No new risks have emerged as a result of this. Also, one of our two Patient Advocates has stood down. Again, a review in underway to better understand the role of Patient Advocates and how this voice can be strengthened at MHLC. There is good assurance regarding the Trust's engagement with and preparation for the Mental Health Act 2025 including a deep-dive during Q1. A recent supreme court ruling has removed the 'acid test' in the assessment of capacity within the Mental Capacity Act. Actions (described below) are underway to better understand the impact of this ruling and the Trust's response to this.

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR03.000	•MHA and MCA training compliance •Purposeful and Productive group •Hospital Managers recruitment strategy •Patient Advocates as members of MHLC	•MH performance report includes data with supporting narrative on MHS and MCA training as well as a range of metrics specific to the MHA. This reports to every MHLC meeting. •Hospital Managers bimonthly report. •PCREF reporting •Purposeful and Productive group	aug-26

Significant gaps in controls	
Ref	*The main areas of weakness which result in ineffective or absent controls*
SR03.001	Local Authority representation at MHLC

Significant gaps in assurance	
Ref	*The main areas of weakness which result in ineffective or absent assurances*
SR03.002	and have subsequently cancelled.
SR03.003	remaining. There needs to be further discussion about Patient Voice at MHLC.
SR03.004	Supreme court ruling that 'acid test' in determining capacity (Mental Capacity Act) is no longer valid.
SR03.005	Feedback from Hospital Managers that there is variation in the quality of preparedness and/or presentation skills at hearings.

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Details of Assurance		
Sources of assurance that demonstrate the controls are effective		
Level 1: Operational Oversight	**Level 2: Reports / Metrics overseen by Board / Committee**	**Level 3: Sources of external oversight / scrutiny**
The Mental Health Legislation Team	Each report to Committee contains evidence of both the timeliness of	Mental Health Services are subjected to random and

Mitigating actions underway for controls and assurance:

Ref	Actions required to mitigate weaknesses	Lead	Target Date	Progress
SR03.006	Review of Positive & Purposeful Steering Group	Gail Harrison and Thabani Songo	okt-26	Actions presented to QSG SLT 20.08.26
SR03.006	Report writing and presentation skills training	Simon Binns and Dr Anil Pillai	des-26	Pilot training session delivered and evaluated. Plans underway to develop this as BAU.

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Strategic Objective	Best place to work	Risk appetite	People- Seek
Strategic Risk		Assuring Committee	People and Culture Committee
If the Trust is unable to recruit, train and retain a skilled workforce that is representative of the population we serve, within an improvement and larning culture, the Trust will not be an employer of choice, and will be unable to deliver sustainable, high-quality services, and acheive its startegic priorities.		Executive lead	Jo Harrison, Chief People Offficer

Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4
	Low	Limited		

Contributory risks from the directorate risk register				Risk Score			
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1	Period 2	Period 3	Period 4
2755	Reduced staffing and lack of appropriate clInical skills in childrens SLT on Paediatric dysphagia	Kelly Barker	Risk and Compliance	12			
2509	Increasing demand in community nursing and static workforce capcity	Phil Hubbard	Risk and Compliance	16			

Executive Lead Narrative: Jo Harrison Date:	The overall assessment is mixed, recognising that governance and workforce management arrangements are established, and evidence demonstrates workforce plan delivery pressures. There is limited assurance in the consistent management of workforce capacity, leadership and management capability and staff experience. The assurance position will improve through sustained evidence and improvement in workforce plan delivery, sickness levels, and culture.

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR04.000	Executive and Board oversight of workforce performance and culture (+) Integrated workforce plan aligned to operational and financial plans (+/-) Workforce establishment review process (+) Vacancy control process (+/-) Recruitment and retention programmes (+) Agency controls (+) Bank controls (+/-) Mandatory training and competency frameworks (+) Workforce inc leadership development & education programmes (+) Equality diversity and inclusion programmes (+) Staff engagement mechanisms eg staff survey, FTSU, (+) Employee relations and grievance processes (+/-) Staff Networks (+) Leadership and management development programme (+/-)	ISPQR reporting, Workforce Plan delivery on bank and agency, Safer Staffing Establishment review process, EDI data and action planning, Staff survey 2025, Well Led development review	28.08.2026

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Significant gaps in controls	
Ref	*The main areas of weakness which result in ineffective or absent controls*
SR04.001	Substantive recruitment ahead of workforce plan
SR04.002	Safer staffing and workforce escalation processes for temporary staffing

SR04.003	Variation exists between services in workforce metrics and performance
SR04.004	Financial constraints restrict ability to recruit to all established posts
SR04.005	Implementation of staff standards

Significant gaps in assurance	
Ref	*The main areas of weakness which result in ineffective or absent assurances*
SR04.006	Workforce plan delivery and review
SR04.007	Succession Planning for Board roles and talent management
SR04.008	Strategic delivery plan for people matters

Details of Assurance		
Sources of assurance that demonstrate the controls are effective		
Level 1: Operational Oversight	**Level 2: Reports / Metrics overseen by Board / Committee**	**Level 3: Sources of external oversight / scrutiny**
	ISPQR reporting, scruitny and oversight through committee and Board,	Internal audit reviews (+/-) Benchmarking - NHSE and Peers (

Mitigating actions underway for controls and assurance:				
Ref	*Actions required to mitigate weaknesses*	*Lead*	*Target Date*	*Progress*
SR04.009	Workforce planning monitoring delivery including review of workforce controls	Joanne Harrison	Immediate 0-6 months (31/03/2026)	M4 data received, triangulation between people matters and finance team to develop workforce plan reporting through People and Culture Committee. Workforce controls review, actions agreed through EMT and Finance and Performance Committee for implementation.
SR04.010	Strategic delivery plan for people matters to support Trust startegy and support continuous cultural improvement	Joanne Harrison	Medium Term 6-12 months (30/09/2027)	Action plans in place following staff survey, EDI annual reporting, well led development review. Feedback loops to be strengthened, with communciation of response action to close feedback loops and build cultural change. Development of year one enabling delivery plan for strategy including strategic KPI's baseline and on-going assessment.

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Strategic Objective	Best use of Resources	Risk appetite	Regulatory - Open
Strategic Risk		Assuring Committee	Finance and Performance Committee
If the Trust's data quality is not sufficiently accurate, timely and consistent, then decision making, performance reporting and benchmarking (including NOF, productivity indicators and reference costs) will be compromised, resulting in mis segmentation, reputational risk, inappropriate funding assumptions and reduced ability for the Trust to adapt to changing funding models.		Executive lead	Farhan Rafiq Director of Transformation, Productivity & Improvement

Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4
	Low	Limited		

Contributory risks from the directorate risk register				Risk Score			
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1	Period 2	Period 3	Period 4
N/A	No open high operational risk formally confirmed as directly contributory to SR05 at the reporting date	N/A	N/A				

Executive Lead Narrative: Farhan Rafiq Date:	Position at 28 August 2026: Limited assurance is recommended for SR05. Since the previous report, the Trust has moved from developing its approach to establishing a structured Data Quality Improvement Plan with defined programme priorities, a data-quality impact heat map for national measures, and a Better Information Better Outcomes business case focused on measurable improvements in appointment recording, outcomes, national indicator confidence and National Cost Collection assurance. The previous crisis-response data-quality issue has been resolved and closed, subject to confirmation on the live risk register. However, assurance remains limited because the programme has not yet moved into fully resourced implementation. Decisions are still required on scope, pace, investment, specialist capacity and prioritisation alongside other Digital, TIP and operational commitments. Appointment-outcoming deployment remains paused pending further process improvement and operational readiness, while current SystmOne limitations and future EPR requirements remain significant dependencies. The immediate priority is to agree a deliverable, phased and resourced programme, establish baselines and trajectories for each priority, and strengthen routine evidence to FPC that changes are being adopted and are improving data quality, productivity and patient outcomes

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*

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SR05.000	Executive-led Data Quality Improvement Working Group with multidisciplinary representation and oversight of delivery, impact, risks, dependencies and escalation. Data Quality Improvement Plan structured around five priority areas: robust national indicator measurement; releasing time for care through improved activity recording and reduced administrative burden; accurate currency and National Cost Collection recording; understanding patient populations and outcomes; and strong data and system foundations. Priority-based DQIWG agenda and reporting, replacing isolated issue-by-issue review with programme-level assurance. Data-quality impact heat map covering proposed 2026/27 national measures and distinguishing data-quality issues from operational performance issues. Performance, finance and workforce reporting aligned to national datasets, including NOF, MHSDS, productivity, PLICS and National Cost Collection. Internal validation prior to submissions, including BI review, exception checking and operational engagement. Targeted workstreams covering CAMHS 104-week waits, SNOMED recording, paired outcome measures, appointment outcoming, unclassified appointments, service-line mapping, currency recording and sickness data. Business-case development to secure the clinical, analytical, digital, training, programme and implementation capacity required to deliver the plan. Links to FPC, EMT, operational governance, Digital/EPR planning, activity-based budgeting and Releasing Time to Care.	**First-line evidence** Operational and clinical review of data exceptions, waiting lists, appointment recording, outcome measures and pathway-specific issues. BI validation of national submissions and development of service-level dashboards, indicator projections and the data-quality impact heat map. CAMHS review arrangements covering SystmOne configuration, SNOMED deployment, outcome measures, super-user training and backlog management. Service-line mapping and triangulation between activity, finance and workforce data. Workforce sickness-data alignment between local dashboards and national reporting. Evidence since May includes approximately 99% compliance for the crisis-response measure following correction of miscoded referrals, service-line activity and cost mapping covering approximately 80% of direct services in the June discussion, and June sickness data reported as aligned with national reporting processes. **Second-line evidence** DQIWG scrutiny against the priority-based Data Quality Improvement Plan. FPC oversight of the high-level Data Quality Plan and data-quality reporting. EMT consideration of the Better Information Better Outcomes business case and associated decisions on scope, investment, resource and pace. Cross-functional challenge from operational, clinical, BI, finance, workforce, digital, clinical safety, governance and improvement leads. Data-quality impact heat map used to differentiate data-quality risk from operational performance risk. The July arrangements explicitly moved DQIWG towards programme-level assurance, and the business-case discussions covered measurable outcomes, financial risk protection, deployment, workforce capacity and ongoing support. **Third-line / external evidence** National submissions and published benchmarking through NOF, MHSDS, Model Health System and National Cost Collection. NHS England methodology, technical guidance and regional/national clarification routes for emerging indicators. Internal Audit or independently commissioned review, where formally commissioned	28th August 2026

Significant gaps in controls	
Ref	*The main areas of weakness which result in ineffective or absent controls*
SR05.001	The Trust now has a high-level Data Quality Improvement Plan
SR05.002	Data-quality maturity and readiness remain variable across services, including differences in system configuration, structured recording, clinical engagement, administrative capacity, training needs and ability to use data for day-to-day management
SR05.003	Activity, finance and workforce triangulation has improved, but incomplete alignment between SystmOne units, teams and cost centres continues to limit service-line granularity and confidence in productivity and costing analysis.
SR05.004	Operational and clinical accountability is developing but is not yet consistently embedded through standard processes, clinical ownership, training, audit, routine management follow-up and benefit realisation across all services.
SR05.005	Current SystmOne and patient-administration limitations restrict real-time waiting-list management, structured outcome capture and automated patient communication; future EPR requirements and transferability of current improvements remain material dependencies

Significant gaps in assurance	
Ref	*The main areas of weakness which result in ineffective or absent assurances*
SR05.006	Limited evidence that improvement interventions are consistently

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SR05.007	Baselines and proposed measures are becoming clearer, but evidence of realised impact on National Cost Collection, productivity, patient outcomes, administrative burden and financial risk protection remains incomplete.
SR05.008	Forward-looking assurance is constrained by unresolved decisions on programme investment, resource availability, delivery pace, scope, phasing, competing priorities and alignment with EPR re-procurement and other Digital and productivity programmes.

Details of Assurance		
Sources of assurance that demonstrate the controls are effective		
Level 1: Operational Oversight	**Level 2: Reports / Metrics overseen by Board / Committee**	**Level 3: Sources of external oversight / scrutiny**
Data Quality Improvement Working Group	Finance & Performance Committee oversight of SR05, Data Quality Plan	National Oversight Framework (NOF) benchmarking and

Mitigating actions underway for controls and assurance:

Ref	*Actions required to mitigate weaknesses*	*Lead*	*Target Date*	*Progress*
SR05.009	Finalise approval and mobilisation of the Data Quality Improvement Plan and Better Information Better Outcomes business case, with a phased delivery plan, agreed baselines, milestones, benefits, resource requirements and business-as-usual ownership	Catherine Sunter / Raj Gohri / Opertional and Clinical Leads	sep-26	High-level plan and five programme priorities established. Business case developed and submitted for EMT discussion. Further decisions are required on preferred option, investment, phasing, procurement route, ongoing support and trade-offs with other organisational priorities (18th August 2026)
SR05.010	Establish clear first-line ownership for each programme priority, supported by named clinical and operational leads, standard escalation routes, implementation support and reporting into DQIWG	Catherine Sunter / Raj Gohri and relevant workstream leads	sep-26	**Completed: Transition of DQIWG to a priority-based programme assurance model and introduction of the Data Quality Impact Heat Map. DQIWG membership and programme structure are established.** Clinical reference arrangements, workstream ownership, implementation capacity and business-as-usual accountability require further completion

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Strategic Objective	Best use of Resources	Risk appetite	Regulatory - Open
Strategic Risk		Assuring Committee	Finance and Performance Committee
If a significant cyber security incident or major digital system failure occurs within the Trust, across system partners, or affecting national NHS infrastructure, then access to critical clinical and corporate systems may be disrupted or unavailable, impacting patient records, care coordination, workforce deployment, statutory reporting, financial processes, and data sharing, resulting in patient harm, regulatory breaches, financial loss, operational disruption, and reputational damage.		Executive lead	Tim Rycroft, Chief Information Officer

Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4
	Limited	Limited		

Contributory risks from the directorate risk register				Risk Score			
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1	Period 2	Period 3	Period 4
	The Digital Services directorate faces ongoing risk relating to reliance on a small number of staff with specialist cyber security, infrastructure, and application knowledge, alongside recruitment and succession challenges. Loss of key personnel would significantly reduce the Trust's ability to prevent, detect, respond to, and recover from a major cyber incident or digital system failure.	Tim Rycroft / CIO	OCIO/IGG	12	12		

Executive Lead Narrative: Tim Rycroft Date:	Reasonable assurance can be provided that appropriate cyber security governance, monitoring and control arrangements are in place and continue to mature. Independent assurance activity, established threat intelligence processes, strengthened AI governance, and ongoing workforce awareness programmes support effective management of cyber risks. While some remediation actions and strategic developments remain in progress, there are no significant issues currently identified that would materially undermine the Trust's ability to manage cyber security risk.

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR09.000	A comprehensive suite of core cyber security controls is established across the Trust, including DSPT compliance, multi-factor authentication, endpoint protection, vulnerability and patch management, access controls, supplier assurance processes, and workforce cyber awareness training.	Assurance over control effectiveness is derived from independent audit and testing activity, DSPT assessment, cyber security performance reporting, policy compliance monitoring, and continuous threat intelligence monitoring. These mechanisms provide evidence that key controls are operating as intended while highlighting areas where further improvement or risk mitigation is required.	aug-26

Significant gaps in controls	
Ref	*The main areas of weakness which result in ineffective or absent controls*
SR09.001	Control implementation is inconsistent across legacy

Significant gaps in assurance	
Ref	*The main areas of weakness which result in ineffective or absent assurances*
SR09.002	Assurance relies heavily on self-assessment with

Details of Assurance		
Sources of assurance that demonstrate the controls are effective		
Level 1: Operational Oversight	**Level 2: Reports / Metrics overseen by Board / Committee**	**Level 3: Sources of external oversight / scrutiny**
Digital operational management maintains	The Information Governance Group (IGG), Information Asset Owner	Independent assurance is obtained through external DSPT

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

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SR09.003	Strengthen independent testing, improve assurance over legacy systems and suppliers, and shift assurance focus from compliance to effectiveness.	Delphine Fitouri (Head of Digital Services)	a) Pen Test (Completed April 2026) b) External Audit of the DSPT (Completed June 2026) c) Completion of DSPT (Completed June 2026) d) Benchmark DSPT Dec 2026.	Independent assurance activity has continued through completion of the 2025/26 DSPT submission, external DSPT audit activity and the current penetration testing programme. These actions are strengthening assurance arrangements across critical systems and suppliers, although further work is required to embed outcome-focused assurance and complete remediation actions arising from reviews.
SR09.004	External threats / International events and proactive actions, as well as reactive response when issues arise	Temitayo Odugbeasan (Cyber Security Manager)	a) On-going (Reccuring events) b) Planned Cyber Resiliience Exercise, WY event, 24th September 2026	Cyber threat monitoring remains well established through participation in national, regional and local intelligence-sharing forums, including NHSE TISP, Microsoft Defender security alerts, Regional Security Lead briefings and West Yorkshire cyber networks. Processes are in place to identify emerging threats and support timely response activities.

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Strategic Objective	Best use of Resources	Risk appetite	Financial - Cautious
Strategic Risk		Assuring Committee	Finance and Performance Committee
If the Trust fails to deliver its savings target and to control financial pressures during 2026/27, then it will fail to deliver its financial plan. Resulting in: reputational damage, regulatory intervention, financial loss, curbs on financial freedoms and flexibilities, and ultimately a detrimental impact to service delivery, service users and staff.		Executive lead	Mike Woodhead Chief Finance Officer

Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4
	Limited	Limited		

Contributory risks from the directorate risk register				Risk Score			
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1	Period 2	Period 3	Period 4
N/A	N/A	N/A	N/A	N/A			

Executive Lead Narrative: Mike Woodhead Date:	CIP delivery is forecast to be off-track and additoinal pressures (eg fair pay for nurses) are crystallising, resulting in a net risk position of £4.5m at month 4. Additional actions, measures and controls have been agreed through EMT and OSPB, but their effectiveness cannot yet be measured.

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR07.000	Monthly reporting SFIs, SoD and SOs Implementation Plans Management controls Budgets and plans	FPC, Audit and Board meetings OSPB and Pipeline Group EMT and SLTs Internal Audit	

Significant gaps in controls	
Ref	*The main areas of weakness which result in ineffective or absent controls*
SR07.001	Incomplete/ under-developed implementation plans
SR07.002	Gaps in management controls

Significant gaps in assurance	
Ref	*The main areas of weakness which result in ineffective or absent assurances*
SR07.003	Pipeline group not fully effective yet
SR07.004	OSPB unable to effectively fulfil role in absence of implementation plans

Details of Assurance		
Sources of assurance that demonstrate the controls are effective		
Level 1: Operational Oversight	Level 2: Reports / Metrics overseen by Board / Committee	Level 3: Sources of external oversight / scrutiny
SROs, OSPB	FPC and Board reports	NHSE reporting, internal and external audit

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

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SR07.005	Agree full implementation plans by end April	OSPB	30th April 2026	Still not complete set of implementation plans, with specific gaps in Trust wide 3% targets and £800k transformation target. Actions included in August OSPB work (reporting to FPC)
SR07.006	Review and strengthen management controls	OSPB	31st Aug 2026	Looking at other Trusts to compare controls around vacancies in over-spending services. Actions agreed in August OSPB work reporting to FPC.

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Strategic Objective	Best use of Resources	Risk appetite	Financial - Cautious
Strategic Risk		Assuring Committee	Finance and Performance Committee
If the Trust fails to deliver on a credible, robust, compliant medium/long-term plan, then its financial performance will continue to deteriorate. Resulting in: reputational damage, regulatory intervention, financial loss, curbs on financial freedoms and flexibilities, and ultimately a detrimental impact to service delivery, service users and staff.		Executive lead	Mike Woodhead Chief Finance Officer

Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4
	Low	Limited		

Contributory risks from the directorate risk register				Risk Score			
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1	Period 2	Period 3	Period 4
N/A	N/A	N/A	N/A	N/A			

Executive Lead Narrative: Mike Woodhead Date:	A credible MTFP was submitted but its credibility is now undermined by SR07.

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR08.000	Monthly reporting SFIs, SoD and SOs Implementation Plans Management controls Budgets and plans	FPC, Audit and Board meetings OSPB and Pipeline Group EMT and SLTs Internal Audit	

Significant gaps in controls	
Ref	*The main areas of weakness which result in ineffective or absent controls*
SR08.001	Incomplete/ under-developed implementation plans
SR08.002	Gaps in management controls

Significant gaps in assurance	
Ref	*The main areas of weakness which result in ineffective or absent assurances*
SR08.003	Pipeline group not fully effective yet
SR08.004	OSPB unable to effectively fulfil role in absence of implementation plans

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Details of Assurance		
Sources of assurance that demonstrate the controls are effective		
Level 1: Operational Oversight	**Level 2: Reports / Metrics overseen by Board / Committee**	**Level 3: Sources of external oversight / scrutiny**
SROs, OSPB	FPC and Board reports	NHSE reporting, internal and external audit

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

SR08.005	Agree full implementation plans by end April	OSPB	30th April 2026	see SR07
SR08.006	Review and strengthen management controls	OSPB	31st Aug 2026	see SR07

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Strategic Objective	Good Governance, Effective Oversight and Accountability	Risk appetite	Regulatory - Open
Strategic Risk		Assuring Committee	Audit Committee
If the Trust does not have robust & effective governance, risk & compliance processes in place, then it will not comply with NHS licencing conditions, CQC, NHSE regulatory & Code of Governance requirements. Resulting in the Trust breaching licence conditions.		Executive lead	Phil Hubbard, Director of Nursing, Professions & Care Standards

Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4
	Significant	Significant		

Contributory risks from the directorate risk register				Risk Score			
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1	Period 2	Period 3	Period 4
2417	ability to meet regulatory requirements	Phillipa Hubbard	Risk and Compliance	6	9		

Executive Lead Narrative: Mike Woodhead Date:	continue to monitor compliance through system and policies, review of quality management structures including Quality Assurance assessments of services, reporting of incident and devleopment of risk registers, Patient Safety and Learning and ensuring compliance against regulatory standards for corporate and clinical governance - 1.9.2026

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR09.000	Compliance & Risk Group Quality Management & Assurance Framework Patient Safety Executive Panel Patient Safety & Learning Group Effectiveness Review process Clinical board & Mandatory Oversight Daily Lean Management Senior Leadership Team meetings Policy & Procedure compliance Annual Governance Report Strategic meetings	Annual Report Annual Governance Statement Quality Account External Audit Internal Audit Well Led external review Well Led Internal Audit BAF/Risk Management Internal Audit Code of Governance Internal Audit CQC assurance reporting CQC engagement meetings Provider Capability Assessment Quality Assurance Programme Deep Dive of Services Go See	

Significant gaps in controls	
Ref	*The main areas of weakness which result in ineffective or absent controls*
SR09.001	Representative effectiveness reviews
SR09.002	Annual process for review of operational quality governance meeting structure

Significant gaps in assurance	
Ref	*The main areas of weakness which result in ineffective or absent assurances*
SR09.003	
SR09.004	

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Details of Assurance		
Sources of assurance that demonstrate the controls are effective		
Level 1: Operational Oversight	**Level 2: Reports / Metrics overseen by Board / Committee**	**Level 3: Sources of external oversight / scrutiny**
Daily Lean Management, review of incidents,	SLT QSG, Compliance and Risk, Clinical Board, Quality and Safety	NHSE, CQC, DHSC

Mitigating actions underway for controls and assurance:				
Ref	*Actions required to mitigate weaknesses*	*Lead*	*Target Date*	*Progress*
SR09.005	Development of the Audit Committee	Fran Stead	aug-26	Planned progress is continuing to take place, with an update on the actions presented to each meeting. This work is also captured within the Well Led Development Plan. 1.9.2026 audit committee review with overall monitoring of well led actions. The development plan incorporates learning from auidt and independent reviews
SR09.006	Review of Quality Governance operational structure	Phillipa Hubbard	sep-26	A revised Quality Governance structure is in process. This includes a proposal to separate Patient Safety and Learning from Deaths (mortality) reporting up to a revised Executive Panel. In addition, the current Patient Safety Learning Group will have amended TOR to reflect learning from a wider range of sources. Importantly, this group will report into QSG SLT beneath QSC. This will inform the trust's Quality Priorities and the resources required to deliver this through Care Trust Way. Parallel to this the trust's is also developing an approach to its Quality Management System (see below). The revised Quality Governance structure will report into QSC by the end of Q2. 1.9.2026 Development of a Quality Managment System to be launched in October 2026. Review of Patient Safety Learning Group and plan reviewed and implemented. Workplans for SLT QSG, Clinical Board and QSC reviewed to ensure quality, clinical effectiveness, ethics and mandatory training are covered

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Strategic Objective	Being the Best Partner	Risk appetite	
		Regulatory - Open	
Strategic Risk		Assuring Committee	Board of Directors
If the Trust does not work together with partners strategically, as Lead/Host Provider for relevant services, then opportunities will be lost to maximise improved service delivery for the population, including efficiencies. Resulting in poorer outcomes and experiences for communities, continuation of health inequality, lack of improvement and financial efficiencies, and reputational damage for the Place.		Executive lead	Therese Patten, Chief Executive

Assurance rating (bi-monthly) (low; limited; significant; high)	Period 1	Period 2	Period 3	Period 4
	Limited	Limited		

Contributory risks from the directorate risk register				Risk Score			
Safeguard Ref	Description	Risk Lead / responsible director	Overseeing group	Period 1	Period 2	Period 3	Period 4

Executive Lead Narrative: Mike Woodhead Date:	The recent proposal to expand the PPP scope, coupled with existing risks and gaps in due diligence work mean that there is only limited assurance on this risk. Board has been updated and a Q2 review will take place in October.

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR10.000	CEO chair Joint Cttee to keep focus on delivery group outputs DOF SRO for internal assurance procure team to support Strategic gateways for board decisions set out Link with IHO pilots, other lead providers to share work Secure legal advice Executive oversight through EMT and board cycle	Place self-assessment tool SRO workplan Board engagement and decision making WY due diligence work PSR process Provider capability rating	

Significant gaps in controls	
Ref	*The main areas of weakness which result in ineffective or absent controls*
SR10.001	Due diligence not done
SR10.002	Understanding of lead-host arrangements
SR10.003	Not all partners bought in to same vision
SR10.004	Integrator capacity and capability
SR10.005	ICB loss of skill in reorganisation
SR10.006	Trust occupied with delivery in challenged year
SR10.007	Trust occupied with delivery in challenged year
SR10.008	Detailed hosting and contractual agreements
SR10.009	Regular reporting on progress/ delivery

Significant gaps in assurance	
Ref	*The main areas of weakness which result in ineffective or absent assurances*
SR10.010	Regular reporting (internally to Trust and externally to

Details of Assurance
Sources of assurance that demonstrate the controls are effective

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Level 1: Operational Oversight	Level 2: Reports / Metrics overseen by Board / Committee	Level 3: Sources of external oversight / scrutiny
EMT reports and meetings	Board and sub-committee reports and meetings	WY and Place reports and meetings

Mitigating actions underway for controls and assurance:				
Ref	*Actions required to mitigate weaknesses*	*Lead*	*Target Date*	*Progress*
SR10.011	SRO stand up due diligence team and develop plan Schedule board OD time			Initial workplan agreed Regular meetings in train with WY colleagues Due dilligence team resourced and have commenced, linking in with Place PPP workstream leads and WY colleagues/forums
SR10.012	Establish EMT focus group			Group established and meeting fortnightly

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BDCFT Public Board Meeting

5 November 2026

Paper title:	Quality & Performance Management System (QPMS): quarterly implementation and assurance update	**Agenda Item 19**
Presented by:	Farhan Rafiq, Executive Director of Transformation, Improvement and Performance	
Prepared by:	Chris Hunt, Head of Improvement & Innovation	
Committees where content has been discussed	Care Trust Way Implementation & Delivery Group	
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		
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
To provide the Board with assurance on progress since the July 2026 update in implementing the Quality & Performance Management System (QPMS), including delivery

Purpose of the report
against the previously shared implementation framework, emerging risks and dependencies, and the next milestones. The paper also sets out how QPMS supports the Trust's ongoing Well-led improvement.

Executive Summary
In July 2026 the Board received the proposed QPMS implementation framework for 2026/27 and asked to receive a further update on implementation progress and organisational maturity. The framework established four connected domains – Planning, Control, Improve and Assure – with cross-cutting work on leadership, capability, maturity and communications. Since July the emphasis has moved from framework design towards mobilisation and practical testing. Executive and wider leadership work has developed the strategy-deployment approach; implementation is being aligned to annual planning, activity, performance management, Daily Lean Management (DLM), improvement and assurance; and the Care Trust Way Implementation & Delivery Group is overseeing deployment and refinement. Overall, the programme is progressing, but QPMS is not yet a fully embedded Trust-wide operating model. Sequencing and terminology have evolved as learning has emerged, including a stronger emphasis on signs of success, practical deployment support and readiness-based testing. Key dependencies remain data and business-intelligence capacity, leadership ownership, improvement support, service readiness and completion of governance interfaces. The assurance offered at this stage is therefore that there is an active, governed programme of implementation with defined next milestones. Future quarterly reports should increasingly evidence adoption, maturity and impact rather than framework development alone.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	☐ Yes ☒ No No specific service change or decision affecting protected groups is proposed through this progress update. Equality implications will continue to be considered through the relevant planning, improvement and assurance activity.

Recommendation(s)
The Board is asked to: • Note progress against the QPMS implementation framework presented in July 2026; • Note where sequencing or terminology has developed in response to learning; • Consider the principal implementation risks, dependencies and mitigations; • Take assurance that QPMS is moving from design into practical application through existing organisational processes and live work; and • Agree that subsequent quarterly updates increasingly focus on evidence of adoption, impact and organisational maturity.

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Links to the Strategic Organisational Risk register (SORR)	N/A – no single SORR risk. QPMS seeks to provide a cross-cutting control and assurance mechanism that supports management of strategic risks across the BAF through stronger strategy deployment, performance management, accountability, improvement, organisational learning and integrated assurance.
Care Quality Commission domains Please check **ALL** that apply	☒ Safe ☒ Effective ☒ Responsive ☒ Caring ☒ Well-Led
Compliance & regulatory implications	QPMS supports the Trust's Well-led development by strengthening strategy deployment, performance and accountability, organisational learning, governance and integrated assurance.

Quality & Performance Management System (QPMS): quarterly implementation and assurance update

1. Purpose and basis of assurance

In July 2026 the Board received the QPMS implementation framework for 2026/27. The Board supported progression to implementation and asked to receive a further update on implementation progress and organisational maturity during 2026/27.

This paper is intentionally an implementation and assurance update. It does not repeat the case for QPMS or the detailed design previously considered by Board. It reports the current position against the July framework, identifies where the implementation approach has been refined through learning, sets out the principal risks and mitigations, and identifies the next milestones.

2. Overall implementation position since July

Since the July update, implementation has moved from agreeing the architecture towards mobilisation and practical application. The principal areas of progress are:

- Executive development on strategy deployment, QPMS and Leader Standard Work, including accountability, leadership routines and organisational learning.
- Leading Better Lives Together in September, used to engage leaders in the new strategy and test the credibility, readiness and support requirements for deployment.
- Development of a practical strategy-deployment approach and alignment with annual planning, activity planning and emerging balanced-scorecard arrangements.
- Further work to connect performance management, Daily Lean Management (DLM), improvement and assurance rather than treat them as separate systems.
- Care Trust Way Implementation & Delivery Group oversight of QPMS implementation, including pilot testing, deployment materials, governance interfaces and the expectations for the November Board update.

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Implementation is progressing and remains consistent with the July framework. Several elements are still being developed or tested and are not yet fully embedded across the Trust.

3. Implementation plan and milestone update

Domain	July 2026 commitment	Position at November	Next quarter milestone (By Feb 2027)	Assurance / issue
PLAN	Strategy deployment; organisational measures; objective deployment; annual planning alignment.	A working strategy-deployment and continuous-planning model has been drafted through executive and leadership work. Practical materials, roles, governance and support arrangements remain under development. Annual planning provides the principal route for testing and refinement.	Test deployment materials and service planning/Catchball; align service priorities, measures and improvement activity.	Progressing. Sequencing has developed in response to learning and the planning timetable.
CONTROL	DLM standards; data capability; performance framework; team/service measures; operational intelligence; ISPQR.	The intended relationship between scorecards, DLM, leadership routines, escalation, improvement and assurance has been further developed. Live operational work is being used to test the approach.	Agree and test a minimum Control standard, scorecard principles, leadership routines and escalation/feedback arrangements.	Progressing, with dependencies on data quality, BI capacity and consistency of implementation.
IMPROVE	Organisational learning framework; learning sources; report-out; spread and adoption.	Existing improvement capability is increasingly being linked to strategic and operational priorities, with emphasis on learning, report-out and use of live improvement work.	Define the minimum learning/improvement framework and strengthen routes for learning, adoption and spread.	Progressing, with further work required on the organisational learning architecture.

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Domain	July 2026 commitment	Position at November	Next quarter milestone (By Feb 2027)	Assurance / issue
ASSURE	QPMS assurance framework; assurance mapping; peer review; service-user assurance; maturity assessment.	Work has increasingly focused on triangulation and Board line of sight to frontline reality. Governance interfaces between QPMS, committees and Board are being mapped.	Progress assurance mapping; refine practical assurance products; continue testing triangulation and frontline validation.	Developing. Governance interfaces and assurance products require further refinement.
CROSS-CUTTING	Leader Standard Work; maturity; leadership development; communications and coaching/problem-solving.	Leadership engagement has strengthened the emphasis on Leader Standard Work, simple shared language, practical implementation support and learning before wider rollout.	Agree minimum Leader Standard Work expectations, deployment support, six-month timeline and maturity/adoption measures.	Progressing. Adoption and consistent use will be the key next test.

4. What has changed since July and why

The implementation approach has been refined as the Trust has moved from framework design into practical application. The changes are intended to support implementation rather than alter the core QPMS model.

- Strategy deployment has become the principal practical entry point. The current work brings the strategy conversation together with operational, workforce, financial and service-planning considerations before translating priorities into service measures, team actions and improvement activity.
- Deployment is being sequenced and tested rather than attempted simultaneously across the Trust. This reflects differences in service structure, leadership capacity, data maturity and readiness.
- Terminology is being simplified. The emerging strategy language of “signs of success” is replacing unnecessary technical language while retaining the discipline of clear priorities, meaningful measures and routine review.
- Implementation support is being designed around existing processes and roles rather than establishing parallel QPMS infrastructure.

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Figure 1 illustrates the emerging strategy-deployment and continuous-planning cycle. This working model is being refined through practical application; the detailed roles, planning products, governance and support arrangements remain under development.

Figure 1. Working model for strategy deployment and annual and continuous planning, subject to testing and refinement.



5. QPMS in practice: evidence of the management system in action

Purposeful & Productive Adult Mental Health Pathway

This programme provides an emerging practical example of how the component parts of QPMS can operate as a connected management system. Rather than establishing a separate QPMS process, the work has brought together operational leadership, performance information, improvement support and clearer accountability around an existing organisational priority. This reflects the intended QPMS approach of connecting existing management and improvement arrangements rather than adding another programme.

The out-of-area mental health placement sprint began in August in response to rising out-of-area placements. The approach introduced a more disciplined management rhythm, with frequent operational review of people at risk of admission or approaching discharge, supported by BI, Improvement & Innovation, PMO, business support and operational colleagues. Delivery plans and workbooks were subsequently strengthened to make interventions, ownership, timescales and responsibilities more visible.

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This provides an early illustration of the QPMS domains working together:

- Plan: a defined operational problem, improvement focus and clearer delivery responsibilities;
- Control: regular review of performance and individual cases through a consistent operational rhythm;

- Improve: tests of change, supported improvement activity and review of what is and is not working; and
- Assure: greater visibility of delivery, ownership, performance and areas requiring further action or escalation.

The work is also demonstrating the importance of moving from short-term intervention to sustainable routine practice. The current focus includes consolidating learning and establishing standard work so that effective ways of working continue beyond the sprint itself.

The learning for QPMS is therefore as important as the improvement itself: effective implementation depends on visible ownership, reliable information, regular management routines, improvement support and follow-through operating together. The next test is whether these disciplines can be sustained as normal management practice and transferred appropriately to other priorities, rather than remaining dependent on the intensity of a time-limited sprint.

Releasing Time to Care and Activity Based Budgeting

A second emerging example is Releasing Time to Care and Activity Based Budgeting. This work is bringing together workforce, finance and activity information at service level to create a clearer understanding of demand, capacity, productivity and opportunities for improvement. Rather than waiting for perfect information, the approach is using the best available data to support service conversations while making data-quality limitations visible and addressing them alongside the improvement work.

This demonstrates a different aspect of QPMS in practice: connecting planning and resource assumptions with routine performance information and locally owned improvement. Current service-level work includes practical issues such as administrative burden, activity visibility, travel time and DNAs, with learning intended to inform future service planning and productivity expectations.

Together, these examples provide early evidence of the behaviours QPMS is intended to make routine: clear priorities, visible measures, disciplined management review, locally owned improvement, appropriate escalation and learning that informs subsequent planning and delivery. Learning from these practical applications will inform the annual and continuous planning approach, minimum management routines, scorecard requirements and deployment support offer. The intention is to use live organisational work to test and refine one connected QPMS operating model, rather than develop separate processes for each programme.

6. Principal implementation risks and mitigations

Risk / dependency	Potential impact	Mitigation / response
QPMS becomes an additional programme	Further reporting and workload rather than simplification.	Implement through annual planning, DLM, ISPQR, existing improvement and assurance arrangements rather than parallel infrastructure.
Data quality and BI capacity	Inconsistent information could weaken control and assurance.	Begin with available information, develop proportionately and align with ongoing data-quality and operational-intelligence work.

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Risk / dependency	Potential impact	Mitigation / response
Leadership capacity and competing priorities	Understanding may not translate into routine use.	Phase implementation, clarify minimum expectations and embed Leader Standard Work within existing management rhythms.
Variation in service readiness	A uniform rollout could be superficial or disproportionately burdensome.	Use pilot testing and readiness-based sequencing; refine the approach before wider adoption.
Improvement and implementation support capacity	Services may identify issues without sufficient support to address them.	The coaching and implementation support offer is being reviewed to support practical deployment. The intention is to clarify how services access proportionate facilitation, coaching and problem-solving support, drawing on existing capability rather than creating a separate QPMS infrastructure. The offer will be refined alongside learning from the practical tests.
Governance interfaces remain under development	Unclear committee routes could fragment assurance.	Complete governance mapping across relevant Board committees and define the purpose of each assurance route.

7. Connection to Well-led

QPMS supports the Trust's wider Well-led development by strengthening the disciplines through which the Board and executive team can evidence strategy deployment, accountability, performance management, improvement, organisational learning and assurance. It is part of how the organisation operates, rather than a separate compliance response.

For Board, the practical Well-led tests are increasingly whether there is a clear line of sight from strategy to delivery; responsibilities and accountabilities are visible; leaders have reliable information and routines through which to act; learning results in improvement and spread; and assurance triangulates data, professional judgement, staff and patient experience and frontline reality

8. Next-quarter milestones

- Strategy deployment: undertake initial service-level deployment/Catchball activity; test practical materials; capture learning and use it to refine the wider deployment roadmap.
- Planning: demonstrate alignment between Better Lives Together, annual planning, service priorities and relevant activity/workforce/financial assumptions.
- Control: agree balanced-scorecard principles and minimum management/DLM routines, including escalation and feedback arrangements.

- Improve: define the minimum organisational learning and improvement offer and strengthen the connection between recurring problems, structured improvement, report-out and spread.
- Assure: progress assurance mapping and clarify how relevant QPMS elements connect with Quality & Safety Committee, Finance & Performance Committee, People & Culture, Audit Committee and Board.
- Leadership and maturity: agree minimum Leader Standard Work expectations and begin to use practical adoption/maturity measures so future Board reports can evidence use and impact, not only completion of development activity.

9. Overall assurance and conclusion

The programme has progressed since July from framework design towards practical mobilisation and testing. The direction remains consistent with that previously shared with Board, although sequencing and terminology have evolved as the model has been tested with leaders and aligned to annual planning.

Material implementation work remains, particularly around data maturity, leadership capacity, governance interfaces and consistent adoption. The assurance at this stage is that the July programme is actively progressing with clear next milestones; it is not yet evidence that QPMS is fully embedded.

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BDCFT Public Board Meeting

5 November 2026

Paper title:	BDCFT as an anchor institution: proposed social value framework and delivery plan	**Agenda Item** **20**
Presented by:	Emma Clarke and Farhan Rafiq	
Prepared by:	Emma Clarke, Energy, Waste and Sustainability Manager	
Committees where content has been discussed	N/A	
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		
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	x
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	x
	Improving the experience of people who use our services	x
Making Best Use of Resources	Financial sustainability	
	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
To seek Board approval for a Trust-wide approach to social value and anchor institution activity, including proposed aims, governance, delivery priorities, measurement and annual reporting.
Executive Summary

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Social value is the positive, measurable impact an organization has on society, the local economy, and the environment. BDCFT already creates social and economic benefit through its service delivery but beyond that, the Trust is a significant local employer, procurer, asset holder, service provider and civic partner, therefore can achieve even greater social value.

The Trust has mandated Social Value within the Better Lives strategy and we already provide significant social value. However, the activity is not measured and evidenced in one place. The proposed approach will embed social value into existing decisions and delivery rather than creating a separate programme but will use the anchor institution progression framework and Bradford Council's priorities as a baseline and focuses improvement on employment and skills, procurement and supply chains, services and communities, estate and environment, and partnership leadership. This approach is to operationalise the strategic commitment, combining evidence to monitor and evaluate our, and our suppliers, social value activity to maximise local benefit.

Board approval is sought for the draft Social Value Statement, an initial 12-month mobilisation phase, a cross-Trust steering group, clear executive sponsorship, a social value commitments register, and an annual report of achievements.

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: 1. Approve the Social Value statement; 2. Approve the Trust's intention to act as an anchor institution; 3. Approve the proposed aims and delivery priorities; 4. Endorse creation of an executive-sponsored Social Value Steering Group; 5. Require a register and routine contract-management review of social value commitments; and 6. Request a progress report within 12 months.

Links to the Strategic Organisational Risk register (SORR)	SR02 Health Equity SR10 Being the Best Partner. This work supports delivery against these SOR.
Care Quality Commission domains Please check **ALL** that apply	☒ Safe ☒ Caring ☒ Effective ☒ Well-Led ☒ Responsive
Compliance & regulatory implications	Relevant requirements include the Public Services (Social Value) Act 2012, NHS procurement and social value requirements, the NHS Standard Contract.

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BDCFT as an Anchor Institution: Proposed Social Value Framework and Delivery Plan

1. Purpose

This paper sets out BDCFTs current position on social value and its role as an anchor institution. It explains the internal and external case for action, summarises work already under way, identifies key partners and proposes aims, governance, delivery priorities and measures for the next phase.

The intention is not to create social value as a separate activity. It is to make the wider benefit created through the Trust's everyday decisions more deliberate, joined-up, visible and accountable.

2. Introduction

BDCFT is rooted in Bradford and Craven and has influence beyond the direct provision of care through its workforce, purchasing, estate, environmental impact, partnerships and community relationships. NHS England describes anchor institutions as organisations whose long-term sustainability is tied to the wellbeing of the populations they serve.

The Trust's refreshed Better Lives strategy (section 2.5.1) recognises a wider responsibility to understand and increase the social value it creates, and to strengthen how this is defined, measured and reported. This provides a timely strategic mandate for a coordinated approach. In addition, Government procurement requirements mean we will be asked to deliver social value in any new contract we bid for, or we commission. We therefore have the strategic and regulatory, as well as ethical, obligation.

A preliminary self-assessment against the Joseph Rowntree Foundation anchor institution progression framework indicates relative strengths in employment and service delivery, alongside material opportunities in local supply chains, systematic contract monitoring, use of land and assets, corporate ownership, measurement and reporting (see Appendix 1). Existing activity is undertaken but there is no single framework, governance route, evidence base or annual account of impact.

It is therefore recommended that the Board approve an explicit anchor institution commitment and a focused 12-month mobilisation phase. This will establish governance, validate the baseline with relevant teams, agree a small set of measurable priorities, improve procurement and contract management, gather evidence and stories, from which we can draft an annual report. In addition, a published Social Value Statement to sit alongside our Modern Slavery statement will be a public signal of intent (see Appendix 2).

3. What social value and an anchor role mean for BDCFT

Social value is the additional social, economic and environmental benefit created through the way the Trust makes decisions, spends money, employs and develops people, manages its estate, delivers services and works with communities and partners.

a. External benefits

- Reducing health inequalities by addressing wider determinants such as employment, skills, income, digital inclusion, environment, social connection and access to support.
- Keeping more benefit within Bradford and Craven by increasing opportunities for local suppliers, SMEs and VCSE organisations where lawful, proportionate and value for money.
- Creating employment, training, apprenticeship and work-experience opportunities, with particular attention to communities and groups experiencing disadvantage.
- Using supplier commitments, major capital schemes and service partnerships to generate measurable community and environmental outcomes.

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- Strengthening community resilience, prevention and access by connecting service users with suitable district-wide social value activity and community offers.
- Increasing collective impact by aligning activity across NHS partners, the Council, procurement partners, education providers, the VCSE sector and other anchors.

b. Internal benefits

- Clearer alignment between Better Lives strategy commitments and operational decisions.
- Better evidence of how Trust resources create value beyond direct service outputs, supporting Board assurance, regulatory narratives and public accountability.
- More consistent procurement specifications, evaluation, contract management and benefits realisation.
- Improved coordination across workforce, procurement, estates, sustainability, services, charity, volunteering, finance, strategy and communications.
- A stronger staff proposition through inclusive employment, development, wellbeing and purposeful connection to local communities.

4. Current position and evidence

Existing work includes sustainable procurement requirements, social value questions within large contracts, e.g Lynfield Mount redevelopment, inclusive employment and flexible working practices, partnership work, charity and volunteering activity (including Volunteer to Career), environmental programmes, community-based service delivery, green therapy and nature partnerships, and wider work on health inequalities.

However, the activity is dispersed; ownership is not fully embedded; local spend is not routinely analysed; supplier commitments are not held in one register; monitoring and enforcement are inconsistent; impact stories and quantitative evidence are not systematically captured; and annual reporting is not established.

A Bradford & District Social Value Working Group has been established as a delivery-focused forum. Current collaboration includes Bradford Teaching Hospitals and Airedale General Hospital Trusts, Bradford Council and the NHS North of England Commercial Procurement Collaborative. The group has been considering common language, shared priorities, measurement, supplier engagement and practical opportunities, while avoiding duplication with wider Council-led governance.

5. Proposed ambition and aims

Proposed ambition: BDCFT will use its role as a major local employer, buyer, service provider, partner and steward of assets to improve health, reduce inequalities and create lasting social, economic and environmental benefit for Bradford and Craven. The proposed aims are to:

- Embed social value and anchor thinking into strategy, governance, investment, procurement, service change and business cases.
- Focus the Trust's influence on health inequality priorities that respond to local need and complement partner activity.
- Make employment, skills and progression opportunities more inclusive and accessible.
- Secure, manage and evidence social value through contracts and capital programmes.

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- Measure and communicate outcomes transparently, using data and human stories without overstating impact.
- Assess how the Better Lives Charity can be embedded across the Trust and its contractors to increase opportunities and address conflict of interest concerns which means they are often overlooked.
- Work with other anchors to combine effort and increase district-wide impact.

The outcome of this work will be a clear and consolidated dataset of relevant core data and qualitative stories, which can be used in BDCFT commissioning activity, Trust activity, partnership work and local communications. It will differentiate between Trust and supplier activity, but with a clear goal of delivering local employment, skills, health and wellbeing and community value. Examples of measurable benefit will be apprenticeships, work experience, volunteer to career opportunities for priority communities to support the Bradford local needs assessment. Ultimately, BDCFT and supplier social value commitments will have a tangible impact on the health and wellbeing of individuals.

6. Proposed delivery priorities

Priority	First-phase actions
1. Inclusive employment and skills	• Validate workforce baseline; • Identify targeted pathways; • Map apprenticeships, placements and progression; • Targeted opportunities for specific locations or populations, • Strengthen links with education and employment partners.
2. Responsible procurement and supplier delivery	• Adopt the Sustainable Procurement Policy; • Create a contract commitments register; • Improve handover from tender to contract management; • Supplier engagement; • Analyse local and SME spend.
3. Health inequality, prevention and communities	• Link with health inequalities; • Map existing prevention activity; • Connect service users to suitable social value offers or social prescribing; • Streamline opportunities for suppliers and contractors to work with Better Lives charity • Volunteering and community anchor work.
4. Estate, environment and capital	• Apply proportionate social value to capital schemes; • Include community benefit in the management of the estate; • Deliver nature recovery on BDCFT sites.
5. Leadership, measurement and reporting	• Establish governance; • Agree outcomes and definitions; • Develop a baseline and dashboard; • Draft an annual statement; • Share learning internally and externally.

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7. How we will deliver it
    a. Governance

- Executive sponsor (Director of Transformation): to provide authority, remove barriers and report to Board.

- Operational lead (Energy, Waste and Sustainability Manager): to coordinate the programme, partnerships, reporting and improvement plan.
- Social Value Steering Group: time-limited initially, representation from Strategy, Workforce, Procurement, Capital, Sustainability, Health Inequalities, Clinical Services, Better Lives Charity/Volunteering, and Contract Management.
- Existing governance: Six monthly progress updates to the Finance & Performance Committee, with an annual Board report and exception reporting where risks or material delivery issues arise.
- External working: continue the Bradford & District working group and connect to Council, place and West Yorkshire structures through the operational lead.

b. Delivery method

- Validate the anchor progression baseline with relevant owners and agree priority gaps.
- Develop a Social Value Framework and 12-month action plan, aligned to the Trust Strategy and the anchor institutions framework.
- Build social value into relevant templates, business cases, tender evaluation, contract mobilisation, contract review and capital governance.
- Create a central register of social value commitments (contract clauses), owners, evidence, due dates and delivery status.
- Agree a small, decision-useful dashboard rather than a long list of measures.
- Capture case studies with clear attribution, beneficiary voice where appropriate, and evidence of outcomes.
- Publish an annual Social Value Statement covering priorities, activity, outcomes, limitations and next steps.

c. Resources and capacity

Initial coordination can build on existing roles and governance, The first 12 months should test the workload and clarify responsibilities but will require commitment from a Steering Group. No additional resource decision is requested at this stage.

8. Equality impact

The employment, skills and community activity is specifically intended to reach disadvantaged or underrepresented populations and therefore there is a positive impact. The steering group will discuss how to monitor the equality outcomes in line with GDPR and equality regulations.

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9. Risks

Risk	Mitigation
Capacity: There is a risk that Social Value becomes an additional programme of activity rather than becoming embedded within existing processes.	Use existing processes, governance and information wherever possible and keep the initial framework proportionate
Supplier commitments not being delivered or monitored consistently	Good contract management, establish clear ownership and a mechanism for recording and monitoring relevant commitments
Equity: benefits not reaching priority communities (those experiencing the greatest inequalities)	Connect Social Value priorities to existing health equity arrangements and develop an understanding of who benefits from activity.
Overstating impact: There is a risk of measuring activity without being able to demonstrate meaningful impact, or of double-counting benefits.	Establish an agreed baseline, definitions and proportionate evidence requirements, distinguishing between commitments, outputs and outcomes.

10. Recommendations

The Board are asked to:

- Approve the Social Value statement;
- Approve the Trust's intention to act as an anchor institution;
- Approve the proposed aims and delivery priorities;
- Endorse creation of an executive-sponsored Social Value Steering Group;
- Require a register and routine contract-management review of social value commitments; and
- Request a progress report within 12 months,

Following an initial 12 months of concerted activity, the Board will be asked to review progress and consider next steps, which may include options for longer-term resource.

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Appendix 1: Joseph Rowntree Foundation Anchor Institutions Framework

Bradford District Care
NHS Foundation Trust

A preliminary assessment was undertaken by the Energy, Waste and Sustainability Manager in 2025. It is recommended an update is undertaken with input from subject matter stakeholders.

Dimensions	Dimensions score	out of	Score	Themes	Theme score	out of…
Employer	29	44	65.9%	Recruitment	9	12
				Pay and conditions	9	16
				Training, development and progression	8	12
				Healthy workplaces	3	4
Procurer	19	40	47.5%	Local supply chains	5	16
				Social value from procuring goods and services	14	24
Bricks and mortar	13	28	46.4%	New development	8	16
				Best use of land and assets	5	12
Service delivery	8	12	66.7%	Core service delivery and disadvantaged communities	5	8
				Links to community anchors	3	4
Corporate and civic	14	28	50.0%	Internal anchor ownership	8	20
				External civic role and partnerships	6	8

The full assessment is available on request from the Energy, Waste and Sustainability Manager

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Appendix 2: DRAFT BDCFT Social Value Statement 2027

NHS
Bradford District Care
NHS Foundation Trust

BDCFT recognises that as one of the largest employers in the district, we contribute to the local community and therefore have a responsibility to support the health and wellbeing of the population it serves. This goes beyond the direct provision of care, and requires the Trust to maximise social, economic and environmental benefit for the population through its workforce, purchasing, estate, environmental impact, partnerships and community relationships.

The Trust will do this by:

- Embedding social value and anchor institution thinking into strategy, governance, investment, procurement, service change and business cases.
- Focus the Trust's influence on health inequality priorities that respond to local needs.
- Support social mobility by making employment, skills and progression opportunities more inclusive and accessible, targeting disadvantaged and underrepresented populations and communities across Bradford.
- Include social value in all contracts and capital programmes, and monitor and evaluate the outcomes, including local and SME procurement.
- Report our social value annually, using data and human stories.
- Increase opportunities for the Better Lives Charity and wider VCSE to benefit from Trust suppliers and contractors.
- Work with other anchor organisation to combine effort and increase district-wide impact.

By committing to Social Value, the Trust is meeting its requirement as a public sector anchor organisation to use our position to create positive impact, reduce inequality and strengthen communities.

Signed by an Exec

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AAAD: Effective Oversight: Escalation and Assurance

NHS Bradford District Care NHS Foundation Trust

Report to:	**Board of Directors (Public)**	**Meeting date:**	**TBC**
Report from:	**People and Culture Committee**	**Meeting date:**	**17/09/2026**
Quorate?	**Yes ☒ No ☐**		
Members present	Mark Rawcliffe (Chair/NED), Cleveland Henry (NED) Joanne Harrison, Phillipa Hubbard		
In attendance	Jess Greenwood-Owens (secretary), Michelle Holland, Fran Stead, Lisa Wright, Terence Calvert, Michelle Holgate, Dr Anitha Mukundan Timed business: Bronte Dines-Allen, Naomi Fernandez, Dr Sefat Roshny Jo Wilson, Claire Ingle, Emma Stott, Danielle Stephenson		
Observers	N/A		
Apologies	Tim Rycroft, Therese Patten, Dr Sal Uka, Farhan Rafiq, Mike Woodhead, Kelly Barker.		

Best Place to Work	**Theme 1** – Looking after our people	**BP2W:T1**
	Theme 2 – Belonging in our organisation	**BP2W:T2**
	Theme 3 – New ways of working and delivering care	**BP2W:T3**
	Theme 4 – Growing for the future	**BP2W:T4**

Agenda items

- Learning from your experience (EDI)
- Strategic Narrative Report
- Integrated Strategic Performance & Quality Report
- Recruitment Activity Update
- Employee Relations Activity
- Rostering Activity including OSPB highlights report
- Medical Workforce Report (including 10 Point Plan)
- Subject Focus: Induction Activity
- NHSE NHS College of Leadership & Management
- Guardian of Safe working (Working time directives)
- WRES Update
- WDES Update
- Alert, Advise, Assure + Decision AAA+D Report/s: AAAD: Senior Leadership Team, People, Planning & Innovation/ AAAD: Strategic EDI Partnership Group
- Well-Led Implementation Plan Update
- Provider Capability Assessment
- Board Assurance Framework
- Strategic Risk Assurance Report
- Confirmation of Escalation Reporting
- Annual Workplan 2026-27

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Alert items agreed by Committee	• Workforce risks relating to sickness absence, return-to-work compliance and workforce capacity were highlighted. • Financial pressures requiring strengthened workforce controls and vacancy management arrangements were noted. • National workforce developments, including consultant industrial action, nursing job evaluation requirements and proposed employment legislation changes, were highlighted as areas requiring ongoing monitoring. • Received a powerful Learning from Your Experience presentation from the Rainbow Alliance, highlighting the experiences of LGBTQ+ colleagues, the impact of current challenges on wellbeing, confidence and inclusion, and the importance of continued allyship and organisational support to maintain an inclusive culture across the Trust.
Advise items agreed by Committee	• Continued focus was advised on workforce controls, vacancy management, staff wellbeing and return-to-work processes. • Progression of the Avoidable Harm programme, workforce digital transformation initiatives and board succession planning arrangements was supported. • Further development of workforce intelligence, equality data and induction assurance arrangements was advised to support organisational improvement.
Assure items agreed by Committee	• Recruitment performance remained positive, with key workforce metrics including appraisal compliance, clinical supervision and mandatory training remaining on target. • Formal employee relations cases had reduced significantly and the Avoidable Harm approach was demonstrating positive impact. • Agency reliance continued to reduce through successful recruitment activity and increased use of bank staffing arrangements. • Workforce intelligence capability, induction arrangements and equality improvement initiatives continued to develop positively. • Well-Led and Provider Capability Assessment improvement plans remained in place to support organisational development and governance.
Decisions made by Committee	The following items were approved: • Minutes of previous meeting and AAAD • Action log • Workforce Disability Equality Standard (WDES) • Provider Capability Assessment • Board Assurance Framework • Strategic Risk Assurance Report
New risks identified by Committee	• N/A

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Items to be considered by other Committees/Groups	• N/A		
Feedback following discussion at 'parent' meeting	TBC		
Report completed by	Jess Greenwood-Owens Corporate Governance Officer	**Date**	**21/09/2026**
On Behalf of Chair	Mark Rawcliffe (NED/Chair)		

Close Holly
29/10/2026 15:09:24

AAAD: Effective Oversight: Escalation and Assurance

Report to:	**Board of Directors (Public)**	**Meeting date:**	**05/11/2026**
Report from:	**People and Culture Committee**	**Meeting date:**	**22/10/2026**
Quorate?	**Yes ☐ No ☒**		
Members present	Cleveland Henry (NED/Chair), Joanne Harrison, Dr Sal Uka, Tim Rycroft (part meeting)		
In attendance	Michelle Holland, Christopher Dixon, Rachel Trawally, Jo Wilson Jess Greenwood-Owens (Secretary), Terence Calvert Timed business: Holly Close, Dr Anita Brewin, Dr Sefat Roshny, Lisa Wright, Naomi Fernandez, Danielle Stephenson.		
Observers	N/A		
Apologies	Mark Rawcliffe (Chair/NED), Mike Woodhead, Phillipa Hubbard, Kelly Barker, Farhan Rafiq		

Best Place to Work	**Theme 1** – Looking after our people	**BP2W:T1**
	Theme 2 – Belonging in our organisation	**BP2W:T2**
	Theme 3 – New ways of working and delivering care	**BP2W:T3**
	Theme 4 – Growing for the future	**BP2W:T4**

Agenda items

- Welcome, apologies and confirmation of quoracy
- Declaration of any conflicts of interest
- Trust Risk Appetite Matrix
- Minutes of the previous meeting & AAAD report
- Matters Arising
- Action Log
- Strategic Narrative Report
- Integrated Strategic Performance & Quality Report
- Staff Survey Update – progress report / Mid-point review
- Guardian of Safe Working (Working Time Directives)
- Staff Support & Therapy Service (SSTS) Annual Report
- Menopause Update
- Public Sector Equality Duty Report (including update on Strategy and Equality Objectives)
- Workforce Plan – Month 5
- Alert, Advise, Assure + Decision AAA+D Reports: Senior Leadership Team, People, Planning & Innovation and Strategic EDI Partnership Group
- Strategic Risk Assurance Report
- Confirmation of Escalation Reporting
- Annual Workplan 2026–27
- Any Other Business
- Meeting Evaluation

Close Holly 29/10/2026 15:09:24

Alert items agreed by Committee	• Sickness absence remained a significant workforce challenge, with an increase reported in the latest period. A recovery plan and refreshed approach to sickness absence management were being developed, alongside work with trade union colleagues. • Significant reductions in bank and agency usage had been achieved; however, these improvements were not yet reflected in the financial position. Further work was underway to understand and triangulate workforce usage and financial data.
Advise items agreed by Committee	• The NHS Staff Survey was at its midpoint, with a 35% response rate for substantive staff and 10% for bank staff. Response rates were ahead of the equivalent point in the previous year and the relevant benchmark, although variation between teams remained. Targeted work was continuing to improve participation and understand themes within individual teams. • The Committee noted the new workforce NOF measures and that the Trust was seeking clarification on it's the temporary staffing position with NHS England. • The Public Sector Equality Duty report and Menopause report were to be provided to Board for approval and publication.
Assure items agreed by Committee	• Labour turnover, clinical supervision and mandatory training were performing above target, and employee relations case metrics showed improvement in the number of formal cases being managed. • Substantive workforce growth remained on track to deliver against the planned year-end position, alongside significant reductions in bank and agency usage. • The Staff Support and Therapy Service continued to demonstrate positive outcomes and strong staff feedback. The Committee noted the value of the service while recognising the need to consider future capacity and waiting times. • The Guardian of Safe Working reported no significant concerns from exception reporting. Further development of reporting would include trend and hotspot analysis to strengthen oversight and identify areas requiring improvement.
Decisions made by Committee	As the Committee was not quorate, the following items have been circulated for approval following the meeting: • Minutes of the previous meeting & AAAD Report • Action Log • Menopause at Work Update 2026 • Public Sector Equality Duty Report 2026/27 • Strategic Risk Assurance Report
New risks identified by Committee	• None identified.
Items to be considered by other Committees/Groups	• Menopause at Work Update 2026 and Public Sector Equality Duty Report 2026/27 attached for information to Public Board.

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Feedback following discussion at 'parent' meeting	TBC		
Report completed by	Corporate Governance Officer	**Date**	**22/10/2026**
On Behalf of Chair	Cleveland Henry (NED/Chair)		

Close Holly
29/10/2026 15:09:24

NHS
Bradford District Care
NHS Foundation Trust

Board of Directors – Held in Public

22 October 2026

Paper title:	Menopause at Work Update 2026	**Agenda Item** **21.0.2**
Presented by:	Lisa Wright Head of Equality, Diversity and Inclusion	
Prepared by:	Lisa Wright, Head of EDI, Nicki Cook Lead CBT/EMDR Therapist	
Committees where content has been discussed previously	Beacon Staff Network	
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	y
	Belonging to our organisation	y
	New ways of working and delivering care	
	Growing for the future	
Delivering Best Quality Services	Improving Access and Flow	
	Learning for Improvement	y
	Improving the experience of people who use our services	
Making Best Use of Resources	Financial sustainability	
	Our environment and workplace	y
	Giving back to our communities	
Being the Best Partner	Partnership	
Good governance	Governance, accountability & oversight	y

Purpose of the report

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This report updates the People and Culture Committee on activity and performance in supporting colleagues affected by menopause. It summarises progress, engagement, available support, workforce insights and emerging themes, highlighting achievements, challenges and areas for improvement. It also outlines planned actions to strengthen an inclusive, informed and supportive workplace culture.

Executive Summary

This report provides assurance on the Trust's progress in supporting colleagues affected by menopause and maintaining inclusive workplace practice.

Support includes an updated policy, Menopause Passport and risk assessment, manager guidance, training, a Menopause Café, trained buddies, online resources and improved working environments.

Workforce data indicates that 59% of colleagues are within perimenopausal or menopausal age groups, reinforcing the importance of consistent support and workplace adjustments where appropriate.

Key risks include inconsistent lived experience, limited menopause related absence data and emerging gender pay gap requirements. The Committee is asked to note progress and approve the draft Menopause Action Plan for implementation and annual monitoring.

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 People and Culture Committee is asked to:

- Note the feedback, activity, outputs and outcomes relating to the maintenance of BDCFT's compliance with the Henpicked Menopause Accreditation Standards and Gender Pay Gap requirements to have a Menopause Action Plan.
- Approve the draft Menopause Action Plan which will support compliance with the government Gender Pay Gap requirements[1].

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: If the Trust does not effectively contribute to delivering health equity across the population it serves, then unwarranted variation in access, experience and outcomes for protected and inclusion health groups will

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[1] Overview - GOV.UK

	persist or worsen, resulting in negative impacts on people's lives, failure to meet national expectations (including Core20PLUS5 and EDS), misalignment with Trust strategy, reputational damage, and failure to meet the Trust's moral and statutory obligations as an NHS provider to its communities. This paper relates to Health Equity within the workforce.
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: • Equality Act 2010 – Gender Pay Gap requirements.

People and Culture Committee

22.10.26
Menopause at Work Update 2026

1 Purpose

Menopause is a natural life stage that can have a significant and varied impact on colleagues' health, wellbeing and working lives. Symptoms may affect attendance, confidence and the ability to perform effectively at work; however, timely support and appropriate workplace adjustments can help colleagues remain well and continue to thrive.

As an NHS employer, the Trust has an important role in creating an informed and inclusive culture where menopause can be discussed openly and sensitively. This report provides assurance on the support available, progress against our commitments and the further actions required to improve colleagues' experiences.

NHS organisations must meet their duties under the Equality Act 2010, including the Public Sector Equality Duty, and must not discriminate, harass or victimise colleagues because of protected characteristics such as sex, age or disability. Although menopause is not itself a protected characteristic, symptoms may meet the legal definition of disability, requiring reasonable adjustments.

Employers must also assess and manage workplace risks under health and safety legislation.

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From April 2026, organisations with 250 or more employees may publish voluntary menopause action plans alongside gender pay gap information, ahead of anticipated mandatory requirements from spring 2027. The Trust has published pay gap data and the actions to be

taken. This is a development on that work in preparation for mandatory publication in April 2027.

2 Proposed Outcome

The Trust aims to create a workplace where colleagues experiencing menopause feel informed, valued and confident to seek support without stigma. Through this work, we seek to increase awareness, equip managers to respond consistently and compassionately, improve access to reasonable workplace adjustments, and reduce avoidable impacts on wellbeing, attendance and retention.

We also aim to embed sustainable good practice, maintain the Henpicked Menopause Friendly Standards, meet emerging menopause action plan expectations, and use colleague feedback and workforce data to measure progress and target further improvement.

Our workforce profile makes menopause support particularly important to the Trust. In the 2025 NHS Staff Survey, 78% of respondents identified as female and within ESR 59% of colleagues are in perimenopausal or menopausal age brackets. This means colleagues are likely to work through the perimenopause and menopause while undertaking demanding clinical and non-clinical roles. Menopause can also affect trans, non-binary and intersex colleagues. It can affect partners and family members who are supporting a loved one through this period of their lives. Providing informed management, accessible support and appropriate workplace adjustments is therefore essential to colleagues' wellbeing, attendance and retention, and to maintaining a skilled, experienced workforce capable of delivering high-quality care.

There are no specific questions in the NHS staff survey about menopause. Responses relating to general health, wellbeing, burnout, and flexible working can be analysed by biological sex and age to provide an indicative set of experience measures. The information below provides a baseline assessment of this data for 2025.

No.	Staff Survey Question	Male	Female
Flexible Working			
Q4d	The Opportunities for flexible working patterns (% of respondents who answered satisfied or very satisfied)	72%	70%
Q6d	I can approach my immediate manager to talk openly about flexible working (% of respondents who agree or strongly agree).	83%	82%
Health and Wellbeing			
Q9d	My immediate manager takes a positive interest in my health and wellbeing (% of respondents who agree or strongly agree).	83%	81%
Q11a	My organisation takes positive action on health and wellbeing (& respondents agree or strongly agree).	72%	71%
Q12b	How often, if at all, do you feel burnt out because of your work (% respondents who answered often or always).	23%	24%

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Female experiences appear marginally less positive across every measure, with the largest gaps being only two percentage points. This suggests a consistent pattern worth monitoring, rather than a substantial gender disparity.

When we consider the same questions by age the following patterns emerge:

No.	Staff Survey Question	21 - 30	31 - 40	41 – 50	51 - 65	66+
Flexible Working						
Q4d	The Opportunities for flexible working patterns (% of respondents who answered satisfied or very satisfied)	61%	68%	74%	70%	75%
Q6d	I can approach my immediate manager to talk openly about flexible working (% of respondents who agree or strongly agree).	82%	81%	82%	82%	78%
Health and Wellbeing						
Q9d	My immediate manager takes a positive interest in my health and wellbeing (% of respondents who agree or strongly agree).	83%	79%	81%	79%	82%
Q11a	My organisation takes positive action on health and wellbeing (& respondents agree or strongly agree).	70%	66%	70%	71%	75%
Q12b	How often, if at all, do you feel burnt out because of your work (% respondents who answered often or always).	32%	28%	26%	20%	21%

Younger employees, particularly those aged 21–30 appear to have fewer positive experiences of flexible working and are considerably more likely to report burnout. Employees aged 41–65, which includes many colleagues who may be experiencing perimenopause or menopause, report comparatively positive access to flexible working and lower burnout.

For both the biological sex and age analysis the figures are not specific to menopause and should be treated as an indicative baseline rather than evidence of its impact. It is not yet possible to filter the staff survey data by both age and biological sex together. The provides assurance that there is not a large disparity in experience.

3 Interventions

3.1 Policies and Practices

The Menopause Policy was launched in 2023 along with a programme of implementation plans. Since that time the activity below has been established to support colleagues to meet the standards set out in it.

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The Policy has been reviewed during the last few months to be updated against new requirements and in response to extensive feedback from engaging with colleagues. It is due for discussion and potential approval in October 2026. Once approved the Menopause Action Plan will support its implementation. This plan is shared for approval in appendix 1.

Key policy amendments are:

- The inclusion of a Menopause Passport and Risk Assessment document.
- Definitions of menopause symptoms to include mental distress and suicidal thoughts.
- Referral information for urgent mental health support via 111 and First Response.
- A flow chart for managers.
- Links to important supportive assessments for example:
    - DSE assessment
    - Stress Risk Assessment
    - Wellness Action Plan
    - Reasonable Adjustments Arrangement Form and resources.

3.2 Engagement

The Staff Support and Therapy Service (SSTS) launched a Menopause Café which provides a peer support group for staff going through the menopause. Partners of people going through the menopause have also attended for support. There are 30 members of the group.

The SSTS attend the monthly colleague induction with a stall which has information about all of the support and information available about menopause at work.

An all staff broadcast is planned for World Menopause Day. This will go out live to all staff and a recording will be made for colleagues to revisit. The content will deliver key messages about support and workplace strategic aims.

3.3 Training and Awareness

A Menopause sharepoint resource[2] has been developed and launched. This includes information about the support available to managers and colleagues, useful links and resources for example a newly developed Understanding Menopause Booklet, Partners Guide to Menopause, guidance for managers, a conversation plan and reasonable adjustment documents. The page has had 1446 views since its launch.

Two series of training have been designed and launched by the SSTS. This includes a workshop for managers supporting someone through menopause at work and a workshop for colleagues experiencing menopause at work. Analysis of this data is included within the SSTS audit and wellbeing reports. 98 colleagues have attended the Menopause Awareness Training with 100% of respondents feeling that it was helpful, and they would recommend it to a colleague.

A group of 13 Menopause Buddies[3] have been trained to act as supportive and knowledgeable points of contact within the Trust they listen to colleagues experiences, direct to resources both in and outside of the organisation and inform managers and colleagues of policy and practice. An awareness badge has been provided to all buddies to help identify them.

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[2] Menopause
[3] Menopause Buddies

An eight-week nutrition and the menopause course ran with a dietician as part of the SSTS's core offer. This was well received.

The national NHS Menopause Awareness e-learning is available on ESR for all colleagues to access.

3.4 Culture

The Trust gained the Menopause Hen Picked accreditation[4] in 2023. This measured the Trust against five criteria; culture, policies and practices, training, engagement and working environment. Although the decision was taken not to reaccredit in June 2026 due to the cost of the accreditation process the five pillars are used to guide the Trusts work and any updated guidance from Henpicked is utilised to maintain standards.

The lead for the Menopause support through SSTS has been nominated for a Living our Values Award for their outstanding commitment, drive, knowledge and support to this work.

3.5 Working Environment

The redevelopment of Trust estate has enabled new spaces that are more flexible and responsive to staff needs in relation to the Menopause. For example, the meeting pods at New Mill have adjustable lighting and air conditioning. New furniture is available to enable colleagues to adjust desk height, work in quiet spaces or in single offices. Quiet rooms are available to support decompression and regulation and a wellbeing room has been opened with regular drop ins linked to health and wellbeing.

The Lynfield Mount Redevelopment offers similar opportunities to support colleagues going through the menopause and an equality impact assessment has been completed to maximise potential and identify and potential negatives equality impacts relating to age, sex and disability to mitigate.

A scheme to provide accessible uniforms was established to support people who needed natural fibre uniforms. This needs to be re-established as part of the reviewed policy launch.

4 Risk and Implications

Lived experience of menopause at work has been identified by the government as a key factor that impacts on Gender Pay Gaps, this is why menopause actions for employers have been identified as part of a Gender Pay Gap Action requirements. These plans will require publishing alongside Gender Pay Gap data on the government pay gap portal by Spring 2027.

The symptoms of menopause are likely to contribute to absence within the workplace. If the symptoms are affecting day to day activities for more than (or likely to be more than) 12 months they could be considered a disability so reasonable adjustments need to be made following the Trusts Disability Policy as appropriate.

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[4] The Menopause Friendly Accreditation | Menopause Friendly UK

Colleagues experiencing menopause systems that are affecting attendance need to access the targeted menopause support available via the Menopause Café and buddies, training, Staff Support and Therapy Service, Physiotherapy and Primary Care Wellbeing Service support. As the reporting of menopause and menopause related absence within ESR and health roster is low and not possible it is difficult to monitor the impact of this at the moment.

Although the policy sets out expectations for consistent processes relating to menopause at work there are examples of this not being the lived experience of those attending the Menopause Café. A summary of feedback from there and the recent policy review is included in appendix 2.

5 Results

It is proposed that an annual review of progress is brought to the People and Culture Committee and that the data set out in this paper is included in the Gender Pay Gap monitoring from 2027 as part of the action plan updates.

Lisa Wright
Head of EDI
30.09.26

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Appendix 1 Pay Gap and Menopause Action Plan 2026-2028

Aim: To reduce gender pay inequalities, improve representation at senior levels, and create an inclusive workplace where all employees can progress and thrive. Success will be measured within the NHS Workforce Race Equality Standard and Pay Gap reporting. Data will be taken from the NHS Staff Survey, ESR, TRAC and from qualitative feedback reported via AAA+D reports.

No.	Action	Lead	Timescale	Success Measure (Staff Survey, WRES and WDES reporting)
Recruiting Staff – Fair recruitment and hiring				
1	Review all recruitment materials to ensure inclusive language and eliminate gendered wording.	Head of Recruitment	Q1 2027/8	Adverts do not include gendered language unless it is a Genuine Occupational Requirement of the role.
2	Inclusion Ambassadors to review adverts and develop community list for advertising roles.	EDI Project Officer	Q2 2027/8	Feedback from Inclusion Ambassadors is included in future reports.
3	Analysis of acting-up and promotion data and processes.	WISPA	Q2 2027/8	Staff survey improvement in equal opportunities to career progression.
4	Advertise flexible working options at point of advert, review flexible working uptake and remove barriers to accessing arrangements across all staff groups.	Working Well Group	Q4 2027/8	Increased satisfaction with flexible working.
Developing and Promoting Colleagues – Ensure Equitable Progression				
5	Promote NHS talent management programmes to under-represented groups. Analyse take up data within the NHS Workforce Disability and Race Equality Standards.	Learning and Development	Q3 2027/8	Increased applications for senior roles from under-represented groups by 20%.

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6	Monitor take up and impact of mentoring and coaching programmes by protected characteristic.	Learning and Development	Q3 2027/8	Baseline established with target for any increase required set.
Increase Transparency and Engagement				
7	Align the Supporting Women in Leadership Forum (SWLF) with the staff network reporting structures to ensure feedback is shared and acted upon.	EDI Team and SWLF	Q3 2027/8	AAA+D reports shared.
8	Improve menopause-related workforce data, particularly absence recording, use of adjustments, training uptake and retention.	WISPA and SSTS Team	Q4 2027/8	Absence data can be filtered to show menopause related absences. Take up of menopause related support is tracked and evaluated for impact.
9	Publish gender pay gap data alongside a detailed annual action plan and progress report.	Head of EDI	Annually from February 2027	Annual publication completed and shared with colleagues.
10	Support the Menopause Buddies to engage with employees affected by menopause and managers implementing the Menopause Policy. Collate their feedback to provide lived experience information to inform the delivery of this plan.	Head of EDI, SSTS Menopause Lead.	Q3 2027/8	AAA+D reports shared. Increase in staff stories and case studies.
Supporting employees experiencing menopause				

Close Holly
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11	Launch reviewed Menopause at Work Policy	EDI Team	Q1 2027/8	Feedback from the user survey is positive.
12	Deliver menopause awareness training for managers.	Staff Support and Therapy Service	Q2 2027/8	90% of new managers trained.
13	Strengthen menopause support through policy review including: • Launch of the Menopause Passport and Risk Assessment. • Enhancement of support information for managers and employees relating to Menopause Related Workplace Adjustments on sharepoint. • Update the Disability Policy with a section about Menopause and within the Reasonable Adjustments Agreement form.	Head of EDI	Q1 2027/8	Positive improvement in staff survey responses regarding support.
14	Grow the Menopause Café's increasing membership and ensuring feedback is included in a AAA+D report into the Trusts governance structures.	EDI Team and SSTS	Q4 2027/8	Increase in attendance and membership, AAA-D reports are shared with the Strategic Staff EDI Partnership.
15	Re-establish the accessible uniform scheme, including access to natural-fibre alternatives.	EDI Team, Clinical Admin and Infection Prevention	Q3 2027/8	Take up and satisfaction of accessible uniforms is measured. Feedback is positive.

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Appendix 2 Menopause Café and Menopause Policy Feedback

Over the summer of 2026 feedback was collated from colleagues on implementation of the 2023 Menopause Policy. This has been added to feedback shared through menopause buddies and at café's and is summarised and detailed below for information.



Uniforms: Standard clinical uniforms may not be breathable or menopause-friendly, while staff purchasing suitable alternatives have been told these do not comply with the uniform policy.

Workplace temperature: Many clinical bases lack air conditioning and access to private, cool spaces. Hot weather can worsen menopause symptoms and contribute to fatigue and headaches.

Privacy and facilities: Small toilet cubicles and washbasins located in communal areas make it difficult for staff to manage heavy or unexpected bleeding privately and with dignity.

Surgical Menopause can make symptoms onset quickly and be severe. This needs to be mentioned in the policy.

Support assessments, equality and governance: Clarify who completes support and risk assessments, how often they are reviewed, and how agreed actions, responsibilities and review dates should be documented. The policy should also clearly reflect menopause-related equality and legal considerations.

Close Key
29/10/2026 16:09:14

Reporting and related guidance: Add clear SharePoint guidance on recording menopause-related absence, confidentiality, health passports and associated forms.

Broaden support: Strengthen support for partners, carers and colleagues indirectly affected by menopause, with clear signposting to available resources and peer support.

Reasonable adjustments and practical guidance: Provide examples of flexible working, environmental and cognitive support across different work settings, including adjustments for physically demanding roles and menopause-related medical appointments. Ensure moving and handling training refers to menopause and bone health risks over 50. Adjustments should be tailored, implemented promptly and reviewed regularly without repeated justification.

Leadership and manager accountability: Set clear expectations for compassionate, confidential and proactive management, with defined responsibilities and escalation routes, targeted manager training, and menopause champions at team and executive level.

Update the policy **language and definitions** in relation to biological sex and ensure that trans and gender non-conforming colleagues are also referenced as appropriate.

Consider introducing a **portable menopause passport** to help staff communicate their needs when moving between roles.

Awareness, education and visibility: Launch a coordinated campaign involving People Services, Wellbeing, EDI, staff networks and menopause buddies. Promote symptom recognition at younger ages, Trust induction, refreshed Connect pages, menopause cafés and opportunities to become a Menopause Buddy.

Include bone health: Highlight the link between menopause, reduced bone density and osteoporosis, which can be underdiagnosed.

Improve accessibility and reach: Clearly state whether support is online or in person, offer regular virtual and varied-location drop-ins, and give community staff sufficient notice of events.

Demonstrate responsiveness: Show how staff feedback has influenced the updated policy while retaining positively received content, including its recognition of neurodiversity.

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29/10/2026 15:09:24

Bradford District Care
NHS Foundation Trust

Board of Directors – held in Public

5 November 2026

Paper title:	Public Sector Equality Duty Report 2026/27	**Agenda Item** **21.0.5**
Presented by:	Lisa Wright Head of Equality, Diversity and Inclusion (EDI)	
Prepared by:	Lisa Wright Head of EDI	
Committees where content has been discussed previously		
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 within this report contributes to the delivery of the following themes within the BAF.		
Being the Best Place to Work	Looking after our people	Y
	Belonging to our organisation	Y
	New ways of working and delivering care	Y
	Growing for the future	Y
Delivering Best Quality Services	Improving Access and Flow	Y
	Learning for Improvement	Y
	Improving the experience of people who use our services	Y
Making Best Use of Resources	Financial sustainability	Y
	Our environment and workplace	Y
	Giving back to our communities	Y
Being the Best Partner	Partnership	Y
Good governance	Governance, accountability & oversight	Y

Purpose of the report

The attached Public Sector Equality Duty Report 2026/27 provides a public summary of the work the Trust is undertaking to meet its obligations under the Equality Act 2010, including the Public Sector Equality Duty and the specific duty to publish equality information.

Rose Hay 29/10/2026 15:39:24

Executive Summary	
Section 149 of the Equality Act 2010 requires public authorities, when carrying out their functions, to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation; advance equality of opportunity; and foster good relations between people who share a protected characteristic and those who do not. The Equality Act 2010 (Specific Duties) Regulations 2011, as amended, also require the Trust to publish information demonstrating compliance with the Public Sector Equality Duty at least annually and to publish equality objectives at least every four years. The Public Sector Equality Duty Report 2026/27 provides a snapshot of equality work across the Trust to address inequalities, advance equality and support inclusion for staff, service users and carers. It recognises progress and achievements while acknowledging the areas where further sustained action is required to realise the Trust's equality ambitions. Most of the information within the report has been shared and discussed at Trust committees and governance groups throughout the year in individual standard and compliance reports.	
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 the report for publication on the Bradford District Care Foundation Trust website. • Note the activity, outputs and outcomes shared within the report.

Links to the Strategic Organisational Risk register (SORR)	The work contained within this report links to the following corporate risks identified in the SORR:
Care Quality Commission domains Please check **ALL** 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: • Equality Act 2010, including the Public Sector Equality Duty under section 149, and the Equality Act 2010 (Specific Duties) Regulations 2011, as amended • NHS equality, diversity and inclusion improvement plan

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	• NHS Patient and Carer Race Equality Framework (PCREF) • Statutory health inequalities duties, including those under the NHS Act 2006, as amended by the Health and Care Act 2022 • NHS Workforce Race Equality Standard (WRES), NHS Workforce Disability Equality Standard (WDES) and gender pay gap reporting requirements • NHS Equality Delivery System 2022 (EDS 2022) • Accessible Information Standard

Close Holly
29/10/2026 15:09:24

Bradford District Care
NHS Foundation Trust

Bradford District Care Foundation Trust

How We Meet the Public Sector Equality Duty Report 2026 - 2027



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For further information about any of the content in this report, or to request it in a different format, please contact EDI@bdct.nhs.uk.

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Introduction

At Bradford District Care Foundation Trust (BDCFT), we aspire to create better lives together by delivering our strategic priorities to:

- Support and value our workforce, creating the conditions they need to deliver safe, high-quality care;
- Provide safe, effective and compassionate care;
- Use our resources effectively to deliver the greatest benefit for our communities; and
- Work together with partners to improve care for our communities.

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

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

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

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



EQUALITY DIVERSITY INCLUSION

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

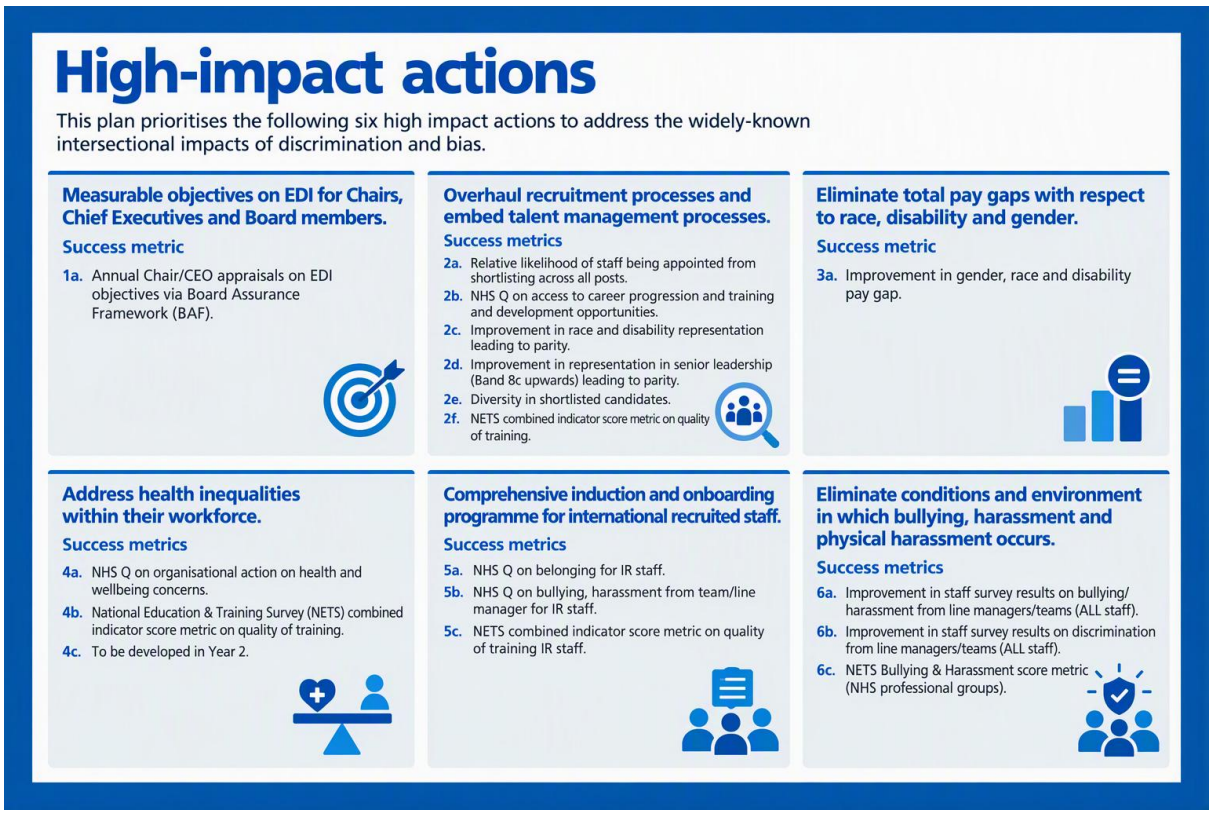
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Chapter One: Strategic Priorities, Drivers and Reporting

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

NHS England's Equality, Diversity and Inclusion Improvement Plan

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



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

- Ensured that Executive members have specific equality objectives within their portfolios and are aligned as sponsors of a staff network.
- Implemented our Well-Led Action Plan to strengthen the assessment of equality-related performance and experience information within our governance structures.
- Delivered a comprehensive apprenticeship programme, regularly analysing participation and impact by equality demographic.

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- Increased the representation of ethnically and culturally diverse colleagues across the Trust.
- Published our gender, ethnicity and disability pay gap information.
- Reviewed and continued to implement our Disability Policy and Menopause Policy.
- Delivered an Inclusive Recruitment Programme, updated the related policies and offered training and case studies.



- Begun to establish a subgroup of the Aspiring Cultures Staff Network for Non-Medical International Colleagues.
- Delivered training to support our anti-racism framework and our 'See it, Say it, Stop it' campaign for tackling abuse from patients and the public to staff.
- Delivered Active Bystander Training in collaboration with the British Medical Association to the Medical Senior Leadership Team.

Better Lives, Together



Our Trust's Better Lives, Together Strategy was refreshed in 2026 following comprehensive engagement. The strategy sets out the organisation's priorities for the next five years. Reducing health inequalities is a golden thread woven throughout the new strategy, and belonging and inclusion are embedded in its vision, purpose and values, with a commitment to a compassionate and inclusive environment. The strategy includes 10 breakthrough programmes, which are underpinned by equity principles and will support the delivery of change. These are:



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We are developing a strategic Health Equity Approach to further support our intention to deliver our strategic priorities and have launched an Equity Essentials programme building workforce leadership, awareness, capability and confidence in identifying and working to reduce inequalities.

Chief Executive Officers (CEO) Pledge to Equality Diversity

Within the first year of her appointment, substantive Chief Executive Officer Therese Patten made a pledge to equality, diversity and inclusion. The aim of the Trusts Belonging and Inclusion Plan is to support and bring Therese's pledge to life and to deliver the strategic objectives needed to drive, embed and sustain equality, diversity and inclusion throughout the organisation, improving staff and patient experience. The pledge continues to drive our equality work across all workstreams.

CEO PLEDGE

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

Our Antiracism Commitment and Progress

The Trust is striving to be an anti-racist organisation. In 2020 we made a pledge to support our aim. We have reissued this pledge throughout 2025 and 2026 to ensure our workforce are aware of our aspirations and what we expect of our people.



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Reflective spaces continue to be held across the organisation, giving people the opportunity to come together, share their feelings, experiences and concerns, and

stand together in delivering our anti-racism pledge. We have audited our anti-racism framework against the Lord Mann recommendations, which were launched in 2026, and have a workplan in place to ensure that our approach addresses all forms of racism, discrimination, prejudice and exclusion in a proactive, consistent and holistic way.

Public Sector Equality Duty (PSED)

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

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

The Public Sector Equality Duty came into force in April 2011.

Bradford District Care Foundation Trust Equality Objectives

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

Strategic Priority	Equality Objective	Focusing on
Workforce Equality		
We will be the **best place to work** for everyone.	We will identify and address inequality of experience and under-representation within the workforce. We will identify, celebrate and spread good practice. We will engage with stakeholders in this work to inform and provide scrutiny of our performance.	• The 9 NHS Workforce Race Equality Indicators[i]. • The 3 NHS Bank Workforce Race Equality Standard indicators.[ii] • The 3 Medical Workforce Race Equality Standard indicators.[iii] • Reducing the Trusts Gender Pay Gap, Ethnicity Pay Gap and Disability Pay Gap. • Going for Gold with the NHS Rainbow Badge Assessment. • The 13 NHS Workforce Disability Standard indicators[iv]. • The Equality Delivery System 2022 Domain 1 and 2 indicators[v].
Health Inequalities		
We will deliver the **best quality services** to all. We will identify and address inequalities of access, patient experience and health outcomes. We will identify, celebrate and spread good practice within and outside of the Trust.		• The Patient and Carer Race Equality Framework core and local indicators[vi]. • The NHS England Health Inequalities Statutory Duty requirements[vii]. • Accessible Information Standard. • The EDS22 Domain 1 indicators. • Sexual Orientation Mentoring Standard.

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We will engage with stakeholders in this work to inform and provide scrutiny of our performance.	• Unicef Baby Friendly Gold Accreditation
	• Lord Mann Review recommendations

Belonging and Inclusion Plan 2025 - 2028

Our Belonging and Inclusion Plan sets the direction for our health equity, equality, diversity and inclusion (EDI) ambitions and work. It reflects the Trust's commitment to ensuring that our services are equitable, accessible to all, person-centred and equipped to meet the individual and diverse needs of the communities we serve. Belonging and inclusion are key elements of our Trust's Better Lives, Together Strategy.



Graphic from colleague and patient engagement feedback on 'what belonging means to me'

These strategies are a call to action to our people to view and carry out their roles through an equity lens. It also sets out our workforce aspirations, supporting the organisation's strategic priority to promote diversity, belonging and inclusion for all colleagues and empowering everyone to lead within an open culture that reflects our values and commitment to equity.

Our vision for the plan is threefold:

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

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To view the plan please visit BDCFT Belonging and Inclusion Plan 2025-2028.

NHS Equality Delivery System 2022 (EDS22)

In 2026 we assessed our equality, delivery and inclusion performance using the NHS England Equality Delivery System 22. More information on this framework can be found here NHS England » Equality Delivery System 2022.

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

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

For Domain 1 we focused our 2026 assessment on Mental Health and the NHS Patient and Carer Race Equality Framework. Three services were selected for analysis. They were Learning Disability Inpatients, City Community Mental Health Team (Adults) and the Proactive Care Team. A partnership engagement event was held with our Acute Sector partners to approve our draft scores for these services.

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

EDS Domain	Score
Domain 1: Provided and Commissioned Services • Domain 1 Learning Disability Inpatients • Domain 1 City Community Mental Health Team adults • Domain 1 Proactive Care Team	 6 9 12
Sub-Total	27
Mean Average	**9**
Domain 2 Workforce Health and Wellbeing	10
Domain 3: Inclusive Leadership	6
Total	27 - Achieving

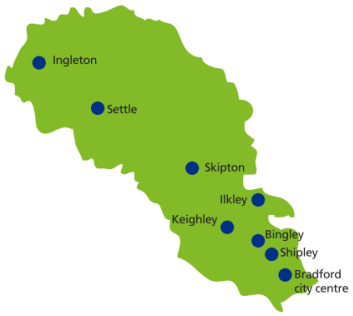
Following completion of this assessment, the Trust was deemed to be ‘achieving’, as defined within the framework. The overall score increased from 22 in 2025 to 27 in 2026. The equality impact assessment findings, action plan and engagement summary have been completed and published as evidence. These actions became part of the EDI priorities for 2026/27 and will be embedded in our Belonging and Inclusion Work Programme.

We are currently carrying out our 2027 assessment of three new services. The outcome of that assessment will be published in February 2027. To get involved, please contact EDI@bdct.nhs.uk.

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Chapter Two: The Bradford, Airedale and Craven Community

The Populations We Serve – Demographics



BDCFT provides services to Bradford District, which has an estimated resident population of 647,000 across 595 square miles. Bradford has the fifth largest population in England. The population density is 4,493 people per square kilometre, which is the highest in West Yorkshire. The population is ageing; by 2040, the number of people aged 65 and over is projected to grow by 27%, and the number aged 85 and over by 53%.

In the 2021 Census, 51.5% of residents described themselves as female and 48.5% described themselves as male. A total of 91.7% identified with the sex they were registered as at birth, and 0.1% (547 people) identified as a trans woman or trans man. A further 0.5% (2,735 people) did not specify an identity or selected another gender identity.

51% of residents are described as relatively healthy; 38% live with long-term conditions; and 30% of ill health is linked to lifestyle factors. Around one in three people live in poverty.

Life expectancy at birth is 77.3 years for males and 81.5 years for females. Bradford has a youthful population, with 23% of the total population aged under 16, the fourth-highest proportion of young people in England. There are major inequalities in life expectancy and healthy life expectancy, with gaps of up to eight years in female life expectancy, 10 years in male life expectancy, 23 years in female healthy life expectancy and 20 years in male healthy life expectancy.

Bradford is an incredibly ethnically diverse area with over 125 different languages spoken by its residents. The Trust spends around £350,000 a year on interpreting to support quality care for people using our services and their families. The five most regularly interpreted languages are Urdu, Punjabi, Arabic, Slovakian and Polish.

In the 2021 Census, 28% of Bradford residents reported having no religion. A further 33% described themselves as Christian, a reduction from 46% in 2011, while 31% described themselves as Muslim, up from 25% in 2011. Religion and belief are important aspects of identity for many Bradfordians and therefore feature in our care assessments where appropriate, guided by our Spiritual Care Policy.

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Bradford has a thriving LGBT+ community. It is estimated that between 5% and 7% of the national population is LGBT+, which equates to approximately 31,350 people in Bradford. A total of 2.3% of the Bradford population identified as gay, lesbian, bisexual

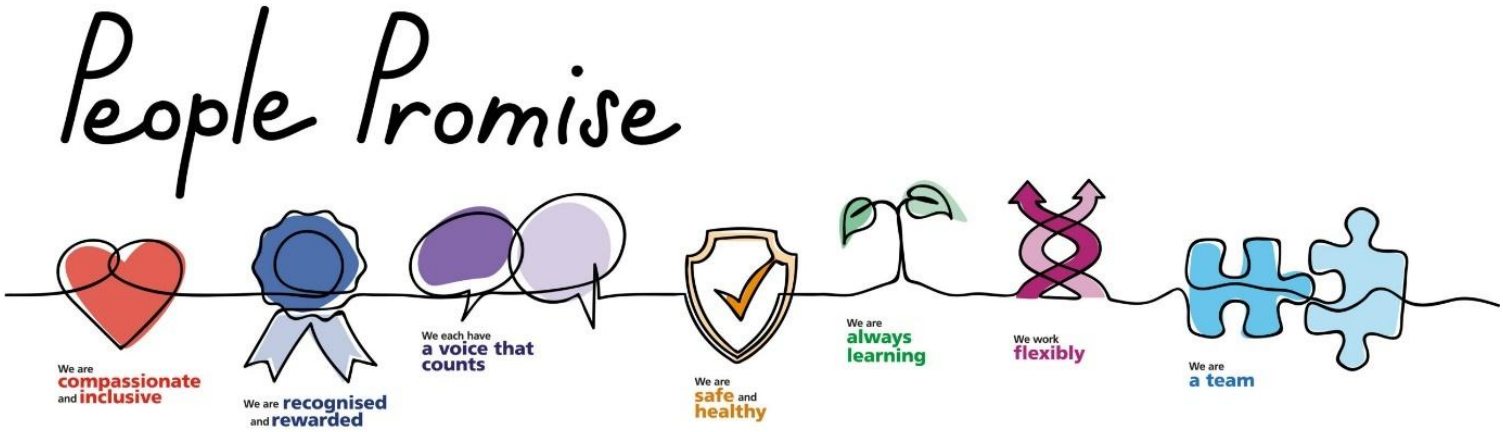
or another sexual orientation. A further 88.9% of residents identified as straight or heterosexual. The Trust is committed to delivering LGBT+-friendly and competent services.

Craven has a population of 56,900 people. In contrast to Bradford, it is the third least densely populated of Yorkshire and the Humber's 21 local authority areas. The district extends north from Skipton. The median age of residents has increased from 47 to 50. A total of 39% of Craven residents reported having no religion, 54% identified as Christian, 1.1% as Muslim, 0.4% as another religion, 0.2% as Buddhist or Hindu and 0.1% as Jewish. In the 2021 Census, 97% of the Craven population identified as White, while 1.7% identified as Asian, Asian British or Asian Welsh.

A total of 56% of the Craven population reported being disabled, a decrease from 7% in 2011. It is estimated that 7% (3,752 people) of the Craven community are lesbian, gay or bisexual.

Ubd.bradford.gov.uk, 2021, Office of National Statistics 2022

Chapter Three: Our People



Workforce Equality Standards and Reporting Requirements

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

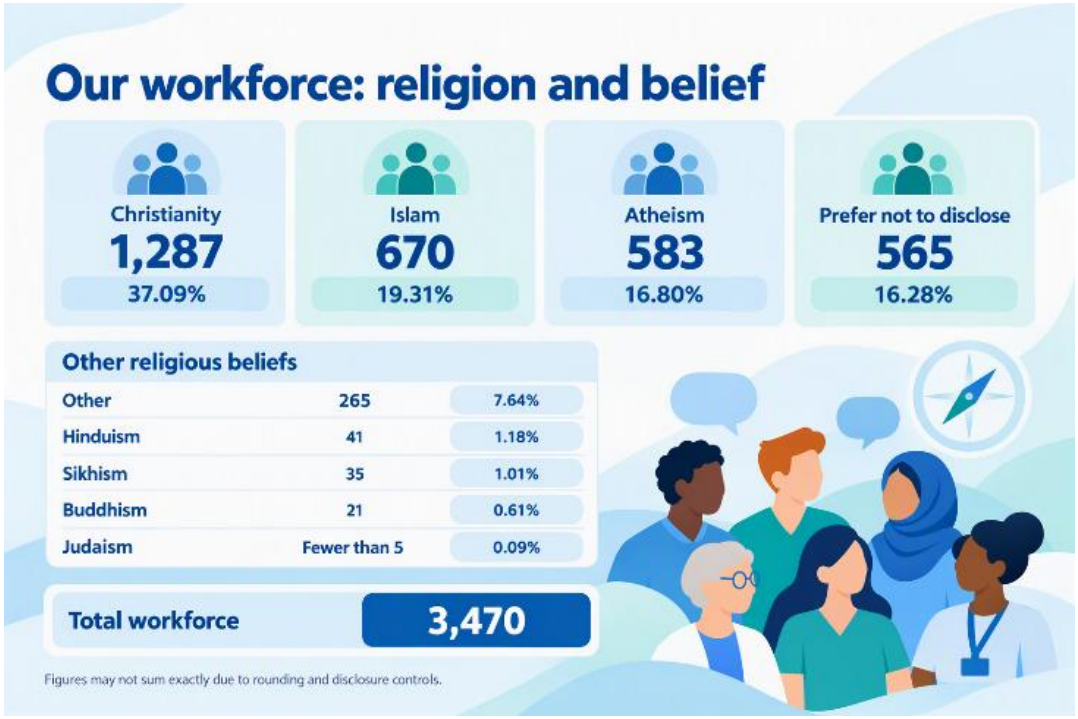
A summary of our most recent analysis from June 2026 provides the following information. The definitions and categorisations are taken from the Electronic Staff Record.

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Equality Protected Characteristic	Staff Data Jan – Jun 2024
Gender	80% Women and 20% Men
Disability – reducing *the % of staff who leave this category blank has been a top priority for us. It has reduced to 9% in 2024.*	77% non-Disabled 14% Disabled
Age	0.1% Aged under 20 16% Aged 21 to 30 25% Aged 31 – 40 28% Aged 41 – 50 23% Aged 51 - 60 8% Aged 61+
Ethnicity	64% White and 32% BME
Sexual Orientation – *reducing the % of staff who do not share their sexual orientation has been a big priority for us. This has decreased by 1%.*	1.99% Lesbian or Gay 1.79% Bisexual 0.55% Other sexual orientation 11% Not Stated 83% Heterosexual or Straight

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

We have been working hard to decrease the percentage of colleagues who do not tell us about their religion or belief. It reduced by 2% in 2025-2026.



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NHS Workforce Equality Standards

The NHS has a set of workforce standards and reporting requirements aimed at ensuring that we identify and address inequality, discrimination and good practice affecting our staff. We want our workforce to thrive and enjoy coming to work. We want

people to feel that they can bring their 'whole selves to work', celebrating their diversity in an inclusive environment. The following sections outline what we have been doing to meet our goals.

NHS Workforce Race Equality Standard 2024



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

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

The data is taken from the 2025 NHS BDCFT Staff Survey and from a snapshot of workforce information on 31st March 2026. In the 2026 WRES return, there were improvements across six of the nine metrics; two metrics remained static and one deteriorated. There are still considerable gaps between the experiences of Black, Asian and Minority Ethnic (BAME) staff and those of White staff. The table below presents the 2025 WRES data taken from the Electronic Staff Record on 31st March 2026 and People Services records over the reporting period.

WRES Metric No.	**Metrics**	**2025**	**202**
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce		
	Ethnically diverse staffs representation in the whole workforce	30%	**32%**
	Ethnically diverse staffs representation 8a and above	29%	**33%**
	Ethnically diverse staffs representation 8c and above	41%	**47%**
2	Relative likelihood of staff being appointed from shortlisting across all posts	1.25	**2.13**
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	4.08	**4.27**
4	Relative likelihood of staff accessing non-mandatory training and CPD	1.03	**0.93**
9	Percentage difference between the organisations' Board voting membership and its overall workforce	-11%	**-4%**

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The WRES data shows encouraging progress in workforce representation. Ethnically and culturally diverse staff representation increased from 30% to 32% across the workforce, from 29% to 33% at Band 8a and above, and from 41% to 47% at Band 8c and above. The gap between Board voting membership and overall workforce representation also narrowed from 11% to 4%.

Access to non-mandatory training and continuing professional development became more equitable, with the relative likelihood improving from 1.03 to 0.93. However, disparities increased in recruitment and formal disciplinary processes: the relative likelihood of appointment from shortlisting rose from 1.25 to 2.13, while the likelihood of entering a formal disciplinary process increased from 4.08 to 4.27. These findings reinforce the need for targeted action to improve fairness in recruitment and reduce disproportionate disciplinary rates.

This table shows the data taken from the 2025 staff survey.

WRES Metric No.	**Metrics**	**2025**		**2024**			
		BDCFT				**National Benchmark**	
	Staff Response	**White**	**BME***	**White**	**BME***	**White**	**BME***
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	16%	**24%**	18%	24%	21%	**32%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	17%	**19%**	16%	17%	16%	**21%**
7	Percentage of staff believing that the organisation provides equal opportunity for career progression and promotion	51%	**57%**	63%	53%	61%	**51%**
8	Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	5	**11%**	5%	11%	6%	**13%**

The percentages are green, amber or red depending on how we perform when compared to our 2024 data and the national benchmark.

In 2025, 24% of ECD staff reported harassment, bullying or abuse from patients, relatives or the public, compared with 16% of White staff. The ECD figure was unchanged from 2024, while the White figure improved from 18%; both results were better than the national benchmarks of 32% and 21% respectively.

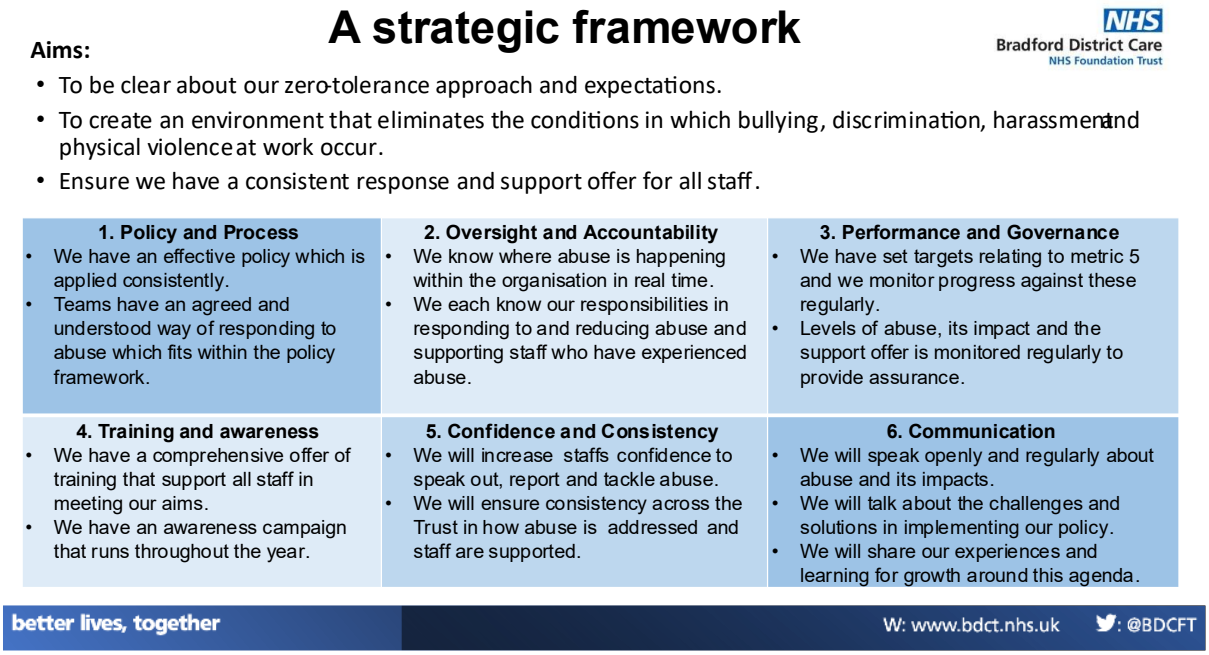
Reports of harassment, bullying or abuse from colleagues increased to 19% for ECD staff and 17% for White staff, although the ECD result remained better than the 21% national benchmark.

Perceptions of equal opportunities for career progression improved among ECD staff from 53% to 57%, exceeding the 51% national benchmark, but fell among White staff from 63% to 51%. Reported workplace discrimination remained unchanged, at 11% for ECD staff and 5% for White staff, with both results performing better than the corresponding national benchmarks. Overall, the data indicates some positive

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performance against national comparisons, but persistent gaps between the experiences of White and ECD staff require continued targeted action.

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



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

Medical workforce race equality standard

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

The report has the following key roles: -

- To enable organisations to understand the challenges that exist in the medical workforce, with the aim of encouraging improvement by learning and sharing good practice.
- To provide a national picture of MWRES in practice, to colleagues, NHS organisations, royal colleges and the public on the developments in the workforce race equality agenda.

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

- Lord Mann Review Recommendations Work Programme,
- Act Against Racism Royal College of Psychiatrists Campaign,
- NHS EDI Improvement Plan High Impact Action Five,
- Nursing and Midwifery Council Anti Racism Gap Analysis.

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Bank Workforce Race Equality Standard

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

There are nine metrics in the Bank WRES, which provide an overview of the experience and representation of ECD staff within the NHS bank workforce: NHS England » Technical guidance for the Bank Workforce Race Equality Standard (Bank WRES).

In the 2025 BDCFT Bank Staff survey:

- 33% of White bank staff and 61% of ECD bank staff reported having been bullied, harassed or abused by patients, carers or the public in the last 12 months.
- 13% of White bank staff and 20% of ECD bank staff reported having been bullied, harassed or abused by managers or staff in the last 12 months.
- 17% of White bank staff and 63% of ECD bank staff said they had experienced physical violence from patients, relatives or the public in the last 12 months.
- 50% of White bank staff and 53% of ECD bank staff are satisfied with the extent to which the organisation values their work.
- 62% of White bank staff and 66% of ECD bank staff said they would feel safe to speak up about anything that concerns them in their organisation.

The Bank WRES findings show clear differences in the experiences of White and ECD bank staff. ECD staff reported substantially higher levels of bullying, harassment, abuse and physical violence, particularly from patients, relatives and the public. However, responses relating to feeling valued and feeling safe to speak up were broadly similar, with ECD staff reporting slightly more positive results. The findings highlight the need for targeted action to improve experiences of ECD bank staff.

NHS Workforce Disability Equality Standard

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

The WDES uses the term “disabled” to refer to members of the NHS workforce who identify themselves as having a disability in the annual NHS Staff Survey or the Trust’s Electronic Staff Record (ESR). One of our key actions is to increase the number of staff who feel able to share information with their manager about their health, disability and wellbeing.

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The following table provides an overview of the 2026 results taken from the Electronic Staff Record and internal data systems for recruitment and employee relations.

No.	Metrics	2025	2026
1	Percentage of staff from AfC paybands or medical and dental subgroups and very senior managers (including Executive Board Members) compared with the percentage of staff in the overall workforce.		
	Percentage of disabled staff in the whole organisation	17%	18%
	Percentage of disabled staff in bands 8a and above	16%	16%
	% difference between an organisation's board voting membership and its overall workforce		-9%
2	Relative likelihood of non-disabled applicants compared to disabled applicants being appointed from shortlisting across all posts.	2.08	0.54

The table below provides the metric data taken from the BDCFT 2025 Staff Survey.

WDES Metric No.	Metrics	2025				2024	
		BDCFT		National Benchmark		BDCFT	
	Staff Response	With LTC	Without	With LTC	Without	With LTC*	Without LTC
4a	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months.	23%	15%	27%	22%	24%	18%
4b	Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.	13%	4%	12%	6%	11%	7%
4c	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.	20%	12%	19%	11%	16%	11%
4d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	62%	60%	62%	66%	64%	62%
5	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.	56%	61%	52%	59%	57%	62%
6	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	19%	10%	18%	12%	15%	11%
7	Percentage of staff satisfied with the extent to which their organisation values their work.	45%	57%	42%	53%	48%	56%
8	Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work.	82%	N/A	79%	N/A	84%	N/A
9	Staff engagement score (0-10)	6.73	7.23	6.64	7.17	6.89	7.20

The percentages are green, amber or red depending on how we perform when compared to our 2025 WRES return

Disabled colleague representation increased across the organisation, rising from 17% in 2025 to 18% in 2026. Representation of disabled staff at Band 8a and above remained stable at 16%. The difference between representation among Board voting members and the overall workforce was nine percentage points in 2026. Recruitment outcomes improved significantly: the relative likelihood of non-disabled applicants being appointed compared with disabled applicants reduced from 2.08 to 0.54.

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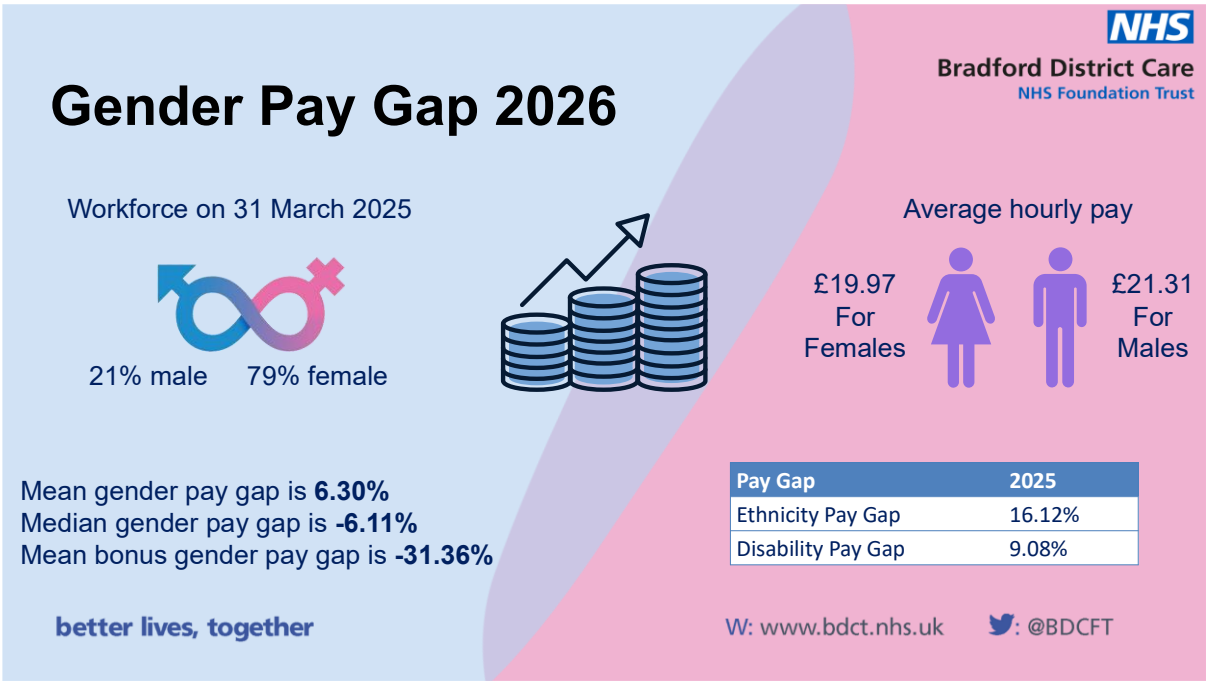
Overall, the data indicates progress in workforce representation and recruitment equity, although senior and Board-level representation will continue to be monitored.

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

Despite these improvements, there are still gaps in staff experiences across all metrics that need to be closed.

Gender Pay Gap

The Equality Act 2017 Regulations require organisations with more than 250 staff to publish their Gender Pay Gap (GPG) and Bonus Gender Pay Gap (BGPG) data on the Government's reporting website by 31st March each year. There is clear guidance[1] on how to carry out the calculations in a way that can be benchmarked nationally. The data is a snapshot of the workforce on 31st March of the previous year, meaning that the data presented here is from 31st March 2025.



The BGPG is calculated from Clinical Excellence Awards (CEA) within the Trust. A CEA may be awarded to eligible consultants who have at least one year's service and are able to demonstrate that they have made a significant difference above and beyond their role to research and / or delivery of new or innovative ways of working or developing the service. The aspiration is that the Trust remains in the top performing quartile of Foundation Trusts. We have collaborated with Bradford, Airedale and Craven public sector partners to compare pay gaps and resources and plan our actions together.

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

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

Chapter Four: Supporting and valuing our workforce, creating the conditions needed to deliver safe, high quality care

Trust Induction

EDI and health equity are woven throughout the Trust induction. New staff come together in their first few weeks for a corporate induction, where they meet our executives and support teams; hear about our policies and procedures, staff networks and wellbeing offer; and learn about our equality priorities and what they can do to further equity within their new role. They are also introduced to our chaplains and our EDI training and support offer.

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

We also ask candidates after their interview how inclusive they found the recruitment process. The results present a positive picture: respondents generally experienced the recruitment process as fair, respectful, inclusive and easy to navigate. Suggestions for improvement include making interview questions easier to process, consistently offering reasonable adjustments and providing clearer practical accessibility information, such as parking arrangements.

Staff Networks



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

The networks are led by staff voluntarily alongside their substantive roles. Chairs are given time each month to coordinate the network and staff are supported and encouraged to attend within their work time. Each network has a small budget to support them with their priorities. We would like to take this

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opportunity to thank all those colleagues who participate and lead the networks. They are vital to our EDI work and Trust values.

Rainbow Alliance



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

The main aims of our Rainbow Alliance are to:

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

The Alliance has advised the EDI Team and our Board on how to respond to the Supreme Court ruling on the definition of biological sex and has responded to the draft Code of Practice consultation that followed. The Alliance has established an LGBT+ Parents and Carers Subgroup and held relaxed 'crafternoon' Pride events for members.

The network now includes 70 colleagues from across the Trust and continues to grow. The Co-Chairs of the Rainbow Alliance have worked hard to establish a steering group to support the network's development.

Beacon Network

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

The network creates a collective voice by sharing lived experiences in strategic forums across the Trust to improve equality for disabled staff and carers. It aims to use members' energy and ideas to run campaigns that raise awareness of disability, equality and carer issues throughout the year. The Trust is a Mindful Employer, Disability Confident Employer and Carer Confident Employer. The Beacon Network supports our commitment to these standards. The network launched in 2020 and now has 180 members and three thriving subgroups offering specific support to members. The group oversees the Trusts maintenance of disabilitry and carer related employee standards.

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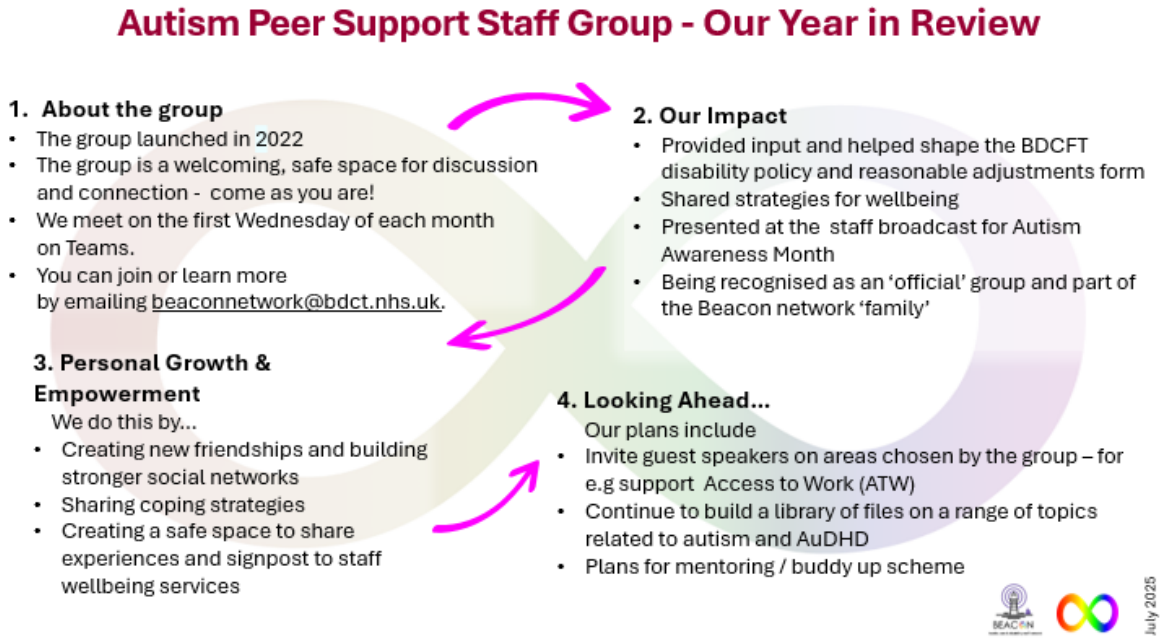
Beacon Network Family of Subgroups



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

The **Working Carers Group** meets quarterly to provide an informal and confidential space to connect with other colleagues who are juggling caring for someone and working at the Trust.

'Condensing my working hours so I have a 9 day fortnight has allowed me to get to carers meetings and "me time" booked in on non-working days which helps with my wellbeing'.



Aspiring Cultures Staff Network

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

and watches over the effective implementation of our Anti-Racism Framework and policies.

The prime purpose of the Network is to:

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

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



The network has also contributed members' lived experience to our work to improve mental health services for ethnically diverse service users and carers through the NHS Patient and Carer Race Equality Framework.

This year the network is launching a new subgroup to support International Non-Medical colleagues within the BDCFT workforce.

Menopause

Bradford District Care Foundation Trust celebrates diversity in our workforce, and we endeavour to support staff and managers through the menopause journey. The Trust's Menopause Cafés continue to provide peer support, enabling colleagues affected by menopause to come together and share their experiences.

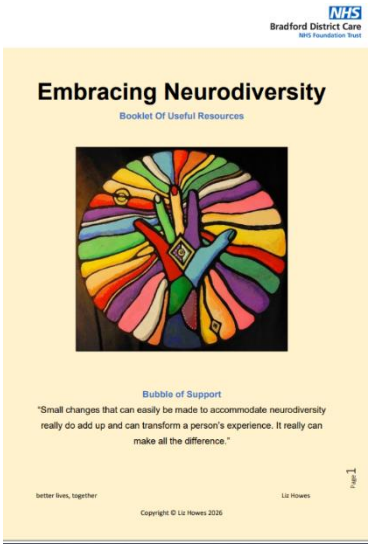
The groups have provided a strategic influence around the issues affecting staff which was used during 2026 to update the Menopause Policy and resources. A group of Menopause Buddies have been trained. The Staff Psychological Support Service have been organising workshops that enable managers to ensure staff affected by the menopause are well supported. Over 100 colleagues have attended these workshops.

In 2024 we achieved the Hen Picked Menopause Accreditation and we continue to uphold the standards of that accreditation.

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Neurodiversity

Support for neurodivergent colleagues has grown over the past year. Training and resources are in place to support reasonable adjustments and the creation of accessible and inclusive work environments.



In 2026, we began developing a Neuroaffirmative Strategic Approach spanning priorities for our workforce, patients and communities. We were awarded bronze status through the Autistica Neurodiversity Employers Index programme and have embedded actions in our Belonging and Inclusion Plan to move towards silver and gold status. The assessment forms part of our commitment to the Bradford, Airedale and Craven Health and Care Partnership's aim to become a neurodiversity-friendly district.

Veterans

In 2024, the Trust was awarded the NHS Veteran Aware accreditation after successfully meeting eight standards that demonstrate our commitment to the Armed Forces Covenant. The accreditation marks our commitment to supporting the region's serving personnel, service families, veterans and cadets.

Workforce Wellbeing

The Trust has a comprehensive wellbeing offer for staff, supporting our strategic ambition to support and value the workforce. We monitor uptake and outcomes to ensure that the offer is equitable, and we have strategic objectives to target support towards the teams or staff groups that need it most.

We assess our offer and its effectiveness as part of the annual NHS Equality Delivery System assessment. In 2026, our offer was rated 10 out of 12 when assessed in relation to targeting priority health conditions; abuse, bullying and harassment at work; access to independent support; and how likely staff are to recommend the Trust as a place to work and receive treatment, all considered through an EDI lens. This is an increase of two points from 2025. The assessment is peer reviewed with West Yorkshire NHS mental health organisations.

Smarter Spaces and Redeveloping our Estate

The trust wants to offer the best possible facilities to our staff and the people using our services. During 2025 we have started an exciting renovation of our Trust Headquarters, New Mill in Saltaire. We have opened a new multiuse workplace after extensive engagement with staff and service users about how we can make our environment inclusive and accessible.



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The new workspace includes drop-in and bookable workstations, meeting rooms, pods, booths and training

rooms. The provision includes soundproofing, adaptable lighting and temperature control, sit-to-stand desks, accessible toilets, prayer rooms and quiet spaces. A new wellbeing room was opened in September 2026 to provide a quiet space focused on colleague health and wellbeing.

New clinical spaces were also opened to patients with similar accessibility and inclusion features. Feedback from those using the spaces has been positive with our Staff Networks praising the engagement and co-production processes used to ensure equality has been considered throughout.

We carried out an equality impact assessment of our plans to redevelop Lynfield Mount Hospital and are excited about the next steps on the journey.

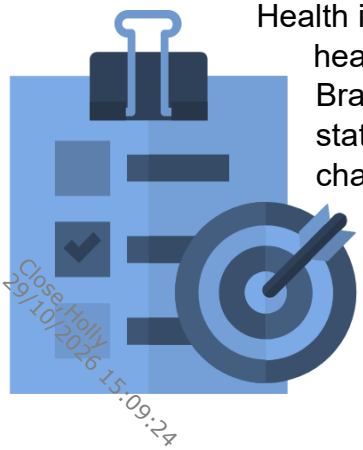
Chapter Five: Developing policy to deliver our EDI priorities

Policies set expectations for our organisation and staff, supporting us to meet the standards to which we aspire and to create better lives together. Over the past year, we have developed and updated a range of policies and strategic intentions, including our Disability Policy, Preventing and Addressing Sexual Harassment in the Workplace Policy, Menopause Policy and Disciplinary Policy. All of our Trust policies are equality impact assessed and quality assured with implementation monitored.

We are in the process of updating the Domestic Abuse Procedure and Trans Equality Policy.

We evaluate the impact of our policies using key performance measures linked to them. We use the findings to update and review implementation, targeting our training and support towards priority services and areas.

Chapter Six: Improving Health Equity



Health inequalities are differences in health status or the distribution of health determinants between different population groups. Within Bradford, Airedale and Craven there are stark differences in health status and determinants both geographically and by protected characteristic groups.

Bradford has a high level of deprivation and is one of the most deprived local authority areas in England ranking 21st out of 317. What are health inequalities? | The King's Fund (kingsfund.org.uk).

In 2023, 2025 and 2026 we analysed our workforce data, mapping it to the Index of Multiple Deprivation for the West Yorkshire region. We use this information to target our EDI work for colleagues.

The consequences of health inequalities are wide ranging. There is a ten-year difference in life expectancy between the most deprived and affluent wards of the district. Bradford JSNA.

In our Belonging and Inclusion Plan we have committed to being proactive in the identification of health inequalities in our services. We have developed a draft Health Equity Approach to improve health equity, specifically access, experience and health outcomes for protected equality and inclusion health groups. We intend to launch this to support our new Better Lives, Together aspiration to provide safe, effective, compassionate care that addresses health inequalities and promotes health equity.



We have developed an integrated dashboard that provides a live view of our mental health caseload, broken down by ethnicity, sex, sexual orientation, age and Index of Multiple Deprivation. This enables the 600 colleagues with access to view the experience and access data we hold through an equality lens. We are focused on upskilling staff to use this data confidently in operational planning to improve health

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equity and to build patient-related outcome measures into the system. We have designed a new Integrated Strategic Performance and Quality Report, which summarises performance against a wide range of metrics used to monitor implementation of our new organisational strategy. Work is under way to ensure that this is considered through a health equity lens.

We have developed new training for service leads on using the Equality Impact Assessment (EIA) Policy to systematically screen our policies, procedures, services and decision-making processes. We use our EIA process to assess quality and equality when developing business cases and policies across the Trust.

The Trust has substantiated a Reducing Health Inequalities Lead post to support this work.

EDI Influencers

We have a network of EDI Influencers across the Trust. These colleagues from our operational services support the mobilisation and delivery of the Belonging and Inclusion Plan and health equity approach at service and team level. They are leading innovation and equality interventions within their role. We share good practice, identify priorities and influence how we deliver on our equality objectives. The case studies in this section are led by EDI Influencers.



Some examples of our key priorities are set out below:

Accessible Information Standard

The Trust is required to comply with the Accessible Information Standard. Further information about the standard is available from NHS England » Accessible Information Standard.

As part of the Accessible Information Standard, organisations that provide NHS care or adult social care must do five things. They must:

1. Ask people if they have any information or communication needs and find out how to meet their needs.
2. Record those needs clearly and in a set way.
3. Highlight or flag the person's file or notes so they have information or communication needs and how to meet those needs.
4. Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.
5. Take steps to ensure that people receive information which they can access and understand and receive communication support if they need it.

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In 2016 the Trust prepared for the implementation of the standard by developing e-learning and establishing recording and flagging mechanisms in patient records. We established a task group that met monthly to ensure services were well placed to meet the needs of people using our services. We called upon the expertise and services of voluntary and community sector partners and our peers across the region.



10 years on we have evaluated our compliance and we intend to strengthen our performance around the five requirements.

In August 2026 we launched a digital flag within our patient record so that patients can tell us if they have any reasonable adjustment requirements for appointments or that they are a veteran.

Our colleagues can also ask and record any specific needs to support patients on their care pathway. We will be auditing how the information is improving patient experience and health outcomes.

We have also developed intranet resources for our colleagues to use when meeting the needs of our diverse population. Examples include:

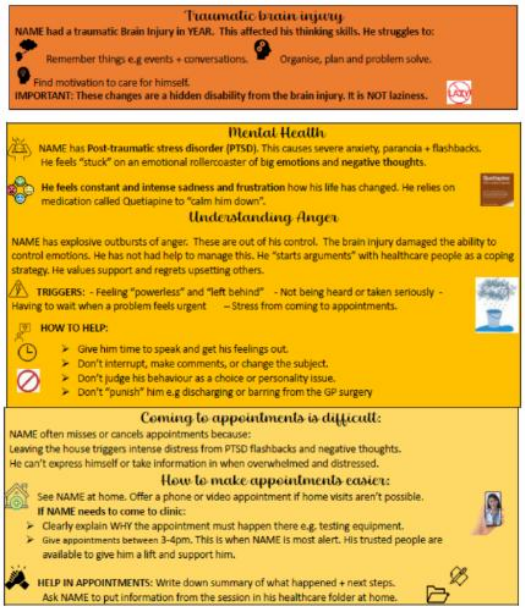
- 'Spiritual Care for Service Users' which includes information on how to refer a patient to a chaplain, our policy and our Spiritual Care Strategic Framework.
- 'Reasonable adjustments for service users' with information about communication, appointment related adjustments, physical and environmental adjustments and support preferences.
- 'Supporting Trans Service Users' which includes our pledge to Trans Equality, information about NHS record processes for Trans patients and guidance on confidentiality.



Our EDI Influencers have developed resources to help patients and carers understand and engage effectively with their care.

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These Easy Read resources have made a significant difference to health outcomes. Some examples are included below.



Traumatic brain injury

NAME had a traumatic Brain Injury in YEAR. This affected his thinking skills. He struggles to:

Remember things e.g events + conversations.

Organise, plan and problem solve.

Find motivation to care for himself.

IMPORTANT: These changes are a hidden disability from the brain injury. It is NOT laziness.

Mental Health

NAME has Post-traumatic stress disorder (PTSD). This causes severe anxiety, paranoia + flashbacks. He feels "stuck" on an emotional rollercoaster of big emotions and negative thoughts.

He feels constant and intense sadness and frustration how his life has changed. He relies on medication called Quetiapine to "calm him down".

Understanding Anger

NAME has explosive outbursts of anger. These are out of his control. The brain injury damaged the ability to control emotions. He has not had help to manage this. He "starts arguments" with healthcare people as a coping strategy. He values support and regrets upsetting others.

TRIGGERS: - Feeling "powerless" and "left behind" - Not being heard or taken seriously - Having to wait when a problem feels urgent – Stress from coming to appointments.

HOW TO HELP:

- Give him time to speak and get his feelings out.
- Don't interrupt, make comments, or change the subject.
- Don't judge his behaviour as a choice or personality issue.
- Don't "punish" him e.g discharging or barring from the GP surgery

Coming to appointments is difficult:

NAME often misses or cancels appointments because:
Leaving the house triggers intense distress from PTSD flashbacks and negative thoughts.
He can't express himself or take information in when overwhelmed and distressed.

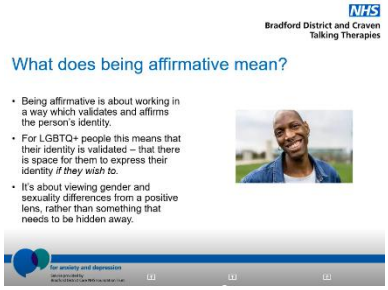
How to make appointments easier:

See NAME at home. Offer a phone or video appointment if home visits aren't possible.

If NAME needs to come to clinic:

- Clearly explain WHY the appointment must happen there e.g. testing equipment.
- Give appointments between 3-4pm. This is when NAME is most alert. His trusted people are available to give him a lift and support him.

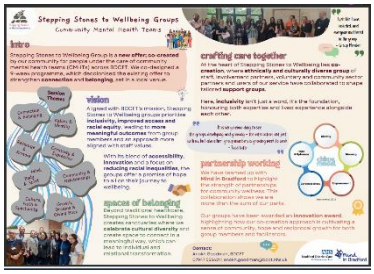
HELP IN APPOINTMENTS: Write down summary of what happened + next steps. Ask NAME to put information from the session in his healthcare folder at home.



NHS
Bradford District and Craven Talking Therapies

What does being affirmative mean?

- Being affirmative is about working in a way which validates and affirms the person's identity.
- For LGBTQ+ people this means that their identity is validated – that there is space for them to express their identity *if they wish to.*
- It's about viewing gender and sexuality differences from a positive lens, rather than something that needs to be hidden away.



Stepping Stones to Wellbeing Groups
Community Mental Health Teams

Intro

vision

crafting care together

partnership working

spaces of belonging



DIVERSITY INCLUSION

Bradford District Care
NHS Foundation Trust

PCREF

Health Equity Newsletter

PUTTING EQUITY INTO PRACTICE | LEARNING, LISTENING & ACTING TOGETHER

WELCOME: Small Changes, Big Impact

Health equity is often achieved through small everyday actions that make services more accessible, inclusive and responsive to people's needs. Across our Trust, teams are finding innovative ways to remove barriers and ensure that everyone has a fair opportunity to achieve good health outcomes.

This newsletter celebrates some of that work. From supporting care-experienced young people through digital Health Passports to amplifying lived experience through PCREF, the stories in this edition demonstrate how listening, learning and acting can create meaningful change.

As you read, we encourage you to reflect on one question:
What is one thing I can do differently to reduce inequalities in my role?

The answer may seem small, but collectively those actions can transform experiences and outcomes for the people we serve.

Brontë Dines-Allen
Reducing Health Inequalities Lead

CASE STUDY: Digital Health Passports (PKB)

Care-experienced young people can face significant barriers to accessing and managing their health information. To address this, Bradford District Care's Children in Care team has introduced a digital Health Passport using Patients Know Best (PKB).

The passport provides secure access to health information, direct messaging with nurses and a trusted library of resources. Young people can also choose who has access to their information, increasing privacy and control.

Early feedback has been extremely positive, with young people reporting that they feel more informed and connected to their care.

One young person said:
"It's good I can message the nurse. I don't have to keep stuff in my head – I can look at it online."

This initiative demonstrates how digital innovation, co-production and trauma-informed practice can work together to reduce health inequalities and empower care-experienced young people.

better lives, together

W: www.bdct.nhs.uk @BDCFT

Health Literacy

People need trustworthy information to make decisions about their health, but Patient Information Forum figures published in 2023 show that:

- 5 million adults cannot find relevant data in standard health information
- 1.7 million are unable to explain symptoms and feelings over the phone
- 1 million cannot follow a letter from a GP surgery or hospital department
- 6.5 million cannot measure or record height and weight on a chart
- 9 million people are unable to use digital tools without help

Health literacy means more than just the ability to read and understand health-related information. It also includes the confidence to navigate healthcare services and make well-informed decisions about self-management. Health literacy is a life skill for everyone. In Bradford it is estimated that 52% of adults (16-65) have low health literacy. It is estimated that 70% of adults (16-65) have low levels of health literacy and numeracy.

This information is taken from Geodata http://healthliteracy.geodata.uk/ .

We have launched Health Literacy Training and e-learning for professionals to understand how to make information accessible to our population.

We have developed an intranet page for staff with resources and guidance on creating easy read material, assessing the reading age required to read core leaflets, letters and information we use and as a portal to ask questions and for support.

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Rainbow Badge Phase II

In 2021, the Trust became a pilot site for Phase II of the NHS Rainbow Badge Scheme. The former Chair and Vice-Chair of the Rainbow Alliance ensured that we were one of 10 trusts taking part in the pilot to develop and test an assessment framework awarding trusts bronze, silver or gold status for LGBT+ equality.

A third of our staff have attended the Rainbow Badge Training, made a pledge and now proudly wear their badge. The badge is a visible signal to LGBT+ people that they are welcome, supported and can approach our staff to talk about any issues relating to their care, their sexual orientation or gender identity. We use the badge to visibly demonstrate our alliance with the LGBT+ community as an organisation.

In the initial assessment the Trust was assessed as Bronze against the pilot framework. This is an excellent start and testament to the relentless efforts of our Rainbow Alliance. The network has convened a steering group and along with the EDI Team aim to move the Trust towards Silver rated performance over the next few years.

Key activities this year include the following:

- Engaging with LGBT+ colleagues and patients to understand the impacts of the supreme court ruling on biological sex.
- Auditing our toilet, washing and changing facilities.
- Increased visibility of LGBT+ people in our resources for patients.
- Providing appropriate resources and information to encourage signposting of LGBT+ people to specialist support agencies.
- Ongoing review of policies and clinical paperwork to remove gendered language.
- Developing inclusive signage and imagery in our new spaces and online resources.



Our Trust Board refreshed and updated their LGBT+ equality knowledge and commitments. We monitor how staff implement their Rainbow Badge Pledges.



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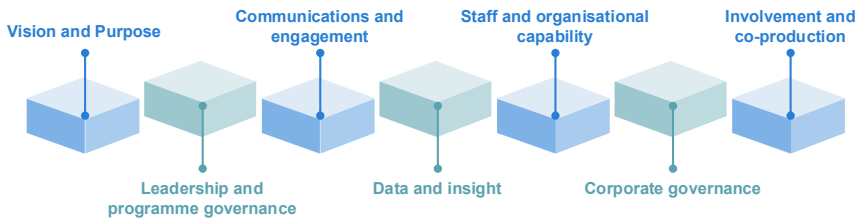
NHS Patient and Carer Race Equality Framework (PCREF)

The PCREF sets out three components, with several tests for NHS mental health service providers to undertake when assessing their performance in relation to equality of access, patient experience and health outcomes for ethnically diverse people using our services. The framework aims to improve trust and confidence in mental health services among these groups.

PCREF Programme has seven workstreams aimed at implementing the PCREF and making sustained and innovative change in partnership with our Act as One Partners.

With our health and social care partners, we have commissioned the Hope and Light Project to provide scrutiny, involvement and support for community voices across Bradford, Airedale and Craven.

These 7 workstreams divide our PCREF ambitions into manageable components:

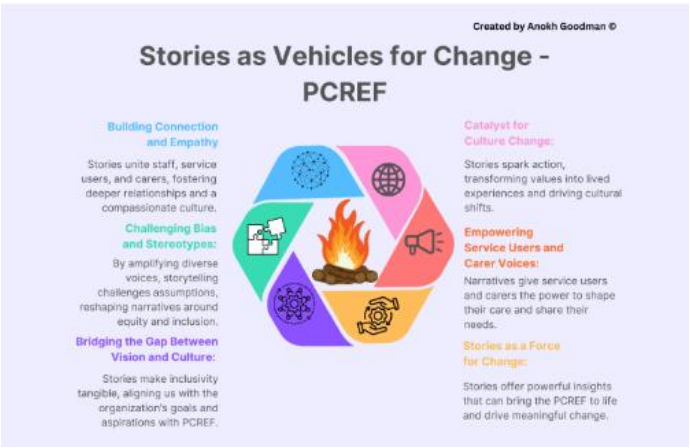


A representative place has been established on the Trust's Council of Governors, and the project leads are integral members of the PCREF Partnership.

We are reporting progress on implementation and performance to our Mental Health Legislation Committee, Quality and Safety Committee and Trust Board. We are working in partnership with our national and West Yorkshire Mental Health Peers to share resources, data and information and we will be reporting our progress to the Healthy Minds Partnership. You can read our Patient Carer Race Equality Framework (PCREF) Annual Report and Action Plan 2026 for detailed information.

Some highlights include:

- Launching our Cultural Competency and Humility Programme for staff, training 170 staff since the launch in June 2025. Using stories to create connection and begin significant change.
- Launching a PCREF data dashboard which enables us to see our performance, track our progress and identify areas of priority at the touch of a button.

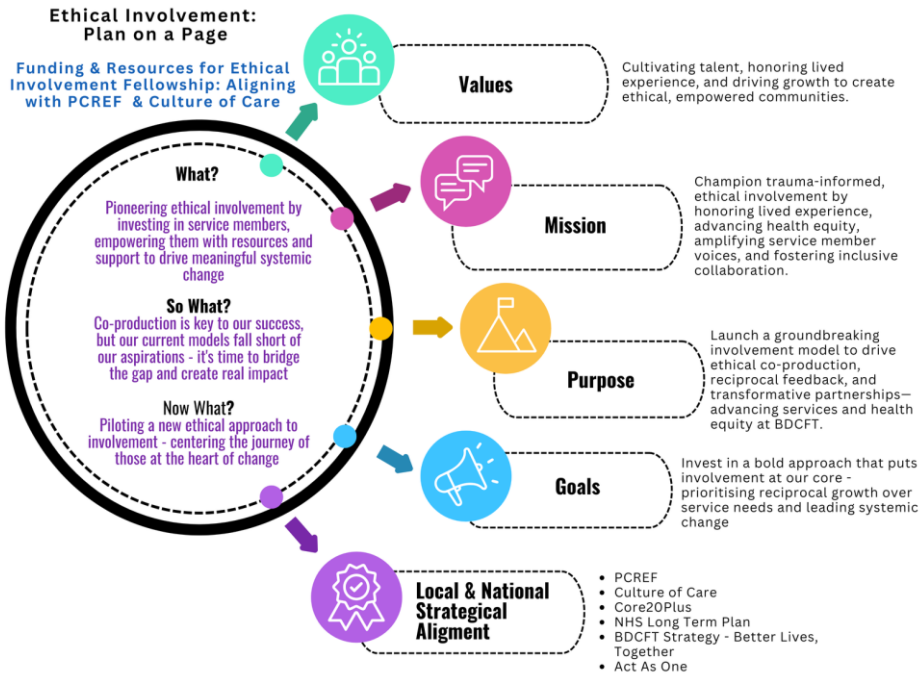


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- Launching the ‘Amplifying Voice’ Network to ensure the data has a strong lived experience narrative alongside it.



- Developing an Involvement Fellowship to create meaningful community coproduction within the programme.

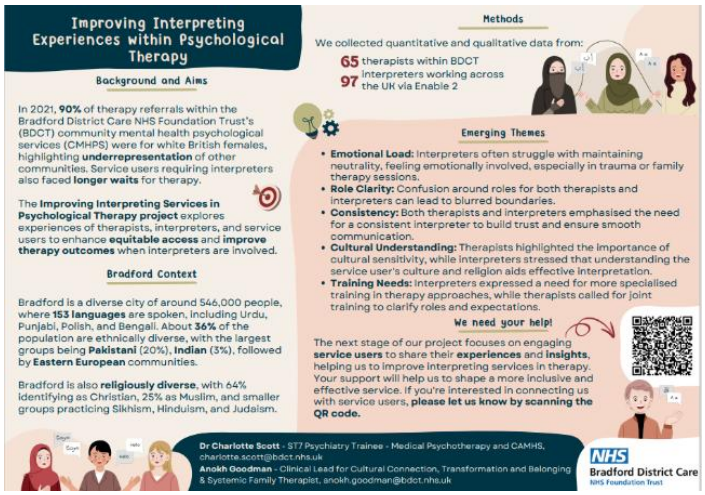


- Launching Equity Essentials, a lunch and learn programme designed to increase confidence and leadership capability amongst colleagues.
- Ensuring spoken family language is a major consideration in the Speech and Language Therapy *Early Language Support for Every Child* project, Bradford is a pathfinder site for ELSEC, screening children on their language skills. The

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Speech and Language Team are using two unique screening tools, one of which they have developed within their service to find the child's strongest language. This will improve access and health outcomes.

- Improving Interpreting Experiences in Therapy Project; This initiative aims to enhance communication in therapeutic settings for non-native speakers, ensuring that language differences do not become barriers to care.

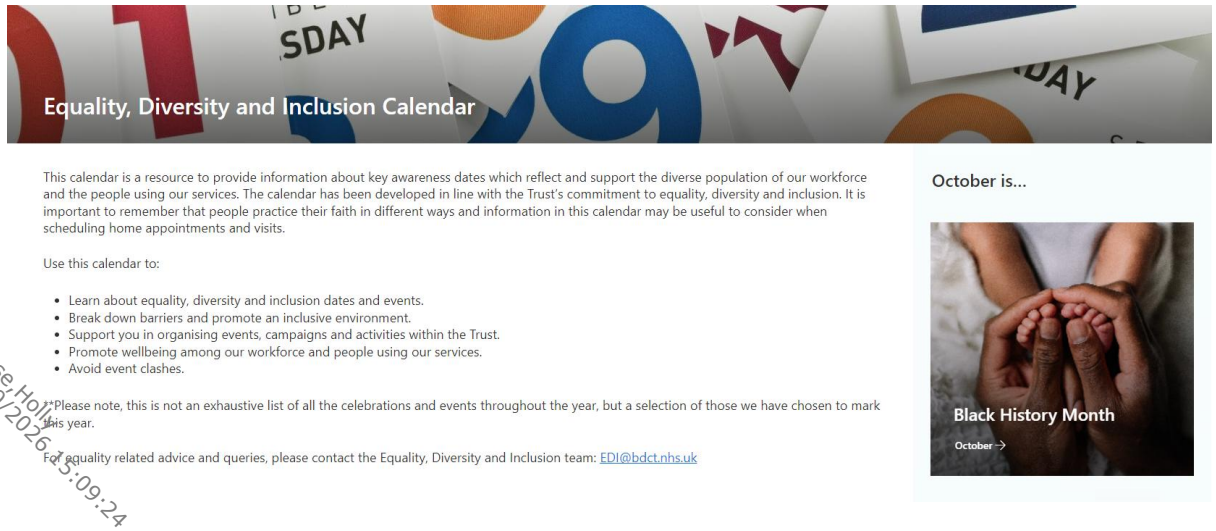


For more information on these or our other examples of improving health equity please contact EDI@bdct.nhs.uk.

Chapter Seven: Other EDI activity in the Trust

EDI Calendar

The Trust has an interactive equality calendar. Its purpose is to celebrate significant events for people who identify with different diversity groups and to raise awareness, visibility and understanding. Occasions marked by the Trust include International Women's Day, LGBT+ History Month and Pride, South Asian Heritage Month, Black History Month, Disability History Month, and religious and health awareness days. These have been recognised through a range of media, including internal communications, presentations and social media.



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We are Compassionate

In April 2025, the Trust launched the 'We Are Compassionate' programme, which includes workshops for teams to consider the Trust's values and behaviours, as well as their own ways of working.

The project supports the delivery of our Belonging and Inclusion Plan and strengthens our "we care" value across the Trust and all our services. The project includes an incivility campaign supporting a compassionate culture in which bullying, and harassment are unacceptable. Throughout 2026 the EDI team have been delivering training across the organisation to support teams in identifying what makes a good and a bad day at work; how we can have more good days through value, appreciation, constructive feedback and a culture of kindness.

This aligns with the NHS Long Term Plan 'levels of bullying and harassment must come down if the NHS is to achieve its aims of becoming the best place to work and being an employer of excellence' and with the NHS People Plan, 'Compassionate and inclusive culture at the very heart of the NHS'.

The project introduces an intranet page for staff with e-learning and resolution resources which sit alongside our Trust policies to support staff in speaking up around incivility and building inclusive, thriving workspaces.

We hope that the programme will impact on a whole host of issues experienced by the NHS including sickness absence costs, employee turnover, productivity, presenteeism, discrimination and costs of industrial relations associated with bullying, harassment and incivility.

Anti-racist tool kit



To support our pledge to be an anti-racist organisation and continue the dialogue about race equity, we developed an anti-racist toolkit.

The toolkit is available on the Trust's intranet. It is divided into three sections: 'The Fear Zone', which explores barriers to these conversations; 'The Learning Zone', which provides education and raises awareness about race; and 'The Growth Zone', which offers support on how to have these conversations.

The EDI Team is developing the online resource into an e-learning toolkit to support staff in moving to the Growth Zone and disrupting systemic racism.

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Partnership Working across the Integrated Care System

The EDI agenda spans across geographical and organisational boundaries.

Bradford District Care Foundation Trust is a partner in the Bradford District and Craven – Act as One. Act as One is the guiding principle of how we work together across the health, care, community, voluntary and independent organisations in Bradford District and Craven. Act as One brings senior leads formally together with clear governance arrangements and shared decision-making processes. Together they have responsibility for delivering our shared strategy for our communities, of Happy, Healthy at Home. This means that every organisation is committed to developing and delivering joined-up health care with our local communities.

We have been working with our Bradford District colleagues in the Bradford System Equalities Group as a subgroup of that partnership to deliver shared equality goals and share resources.

The West Yorkshire Integrated Care System is leading work to coordinate our approaches to addressing health inequality and inequalities within the workforce. We are a member of many specialist communities of practice sharing resources, information and working together for change. Our staff networks have been engaged in ICS programmes and in national initiatives giving them a louder voice for change.

Chapter Eight: Resourcing, Review and Audit

Equality, Diversity and Inclusion Resourcing

Equality, Diversity and Inclusion is a high priority in the Trust. A small team is employed to meet the legal requirements and support our strategic ambitions. There are many other colleagues across the Trust supporting and driving change within their networks, roles, services and partnerships.

Equality, Diversity and Inclusion Governance

Accountability and scrutiny for equality, diversity and inclusion are provided through various mechanisms, including Board meetings, the People and Culture Committee, the Quality and Safety Committee and the Senior Leadership Team. These structures check that robust mechanisms are in place to ensure that the EDI agenda continues to progress for our workforce and service users. Progress is reported regularly to the People and Culture Committee, the Quality and Safety Committee and the Trust Board.

For more information about anything in this report, or to receive the information in an alternative format, please email EDI@bdct.nhs.uk.

[i] WRES (england.nhs.uk)
[ii] NHS England » Technical guidance for the Bank Workforce Race Equality Standard (Bank WRES)
[iii] MWRES-DIGITAL-2020_FINAL.pdf (england.nhs.uk)
[iv] NHS England » NHS Workforce Disability Equality Standard: Metrics
[v] NHS England » Equality Delivery System 2022
[vi] NHS England » Patient and carer race equality framework

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Effective Oversight: Escalation and Assurance

Report to:	**Board of Directors**	**Meeting date:**	
Report from:	**Audit Committee**	**Meeting date:**	**23 September 2026**
Quorate?	**Yes ☒ No ☐**		
Members present	Warren Brown, Sally Napper		
In attendance	Fran Stead, Chris Boyne, Leanne Sobratee, Salma Younis, Mike Woodhead, Chris Smith, Chris Dixon		
Observers	None		
Apologies	Chris Malish, Richard Cliff		
Good Governance	Governance, accountability, and effective oversight		**GG**
Agenda items	• Strategic Narrative Report • Strategic Risk Assurance Report • Board Assurance Framework • Compliance and High Risk Report • Well Led Development Plan Action • Managing Conflicts of Interest in the NHS Policy & Procedure • Business Conduct, Bribery and Conflict of Interests in the NHS Procedure • Provider Capability Assessment • Committee Effectiveness Review • Annual Litigation Report • Review of Losses & Special Payments • Waiver of Standing Orders & Standing Financial Instructions • Proposed Write Off of Outstanding Debt • External Audit Technical Update • Internal Audit: Follow up reports • Internal Audit: Progress report • Policy for Procurement for Non Audit Services by External Auditors • Confirmation of Alert, Advise, Assure and Decision Report		
Alert items agreed by Committee	• Internal Audits - the need to reinforce expectations regarding the use of revised target dates.		
Advise items agreed by Committee	• The Committee noted plans to incorporate findings from recent external reviews, including the Thirlwall Inquiry and Aubrey review, into the Well-Led Development Plan to ensure learning and improvement actions are systematically tracked and monitored. • The Committee received updates on Strategic Risk, the Board Assurance Framework (BAF), the Well-Led Development Plan		

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	and the Provider Capability Assessment (PCA). Members were advised that further work was underway to strengthen integration between strategic risk and BAF processes, improve reporting alignment across committees and the Board, and develop a refreshed BAF approach under the Trust's new five-year strategy. Benchmarking and engagement with governance experts, including the Good Governance Institute, had informed the proposed improvements.
Assure items agreed by Committee	The Committee received assurance from multiple sources: • Strategic Risk and Board Assurance Framework arrangements continue to operate effectively, with ongoing improvement work being undertaken to strengthen integration and oversight. • The Trust's Well-Led Development Plan continues to demonstrate improvement, with an upward trend in assurance ratings across oversight meetings and the introduction of an archive process for completed actions. • The Provider Capability Assessment is progressing to plan, with evidence and self-assessments being reviewed through appropriate committees prior to Board consideration and submission to NHS England. • The Trust remains compliant with NHS provider licence requirements and is not subject to any regulatory enforcement action. The relevant PCA domains were assessed as fully compliant. • Internal Audit reported good progress against the 2026/27 audit plan, with approximately 40% of planned work completed and recent audits, including Mental Capacity Act, Fit and Proper Persons, and Restrictive Interventions and Seclusion, receiving Significant Assurance opinions. • The annual Litigation Report demonstrated a low number of claims, a slight reduction in the Trust's contribution payable to NHS Resolution, and robust mechanisms to capture and disseminate learning from claims and inquests. • There had been nine losses and special payments reported during 2026/27 to date, with no unusual themes identified. • No waivers of Standing Orders or Standing Financial Instructions and no proposed debt write-offs were reported. • External Audit provided assurance regarding sector developments, including AI governance, digital transformation, contract management and audit independence arrangements.
Decisions made by Committee	• Item 04.0 – AAAD & Minutes • Item 07.1 - Strategic Risk Assurance Report - September 2026 • Item 07.2 – Board Assurance Framework • Item 07.2 – Compliance & Risk Report • Item 07.4 – Well Led Development Plan update • Item 07.5 – Managing Conflicts of Interest in the NHS Policy & Procedure

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	• Item 07.5 - Business Conduct, Bribery and Conflict of Interests in the NHS Procedure • Item 07.6 – Provider Capability Assessment • Item 07.7 – Committee Effectiveness Review • Item 14.0 – Policy for Procurement for Non-Audit Services by External Auditors		
New risks identified by Committee	• No New risks identified		
Feedback following discussion at 'parent' meeting			
Report completed by	Nazmeen Khan – Corporate Governance Officer	**Date**	**23.09.2026**
On Behalf of Chair	**Warren Brown, Non-Executive Director**		

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AAAD: Effective Oversight: Escalation and Assurance

Report to:	**Board of Directors (Public)**	**Meeting date:**	**TBC**
Report from:	**Charitable Funds Committee**	**Meeting date:**	**29.10.2026**
Quorate?	**Yes ☒ No ☐**		
Members present	Sally Napper (Chair), Sarah Jones, Mike Woodhead		
In attendance	Kelly Barker Catherine Jowitt, Nazmeen Khan, Chris Smith, Laura Whitam, Tracy Robinson, Sarah Heseldon.		
Observers	N/A		
Apologies	Rachel Trawally		

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**

Agenda items (not including standard items)	• Future Staffing Structure – Virtually Approved • Hospital Rooms Combined Agreement - Virtually Approved • Learning from your experience: VIP Red Bags • Charity Risk Register • Charity Strategic Update • Charity Annual Accounts • Approval of Fund Objectives & managers • Transactions and Balances • Charity Grant Applications • Charity Annual Report • External Audit Reporting on the Annual Accounts Narrative: • .1 External Audit: ISA 260 • .2 Auditors report. • .3 Management letter • Confirmation of Escalation Reporting • Any Other Business • .1 Charity Reserves Policy
Alert items agreed by Committee	
Advise items agreed by Committee	• The Committee noted a potential sustainability risk relating to the School Health Hub following changes to the 0–19 service arrangements. Discussions were continuing regarding transitional arrangements and the future delivery model. NHS Charities Together had indicated flexibility to extend the use of underspent grant funding, potentially to December 2027, to support transition and sustainability. • The Committee received a positive presentation on the VIP Red Bag scheme, which supports people with learning

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	disabilities to communicate their needs and access reasonable adjustments when using health services. Approximately 420 bags remained in stock, but longer-term funding would need to be considered. The Committee supported exploring a more consistent, system-wide approach across West Yorkshire and consideration of whether future provision should form part of core funding rather than rely on charitable funding. • The Committee noted the Charity's increasing grant activity and the need for closer oversight of reserves, available grant funding and income generation, particularly alongside delivery of the Hospital Rooms project. • The Reserves Policy was approved, subject to a six-month review to ensure any future employment-related matters concerning the Charity Team could be appropriately reflected within the policy.
Assure items agreed by Committee	• The Committee received assurance on the positive impact of the VIP Red Bag scheme, which supports people with learning disabilities to communicate their needs and access appropriate reasonable adjustments when receiving healthcare. The scheme had received positive feedback from service users, families and healthcare staff, with increased recognition of the bags across local services. The Committee welcomed the benefits demonstrated and supported consideration of a sustainable, system-wide approach to future provision. • The Committee noted that there were no live risks on the Charity Risk Register. • The Committee received the 2025/26 annual accounts, which had received an unqualified audit opinion, and approved them for onward consideration by Audit Committee in December. • The Committee approved the Charity Annual Report and received assurance regarding progress across fundraising, grants, partnerships and staff engagement.
Decisions made by Committee	The Committee was quorate, the following items were approved by members within the meeting. • Item 04.0 - 25 June 2026 Minutes • Item 04.0 - 25 June 2026 AAAD • Item 10.0 - Charity Annual Accounts • Item 14.0 - Charity Annual Report • Item 15.0 - External Audit Reporting on the Annual Accounts Narrative: 1 External Audit: ISA 260 .2 Auditors report. .3 Management letter • Item 19.0 - Charity Reserves Policy subject to a six-month review
New risks identified by Committee	No items were raised.

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Items to be considered by other Committees/Groups	No items were raised.		
Feedback following discussion at 'parent' meeting	No items were raised		
Report completed by	Nazmeen Khan Corporate Governance Officer	**Date**	29.10.2026
On Behalf of Chair	Sally Napper, Non-Executive Director		

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NHS
Bradford District Care
NHS Foundation Trust

Board of Directors

5 November 2026

Paper title:	Well Led Development Plan – November 2026	**Agenda Item** **24.0**
Presented by:	Fran Stead, Trust Secretary	
Prepared by:	Fran Stead, Trust Secretary and Corporate Governance team	
Committees where content has been discussed previously	Board Committees; Board of Directors during 2025 & 2026	
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	
	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

The purpose of this report is to provide an update as of the reporting period on the actions within the Well Led Development Plan that the Board is assurance receiver for.

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Executive Summary

The Well Led Development Plan is the Board endorsed tool for the Trust to monitor and receive assurance/escalation on all management agreed governance actions.

The process to deliver Well Led, sits with the Corporate Governance team, with each agreed action having a delivery lead; senior responsible officer; oversight meeting.

A two-phase approach is in place for the actions (it is for the Senior Responsible Officer to confirm if both phases are required or not):

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

The Well Led Development Plan is presented on a quarterly basis to the relevant oversight meeting to track delivery. With the Audit Committee also monitoring effectiveness of the process. The Board will also monitor overall delivery of the Plan.

There are four categories for reporting:

- actions archived following completion
- actions not due yet
- action completed
- actions overdue
- actions requesting an extension.

A performance monitoring table is included to track progress made.

Any actions that are listed as complete, will move to the 'completed actions worksheet', to be archived, following agreement by the Senior Responsible Officer.

As a learning and improvement organisation, all process improvements will be tracked. This is an iterative process which will continue to evolve during 2026/27.

Following consideration of the County Durham and Darlington breast surgery inquiry recommendations, agreed actions and responsible officers will be added to the Well Led Development Plan in November, with progress reported to the Board in January. The same approach will be considered for the Countess of Chester Hospital inquiry recommendations.

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:

- be assured on the process being delivered as a new process agreed by the Board
- note and discuss the updates provided
- agree any actions associated with the work and the above actions
- consider any evidence presented for those actions that have been listed as complete for phase 1, and agree to close the actions (if any outlined within section 7 of the report)
- consider the and approve any extension requests for actions in phase 1 (if any outlined within section 7 of the report)
- consider any overdue actions for phase 1 & further assurance required (if any outlined within section 7 of the report)
- note that the full report will be presented to the Audit Committee; & Board held in public, as outlined above.

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: Not applicable
Care Quality Commission domains Please check **ALL** 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 - Provider Licence - NHS Act 2006 - Health & Care Act 2022 - Trust Constitution - NHS Code of Governance - Trust Strategy: Better Lives, Together

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Bradford District Care
NHS Foundation Trust

Board of Directors

Well Led Development Plan – November 2026

1 Purpose

The purpose of this report is to provide an update as of the reporting period on the delivery of the Well Led Development Plan, & the actions within the Plan that the Board is assurance receiver for.

2 Better Lives Together (BLT)

The Trust strategy describes our role in connecting people to the best-quality care, where and when they need it, and in being a national role model as an employer.



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

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

As part of the 2026–2031 Trust strategy refresh, the following strategic priorities were agreed:

- Supporting and valuing our workforce, creating the conditions they need to deliver safe, high-quality care
- Providing safe, effective and compassionate care
- Using our resources effectively to deliver the greatest benefit for our communities
- Working together with partners to improve care for our communities

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

3 Trust process

The Well Led Development Plan is the Trust's tool to monitor and receive assurance on the delivery of agreed improvement actions. The actions are linked to corporate governance; CQC Well Led framework; NHS Code of Governance; and the Healthy NHS Board.

The NHS England framework for Insightful Board, and Leadership Competency framework is also considered.

Actions are identified by internal and external reviews, this can include independent Well Led review and the annual effectiveness reviews.

The new process was created to support an integrated approach to ensuring 'good governance, effective oversight and accountability'. Recognising that the Trust has a number of existing processes in place to test existing processes. The Plan will not duplicate action management already taking place, such as Internal Audit. It will act as a home for management agreed actions relating to the areas outlined above in support of triangulation of improvement work and an integrated approach.



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*some actions will be completed for phase 1 only, when this is appropriate, this will be confirmed by the SRO.

4 Process improvements

As an improvement organisation & with this being a new process it will be iterative throughout 2026/27. This is to learn, facilitate co-production, & ensure the process is effective. Following which, it will be reviewed as part of the annual effectiveness plans.

This is the fourth iteration of the report, which includes updates made following feedback received. As an iterative process, further feedback will be gathered to refine the reporting process throughout 2026/27. Key changes made include:

- Action leads submitting evidence for completed actions & confirm embedding plans.
- Creation of performance metrics to allow for progress tracking to take place.
- Inclusion of the performance monitoring part that shows the assurance tracking, & progress for each group of actions within each quality statement that relate to this meeting.
- Inclusion of the 4-point assurance ratings for phase 1 of this work (for individual actions, & for the group of actions within each quality statement).
- Creation of a process for action leads to schedule any discussion & presenting of evidence to corporate governance meetings.
- Inclusion of any new agreed actions following the 2025/26 effectiveness review recommendations being gathered.
- Planned discussion to take place with the new Chair & Trust Secretary on the Well Led Plan, current process & future improvements.
- Process for presenting plans for phase 2 (embedding) back to oversight group.
- Review of the process during Summer 2026, including the addition of categories for the actions.
- Review of existing actions during Summer 2026, to remove duplication and capture any new management agreed actions (new or merged actions noted within the comment section).
- Introduction of ‘Completed Actions’ worksheet for any actions that have been agreed by the Senior Responsible Officer to be archived.

Planned improvements:

- Inclusion of management actions from review of the recommendations within the Aubrey Report and Audit Committee effectiveness review to be included within the Well Led Development Plan.
- Prioritisation exercise to take place with the Senior Responsible Officers to consider the delivery plans.
- Review of the process to be undertaken by Corporate Governance.

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5 Assurance rating

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

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



6 Performance monitoring

The table below summarises progress against the actions for which the Board is the oversight group.

Ref.	Quality statement	Total actions	Board actions	Assurance rating		Position	
				May 2026	September 2026	Position at May 2026	Position at September 2026
QS1	Shared direction & culture	5	3	Low	Significant	2 actions not yet due; 1 action past its due date, with an extension requested (QS1.3).	2 actions completed and archived following evidence presented previously; 1 action completed for phase 1, with evidence presented in September 2026.
QS2	Capable, compassionate & inclusive leaders	5	3	Limited	Significant	2 actions completed for phase 1, with evidence presented in May 2026; 1 action requesting an extension (QS2.1).	2 actions completed and archived following evidence presented previously; 1 action completed for phase 1, with evidence presented in July 2026.
QS3	Freedom to speak up	3	0	N/A	N/A	N/A	N/A
QS4	Workforce equality, diversity & inclusion	2	1	Significant	Significant	1 action completed for phase 1, with evidence presented in May 2026.	1 action not yet due for phase 2.
QS5	Governance, management & sustainability	30	7	Low	Significant	2 actions listed as complete, with evidence presented in May 2026; 1 action not yet due (QS5.7); 4 actions past their due dates, with	4 actions completed and archived following evidence presented previously; 1 action completed for phase 1; 1 action completed,

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						extensions requested (QS5.2, QS5.10, QS5.11 and QS5.26).	with evidence presented to the Board in July 2026; 1 action not yet due.
QS6	Partnerships & communities	5	3	Low	Limited	1 action completed, with evidence presented in April 2026; 1 action not yet due; 1 action past its due date, with an extension requested (QS6.3).	2 actions not yet due; 1 action completed and archived following evidence presented previously.
QS7	Learning, improvement & innovation	4	0	N/A	N/A	N/A	N/A
QS8	Environmental sustainability	3	0	N/A	N/A	N/A	N/A

7 Progress update: September 2026

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

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

Areas to note/action:

QS5.33 new action added Summer 2026 – Board Skills Matrix refresh

Actions archived
QS1.1(merged into action QS5.32)
QS1.4 (merged into action QS5.32)
QS2.1 (merged into action QS5.33)
QS2.2 (merged into action QS5.33)
QS2.3 (merged into action QS5.33)
QS5.1 (action complete – Phase 1 only)
QS5.10 (merged into action QS5.34)

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QS5.11 (merged into action QS5.35)
QS5.26 (action complete – Phase 1 only)
QS6.4 (action complete – Phase 1 only)

Actions note due yet for phase 1 (**no action** required at this stage)
QS6.1
QS6.3

Actions listed as 'complete'
QS1.3 (complete for phase 1)
QS4.2 (complete for phase 1)
QS5.7 (complete for Phase 1)
QS5.17 (complete for phase 1)

Overdue actions for phase 1 (**assurance to be received** from delivery leads on progress & timescale for delivery)
None

Actions requesting a new delivery date (supported by lead Executive, presented to Committee to be **approved**)
None

Quality Statement 1: Shared direction and culture								
We have a shared vision, strategy & culture. This is based on transparency, equity, equality & human rights, diversity & inclusion, engagement, & understanding challenges & the needs of people & our communities in order to meet these. Covering: Strategy & vision – organisational culture – values – addressing social impact these.								
Ref.	**Action**	**Due**	**Delivery lead**	**Board/ EMT lead**	**Oversight group**	**Progress**	**Evidence**	**Assurance rating**
QS1.1	The Trust should consider ways in which it can reinforce its strategy & objectives through day-to-day operations including greater linkage with operational plans, team meetings, supervision etc.	31/07/2026 (Phase 1)	Chris Hunt	Sarah Jones & Therese Patten	Board of Directors	This work will be considered as part of the strategy development process, due for completion next Summer. Part of this will be the introduction of a Quality Management System, which will support with strategy deployment, integration & alignment of the strategy with the Care Trust Way, as our accountability & performance		Merged into action QS5.34 Integrated Governance Guide refresh

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						framework. There will be further discussion with the Board on the strategy deployment phase, & creation of the Quality Management System		
QS1.3	The Trust should consider expanding its current range of measurements to oversee the delivery of its strategy within the context of the Board's Integrated Performance & Assurance Report. To include consideration of corporate performance.	~~30/04/2026~~ 31/07/2026 (Phase 1)	Clifton Springthorpe	Farhan Rafiq	Board of Directors	Executive workshop due to take place October 2025, aligned to Insightful Board guidance. Dec 25 Update - A rearranged executive workshop took place on 17th November. This reviewed the current ISPR, looked at strengths and gaps, and discussion took place around what need to be included going forwards to make it fit for purpose while being flexible to ensure current challenges are highlights. Feb 26 Update - The aim remains to have a revised version in place for April 2026 and a Board Development session is planned for 30th April where a new Integrated Performance Report will be shared for further development and use, ensuring it meets the Board's requirements.	ISPQR Board Development Session April 2026 ISPQR Committee & Board July 2026 & onwards	Phase 1 completed (July 2026)
QS1.4	The Trust should ensure that it has an up-to-date suite of connected enabling strategies that together support delivery of the overarching Trust strategy.	31/07/2026 (Phase 1)	SLT lead's	Farhan Rafiq	Board of Directors	This work will be considered as part of the strategy development process, due for completion next Summer.		Merged into action QS5.34 Integrated Governance

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								Guide refresh

Quality Statement 2: Capable, compassionate & inclusive leaders								
We have inclusive leaders at all levels who understand the context in which we deliver care, treatment & support & embody the culture & values of their workforce & organisation. They have the skills, knowledge, experience & credibility to lead effectively. They do so with integrity, openness & honesty. Covering: Leadership competency, support & development – safe recruitment of leaders / FPPR – compassionate & capable leaders – roles & accountability – succession planning / talent management								
Ref.	**Action**	**Due**	**Delivery lead**	**Board/ EMT lead**	**Oversight group**	**Progress**	**Evidence**	**Assurance rating**
QS2.1	The Trust should consider its overall NED capacity alongside the requirements of the Trusts forward agenda & the need for postholders to fulfil in-role responsibilities.	~~31/03/2026~~ 30/08/2026 (Phase 1)	Rachel Trawally	Sarah Jones/ Fran Stead	Board Nomination & Remuneration Committee	Following the recent appointment of two new NEDs have been appointed. One started on 19 Jan and the other started on 1 April 2026. The new Chair in Common role commenced on 1 March 2026. Work has started to review the skills matrix and chairs on committees to ensure this aligns with the balance of the updated NED membership. This will be updated after the NED appraisals in May/June.	Board skills matrix. Annual effectiveness review. Go see visit log. Attendance. Review of Chair and NED membership on Committees.	Merged into action QS5.33 Board Skills Matrix refresh
QS2.2	Board members should prioritise attendance at Board & committee meetings wherever possible to help discharge personal & corporate responsibilities and liabilities. **Committee**: including in-person attendance, suggested at twice / year minimum.	31/03/2026 (Phase 1)	Rachel Trawally	Sarah Jones	Board of Directors	Board members have been asked to attend Board in person and improvements to in-person attendance has been made. It was agreed for April 2026 onwards the new schedule will combine Go See visit on Board in private meeting dates which will support commitment to attend. However following the new Chair in Common, from 1 May Board meetings will be held in person, with the exception of May and Dec which will be	Committee attendance tracker	Merged into action QS5.33 Board Skills Matrix refresh

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						online. A full board in person development session will be held in July. Board development sessions have been moved back to board held in private days to reduce meeting times and combine meetings on same day. Two new NEDs recently started and commitment was stressed as part of the interview process and application. Committees will continue as hybrid meetings. The committee schedule was reviewed and presented to Board in April and discussions are being held around expected attendance and feasibility of in person meetings at May NED Appraisals. Going forward any attendance issues will be raised with the Chair at regular governance catch ups to address any issues as they arise. The new Chair in Common is undertaking 121s with all NEDs where the importance of attendance will be highlighted. COMPLETE		
QS2.3	The Trust should consider the merits / demerits of continuing its current approach to hybrid meetings for all Board & committee meetings.	31/03/2026 (Phase 1)	Rachel Trawally	Sarah Jones	Board of Directors	This has been implemented as part of the new Chair onboarding. As above QS2.2 encouraging improvements have been made to in person attendance. The new Chair has communicated her intention for al Board meetings to be held in person only and this will be progressed from 1 May 2026.	Email of new ways of working sent to all Board members	Merged into action QS5.33 Board Skills Matrix refresh

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						Committees will continue as hybrid meetings. COMPLETE		

Quality Statement 4: Workforce equality, diversity & inclusion								
We value diversity in our workforce. We work towards an inclusive & fair culture by improving equality & equity for people who work for us. We foster a positive culture where people feel that they can speak up & that their voice will be heard. Covering: Fair & equitable treatment of staff – staff human rights – well-being of workforce – gender pay gap – workforce diversity – flexible working arrangements – WRES & WDES								
Ref.	**Action**	**Due**	**Delivery lead**	**Board/ EMT lead**	**Oversight group**	**Progress**	**Evidence**	**Assurance rating**
QS4.2	The Trust should continue to actively consider ways in which it can attain a representative Board & senior leadership cohort.	31/03/2026 (Phase 1)	Lisa Wright & Rachel Trawally	Bob Champion & Sarah Jones	Board Nomination & Remuneration Committee	The WRES, WDES and Gender Pay Gap review representation at senior levels and across all care groups, directorates, bands and professions. The intention is to increase diversity at all levels to be representative of the local population. The data on this is reported regularly to the People and Culture Committee and is available on the BDCFT website in the Publication Scheme pages . The most recent data reported shows that for the WRES representation in the Trust went from 26% in 2023 to 28% in 2024, at 8a and above representation has gone from 27 - 29% and at 8c and above it is 40%. For the WDES 14% of staff at organisation and 8a and above level are have shared they have a disability. This data is looked at in detail to compare where under-representation remains. An inclusive recruitment programme has been delivered during 2025 to support consistent performance.	Public Sector Equality Duty Report Board Skills Matrix	Phase 1 completed (July 2026)

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						For VSM inclusive recruitment includes positive action in advertising, core statements in adverts, sharing the Trusts charter marks relating to EDI, stakeholder panels including stakeholders from the Trusts staff networks, involvement from service users and specific questions relating to EDI and values. The representation of disabled people on the Board when compared to the organisation has gone from -2% in 2023 to 4% in 2024. For ethnicity the representation had reduced in 2024 from -12.03% to -15.60%. This has changed with increased representation through recruitment in 2025.		

Quality Statement 5: Governance, management & sustainability

We have clear responsibilities, roles, systems of accountability & good governance. We use these to manage & deliver good quality, sustainable care, treatment & support. We act on the best information about risk, performance & outcomes, & we share this securely with others when appropriate. Covering: Roles, responsibilities & accountability – governance, quality assurance & management – cyber security, data security & protection toolkit (DSPT) – emergency preparedness, including climate events – sustainability, including financial & workforce – data security/data protection – statutory & regulatory requirements – workforce planning – external actions (e.g. safety alerts) – records / digital records

Ref.	Action	Due	Delivery lead	Board/ EMT lead	Oversight group	Progress	Evidence	Assurance rating
QS5.1	The Trust should consider the outcome of this review & ensure that it has adequate & effective Board & Committee oversight and governance processes of all relevant aspects of Trust business.	30/04/2026 (Phase 1)	Rachel Trawally	Sarah Jones & Fran Stead	Board of Directors	A well led action plan has been developed also incorporating committee effectiveness review actions. A review of this alongside the Provider Capability Assessment has taken place to ensure the work is aligned. A new strategic risk is being proposed which is focused on governance & compliance. The reports are going	Well Led Development Plan presented to all Corporate Governance meetings	Action complete – archive at Phase 1

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						to each of the sub committees, to Audit Committee and Board.		
QS5.7	The Trust should ensure that the Board retains adequate oversight of the effectiveness of EPRR.	31/01/2026 (Phase 1)	Chris Wright	Sarah Jones & Kelly Barker	Board of Directors	The Board receive an annual report on EPRR activities for the Trust. They are also updated on the annual assessment of EPRR Core Standards (the EPRR equivalent of a CQC inspection) as led by NHS England and receive copies of all audit reports from external specialists. In addition, the routine oversight and management of EPRR activities is regularly maintained by the Trust's Resilience Group, which is made up of representatives from across all areas of BDCFT services. This group provides the necessary governance, management and quality assurance for all EPRR activities, policies, plans and incidents. Chaired by Kelly Barker, Chief Operating Officer (and Accountable Emergency Officer for the Trust).	Report on EPRR processes	Phase 1 completed (July 2026)
QS5.10	**Committee:** an induction would be beneficial for joiners.	~~31/03/2026~~ 30/09/2026 (Phase 1)	Rachel Trawally	Sarah Jones & Fran Stead	Board of Directors	Following feedback and building on a successful past delivery model, work is taking place to re-set the Induction programme for Board members. On behalf of the Trust Secretary, the DTS is leading this work and it will be used to onboard the 2 new NEDs over the coming months. A welcome pack has been introduced for new starters and induction meetings are underway for the two new NEDs and the		Merged into action QS5.34 Integrated Governance Guide refresh

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						new Chair. Induction documentation is also being developed by Committee secretaries for new members to support them joining a committee. Inductions meetings are also being introduced for new committee members, and documentation has been drafted for new chairs and being developed for new committee members.		
QS5.11	**Committee:** further work to do on the flow & interaction across Committee's & Board. Formalise Joint Committee.	~~31/03/2026~~ 30/09/2026 (Phase 1)	Rachel Trawally	Sarah Jones & Fran Stead	Board of Directors	This is being considered as part of the annual effectiveness review for Board and Committee meetings. The committee board effectiveness review results have been presented at March committee meetings. Any new actions will be built in to the updated version of the well led development plan for taking forward. Joint Committees are not to be a standard committee, and where possible agenda items will be covered as part of Board/Board development.		Merged into action QS5.35 Meeting Structure refresh
QS5.17	**Committee & CoG:** make the work of the Board & Committees, Governors more visible.	30/09/2026 (Phase 1)	Rachel Trawally	Sarah Jones & Fran Stead	Board of Directors Council of Governors	Work is currently being undertaken to review and update content on the intranet and external website. Introduced Governance report to Board and CoG, and a Go See report to Board.	Governance Report – Board meeting throughout 2026, Board Work Plan, agenda & minutes	Phase 1 completed (July 2026)
~~QS5.26~~	**IA:** The Trust should ensure the Board of Directors Nomination and Remuneration Committee	~~31/03/2026~~	Rachel Trawally	Sarah Jones/ Fran Stead	Board of Directors	Current ToR in place. Review of ToR to be undertaken during 2026. Draft 1 produced, benchmarking taking place during	Terms of Reference Board Nomination	Action complete – archive

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	Terms of Reference document is reviewed and updated, as required.	31/07/2026 (Phase 1)				Spring. Final draft to be shared for consultation, scheduled to be approved at Board Nomination & Remuneration Committee, June 2026, & to be ratified by the Board July 2026.	and Remuneration Committee; agenda & minutes Board meeting presented	at Phase 1
QS5.33	Board Skills Matrix: to develop the report format for the Board Skills Matrix, including benchmarking, & undertake the exercise on an annual basis, to be included in Board work plans (Board of Directors; Board Nomination & Remuneration Committee)	31/12/2026 (Phase 1)	Rachel Trawally	Sarah Jones/ Fran Stead	Board of Directors	New action – added Summer 2026		

Quality Statement 6: Partnerships & communities

We understand our duty to collaborate & work in partnership, so our services work seamlessly for people. We share information & learning with partners & collaborate for improvement.
Covering: Sharing good practices & learning - integration health & social care - partnership working & collaboration

Ref.	Action	Due	Delivery lead	Board/ EMT lead	Oversight group	Progress	Evidence	Assurance rating
QS6.1	The Trust should consider the merits / demerits if wider involvement of the whole Board in system/partnership engagement including Board oversight & ownership of the external communications strategy/plan and stakeholder mapping.	30/09/2026	Fran Stead	Sarah Jones, Therese Patten	Board of Directors	This will be considered as part of the strategy development programme with a discussion item to be scheduled at Board.		Limited (not due yet)
QS6.3	The Trust should consider its approach to 'Go See' visits with an aim to improve the value add for all participants.	~~31/03/2026~~	Rachel Trawally	Fran Stead	Board of Directors	The current process for Go See is being developed with the schedule being planned in	EMT presentation. Survey results. action plan. Oct board report	Limited (not due yet)

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	IA: The Trust should ensure that all areas on their 'Go See' tracker that have been identified for a visit, are visited as scheduled by an Executive Director or Non-Executive Director. Where visits have not taken place, steps should be made to re-arrange.	30/09/2026 (Phase 1)				further advance. Reporting on the process has now commenced at Board. The committee planner schedule went to Board in January which included scheduled Go See visits on Board held in private days from may onwards to provide additional time to carry out visits. A discussion on triangulation will take place to consider the various data and experience reporting processes. This process will also be discussed with the new chair. UPDATE: the new chair has moved board development sessions back to private board days when Go See visits were being planned. A presentation is being prepared to go to EMT for discussion on improvements in May 2026 and progress will be updated after this.		
QS6.4	The Trust should consider the adequacy of current qualitative feedback in Board & Committee meetings & whether there is an appropriate balance of quantitative & qualitative feedback to inform discussions.	31/03/2026 (Phase 1)	Rachel Trawally	Sarah Jones & Fran Stead	Board of Directors	Considered as part of the annual effectiveness review process.	Findings of the 2025/26 annual effectiveness reviews – presented to Board April 2026 as part of the Annual Governance Reports	Action complete – archive at Phase 1

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8 Next steps

Following the national inquiry into breast surgery services at County Durham and Darlington NHS Foundation Trust, the Trust reviewed the report's findings, identified the required actions and assigned a senior responsible officer to each recommendation. The agreed actions will be incorporated into the Well Led Development Plan in November, with an update to the Board in January on how they have been addressed.

The same process will be considered for the recommendations from the national inquiry into the events surrounding at the Countess of Chester Hospital from 2015 to 2018.

The Board is asked to

- be assured on the process being delivered as a new process agreed by the Board
- note and discuss the updates provided
- agree any actions associated with the work and the above actions
- consider any evidence presented for those actions that have been listed as complete for phase 1, and agree to close the actions (if any outlined within section 7 of the report)
- consider the and approve any extension requests for actions in phase 1 (if any outlined within section 7 of the report)
- consider any overdue actions for phase 1 & further assurance required (if any outlined within section 7 of the report)
- note that the full report will be presented to the Audit Committee; & Board held in public, as outlined above.

Fran Stead
Trust Secretary
September 2026

Close Holly
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NHS
Bradford District Care
NHS Foundation Trust

Board of Directors – meeting held in public

5 November 2026

Paper title:	Governance Report	**Agenda Item** **25.0**
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	Executive Management Team Board Nomination and Remuneration Committee
Purpose of the paper Please check **ONE** box only:	☒ For approval ☐ For information ☐ For discussion
Link to Trust Strategic Vision Please check **ALL** 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 **ALL** 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 Committee schedule and have proposed the Committee schedule for 2027/28.

The report also make reference to a number of Council of Governor updates in particular that the Trust continues to run an election campaign which is now at the ballot stage

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following two contested seats. The election campaign will conclude on Thursday 12 November 2026.

The Trust submitted its 2026 Provider Capability Assessment to NHS England on 2 October 2026 and the Trust continues to monitor the NHS Modernisation Bill as it makes its way through parliament.

Finally, the report documents a number of key leadership changes for the Trust, specifically the conclusion of the Chief Medical Officer recruitment campaign and the formal acting up arrangements following the secondment of the substantive Chief Executive Officer.

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 Committee Schedule for 2027/28. • Note the submission of the 2026 Provider Capability Assessment Process • Note the changes made to the Executive Leadership Team

Links to the Strategic Organisational Risk register (SORR)	N/A
Care Quality Commission domains Please check **ALL** 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

5 November 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

Committee Cycle:
The Committee Meeting Planner for 2027/28 has been reviewed and updated to provide a coordinated committee cycle and support effective planning of the Trust's committee business. The committee cycle has also been reviewed alongside colleagues at Airedale NHS FT and Bradford Teaching Hospitals NHS FT to support shared learning and alignment. Discussions remain ongoing regarding Place meetings to support effective flow and scheduling arrangements. Following consultation with EMT and the Chair, the proposed planner is presented to the Board for approval.

Engagement and Involvement

Council of Governors
Appointment and Resignations:
During this period, the Council of Governors has seen a number of resignations:

- David Hesford Staff Governor: Clinical
- James Hobson Public Governor: Keighley
- Deborah Buxton Appointed Governor: Barnardo's

On behalf of the Trust, the Council thanked them for their commitment and hard work.

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 commenced an election process for vacant Public and Staff Governor seats with nominations opening on 10 September 2026. The following seven seats were up for election:

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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	2 Seats	

Following the closing of the nomination period on Friday 2 October 2026; two Governors were elected unopposed for both the Staff Clinical Governor and Public Governor: Shipley seat. On behalf of the Trust, we would like to welcome both Governors as they take up their role. A dedicated induction period will begin in the coming weeks.

Two seats were contested during this election period: Bradford West and Keighley. As more than one candidate stood for each seat, constituents in these areas have been invited to vote for their preferred candidate to represent them on the Council of Governors. The ballot opened on 21 October 2026 and will close on 11 November 2026, with the results due to be announced on 12 November 2026.

Candidates standing in the contested elections have also been invited to observe the Council of Governors meeting held in public on 11 November 2026, ahead of the election results being announced.

Further updates and information about the conclusion of the election will be provided in the coming weeks.

The NHS 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. The NHS Modernisation Bill has now completed its initial commons stages and is beginning its passage through the House of Lords, with a second reading debate taking place in the House of Lords on 13 October 2026.

The second reading included discussion on the proposed changes to NHS Foundation Trust governance. The Bill will now move to Committee stage for detailed consideration which is schedule for Wednesday 28 October 2026. The Trust will continue to monitor developments as the legislation progresses.

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Annual Members' Meeting:

The Trust's Annual Members' Meeting took place on Thursday 24 September at Fountains Church in Bradford. The Trust would like to thank colleagues and members of the public who attended.

During the Annual Members' Meeting, the following constitutional changes were approved:

- Removal of the appointed Governor seat for Bradford Assembly
- Reduction to one Bradford Council Member

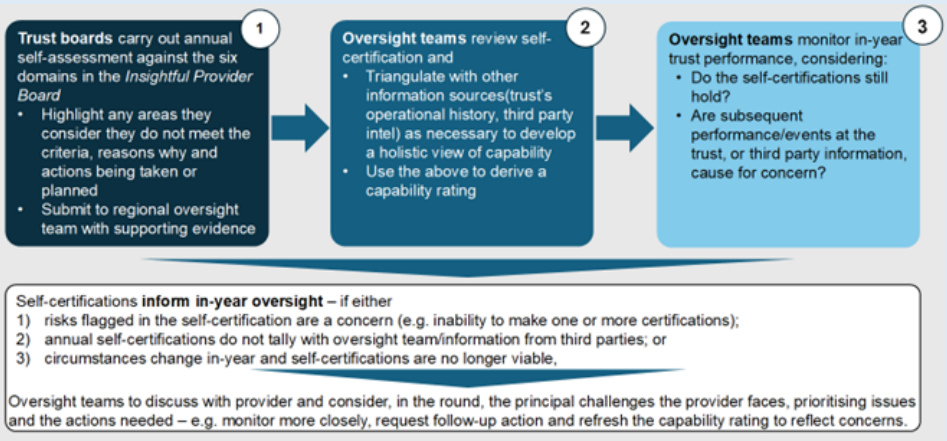
The Trust's External Auditor also attended the meeting and confirmed that the Annual Governance Statement had been prepared in line with the Annual Reporting Manual requirements. KPMG also confirmed that, for 2025/26, an unqualified (clean) consistency certificate had been issued in respect of the Trust's Annual Accounts.

The Trust's Better Lives Together Strategy 2026–31 was also formally launched at the meeting. For more detail on the strategy, please follow this link: https://www.bdct.nhs.uk/about-us/our-trust/our-priorities-and-values/

Compliance

Provider Capability Assessment

The Trust has now submitted the Provider Capability Assessment (PCA) for 2026 to NHS England on Friday 2 October 2026. 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



Regional teams will now 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.

People Matters

Outcome of Chief Medical Officer Recruitment

The recruitment campaign for the substantive post of the Chief Medical Officer has now successfully concluded. Dr Sal Uka, who was the Trusts interim Chief Medical Officer, has been appointed to the role.

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Thank you to those who were involved in the process, in particular the Executive Support Team and Recruitment Team for making this a successful campaign.

Executive Leadership Changes

Following the announcement that Therese Patten, Chief Executive Officer, had commenced a 12-month secondment, the Trust enacted agreed acting-up arrangements as part of the Board's response and resilience plans, with Phil Hubbard, Director of Nursing and Deputy Chief Executive, stepping into the role of Acting Chief Executive. The Board Nomination and Remuneration Committee have approved the recruitment strategy for the Deputy Chief Executive; and Chief Nurse position with more information provided shortly.

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We Care We Listen We Deliver

NHS
Bradford District Care
NHS Foundation Trust

Board, Council of Governors and Sub-Committees Meeting Schedule

Board

Name of meeting	Day	Dates 27/28	Time
Board held in Private	Thursday	01/04/2027	12.45-14.00
Board held in Public	Thursday	01/04/2027	9.30-12.15
Board Development 1	Thursday	29/04/2027	9.00-12.00
Board held in Private (online)	Thursday	06/05/2027	9.30-11.00
Board held in Public	Thursday	03/06/2027	9.30-12.30
Board held in Private	Thursday	03/06/2027	12.30-15.00
Board Nominations and Remuneration Committee (online)	Wednesday	16/06/2027	9.30-10.00
Extraordinary Board held in Private (online)	Thursday	24/06/2027	9.00-10.00
Board Development 2 (ALL DAY)	Thursday	08/07/2027	10.30-16.00
Board held in Public	Thursday	22/07/2027	9.30-12.30
Board held in Private	Thursday	22/07/2027	12.30-15.00
Board held in Public	Thursday	09/09/2027	9.30-12.30
Board held in Private	Thursday	09/09/2027	12.30-15.00
Board held in Private	Thursday	30/09/2027	9.30-11.30
Board Development 3	Thursday	30/09/2027	11.30-15.00
Board held in Public	Thursday	04/11/2027	9.30-12.30
Board held in Private	Thursday	04/11/2027	12.30-15.00
Board held in Private (online)	Thursday	02/12/2027	9.30-11.30
Board development 4 (online)	Thursday	02/12/2027	11.30-15.00
Board held in Public	Thursday	13/01/2028	9.30-12.30
Board held in Private	Thursday	13/01/2028	12.30-15.00
Board held in Private	Thursday	03/02/2028	9.30-11.30
Board development 5	Thursday	03/02/2028	11.30-15.00
Board held in Public	Thursday	02/03/2028	9.30-12.30
Board held in Private	Thursday	02/03/2028	12.30-15.00

- Please note a lunch break is not shown on the timings but will be incorporated within the Board sessions

Council of Governors

Name of meeting	Day	Dates 27/28	Time
Council of Governors Private	Wednesday	12/05/2027	16.30-17.00
Council of Governors Public	Wednesday	12/05/2027	17.00-18.30
Council of Governors Nominations and Remuneration Committee (online)	Wednesday	16/06/2027	10.00-10.30
Council of Governors Private	Wednesday	28/07/2027	16.30-17.00
Council of Governors Public	Wednesday	28/07/2027	17.00-18.30
Council of Governors Private	Wednesday	10/11/2027	16.30-17.00
Council of Governors Public	Wednesday	10/11/2027	17.00-18.30
Council of Governors Private	Wednesday	09/02/2028	16.30-17.00
Council of Governors Public	Wednesday	09/02/2028	17.00-18.30

AMM

Annual Members Meeting	Thursday	23/09/2027	13.00-17.00

Sub-Committees

Name of meeting	Day	Dates 27/28	Time
Audit Committee	Thursday	17/06/2027	9.30-12.00
Audit Committee	Wednesday	22/09/2027	13.00-15.30
Audit Committee	Thursday	09/12/2027	9.30-12.00
Audit Committee	Thursday	23/03/2028	9.30-12.00
Charity Funds Committee	Thursday	24/06/2027	10.00-12pm
Charity Funds Committee	Thursday	28/10/2027	9.30-11.00
Charity Funds Committee	Thursday	17/02/2028	9.30-11.00
Finance and Performance Committee	Wednesday	26/05/2027	9.30-11.30
Finance and Performance Committee	Wednesday	21/07/2027	9.30-11.30
Finance and Performance Committee	Wednesday	22/09/2027	9.30-11.30
Finance and Performance Committee	Wednesday	24/11/2027	9.30-11.30
Finance and Performance Committee	Wednesday	15/12/2027	9.30-11.30
Finance and Performance Committee	Wednesday	23/02/2028	9.30-11.30
Finance and Performance Committee	Wednesday	22/03/2028	9.30-11.30
Mental Health Leg Committee	Thursday	20/05/2027	9.30-11.30
Mental Health Leg Committee	Thursday	15/07/2027	9.30-11.30
Mental Health Leg Committee	Thursday	16/09/2027	9.30-11.30
Mental Health Leg Committee	Thursday	18/11/2027	9.30-11.30
Mental Health Leg Committee	Thursday	20/01/2028	9.30-11.30
Mental Health Leg Committee	Thursday	16/03/2028	9.30-11.30
People and Culture Committee	Thursday	20/05/2027	12.30-14.30
People and Culture Committee	Thursday	17/06/2027	12.30-14.30
People and Culture Committee	Thursday	16/09/2027	12.30-14.30
People and Culture Committee	Thursday	21/10/2027	12.30-14.30
People and Culture Committee	Thursday	16/12/2027	12.30-14.30
People and Culture Committee	Thursday	20/01/2028	12.30-14.30
People and Culture Committee	Thursday	16/03/2028	12.30-14.30
Quality and Safety Committee	Wednesday	14/04/2027	9.30-11.00
Quality and Safety Committee	Wednesday	19/05/2027	9.30-12.00
Quality and Safety Committee	Wednesday	16/06/2027	9.30-11.30
Quality and Safety Committee	Wednesday	14/07/2027	9.30-12.00
Quality and Safety Committee	Wednesday	15/09/2027	9.30-12.00
Quality and Safety Committee	Wednesday	20/10/2027	9.30-11.30
Quality and Safety Committee	Wednesday	17/11/2027	9.30-12.00
Quality and Safety Committee	Thursday	16/12/2027	9.30-11.30
Quality and Safety Committee	Wednesday	19/01/2028	9.30-12.00
Quality and Safety Committee	Wednesday	16/02/2028	9.30-11.30
Quality and Safety Committee	Wednesday	15/03/2028	9.30-12.00

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West Yorkshire
Health and Care Partnership
Mental Health, Learning Disabilities & Autism

Escalation and Assurance Report

Report from: West Yorkshire (WY) Integrated Care System (ICS) Mental Health, Learning Disability & Autism (MHLDA) Committee-in-Common

Date of the meeting 14/10/2026

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert/Action:
• No items
Advise:
• **ICB Operating Model:** Ongoing work is required to clarify the future operating model, including the respective roles of the ICB, PPPs and the collaborative. Significant workforce changes have reduced MHLDA knowledge and expertise within the ICB, reinforcing the need for clear responsibilities, governance arrangements, funding flows and oversight to support future delivery across West Yorkshire. • **Neurodiversity**: Work is underway to manage expenditure relating to accredited providers; however, extended waiting times of approximately two years continue to present a significant challenge for the ICB, with associated reputational, media and potential legal risks.
Assure:
• **ATU:** A new Clinical Lead has been appointed and work is progressing on the future ATU pathway model, with early improvements seen in length of stay. • **UEC**: Progress continues with the RCRP model, with positive developments reported through the reset process, linked is the development and implementation of a West Yorkshire-wide AWOL policy and improved multi-agency risk management arrangements. • **Workforce**: WY alignment work continues for banding arrangements, with an initial focus on Agenda for Change Band 5 nursing roles. • **Neurodiversity**: Progress continues on the WY Neurodiversity Hub specifications, which align with the prevalence review recommendations and support the development of a needs-led model of care. • **CinC endorsement**: The recommendation as set in the 'Addressing Variation across the Collaborative', progress updates will be reported at future meetings.

Report completed by: Keir Shillaker, WY MHLDA Programme Director **Date:** 19/10/2026

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Distribution: Chairs and Company Secretaries of Bradford District Care NHS Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds & York Partnership NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust.

Close Holly
29/10/2026 15:09:24

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

NHS
Bradford District Care
NHS Foundation Trust

			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 appetitie 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	**Stategic Risk Assurance Report/Summary**	FS (Trust Secretary)	X	X	X	X	X	X	X
All	**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, Reslience and Response Assessment and Declaration (TBC)**	KB (COO)				X			
Best Quality Services	**Learning from Deaths report (date TBC)**	SU (CMO)							
Best Quality Services	**Organisational Risk Register/Reporting**	FS (Trust Secretary)	X	X	X	X	X	X	X
Best Quality Services	**Risk Management - update on RMS/risk tolerance**	Paula Riely					X		
Best Quality Services	**AAAD Mental Health Legislation Committee**	WB (NED)/CGT		X	X		X	X	X
Best Quality Services	**AAAD Quality and Safety Committee**	AM (NED)/CGT	X	X	X		X	X	X
Best Quality Services	**Compliance Against Care Quality Commission Registration (as required)**				X				
Best Quality Services	**Care Quality Commission Update and Developments (as required)**								
Best Quality Services	**NHS England Quarterly Submissions**	C Risdon			X		X		
Best Quality Services	**Complaints annual report**	Rebecca Le-Hair/Elizabeth Hadley-Day			X				
Best Quality Services	**Annual quality account (for info)**	L Graham		X					
Best Quality Services	**GoSee report thematic learning report (annual)**	RT (Deputy Trust Secretary)						X	
Best Place to Work	**Staff Survey Results**	H Farrar	X	X					
	Annual safer staffing report			X					
Best Place to Work	**AAAD People and Culture Committee**	MR (NED)/CGT		X	X		X	X	X

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Best Place to Work	**Freedom to speak up guardian bi-annual thematic report**	R Wixey		X				X	
Best Place to Work	**Medical appraisal and revalidation annual report**	SU (CMO)			X				
Best Place to Work	**Guardian of safe working annual report**				X				
Best Place to Work	**Gender pay gap annual report (include in PCC AAAD report)**	L Wright	X						X
Best Use of Resources	**Final financial plan 2025-26 (tbc)**	C Risdon							
Best Use of Resources	**Operational plan 2026-27 (tbc)**	C Risdon							
Best Use of Resources	**Finance report**	C Risdon	X	X	X	X	X	X	X
Best Use of Resources	**Green plan**	Emma Clarke	X		X				
Best Use of Resources	**AAAD Finance and Performance Committee**	CH (NED)/CGT		X		X	X	X	X
Best Use of Resources	**AAAD Charity Funds Committee**	MR (NED)/CGT			X		X		X
Good Governance	**NHS Oversight Framework quarterly report**	FR (ED TIP)	X		X		X	X	
Good Governance	**AAAD Audit Committee**	CM (NED)/CGT		X	X		X	X	
Good Governance	**Annual Declaration of Interest for the Board of Directors**	Executive Assistant		X	X				
Good Governance	**Annual Declaration of Fit and Proper Person Regulation for the Board of Directors**	Executive Assistant		X	X				
Good Governance	**Annual Declaration of Independence (NED)**	Executive Assistant		X	X				
Good Governance	**Annual Review of Division of Duties of the Chair and Chief Executive (timing tbc)**	FS (Trust Secretary)							
Good Governance	**Scheme of Delegation and Standing Financial Instruction Ratification**	C Risdon					X		
Good Governance	**Use of the Trust Seal - annual report**	FS (Trust Secretary)			X				
Good Governance	**BoD Annual Effectiveness Review**	FS (Trust Secretary)			X				
Good Governance	**BoD Terms of reference annual review**	FS (Trust Secretary)			X				X
Good Governance	**Sub-Committee annual reports**	CGT	X						X
Good Governance	**Sub-Committee annual terms of reference report**	CGT	X		X				X
Good Governance	**Sub-Committee annual effectiveness review report**	CGT	X		X				X
Best Use of Resources	**Senior Information Risk Owner Annual Report**	Delphine Fitouri (Head of Digital Services)			X				
Good Governance	**Annual Review of the Constitution**	FS (Trust Secretary)				X			
Good Governance	**Health Safety and Security Annual Report**				X				
Good Governance	**Board Development Programme Work Plan**	CGT			X			X	X
	Board of Directors meeting Annual work plan	CGT	X	X	X	X	X	X	X
	Notification future public meeting dates	CGT	X	X				X	
Good Governance	**AAA: WY&H Mental Health, Learning Disabilities and Autism Committee in Common (as received)**	RT (Deputy Trust Secretary)				X			
Good Governance	**AAA: WY Commissioning Hub (as received)**	RT (Deputy Trust Secretary)		X					
Good Governance	**AAA: Committees in Common (CinC) for the Community Collaborative *(as received)***	RT (Deputy Trust Secretary)							
Good Governance	**Annual Review of Board Skills Matrix**	CGT				X			
Best Use of Resources	**Green plan**	E Clarke	X						
Good Governance	**Well led development plan**	FS (Trust Secretary)	X	X	X	X	X	X	X

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