Council of Governor - Public - 11 November 2026

Wednesday 11 November 2026, 17:00 - 18:30

MS Teams

Agenda

17:00 - 17:05
5 min

1. Welcome and Apologies for absence & confirmation of quoracy (verbal)

Discussion *Sarah Jones*

For Discussion

Item 01.0 - Council of Governors - Public Agenda - 11 November 2026 v.0.1.3.pdf (3 pages)
Item 01.0.1 -Public CoG Attendance Tracker.pdf (1 pages)

17:05 - 17:05
0 min

2. Declaration of any conflicts of interest (enclosure)

Information *Sarah Jones*

For Information

Item 02.0 - BDCFT Declaration of Interests for Council of Governors - November 2026.pdf (1 pages)

17:05 - 17:05
0 min

3. Minutes of the previous meeting held on 29 July 2026 (enclosure)

Approval *Sarah Jones*

For Approval

Item 03.0.0 - Council of Governors Meeting - Public - Minutes - 29.07.2026 - Chair Approved.pdf (11 pages)

17:05 - 17:05
0 min

4. Matters arising (verbal)

Sarah Jones

For Discussion

17:05 - 17:05
0 min

5. Action log (enclosure)

Discussion *Sarah Jones*

For Discussion

Item 05.0 - Council of Governors - Public Action Log - for November 2026.pdf (3 pages)

Governor Feedback and Involvement

17:05 - 17:10
5 min

6. Issues and Questions from Communities (verbal)

Discussion *Governors*

For Discussion

Close Holly 11/11/2026 11:37:53

Good Governance

17:10 - 17:30
20 min

7. Alert, Advise, Assure and Decision report/Assurance Reporting (enclosures):

For Assurance

For

7.1. Audit Committee held 23 September 2026

Warren Brown

For Assurance

Item 07.1.0 -AAAD - Effective Oversight Escalation and Assurance - Audit Committee 23.09.2026 - Chair Approved.pdf (3 pages)

7.2. Charitable Funds Committee held 29 October 2026

Sally Napper

For Assurance

Item 07.2.0 - AAAD - Effective Oversight Escalation and Assurance CFC 29 October 2026 - Chair Approved.pdf (3 pages)

7.3. Finance and Performance Committee held 20 August and 23 September 2026

Cleveland Henry

For Assurance

Item 07.3.0 - AAAD - Effective Oversight Escalation and Assurance - FPC August 2026 PUBLIC RATIFIED.pdf (2 pages)
Item 07.3.1 - AAAD - Effective Oversight Escalation and Assurance - FPC 23 Sept 2026 CHAIR EXEC APP.pdf (3 pages)

7.4. Mental Health Legislation Committee held 17 September 2026

Warren Brown

For Assurance

Item 07.4.0 - AAAD - Effective Oversight Escalation and Assurance - MHLC 17 Sept 2026 CHAIR EXEC APP.pdf (3 pages)

7.5. People and Culture Committee held 21 May 2026 and 18 June 2026

Cleveland Henry

For Assurance

Item 07.5.0 - AAAD - Effective Oversight Escalation and Assurance - PCC 17 Sept 2026 CHAIR EXEC APP.pdf (3 pages)
Item 07.5.1 - AAAD - Effective Oversight Escalation and Assurance - PCC Oct 2026 CHAIR EXEC APP.pdf (3 pages)

7.6. Quality and Safety Committee held 16 September and 21 October 2026

Alyson McGregor

For Assurance

Item 07.6.0 - AAAD - Effective Oversight Escalation and Assurance - QSC Sept 2026 - Final - Chair Approved.pdf (4 pages)
Item 07.6.1 - AAAD - Effective Oversight Escalation and Assurance - QSC October 2026 - Chair Approved.pdf (3 pages)

Strategy and Partnerships

Close Holly 11/11/2026 11:37:53

17:30 - 17:35
5 min

8. Chair's Report (enclosure)

For Assurance *Sarah Jones*

For Assurance

17:35 - 17:45
10 min

9. Update on Bradford Place Governance Structures (enclosure)

Phillipa Hubbard

For Assurance

Item 09.0 - Update on Bradford Place Governance Structures - BDC PPP - Governance Proposal V4.pdf (5 pages)

17:45 - 17:50
5 min

10. Patient Safety Partners (verbal)

For Assurance *Christopher Dixon*

For Assurance

17:50 - 17:55
5 min

Break (5:50 – 5.55pm)

Good Governance

17:55 - 18:05
10 min

11. Governance Report (enclosure) • Governor Elections & changes • Feedback from The Future of Governors – Joint Session – 10 August 2026 • Feedback from AdminControl survey • CiC Effectiveness Review • Board Leadership Changes • Well Led Report

Rachel Trawally

Item 11.0.0 - Governance Report - Public Council of Governors - 11 November 2026 v.0.2.pdf (18 pages)
Item 11.0.1 - Appendix 1 - 10.08.26 Role of Governors workshop feedback FINAL.pdf (8 pages)
Item 11.0.2 - Appendix 3 - How the Council of Governors Does Business - Council of Governors Etiquette v.04.3.pdf (16 pages)
Item 11.0.3 - Appendix 3 - Policy and Procedure for Council of Governor Conduct and Behaviour v.11.2.pdf (22 pages)
Item 11.0.4 - Appendix 3 - Council of Governors - Terms of Reference - November 2026 - Draft.pdf (8 pages)

Best Use of Resources

18:05 - 18:15
10 min

12. Integrated Strategic Performance and Quality Report (enclosure)

For Assurance *Claire Risdon & Kelly Barker*

For Assurance

Item 12.0.0 - ISPQR - October 2026 - Council of Governors Cover Paper FINAL.pdf (6 pages)
Item 12.0.1 - ISPQR - October 2026 (September Data) FINAL.pdf (65 pages)

18:15 - 18:25
10 min

13. Lynfield Mount Update (enclosure)

Claire Risdon

Item 13.0.0 - LMHR Update - ART 5112026.pdf (2 pages)
Item 13.0.1 - LMH Redevelopment - Highlight Report for Governors - November 2026 - ART.pdf (6 pages)

Good Governance

Close Holly 11/11/2026 11:37:51

18:25 - 18:25
0 min

14. Council of Governors Annual Work Plan (enclosure)

For Information *For Information*

Item 14.0 - Council of Governors Annual Work Plan 2026-27.pdf (1 pages)

18:25 - 18:30
5 min

15. Any other business (verbal)

Discussion *Sarah Jones*

18:30 - 18:30
0 min

16. Meeting evaluation (verbal) Was the meeting conducted in line with the Trust values?

Discussion

Date of the Next Meeting: 10 February 2027. Final details to be confirmed by Corporate Governance

Close Holly
11/11/2026 11:37:53

Council of Governors – held in public

Date: Wednesday 11 November 2026

Time: 17:00-18:30

Venue: Meeting to be held on Microsoft Teams

AGENDA

The Council of Governors 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 Council of Governors held in Public (contact details are at the end of the agenda).

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

Strategic Priority			Lead	Purpose	Time
GG	1	**Welcome and apologies for absence** (verbal)	**S Jones**	**For discussion**	**5.00pm**
	2	**Declaration of any conflicts of interest** (enclosure)	**S Jones**	**For information**	**-**
	3	**Minutes of the previous meeting held on 29 July 2026 & the minutes from the Annual Members' Meeting 24 September 2026.** (enclosure)	**S Jones**	**For approval**	**-**
	4	**Matters arising** (verbal)	**S Jones**	**For discussion**	
	5	**Action log** (enclosure)	**S Jones**	**For approval**	

Governor Feedback and Involvement

All	**6**	**Issues and Questions from Communities** (verbal)	**Governors**	**For discussion**	**5.05pm**

Good Governance

	7	**Alert, Advise, Assure and Decision report/Assurance Reporting** (enclosures): **7.1 Audit Committee held 23 September 2026**	**W Brown**	**For Assurance**	**5.10pm**

Close Healy 23/11/2026 14:37:53

CG		**7.2 Charitable Funds Committee held 29 October 2026** **7.3 Finance and Performance Committee held 20 August and 23 September 2026** **7.4 Mental Health Legislation Committee held 17 September 2026** **7.5 People and Culture Committee held 17 September and 22 October 2026** **7.6 Quality and Safety Committee held 16 September and 21 October 2026**	**S Napper** **C Henry** **W Brown** **C Henry** **A McGregor**		

Strategy and partnerships

All	**8**	**Chair's Report** (enclosure)	**S Jones**	**For assurance**	**5.30pm**
BP	**9**	**Update on Bradford Place Governance Structures** (enclosure)	**P Hubbard**	**For assurance**	**5.35pm**
BP	**10**	**Patient Safety Partners** (verbal)	**C Dixon**	**Verbal**	**5.45pm**

Break (5.50 – 5.55pm)

Good Governance

CG	**11**	**Governance Report** (enclosure) • **Governor Elections & changes** • **Feedback from The Future of Governors – Joint Session – 10 August 2026** • **Feedback from AdminControl survey** • **CiC Effectiveness Review** • **Board Leadership Changes** • **Well Led Report**	**R Trawally**	**For assurance**	**5.55pm**

Best Use of Resources

BUoR	**12**	**Integrated Strategic Performance and Quality Report** (enclosure)	**Claire Risdon / K Barker**	**For Assurance**	**6.05pm**
BUoR	**13**	**Lynfield Mount Update** (enclosure)	**Claire Risdon**		**6.15pm**

Clare Holly 10/11/2026 14:37:53

CG	14	**Council of Governors Annual Work Plan** (enclosure)	For Information	For Information	-
	15	**Any other business** (verbal)	S Jones	For Discussion	6:25pm
	16	**Meeting evaluation** (verbal) **Was the meeting conducted in line with the Trust values?**	S Jones	For Discussion	-

Date of the Next Meeting: 10 February 2027. Final details to be confirmed by Corporate Governance

Questions for the Council of Governors can be submitted to:
Name: Fran Stead (Trust Secretary)
Email: fran.stead@bdct.nhs.uk

Name: Sarah Jones (Chair in Common)
Email: sarah.jones@bdct.nhs.uk

Expressions of interest to observe the meeting using Microsoft Teams:
Email: corporate.governance@bdct.nhs.uk

Strategic Priorities (Key)

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

Close Holly 11/11/2026 11:37:53

Initial	Full Name	Job Role / Title	Terms of Reference/Report writer	Date 13/05/2026 Private	Date 13/05/2026 Public	Date 29/07/2026 Private	Date 29/07/2026 Public	Date 24/09/2026 AMM	Date 11/11/2026 Private	Date 11/11/2026 Public	Date 10/02/2027 Private	Date 10/02/2027 Public
AJ	Aidan Jones	Staff Governor: Non-Clinical	Member	X	X (Left at 18:00)	D	D					
AA	Arshad Ali	Staff Governor: Clinical	Member	o	o	o	X (joined at 18.03)	N/A - no longer a governor				
AK	Aurangzeb Khan	Public Governor: Bradford East	Member	o	o	o	o					
CAB	Cllr Andy Brown	Appointed Governor: North Yorkshire Council	Member	X	X	X (Left at 16:39)	D					
DH	David Hesford	Staff Governor: Clinical	Member	X	X (Left at 18.20)	D	D		N/A - no longer a governor			
DD	Debbie Davies	Appointed Governor: Bradford Council	Member	D	D	N/A - no longer a governor						
DB	Deborah Buxton	Appointed Governor: Barnardos	Member	D	D	D	D		N/A - no longer a governor			
EW	Emmerson Walgrove	Public Governor: Bradford West	Member	X	X	D	D					
IK	Imran Khan	Public Governor: Bradford West	Member	o	o	o	o					
JH	James Hobson	Public Governor: Keighley	Member	X	X (Left at 18.22)	X	X		N/A - no longer a governor			
MH	Masira Hans	Appointed Governor:Noor Project: Hope and Light	Member	X	X (Left at 18.08)	X	X					
MF	Michael Frazer	Public Governor: Bradford East	Member	o	o	o	o					
ML	Michael Lodge	Public Governor: Rest of England	Member	X	X	X	X					
MA	Mufeed Ansari	Public Governor: Bradford East	Member	D	D	o	o					
RJ	Rob James	Appointed Governor: Bradford University	Member	X	X	X	X					
TR	Tabaro Rwegema	Staff Governor: Clinical	Member	o	o	o	o					
TH	Terry Henry	Staff Governor: Non-Clinical	Member	X	X	X	X					
TG	Tosh (Hitesh) Govan	Public Governor: Bradford South	Member	X	X	X	X					
TR	Trevor Ramsay	Public Governor: Bradford West	Member	X	X	X	X					
JM	Cllr Jayne Morgan	Appointed Governor: Bradford Council	Member	N/A	N/A	D	o					
UG	Umar Ghafoor	Public Governor: Bradford South	Member	X	X	o	o					

Key

X	Attending
T	Tentative
*	Annual Members meeting
o	No apologies given

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Start time	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 to	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 includ	Declarations made in respect of spouse, co-habiting partner, or close associate
13/02/2026 09:21	Aidan Jones	No	No	No	No	No	No	No	No
30/01/2026 08:09	Andy Brown	None	I own a range of shares which currently are: Abingdon Health, Doc Martens, Naked Wines, Fevertree Drinks, Gear4Music, Genuit Group, Schneider Electric, Vistry Group, Pensana, Whitbread, Pearson, Synectic, Smith and Nephew, Wickes Group, Smurfit Westrock, Filtronic	None	None	None	None	North Yorkshire Councillor where I am a member of the Care Scrutiny Committee Green Party member	None
31/01/2026 08:24	Aurangzeb khan	None	None	None	None	None	None	None	None
11/02/2026 22:12	Emmerson Walgrove	Director and Trustee, Bradford Cyrenians Ltd	None	None	Director and Trustee, Bradford Cyrenians Ltd Director and Trustee, Sight Airedale	None	Nome	None	None
03/02/2026 13:32	Emmerson Wayne Walgrove	Vice Chair and Trustee of the City of Leeds Sea Cadets (Leeds Unit 424 of the Sea Cadets Corp) Vice Chair and Trustee of Prism Independent School and Youth Project Director and Trustee at Bradford Cyrenians Ltd Trustee of the Parish of S.Chad, Toller Lane, Bradford	None	None	None	None	None	None	None
30/01/2026 13:07	Hitesh Govan	none	none	none	none	none	none	none	My wife Manisha Govan works for the NHS as a Head of HR
15/02/2026 06:50	Imran Khan	None	None	None	None	None	None	None	None
13/02/2026 10:07	Masira Hans	NA	NA	NA	BDC Mind	NA	BDC Mind	NA	NA
13/02/2026 09:16	Michael Frazer	nil	nil	nil	nil	no	no	no	none
30/01/2026 11:19	Mike Lodge	None	None	None	None, other than as Lead Governor at this Trust	None	None	None	None
11/02/2026 16:56	Mufeed Ansari	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
02/02/2026 13:39	Robert S James	None	None	None	None	None	None, other than the obvious one that I am an Executive Board member at University of Bradford.	None	None
11/02/2026 13:22	Terry J Henry	None	None	None	None	None	None	None	None
03/02/2026 22:40	Umar Ghafoor	Umar Ghafoor Trading ltd	n/a	n/a	n/a	n/a	n/a	Trustee - Exceed academies	n/a
8/28/2026 11:19:00 AM	Cllr Jayne Morgan	None	None	None	None	None	None	None	None

Close Holly 11/11/2026 11:37:53

NHS
Bradford District Care
NHS Foundation Trust

Council of Governors' Meeting held in Public.
Wednesday 29 July 2026 at 5.00pm
Meeting held on Microsoft Teams

Agenda item

XX

Members present:	Sarah Jones	Chair in Common
	Arshad Ali	Staff Governor: Clinical *(from items 11 -14)*
	Tosh Govan	Public Governor: Bradford South
	Masira Hans	Appointed Governor: Hope and Light
	Terry Henry	Staff Governor: Non-Clinical and Deputy Lead Governor
	James Hobson	Public Governor: Keighley
	Robert James	Appointed Governor: Bradford University
	Mike Lodge	Public Governor: Rest of England and Wales and Lead Governor
	Trevor Ramsay	Public Governor: Bradford West
In attendance	Therese Patten	Chief Executive Officer
	Kelly Barker	Chief Operating Officer
	Warren Brown	Non-Executive Director
	Holly Close	Senior Corporate Governance Officer & Executive Suppor Manager (Secretariat)
	Cleveland Henry	Non-Executive Director
	Michelle Holland	Deputy Director of HR and Organisational Development (Deputising for J Harrison) *(from items 1 – 9)*
	Phil Hubbard	Director of Nursing, Professions and Care Standards, DIPC, Deputy Chief Executive *(from items 1 – 8.5)*
	Chris Malish	Non-Executive Director
	Mark Rawcliffe	Non-Executive Director and Deputy Trust Chair
	Claire Risdon	Operational Director of Finance *(for items 1 – 8.3)*
	Tim Rycroft	Chief Information Officer
	Fran Stead	Trust Secretary
	Rachel Trawally	Corporate Governance Manager and Deputy Trust Secretary
	Rebecca Wixey	Freedom to Speak Up Guardian *(for item 09.0)*
	Mike Woodhead	Chief Finance Officer
	Sal Uka	Chief Medical Officer
Apologies:	Deborah Buxton	Appointed Governor: Barnardo's
	Jo Harrison	Joint Chief People Officer
	David Hesford	Staff Governor: Clinical
	Aidan Jones	Staff Governor: Non-Clinical
	Alyson McGregor	Non-Executive Director
	Councillor Jayne Morgan	Appointed Governor: Bradford Council
	Farhan Rafiq	Director of Transformation, Improvement and Productivity

Close Holly 11/11/2026 11:37:53

MINUTES

Item	Discussion	Action
023	**Apologies for absence & confirmation of quoracy** (agenda item 1) The Chair, S Jones, opened the meeting. Apologies were received from several members. The meeting was quorate.	
024	**Declarations of Interest** (agenda item 2) No declarations of conflicts of interest were made.	
025	**Minutes of the Council of Governors' meeting held on 13 May 2026** (agenda item 3) The minutes of the Council of Governors meeting held on 13 May 2026 was approved as an accurate record.	
026	**Matters Arising** (agenda item 4) There were no matters arising that were not already included in the action log or scheduled for discussion on the agenda.	
027	**Action Log** (agenda item 5) H Close, Senior Corporate Governance Officer and Executive Support Manager provided an update on the action log. It was reported that there was one action that was open, but this was not due to come back to the Council of Governors until November 2026. **The Council of Governors:** • **noted the contents of the action log.** • **agreed to close the actions that had been listed as completed; and noted that no actions were overdue, and no further actions were required associated with the contents of the log**	
028	**Issues and Questions from Communities** (agenda item 6) No questions or issues had been received from the community for this meeting.	
029	**Alert, Advise, Assure and Decision report/Assurance Reporting (AAAD): Audit Committee held 18 June 2026** (agenda item 7.1) C Malish, Non-Executive Director presented the Audit Committee Report following the meeting held on 18 June. It was noted that the Trust had received	

Close Holly 11/11/2026 11:31:53

Item	Discussion	Action
	an unqualified external audit opinion and a positive internal audit opinion, with no significant weaknesses identified. Assurance had also been received regarding the Well-Led Development Plan, and no outstanding debt write-offs were reported. Overall, the Committee received a high level of assurance and acknowledged the work undertaken by officers to support the audit process. T Govan, Public Governor: Bradford South sought clarification regarding the risks associated with the Lynfield Mount capital development project and the mitigating actions in place should risks materialise. C Malish advised that the project was subject to a comprehensive governance and oversight framework and that the risks highlighted by external auditors reflected the inherent risks associated with large-scale capital developments rather than any specific concerns. M Woodhead, Chief Finance Officer explained that the principal risks related to cost control and potential project delays, including unforeseen issues arising during construction. It was established that a detailed and fully costed risk register was in place, supported by contingency provisions to manage unexpected issues. It was also reported that no significant risks had materialised to date and that the project was progressing well. In response to T Govan's question regarding the completion date for the project, M Woodhead advised that the project remained scheduled for completion by February 2029, although completion was currently anticipated to be achieved earlier, during late 2028. **The Council of Governors noted the contents of the Audit Committee**	
030	**Alert, Advise, Assure and Decision report/Assurance Reporting: Charitable Funds Committee held 25 June 2026** (agenda item 7.2) S Napper, Non-Executive Director presented the Charitable Funds Committee report following the meeting held in May. It was noted that there was ongoing work relating to a funding bid with Hospital Rooms, a charity supporting the development of therapeutic art environments. It was explained that whilst external funding would cover the majority of costs, the Trust would be required to contribute £250k and was exploring additional fundraising opportunities. It was reported that the project had progressed to the next stage of the application process. S Napper also shared that there had been an increase in charitable income and funding applications over the previous 12 months, with work underway to develop a reserves policy to support future financial sustainability. M Lodge, Public Governor: Rest of England and Wales and Lead Governor sought ressurance that the project met charitable funding criteria and did not represent a dependency for the wider Lynfield Mount redevelopment programme.	

Close Holly 11/11/2026 1:37:53

Item	Discussion	Action
	S Napper and C Risdon, Operational Director of Finance confirmed that the project would enhance the experience of service users beyond the core provision funded by the Trust and therefore met the requirements for charitable funding. It was noted that the project would complement, rather than support, the Lynfield Mount redevelopment and would also benefit areas not included within the capital programme. **The Council of Governors noted the contents of the Charitable Funds Committee AAAD.**	
031	**Alert, Advise, Assure and Decision report/Assurance Reporting: Finance and Performance Committee held 27 May and 22 July 2026** (agenda item 7.3) C Henry, Non-Executive Director presented the Finance and Performance Committee Chair's Report, covering meetings held on 27 May and 22 July. It was fed back that there had been improved performance across a number of services, including community services and talking therapies, and assurance was received that the Lynfield Mount programme remained on track. C Henry also discussed the ongoing financial risks relating to access and flow, cost improvement plans, out-of-area placements and savings delivery. It was established that additional scrutiny was underway, with an extraordinary meeting scheduled for August to review progress. Ongoing work to assess the potential impact of forthcoming NHS England financial reforms was also discussed. R James, Appointed Governor: Bradford University suggested that future assurance reports could include fewer acronyms and more contextual information to help Governors better understand the significance of reported risks. The comments were noted. M Lodge sought assurance regarding community capacity pressures, specialist housing availability and out-of-area placements. K Barker, Chief Operating Officer advised that these were recognised system-wide challenges and confirmed that the Trust was working closely with local authorities, voluntary sector partners and the West Yorkshire Integrated Care Board to develop both operational and strategic solutions. Governors also heard that a joint needs assessment was planned to support future service planning across West Yorkshire. In response to a query regarding Somerset House, M Woodhead advised that services had already relocated from the site and that the sale was nearing completion. The proceeds would be reinvested in other parts of the Trust's estate.	

Close Holly 11/11/2026 11:37:53

Item	Discussion	Action
	The Council of Governors noted the contents of the Finance and Performance Committee AAAD.	
032	**Alert, Advise, Assure and Decision report/Assurance Reporting: Mental Health Legislation Committee held 21 May 2026 and 16 July 2026** (agenda item 7.4) W Brown, Non-Executive Director presented the Mental Health Legislation Committee reports following meetings held in May and July. Updates relating to parking arrangements for Associate Hospital Managers, recruitment to Associate Hospital Manager roles, tribunal delays and the quality of clinical reports were received. W Brown shared that the Committee received updates on the Mental Health Act 2025 and deprivation of liberty safeguards, noting that further national guidance was awaited. Assurance was also received regarding the use of Community Treatment Orders, reductions in physical restraint and seclusion, strategic risks, Mental Health Act complaints, ligature detection systems and compliance with Mental Health Act and Mental Capacity Act training requirements. T Ramsay, Public Governor: Bradford West sought clarification regarding the potential impact of future changes to deprivation of liberty safeguards on advocacy services. W Brown advised that the direction of travel remained focused on strengthening patient protections, although the implications would become clearer once national guidance was available. M Lodge sought assurance regarding the quality of clinical reports. S Uka, Chief Medical Officer advised that a programme of multi-professional training had been introduced to support report writing and presentation skills, alongside the introduction of a real-time feedback process to support staff development and improve consistency. **The Council of Governors noted the contents of the Mental Health Legislation Committee AAAD.**	
033	**Alert, Advise, Assure and Decision report/Assurance Reporting: People and Culture Committee held 21 May 2026 and 18 June 2026** (agenda item 7.5) M Rawcliffe, Non-Executive Director presented the People and Culture Committee reports following meetings held in May and June. It was noted that workforce data had highlighted disparities in recruitment outcomes, disciplinary processes and staff experience. The Committee also discussed work to improve data quality, reduce formal employee relations cases and support apprenticeships.	

Close Holly 11/11/2026 11:37:53

Item	Discussion	Action
	Assurance was received by the Committee regarding improvements in vacancy rates, staff retention, clinical supervision, mandatory training and leadership development. No questions were raised. **The Council of Governors noted the contents of the People and Culture Committee AAAD.**	
034	**Alert, Advise, Assure and Decision report/Assurance Reporting: Quality and Safety Committee held 20 May 2026, 17 June 2026 and 15 July 2026** (agenda item 7.6) S Napper presented the Quality Committee report covering meetings held in May, June and July. Workload pressures within community nursing and inpatient services, together with concerns relating to self-harm, absences without leave, demand and capacity, out-of-area placements and outpatient waiting times were discussed. It was noted that the Committee had given these areas further scrutiny through detailed discussions and deep dives. Data quality concerns relating to SNOMED coding was highlighted and it was noted that further work was underway to improve data accuracy and reporting. An update was also received on the National Quality Strategy and its alignment with the Trust's existing priorities. Overall, the Committee received assurance on quality performance, risks and improvement activity across its areas of responsibility. No questions were raised. **The Council of Governors noted the contents Quality and Safety Committee AAAD.**	
035	**Freedom to Speak Up Guardian Report** (agenda item 8) R Wixey, Freedom to Speak Up Guardian presented the annual Freedom to Speak Up Report, summarising activity during the previous financial year. There had been 130 cases raised through the Freedom to Speak Up Guardian route, an increase on the previous year. The most common themes related to staff wellbeing, worker safety and workplace behaviours. R Wixey highlighted improvements to the service during the year, including refreshed policies, expanded communications, additional ambassadors, manager training and updated resources to support a positive speaking up culture.	

Close Holly 11/11/2026 12:37:53

Item	Discussion	Action
	M Lodge welcomed the report and sought confirmation that no significant organisational concerns had emerged. R Wixey confirmed that whilst concerns continued to be addressed and learning identified, no major systemic issues had been highlighted. R Wixey also advised that future reports would include comparison against workforce demographic data to provide additional context. The Council thanked Rebecca and the team for their work. **The Council of Governors noted the contents of this report.**	
036	**Chair's Report** (agenda item 9) The Chair provided an update on the Committee in Common arrangements between the three NHS trusts. Governors heard that the Committee brought together the Chief Executives and Chairs or Deputy Chairs of each trust and had delegated authority from the respective Boards to support aligned decision-making across the system. It was explained that this approach would support the development of new place-based ways of working within the NHS. The Chair also highlighted the first quarterly review of the Chair in Common role, with the review notes attached to the report for reference. M Lodge asked for an update on engagement with Bradford Council following changes in its leadership. The Chair confirmed that contact had been initiated but that a meeting with the new Council Leader had not yet taken place. T Patten, Chief Executive Officer advised that they had recently met with the new Council Leader and described the discussion as positive and constructive. It was reported that there was a strong interest in working collaboratively with the Trust and that arrangements were being made to engage with new Cabinet Members. T Patten also advised that the Trust's Neighbourhood Strategy would be presented to the Health and Wellbeing Board in September, with preparatory discussions already scheduled. No further questions were raised. **The Council of Governors noted the continuing engagement that has taken place with external partners, internally at the Trust, and with the Board of Directors.**	
037	**Update on NHS structural changes** (agenda item 10) T Patten provided an update on proposed NHS reforms and the implications for local health systems. It was explained that the NHS Modernisation Bill would support delivery of the Ten Year Health Plan and bring NHS England functions into the Department of Health and Social Care. Governors were also advised of changes to Integrated Care Boards (ICBs), including a reduction in capacity and a greater focus on strategic commissioning, population health and system planning.	

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Item	Discussion	Action
	T Patten outlined proposals for place-based working across West Yorkshire, including the development of Place Provider Partnerships. The intention was to bring organisations together to plan and deliver services more collaboratively, with a single host provider responsible for managing delegated resources on behalf of the partnership. The Board had indicated that The Trust was minded, in principle, to become the host provider for Bradford District and Craven, subject to further due diligence. M Woodhead, as Senior Responsible Officer for the programme, presented an overview of the due diligence process. They explained that extensive work was underway to assess the strategic, financial, workforce, legal, governance and operational implications of becoming a host provider. Key considerations included ensuring all partners shared a common vision, understanding financial and quality risks, establishing appropriate governance arrangements and clarifying accountability. M Woodhead advised that due diligence was expected to be largely completed by December, with a shadow year planned from April 2027 and formal implementation anticipated from April 2028. T Henry, Staff Governor: Non-Clinical and Deputy Lead Governor welcomed the work undertaken to date and commended the level of detail and scrutiny being applied to the process. M Lodge asked how primary care would be involved in the new arrangements. T Patten explained that general practice was represented through the newly established GP Alliance and through existing governance structures, including the Joint Committee and Clinical Forum. Whilst progress had been made, they acknowledged that further work was required to strengthen the primary care voice within the partnership. The Chair thanked those involved in the work and confirmed that Governors would continue to receive updates as the programme progressed. **Action:** Place Governance Structure discussion to be brought back to a future Council of Governors meeting **The Council of Governors noted the contents of the report.**	**TP**
038	**Governance Report** (agenda item 11.1) R Trawally, Corporate Governance Manager and Deputy Trust Secretary presented the Governance Report, providing an update on governance activity and compliance requirements undertaken since the previous meeting. It was confirmed that all required annual compliance activity had been completed with no issues to report. R Trawally also advised that Councillor Jayne Morgan had been appointed as a new Governor for Bradford Council but had been unable to attend the meeting due to prior commitments.	

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Item	Discussion	Action
	R Trawally then introduced the first stage of the Constitution Review, which focused on updating outdated terminology and making minor governance amendments. Proposed changes were highlighted which included reducing Bradford Council representation from two appointed Governors to one and removing the Bradford Assembly appointed Governor position as the organisation no longer existed. It was explained that the Board of Directors had approved the proposed amendments and that, subject to approval by the Council of Governors, the changes would be taken to the Annual Members' Meeting for ratification. No questions were raised and the Council of Governors approved the proposed amendments to the Constitution for submission to the Annual Members' Meeting. R Trawally then highlighted upcoming Governor engagement opportunities, including the workshop scheduled for 10 August to discuss the future role of Governors and the NHS Providers session scheduled for 17 August. Finally, the Chair drew attention to the changes in Governor and Executive Membership detailed within the report, which noted the departure of Councillors Sabiya Khan and Debbie Davies as Appointed Governors for Bradford Council and welcoming Councillor Jayne Morgan to the role from 17 July 2026. Also recognised was the retirement of Bob Champion, Chief People Officer, and the welcome to Jo Harrison, who had taken up a shared Executive Director of People and Organisational Development role across Bradford District Care and Airedale NHS Foundation Trusts. **The Council of Governors:** • **Noted the updates contained within the report.** • **Approved the proposed Stage One amendments to the Trust Constitution, subject to any additional approvals required through the Trust's constitutional process.** • **Took assurance from the successful completion of the Trust's annual governance and statutory compliance requirements for 2025/26.** • **Supported the ongoing programme of governance development, including the Constitution review, Membership Engagement Strategy refresh, governor elections and review of key governance documents.** • **Noted the potential implications of the NHS Modernisation Bill and receive future updates as required.**	
039	**Well Led Report** (agenda item 11.2) F Stead, Trust Secretary presented the report and highlighted the conclusion of the annual effectiveness review process. It was noted that the review had identified a number of actions; however, following cross-referencing against	

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Item	Discussion	Action
	existing Well-Led Development Plan actions, only two new actions had been identified and added to the Plan. Governors were advised that progress against these actions would be reported through the next cycle of meetings. It was also noted that a future report would provide an update on Council of Governors Well-Led actions, much of which had already been completed and would be presented for formal closure. The Council of Governors noted the update. No questions were raised. **The Council of Governors:** • **Noted the update provided and give feedback on this evolving process** • **Were assured on the process being iterative and co-produced with Board colleagues** • **Noted that an effectiveness review of the process will take place** • **Were assured that the findings from the annual effectiveness reviews have been processed.**	
040	**Operational and Financial Performance inc. National Oversight Framework Update** (agenda item 12) K Barker presented the performance update and reported that the Trust remained operationally stable, with strong performance across a number of areas. K Barker shared that the Trust's National Oversight Framework (NOF) rating had improved to Segment Two, with several indicators achieving NOF one status nationally. Key areas of strong performance included the elimination of 52-week waits in community services, improvements in urgent mental health crisis response, and progress against the Data Quality Improvement Plan. K Barker highlighted ongoing pressures within the adult mental health pathway, where increasing demand continued to create operational and financial challenges, particularly in relation to the use of independent sector beds. It was also noted that sickness absence remained an area of focus despite positive performance in staff experience, appraisals and training compliance. M Woodhead provided the finance update and advised that the Trust's financial risk level had increased, resulting in enhanced internal escalation and inclusion on NHS England's financial watch list. Governors heard that, due to significant financial pressures across the region, a new financial oversight regime had been introduced. Under this framework, the Trust had been placed in the Amber Watch category, resulting in additional reporting requirements and increased scrutiny. T Patten advised that, as part of the enhanced regional oversight arrangements, Finance Committee Chairs would be meeting with regional colleagues to discuss governance and committee oversight arrangements.	

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Item	Discussion	Action
	M Lodge welcomed the improvement in the Trust's performance position. The Chair acknowledged the significant work undertaken by the Executive Team and wider organisation in achieving this progress. **The Council of Governors:** • **Took assurance that performance is subject to oversight through the relevant Board Committees and AAA+D reporting routes;** • **Sought further assurance from Non-Executive Directors on the areas of limited or low assurance, particularly access and flow, waiting-related harm, financial sustainability and estates/environment risks; and** • **Noted the transition to the revised Integrated Strategic Performance and Quality Report from July 2026 and the planned Trust-level Strategic Performance Report from September 2026.**	
041	**Council of Governors Annual Work Plan** (agenda item 13) **The Council of Governors noted the contents of the annual work plan.**	
042	**Any Other Business** (agenda item 14) No other business was raised.	
043	**Meeting Evaluation**. **Was the meeting conducted in line with the Trust Values** (agenda item 15) A discussion took place to evaluate the meeting in line with the commitment for continuous improvement within the Trust. The Chair considered the meeting to have been carried out in line with Trust values and closed the meeting. Attendees confirmed that the meeting had been conducted openly and that sufficient opportunity had been provided for participation. The meeting closed at 18:30.	
These minutes were prepared with the assistance of AI tools and reviewed by the Senior Corporate Governance Officer & Executive Support Manager and the Chair for accuracy and completeness		

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Agenda item
05.0

NHS
Bradford District Care
NHS Foundation Trust

Action Log for the Council of Governors Public Meeting for 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**
1. 13/05/2026	**Alert, Advise, Assure and Decision report/Assurance Reporting: Quality and Safety Committee held 18 March 2026 & 15 April 2026** **The Trust Secretary** to consider how future reports can be strengthened to improve clarity and continuity between meetings, including clearer demonstration of assurance and evidence of impact.	F Stead	November 2026	**The Council of Governors is asked to consider this action closed.** This action has been transferred to the Care Trust Integrated Governance Guide action log to be progressed as part of the Integrated Governance Guide refresh, as it applies across all meetings rather than solely to the Council of Governors.
2. 29/07/2026	**Update on NHS structural changes** Place Governance Structure discussion to be brought back to a future Council of Governors meeting.	T Patten	November 2026	**The Council of Governors is asked to consider this action closed.** Item has been added to agenda for November 2026 Committee.

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Actions closed at the last meeting				
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**
13/05/2026	Chair's Report The Corporate Governance Team to coordinate sending a letter of thanks to Cllr Sabiya Khan.	CGT	July 2026	The Council of Governors is asked to consider this action closed. Letter of thanks sent to Cllr Khan on 13 May 2026.
13/05/2026	Place Strategic Ambition The Corporate Governance Team to share the Act as One Governance Framework with Governors	CGT	July 2026	The Council of Governors is asked to consider this action closed. Framework has been shared with the Governors on 2 June 2026.
13/05/2026	Place Strategic Ambition The Corporate Governance Team to plan a dedicated session on the place provider partnership arrangements and invite Mike Woodhead, system lead to provide a more detailed overview as arrangements develop.	CGT	July 2026	The Council of Governors is asked to consider this action closed. Item has been added to the forward planner for the Council of Governor meetings.
13/05/2026	Place Strategic Ambition The Corporate Governance Team to schedule a comprehensive overview of the system architecture to July's meetings.	CGT	July 2026	The Council of Governors is asked to consider this action closed. Item has been added to the agenda for July's meeting.

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13/05/2026	Governance Report The Trust Secretary to share updated Well Led report with Governors that incorporates evidence of delivery ahead of the next Council of Governors meeting	F Stead	July 2026	The Council of Governors is asked to consider this action closed. This will be presented at the meeting on 29 July 2026.
13/05/2026	Operational and Financial Performance The Trust Secretary to feed into discussions the need to improve the clarity of graphs within reports particularly related to performance data.	F Stead	July 2026	The Council of Governors is asked to consider this action closed. This has been shared with the relevant leads for consideration.
13/05/2026	Any Other Business The Deputy Director of Nursing and Professions to organise a session on Involvement Partners and their role and contribution to the trust and also incorporate an update on patient safety partners	C Dixon	November 2026	The Council of Governors is asked to consider this action closed. Session to be presented at November's meeting, once new policy has been implemented.
13/05/2026	Any Other Business The Corporate Governance Team to organise a session on the Care Trust Way for Governors at a future meeting.	CGT	July 2026	The Council of Governors is asked to consider this action closed. Item has been added to the forward planner for future meetings.

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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 Close Holly 11/11/2026 11:37:53	• 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

	• 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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Effective Oversight: Escalation and Assurance

Report to:	**Board of Directors held in Public**	**Meeting date:**	**TBC**
Report from:	**Extra Ordinary Finance & Performance Committee**	**Meeting date:**	**20/08/2026**
Quorate?	**Yes ☒ No ☐**		
Members present	Cleveland Henry (Chair/NED) Mark Rawcliffe (NED) (part meeting), Warren Brown (NED), Mike Woodhead, Dr Sal Uka, Philippa Hubbard, Therese Patten, Farhan Rafiq.		
In attendance	Clare Risdon, Rachel Trawally, Alix Jeavons		
Observers	N/A		
Apologies	Jo Harrison, Kelly Barker, Jess Greenwood-Owens (Secretary), Fran Stead, Tim Rycroft,		
Best Quality Services	**Theme 3** – Improving the experience of people using our services		**BQS:T3**
Agenda items	• Apologies for absence & confirmation of quoracy • Declaration of any conflicts of interest • Financial Recovery and Sustainability: Management Response, Delivery Grip and Assurance • Any Other Business • Meeting Evaluation (verbal)		
Alert items agreed by Committee	• Ongoing challenges remained in delivery of the Trust's financial plan, requiring continued focus on recovery actions. • Further quantification was required to assess the full impact of a number of recovery actions and transformation opportunities. • Emerging issues require timely escalation where recovery actions are not progressing as planned.		
Advise items agreed by Committee	• Enhanced financial recovery arrangements were in place, including strengthened governance, increased executive oversight, enhanced financial controls and more frequent monitoring. • A structured recovery approach was being implemented, supported by clear ownership, accountability and reporting mechanisms. • Work was underway to quantify the benefits associated with recovery actions and longer-term transformation opportunities.		
Assure items agreed by Committee	• Concerns raised at previous meetings had been addressed through the development of a strengthened recovery framework and governance approach. • Enhanced oversight, scrutiny and escalation arrangements were in place to support delivery of the financial recovery programme.		

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	• Good progress had been made in implementing recovery actions; however, assurance on delivery of financial benefits would require further evidence over the coming months.		
Decisions made by Committee	N/A		
New risks identified by Committee	• Strengthened governance and oversight arrangements may not translate into delivery of the required financial benefits at the pace needed. • Delivery of the recovery programme would require sustained organisational focus and capacity over the coming months. • Benefits associated with some transformation opportunities remain unquantified, reducing confidence in the overall recovery trajectory. • Implementation and delivery pace remain the principal challenge in achieving the required financial improvement.		
Items to be considered by other Committees/Groups	• **Board**: Continued updates on progress, delivery and assurance relating to the financial recovery programme. • **Executive Management Team (EMT):** Weekly oversight of recovery actions, financial controls and delivery against plan. • **Organisational Service Performance Board (OSPB):** Monitoring of programme delivery, risks and recovery actions through established oversight arrangements. • **People & Culture Committee:** Updates on workforce controls and medical staffing/job planning arrangements, as appropriate.		
Feedback following discussion at 'parent' meeting	TBC		
Report completed by	Corporate Governance Officer	**Date**	24/08/2026
On Behalf of Chair	Cleveland Henry		

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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		

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	• 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 11/11/2026 11:37:53	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		

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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 11/11/2026 11:37:53	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		

Close Holly
11/11/2026 11:37:53

AAAD: Effective Oversight: Escalation and Assurance

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

Close Holly 11/11/2026 11:37:53

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

Close Holly 11/11/2025 17:53

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
11/11/2026 11:37:53

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 11/11/2026 11:37:53

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
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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)

Close Holly 11/11/2026 11:37:53

	• 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

Close Holly 11/11/2026 11:37:53

- 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.

Close Holly
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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)		

Close Holly
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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

Close Holly 11/11/2026 11:37:53

	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	

Clare Hoyle 11/11/2025 11:37:53

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)		

Close Holly
11/11/2026 11:37:53

Bradford District and Craven
Health and Care Partnership

ACTasONE

BDC System Governance Proposal

October 2026

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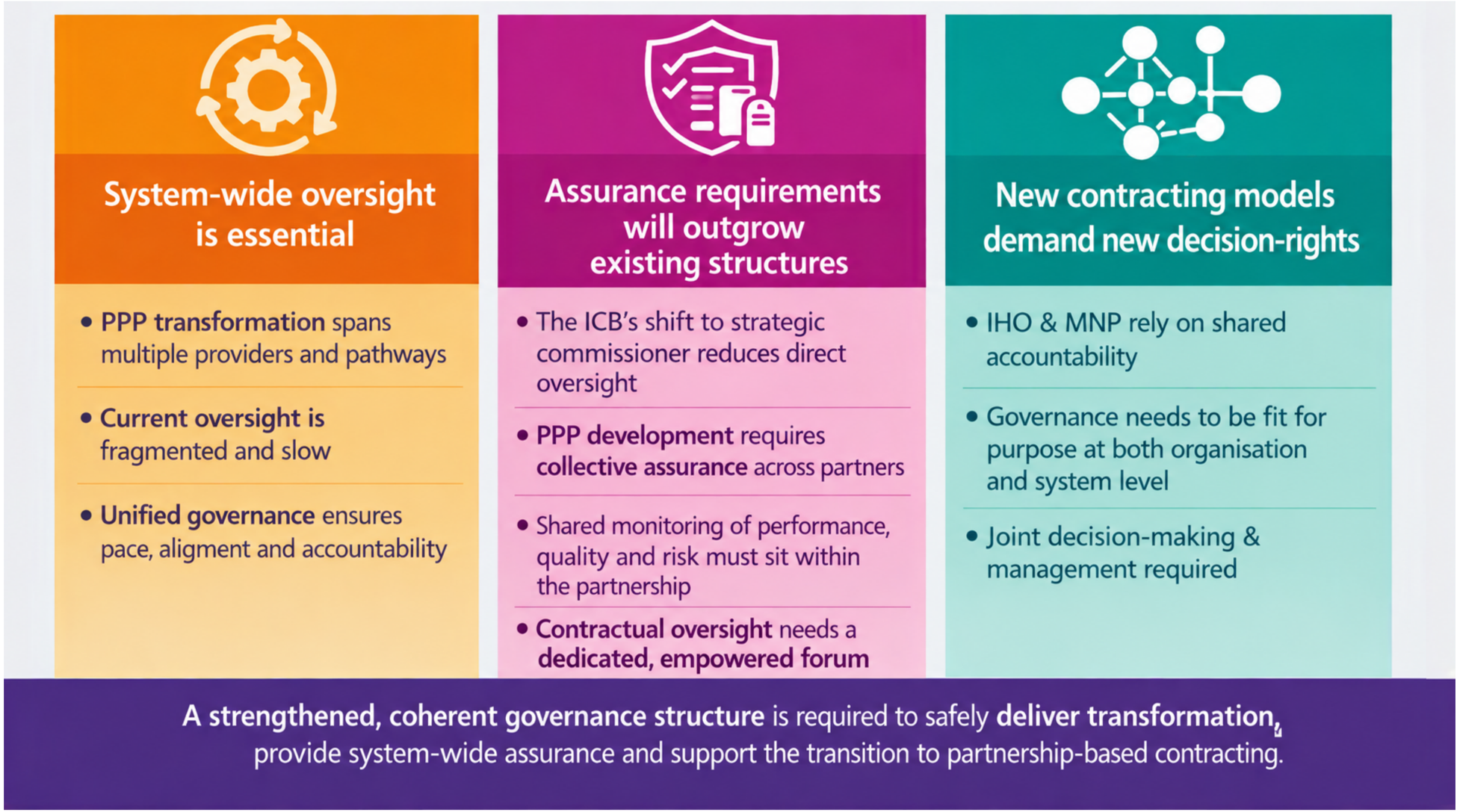
11/11/2026 11:37:53

The Case for Change

Bradford District and Craven
Health and Care Partnership
ACTasONE



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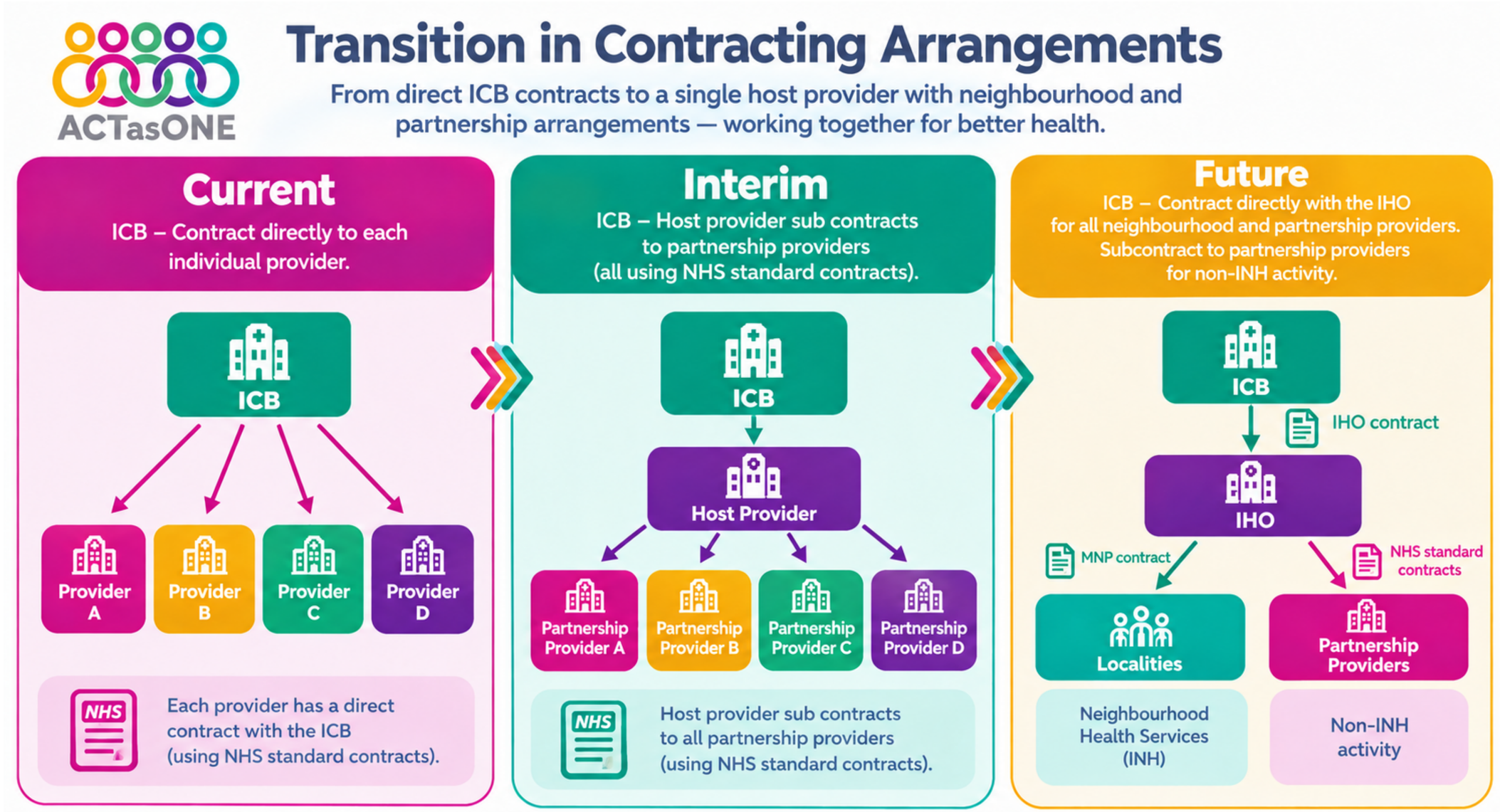
Contractual Alignment



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Why this approach?

Bradford District and Craven Health and Care Partnership

ACTasONE

1. Enables Maturity and National Alignment

- Supports progressive development of partnership governance maturity
- Aligns with the national shift to IHO and MNP contracting models
- Builds readiness for integrated accountability and partnership-led contracting arrangements

2. Balances Partnership Ambition with System Oversight

- Serves the Partnership's transformation ambitions whilst strengthening system assurance
- Provides appropriate oversight for the system, host provider and ICB
- Ensures clarity of roles and accountability across organisational boundaries

3. Embeds Clinical and Professional Leadership

- Integrates clinical leadership within governance and transformation oversight
- Strengthens the clinical voice in system-wide decision-making
- Promotes co-design and ownership across providers and professional groups

4. Creates a Sustainable, Scalable Governance Model

- Establishes a framework that can evolve as the partnership matures
- Reduces duplication and complexity across existing committees and boards
- Provides a single, coherent route for assurance, decision-making and escalation

5. Supports Cultural and Behavioural Change

- Reinforces collaborative behaviours and shared accountability
- Encourages system thinking rather than organisational protectionism
- Builds trust and transparency across partners

Chris Holly
17/11/2026 11:37:33

Transition to the Vision & Future Opportunities

Shadow Go-Live Configuration

- The initial governance requirements for the system to operate in shadow form are met through the current structure excluding the Locality Delivery layer.
- This provides a streamlined, functional model for early operation while contractual arrangements continue to mature nationally and locally.

Locality Delivery Layer – Future Essential Component

- As national policy on delegated contracting evolves, the Locality Delivery layer will become a critical part of the long-term governance model.
- Locality Boards will be central to delivering the system's ambitions for:
    - Left shift
    - Integrated Neighbourhood Health
    - Population-level delivery and improvement
- With maturity, Locality Boards will be able to receive delegated budgets, enabling contractually aligned delivery & stronger population level accountability.

Future Streamlining of Strategic Delivery Groups (SDGs)

- As SDG programmes mature, there may be opportunities to streamline the SDG structure into a more integrated, long-term configuration.
- A future model could focus on all-age, cross-population Integrated Neighbourhood Health
- This would reduce duplication, strengthen alignment across Place, and support clearer system priorities.

Alignment with West Yorkshire Programmes

- Throughout both the transition period and the future governance model, the system will need to maintain clear alignment with wider West Yorkshire programmes.
- As WY programmes evolve, interfaces, reporting lines and decision-making pathways must remain coherent and connected.
- Ensuring alignment will support consistency across Place, reduce duplication, and reinforce shared system priorities.
- This will be essential as Locality Delivery arrangements mature and as SDGs evolve into a more streamlined, long-term configuration.

Organisational Development & Terms of Engagement

- OD and clear Terms of Engagement are essential to support partners, teams and leaders to transition confidently into new governance and delivery arrangements.
- Together they embed shared behaviours, expectations and ways of working that underpin effective partnership and future system operation.

Close Holly
11/11/2026 11:37:53

NHS
Bradford District Care
NHS Foundation Trust

Council of Governors – meeting held in public

11 November 2026

Paper title:	Governance Report	**Agenda Item** **11.0**
Presented by:	Holly Close, Senior Corporate Governance Officer & Executive Support Manager	
Prepared by:	Holly Close, Senior Corporate Governance Officer & Executive Support Manager & Rachel Trawally, Corporate Governance Manager and Deputy Trust Secretary	

Committees where content has been discussed previously	N/A
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 Council of Governors on key governance matters that have taken place over the last quarter and upcoming areas of interest for Governors to be aware of.

Executive Summary
This report provides an update on key governance activity undertaken over the last quarter, including ongoing work to support effective and well-led governance arrangements. The report details changes within the Council of Governors, including the departure of four Governors and the six-month extension of the Lead Governor post. It also notes changes within the Trust's Executive Leadership Team.

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The report highlights progress on the governor elections, governor development work, and opportunities for governor involvement. The report also outlines the potential implications of the Health Bill, particularly proposals affecting NHS Foundation Trust governance arrangements, including members and Councils of Governors.	
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 Council of Governors is asked to: • Note the updates contained within the report. • Approve the six-month extension of the Lead Governor to provide continuity and retain valuable experience during the coming months, while clarity is sought regarding the Health Bill. • Approve the changes made to the Council of Governors' Terms of Reference. • Approve the refreshed Council of Governors' Code of Conduct and the new *How the Council of Governors Does Business – Council of Governors' Etiquette* procedure. • Take assurance from the completion and submission of the Trust's Provider Capability Assessment self-assessment for 2026. • Support the ongoing programme of governance development, including the Constitution review, governor elections and review of key governance documents. • Note the potential implications of the Health Bill and receive future updates as required.

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 Close Holly 11/11/2026 11:37:53	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

Council of Governors – meeting held in public

11 November 2026

Governance Report

Background / Context:

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

Governor Changes:

Appointment & Resignations
During this period, the Council of Governors has seen a number of resignations:

- Arshad Ali Public Governor: Clinical
- 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.

People:

Outcome of Chief Medical Officer Recruitment
The recruitment campaign for the substantive post of Chief Medical Officer has now successfully concluded. The advert for the role went live on 17 August, with a closing date of 6 September. Shortlisting took place on 7 September, with interviews held on 22 and 23 September 2026. Dr Sal Uka, who was the Trusts interim Chief Medical Officer, has been appointed to the role.

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.

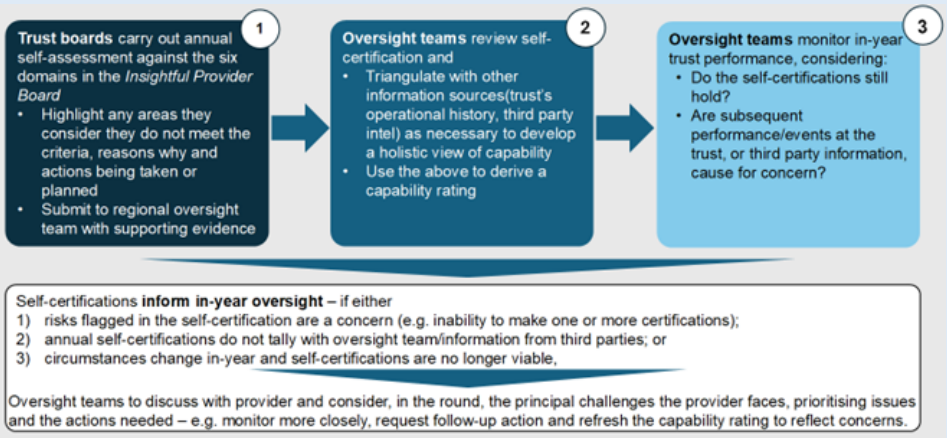
Executive Leadership Changes
Following the announcement that Therese Patten, Chief Executive Officer, had commenced a 12-month secondment, the Trust enacted agreed acting-up arrangements as part of the Board's response and resilience plans, with Phil Hubbard, Director of Nursing and Deputy

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.

Compliance

Provider Capability Assessment

The Trust 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 with 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.

The Health 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.

Governance Matters:

Council of Governor Elections:

In accordance with Schedule 7 of the NHS Act 2006 and the Trust Constitution, the Corporate Governance Team commenced an election process on behalf of the Council of Governors for vacant Public and Staff Governor seats, with nominations opening on 10 September 2026. Six constituencies, comprising eight seats, were included in the 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; the Governor election process has progressed, with the outcome of uncontested seats confirmed. Induction and support arrangement will be put in place for new Governors as appropriate.

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.

Lead Governor Proposed Six-Month Extension:
To provide continuity and retain valuable experience during the coming months, particularly while further clarity is awaited regarding the NHS ten-year plan and the future direction of governance arrangements, Governors were consulted on a proposal for Mike Lodge to continue as Lead Governor for a further six months. No concerns were raised and Mike has agreed to continue in the role. The Council of Governors is therefore asked to formally ratify the six-month extension.

Chair in Common 6 month Effectiveness Review:
The six-month effectiveness review of the Chair in Common arrangements took place on 5 October 2026, involving the Chair in Common, Lead Governors and Senior Independent Directors from Bradford District Care NHS Foundation Trust and Airedale NHS Foundation Trust. Trust Secretaries from both organisations were also in attendance. The review was convened in accordance with the Governance Framework agreed by both Trust Boards and Councils of Governors. Its purpose was to assess the effectiveness of the Chair in Common

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role arrangements during the first six months and identify any opportunities for further development of the role. Further details and outcomes from the review will be presented in due course.

Governor Involvement:

As Governors you are invited to observe our public Board meetings, Board Sub-Committee meetings, and to join Go See visits. These opportunities are designed to help you learn more about how the Trust works and to support your statutory duty to hold our Non-Executive Directors to account. Go See visits offer a chance to see services first-hand, meet teams, hear what is working well and where there are challenges, and discuss potential improvements. Below is a table that provides details of both Public Board and Sub-Committee dates. All meetings are held hybrid on MS Teams and also at New Mill. If you would like to observe a meeting or attend a Go See—either on a regular basis or as a one-off—**please email corporate.governance@bdct.nhs.uk and we will arrange this for you.**

Meeting Dates & Times:

Date	Time	Meeting
14/01/2027	9.30-12.30	Board held in Public
10/12/2026	9:30 – 12:00	Audit Committee
25/11/2026	9.30-11.30	Finance and Performance Committee
16/12/2026	9.30-11.30	Finance and Performance Committee
19/11/2026	9.30-11.30	Mental Health Legislation Committee
21/01/2027	9.30-11.30	Mental Health Legislation Committee
17/12/2026	12.30-14.30	People and Culture Committee
21/01/2027	12.30-14.30	People and Culture Committee
18/11/2026	9.30-12.00	Quality and Safety Committee
20/01/2027	9.30-11.30	Quality and Safety Committee
20/01/2027	09.30-12.00	Quality and Safety Committee

Governor Involvement at Go See Visits:

Date	Service Visited	Governor(s) Involved	Board/EMT Member
31.07.2026	School Nursing – Immunisation Team	Mike Lodge	Sal Uka
13.08.2026	Looked After Children's Team	James Hobson	Sal Uka

Governor Volunteer Opportunities – Trust Welcome

As part of ongoing efforts to strengthen Governor visibility and engagement, the Corporate Governance Team is continuing to seek Governor volunteers to support the Trust Welcome Days taking place throughout the year. Governors are invited to assist at the marketplace stalls, engaging with new starters about the role of the Council of Governors and wider involvement

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opportunities. All materials are provided. Opportunities are available across a number of welcome sessions held at Victoria Hall, Saltaire, running from 10:30 – 12:10:

- 03/11
- 01/12

If you would like to volunteer, please email corporate.governance@bdct.nhs.uk

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/

Governor Partnership Working
As Governors will be aware, Governors from Bradford District Care NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust and Airedale NHS Foundation Trust met on 10 August 2026 at Airedale NHS Foundation Trust to begin exploring the implications of the NHS Ten Year Health Plan, including the Government's proposals to remove the statutory requirement for NHS Foundation Trusts to maintain a Council of Governors, and how any future changes may operate across Bradford District and Craven. The Trust recognises and values the importance of representation, involvement and engagement.

The output from this event can be found in Appendix 1.

The session also included a tour of the Airedale estate to view the impact of Reinforced Autoclaved Aerated Concrete (RAAC).

A further joint Governor development session is currently in the process of being planned for November at the Trust. Governors from across the three Trusts will be invited to take part in the event.

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Council of Governors Development Work

Council of Governors Code of Conduct:
A comprehensive review of the Council of Governors' Code of Conduct has now been completed, alongside the development of a new procedure, *How the Council of Governors Does Business – Council of Governors' Etiquette*. Both documents were shared with Governors on 11 September 2026 for review and feedback. No feedback was received and the documents are therefore presented for formal approval, which can be found within Appendix 2. Following approval, Governors will be asked to sign the refreshed Code of Conduct.

Terms of Reference:
Good governance requires an annual review of the Terms of Reference that support groups and committees. In line with this, the Council of Governors' Terms of Reference have been reviewed by the Corporate Governance Team on behalf of the Council.

The proposed amendments to the Terms of Reference are:

- The Appointed Governor table has been updated to reflect the constitutional changes approved at the Annual Members' Meeting in 2026: removal of the appointed Governor seat for Bradford Assembly and reduction to one Bradford Council Member.

These proposed amendments are highlighted in track changes in Appendix 3.

Well Led Development Plan:
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.

A number of processes are facilitated within the Trust, supplemented by independent testing processes (such as external reviews), to test compliance with the above requirements and the effectiveness of existing governance. This is in support of the Trust being an improvement organisation.

The Well Led Development Plan is the place where all agreed actions are tracked.

The Council of Governors are reminded that this work has two phases, they are:

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

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

Performance against delivery is reported quarterly to the oversight meeting regarding the actions its monitoring. The full plan is reported to the Audit Committee and Board held in public.

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Below are actions within the Well Led Development Plan that are assigned to the Council of Governors.

Ref.	Quality statement	Total actions	CoG actions	Assurance rating	Position
				November 2026	Position at November 2026
QS1	Shared direction & culture	5	0	N/A	
QS2	Capable, compassionate & inclusive leaders	5	0	N/A	
QS3	Freedom to speak up	3	0	N/A	
QS4	Workforce equality, diversity & inclusion	2	0	N/A	
QS5	Governance, management & sustainability	30	1	Significant	1 action completed for phase 1
QS6	Partnerships & communities	5	0	N/A	
QS7	Learning, improvement & innovation	4	0	N/A	
QS8	Environmental sustainability	3	0	N/A	

Progress update: November 2026

Below is the action within the Plan that is assigned to the Council of Governors, including a progress update.

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

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Table two lists the actions that have been closed and are not required for phase two.

Actions note due yet for phase 1 (**no action** required at this stage)
None

Actions listed as 'complete'
QS5.5 (complete for phase 1 and not required for phase 2)
QS5.9 (complete for phase 1 and not required for phase 2)
QS5.13 (complete for phase 1 and not required for phase 2)
QS5.14 (complete for phase 1 and not required for phase 2)
QS5.16 (complete for phase 1)
QS5.17 (complete for phase 1 and not required for phase 2)
QS5.22 (complete for phase 1 and not required for phase 2)

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

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Quality Statement 5: Governance, management & sustainability

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

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

Ref	Action	Due	Delivery lead	Board/EMT lead	Oversight Group	Progress	Evidence	Assurance Rating
QS5. 16	**Committee & CoG:** consideration on how health equity becomes embedded across all meetings.	05/05/2026 (Phase 1)	Lisa Wright	Kelly Barker & Committee Chair's	Committee's (FPC; MHLC; PCC; QSC) Council of Governors	Working in partnership with Farhan to revise the ISPR, Health Equity Dashboard linked to PCREF in test mode. Mental Health will happen much quicker due to PCREF. Health Equity Review planned - to include, papers, guidance and training for committee members. Development of draft Health Equity Approach to be embedded into the review of the Organisational Strategy. Inclusion of Health Equity domain to the 2025 - 2028 Belonging and Inclusion Plan which is reviewed every 6 months with deep dive topics in between.	PCREF papers	Phase 1 completed (July 2026)

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Table two: Closed Actions for Council of Governors:

Reference	Theme	Action	Phase 1 Due date	Rating	Phase 2 Embedded Due Date	Delivery lead	Board/EMT lead	Oversight group	Phase 1 Progress	Phase 2 Progress	Evidence	Embedded by Evidence	Comments
QS5.5	Effective meetings & Training, development, succession	The Trust should consider strengthening support for governors & the effectiveness of the Council of Governors meetings to enable effective discharge of their role. CoG: training on the role of Senior Independent Director (& other roles). CoG: consider framework for Governor Time Out sessions.	31-12-25	Significant (good)	CLOSED	Rachel Trawally	Sarah Jones & Fran Stead	Council of Governors	The governor induction offer (welcome session and handbook) has been reviewed and updated, alongside a wider training plan and informal support sessions to improve role clarity. The updated governor training sessions are scheduled from May to July with staggered times/days and a mix of in-person and Microsoft Teams delivery. Feedback on the Governor Timeout sessions was that they are useful, but the timing does not suit everyone; responses were low and as no	NOT REQUIRED FOR PHASE 2	Governor training materials, CoG effectiveness review output, time out session feedback. SID job spec to CoG meeting	NOT REQUIRED FOR PHASE 2	To be reported as closed

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		IA: The Trust should ensure that discussions during Governor's meetings are aligned with the activities, roles and responsibilities required of the governor role, as per their job descriptions.							alternative was suggested, sessions will continue as scheduled while we work with the Lead Governor to improve engagement and maximise benefit. Governor training materials have been updated to include the Senior Independent Director (SID) role, with the SID job specification shared in the February Council of Governors papers for clarity. A Council of Governors effectiveness review has been completed, with outcomes to be reported in the May papers.COMPLETE				
QS5.9	Effective Meetings	Committee: some reports were too operational. CoG: consideration on inclusivity & accessibility of reports.	30-09-26	Limited/ significant	CLOSED	Rachel Trawally	Fran Stead	Audit Committee Council of Governors	This work is part of the Integrated Governance Guide framework, which will be developed by the CG team in the comings months. The work includes training, standardisation,	To be superseded with new action on Integrated Governance Guide	Refreshed Integrated Governance Guide. Training materials for report writers. Updated report templates	NOT REQUIRED FOR PHASE 2	superseded by QS5.34. To be reported as closed

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									and acts as an information sharing guide to support colleagues, including templates. Opportunity to engage EDI colleagues to strengthen accessibility templates and guidance		and guidance and Integrated Governance Guide update. Evidence of EDI input		
QS5.13	Effective meetings	Committee & CoG: ensure timely circulation of paperwork, including presentations .	30-09-26	Significant (good)	NO PHASE 2	Rachel Trawally	Fran Stead	Committee's (all) Council of Governors	Work is aligned to action QS5.8. A Board agreed paperwork circulation process is in place which includes the dates of paperwork submission and circulation. There are some challenges still with paperwork being received in time, it has been agreed that Corporate Governance will circulate all received papers on the agreed circulation date. This will also be considered as part of the annual effectiveness review outcomes. Further work will	Phase 2 to be superseded with new action on Integrated Governance Guide	Integrated governance guide. Committee circulation deadline tracker. Annual effectiveness review outcomes feedback	NOT REQUIRED FOR PHASE 2	superseded by QS5.34. To be reported as closed

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									be undertaken as part of the Integrated Governance Guide refresh				
QS5.14	Effective Meetings	Committee & CoG: undertake annual review of membership & attendance, & work with the Chair to ensure all members & attendees contribute.	31-03-26	Significant (good)	CLOSED	Rachel Trawally	Committee Chair's Simon Lewis	Committee's (all) Council of Governors	This work is aligned to action QS5.12. Inductions for new NEDs will include attendance requirements, and the new chair will be working with NEDs on engagement and attendance. Attendance reports will be introduced by Corporate Governance from 1 April, issued to the Chair on a quarterly basis to track attendance throughout the year as opposed to at the end of the year only where it features within the Annual Governance Report. Some progress has been noted but it remains a risk to effective	NOT REQUIRED FOR PHASE 2	Attendance trackers from committee trackers. Annual attendance reporting through the annual effectiveness review report and annual report, andTerms of reference report March 2026 (see 5.11 and 5.12 folders for evidence)	NOT REQUIRED FOR PHASE 2	To be reported as closed

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									meetings. Action Complete for Phase 1				
QS5.17	Effective Meetings	Committee & CoG: make the work of the Board & Committees, Governors more visible.	30-09-26	Significant (good)	NO PHASE 2	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.	to close after phase 1 web updates complete	Governance and go see board report and to CoG. Screenshots internet updates. Board and CoG reports. Document on website updates	NOT REQUIRED FOR PHASE 2	To be reported as closed
QS5.22	Effective Meetings	CoG: review frequency of meetings.	31-03-26	Significant (good)	CLOSED	Rachel Trawally	Sarah Jones	Council of Governors	National guidance suggests 4 CoG meetings per year, which the Trust is in line with. Benchmarking undertaken, results show other foundation trusts having between 2 & 4 meetings per year. More work to do on promotion of Annual Members' Meeting being recognised by governors as one of their business meetings. The	NOT REQUIRED FOR PHASE 2	Benchmarking analysis. CoG meeting schedule. CoG effectiveness review outputs. Governor training and engagement evidence	NOT REQUIRED FOR PHASE 2	To be reported as closed

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									annual effectiveness review for CoG is currently being undertaken and being presented to May CoG and any feedback from this will be considered and added to the updated well led action plan.Extension request to July 2026 to allow for feedback from effectiveness review to be embedded. Actions from the effectiveness review will be added to the well led development plan. The outcomes have been reported to CoG in may and the action can now be closed. Phase 1 complete				

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Training and role delivery

Following the conclusion of the 2026 Governor elections, newly appointed Governors will be invited to take part in an induction session to support them in their new role. Further details will be shared in the coming weeks.

AdminControl Survey Results

The AdminControl Implementation Feedback Survey received 15 responses between 26 June and 31 July 2026, with feedback from a broad range of users. Overall findings were positive, with 67% rating their experience as good or excellent and 73% finding meeting papers very or somewhat easy to access. Areas identified for improvement included user guidance, navigation, access to current papers, loading speeds and accessibility. Targeted actions are being progressed to strengthen user support, make practical improvements to the user experience and investigate the specific technical and accessibility issues raised.

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Airedale NHS Foundation Trust

Bradford District Care NHS Foundation Trust

Bradford Teaching Hospitals NHS Foundation Trust

The future of the Governor role – Health Modernisation Bill

Airedale NHS FT, Bradford District Care NHS FT and Bradford Teaching Hospital NHS FT

Feedback from Workshop

held on 10 August 2026

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ACTasONE

NHS Airedale NHS Foundation Trust

NHS Bradford District Care NHS Foundation Trust

NHS Bradford Teaching Hospitals NHS Foundation Trust

Attendees

Trust	Attendee	Role
AFT	Linda Dobson	Lead Governor (Keighley Central/East)
	Chris Church	Stakeholder Governor (Pendle BC)
	Peter Home	Public Governor (Bingley)
	Sheila Lambert	Public Governor Keighley West & Worth Valley)
	Chris Nolan	Public Governor (West Craven)
	Lee Speight	Public Governor (Bingley Rural)
BTHFT	Mark Chambers	Lead Governor (Patient Governor)
	Daniel Balaz	Public Governor (Shipley)
	Farideh Javid	Public Governor (Bradford South)
	Bryan Machin	Non-Executive Director and SID
	Andy Waller	Public Governor (Rest of England & Wales)
BDCFT	Mike Lodge	Lead Governor (Rest of England)
	Trevor Ramsey	Public Governor (Bradford West)
Other attendees	Sarah Jones	Chair – AFT & BDCT
	Jane Osler	Interim Head of Corporate Governance, AFT
	Jasmine Powell	Corporate Governance & Membership Manager, AFT
	Holly Close	Membership Manager, BDCFT
	Fran Stead	Trust Secretary, BDCFT

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Presentation themes/topics:

- **Health Modernisation Bill – key aims**
- **Governance changes**
- **Future scenarios and transfer of statutory powers**
- **Engagement and involvement – links to strategy and service developments**
- **Discussion:**

What should the future look like?

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NHS Airedale NHS Foundation Trust

NHS Bradford District Care NHS Foundation Trust

NHS Bradford Teaching Hospitals NHS Foundation Trust

Initial thoughts from Lead Governors:

Principles:

- Lay voice is essential
- FTs to make things ‘open’ as a default
- All FT’s have developed different models and ways of working
- Public engagement is crucial

- Good to see all 3 FTs working together – opportunity to learn fron collaborate together
- Need to take advantage of Place-based working
- Confidence in the consultation exercise



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NHS Airedale NHS Foundation Trust

NHS Bradford District Care NHS Foundation Trust

NHS Bradford Teaching Hospitals NHS Foundation Trust

Initial thoughts from Lead Governors:

Governance:

- Recognition that appropriate governance is fundamental and wish to see an improvement
- Current model is 22 years old and much has changed.
- Concern for local accountability and how that will be retained
- Concern that proposals could see Boards ‘marking their own homework’
- How do we engage with NEDs in the future model and who/how assesses their performance?
- How do we hold FTs to account in the future – will there be a communications channel?

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Initial thoughts from Lead Governors:

General points:

- Significant lack of knowledge and understanding about the proposal to remove Governors
- The degree of change is questionable – it's only the statutory responsibilities being removed
- Question around who will the new 'governors' will be
- Capabilities, experience and skills within the body of the Council have been disregarded and their contribution undermined
- The role of 'the people' should not be underestimated
- Need to lead and shape our future

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NHS Airedale NHS Foundation Trust

NHS Bradford District Care NHS Foundation Trust

NHS Bradford Teaching Hospitals NHS Foundation Trust

Discussion Feedback: *What should the future look like?*

- Feedback forums and processes already in place - the future model needs have a structure and a link into existing arrangements
- Governor's interest and passion for the role needs to be valued
- Where will accountability sit in the constitution? - needs to be simple and engaging
- Involvement in the community needs to be proactive – attendance at events (newsletter not sufficient)
- How will the shared learning work? – systems and processes
- Need to retain the scrutiny role so Boards can be confident in their forward plans
- What can we create that will help the Board to act in the community's best interests
- Potential for establishing Expert Groups to support the Board functions
- How will 'governors' feedback to the Trust if they are not linked into the Trust?
- Communications should include being able to reach into and link with all 3 Trusts



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Airedale NHS Foundation Trust

Bradford District Care NHS Foundation Trust

Bradford Teaching Hospitals NHS Foundation Trust

Next Steps

- Presentation slide deck to be circulated to all Governors
- Discussion at each CoG
- Agreed to schedule another workshop session in the Autumn (venue BDCFT)
- Agreed to share best practice across all 3 Trusts
- Feedback to follow from the NHS Alliance Workshops held in August



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THANK YOU TO ALL GOVERNORS FOR YOUR CONTRIBUTION

Bradford District Care
NHS Foundation Trust

How the Council of Governors Does Business

Council of Governors Etiquette

The key messages the reader should note about this document are:

1. This document sets out the standards of conduct and behaviour expected of all Governors when they are attending meetings and Trust Go See Visits.
2. This procedure complements the Policy and Procedure for Council of Governor Conduct and Behaviour.
3. This procedure sets out what is expected of Governors and the Corporate Goverance Team.

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Issue Date	dd/mm/yyyy	Review Date	dd/mm/yyyy

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INTRODUCTION

This procedure has been developed to support Governors in their role and should be read alongside the Policy and Procedure for Council of Governor Conduct and Behaviour. It provides practical guidance on expected standards of behaviour when attending Council of Governors meetings, observing Board Sub-Committee meetings, and participating in Trust Go See Visits.

This should also be read in conjunction with the Standing Order for the Council of Governors (Annex 6 of the Constitution) as this sets out in detail the governance arrangements for the operation of a Council of Governors' meeting of someone in public life, including the need to declare any conflict of interest.

This document has been developed to support effective meetings by helping members remain focussed on their duties and on how they contribute during discussions. It also sets out the standards of behaviour expected at Council of Governors' meetings, ensuring individuals demonstrate the high level of conduct required and act in line with the Trust's values. In addition, the document clarifies the expectations for Governors during Trust Go See Visits and outlines their responsibilities when observing Board Sub-Committee meetings.

Where there is any inconsistency between this procedure and the Constitution, the Constitution shall prevail.

1 ROLE OF THE GOVERNOR DUTIES AND LIABILITIES

Notwithstanding any statutory responsibilities and obligations imposed by NHS England or their successor body the role of the governor and the Council of Governors is to hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors.

In doing this governors should be guided by, and represent the interest of, all patients, members, local public and staff.

The role is set out in detail in the Trust's Constitution; Monitor's NHS Foundation Trust Code of Governance; and Your statutory duties: A reference guide for NHS Foundation Trust Governors and Addendum - System working and collaboration: role of foundation trust councils of governors October 2022.

The Council of Governors is not responsible for the day-to-day management of the Trust, nor may the Council of Governors take decisions about the commitment or use of Trust resources. In carrying out its work the Council of Governors needs to take account of and respect the statutory duties and liabilities of the Board of Directors and individual directors, as detailed in the Constitution and statute.

2 Duties

Chair of the Trust

The Chair of the Trust will be the final arbiter in breaches of the principles and requirements of this procedure.

Trust Secretary

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The Trust Secretary will ensure that all governors are aware of the requirements of this procedure and that it remains fit for purpose in accordance with the needs of the Council of Governors.

Governors
Must abide by the requirements of the procedure to ensure high standards of conduct are maintained at meetings of the Council and apply the principles to any other meeting they may be part of.

3 Council of Governors Meeting Etiquette

Governors

During meetings, Governors are expected to give their full attention to proceedings, listen respectfully to others, avoid unnecessary distractions, and contribute in a way that supports constructive and effective discussion.

Governors are expected to follow the Code of Conduct and Standards of Behaviour for Governors (CG-0010).

Governors must declare any actual, potential or perceived conflict of interest, or any pecuniary interest, in relation to an item on the agenda.

Corporate Governance Team

In conjunction with the Corporate Governance Team the Trust Secretary will:

- Ensure the meeting environment is appropriate and that 'housekeeping' arrangements have been executed properly
- Ensure there is a record of the meeting for the purpose of the minutes. Meetings will normally be recorded to support accurate minuting
- Assist the Chair with any points of governance or arrangements in respect of the meeting.

4 PROTOCOL FOR GOVERNOR OBSERVATION OF BOARD SUB-COMMITTEES

4.1 Purpose

Governors are invited to observe Board Sub-Committees as part of the statutory role of holding Non-Executive Directors to account. This is an opportunity to observe how assurance is gained rather than to influence discussion or decisions. It also provides a valuable chance to learn more about the Trust and its services.

When carrying out this role, Governors are expected to act in the best interests of the Trust and in line with its value, as well as the Policy and Procedure for Council of Governor Conduct and Behaviour.

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4.2 Key Principles of Governors Observation at Board Sub-Committees

- From the start of the new financial year (1 April), the Corporate Governance Team will invite all Governors to express their interest in observing a Board Sub-Committee for the new financial year

- Governors will continue to be approached until all committees have an observer in place

- Governors who are interested in observing a Board Sub-Committee will email the Corporate Goverance Team at corporate.governance@bdct.nhs.uk

- Each Committee may have up to two Governor observers. Governors do not count toward quorum

- A governor can be an observer for a fixed term of 12 months (or until the end of their Term of Office if their end date is before the 12 months end point)

- To allow for as many Governors as possible to undertake this role, we encourage a variety of Governors to take up this role

- Where more than two Governors express interest in the same committee, a combined and fair approach will be used. Governors with no previous committee-observation experience will be prioritised to ensure equal access to development opportunities. If more than two governors still remain after this, a neutral random draw will determine who is appointed. Any governors not selected will be added to a rotation list, so they are next in line when a vacancy arises, ensuring the process remains transparent, consistent and equitable

- Governors must notify the Corporate Governance Team of their attendance for each meeting, including where they are attending on a one-off basis or as part of an agreed annual arrangement.

- Governors should observe objectively, being mindful of the boundaries of the role and maintaining confidentiality and professionalism throughout. Participation in discussions is not expected. A short reminder email will be shared in advance to help with this

- It is the role of the Non-Executive Directors, rather than Governors, to form a view on or request further assurance about the content of any report considered at the meeting.

- Paper will be provided to help Governors follow the meeting through AdminControl. Governors attend in an observing role and will not participate but there may have opportunities for follow-up conversations after the meeting.

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- Observers are encouraged to report back to the Council of Governors to ensure transparency and shared learning.

5 OBSERVING PUBLIC BOARD

- Governors will continue to be invited to observe all Public Board meetings as and when they can.
- There will be no restrictions on how many Governors can attend. To support attendance, Governors should contact the Corporate Governance Team in advance who will confirm the meeting details with them

6 PROTOCOL FOR GOVERNOR OBSERVATIONS AT GO SEE VISITS

6.1 Purpose

Governors are invited to observe Non-Executive Directors within their Go See Visits as part of the statutory role of holding Non-Executive Directors to account. Go See Visits are an opportunity for Executive Directors, Non-Executive Directors, and Leaders across the Trust to gain an insight into the day-to-day workings of the Trusts services that they are visiting, but also to discuss potential improvements within that service.

6.2 Key Principles of Governors Observation at Go See Visits

- Go See visits should be approached as an opportunity to observe and learn, helping to build understanding rather than to inspect or formally question for assurance.

- Visits are intended to support Governors in their statutory role, including holding Non-Executive Directors to account. They provide an opportunity to see how Non-Executive Directors carry out their role and how assurance is gained.

- Governors are asked to maintain a respectful and professional presence at all times. Go See visits are not intended to assess staff performance or operational decisions.

- Go See visits are a valuable opportunity to learn more about Trust services, including their challenges and successes. This helps support Governors in the role of representing constituents.

- During Go See visits, colleagues may discuss confidential material, and Governors must maintain that confidentiality. Occasionally matters discussed include sensitive or person-identifiable information, and Governors may be asked to leave the room for the duration of such discussions, to maintain the person's confidentiality

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7 DEFINITIONS

Definitions of terms significant to this policy are set out in the table below.

Term Used	Definition
Governor	Means a person elected or appointed within an NHS Foundation Trust
Committees	Means a committee appointed by the Board or the Council of Governors with specific terms of reference, chair, and membership approved by Board
Go See Visits	The Go See visit offers an opportunity for Leaders to leave their daily routine to get an overview of what is going on in the workplace, offering the ability to gain insights into potential improvement opportunities.

8 APPENDIX A: DOCUMENT PRODUCTION DETAILS

Title:	How the Council of Governors Does Business – Council of Governors Etiquette
Version:	1.0
Name and Title of Responsible Director:	Fran Stead, Trust Secretary
Name and Title of Responsible Deputy Director/ General Manager:	Rachel Trawally, Corporate Governance Manager and Deputy Trust Secretary
Name and Title of Author:	Holly Close, Corporate Governance Manager
Title of Responsible Committee / Group (or Trust Board):	Council of Governors
Persons/Groups/Committees consulted:	Not Applicable
Service User, Patient and Carer consultation:	Not Applicable
Target Audience:	Council of Governors
Approved by:	Council of Governors
Date Approved:	TBC
Ratified by:	TBC
Date Ratified:	TBC
Date Issued:	TBC
Review Date:	TBC
Frequency of Review:	Yearly
Copies available from:	Connect, Corporate Governance Team
Where is previous copy archived (if applicable):	Corporate Governance Team files
Amendment Summary:	Not applicable as newly introduced document.

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Amendment detail:

Amendment number	Page	Subject

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9 APPENDIX B: EQUALITY IMPACT ASSESSMENT (EQIA)

Area	Response
Policy/Procedure	Procedure
Manager	Rachel Trawally, Corporate Goverance Officer and Deputy Trust Secretary
Directorate	Corporate Governance
Date	15/01/2026
Review date	TBC
Purpose of Policy	This document sets out the standards of conduct and behaviour expected of all Governors when they are attending meetings and Trust Go See Visits.
Associated frameworks e.g. national targets NSF's	N/A
Who does it affect	Governors
Consultation process carried out	To be shared with Lead and Deputy Lead Governor
QA Approved by	??

Equality protected characteristic	Impact Positive	Impact Negative	Rationale for response
Age	Y	*N*	The policy/procedure applies equitably to governors of all ages and does not impose age-based criteria or restrictions. Flexibility around meeting attendance, reasonable cause for absence, and the availability of remote participation support inclusion of both working-age and older governors, helping to mitigate any potential indirect age-related disadvantage.
Disability	Y	*N*	The policy is applied consistently to all governors and does not place disabled individuals at a disadvantage. The Trust is committed to making reasonable adjustments to enable governors with disabilities to participate fully, including alternative formats for documentation, accessible meeting arrangements, and flexibility in how duties are undertaken where required.
Gender Reassignment	Y	*N*	The policy is inclusive and applies equally regardless of gender identity. Expectations of conduct, participation, and professionalism are neutral and aligned to the Trust's values of dignity and respect, supporting an inclusive environment free from discrimination or harassment.
Race	Y	*N*	The policy sets out standards of conduct and governance that are applied consistently to all governors, irrespective of race or ethnicity.
Religion or Belief	Y	*N*	The policy does not restrict or disadvantage any individual on the basis of religion or belief. Where required, reasonable consideration can be given

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Equality protected characteristic	Impact Positive	Impact Negative	Rationale for response
			to meeting arrangements or participation to support religious observance, in line with the Trust's commitment to equality and fairness.
Pregnancy & Maternity	Y	*N*	The policy is not expected to have a negative impact on individuals who are pregnant or on maternity leave. Flexibility in attendance, meeting formats, and reasonable cause provisions support ongoing inclusion and participation where appropriate, helping to mitigate any potential disadvantage.
Sex	Y	*N*	The policy applies equally to all governors regardless of sex. It promotes respectful behaviour, fairness, and equality in governance activity.
Sexual Orientation	Y	*N*	The policy is neutral in relation to sexual orientation and promotes an environment of respect, dignity, and inclusion. There are no provisions that disadvantage individuals based on sexual orientation, and the expectations set support equality and fair treatment for all governors.

Equality Analysis SIGN - OFF		
Have any adverse impacts been identified on any equality groups which are both highly significant and illegal?		No
Are you satisfied that the conclusions of the EqIA Screening are accurate? The Trust will publish a summary of the impact analysis carried out to meet the duty and make this available to the public on the Trust Internet site.		Yes
Completed by Manager	Rachel Trawally	
Q A approved		
Director approved		

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10 APPENDIX C: SUSTAINABILITY IMPACT ASSESSMENT (SIA)

		Green Plan Objective (tick all that apply)	
Policy title:	How the Council of Governors Does Business	Embed a Trust-wide approach to sustainability	✓

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Person completing	Holly Close	Consider the environmental impacts of everything we do	✓
Responsible team	Corporate Governance Team	Reduce carbon emissions	
Directorate	Corporate Governance	Reduce consumption and waste	
Date assessment completed		Make a positive impact on our people and communities	✓

Sustainability Theme		Impact	Comments
	**CARBON**	Neutral	See travel below
	**WATER**	No Impact	
	**WASTE**	No Impact	This is assuming governors do not print papers for meetings. If documents are printed and discarded as confidential waste, there will be a small negative impact of the role on waste arisings.
	**CAPITAL WORKS**	No Impact	
	**TRAVEL**	Negative	Small negative impact of participation in meetings and go see visits. This is higher for face to face involving (single occupancy) car travel. Mitigated by meetings being online and visits organised to minimise travel.
	**PROCUREMENT/ SUSTAINABLE USE OF RESOURCES -**	No Impact	
	**MODELS OF CARE**	No Impact	
	**ADAPTATION**	No Impact	

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	PEOPLE	No Impact	

SIA sign off		
Are you satisfied that mitigating actions have been identified to address any adverse impacts		**Y**/N
Do you confirm that you will review mitigating actions within a reasonable timeframe?		**Y**/N
Completed by	Holly Close	Corporate Governance Officer
SIA approved	Emma Clarke	Energy, Waste and Sustainability Manager
Director approved	Name	Role

TRUST-WIDE PROCEDURE DOCUMENT COMPLIANCE CHECKLIST (NOT AN APPENDIX AND WILL BE REMOVED FROM FINAL VERSION OF POLICY WHEN ISSUED)

The Trust-wide Procedure Compliance Checklist is available to the author to ensure a uniform approach to its development and management and should be utilised as a source of assurance by them and the responsible director or deputy director for it to ensure that all requirements are met. It will not be included in the final version of the policy and should be removed from the final version of it and filed separately by the author or policy lead.

Failure comply with BDCFT's Trust-wide procedure template may mean that the document cannot proceed to approval and ratification.

	How the Council of Governors Does Business – Council of Governors Etiquette	**Yes/No/ Unsure**	**Comments**
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is policy, procedure or strategy?	Y	
2.	**Rationale**		
	Are reasons for development of the procedural document stated, e.g. in the Introduction or Scope sections?	Y	
3.	**Development Process**		

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	How the Council of Governors Does Business – Council of Governors Etiquette	**Yes/No/ Unsure**	**Comments**
	Is the method described in brief e.g. in the Introduction section or Appendix A?	Y	
	Are people involved in the development identified, e.g. in the Production and Review Details (Appendix A)?	Y	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	
	Is there evidence of consultation with stakeholders, service users, patients or carers, e.g. in the Production and Review Details (Appendix A), if required?		This will be shared with Lead and Deputy Lead Governor once final draft has been confirmed within the team.
	Have the requirements of the following been taken into account where applicable, if appropriate: Mental Health Act Mental Capacity Act Care Programme Approach (CPA) Guidance	N/A	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous, e.g. in Appendix A?	Y	
	Are the intended outcomes described in the Core Content section?	Y	
	Are the statements clear and unambiguous?	Y	
	Are any amendments compared to a previous version of the document summarised or where appropriate listed in more detail in the Production and Review Details (Appendix A)?	N/A	
	The Trust is transitioning services to agile working: please consider and include implications for agile workers and the management of agile within all policies and procedures.	N/A	
	Accessible Information Standard. All organisations that provide NHS or adult social care are legally required to meet the standard law (Section 250 of the Health and Social Care Act 2012) and to ensure that people who have a disability, impairment or sensory loss are asked if they have any accessible information needs and if they do that these needs are met. This might include making sure that people get information in different formats if they	Y	

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	How the Council of Governors Does Business – Council of Governors Etiquette	Yes/No/ Unsure	Comments
	need it, for example in large print, braille, easy read or via email or that people get support with communication that they need, for example support from a British Sign Language (BSL) interpreter, deafblind manual interpreter or advocate. Under the Standard organisations must do the following five things. So please consider when writing your policy and any associated procedures how you will: 1. Ask people if they have any information or communication needs and how these needs might be met. 2. Record those needs clearly and in a set way in the appropriate clinical system. 3. Highlight or flag the person's file or notes so it is clear that 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. For more information and support with the Accessible Information Standard contact Fiona Sherburn, Deputy Director of HR & Workforce Development.		
	Information Governance Information governance and GDPR has been considered in terms of information sharing. For more information about Information Governance contact: Gaynor Toczek, Information Governance & Security Manager, Administration.	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly throughout and in the References and Appendices?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6.	**Approval and Ratification**		

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	How the Council of Governors Does Business – Council of Governors Etiquette	**Yes/No/ Unsure**	**Comments**
	Does the document identify which committee/group will approve it, e.g. in the Production and Review Details (Appendix A)?	Y	
	If appropriate has the joint Human Resources/Staff Side Committee (or equivalent) approved the document and is this sated in the Production and Review Details (Appendix A)?	N/A	
	Does the document identify which committee/group will ratify it in the Production and Review Details (Appendix A)?	Y	
7.	**Dissemination and Implementation**		
	This should be done as per the guidance on the Policy and Trust-Wide Procedure Development and Management Policy.	Y	
8.	**Document Control**		
	Does the document identify where it will be held in the Production and Review Details (Appendix A)?	Y	
	Have archiving arrangements for superseded documents been addressed, in the Production and Review Details (Appendix A)?		
9.	**Review Date**		
	Is the review date identified in the Production and Review Details (Appendix A)?		This will be done after the procedure has been ratified
	Is the frequency of review identified in the Production and Review Details (Appendix A)? If so is it acceptable?		This will be done after the procedure has been ratified
10.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document, in the Production and Review Details (Appendix A)?	Y	

Author Approval			
The Author should complete, sign and date this Policy Document Compliance Checklist to show they have applied it.			
Author	Holly Close	Date	15/01/26
Signature	h.close		

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Bradford District Care
NHS Foundation Trust

Policy and Procedure for Council of Governor Conduct and Behaviour

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The key messages the reader should note about this document are:

1. This document sets out the standards of conduct and behaviour expected of all Governors.
2. This document provides support to Governors about their role and fulfilling their statutory duties.
3. This code applies at all times when Governors are carrying out the business of the Trust or representing the Trust, and it is a condition of office that each Governor agrees to.

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Issue Date	dd/mm/yyyy	Review Date	dd/mm/yyyy

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1 INTRODUCTION

The purpose of this policy is to provide clear guidance on the standards of conduct and behaviour expected of all governors.

This policy, with the Code of Conduct for Directors and the NHS Constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Foundation Trust. The policy is intended to operate in conjunction with the Constitution, Standing Orders, and NHS England's Code of Governance. The policy applies at all times when Governors are carrying out the business of the Trust or representing the Trust.

Governors shall, at all times, comply with the Constitution, as amended from time to time, the Trust's Provider Licence, this policy, and any guidance and directions issued from time to time by NHS England, the Independent Regulator of Foundation Trusts. This policy shall not limit or invalidate the duty of Governors to act in accordance with the Constitution and the Trust's Provider Licence.

Where there is any inconsistency between this policy and the Constitution, the Constitution shall prevail.

2 ROLE OF THE GOVERNOR DUTIES AND LIABILITIES

Notwithstanding any statutory responsibilities and obligations imposed by NHS England or their successor body the role of the governor and the Council of Governors is to hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors.

In doing this governors should be guided by, and represent the interest of, all patients, members, local public and staff.

The role is set out in detail in the Trust's Constitution; Monitor's NHS Foundation Trust Code of Governance; and Your statutory duties: A reference guide for NHS Foundation Trust Governors and Addendum - System working and collaboration: role of foundation trust councils of governors October 2022.

The Council of Governors is not responsible for the day-to-day management of the Trust, nor may the Council of Governors take decisions about the commitment or use of Trust resources. In carrying out its work the Council of Governors needs to take account of and respect the statutory duties and liabilities of the Board of Directors and individual directors, as detailed in the Constitution and statute.

3 Agreement

Governors are asked to sign and return a statement to the Trust Secretary confirming their agreement to this Policy of Conduct. The Constitution sets out that Governors who are unable to do this may be unable to continue in the role.

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It is also important that all required documentation, including declarations of interest, is completed and kept up to date. Where this is not possible, this may affect a Governor's ability to continue in post, in line with the Trust's Constitution.

Council of Governors – Roles and Responsibilities

- As a Governor, you will be expected to contribute the time necessary to take part in meetings, training and other key responsibilities.
- As a Governor you are responsible for representing the interests of the Trust's members as a whole, the public and partner organisations and for regularly feeding back information about the Trust, its vision, and its performance to the constituencies and the stakeholder organisations that either elected or appointed you.
- The Council of Governors are responsible for holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, including ensuring that the Board of Directors acts in such a manner that the Trust does not breach its Provider Licence. In carrying out its work, the Council of Governors needs to take account of and respect the statutory duties and liabilities of the Board of Directors and individual Directors.
- Governors should make every effort to attend the meetings of the Council of Governors where practicable.

  Where a Governor is not able to attend a meeting, they shall submit apologies to the secretariat for the Council of Governors in advance wherever possible. The Constitution provides that a Governor shall immediately cease to hold office if they have failed to attend two meetings of the Council of Governors in any financial year, unless the other Governors are satisfied that the absences were due to reasonable causes and that they will be able to start attending meetings of the Council of Governors again within such a period as the other Governors consider reasonable.
- Governors are encouraged to follow the meeting etiquette as set out in the Procedure relating to how the Council of Governors does business – Council of Governors meeting etiquette.
- The role is set out in detail in the Constitution, Standing Orders, NHS England's Code of Governance and is further addressed in NHS England's guidance for Governors.

3.1 General Principles

As a Governor of the Trust, you will be expected, at all times, to:

1. Act in the best interests of the Trust;

2. Comply with the Trust's Constitution, including the Standing Orders for the Council of Governors, and the Trust's Provider Licence

3. Act in line with the Trust's values, principles, vision and objectives, demonstrating the behaviours set out in 'We Care, We Listen' and 'We Deliver'

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4. Comply with the Trust's policies and procedures;

5. Contribute to the workings of the Council of Governors to enable it to fulfil its functions;

6. Recognise that the Council of Governors exercises collective decision-making and that Governors do not exist in isolation;

7. Acknowledge that, other than when you are attending meetings and events as a Governor, you have no more rights or privileges than any other member of the Trust;

8. Recognise that the Council of Governors does not have a managerial role within the Trust;

9. Value, respect and treat with dignity and fairness all Governor colleagues, all members of the Trust's staff that you may come into contact with and all members of the public accessing the Trust's facilities, all service users, relatives, carers and partner organisations;

10. Respect the confidentiality of the information you receive in your role as Governor especially the confidentiality of individual service users of the Trust;

11. Must not seek to prevent a person from gaining access to information to which they are legally entitled;

12. Act with integrity and objectivity without any expectation of personal benefit;

13. Represent the constituency that elected you or the organisation that appointed you, while ensuring members are kept informed and able to influence services;

14. Ensure that the best interests of the public, service users, and colleagues are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;

15. Act as a positive ambassador for the Trust, working collaboratively with colleagues and partners, and ensuring your conduct is always respectful, fair, and inclusive;

16. Attend meetings of the Council of Governors and required training events;

17. Use the Trust's dedicated Board-pack system to view and annotate meeting papers, unless you have specific accessibility needs that require the papers to be provided in an alternative format

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18. Seek to ensure that nobody is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin;

19. Promote social inclusion through your role as Governor, so as to ensure that the development and delivery of initiatives do not prejudice any part of the community on the grounds of age, sex, disability, marital status, sexual orientation or religious belief. You must not promote any personal or political view that undermines such objective;

20. Not make, permit or knowingly allow to be made any untrue or misleading statement relating to your own duties as a Governor or the functions of the Trust;

21. Support and assist the Accounting Officer of the Trust in their responsibility to answer to the Independent Regulator, Commissioners and the public in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets; and

22. Uphold the seven Nolan principles of public life, which are listed below. A further detailed description is contained with Appendix D:

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

3.2 Eligibility to be a Governor

Governors must continue to meet the Trust's eligibility criteria throughout their term of office. Governors are expected to notify the Trust Secretary as soon as reasonably practicable of any change in circumstances which may disqualify them from remaining in office.

In accordance with the Trust's Constitution, a Governor who fails to attend two meetings of the Council of Governors in any financial year may be removed from office unless the remaining Governors are satisfied that:

(a) the absences were due to reasonable causes; and

(b) they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

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3.3 Personal Conduct

Governors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute. Specifically, Governors must treat others

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with respect; not breach the equality enactments and not bully any person. Governors must not seek to use their position improperly to confer an advantage or disadvantage on any person and must comply with the Trust's rules on the use of its resources. Finally, Governors must have regard to advice provided by the Chair and Trust Secretary pursuant to their statutory duties.

3.4 Confidentiality

Governors must comply with the Trust's confidentiality policies and procedures. Governors must not disclose any confidential information, except in specified lawful circumstances and only when internal processes have been exhausted. The Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation such as defined in the GDPR, which must be followed at all times by the Council of Governors and individual governors.

3.5 Fit and Proper Person Test

It is a condition of the Trust's Provider Licence that each Governor serving on the Council of Governors is a `fit and proper person' as defined in the Trust's Provider Licence. Governors must certify on appointment, and each year that they are / remain a fit and proper person.

A provision relating to the fit and proper person test is contained in the `declaration of interest' form.

3.6 Training and Development

The Trust is committed to providing appropriate training and development opportunities for Governors to enable them to carry out their role effectively. Governors are expected to undertake and to participate in training and development opportunities that have been identified as appropriate for them.

As part of their responsibility to hold Non-Executive Directors to account, Governors may be invited to contribute constructive feedback to relevant appraisal processes. Governors should also participate in any appraisal activities and skills audits undertaken by the Trust to support effective governance and continuous improvement.

3.7 Reasonable Adjustments

The Trust will make reasonable adjustments to ensure that Governors are able to fulfil their duties.

3.8 Conflicts of Interest

Governors have a duty to avoid a situation in which they have a direct or indirect interest that conflicts or may conflict with the interests of the Trust. Governors must not accept a benefit from a third party by reason of being a Governor or doing (or not doing) anything in that capacity. Governors must not offer a benefit to a third party by reason of being a Governor for doing (or not doing) anything in that capacity.

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Governors must declare the nature and extent of any interest at the earliest opportunity. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. It is then for the Chair to advise whether it is necessary for the Governor to refrain from participating in discussion of the item or withdraw from the meeting. Failure to comply is likely to constitute a breach of this Policy and the Trust's constitution.

3.9 Register of Interests

Governors are required to register all relevant interests on the Trust's register of interests in accordance with the provisions of the Constitution. It is the responsibility of each Governor to update the register entry if their interests change. A pro forma is included in the induction pack.

Failure to register an interest in a timely manner may constitute a breach of this Policy.

3.10 Qualification to Vote

All elected Governors shall make the declarations required by virtue of the Constitution so as to declare that they are eligible to vote.

3.11 Non-Compliance with this policy

Non-compliance may result in any or all of the following actions:

1. The Chair of the Trust (or in their absence, the Deputy Chair) shall be authorised to take such action as may be immediately required, including the exclusion of the Governor concerned from any meeting.

2. The Council of Governors may decide at a formal meeting by a majority of those in attendance to lay a formal charge of misconduct.

3. The Governor concerned shall be notified of the specific details of the conduct, which is deemed to be misconduct and shall be given the opportunity to respond to the charge. The Governor may be invited to attend at a meeting of the Council and address the Council in person.

4. The Council shall consider any response provided by the Governor and shall decide at a formal meeting by a majority of those in attendance whether to uphold the charge.

5. If the charge is upheld, the Council may impose such sanctions as deemed appropriate, including removing the Governor from office if considered appropriate in accordance with the Constitution.

3.12 Interpretation of the Policy

Questions and concerns about the application of this policy should be raised with the Trust Secretary. At meetings, the Chair will be the final arbiter of interpretation of the Policy.

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3.13 Expenses

The position of Governor is unremunerated, though reasonable out-of-pocket expenses are paid. Please refer to the Trust's policy on Governor expenses and how to claim for reimbursement for costs incurred on behalf of the Trust

3.14 Media

Ensure that at no time or for any reason no contact is made with the press or media in any official capacity as a Governor unless authorised to do so by the Board of Directors or the Trust's Communication Department; and if approached by the press or media direct all enquiries to the Trust's Communication Department.

3.15 Changes to the Policy

Changes may be recommended by the Council of Governors but the policy may be altered only with the approval of a simple majority of both the Council and the Board of Directors.

This policy has been agreed by the Council of Governors. The Trust Secretary will lead periodically a review of the Code. It is for Governors to agree to any amendments or revisions to the Code.

4 DEFINITIONS

Definitions of terms significant to this policy are set out in the table below.

Term Used	Definition
Fit and Proper Person Test	The Trust's Licence section G4, paragraph 1 requires all governors to be fit and proper in order to hold a public office.
Nolan Principles	The Nolan Principles, also known as the 7 principles of public life, are a set of ethical standards for individuals in public service
Governor	Means a person elected or appointed within an NHS Foundation Trust

5 EQUALITY IMPACT ASSESSMENT

The Trust has no intent to discriminate and endeavours to develop and implement policies that meet the diverse needs of our workforce and the people we serve, ensuring that none are placed at a disadvantage over others. Our philosophy and commitment to care goes above and beyond our legal duty to enable us to provide high-quality services. Our Equality Analysis and equality monitoring is a core service improvement tool which enables the organisation to address the needs of disadvantaged groups. The aim of Equality analysis is to remove or minimise disadvantages suffered by people because of their protected characteristics.

An impact assessment has been undertaken to consider the need and assess the impact of this Policy document and is evidenced at Appendix B.

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6 APPENDIX A: DOCUMENT PRODUCTION DETAILS

Title:	Code of Conduct for the Governors of the Trust
Version:	1.0
Name and Title of Responsible Director:	Fran Stead, Trust Secretary
Name and Title of Responsible Deputy Director/ General Manager:	Rachel Trawally, Corporate Governance Manager and Deputy Trust Secretary
Name and Title of Author:	Holly Close, Corporate Governance Manager
Title of Responsible Committee / Group (or Trust Board):	Council of Governors
Persons/Groups/Committees consulted:	Not Applicable
Service User, Patient and Carer consultation:	Not Applicable
Target Audience:	Council of Governors
Approved by:	Council of Governors
Date Approved:	TBC
Ratified by:	TBC
Date Ratified:	TBC
Date Issued:	TBC
Review Date:	TBC
Frequency of Review:	Yearly
Copies available from:	Connect, Corporate Governance Team
Where is previous copy archived (if applicable):	Corporate Governance Team files
Amendment Summary:	The Code of Conduct has been refreshed to align with other Trust documents. New hyperlinks have been added to key governance documents, and additional sections have been introduced covering Council of Governors etiquette, confidentiality, expenses, personal conduct and media guidance. The document now also includes an appendix outlining the Nolan Principles.

Amendment detail:

Amendment number	Page	Subject
1.	N/A	The Code of Conduct template has been revised to ensure alignment with other Trust documents.
2.	3 & 4	Amendment of 'Monitor' to 'NHS England' due to the merging of NHS organisations.
3.	3	Hyperlinks added in for Trust's Constitution, standing orders and Code of Governance for NHS Provider Trusts

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4.	4	Section related to the procedure for how the Council of Governors Does Business – Council of Governors Etiquette added into the agreement section
5.	6	Section added in relation to Confidentiality
6.	6	Hyperlink added in for Trust's confidentiality policies
7.	8	Section added in relation to Expenses
8.	8	Section added in relation to Personal Conduct
9.	8	Section added in relation to Media
10.	13	Appendix included about the Nolan Principles

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7 APPENDIX B: EQUALITY IMPACT ASSESSMENT (EQIA)

Area	Response
Policy/Procedure	Policy
Manager	Rachel Trawally, Corporate Goverance Officer and Deputy Trust Secretary
Directorate	Corporate Governance
Date	15/01/2026
Review date	TBC
Purpose of Policy	This document sets out the standards of conduct and behaviour expected of all Governors
Associated frameworks e.g. national targets NSF's	N/A
Who does it affect	Governors
Consultation process carried out	To be shared with Lead and Deputy Lead Governor
QA Approved by	??

Equality protected characteristic	Impact Positive	Impact Negative	Rationale for response
Age	Y	*N*	The policy/procedure applies equitably to governors of all ages and does not impose age-based criteria or restrictions. Flexibility around meeting attendance, reasonable cause for absence, and the availability of remote participation support inclusion of both working-age and older governors, helping to mitigate any potential indirect age-related disadvantage.
Disability	Y	*N*	The policy is applied consistently to all governors and does not place disabled individuals at a disadvantage. The Trust is committed to making reasonable adjustments to enable governors with disabilities to participate fully, including alternative formats for documentation, accessible meeting arrangements, and flexibility in how duties are undertaken where required.
Gender Reassignment	Y	*N*	The policy is inclusive and applies equally regardless of gender identity. Expectations of conduct, participation, and professionalism are neutral and aligned to the Trust's values of dignity and respect, supporting an inclusive environment free from discrimination or harassment.
Race	Y	*N*	The policy sets out standards of conduct and governance that are applied consistently to all governors, irrespective of race or ethnicity.
Religion or Belief	Y	*N*	The policy does not restrict or disadvantage any individual on the basis of religion or belief. Where

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Equality protected characteristic	Impact Positive	Impact Negative	Rationale for response
			required, reasonable consideration can be given to meeting arrangements or participation to support religious observance, in line with the Trust's commitment to equality and fairness.
Pregnancy & Maternity	Y	*N*	The policy is not expected to have a negative impact on individuals who are pregnant or on maternity leave. Flexibility in attendance, meeting formats, and reasonable cause provisions support ongoing inclusion and participation where appropriate, helping to mitigate any potential disadvantage.
Sex	Y	*N*	The policy applies equally to all governors regardless of sex. It promotes respectful behaviour, fairness, and equality in governance activity.
Sexual Orientation	Y	*N*	The policy is neutral in relation to sexual orientation and promotes an environment of respect, dignity, and inclusion. There are no provisions that disadvantage individuals based on sexual orientation, and the expectations set support equality and fair treatment for all governors.

Equality Analysis SIGN - OFF		
Have any adverse impacts been identified on any equality groups which are both highly significant and illegal?		No
Are you satisfied that the conclusions of the EqIA Screening are accurate? The Trust will publish a summary of the impact analysis carried out to meet the duty and make this available to the public on the Trust Internet site.		Yes
Completed by Manager	Rachel Trawally	
Q A approved		
Director approved		

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8 APPENDIX C: SUSTAINABILTY IMPACT ASSESSMENT (SIA)

		Green Plan Objective (tick all that apply)	
Policy title:	How the Council of Governors Does Business	Embed a Trust-wide approach to sustainability	
Person completing	Holly Close	Consider the environmental impacts of everything we do	
Responsible team	Corporate Governance Team	Reduce carbon emissions	
Directorate	Corporate Governance	Reduce consumption and waste	
Date assessment completed		Make a positive impact on our people and communities	✓

Sustainability Theme		Impact	Comments
	CARBON	No Impact	
	WATER	No Impact	
	WASTE	No Impact	
	CAPITAL WORKS	No Impact	
	TRAVEL	No Impact	
	PROCUREMENT/ SUSTAINABLE USE OF RESOURCES -	No Impact	

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	**MODELS OF CARE**	No Impact	
	**ADAPTATION**	No Impact	
	**PEOPLE**	No Impact	

SIA sign off		
Are you satisfied that mitigating actions have been identified to address any adverse impacts		**Y**/N
Do you confirm that you will review mitigating actions within a reasonable timeframe?		**Y**/N
Completed by	Holly Close	Corporate Governance Officer
SIA approved	Emma Clarke	Energy, Waste and Sustainability Manager
Director approved	Name	Role

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9 APPENDIX D: DECLARATION

Name: (please print) _____

I declare that I have read this Policy and Procedure and that I agree to abide by the principles and other terms contained within it. I understand that should I not do so, this may result in me being removed from the Council of Governors.

Signed: _____

Dated: _____

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10 APPENDIX E: NOLAN PRINCIPLES OF PUBLIC LIFE

- **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or material benefits for themselves, their family or their friends.

- **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their office.

- **Objectivity** – In carrying out public business, including making public appointments or recommending individuals for rewards and benefits, holders of public office should make choices based on merit alone.

- **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

- **Openness** – Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

- **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

- **Leadership** – Holders of public office should promote and support these principles by leadership and example.

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POLICY DOCUMENT COMPLIANCE CHECKLIST (NOT AN APPENDIX AND WILL BE REMOVED FROM FINAL VERSION OF POLICY WHEN ISSUED)

The Policy Document Compliance Checklist is available to the author to ensure a uniform approach to its development and management and should be utilised as a source of assurance by them and the responsible director or deputy director for it to ensure that all requirements are met.

The Policy Document Compliance Checklist will not be included in the final version of the policy and should be removed from the final version of it and filed separately by the author or policy lead.

Failure comply with BDCFT's standard policy template may mean that the policy cannot proceed to approval and ratification.

	Insert title of document being reviewed	**Yes/No/ Unsure**	**Comments**
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is policy, procedure or strategy?	Yes	
2.	**Rationale**		
	Are reasons for development of the procedural document stated, e.g. in the Introduction or Scope sections?	Yes	
3.	**Development Process**		
	Is the method described in brief e.g. in the Introduction, Scope sections or Appendix A?	Yes	
	Are people involved in the development identified, e.g. in the Production and Review Details (Appendix A)?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders, service users, patients or carers, e.g. in the Production and Review Details (Appendix A)?	Yes	Will be discussing with Lead and Deputy Lead Governor. Benchmarking undertaken
	Have the requirements of the following been taken into account where applicable: Mental Health Act Mental Capacity Act Care Programme Approach (CPA) Guidance	Yes	

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Insert title of document being reviewed		Yes/No/ Unsure	Comments
4.	**Content**		
	Is the objective of the document clear, e.g. in the Scope section?	Yes	
	Is the target population clear and unambiguous, e.g. in the Scope section or Appendix A?	Yes	
	Are the intended outcomes described in the Core Content section?	Yes	
	Are the statements clear and unambiguous?	Yes	
	Are any amendments compared to a previous version of the document summarised or where appropriate listed in more detail in the Production and Review Details (Appendix A)?	Yes	
	The Trust is transitioning services to agile working: please consider and include implications for agile workers and the management of agile within all policies and procedures.	N/A	
	Accessible Information Standard. All organisations that provide NHS or adult social care are legally required to meet the standard law (Section 250 of the Health and Social Care Act 2012) and to ensure that people who have a disability, impairment or sensory loss are asked if they have any accessible information needs and if they do that these needs are met. This might include making sure that people get information in different formats if they need it, for example in large print, braille, easy read or via email or that people get support with communication that they need, for example support from a British Sign Language (BSL) interpreter, deafblind manual interpreter or advocate. Under the Standard organisations must do the following five things. So please consider when writing your policy and any associated procedures how you will: 1. Ask people if they have any information or communication needs and how these needs might be met.	Yes	

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	Insert title of document being reviewed	Yes/No/ Unsure	Comments
	2. Record those needs clearly and in a set way in the appropriate clinical system. 3. Highlight or flag the person's file or notes so it is clear that 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. For more information and support with the Accessible Information Standard contact Fiona Sherburn, Deputy Director of HR & Workforce Development.		
	Information Governance Information Governance and data protection requirements have been considered to ensure that information sharing complies with the latest legal and regulatory standards. This includes adherence to the **UK General Data Protection Regulation (UK GDPR)**, the **Data Protection Act 2018**, and recent amendments introduced by the **Data (Use and Access) Act 2025**, which modernises aspects of UK data protection law. For further details on Information Governance, please contact: **IG Department** Email: IG.department@bdct.nhs.uk	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly throughout and in the References to External Documents, Associated Internal Documentation sections and Appendices?	Yes	
	Are key references cited?	N/A	
	Are supporting documents referenced?	N/A	
6.	**Approval and Ratification**		

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	Insert title of document being reviewed	Yes/No/ Unsure	Comments
	Does the document identify which committee/group will approve it, e.g. in the Production and Review Details (Appendix A)?	Yes	
	If appropriate has the joint Human Resources/Staff Side Committee (or equivalent) approved the document and is this sated in the Production and Review Details (Appendix A)?	N/A	
	Does the document identify which committee/group will ratify it in the Production and Review Details (Appendix A)?	Yes	
7.	**Dissemination and Implementation**		
	This should be done as per the guidance on the Policy and Trust-Wide Procedure Development and Management Policy.	Yes	
	Does the plan include the necessary training/support to ensure compliance, e.g. in the Training Needs Analysis section?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held in the Production and Review Details (Appendix A)?	Yes	
	Have archiving arrangements for superseded documents been addressed, in the Production and Review Details (Appendix A)?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable criteria, standards or KPIs to support the monitoring of compliance with and effectiveness of the document in the Monitoring Compliance and Effectiveness section?	N/A	
	Is there a plan to review or audit compliance with the document in the Monitoring Compliance and Effectiveness section?	Yes	
10.	**Review Date**		
	Is the review date identified in the Production and Review Details (Appendix A)?		Will be added when ratified

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	Insert title of document being reviewed	Yes/No/ Unsure	Comments
	Is the frequency of review identified in the Production and Review Details (Appendix A)? If so is it acceptable?		Will be added when ratified
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document, in the Production and Review Details (Appendix A)?	Yes	

Author Approval			
The Author should complete, sign and date this Policy Document Compliance Checklist to show they have applied it.			
Author	Holly Close	Date	15/01/2026
Signature	h.close		

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Council of Governors

Terms of Reference

Version:	~~4~~3
Reviewed by:	Corporate Governance
Ratified by:	Council of Governors
Date reviewed:	~~21 November 2025~~22 October 2026
Date ratified:	~~10 December 2025~~tbc
Job title of author:	~~Corporate Governance Officer~~Senior Corporate Governance Officer and Executive Support Team Manager
Job title of responsible Director:	Chair of the Council of Governors / Chair of the Trust
Date issued:	~~10 December 2025~~TBC
Review date:	November 202~~6~~7
Frequency of review:	Annual

Amendment Summary:

- ~~Removal of the attendance of the Trust Board Secretary at every meeting and instead include the attendance of the Corporate Governance Manager and Deputy Trust Board Secretary at every meeting.~~
- ~~Updates to 'Relationships with other groups and committees' chart to reflect the combining of the 'Nominations' and 'Remuneration' Committee.~~
- ~~Committee secretariat updated from Corporate Governance Manager and Deputy Trust Board Secretary' to 'Corporate Goverance Officer~~'The Appointed Governor table has been updated to reflect the constitutional changes approved at the AMM in 2026. Removal of the appointed Governor seat for Bradford Assembly and Reduction to one Bradford Council Member

1 Name of Group

Council of Governors.

2 Composition of the Group

The membership of the Council of Governors is determined by Annex 3 of the Constitution and is made up of both elected and appointed Governors totalling 27.

Membership is set out below.

Elected Governors (20)

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Constituency	Area/ Class	Number of Governor Seats
Public (15)	Bradford East	3
	Bradford South	3
	Bradford West	3
	Craven	1
	Keighley	2
	Rest of England	1
	Shipley	2
Staff (5)	Clinical Staff Bradford District Care NHS Foundation Trust	3
	Non-Clinical Staff Bradford District Care NHS Foundation Trust	2
Appointed Governors (7)		
Local Authority Governors		
Bradford Council		12
North Yorkshire Council		1
Partner Organisation Governors		
Barnardo's		1
~~Bradford Assembly~~		~~1~~
Bradford University		1
Noor Project – Hope and Light		1

In accordance with the Foundation Trust Code of Governance it is expected that the Council of Governors will invite the Chief Executive to attend all its general meetings, and that other Executive Directors and Non-Executive Directors will be invited to attend as appropriate. The Council may invite other non-members to attend its meetings on an ad-hoc basis, as it considers necessary and appropriate.

The Corporate Governance Manager as the Deputy Trust Board Secretary will be in attendance at each meeting and provide appropriate advice and support to the Chair of the Trust and Council members.

Members of the Council of Governors must ensure that wherever possible they attend every Council meeting. Attendance at meetings will be monitored and shall be reported in the Annual Report. Attendance will be monitored by the Corporate Governance Manager and Deputy Trust Board Secretary, who will act accordingly by means of escalating appropriate information to the Chair of the Trust as it arises.

3 Quoracy

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No business shall be transacted at a meeting of the Council of Governors unless at least one third of the whole number of Governors elected or appointed are present. If a Governor has been disqualified from participating in the discussion on any matter and / or from voting on any resolution by reason of the declaration of a conflict of interest they shall no longer count towards the quorum.

Deputies: There is no constitutional provision for a deputy to attend on behalf of a Governor

Non-quorate meeting: Non-quorate meetings may go ahead unless there has been an instruction from the Chair not to proceed with the meeting. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate Chair: The Chair of the Council of Governors shall be the Chair of the Trust. In the absence of the Chair of the Trust, (or in the event of the Chair declaring an interest in an agenda item) the Deputy Chair shall Chair the meeting. Should the Deputy Chair not be available (or where they too have declared an interest in an agenda item), the meeting shall be chaired by the Lead Governor, or the Deputy Lead Governor. Should the Lead Governor or the Deputy Lead Governor be unable to Chair the meeting, due to a conflict of interest, the meeting can be Chaired by any other Governor as agreed by those Governors present.

4 Meetings of the Committee

Frequency: Meetings of the Council of Governors shall be held at such times as the Council may determine, however the Council of Governors will normally meet four times a year (plus the Annual Members' Meeting) with all meetings being held in public, although this shall not preclude any items of business being conducted in private. Items to be taken in private will be identified in line with agreed criteria, ensuring that as much business as possible is conducted in the public domain.

A full set of papers comprising the agenda, minutes of the previous meeting and associated reports and papers will be sent to all Governors in a timely manner. The agenda, minutes and Council papers of each formal meeting (excluding any confidential private papers) shall be displayed on the Trust website.

Urgent meeting: Any Governor may, in writing to the Chair, request an urgent meeting. The Chair will normally agree to call an urgent meeting to discuss the specific matter unless the opportunity exists to discuss the matter in a more expedient manner. As agreed by the Chair, a meeting can take place via conference call or using digital technology to support a virtual meeting.

Minutes: Corporate Governance shall ensure the minutes of the meeting are taken and will also ensure these are presented to the next Council of Governors' meeting.

5 Authority

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Establishment: The Trust shall establish a Council of Governors in accordance with the requirements of the NHS Act 2006, and paragraph 11 of its Constitution.

Powers: Its powers are detailed in the NHS Act 2006; Trusts' Code of Governance; and the Trust's Constitution.

Cessation: The Council of Governors is a statutory body and as such must remain for as long as it is empowered in statute.

6 Role of the Group

6.1 Purpose of the Group

The general statutory duties of the Council of Governors are to:

- hold the Non-Executive Directors to account (both collectively and individually) for the performance of the Board of Directors
- represent the interests of the members of the Trust as a whole and the interests of the public
- be consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan.

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

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

- we care
- we listen
- we deliver.

Governors must also abide by the "Council of Governors' Code of Conduct which all Governors will sign as part of their induction.

6.3 Duties of the Council of Governors

The Council of Governors will be required to carry out a number of statutory duties under the NHS Act 2006 (as amended by the Health and Social Care Act 2012). These are as follows:

- appoint and, if appropriate, remove the Chair and the Deputy Chair of the Trust (as Non-Executive Directors)
- appoint and, if appropriate, remove the other Non-Executive Directors

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- decide the remuneration and allowances, and the other terms and conditions of office, of the Chair of the Trust and the other Non-Executive Directors
- approve the appointment of the Chief Executive
- support the appointment of the Deputy Chair of the Trust
- appoint and, if appropriate, remove the Trust's auditor (i.e. the organisation that will, amongst other things, check the Trust's finances each year)
- receive the Trust's annual accounts, any report of the auditor on them and the annual report
- require one or more of the Directors or a representative of the Trust's auditors to attend a meeting to obtain information about the Trust's performance, or information about how the Directors have performed their duties in order to determine if there is a need to vote on issues concerning that performance
- approve (or not) by vote:
    - the implementation of any proposals to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England
    - entering into a significant transaction (a significant transaction is defined in the Constitution)
    - an application to NHS Improvement (one of our regulators) for a merger with or the acquisition of another foundation trust or NHS trust
    - an application to NHS Improvement for the separation or dissolution of the foundation trust
    - amendments to the Constitution.
- determine whether it is satisfied that any proposals to carry out activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes will not, to any significant extent, interfere with the Trust's provision of NHS services and notify the Board of its view.

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The Council of Governors is also responsible for:

- considering complaints about any member of the Trust in accordance with Annex 8 of the Constitution and take action which may include expulsion from the membership of the Trust
- agreeing a clear process for the appointment of the Chair of the Trust and the other Non-Executive Directors
- supporting the process for the evaluation or appraisal of the Chair of the Trust and the other Non-Executive Directors, including the outcomes of the evaluation of the Chair of the Trust and the Non-Executive Directors
- assessing its own collective performance and its impact on the Trust and communicate to members how Governors have discharged their duties
- taking the lead in agreeing with the Audit Committee the criteria for appointing, reappointing and removing external auditors
- agreeing with the Executive Directors what information it needs to receive at its meetings
- agreeing who from amongst the Governors should be appointed as the Lead Governor, and Deputy Lead Governor
- responding as appropriate to any matter when referred by the Board of Directors
- participating in the development of the Trust's strategy and values.

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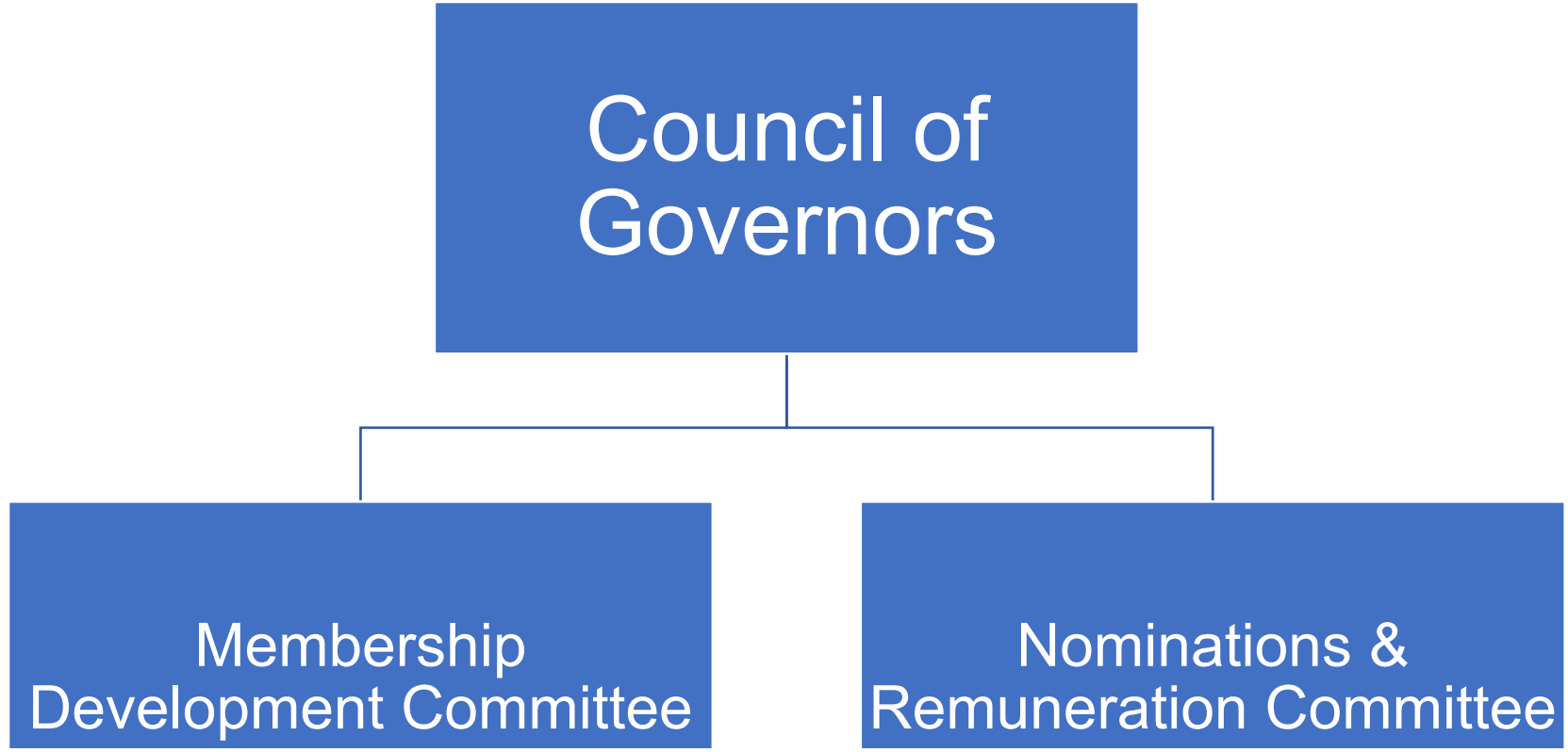
7 Relationships with other groups and committees



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8 Duties of the Chair

The Chair of the Council of Governors shall be responsible for:

- agreeing the agenda in collaboration with Corporate Governance, supported by the Corporate Governance Manager and Deputy Trust Secretary, and in consultation with the Lead and Deputy Lead Governors.
- directing the meeting ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion
- giving direction to the Corporate Governance Officer acting as the meeting Secretariat, and reviewing the draft minutes
- ensuring the agenda is balanced and discussions are productive
- ensuring sufficient information is presented to the Board of Directors in respect of the matters discussed by the Council.

9 Reviews of the terms of reference and effectiveness

The Terms of Reference shall be reviewed by the Corporate Governance Team annually with recommendations presented to the Council of Governors for ratification. The Council of Governors should also carry out an assessment of how effectively it is carrying out its duties and act upon any recommendations for improvement.

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Council of Governors – Meeting Held in Public

11th November 2026

Paper title:	Integrated Strategic Performance and Quality Report – October 2026	**Agenda Item** **12.0**
Presented by:	Kelly Barker - Chief Operating Officer Claire Risdon – Operational Director of Finance	
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 committee 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 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 committee 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 Oversight

Whilst overall performance is stable, four areas continue to require focused executive and committee 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 Committee 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 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 health and reducing inequalities; people; finance

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	and use of resources; and leadership and capability.

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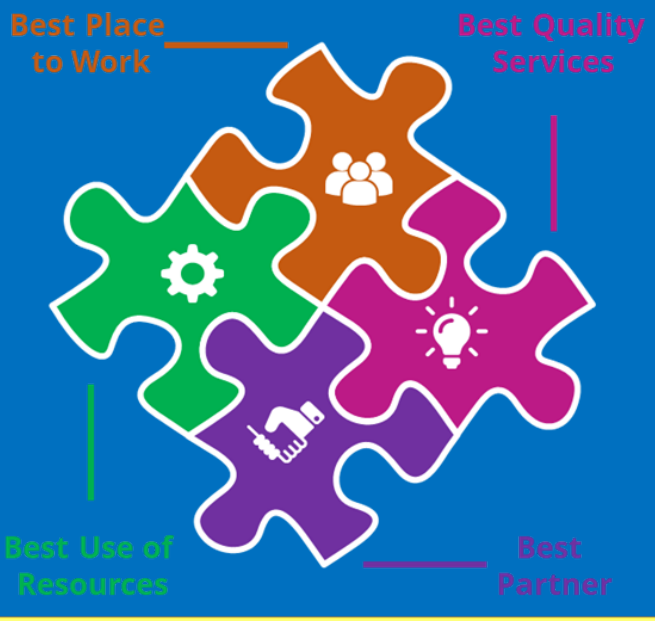
NHS
Bradford District Care
NHS Foundation Trust

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

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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

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

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
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.

Close Holly
11/11/2026 11:37:53

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

Close Holly
11/11/2026 11:37:53

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

Close Holly
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Appendix 1 – NOF Detail Slides

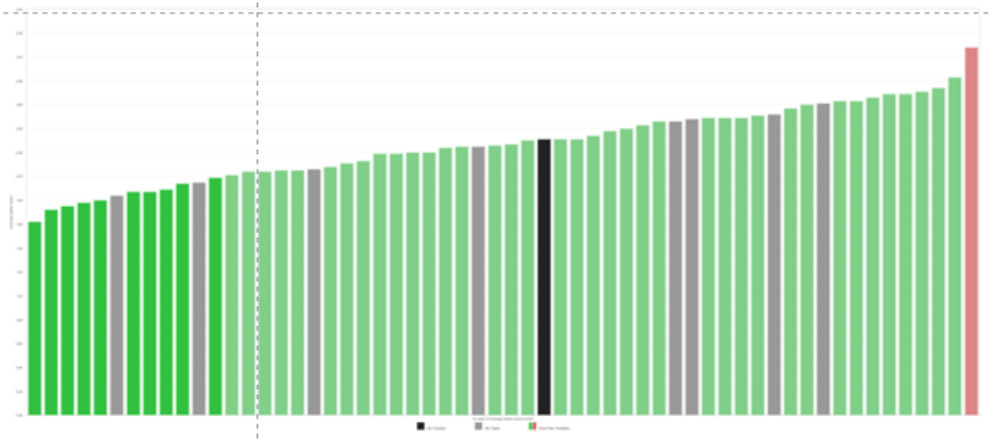
NHS Oversight Framework (NOF) – Non-acute hospital Trusts

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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11/11/2026 11:37:53

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)**						

Close Holly 11/11/2026 11:37:53

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)						

Close Holly 11/11/2026 11:37:53

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)**						

Close Holly 11/11/2026 11:37:53

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)**						

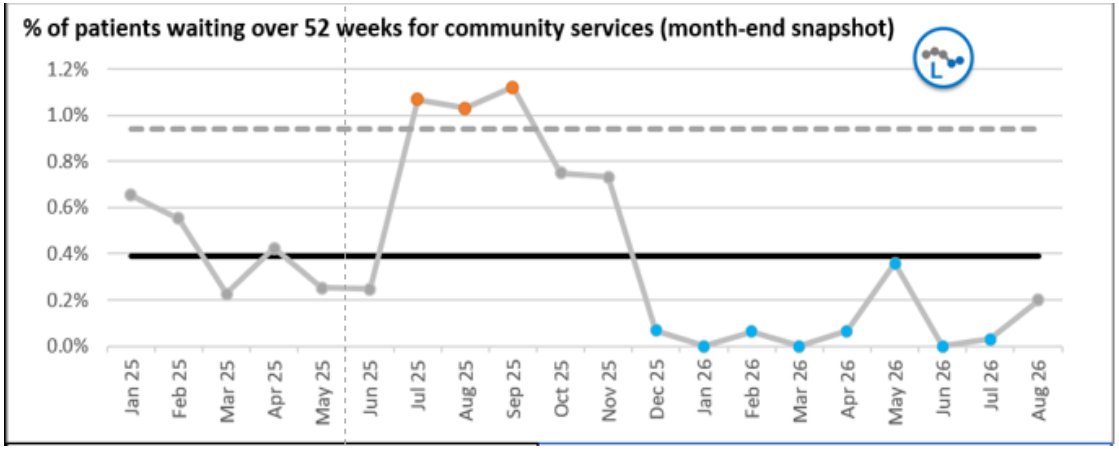
Close Holly 11/11/2026 11:37:53

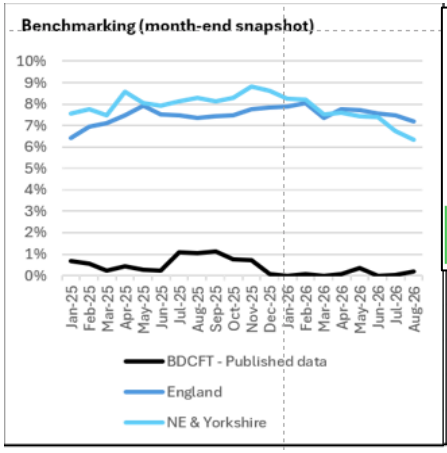
Appendix 2 – Detailed Description of Performance

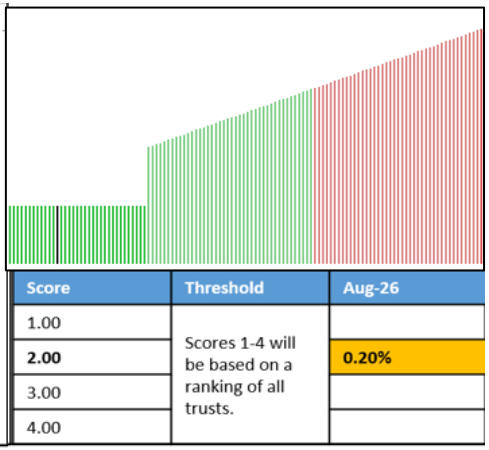
Close Holly
11/11/2026 11:37:53

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





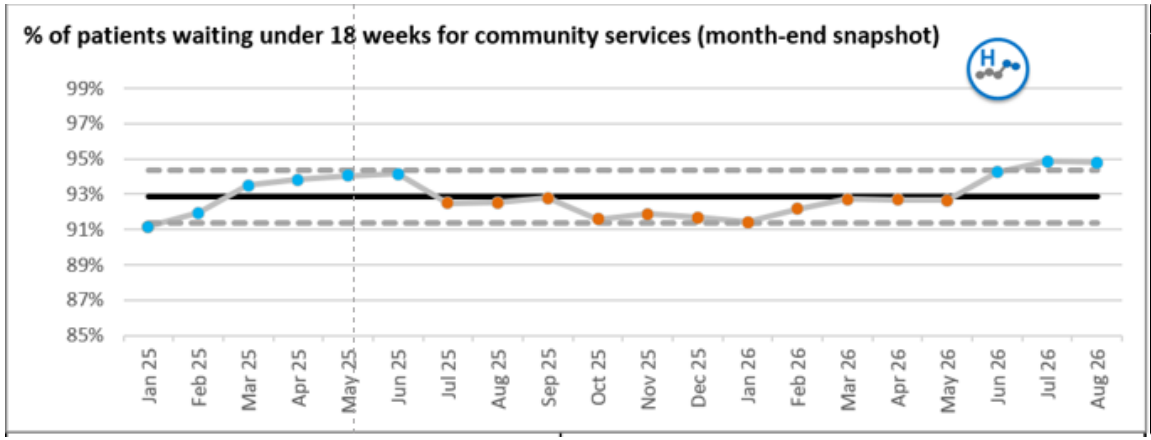


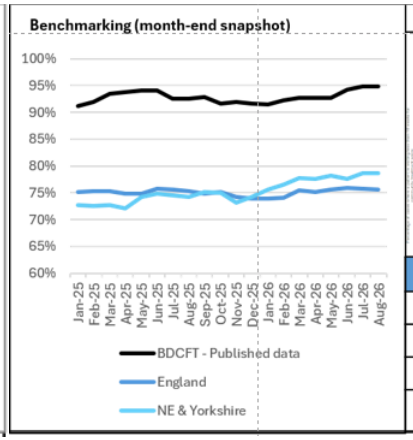
Score	Threshold	Aug-26
1.00	Scores 1-4 will be based on a ranking of all trusts.	
2.00		0.20%
3.00		
4.00		

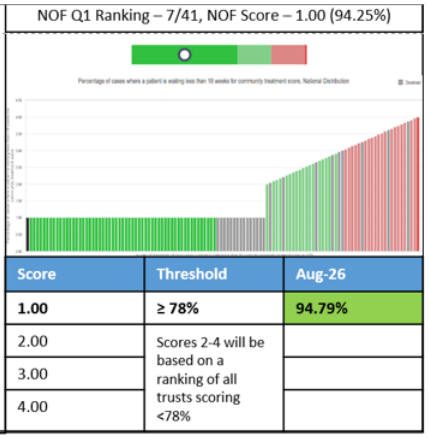
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a National Outcome Framework indicator that helps us track our longest waiters for community 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 11/11/2026 11:37:53

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





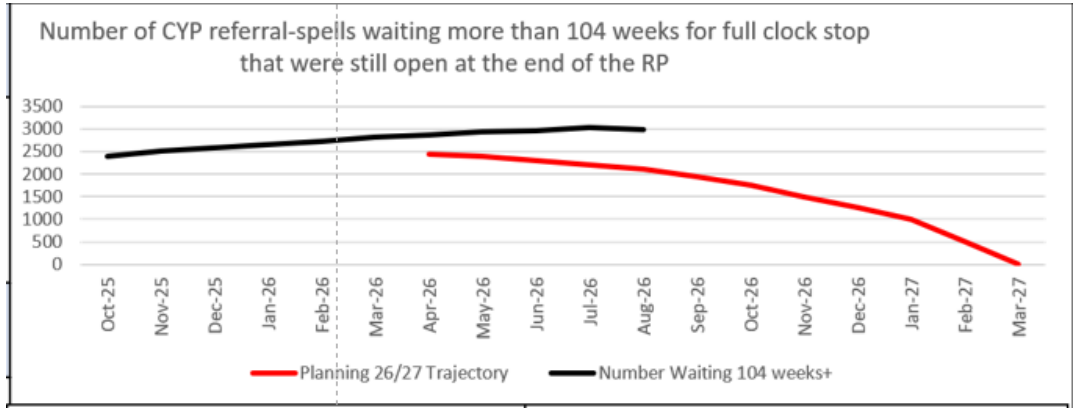


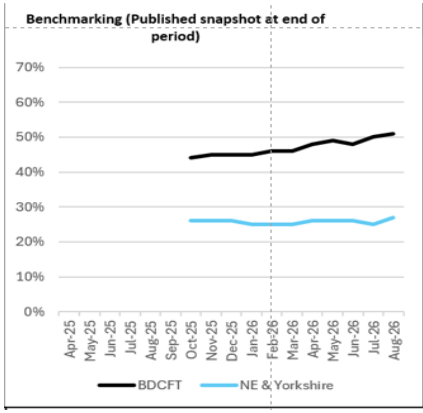
Score	Threshold	Aug-26
1.00	≥ 78%	94.79%
2.00	Scores 2-4 will be based on a ranking of all trusts scoring <78%	
3.00		
4.00		

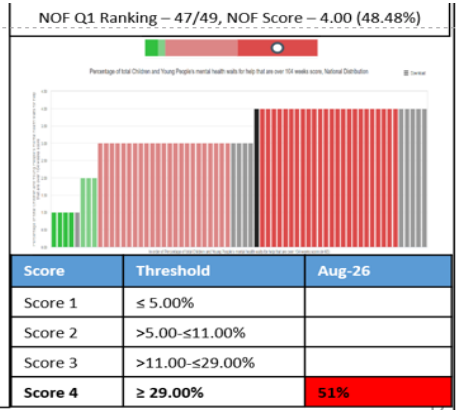
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a National Outcome Framework indicator that helps us track our longest waiters for community 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 11/11/2026 11:37:53

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





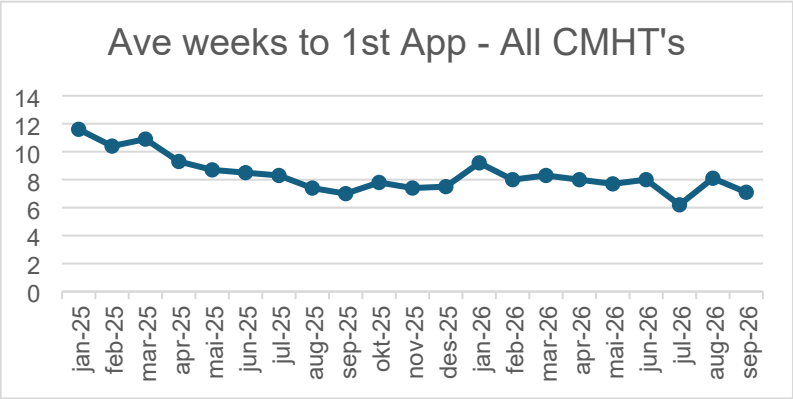


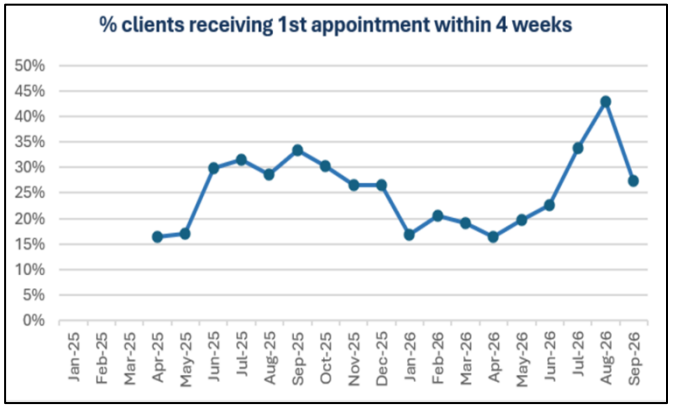
Score	Threshold	Aug-26
Score 1	≤ 5.00%	
Score 2	>5.00-≤11.00%	
Score 3	>11.00-≤29.00%	
Score 4	**≥ 29.00%**	**51%**

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 11/11/2026 11:37:53	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



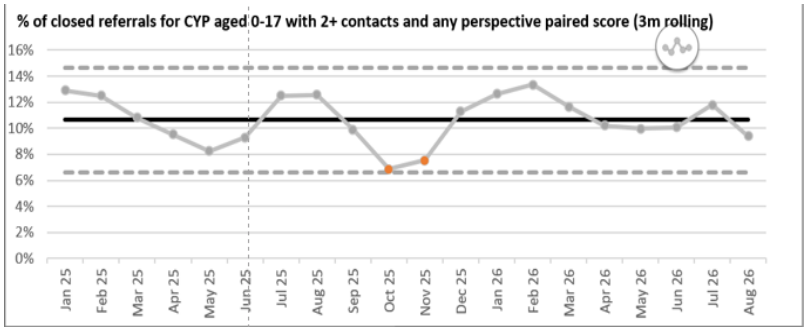


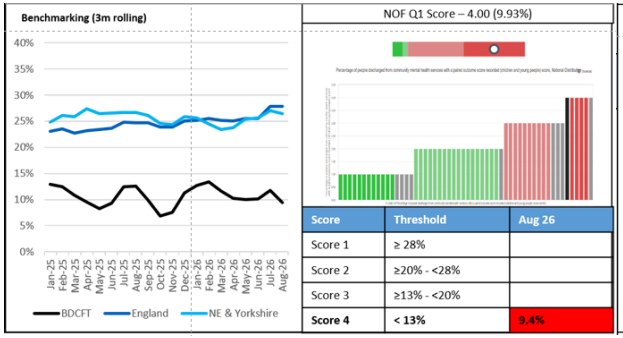
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Timely access to Community Mental Health Teams is a critical indicator of pathway responsiveness 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.

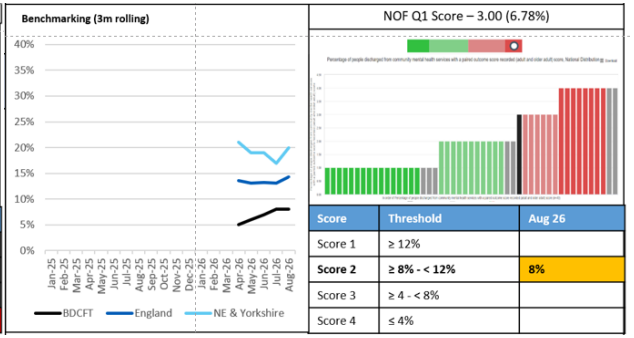
Cope Holly
12/11/2026 11:37:53

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



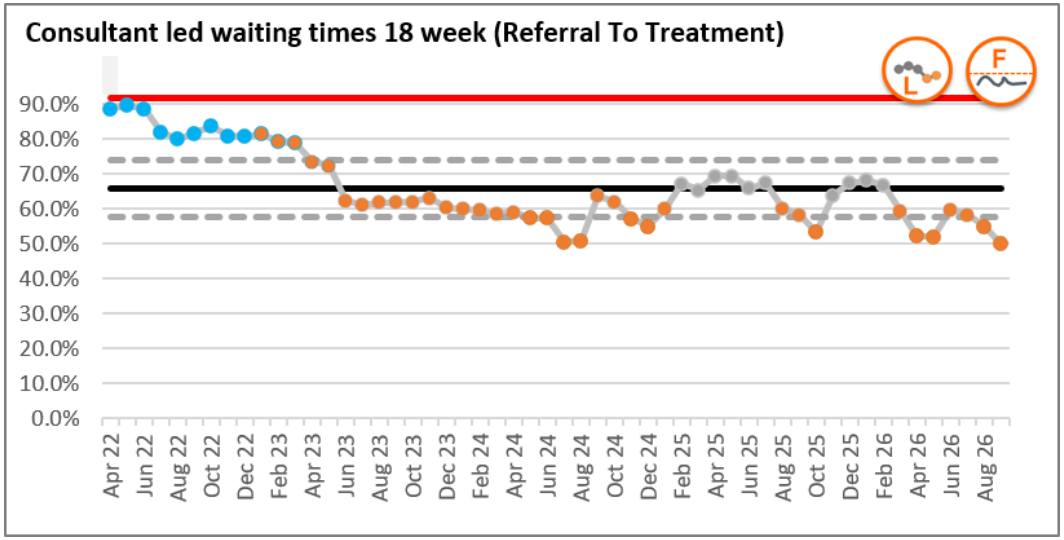




Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This new National Oversight Framework measure tests whether access to mental health services results 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.

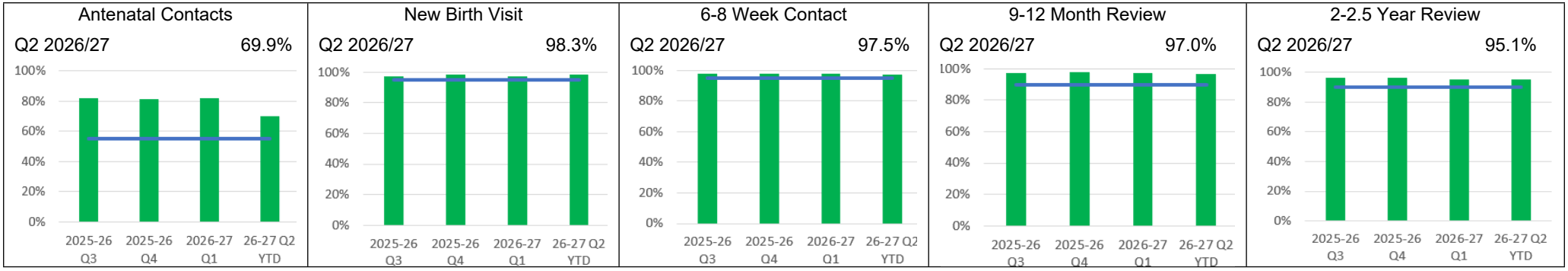
Close Holly 11/11/2026 11:37:53

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 11/11/2026 11:37:53	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.

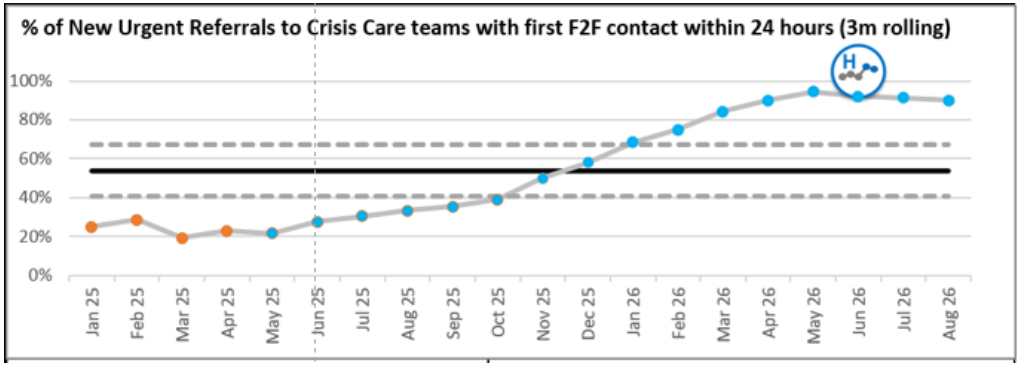
Measure: 0 – 19 metrics					
Domain:	Access to Services	NOF: No	Accountable Exec: Kelly Barker	Author:	Richard Holmes
Target:	Various	Actual: Various	Data Period: Q1 2026/27	DQ Assessment	TBC

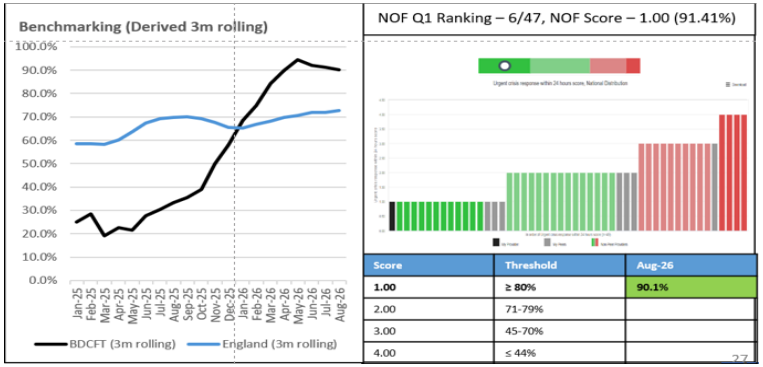


Why is this measure important?	Are we on track or off track? Why?	If we are off track, what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
These indicators are important because they measure compliance against national and local targets 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 11/11/2026 11:37:53

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

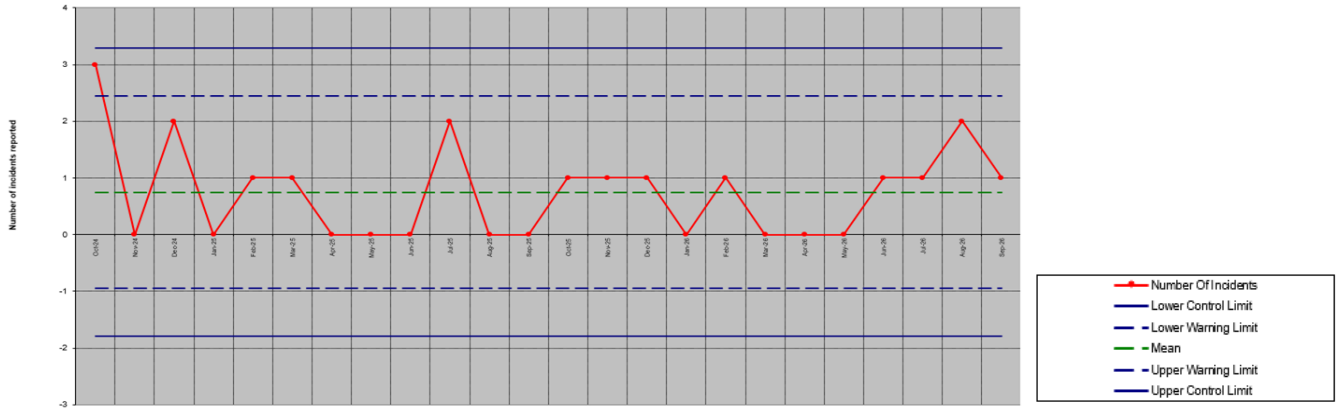




Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Crisis Care Services support individuals experiencing acute mental health need and risk. Timely 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 11/11/2026 11:37:53

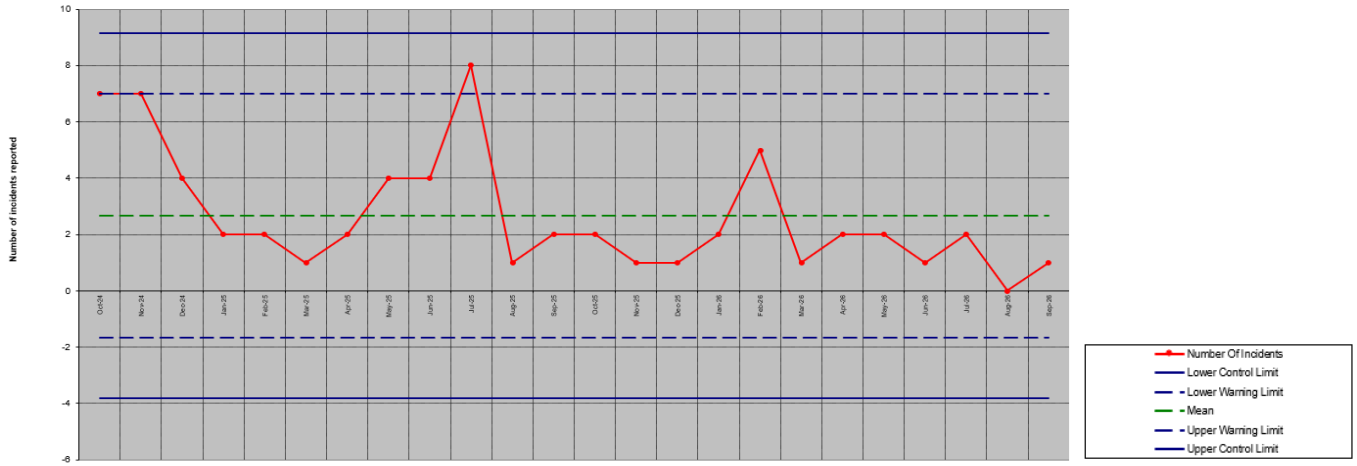
Measure: No Force first - Prone Restraint					
Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon
Target:	No set target	Actual: 1	Data Period: September 2026		DQ Assessment TBD



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.

Oasis Report 2026-01-27 07:53

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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11/12/2026 11:37:52

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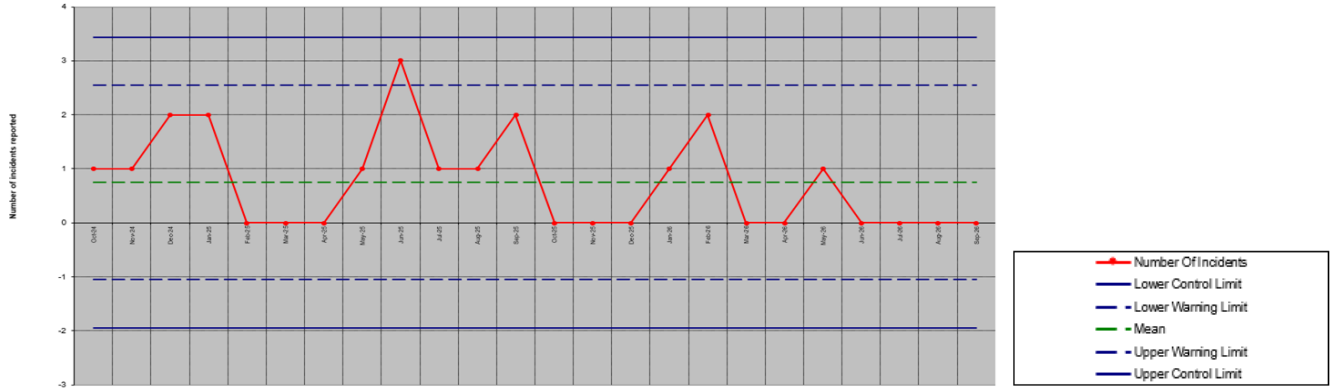
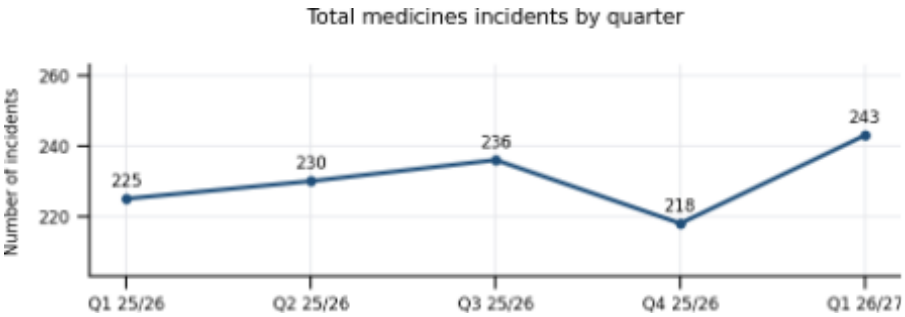
Measure: No Force first - Segregation					
Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon
Target:		Actual: 0	Data Period: September 2026		DQ Assessment TBD

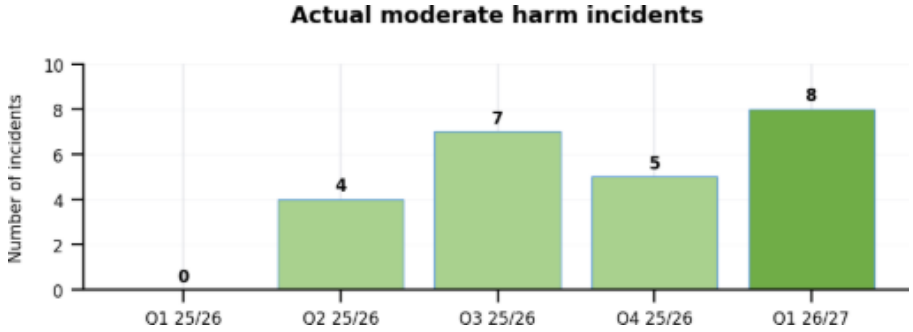


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Segregation is a key quality, safety and human rights measure because it represents a highly restrictive 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.

Close Folly 1/11/2026 11:37:53

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 11/11/2026 11:37:53

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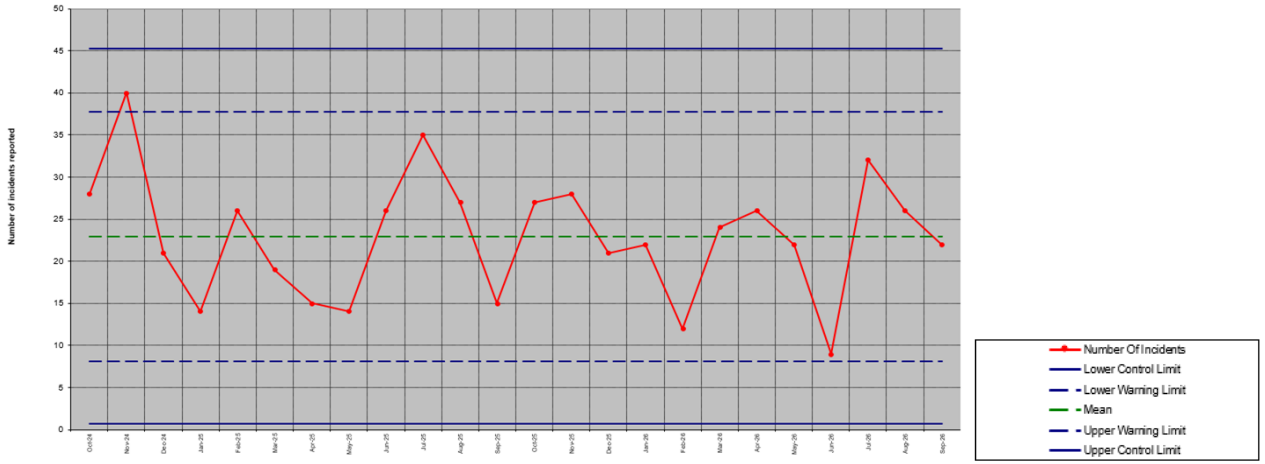
Measure: Falls – number and severity					
Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon
Target:		Actual: 22	Data Period: September 2026		DQ Assessment TBD

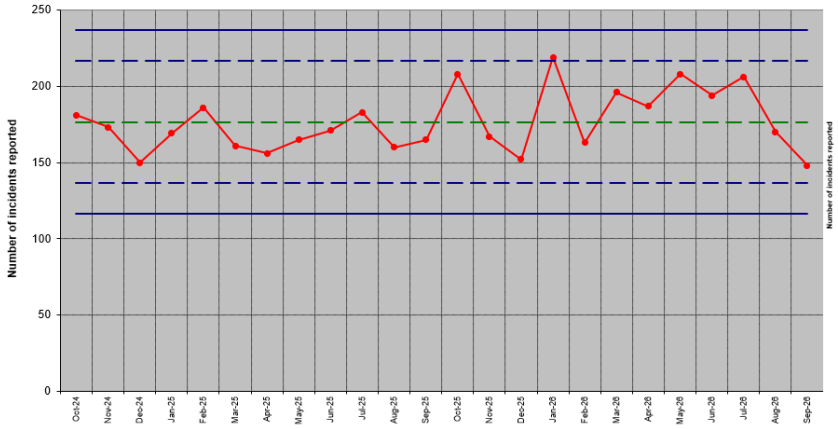


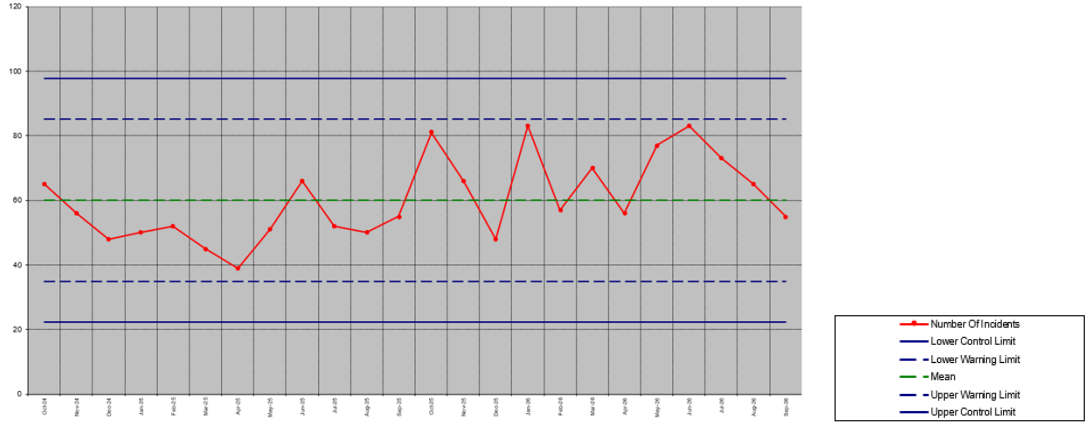
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Falls involving service users are a key quality and patient safety measure because they can result 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

Close Hourly 11/11/2026 14:37:53

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 11/11/2026 11:37:53

Return to Effectiveness of Care Summary

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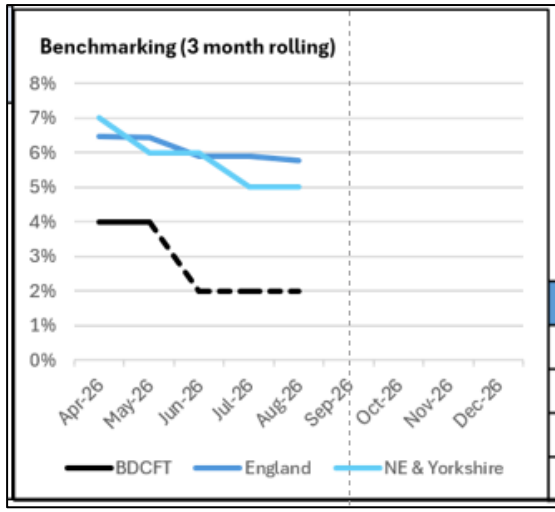
Measure: % of discharges from adult acute mental health beds which were readmitted within 14 days of discharge						
Domain:	Effectiveness of Care	NOF: Yes	Accountable Exec:	Kelly Barker	Author:	Maulbrey Mugani
Target:	<=5%	Actual: 2% (NOF1)	Data Period	Aug 26(3 M Rolling)	DQ Assessment	TBD

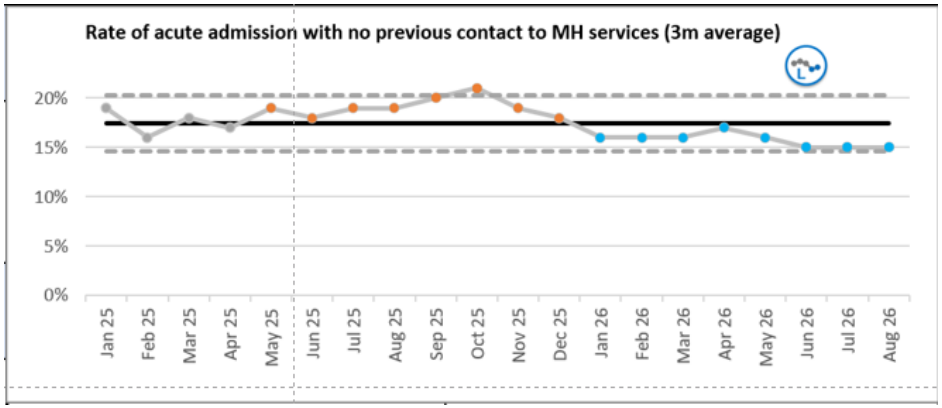


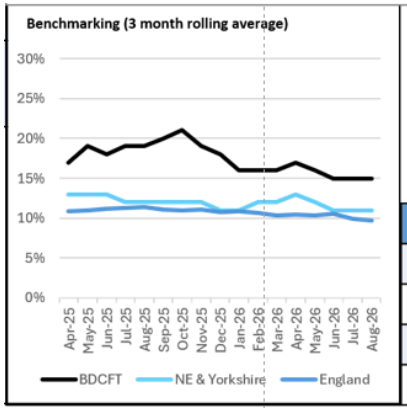
Score	Threshold	Jun-26
1.00	≤ 5%	≏ 2%
2.00	6 - 10%	
3.00	11 - 17%	
4.00	≥ 18%	

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.

Closed Jolly 11/11/2026 11:37:53

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



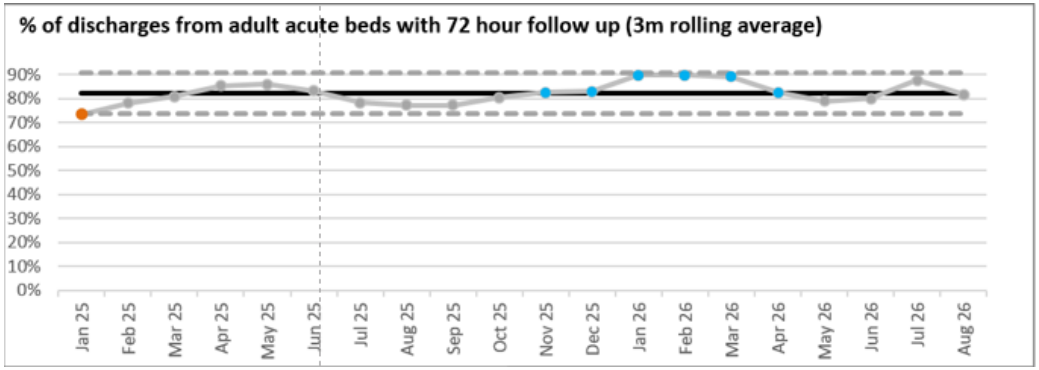


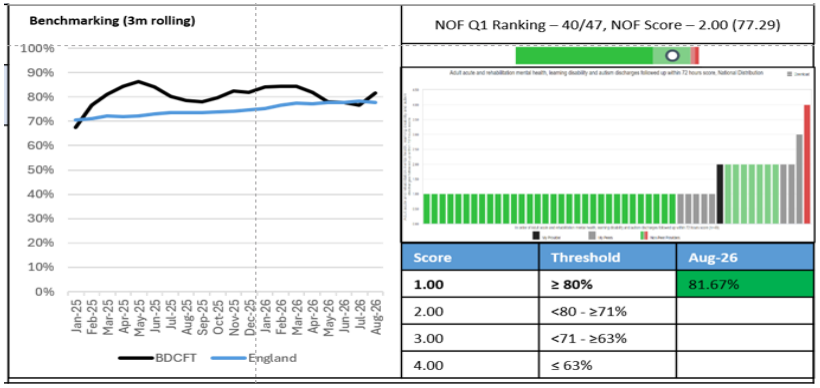
Score	Threshold	Aug-26
1.00	≤ 5.00 %	
2.00	>5.00-≤10.00%	
3.00	**>10.00%-≤15.00%**	**15%**
4.00	> 15.00%	

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 11/11/2026 11:37:53

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



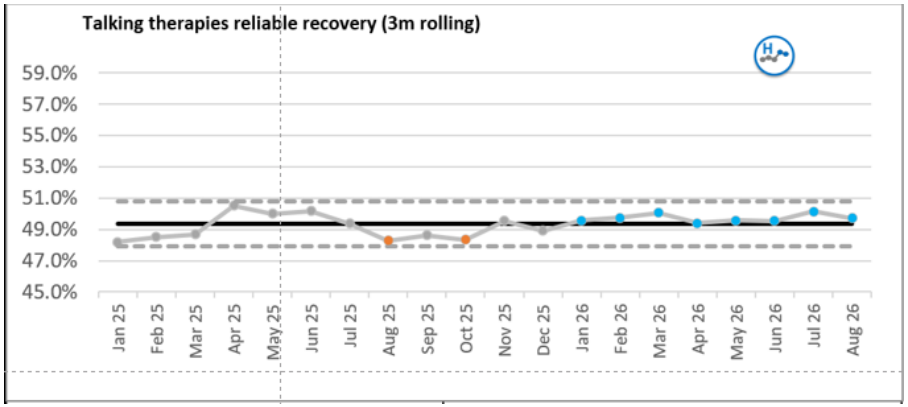


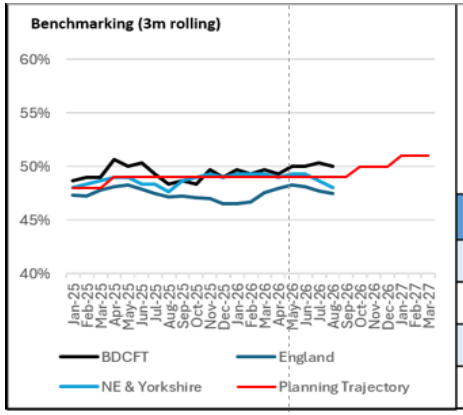
Score	Threshold	Aug-26
1.00	≥ 80%	81.67%
2.00	<80 - ≥71%	
3.00	<71 - ≥63%	
4.00	≤ 63%	

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 11/11/2026 11:37:53

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.

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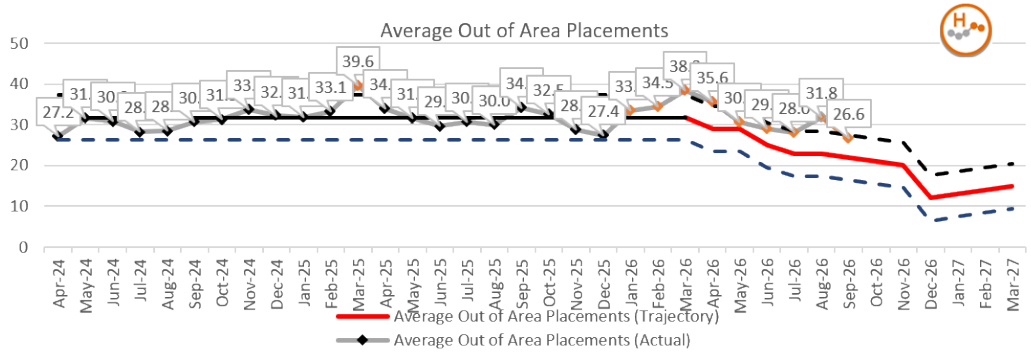
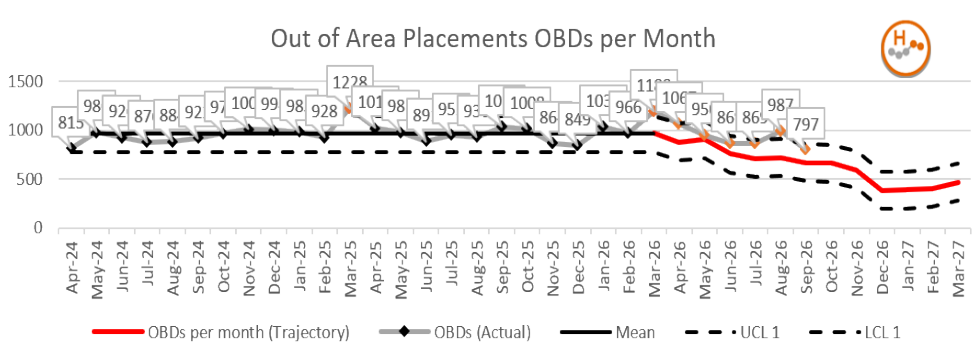
21/11/2026 11:37:53

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

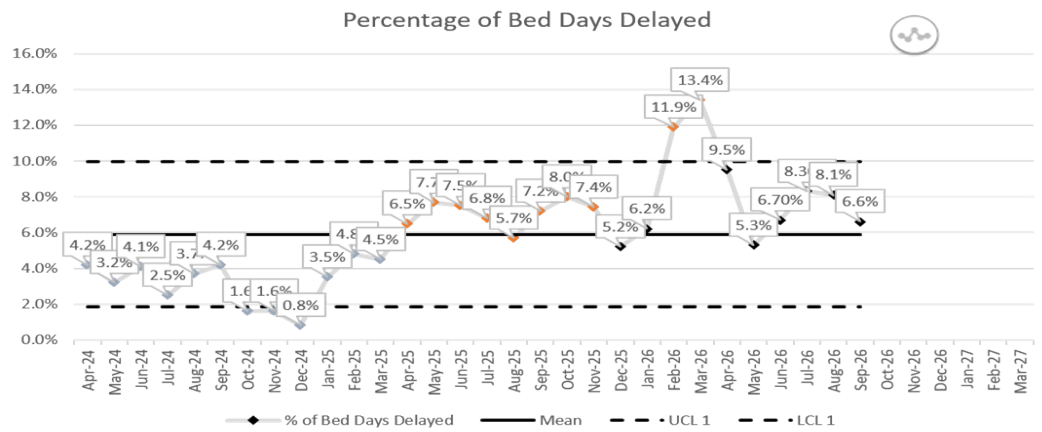




Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Out of Area Placements (OAPs) are a key indicator of pressure across the whole mental health system. 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.

Jessie Holly
12/11/2026 11:37:53

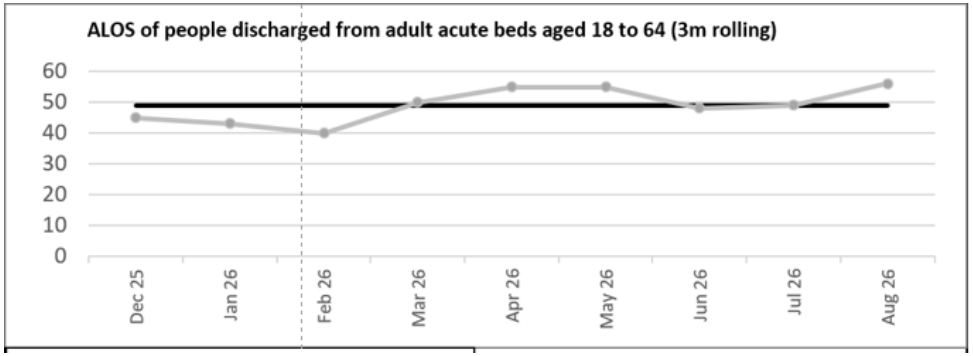
Measure: % of Ward Occupancy Delayed for Acute Wards						
Domain:	Experience of Care	NOF: No	Accountable Exec:	Kelly Barker	Author:	Maulbrey Mugani
Target:	10% or under	Actual: 6.6%	Data Period: Sep 26		DQ Assessment	TBD

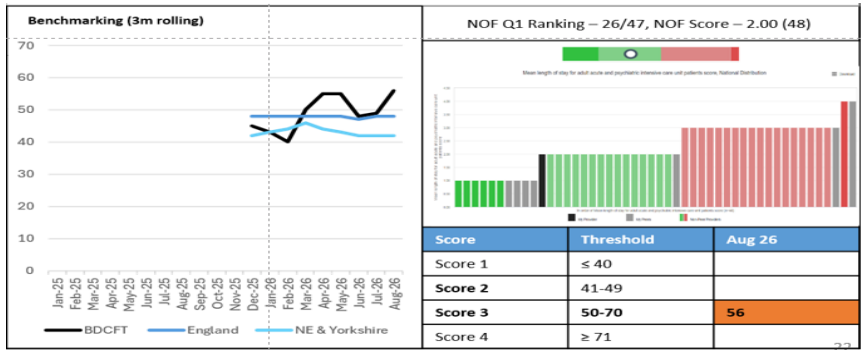


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Delayed occupancy provides an indication of how effectively patients move through inpatient services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

Close Holly 11/11/2026 11:37:53

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



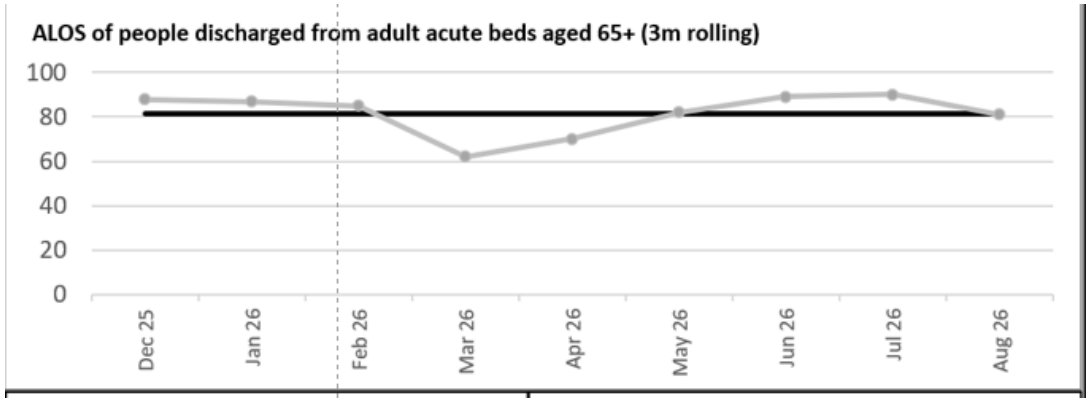


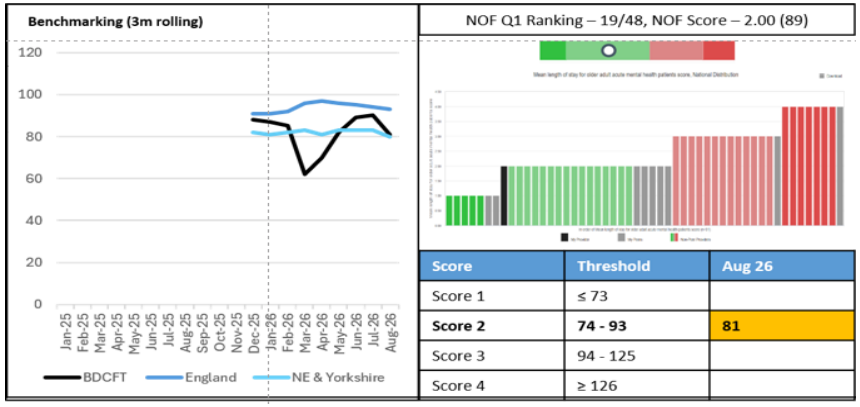
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Length of stay is an important monitor of inpatient flow and bed availability. Maintaining an optimal 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.

Close Holly 11/11/2026 11:37:53

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. Close Holly 11/11/2026 11:37:53	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.

Return to Experience of Care Summary

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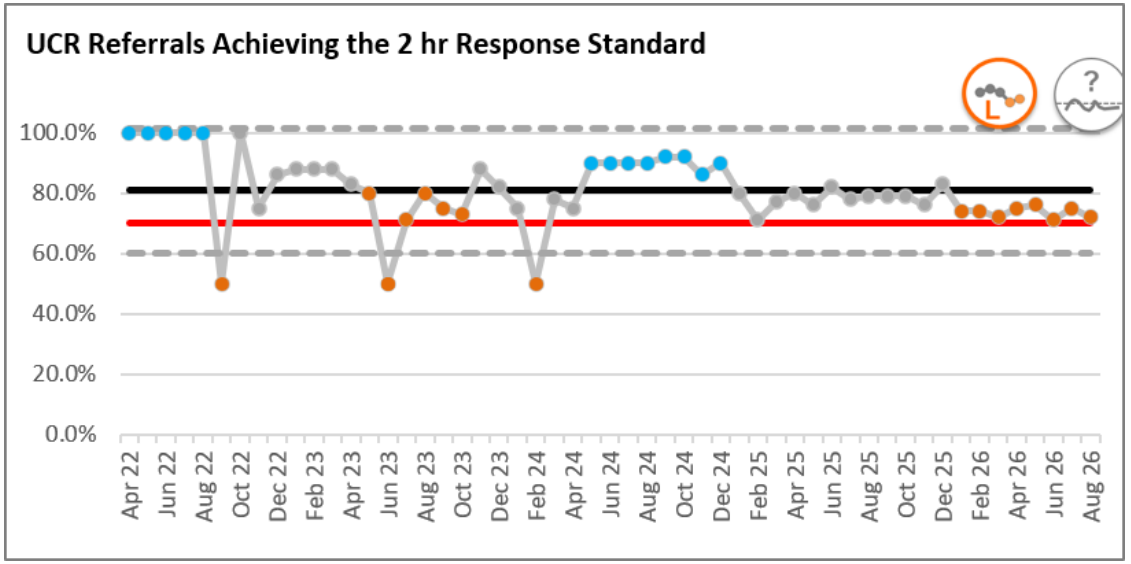
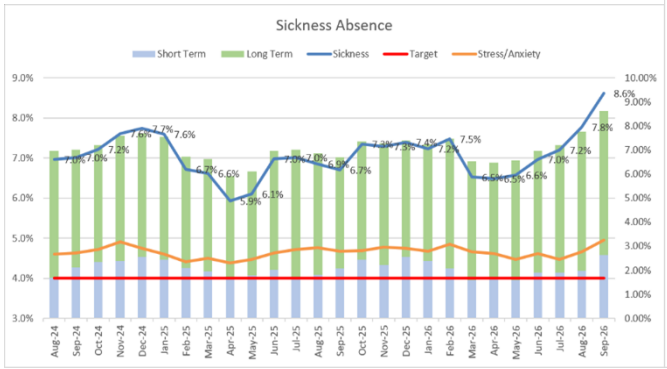
Measure: Urgent Community Response (UCR) Percent Achieving 2hr Standard							
Domain:	Experience of Care	NOF:	No	Accountable Exec:	Kelly Barker	Author: Cliff Springthorpe	
Target:	70%	Actual:	72.0%	Data Period	August 2026	DQ Assessment	TBD

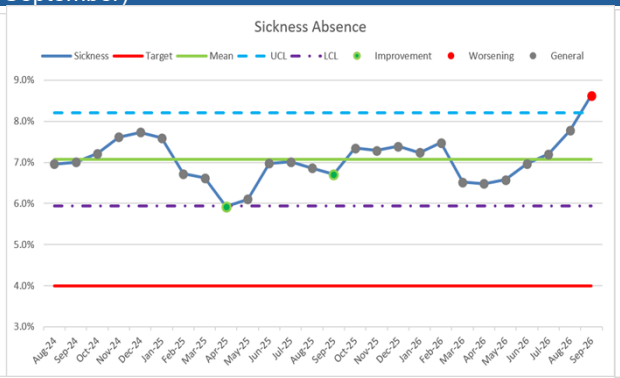


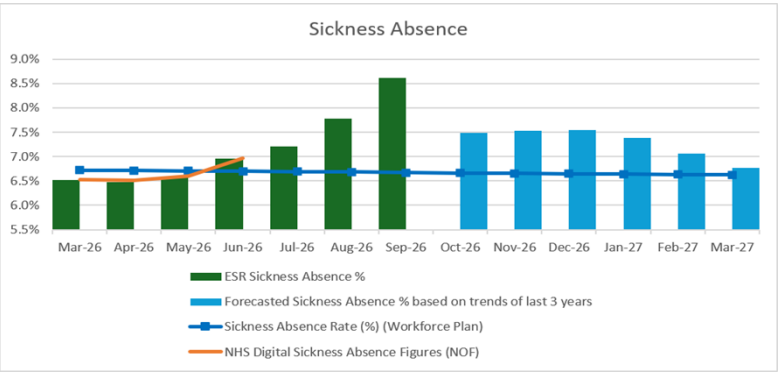
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is no longer a NOF reported indicator but is still a planning requirement for this year. Urgent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

Close Hall
11/11/2026 11:37:53

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 .

Cassie Holly 11/11/2026 11:37:53

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

Close Holly
11/11/2026 11:37:53

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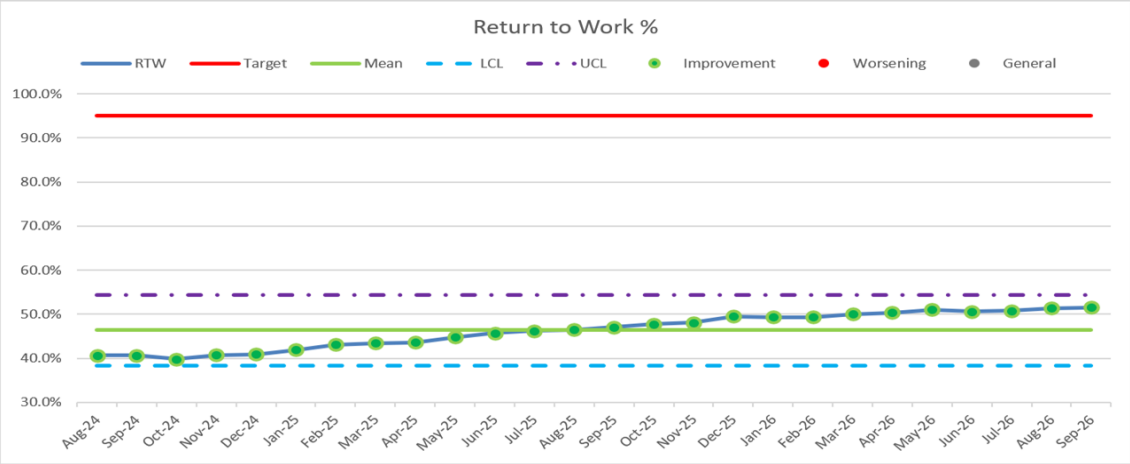
Measure: Return To Work Interview Complete							
Domain:	People	NOF:	No	Accountable Exec:	Jo Harrison	Author: Claire Ingle	
Target:	95%	Actual:	51.5%	Data Period	September 26	DQ Assessment	TBD



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.

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

Close Holly
11/11/2026 11:37:53

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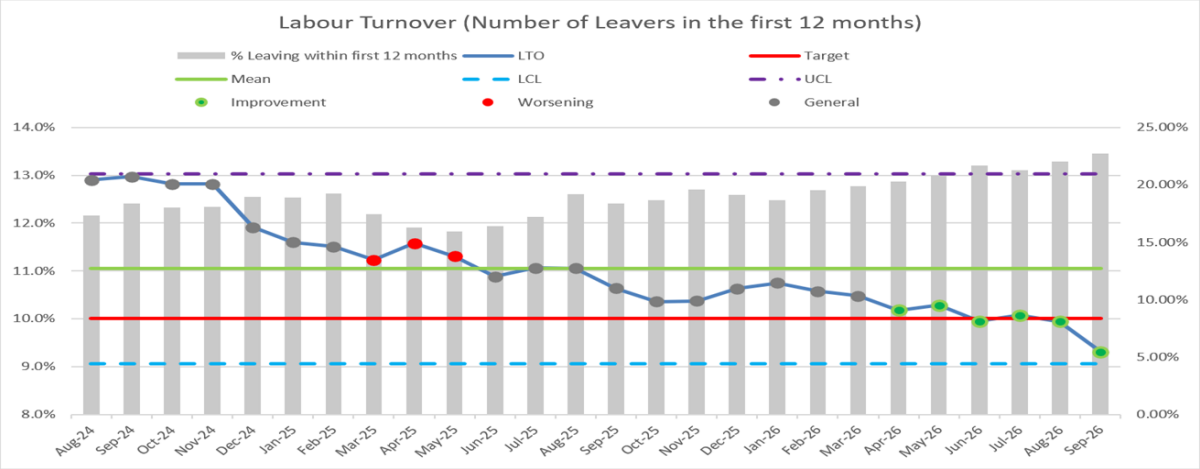
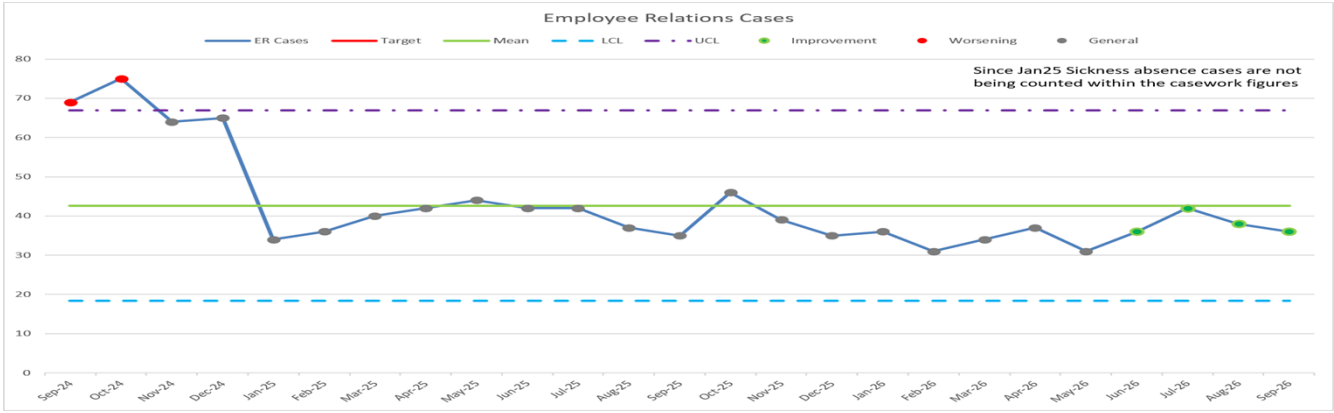
Measure: Labour Turnover						
Domain:	People	NOF: No	Accountable Exec:	Jo Harrison	Author: Claire Ingle	
Target:	10%	Actual:9.3%	Data Period	September 26	DQ Assessment	TBD



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.

Rose Hully
11/11/2026 11:37:53

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



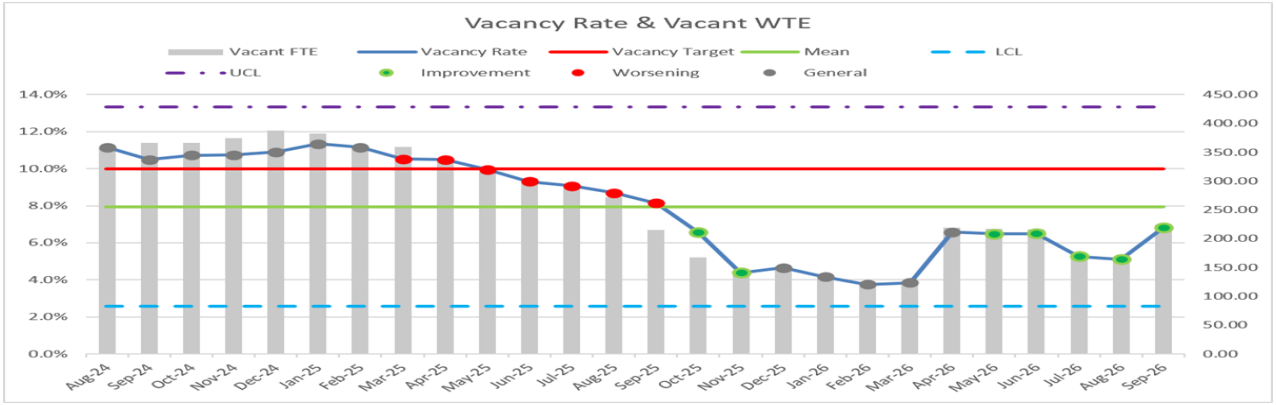
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring the number of Employee Relations cases in the NHS is important because it provides insight 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.

Classification: Official
11/12/2026 11:37:53

		support a more compassionate, learning-focused culture.	

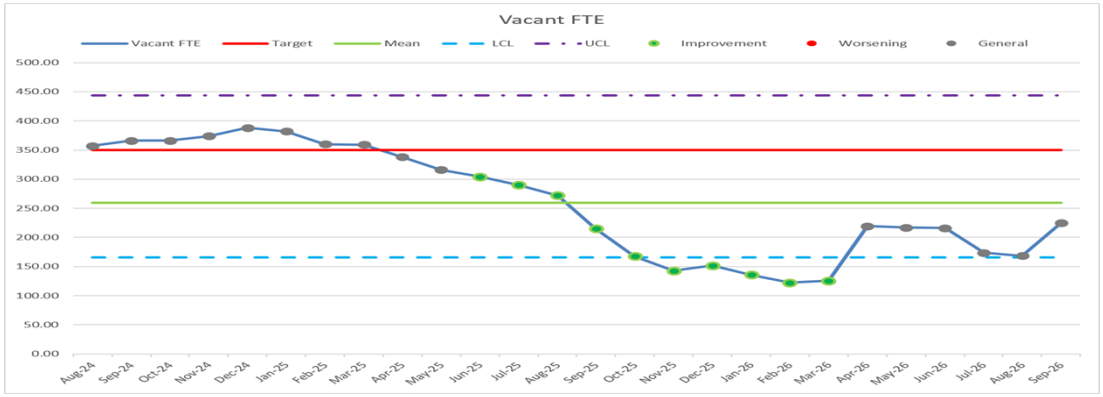
Close Holly
11/11/2026 11:37:53

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.

13/11/2025 14:37:53

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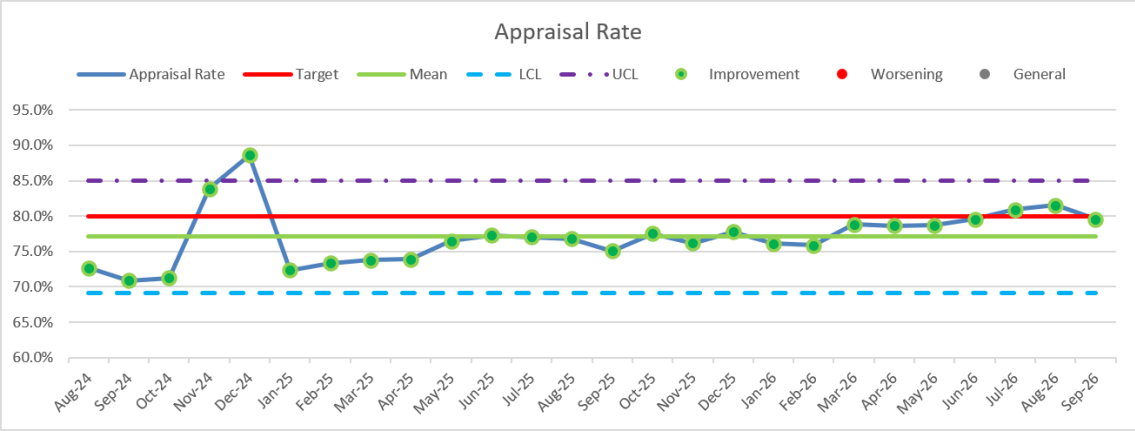
Measure: Appraisal compliance							
Domain:	People	NOF: No		Accountable Exec:	Jo Harrison	Author: Naomi Fernandez	
Target:	80%	Actual:	79.5%	Data Period	September 26	DQ Assessment	TBD



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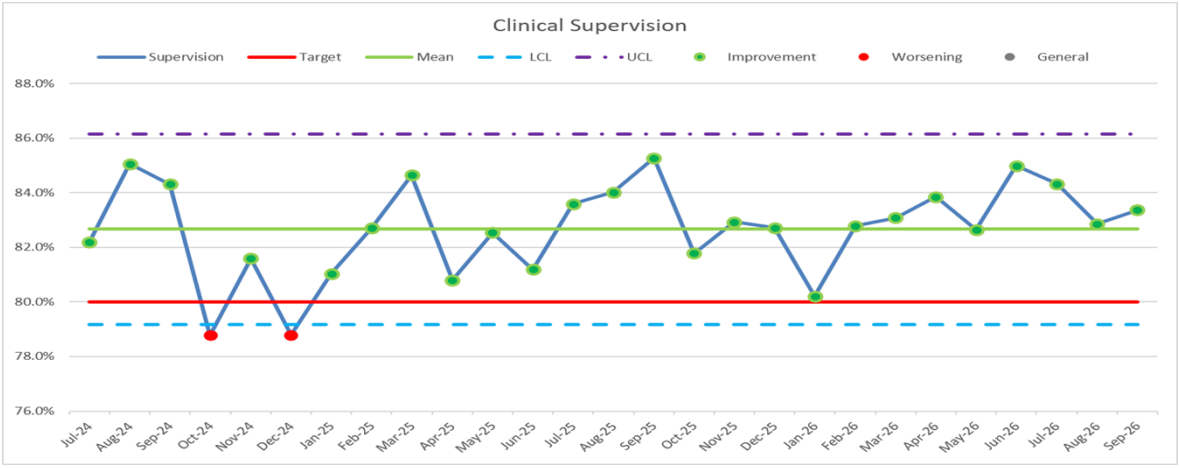
Measure: Clinical supervision							
Domain:	People	NOF: No		Accountable Exec:	Jo Harrison	Author: Naomi Fernandez	
Target:	80%	Actual:	83.3 %	Data Period	September 26	DQ Assessment	TBD



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.

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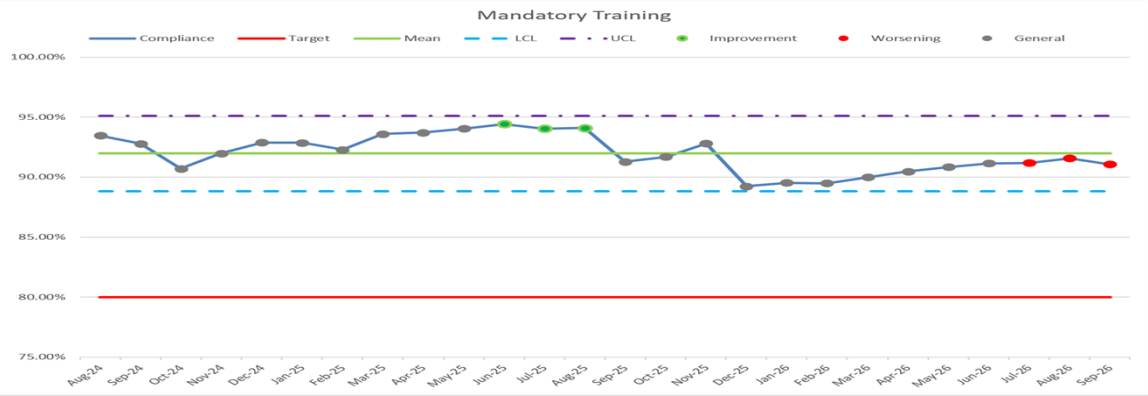
Measure:	Mandatory Training Compliance						
Domain:	People	NOF:	No	Accountable Exec:	Jo Harrison	Author:	Naomi Fernandez
Target:	80%	Actual:	91.07%	Data Period	September 26	DQ Assessment	TBD



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.

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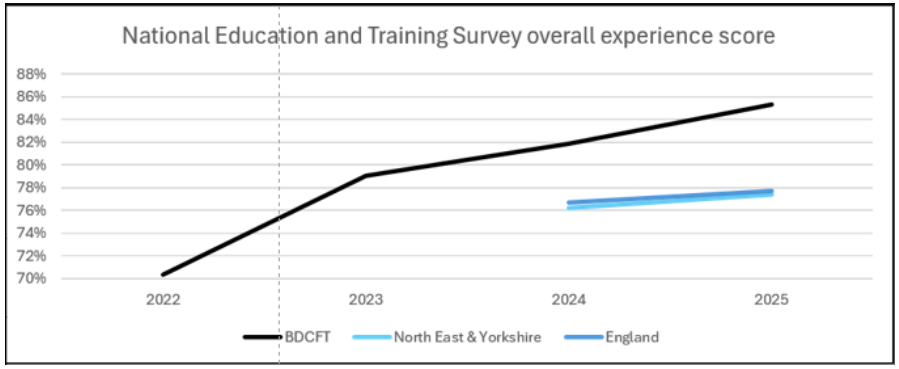
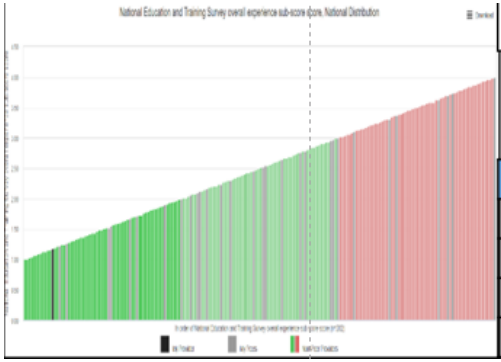
Measure: National Education and Training Survey overall experience sub-score - new measure							
Domain:	People	NOF:	Yes	Accountable Exec:	Jo Harrison	Author: Naomi Fernandez	
Target:	-	Actual:	85.32% (NOF 1)	Data Period	2025	DQ Assessment	TBD





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.		

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Return to Finance and Productivity Summary

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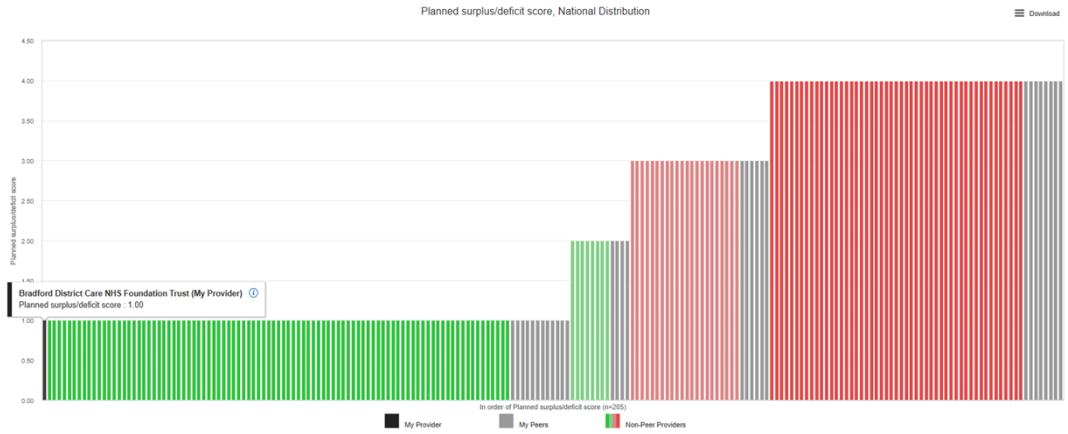
Measure:	Planned surplus / deficit / Variance year to date financial plan						
Domain:	Finance and Productivity	NOF:	Yes	Accountable Exec:	Mike Woodhead	Author:	Anne-Marie Dewhirst
Target:	Achieve Plan for both	Actual:	0.00% (NOF1) / 0.02 (NOF1)	Data Period	Q1 26/27	DQ Assessment	TBD



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.

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Return to Finance and Productivity Summary

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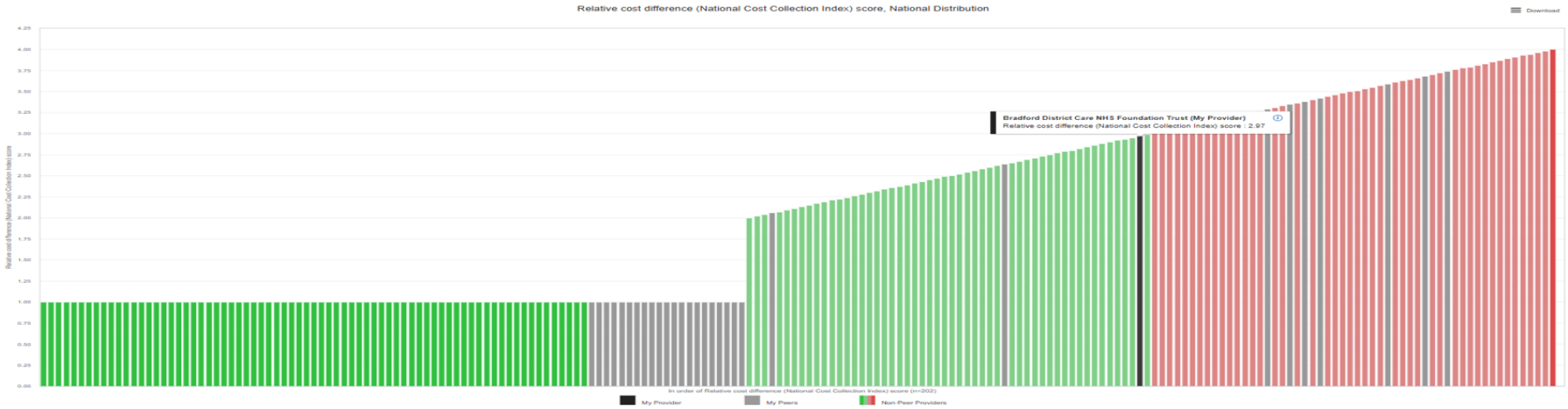
Measure: Relative difference in costs							
Domain:	Finance and Productivity	NOF:	Yes	Accountable Exec:	Mike Woodhead	Author:	Anne-Marie Dewhirst
Target:	Based on ranking	Actual:	106.45 (NOF 2)	Data Period	24/25	DQ Assessment	TBD



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.

Claire Holly
12/11/2026 11:37:53

Appendix 3 – Annual Measures

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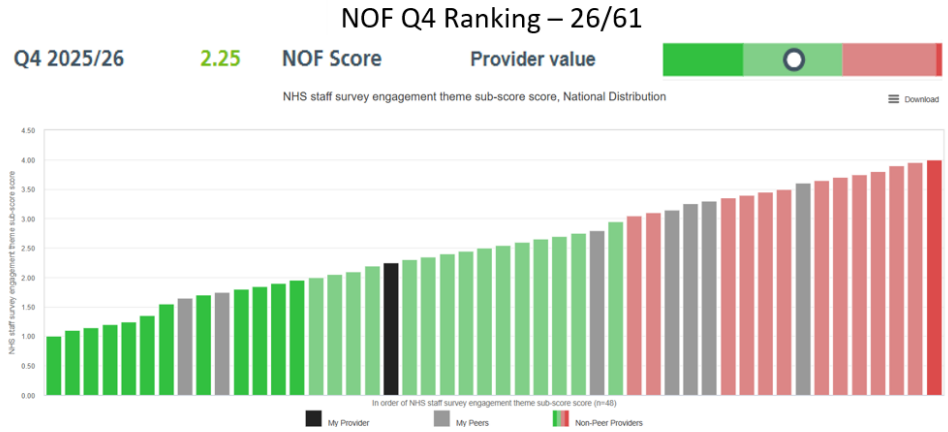
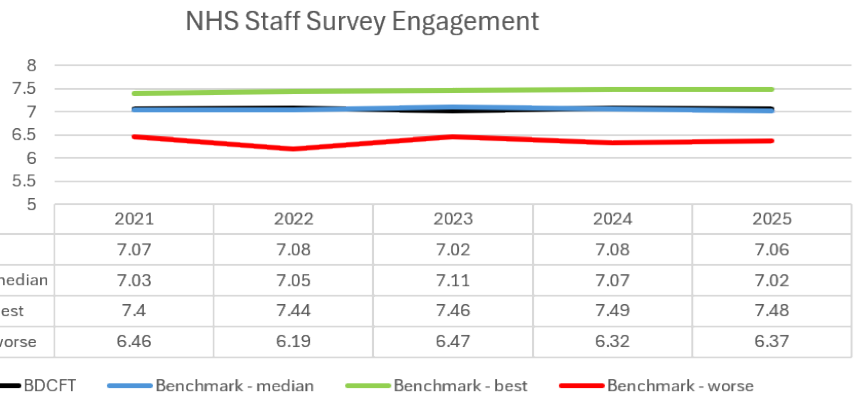
Measure: NHS Staff Survey Engagement Sub Score					
Domain:	People	NOF: Yes	Accountable Exec:	Jo Harrison	Author: Naomi Fernandez
Target:		Actual: 7.06	Data Period: 2025		DQ Assessment TBD





	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.

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NHS
Bradford District Care
NHS Foundation Trust

Council of Governors – Public Meeting

11 November 2026

Paper title:	Lynfield Mount Redevelopment Update	**Agenda Item** **13.0**
Presented by:	Claire Risdon – Operational Director of Finance	
Prepared by:	Alexander Trigg – Deputy Director of Estates	
Committees where content has been discussed previously	Lynfield Mount Redevelopment Project Board	
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	x
	Growing for the future	x
Delivering Best Quality Services	Improving Access and Flow	x
	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	x
Being the Best Partner	Partnership	x
Good governance	Governance, accountability & oversight	x

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Purpose of the report

- The report attached serves to update the Trust's Governors on progress associated with the £65m redevelopment of Lynfield Mount Hospital.
- The redevelopment provides 36 new and 36 inpatient beds across new build and refurbishment phases in addition to improvements in clinical and other accommodation.

Executive Summary

- Delivery of the £65m redevelopment of Lynfield Mount Hospital is progressing satisfactorily to both time and budgetary expectations.
- Good collaborative working relationships have been established between the Trust, Main Contractor McAvoy, and framework partners.
- The substructure for the new ward block is substantially complete, and delivery of the 127 modules which create 36 beds over two floors commences on the 11th November.
- Refurbishment of existing clinical and support accommodation continues collaterally.

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 Council of Governors is asked to:

- Consider the content of the paper for the purposes of information and raise and queries or questions if clarification is sought.

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 ☒ 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: •

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LMH Redevelopment – Update for Council of Governors

Bradford District Care
NHS Foundation Trust

This highlight report updates the Council of Governors on the progress associated with the redevelopment of Lynfield Mount Hospital.

Project Objective/s:	To design and build a new two storey ward block, entrance & landscaping (Phase 2A) with a targeted refurbishment programme to the main existing LMH block (Phase 2B) and the formation of 100% en-suite accommodation on 2 existing acute wards (Phases 3&4). The total project budget is £65m. The project is commenced in April 2026 and is due to be complete in February 2029.		
Project SRO:	Mike Woodhead	**Report Number:**	1
Project Director:	Louise Rigg	**Report Date:**	5th November 2026
Current Project Stage(s):	Phase 1, 2A and 2B – In construction. Phases 3 and 4 – yet to commence.		

1. Status (RAG)

Red – behind delivery against plan and not expected to recover against the original plan.
Amber – behind delivery against plan but expected to get back on track.
Green – going according to plan and within tolerance.

Current status:		**Status trend:** BETTER/SAME/WORSE (since last report)	

Status Summary:

We are pleased to advise that the Redevelopment of Lynfield Mount Hospital is progressing well, adhering overall to programme and budget, and continuing to enjoy good quality collaborative working between the Trust, professional team and Main Contractor, McAvoy.

All prefabricated modules that make up Phase 2A of the building, the new wards, will be delivered from the 11th November up until Christmas, with the balance being delivered up to 26th January post the Christmas construction shutdown period.

Key events in recent weeks have been:

- We successfully delivered a temporary 'Porta-pharm' building to re-house our pharmacy operations to allow the ongoing delivery of Phase 2B. It was a good example of joint working with Estates & Facilities, contractors and Operational and Clinical colleagues.

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1. Status (RAG)

- ✓ We have successfully delivered the refurbishment of the refurbished Section 136 Site at Airedale Centre for Mental Health. This was on the critical path and necessary to allow ongoing possessions within Phase 2B which is being delivered in three sub-phases.
- ✓ Delivery of the prefabricated modules have been re-programmed to fit in with West Yorkshire Police escorting availability. The first modules arrive on Wednesday 11th November which will mark a significant milestone in the projects' progress. In total, 127 modules will be delivered by the end of January.
- ✓ We did experience a small delay to the handover date of Phase 2B Area 1 due to door availability, but this will not materially affect overall completion.
- ✓ There was a delay on the substructure of Phase 2A due to piling issues arising from the site's historic use as a quarry. Again, it is not anticipated that this will have a material effect on the overall delivery programme.

The current contract completion date is February 2029 and remains unchanged.

Taking each phase in turn, the forecast completion dates are:

- Phase 2A is November 2027. The refurbishment of Phase 3 and 4 is dependent upon the completion of Phase 2A.
- Phase 2B is August 2027.
- Phase 3 is July 2028.
- Phase 4 is February 2029.

NEC contract documentation is established and regular a meeting cadence is in place with all parties engaged and committed.

The current total budget cost for the project remains £64,789,755 including the contracted McAvoy works at a baseline target cost of £43,404,839 excl**.** VAT plus enabling works, professional fees, VAT and risk allowances.

A proactive communications and engagement plan is in place to ensure robust and timely messaging to staff, service users, their families and local residents. Considerable work has taken place over the last period including staff and local resident drop-ins and leaflet drops to inform of arrangements for the delivery of modules throughout November 2026 and January 2027.

Current construction risks to the project revolve around the completion of the enabling works in a timely manner, services connections/disconnections and the procurement of enabling works within the provisional sum allowances available. Mitigation measures and sequencing adjustments are in place to maintain programme momentum.

Communication with Northern Power Grid (NPG) remains in place to upgrade the site's incoming electrical supply. An application has been made (with fee paid) to progress this and the Trust's legal advisors have been instructed to advise on the necessary wayleaves, easements and lease required. Close monitoring of this transaction is being maintained as

1. Status (RAG)

successful delivery of this workstream is a key requirement for the successful delivery of the programme.

2. Specific progress by Phase:

Phase 2A : New Build (Modular)

Foundation works continue to progress well, with pile cropping activities ongoing and preparations underway for the construction of pile caps and ground beams. The integrity testing of all installed piles has been completed, with all piles successfully passing the required testing.

Surface water drainage works have been completed, with inspections and Building Control reviews have also been undertaken with no concerns raised.

The water main diversion has been completed, including the installation of two new fire hydrants. This removes a significant constraint ahead of the planned modular building installation works.

Offsite manufacture of the modular building is progressing well within the factory. Structural module construction, underfloor heating installation, roof coverings, screeding and partition installation activities are all underway, with regular quality inspections being carried out by the NEC Supervisor.

Planning condition discharge activities remain ongoing, although approval of the drainage-related planning condition remains outstanding with Yorkshire Water and continues to be monitored as a key project risk.

To maintain programme recovery following the piling challenges, McAvoy has continued to review and re-sequence the works. Podium steel erection commenced on 19th October 2026, with radon protection measures due to commence on 26 October 2026. Preparations for the first phase of modular unit deliveries and installation, commencing in November 2026, are progressing well with crane delivery (with police escort) scheduled for 11th November.

The Project Director continues to progress legal discussions directly with Hempsons to ensure the wayleave and any other legal agreements are appropriately put in place. Northern Power Grid has advised that these agreements require finalisation before an order for the new substation can be placed with its supplier. As noted above, no specific issues to note at this juncture, however the need to close out the legal work without delay remains a requirement for successful programme delivery.

McAvoy has produced a 'factory programme' which outlines offsite activities to construct the modules. The NEC Supervisor/Clerk of Works has visited McAvoy's facilities in Belfast on several occasions and has confirmed good progress.

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Phase 2B: Refurbishment Works

Refurbishment works within Area 1 of the existing Main Block have been completed with handover on the 19th October 2026.

Delays associated with the supply and installation of internal doors impacted completion activities. However, the issue was successfully resolved with an alternative supplier and additional labour resources being allocated to complete the outstanding works and achieve completion of this area in line with programme.

As noted above, Area 2 of this phase was handed over to the contractor in line with programme on 26th October 2026.

Phases 3&4: Ward Refurbishments

Commencement on these phases of the project are dependent upon the completion of phase 2A, the new build, and phase 2B, refurbishment of the main building.

Health and Safety Overview

There have been no reported health and safety incidents or near misses during the reporting period, and the project continues to maintain a strong safety record.

Site activities have continued safely across both the new build and refurbishment works, with the workforce increasing as construction progresses.

Regular inspections and audits continue to be undertaken by both the project team and the Trust's CDM Advisor. No significant health, safety or quality concerns were identified during the reporting period, providing assurance that the works are being delivered in accordance with the project's standards and procedures.

Building Control inspections have also continued throughout the period, including reviews of drainage and foundation works, with no material issues raised.

As the project moves towards the first phase of modular unit installations in November, McAvoy has continued to carefully manage site logistics, access arrangements and construction sequencing to ensure works can be delivered safely while minimising disruption to the live hospital environment.

Overall, health and safety performance remains positive, with no reportable incidents and good levels of compliance being maintained across both the site and offsite manufacturing activities.

Overall

Co-ordination between the LMH Redevelopment Project Team, the contractor and clinical teams remains strong, with regular weekly meetings supporting planning and safe delivery

Project-wide Activities:

- Pharmacy Modular Unit mobilised and operational as expected on 19th October 2026. This enabled the closure of the pharmacy dispensary ready for contractor handover on 26th October 2026 as highlighted above. Thanks to all involved in this as it required weekend working.
- Proactive communications and engagement plan is in place – ICB Chair visited, press releases and staff and local resident drop-in sessions.
- Wayfinding strategy agreed in principle with P&HS Architects with further work required with Networks and Service Users throughout November 2026.

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- Progression of Full Business Case approval conditions for agreement with DHSC.
- Project Risk Register updated and quarterly reviews now scheduled. Review of project contingencies/reserves undertaken by project team.
- Comprehensive review of FBC budgets and allowances undertaken with finance colleagues and project team to restate and align budgets to known commitments.

Slippage & Delays:

- Overall, the project remains broadly in line with programme; however, delays to enabling works and the disconnection of existing services have impacted early-stage activities and required resequencing of works. Opportunities for programme betterment exist in relation to Phase 2B which remain under review.
- Delays to Phase 2A due to piling issues, additional activities to capture the radon barrier installation and delay or resequencing requirements due to modular construction issues in the factory.
- Hempsons, the Trust's legal advisors, continue to support with residual contracts/design team appointments – Trust engagement ongoing.
- Collateral warranties and appointment documentation for T&T's SHEQ remain outstanding.

3. Sustainability:

New Build (2A) BREEAM Excellent/Refurb elements (2B 3 &4) BREEAM Very Good

BREEAM Design Stage
We are seeking the appointment of a revised BREEAM Assessor. We are obtaining quotations from new Assessors who will need to review the design stage credits to confirm the current position and then begin the review of the evidence provided by McAvoy for the construction stage credits.

BREEAM Construction Stage
Key individuals within the McAvoy Delivery Team have been identified as responsible persons for operational and design based credits for the BREEAM consultants to liaise with. Evidence for credits has already starting to be issued and making good progress.

Alexander Trigg BSc MRICS
Deputy Director of Estates & Facilities and Deputy SRO
5th November 202

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Close Holly
11/11/2026 11:37:53

Name of meeting:	Council of Governors
NED Chair:	Sarah Jones
Lead Director:	Fran Stead
Secretariat:	Holly Close
Year:	2026/27

NHS
Bradford District Care
NHS Foundation Trust

Category	Agenda item	Paper author	Item presented	Lead Director	Lead PA	Public hybrid Date 13/05/2026	Public hybrid Date 29/07/2026	Public hybrid Date 11/11/2026	Public hybrid Date 10/02/2027
Good Governance	**Apologies**	Verbal	Senior Corporate Governance Officer	Chair	HC (Senior Corporate Governance Officer)	X	X	X	X
Good Governance	**Declarations of conflicts of interest**	Verbal	Senior Corporate Governance Officer	Chair	HC (Senior Corporate Governance Officer)	X	X	X	X
Good Governance	**Minutes of last meeting**	Senior Corporate Governance Officer	Chair	Chair	HC (Senior Corporate Governance Officer)	X	X	X	X
Good Governance	**AMM Minutes**	Senior Corporate Governance Officer	RT (Deputy Trust Secretary)	FS (Trust Secretary)	HC (Senior Corporate Governance Officer)			X	
Good Governance	**Matters arising**	Senior Corporate Governance Officer	Chair	Chair	HC (Senior Corporate Governance Officer)	X	X	X	X
Good Governance	**Action log**	Senior Corporate Governance Officer	Senior Corporate Governance Officer	FS (Trust Secretary)	HC (Senior Corporate Governance Officer)	X	X	X	X
Good Governance	**Issues and Questions from Communities**	Verbal	Governors	N/A	N/A	X	X	X	X
Good Governance	**Chairs Report**	Chair of the Trust	Chair of the Trust	Chair of the Trust	MH (Executive Assistant)	X	X	X	X
Good Governance	**Governance Report**	Corporate Governance Officer	RT (Deputy Trust Secretary)	FS (Trust Secretary)	HC (Senior Corporate Governance Officer)	X	X	X	X
Good Governance	**BDCT Annual Report**	Corporate Governance Officer	RT (Deputy Trust Secretary)	FS (Trust Secretary)	MH (Executive Assistant)		X		
Good Governance	**Quality Account**	PR (Senior risk and Clinical Audit Manager)	TBC	PH (Director Director of Nursing, Professions and Care Standards)	JR (Executive Assistant)	X			
Good Governance	**Freedom to Speak Up Guardian Report**	RW (Freedom to Speak Up Guardian)	TBC	PH (Director Director of Nursing, Professions and Care Standards)	JR (Executive Assistant)		X		
Good Governance	**Well Led**	Senior Corporate Governance Officer	FS (Trust Secretary)	FS (Trust Secretary)	MH (Executive Assistant)	X	X	X	X
Good Governance	**Proposal for the Annual Members' Meeting**	Senior Corporate Governance Officer	RT (Deputy Trust Secretary)	FS (Trust Secretary)	HC (Senior Corporate Governance Officer)		X		
Good Governance	**Alert, Advise, Assure and Decision reporting / Assurance Report Board Sub-Committees**	Senior Corporate Governance Officer	RT (Deputy Trust Secretary)	FS (Trust Secretary)	HC (Senior Corporate Governance Officer)	X	X	X	X
Good Governance	**Notification of future meeting dates**	Senior Corporate Governance Officer	RT (Deputy Trust Secretary)	FS (Trust Secretary)	HC (Senior Corporate Governance Officer)	X	X	X	X
Good Governance	**Committee Annual Effectiveness review**	Senior Corporate Governance Officer	RT (Deputy Trust Secretary)	FS (Trust Secretary)	HC (Senior Corporate Governance Officer)				X
Good Governance	**Committee annual Terms of Reference review**	Senior Corporate Governance Officer	RT (Deputy Trust Secretary)	FS (Trust Secretary)	HC (Senior Corporate Governance Officer)			X	
Good Governance	**Committee annual Terms of Reference review - Nomination and Remuneration Committee**	Senior Corporate Governance Officer	RT (Deputy Trust Secretary)	FS (Trust Secretary)	HC (Senior Corporate Governance Officer)	X			
Good Governance	**Council of Governors Annual Work Plan**	Senior Corporate Governance Officer	RT (Deputy Trust Secretary)	FS (Trust Secretary)	HC (Senior Corporate Governance Officer)	X	X	X	X
Good Governance	**Comments from Public Observers**	Verbal	Public Observers	N/A	N/A	X	X	X	X
Good Governance	**Chair in Common Governance Framework Review**	FS (Trust Secretary)	RT (Deputy Trust Secretary)	FS (Trust Secretary)	HC (Senior Corporate Governance Officer)			X	
Good Governance	**Governor JD Review**	Senior Corporate Governance Officer	RT (Deputy Trust Secretary)	FS (Trust Secretary)	HC (Corporate Governance Officer)	X			
Best Place to Work	**Staff Survey Update**	HF (Engagement Manager)	HF (Engagement Manager)	BC (Chief People Officer)	(Executive Assitant)	X			
Best Use of our Resources	**Finance and Performance Report**	CS (Cliff Springthorpe) & CR (Operational Director of Finance)	KB (Chief Operating Officer) & CR (Operational Director of Finance)	KB (Chief Operating Officer) & CR (Operational Director of Finance)	DJ (Executive Assistant)	X	X	X	X
Best Use of our Resources	**Lynfield Mount Update**	SE (Deputy Director of Estates and Facilities	SE (Deputy Director of Estates and Facilities	MW (Chief Finance Officer)	ZN (Executive Assistant)			X	X

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