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.0.1.2.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 & the minutes from the Annual Members' Meeting 24 September 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

Claire Holly 05/11/2026 10:35:32

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)

Close Holly 05/11/2026 10:55:3

Strategy and Partnerships

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

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

Good Governance

18:25 - 18:25
0 min

14. Council of Governors Annual Work Plan (enclosure)

For Information *For Information*

Item 13.0 - Council of Governors Annual Work Plan 2026-27.pdf (1 pages)

Close Holly 05/11/2026 10:35:32

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
05/11/2026 10:55:32

Council of Governors – held in public

Date: Thursday 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**

Clerk Holly 05/11/2026 10:55:32

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 03/11/2026 16:55:32

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 05/11/2026 10:55:32

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

Close Holly
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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
05/11/2026 10:55:32

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 05/11/2026 10:55:32

Emmerson Walgrove Public Governor: Bradford West

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 05/11/2026 10:58:32

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 05/11/2026 10:25:32

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 05/11/2026 10:55:32

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 05/11/2026 10:55:32

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 05/11/2026 10:55:32

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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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	• Item 04.0 – AAAD & Minutes • Item 07.1 - Strategic Risk Assurance Report - September 2026 • Item 07.2 – Board Assurance Framework • Item 07.2 – Compliance & Risk Report • Item 07.4 – Well Led Development Plan update • Item 07.5 – Managing Conflicts of Interest in the NHS Policy & Procedure

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	• Item 07.5 - Business Conduct, Bribery and Conflict of Interests in the NHS Procedure • Item 07.6 – Provider Capability Assessment • Item 07.7 – Committee Effectiveness Review • Item 14.0 – Policy for Procurement for Non-Audit Services by External Auditors		
New risks identified by Committee	• No New risks identified		
Feedback following discussion at 'parent' meeting			
Report completed by	Nazmeen Khan – Corporate Governance Officer	**Date**	**23.09.2026**
On Behalf of Chair	**Warren Brown, Non-Executive Director**		

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AAAD: Effective Oversight: Escalation and Assurance

Report to:	**Board of Directors (Public)**	**Meeting date:**	**TBC**
Report from:	**Charitable Funds Committee**	**Meeting date:**	**29.10.2026**
Quorate?	**Yes ☒ No ☐**		
Members present	Sally Napper (Chair), Sarah Jones, Mike Woodhead		
In attendance	Kelly Barker Catherine Jowitt, Nazmeen Khan, Chris Smith, Laura Whitam, Tracy Robinson, Sarah Heseldon.		
Observers	N/A		
Apologies	Rachel Trawally		

Best Use of Resources	**Theme 1**: Financial sustainability	**BUoR:T1**
	Theme 2: Our environment and workspaces	**BUoR:T2**
	Theme 3: Giving back to our communities	**BUoR:T3**

Agenda items (not including standard items)	• Future Staffing Structure – Virtually Approved • Hospital Rooms Combined Agreement - Virtually Approved • Learning from your experience: VIP Red Bags • Charity Risk Register • Charity Strategic Update • Charity Annual Accounts • Approval of Fund Objectives & managers • Transactions and Balances • Charity Grant Applications • Charity Annual Report • External Audit Reporting on the Annual Accounts Narrative: • .1 External Audit: ISA 260 • .2 Auditors report. • .3 Management letter • Confirmation of Escalation Reporting • Any Other Business • .1 Charity Reserves Policy
Alert items agreed by Committee	
Advise items agreed by Committee	• The Committee noted a potential sustainability risk relating to the School Health Hub following changes to the 0–19 service arrangements. Discussions were continuing regarding transitional arrangements and the future delivery model. NHS Charities Together had indicated flexibility to extend the use of underspent grant funding, potentially to December 2027, to support transition and sustainability. • The Committee received a positive presentation on the VIP Red Bag scheme, which supports people with learning

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	disabilities to communicate their needs and access reasonable adjustments when using health services. Approximately 420 bags remained in stock, but longer-term funding would need to be considered. The Committee supported exploring a more consistent, system-wide approach across West Yorkshire and consideration of whether future provision should form part of core funding rather than rely on charitable funding. • The Committee noted the Charity's increasing grant activity and the need for closer oversight of reserves, available grant funding and income generation, particularly alongside delivery of the Hospital Rooms project. • The Reserves Policy was approved, subject to a six-month review to ensure any future employment-related matters concerning the Charity Team could be appropriately reflected within the policy.
Assure items agreed by Committee	• The Committee received assurance on the positive impact of the VIP Red Bag scheme, which supports people with learning disabilities to communicate their needs and access appropriate reasonable adjustments when receiving healthcare. The scheme had received positive feedback from service users, families and healthcare staff, with increased recognition of the bags across local services. The Committee welcomed the benefits demonstrated and supported consideration of a sustainable, system-wide approach to future provision. • The Committee noted that there were no live risks on the Charity Risk Register. • The Committee received the 2025/26 annual accounts, which had received an unqualified audit opinion, and approved them for onward consideration by Audit Committee in December. • The Committee approved the Charity Annual Report and received assurance regarding progress across fundraising, grants, partnerships and staff engagement.
Decisions made by Committee	The Committee was quorate, the following items were approved by members within the meeting. • Item 04.0 - 25 June 2026 Minutes • Item 04.0 - 25 June 2026 AAAD • Item 10.0 - Charity Annual Accounts • Item 14.0 - Charity Annual Report • Item 15.0 - External Audit Reporting on the Annual Accounts Narrative: 1 External Audit: ISA 260 .2 Auditors report. .3 Management letter • Item 19.0 - Charity Reserves Policy subject to a six-month review
New risks identified by Committee	No items were raised.

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Items to be considered by other Committees/Groups	No items were raised.		
Feedback following discussion at 'parent' meeting	No items were raised		
Report completed by	Nazmeen Khan Corporate Governance Officer	**Date**	29.10.2026
On Behalf of Chair	Sally Napper, Non-Executive Director		

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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 05/11/2026 10:55:32	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 05/11/2026 10:55:32	The Committee approved: • Minutes of the previous meeting & AAAD • Action Log • Associate Hospital Manager's Report • Provider capability • Board Assurance Framework • Strategic Risk Report

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

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AAAD: Effective Oversight: Escalation and Assurance

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

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

Agenda items

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

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

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

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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

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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)		

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AAAD: Effective Oversight: Escalation and Assurance

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

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

Agenda items

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

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

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

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

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AAAD: Effective Oversight: Escalation and Assurance

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

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

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

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

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

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Bradford District and Craven
Health and Care Partnership

ACTasONE

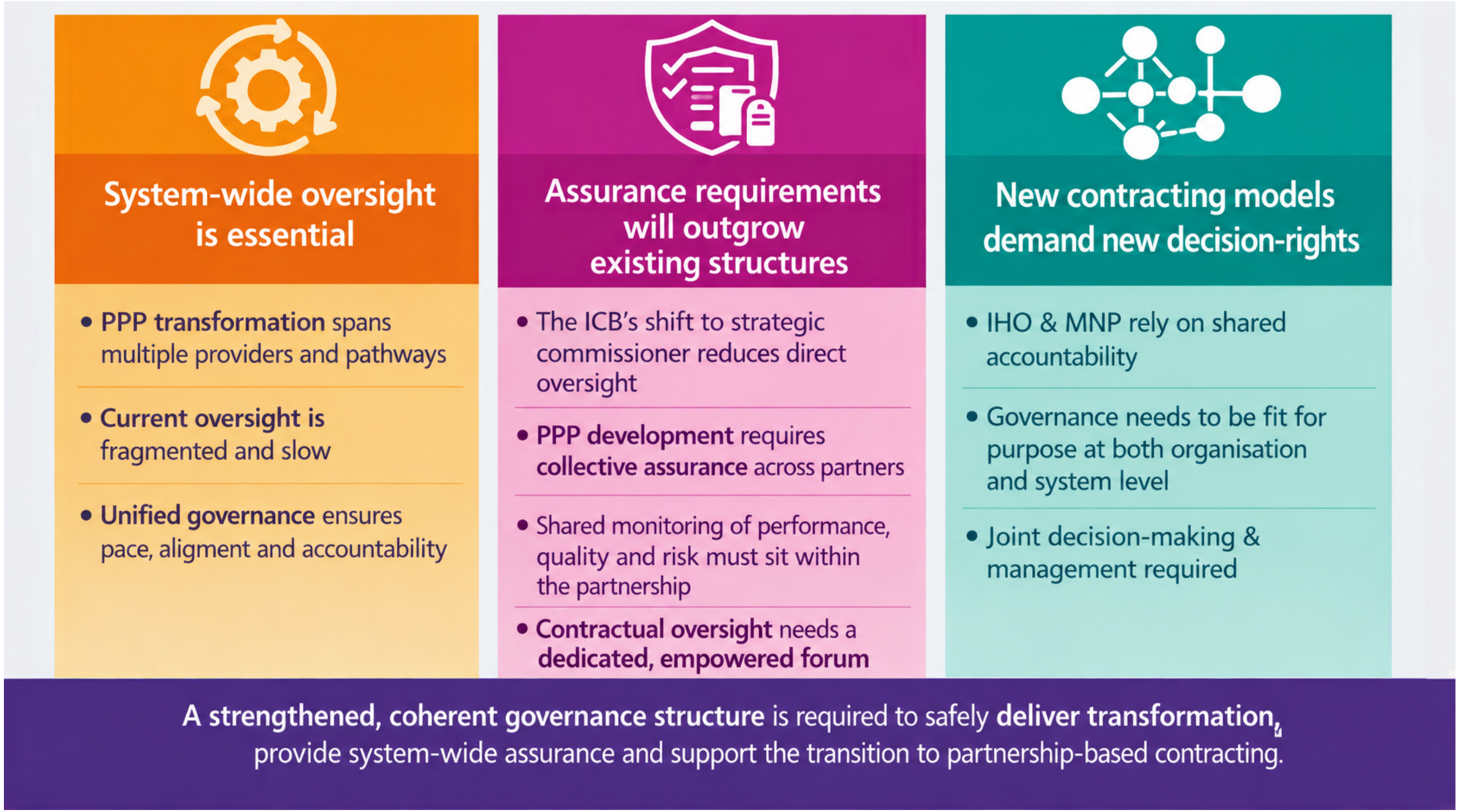
BDC System Governance Proposal

October 2026

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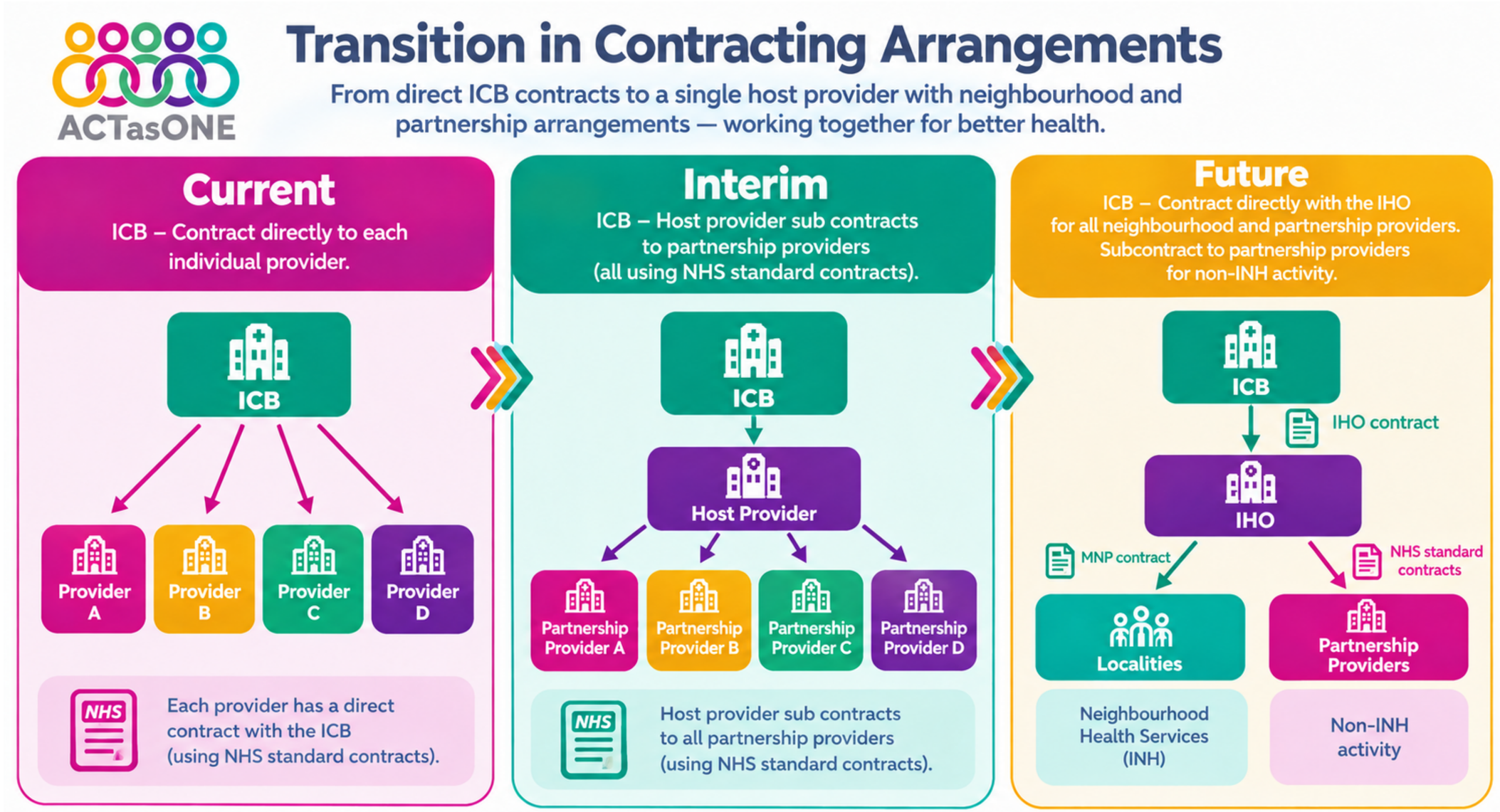
The Case for Change

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
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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
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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**

Closed Holly 05/11/2026 10:55:12

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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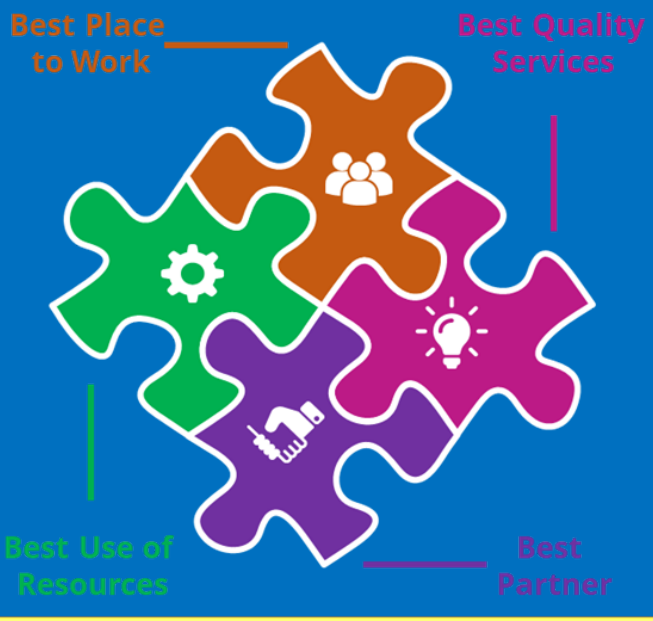
	and use of resources; and leadership and capability.

Close Holly
05/11/2026 10:55:32

NHS
Bradford District Care
NHS Foundation Trust

Integrated Strategic Performance And Quality Report

October 2026 (September Data)



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Introduction

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

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

This report is set out in the following sections:

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

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

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Themes Observed Within This Report

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

Key triangulated themes within this report are:

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

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

2 - Mental health flow is the clearest operational pressure

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

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

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

4 – Access performance is polarised

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

5 – Data quality is a strategic performance risk

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This appears repeatedly across the report:

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

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

Good news stories for celebration

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

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

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

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

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

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

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

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

Red indicators have been under target for 3 or more periods. Those that have dipped under target for one or two periods will remain Amber.
Domain Key:
ATS = access to services, **QPS** = quality and patient safety, **EFC** = effectiveness of care, **EXC** = experience of care, **P** = people, **FP** = finance and productivity

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Executive Summary – KPI Assurance Grid (National Oversight Framework)

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

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

NOF Score 4 Latest Quarter	Domain	Last Quarter Score	NOF Score 3 Latest Quarter	Domain	Last Quarter Score	NOF Score 2 Latest Quarter	Domain	Last Quarter Score	NOF Score 1 Latest Quarter	Domain	Last Quarter Score
% Children and Young People's mental health waits over 104 weeks	Access to Services	New for NOF but Red last report ⇔	Sickness Absence	People and Workforce	4 ⇑	CQC Community MH Satisfaction Score	Experience of Care	2 ⇔	Percent waiting 52 weeks for community services	Access to services	1 ⇔
% of people discharged community MH services with a paired outcome	Access to Services	N/A (New)				Mean LOS for patients discharged from adult acute mental health/PICU	Experience of Care	N/A (New)	Percentage of patients waiting < 18 weeks for community services	Access to services	N/A (New)
Temporary staffing cost relative band	People and Workforce	N/A (New)				NHS staff survey advocacy rate	Experience of Care	N/A (New)	% Patients in Crisis F2F Within 24 hrs	Patient Safety	1 ⇔
% of IP referred to and seen by an in-house tobacco service	Effectiveness of Care and Population Health	N/A (New)				Mean length of stay for patients discharged from older adult acute mental bed	Experience of Care	N/A (New)	% of discharges adult acute MH beds readmitted within 14 days	Effectiveness of Care and Population Health	N/A (New)**
						Adult acute and rehab MH, LD and autism discharges F/Up within 72 hours	Effectiveness of Care and Population Health	N/A (New)	Combined Finance (Planned Surplus / deficit + YTD Variance)	Finance, Productivity, Innovation	1 ⇔
						NHS Staff Survey – Raising Concern Score	Patient Safety	2 ⇔	% of clinical trials set up within 90 days	Finance, Productivity, Innovation	N/A (New)
						Relative Difference in Costs	Finance, Productivity, Innovation	2 ⇔	NET Survey overall experience sub-score	People and Workforce	N/A (New)
						Overall Data Quality Maturity Index score	Finance, Productivity, Innovation	N/A (New)	NHS staff standards sub-score	People and Workforce	N/A (New)
						NHS Staff Survey Engagement Score	People and Workforce	2 ⇔			
						% frontline workers to receive a flu vaccination	People and Workforce	N/A (New)			

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

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

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

Service / Area	NOF / Planning / Other	KPI / Indicator	Latest Month / Period	Measure And RAG Rating	Target	Variation to Target	Data Quality Confidence (Low/Med/High)
PH Community	NOF	Percentage of patients waiting over 52 weeks for community services Link to Slide	Q1 2026/27	0 (NOF 1)	0 (NOF 1)	-	Data quality confidence to be added next time
PH Community	NOF	Percentage of patients waiting under 18 weeks for community services Link to Slide	Q1 2026/27	94.79% (NOF 1)	>= 78% (NOF 1)	16.79%	
MH CYP	NOF & Planning	Proportion of total open CYP MH related waits that are over 104 weeks Link to Slide	Q1 2026/27	51% (NOF 4)	<5% (NOF1) 0 by Mar 27 (planning)	46%	
MH Community	-	Community Mental Health - % of people seen within 4 weeks Link to Slide	September 2026	27.3%	No set target	-	
MH CYP & Adults	NOF	% of people discharged from community mental health services with a paired outcome score recorded (all ages) Link to Slide	Q1 2026/27	CYP 9.4% (NOF 4) Adult 8% (NOF 2) NOF 4 Overall	CYP >= 28% Adult >= 12% (NOF 1)	CYP 18.6% Adult 4%	
Dental	-	Consultant-led waiting times - Community Dental Services - % waiting over 18 weeks Link to Slide	September 2026	50.1%	92%	-41.9%	
PH 0-19	-	0-19 Mandated Contacts - Antenatal Contact Link to Slide	Q2 2026/27	69.9%	55.0%	14.9% above target	
PH 0-19	-	0-19 Mandated Contacts - New Birth Visit Link to Slide	Q2 2026/27	98.3%	90.0%	8.3% above target	
PH 0-19	-	0-19 Mandated Contacts - 6 to 8 Week Contact Link to Slide	Q2 2026/27	97.5%	90.0%	7.5% above target	
PH 0-19	-	0-19 Mandated Contacts - 12 Month Review Link to Slide	Q2 2026/27	97.0%	90.0%	7.0% above target	
PH 0-19	-	0-19 Mandated Contacts - 2 to 2.5 Year Review Link to Slide	Q2 2026/27	95.1%	85.0%	10.1% above target	

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

Service / Area	NOF / Planning / Other	KPI / Indicator	Latest Month / Period	Measure And RAG Rating	Target	Variation	Data Quality Confidence (Low/Med/High)
All	NOF	NHS Staff Survey raising concerns sub-score (MHPRV) Link to Slide	2025	6.80 (NOF 2)	See narrative	-	Data quality confidence to be added next time
MH Crisis	NOF	Proportion of urgent referrals to Crisis Care teams with first face to face contact within 24 hours (3m rolling) - safety (3.25) Link to Slide	Q1 2026/27	90.1%	80%+ (NOF 1)	10.1%	
All	-	Sexual Safety (no slide yet)	New Standard - Reporting To Be Developed				
All	-	No Force first - Prone Restraint Link to Slide	September 2026	1	No Set Target (See Note)	N/A	
All	-	No force first – Seclusion Link to Slide	September 2026	1	No Set Target (See Note)	N/A	
All	-	No force first – Segregation Link to Slide	September 2026	0	No Set Target (See Note)	N/A	
All	-	Medication Incidents Link to Slide	Q1 2026/27	243	No Set Target	N/A	
All	-	Avoidable Harm - pressure ulcers: Total Link to Slide	September 2026	148	No Set Target (See Note)	N/A	
PH Community	-	Avoidable Harm - pressure ulcers: ulcers moderate or above with omissions Link to Slide	September 2026	55	No Set Target (See Note)	N/A	
All	-	Falls – Total reported Link to Slide	September 2026	22	No Set Target (See Note)	N/A	
All	-	Safer staffing - % of hours utilised for enhanced observations (no slide yet)			No Set Target (See Note)	N/A	
All	-	% Red Shifts (Mental Health Inpatients) (no slide yet)	September 2026	0	No Set Target (See Note)	N/A	
All	-	% Black shifts Opel Rating (Physical Health services) (no slide yet)	New Standard – Reporting To Be Developed				

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

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Summary Points

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

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

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

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

Service / Area	NOF / Planning / Other	KPI / Indicator	Latest Month / Period	Measure And RAG Rating	Target	Variation	Data Quality Confidence (Low/Med/High)
Inpatients	Planning	Inappropriate OAP bed days (our spot continuity number and all OAP bed days) Link to Slide	September 2026	797	On / under Trajectory (668 September)	129	Data quality confidence to be added next time
Inpatients	-	% of ward occupancy delayed for Acute Wards Link to Slide	September 2026	6.6%	10% and under	-3.4%	
Inpatients	NOF	Mean length of stay for adult acute and psychiatric intensive care unit (PICU) patients (new measure) Link to Slide	Q1 2026/27	56 (NOF 3)	51 March 2027 – Planning (<=40 for NOF 1)	5	
Inpatients	NOF	Mean length of stay for older adult acute discharges (new measure) Link to Slide	Q1 2026/27	81 (NOF 2)	76 March 2027 – Planning (<=73 for NOF 1)	3	
PH Community	Planning	% of Urgent Community Responses within 2 hours Link to Slide	August 2026	72.0%	70%	2%	
MH All	NOF	CQC community mental health service satisfaction rate Link to Slide	Q1 2026/27	As Expected (NOF 2)	Based on rank	-	

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

Service / Area	NOF / Planning / Other	KPI / Indicator	Latest Month / Period	Measure And RAG Rating	Target	Variation	Data Quality Confidence (Low/Med/High)
All	NOF	NHS Staff Survey Engagement sub score - pulse survey becomes the narrative Link to Slide	September 2026	7.06	7.4+ (NOF 1)	0.34 below target	Data quality confidence to be added next time
All	NOF	Sickness absence rate (3m rolling) - add long term and short term as a narrative Link to Slide	Q1 2026/27	7.06%	4% (NOF 1)	3.06% above target	
All	-	Return to work interview after sickness absence Link to Slide	September 2026	51.55%	95%	43.45% below target	
All	-	Labour Turnover Link to Slide	September 2026	9.31%	10%	0.69% within target	
All	-	Duty Fulfilment of Bank % (slide to be developed)	September 2026	22.14%	20-25%	Within target range	
All	-	Duty Fulfilment of Agency % (slide to be developed)	September 2026	0.44%	2%	0.56% within target	
All	-	Time to fill a vacancy (slide to be developed)	September 2026	11	8 Weeks (as set by NHS E)	3 weeks above target	
All	-	Number of employee relations cases (open cases at a point in time) Link to Slide	September 2026	36	30	6 cases above target	
All	-	Vacancy Rate Link to Slide	September 2026	6.81%	10%	3.19% within target	
All	-	Variation from budgeted establishment Link to Slide	September 2026	224.70	350	125.3 within target	
All	-	Appraisal compliance Link to Slide	September 2026	79.55%	80%	0.45% within target	
All	-	Clinical supervision Link to Slide	September 2026	83.36%	80%	3.36% above target	
All	-	Mandatory training Link to Slide	September 2026	91.07%	80%	11.07% above target	
All	NOF	National Education and Training Survey overall experience sub-score - new measure Link to Slide	Q1 2026/27	85.32% (NOF 1)	Based on rank	-	
All	NOF	NHS Staff Standards sub-score (slide to be developed)	Annual	7.97 out of 10 (NOF 1)	Based on rank	-	
All	NOF	Percentage of frontline healthcare workers to receive a flu vaccination (slide to be developed)	Q1 2025/26 (annual)	46% (NOF 2)	Based on rank	-	
All	NOF	Temporary staffing cost relative band (slide to be developed)	Q1 2026/27	NOF 4	TBC	-	

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Summary Points

- The low vacancy rate whilst positive in terms of performance, is contributing to a reported above plan workforce position and the financial position of the Trust at M5. A review to strengthen the workforce controls is taking place, with a key focus on demand into services, experiences of patients and service users, safer staffing requirements, health and wellbeing of colleagues and Equality and Quality Impacts. Temporary staffing usage is performing ahead of the workforce plan and lower than expected.
- Active support continues into the management of sickness absence across the Trust, including improving return to work rates and quality of support for colleagues, including signposting to the Health and Wellbeing offer. A statistically significant improvement in the number formal employee relations cases has taken place since January 2026, following the implementation of the avoidable harm initiative. Further development of the time to fill a vacancy metric will also take place ahead of the next reporting period.
- Strong, consistent performance continues in relation to labour turnover, appraisal completion, clinical supervision and mandatory training.

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

Service / Area	NOF / Planning / Other	KPI / Indicator	Latest Month / Period	Measure And RAG Rating	Target	Variation	Data Quality Confidence (Low/Med/High)
All	NOF	Forecast outturn against plan Link to Slide	September 2026	Breakeven	On or better than plan (NOF1)	Breakeven	High
All	-	Forecast Performance Against CIP Plan (no slide yet)	September 2026	CIP delivery is forecast to be offtrack by £4.6m (non recurrently mitigated)	On or better than plan	£4.6m off track	High
ALL	-	Financial risk assessment of delivering the Plan (no slide yet)	September 2026	Best Case Risk £0m Likely Case Risk £3.2m Worse Case Risk £8.8m	Risks fully mitigated	£3.2m mitigations to find	High
All	-	Performance against agency cap limit (no slide yet)	September 2026	Forecast Achievement of planned agency expenditure	On or better than plan	Within Agency cap	High
All	-	Performance against bank cap limit (no slide yet)	September 2026	Breached by £1.0m	On or better than plan	£1.0m breach	High
All	-	Cash ratio (no slide yet)	September 2026	FOT = 1.62	Ratio of 1 or more	1.62	High
All	-	Capital Performance YTD (no slide yet)	September 2026	Underspent against plan by £3.7m	Achievement of Plan	Under by £3.7m	High
All	-	Capital Performance Forecast (no slide yet)	September 2026	Forecast Achievement of Plan	Achievement of Plan	At plan	High
All	NOF	Relative difference to cost Link to Slide	December 2025	106.45 (NOF 2)	NCCI 100 or lower (Annual)	106.45	TBC

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

Reported Position

The Trust remains technically on plan and forecasting breakeven, but delivery of the financial position is increasingly dependent on managing a substantial CIP shortfall and mitigating a £3.2m residual risk. NHS England's decision to place the Trust in the 'Watch category' reflects concern over deliverability rather than current financial failure, and there is heightened scrutiny on recovery planning, CIP delivery, workforce costs and governance.

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Financial Risk assessment

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

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

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

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

Management actions

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

Reporting breaches

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

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

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Mental Health Care Group – Service Area Heat Map

Service Area Heat Map

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.

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Physical Health Care Group – Service Area Heat Map

Service Area Heat Map

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

Financial RAG ratings:

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

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Corporate Services – Service Area Heat Map

Service Area Heat Map

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

Financial RAG ratings:

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

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Appendix 1 – NOF Detail Slides

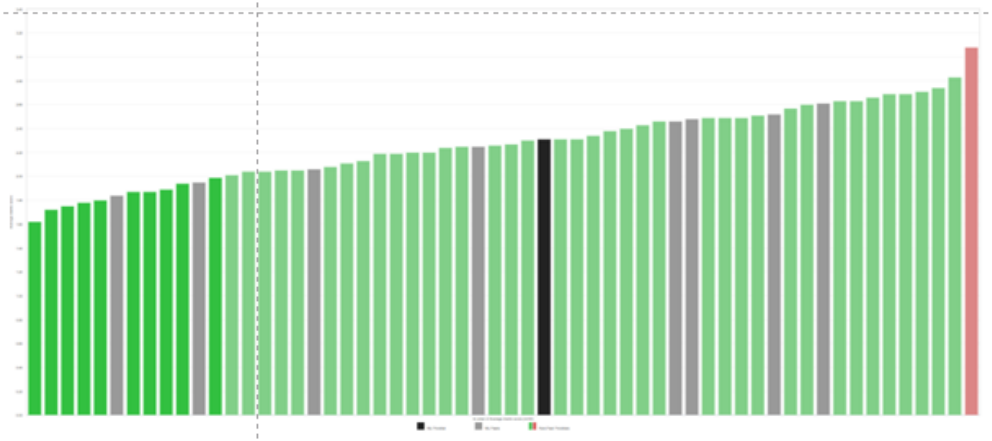
NHS Oversight Framework (NOF) – Non-acute hospital Trusts

NHS
Bradford District Care
NHS Foundation Trust

Overview NOF Q1 2026/27 – Latest Publication

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

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



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National Oversight Framework - Summary

NHS Bradford District Care NHS Foundation Trust

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

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National Oversight Framework - Summary

NHS Bradford District Care NHS Foundation Trust

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

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National Oversight Framework - Summary

NHS Bradford District Care NHS Foundation Trust

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

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

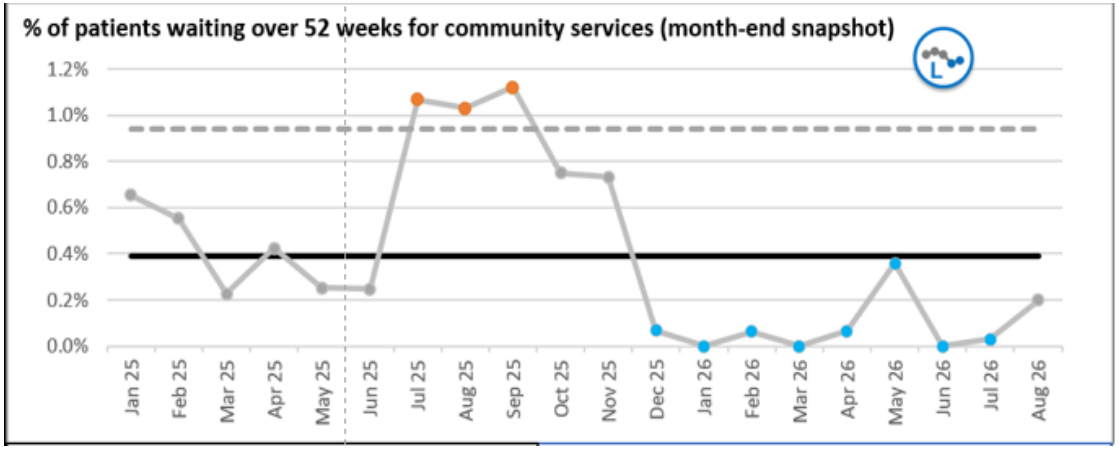
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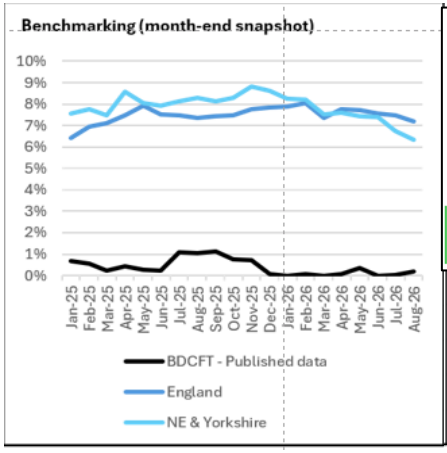
Appendix 2 – Detailed Description of Performance

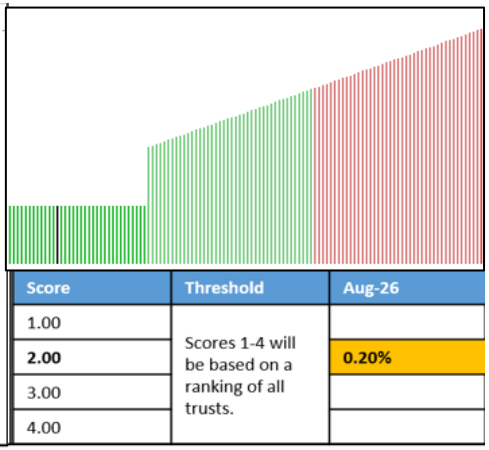
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Measure: Percentage of patients waiting over 52 weeks for community services – month-end snapshot

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





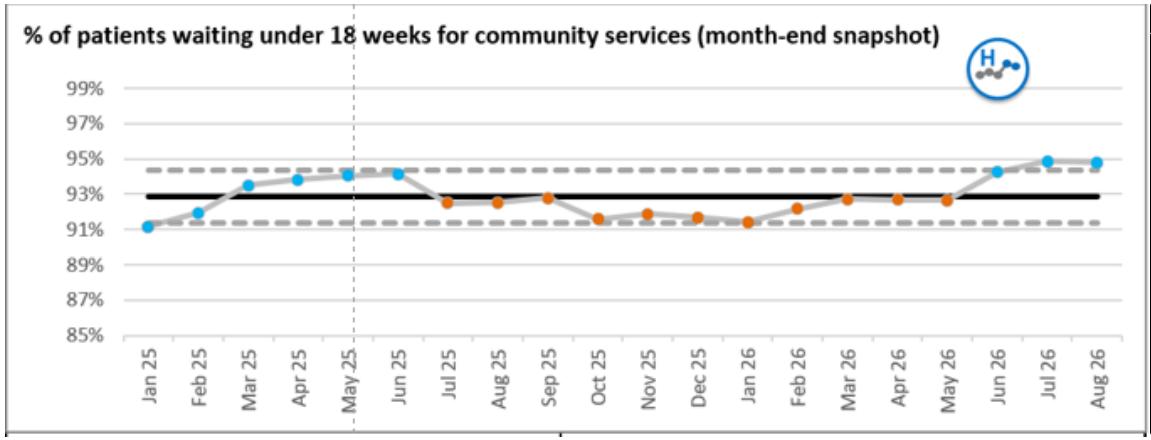


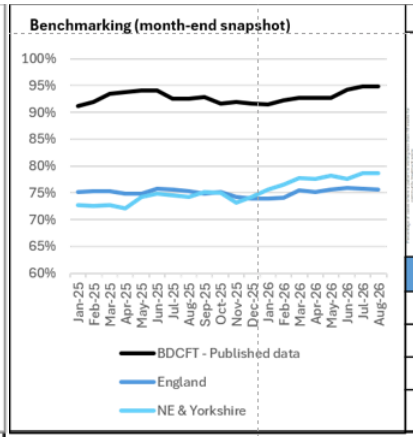
Score	Threshold	Aug-26
1.00	Scores 1-4 will be based on a ranking of all trusts.	
2.00		0.20%
3.00		
4.00		

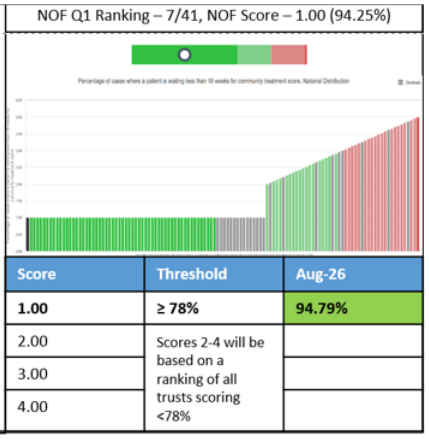
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a National Outcome Framework indicator that helps us track our longest waiters for community based physical health services.	We are currently on track. There was a slight increase in long waiters in May 2026, however these were all seen during June 2026 meaning a NOF score of 1. August data highlights two people currently waiting more than 52 weeks. They have been seen during September, and the figures should be at zero for the next NOF snapshot at the end of September.	Service leads are activity monitoring wating lists and focusing on those areas where we are more likely to get longer waits, for example in Dysphagia where specialist availability can be a challenge.	An agreement is in place with Leeds Teaching Hospital for the regular provision of a Dysphagia specialist and longer waits are being mitigated though active list management.

Close Holly 05/11/2026 10:55:32

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





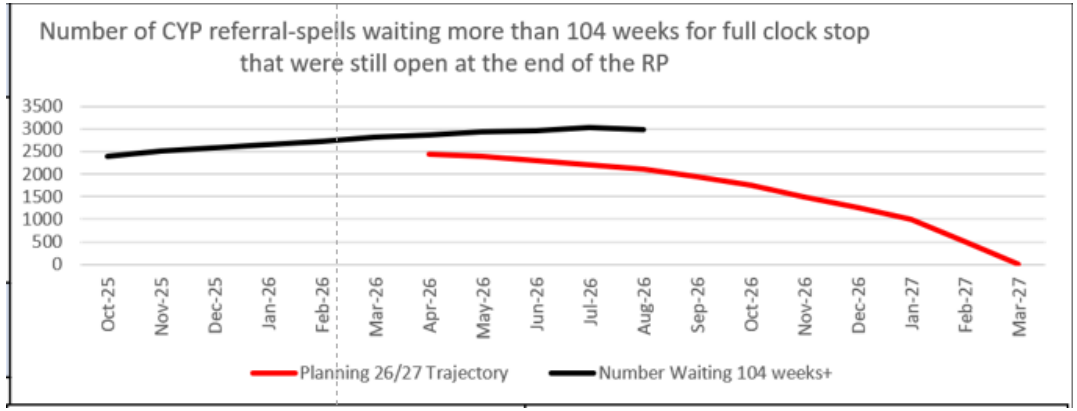


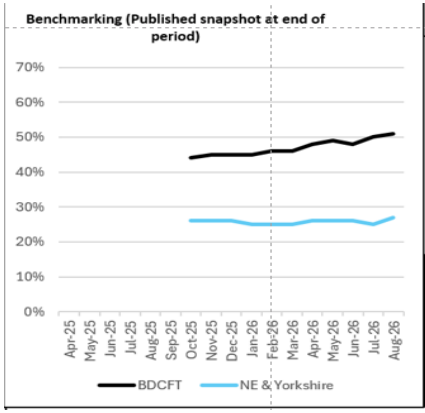
Score	Threshold	Aug-26
1.00	≥ 78%	94.79%
2.00	Scores 2-4 will be based on a ranking of all trusts scoring <78%	
3.00		
4.00		

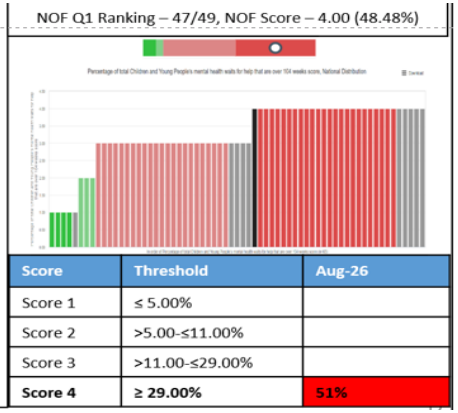
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a National Outcome Framework indicator that helps us track our longest waiters for community 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 05/11/2026 10:55:32

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





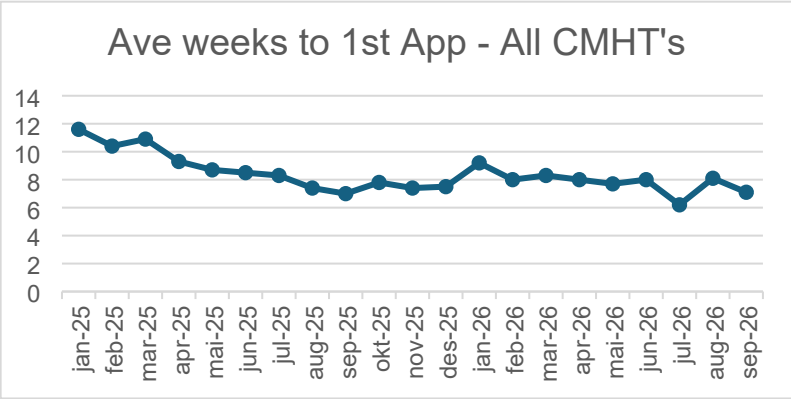


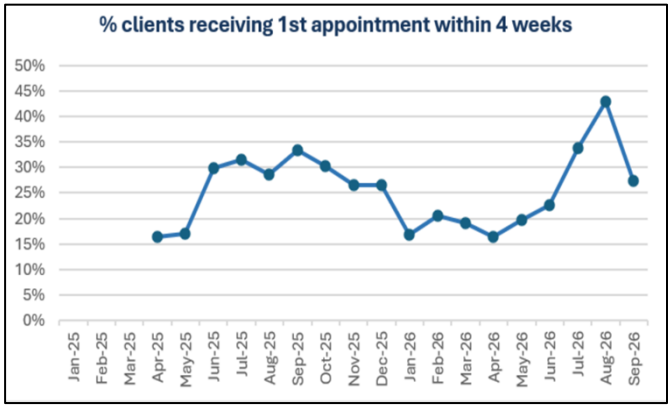
Score	Threshold	Aug-26
Score 1	≤ 5.00%	
Score 2	>5.00-≤11.00%	
Score 3	>11.00-≤29.00%	
Score 4	**≥ 29.00%**	**51%**

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 05/11/2026 10:55:32	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

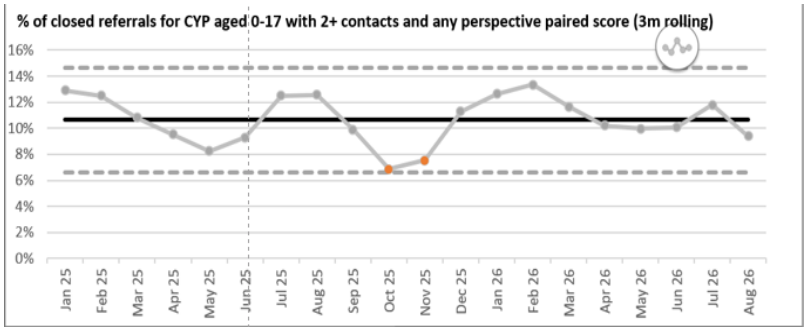


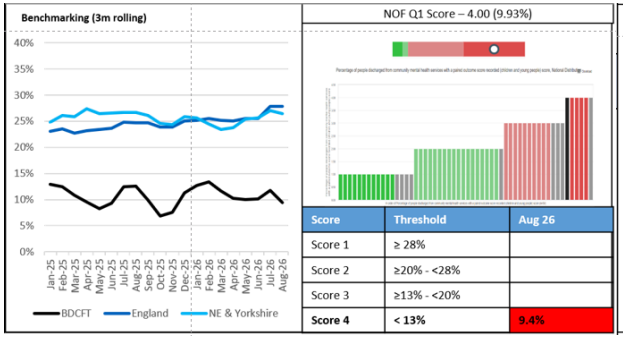


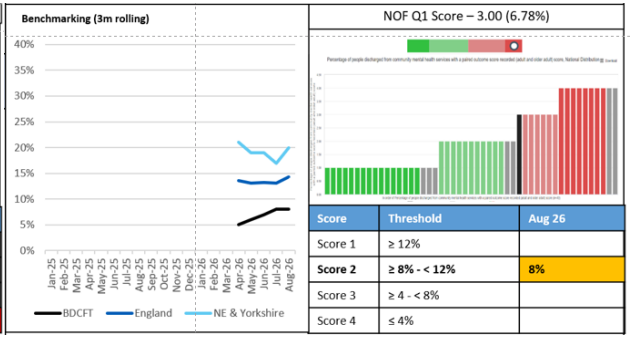
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Timely access to Community Mental Health Teams is a critical indicator of pathway responsiveness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

Close Holly
5/11/2026 10:55:32

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



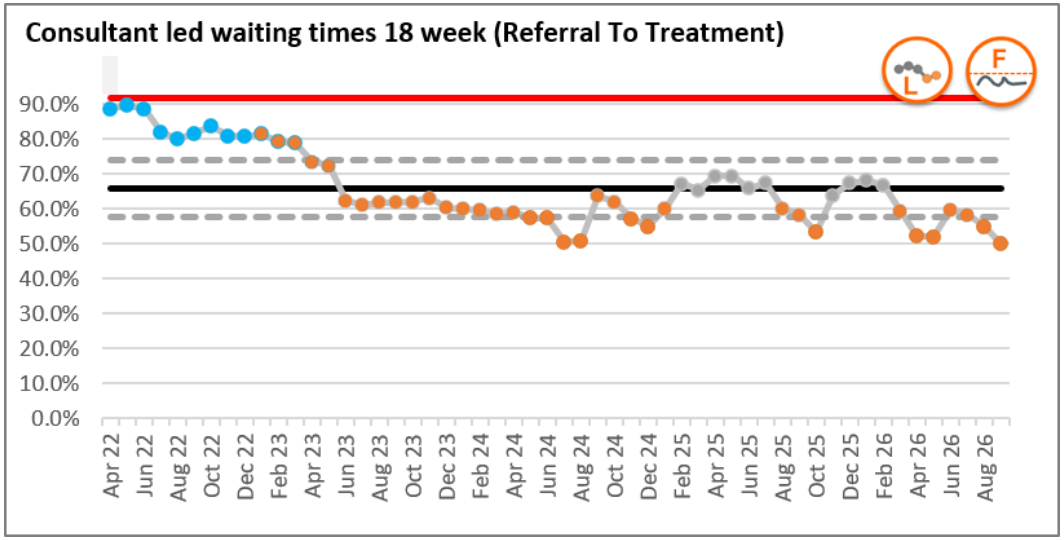




Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This new National Oversight Framework measure tests whether access to mental health services results 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
05/11/2026 10:55:32

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

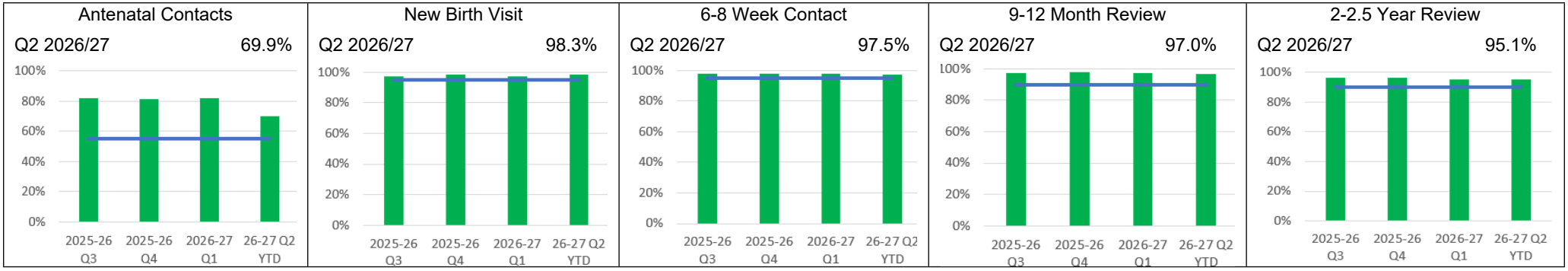


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
BDCFT are the lead provider for the West Yorkshire Community Dental Service. All community providers should be meeting the 18-week referral to treatment (RTT) standard. Close Holly 05/11/2026 10:55:32	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.

Return to Access to Services Summary

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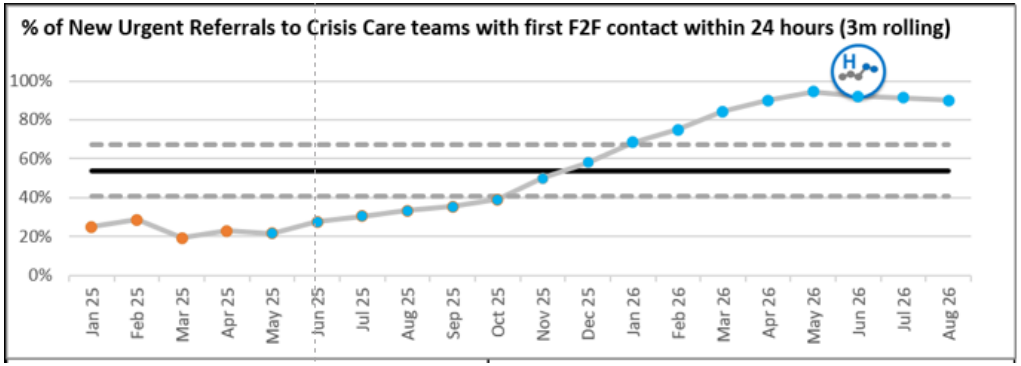
Measure: 0 – 19 metrics					
Domain:	Access to Services	NOF: No	Accountable Exec: Kelly Barker	Author:	Richard Holmes
Target:	Various	Actual: Various	Data Period: Q1 2026/27	DQ Assessment	TBC

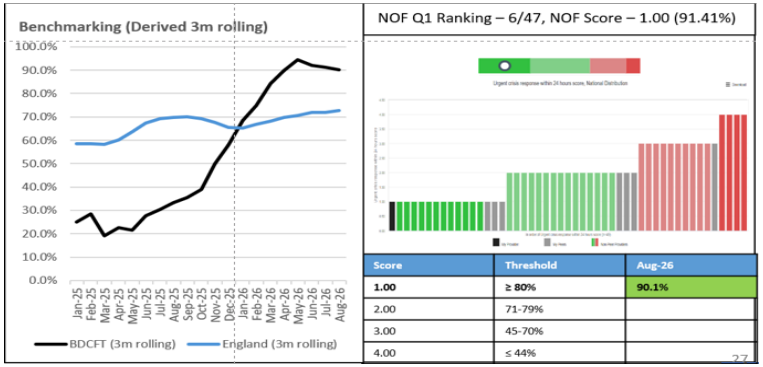


Why is this measure important?	Are we on track or off track? Why?	If we are off track, what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
These indicators are important because they measure compliance against national and local targets 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 05/11/2026 10:55:32

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

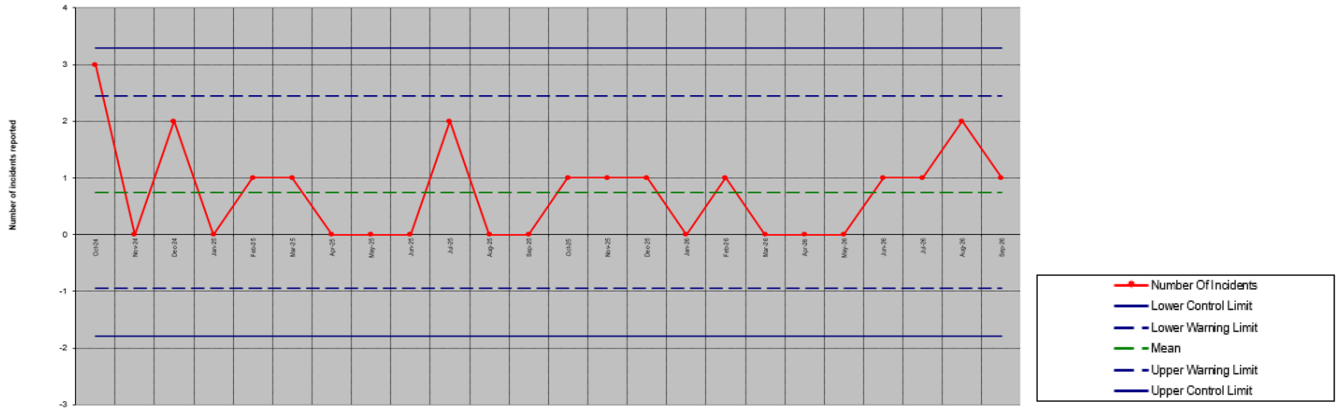




Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Crisis Care Services support individuals experiencing acute mental health need and risk. Timely 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 05/11/2026 10:55:32

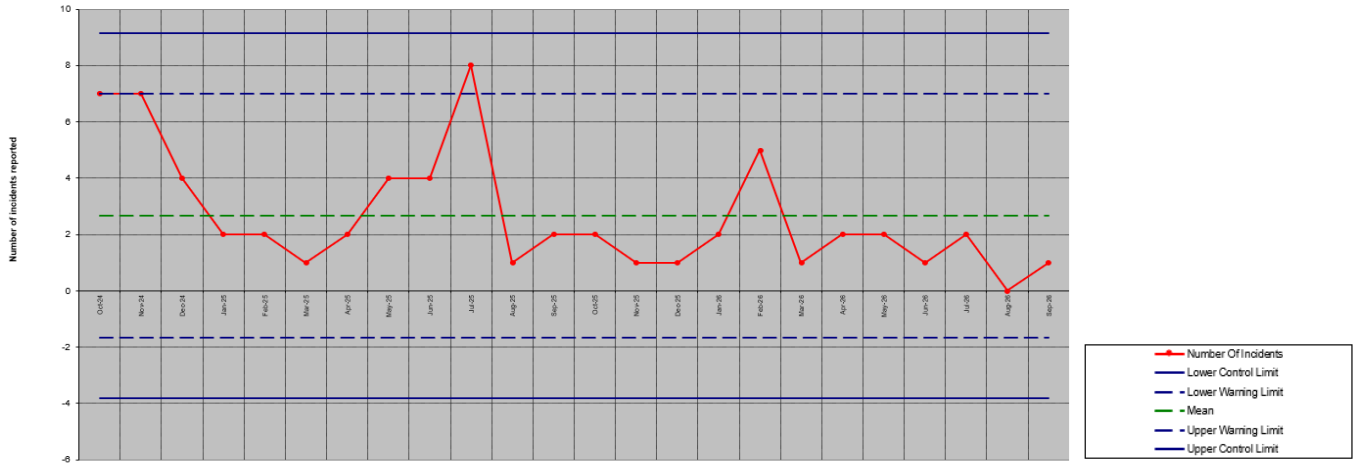
Measure: No Force first - Prone Restraint					
Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon
Target:	No set target	Actual: 1	Data Period: September 2026		DQ Assessment TBD



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 26/11/2026 10:55:32

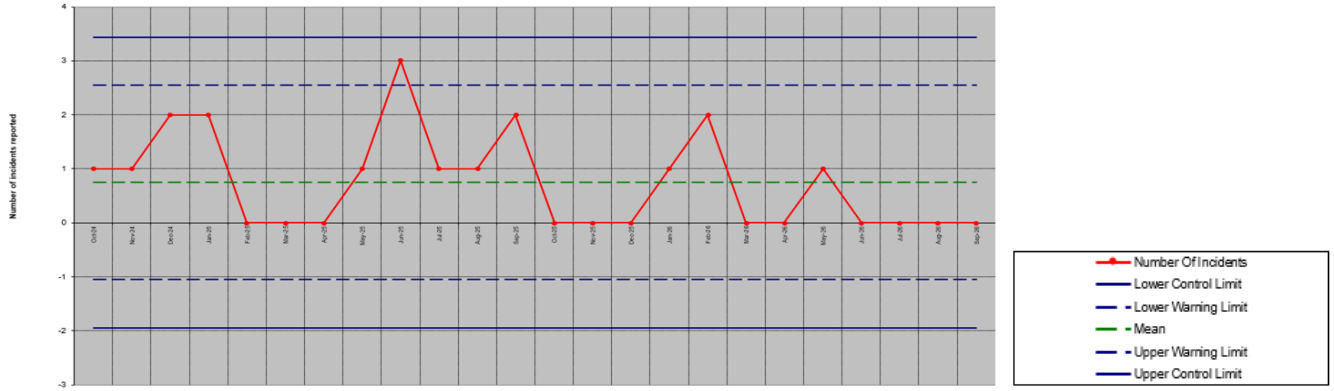
Measure: No Force first - Seclusion					
Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon
Target:		Actual: 1	Data Period September 2026		DQ Assessment TBD



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.

Closed Item
05/11/2026 10:55:32

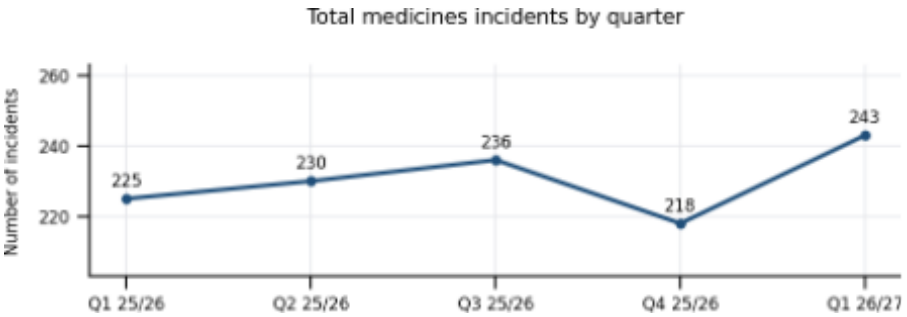
Measure: No Force first - Segregation					
Domain:	Quality and Patient Safety	NOF: No	Accountable Exec:	Phil Hubbard	Author: Chris Dixon
Target:		Actual: 0	Data Period: September 2026		DQ Assessment TBD

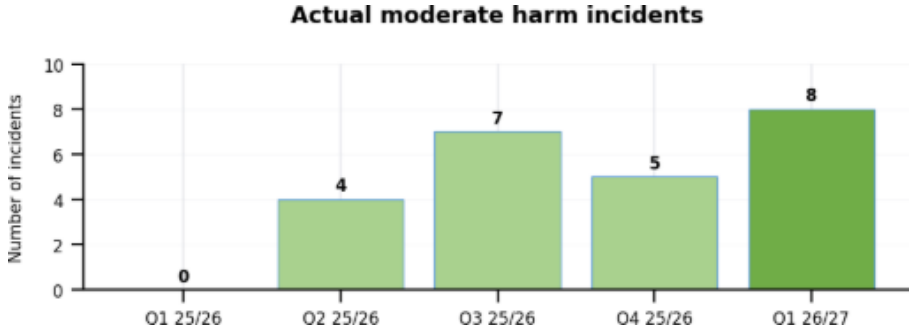


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Segregation is a key quality, safety and human rights measure because it represents a highly restrictive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

Public Board 03/12/2026 10:55:32

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

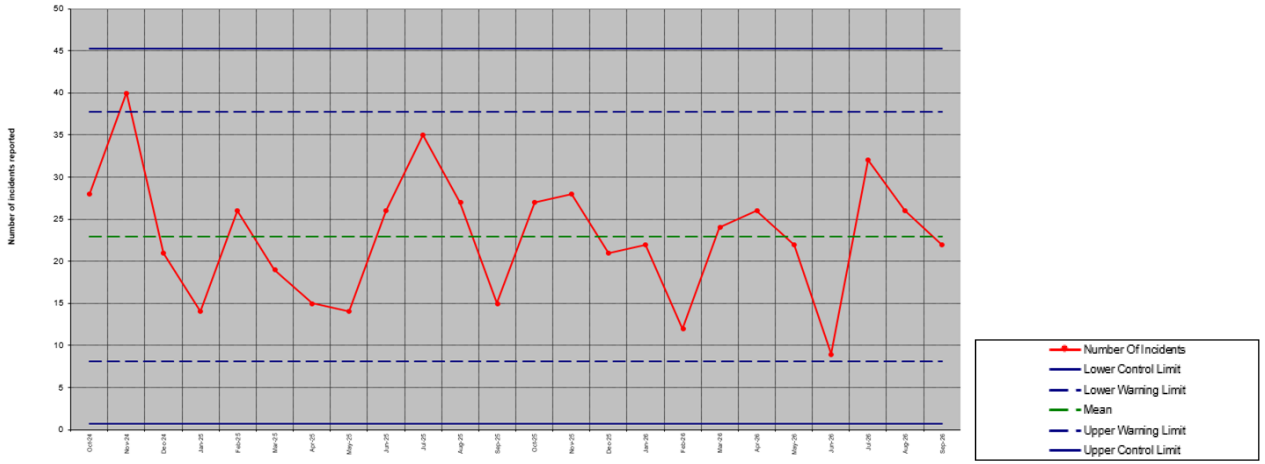




Why is this measure important?	Are we on track or off track? Why?	If off track, what are the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Medicines incidents are a key patient safety indicator, providing assurance on patient harm, emerging 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 05/11/2026 10:55:32

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

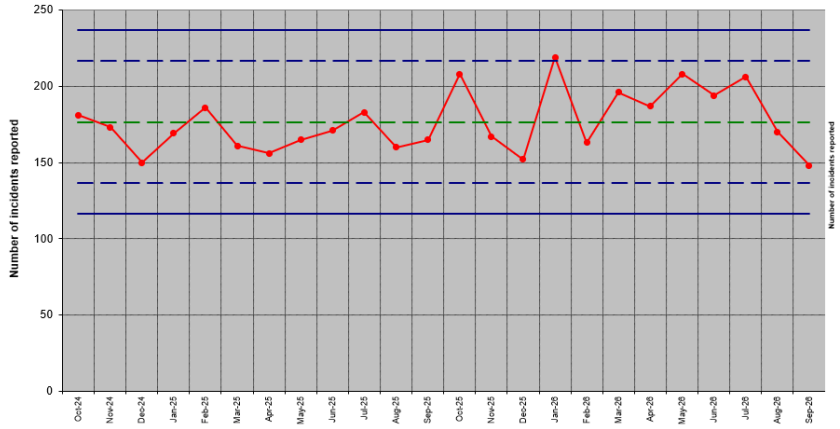


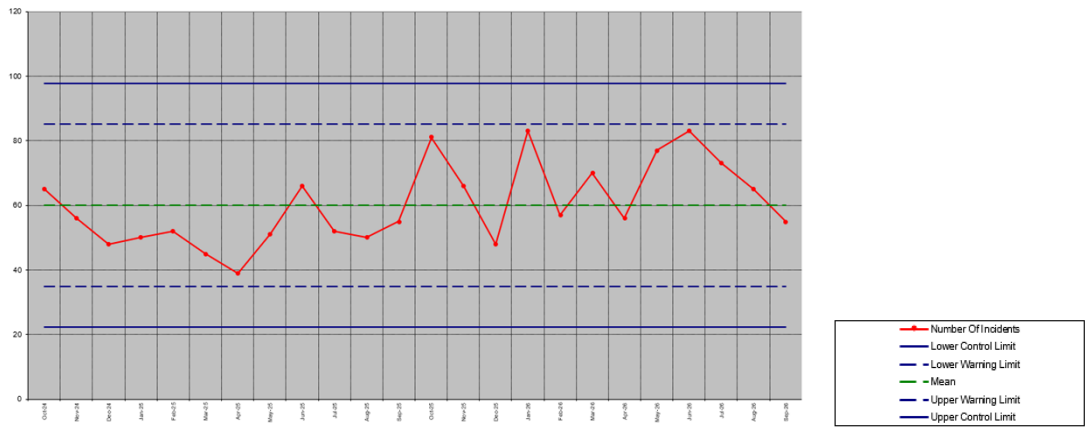
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Falls involving service users are a key quality and patient safety measure because they can result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

Classification: Official
Publication date: 15:55:32

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

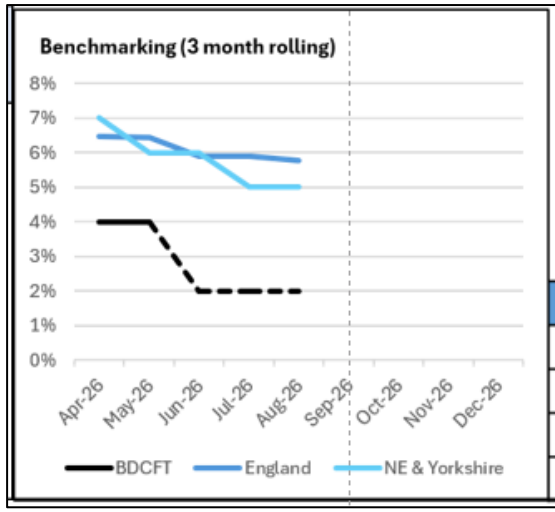




Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Pressure ulcers are an important indicator of harm, quality of care and the effectiveness of prevention. 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 05/11/2026 10:55:32

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

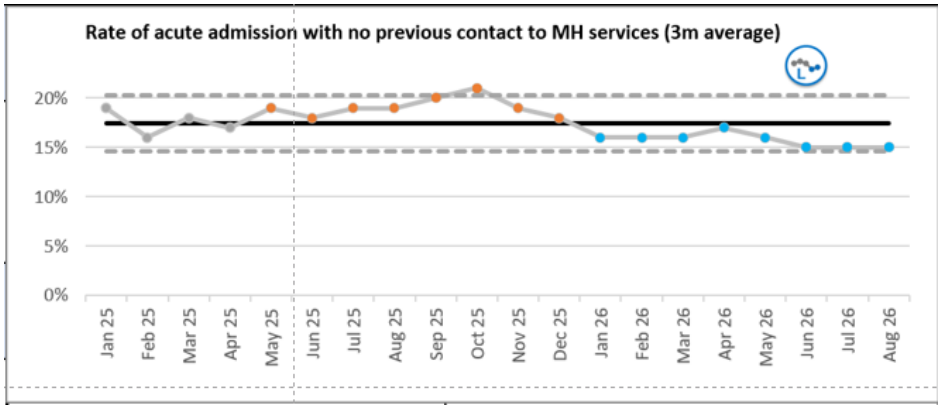


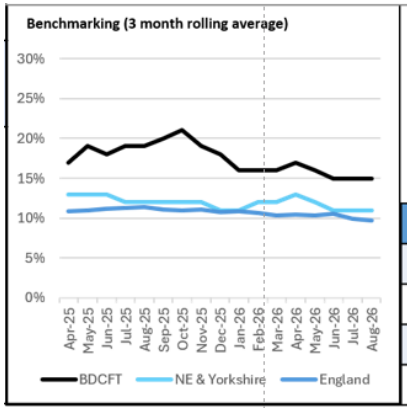
Score	Threshold	Jun-26
1.00	≤ 5%	= 2%
2.00	6 - 10%	
3.00	11 - 17%	
4.00	≥ 18%	

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.

Cosgrove
05/12/26 10:55:32

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



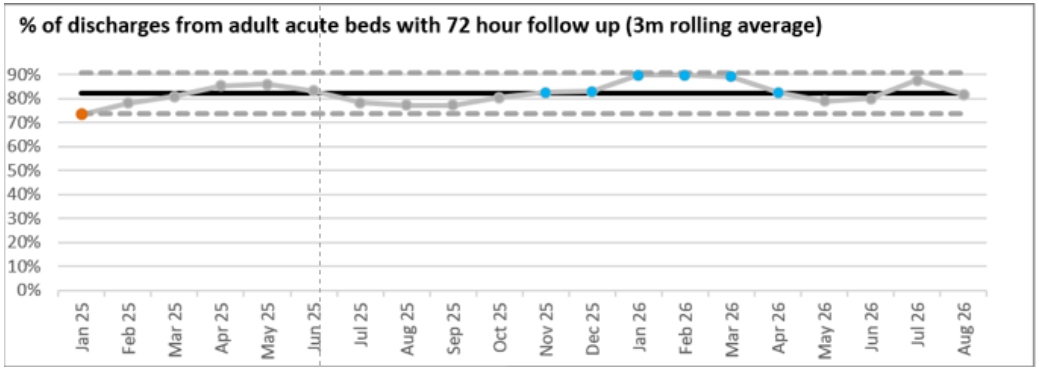


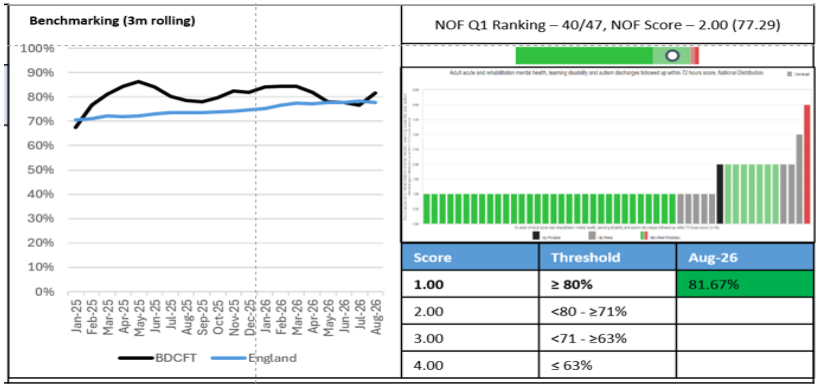
Score	Threshold	Aug-26
1.00	≤ 5.00 %	
2.00	>5.00-≤10.00%	
3.00	**>10.00%-≤15.00%**	**15%**
4.00	> 15.00%	

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 05/11/2026 10:55:32

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



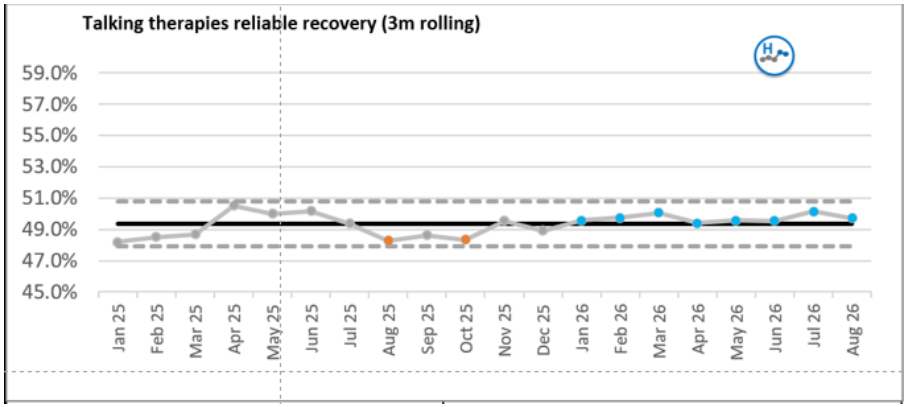


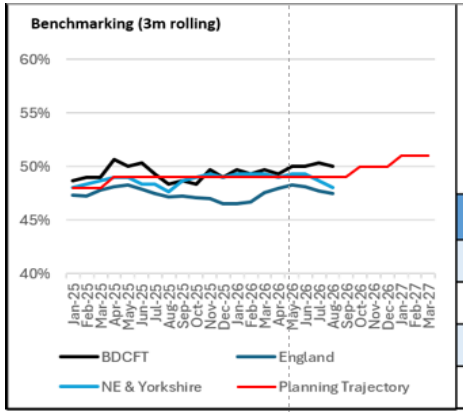
Score	Threshold	Aug-26
1.00	≥ 80%	81.67%
2.00	<80 - ≥71%	
3.00	<71 - ≥63%	
4.00	≤ 63%	

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 05/11/2026 10:55:32

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



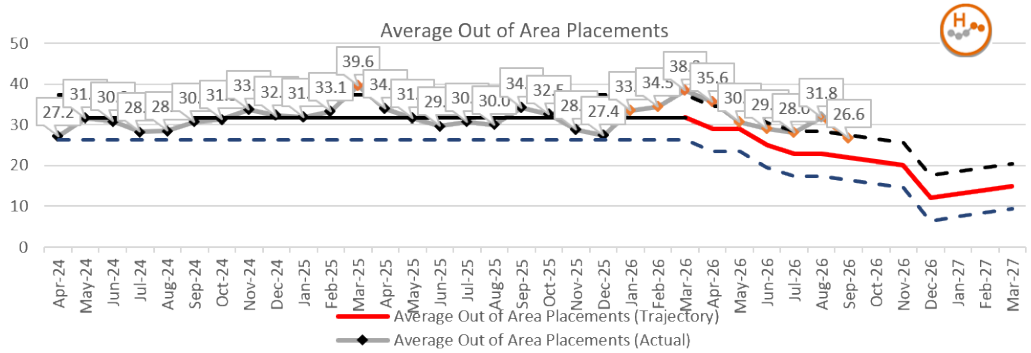


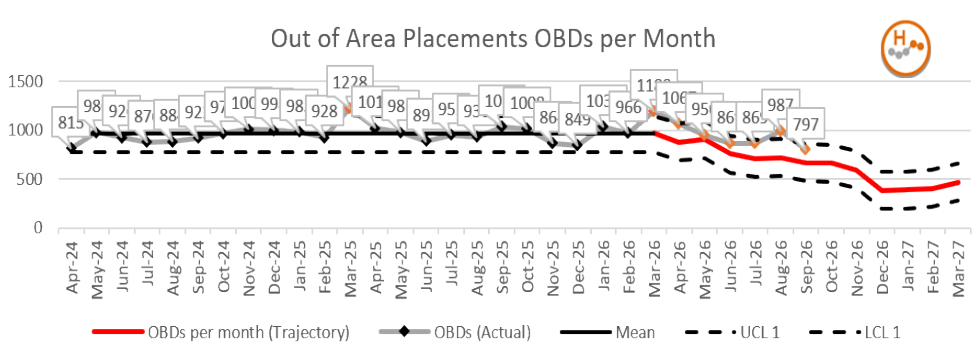
Score	Threshold	Aug-26
Score 1	≥ 52%	
Score 2	**<52% & ≥50%**	**50.0%**
Score 3	<49% & ≥47%	
Score 4	< 47%	

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.

Case Holly
05/11/2026 10:55:32

Measure: Inappropriate OAP bed days (our spot continuity number and all OAP bed days)							
Domain:	Experience of Care	NOF: No		Accountable Exec:	Kelly Barker	Author:	Maulbrey Mugani
Target:	On/under trajectory aim for 0	Actual:	797	Data Period	Sep 2026	DQ Assessment	TBD

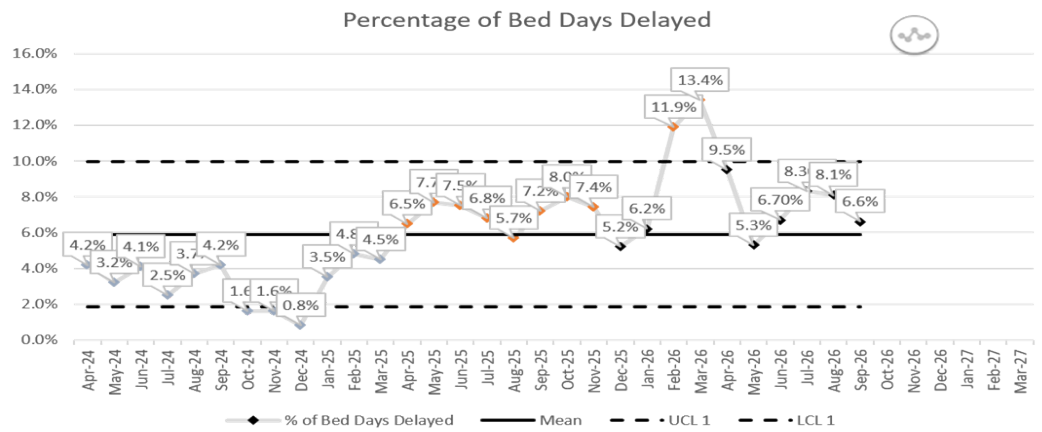




Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Out of Area Placements (OAPs) are a key indicator of pressure across the whole mental health system. They can impact patient experience, continuity of care, family involvement, clinical outcomes and cost. Reducing OAP use remains a strategic priority for the Trust and system partners. The overarching trend demonstrates sustained improvement from the peak position experienced during 2025/26; however, performance remains above trajectory and the pace of improvement needs to accelerate to achieve the March 2027 ambition. OAP bed days remain primarily driven by challenges within inpatient flow, delayed progression through pathways and demand exceeding available local capacity.	We are currently off trajectory. Sept'26 delivered 797 OAP bed days against a planned trajectory of 668. Average OAP occupancy has continued to reduce and remains significantly below historic levels; however, reductions are not yet being achieved at the pace required. Whilst delayed occupancy has improved and remains below the Trust threshold, length of stay across adult acute pathways continues to create pressure within bed capacity. Demand for inpatient admission remains high and a small cohort of individuals with complex discharge, housing, care package or system-related barriers continue to occupy beds for longer than clinically required.	A **Flow Command Sprint** has been established to accelerate reductions in OAP use, focusing on admission avoidance, inpatient flow and discharge. Actions include daily OAP and repatriation reviews, executive oversight of long stays and discharge barriers, strengthened multidisciplinary review, partnership working and community alternatives, with weekly monitoring against trajectories. Patient feedback reinforces the importance of care closer to home, while recent repatriations demonstrate the value of early escalation and executive coordination. Further improvement is expected through 2026/27 but remains dependent on sustained reductions in length of stay and discharge delays	**Mitigations** • Flow Command Sprint governance. • P&P PMO Sprint • Daily and weekly executive review. • System escalation routes with Local Authority and ICB partners. • Enhanced discharge planning and repatriation oversight. • Monitoring of long-stay cohorts and delayed discharge reasons.

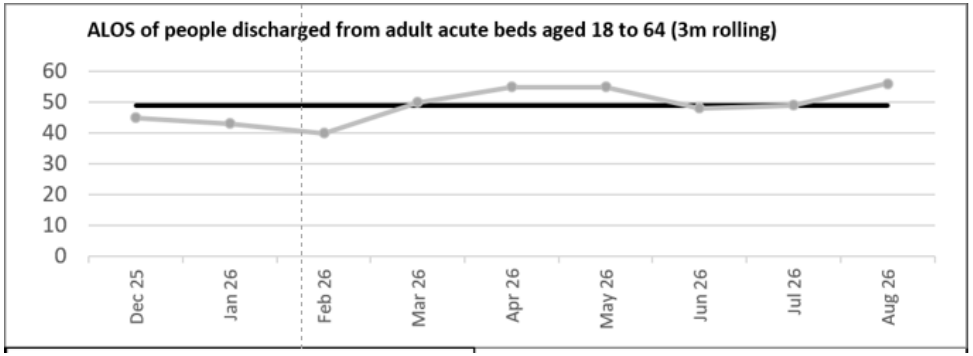
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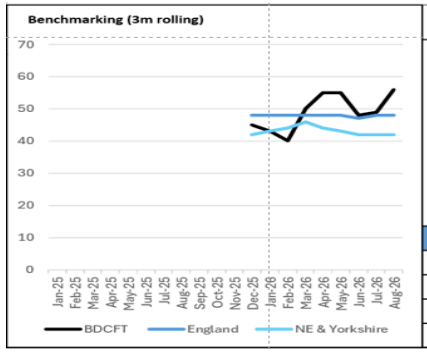
Measure: % of Ward Occupancy Delayed for Acute Wards					
Domain:	Experience of Care	NOF: No	Accountable Exec:	Kelly Barker	Author:	Maulbrey Mugani
Target:	10% or under	Actual: 6.6%	Data Period: Sep 26		DQ Assessment	TBD

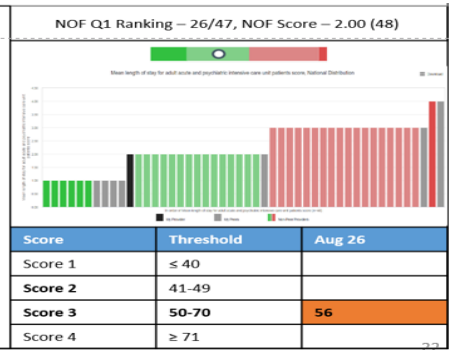


Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Delayed occupancy provides an indication of how effectively patients move through inpatient services once they are clinically ready for discharge. Improving delayed occupancy supports patient experience, increases bed availability, reduces inpatient length of stay and directly contributes towards reducing Out of Area Placements. The long-term trend shows some variation, with deterioration seen earlier in 2026 followed by sustained improvement over recent months. Close Holly 05/11/2026 10:55:32	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.

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







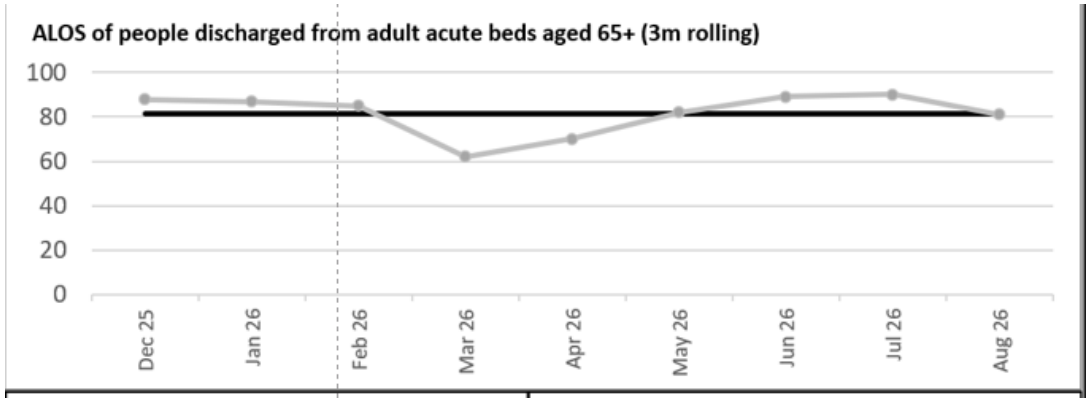
Score	Threshold	Aug 26
Score 1	≤ 40	
Score 2	41-49	
Score 3	50-70	56
Score 4	≥ 71	

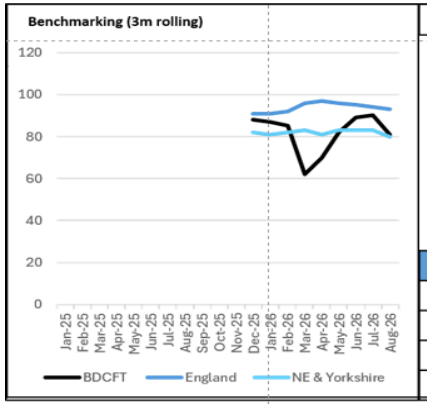
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Length of stay is an important monitor of inpatient flow and bed availability. Maintaining an optimal length of stay ensures that people receive care for the shortest period consistent with recovery, maximises bed capacity and supports reduction of Out of Area Placements. The overall trend remains relatively stable over the last 18 months. Recent improvement has reversed earlier deterioration, and performance is now within the Trust's planning trajectory.	Performance is currently on track against the Trust planning trajectory but not yet achieving the NOF benchmark position. The average length of stay between June-Aug'26 is 56 days. This is above the local planning target of 51 days but remains above the NOF benchmark of 40 days. Length of stay has remained broadly stable over the last twelve months. Whilst delays are not being driven solely by discharge processes, a small number of patients with highly complex presentations and discharge requirements continue to significantly influence overall averages. Benchmarking indicates BDCFT remains above England and regional averages and therefore further improvement is required.	Actions include: • Weekly review of all long-stay patients. • Strengthened expected discharge date processes. • Enhanced discharge planning from admission. • Increased scrutiny of patients exceeding 60 and 90 days. • Flow Command work to improve whole-system flow. • Focus on reducing unwarranted variation between wards. Patient and staff feedback continues to reinforce the importance of clear discharge planning, earlier MDT decision-making and stronger partnership working with community services. We anticipate a gradual reduction in length of stay during 2026/27 which should support delivery of both OAP reduction trajectories and improved patient flow.	Whilst performance remains within local planning assumptions, improvement is required to reach NOF benchmark levels. This remains a key component of the Trust's OAP reduction strategy and should continue to receive Board oversight.

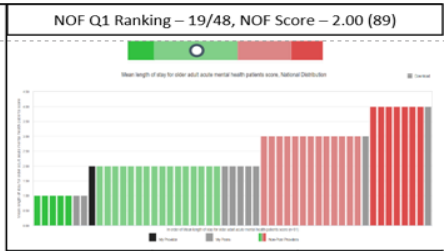
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Measure: Mean length of stay for older adult acute discharges

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





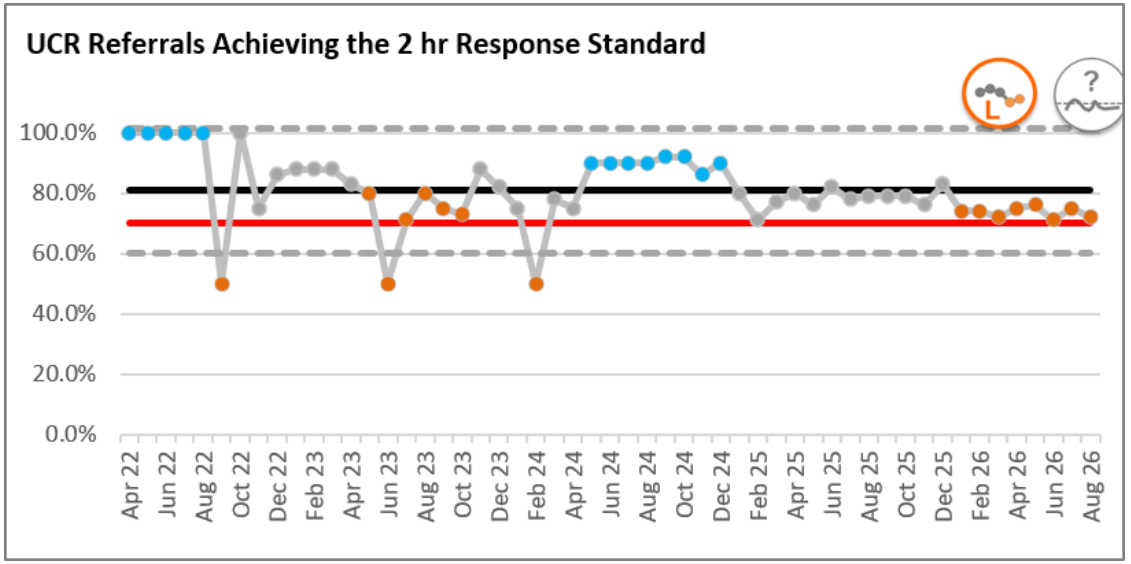


Score	Threshold	Aug 26
Score 1	≤ 73	
Score 2	**74 - 93**	**81**
Score 3	94 - 125	
Score 4	≥ 126	

Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Length of stay is an important monitor of inpatient flow and bed availability. Maintaining an optimal length of stay ensures that people receive care for the shortest period consistent with recovery, maximises bed capacity and supports flow. The overall trend has been reducing over the last 18 months. Recent performance shows a small level of deterioration following a significant reduction in length of stay in March and April.	Performance is currently in line with expectations and is below the England benchmark. Performance over the last 18 months has been broadly better than North East and Yorkshire peers following a significant improvement in the first half of 2024 which coincided with the appointment of the permanent consultant psychiatrist under the functional model following a move from the continuity of care model. The current position for length of stay on Older adult wards reflects that in September 2 patients were clinically ready for discharge and in October 4 patients were CRFD. 8 patients had a LoS >60 days in September, and 12 in October.	We continue to monitor average length of stay at discharge as well as current length of stay for those on the ward. The Discharge Co-ordinator works in collaboration with the Local Authorities to ensure early identification of barriers to discharge. We are starting to look at a review of services and pathways which will be operationalised in Q1 26/27. Integral to this work is patient pathways, reviews of patients CRFD, Estimated date of discharge and the patient journey to and from acute inpatient care	With the expected rise in the older adult population there is a risk that inpatient capacity in the future will be insufficient to deal with significant increased demand. Maintaining a focus on flow and minimising length of stay will support with managing increased demand.

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



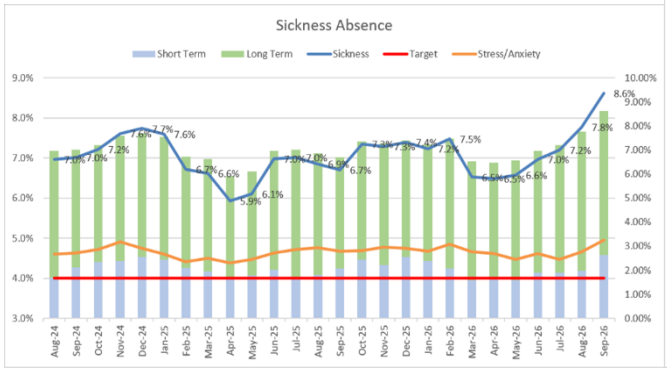
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is no longer a NOF reported indicator but is still a planning requirement for this year. Urgent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

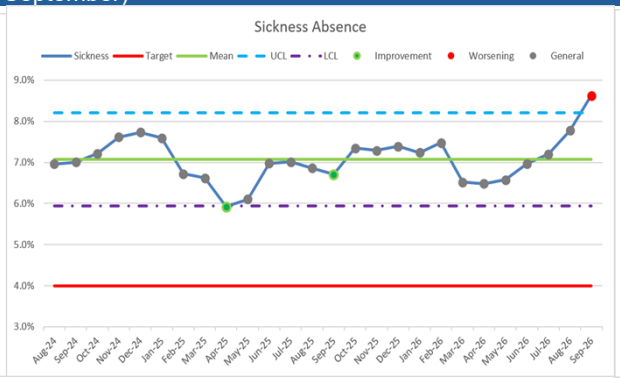
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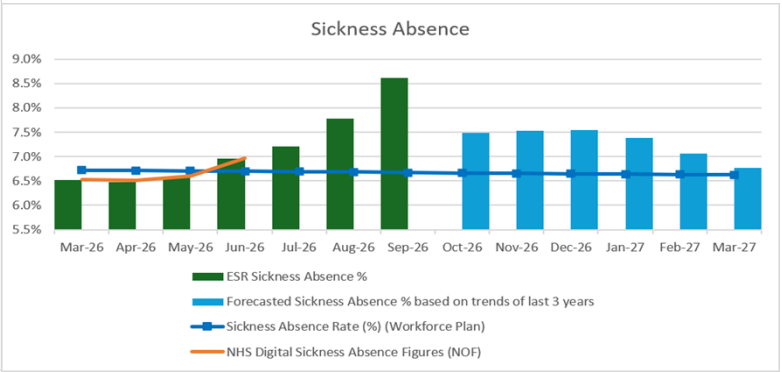
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Measure: Sickness absence rate (3m rolling)							
Domain:	People	NOF:	Yes	Accountable Exec:	Jo Harrison	Author: Claire Ingle	
Target:	4%	Actual:	7.06% (NOF4) (8.6% September)	Data Period	Q1 26/27	DQ Assessment	TBD







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

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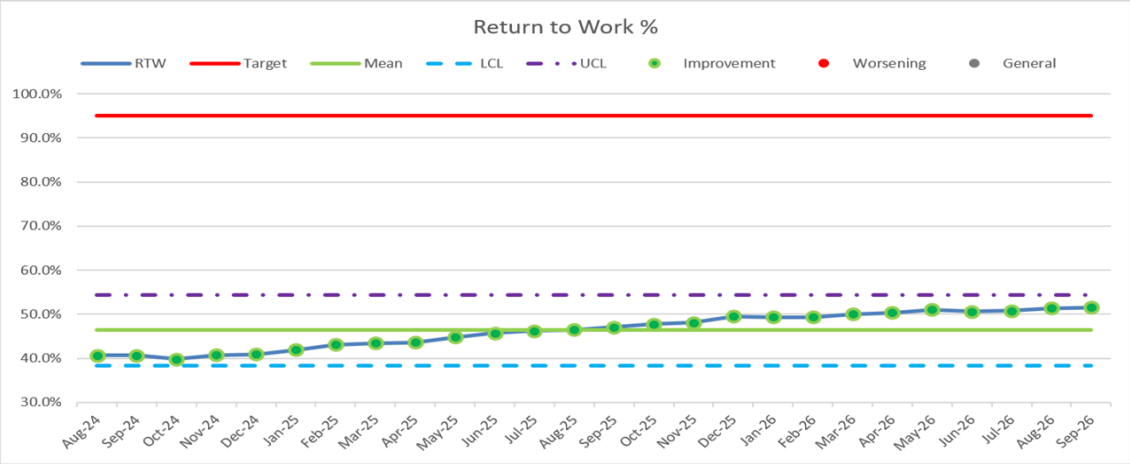
			Mitigation here is the Working well plan that focuses on a clear comms plan and training .

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



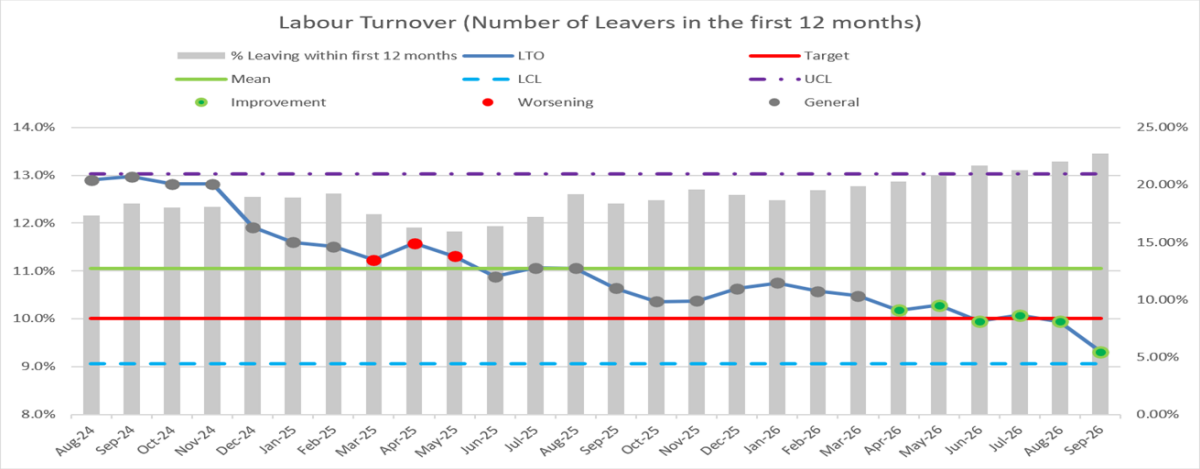
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring return to work interviews following sickness absence in the NHS is important because these interviews provide a structured opportunity to support employee wellbeing, confirm fitness to return, identify any ongoing health concerns, and ensure appropriate workplace adjustments are in place. **SPC charts use three rules to identify significant change:** • Rule 1 – Outside expected range: A point falls outside the control limits, indicating unusual variation that may need investigation. • Rule 2 – Shift: 8 consecutive points above or below the average, indicating a sustained change.	The SPC shows RTW rates since Aug24 monitored against the Trust target of 80%. Currently the completion rate stands at 51.5%, 43.45% below target. Based on the SPC chart rules an improving trend can be seen based on both 6 consecutive increases and 8 consecutive data points above the mean. We are still experiencing challenges such as: Entering of absences retrospectively into HeRo (Health Roster) - this has now been rectified from the end of Sept. Time pressures that managers are reporting to complete RTW's.	Improvements to Return to Work (RTW) processes are focused on better recording, stronger manager engagement and simpler processes. HeRo now allows retrospective RTWs to be recorded, improving data quality and reliability. Managers are being supported through guidance, video demonstrations, drop-in sessions and communications, alongside a leadership focus on increasing RTW completion. The revised attendance policy simplifies RTWs by allowing greater flexibility in how and when conversations take place, supported by a shorter template focused on wellbeing, prevention and avoiding recurrence. Further automation is planned for Q4, including pre-population of information and automatic recording and saving of completed RTWs	The main risk is incomplete recording of Return to Work (RTW) conversations, limiting understanding of absence causes and opportunities for early intervention, prevention and reasonable adjustments. Manager feedback indicates that RTW conversations are taking place, but are not always recorded. Mitigations include a simplified RTW process, retrospective recording in HeRo, manager guidance and video demonstrations, and a revised policy allowing RTW conversations to be recorded when a return is agreed rather than requiring a separate meeting. Further automation will streamline recording, supported by monthly SPC monitoring and weekly follow-up in areas of low compliance.

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

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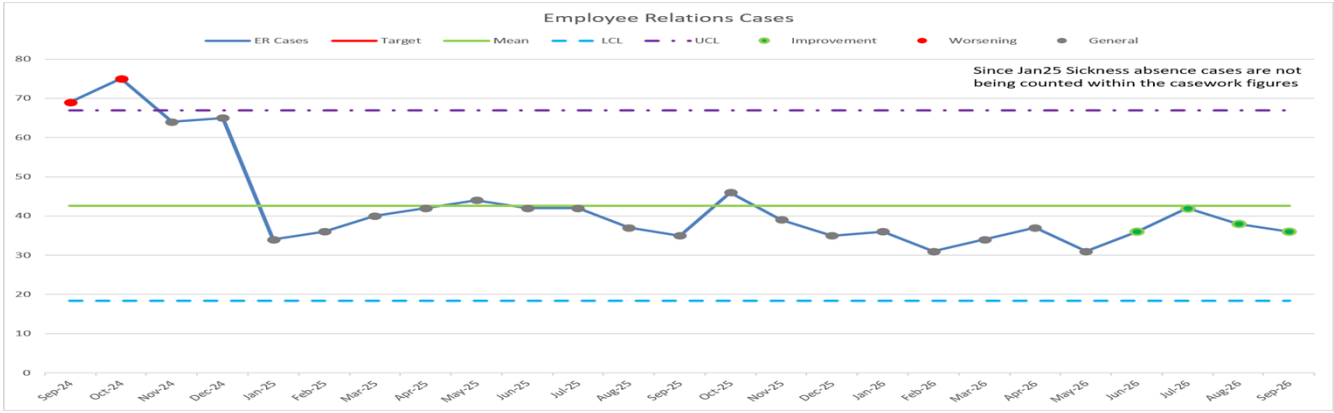
Measure: Labour Turnover						
Domain:	People	NOF: No	Accountable Exec:	Jo Harrison	Author: Claire Ingle	
Target:	10%	Actual:9.3%	Data Period	September 26	DQ Assessment	TBD



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

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



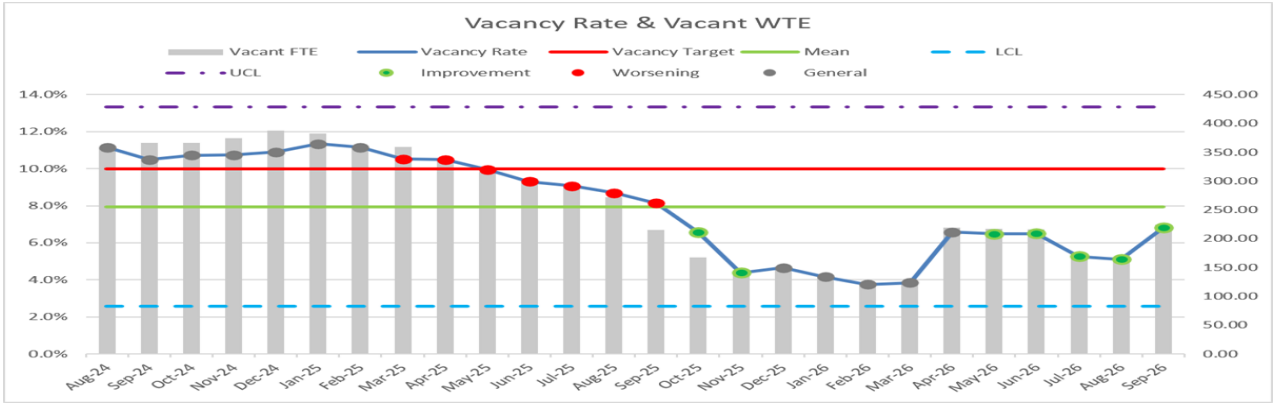
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring the number of Employee Relations cases in the NHS is important because it provides insight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

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		support a more compassionate, learning-focused culture.	

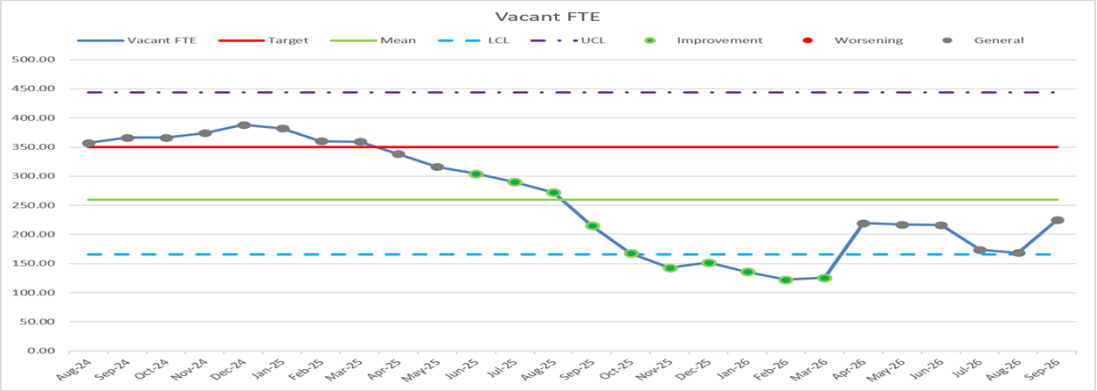
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Measure: Vacancy Rate							
Domain:	People	NOF: No		Accountable Exec:	Jo Harrison	Author: Claire Ingle	
Target:	10%	Actual:	6.81%	Data Period	September 26	DQ Assessment	TBD



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

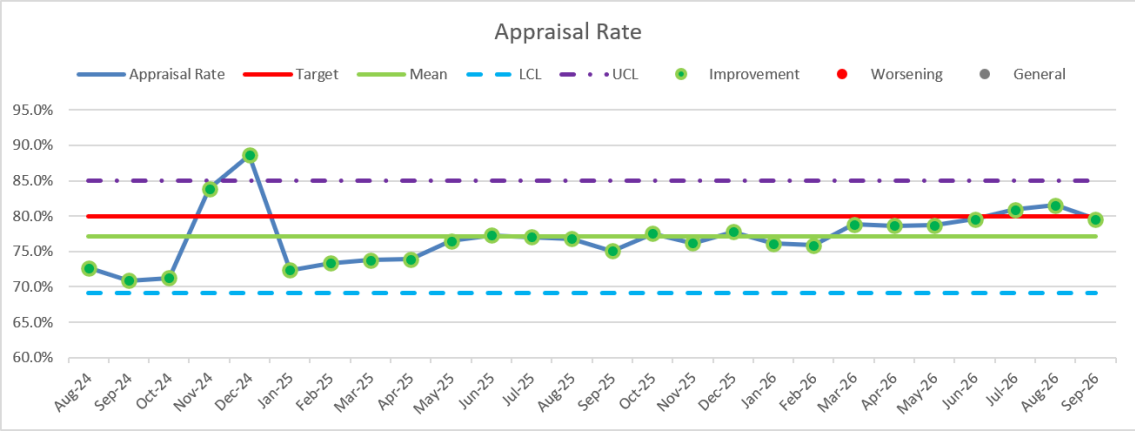
Measure: Variation from budgeted establishment							
Domain:	People	NOF: No		Accountable Exec:	Jo Harrison	Author: Danielle Stephenson	
Target:	350	Actual:	224.70	Data Period	September 26	DQ Assessment	TBD



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring variation from budgeted establishment in the NHS is important because it shows whether the actual workforce is aligned to the staffing levels and costs that have been planned and funded. It is a key measure of workforce efficiency, financial control, and service capacity. **SPC charts use three rules to identify significant change:** • Rule 1 – Outside expected range: A point falls outside the control limits, indicating unusual variation that may need investigation. • Rule 2 – Shift: 8 consecutive points above or below the average, indicating a sustained change. • Rule 3 – Trend: 6 consecutive increases or decreases, indicating a consistent direction of travel.	The SPC shows vacant FTE data since Aug24 monitored against the Trust target of 350. Currently the vacant FTE stands at 224.70, which is 125.3 below target. Based on the SPC rules an improving trend was seen between Jun25 and Mar26 due to both 6 consecutive decreases and 8 consecutive data points below the mean, however data since Apr26 is showing no significant trend.	To stay on track, we need to continue monitoring the Trust's overall vacancy rate to ensure it stays below 10%. We now have two dashboards to support this so we can identify which services may be outside this target area to support further discussions to improve recruitment or look at why they are over established to make more informed decisions. We expect the trend to continue going down as tighter controls are introduced to support with workforce planning triangulated with finance and activity.	We have three directorates to monitor closely as individually September data is showing they are over the 10% vacancy target (by most 4.08%) Recommended mitigations – to understand which services within these directorates are most impacted by over / under establishment and what plans they have in place to mitigate this.

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



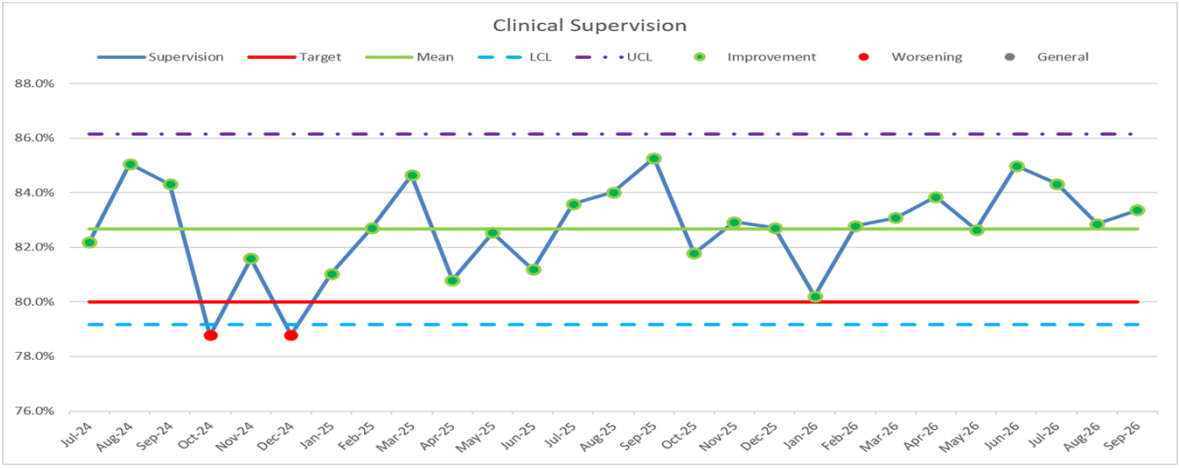
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring appraisal compliance in the NHS is important because appraisals are a key mechanism for supporting staff performance, development, engagement, and ultimately the delivery of high-quality patient care. **SPC charts use three rules to identify significant change:** • Rule 1 – Outside expected range: A point falls outside the control limits, indicating unusual variation that may need investigation. • Rule 2 – Shift: 8 consecutive points above or below the average, indicating a sustained change. • Rule 3 – Trend: 6 consecutive increases or decreases, indicating a consistent direction of travel.	The SPC shows appraisal compliance rates since Aug24 monitored against the Trust target of 80%. Currently the appraisal compliance rate stands at 79.5 %, 0.5% below target. Based on the SPC chart rules all data points are indicating an improving trend, with multiple data points being above the mean. We have appraisal anniversary dates with no set date per annum, % rate for compliance can fluctuate. May be low points in the year due to service pressures, changes in service that may	ESR provides compliance/ due date notifications for managers/staff. Reports on low compliance target support for services and teams. Appraisal rates & quality monitored through annual internal audits. Staff survey data provides staff experience insight and management support, quality and effectiveness of objective setting. Results feed into induction journey & training to develop staff & managers. To embed shared responsibility, support employee life cycle that improves staff experience. Service areas will be contacted monthly that have low compliance rates below the KPI. Service managers asked to improve appraisal uptake and recording in their area to monitor improvement.	Risk - service pressures at points in the year may show low compliance of completion of appraisal. Risk - completion of appraisal yet not quality appraisal and objectives

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	impact completion of appraisal in a timely manner.		

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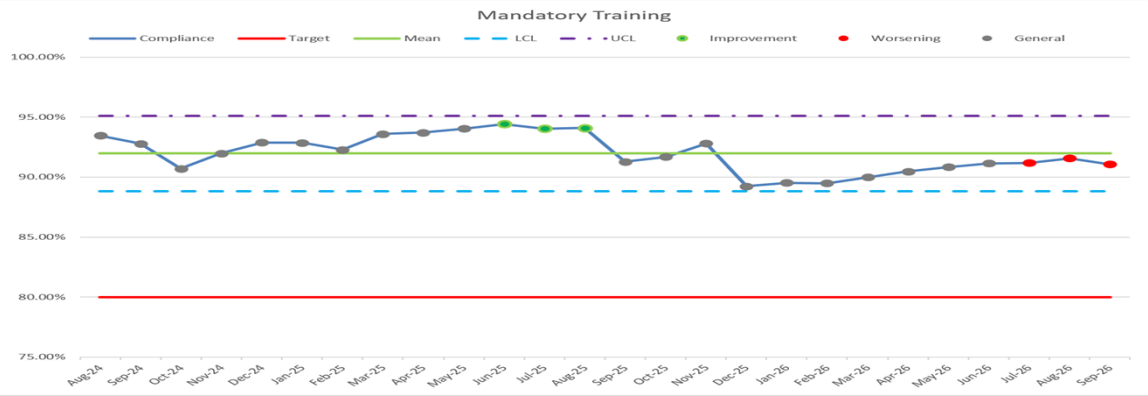
Measure: Clinical supervision							
Domain:	People	NOF: No		Accountable Exec:	Jo Harrison	Author: Naomi Fernandez	
Target:	80%	Actual:	83.3 %	Data Period	September 26	DQ Assessment	TBD



Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring clinical supervision compliance in the NHS is important because clinical supervision is a key safeguard that supports professional practice, staff wellbeing, patient safety, and the delivery of high-quality care. **The SPC charts follow 3 rules:** **Rule 1**: Point outside control limits - "A data point has fallen outside the expected range of variation, indicating a potential special cause requiring investigation." **Rule 2**: Shift (8 consecutive points on one side of the mean) - "Eight consecutive data points above or below the average suggest a sustained shift in performance." **Rule 3**: Trend (6 consecutive increases or decreases) - "Six consecutive increases or decreases indicate a consistent upward or downward trend in performance."	The SPC shows clinical supervision compliance rates since Aug24 monitored against the Trust target of 80%. Currently the clinical supervision compliance rate stands at 83.35%, 3.35% above target. Based on the SPC rules most data points are indicting an improving trend due to the consecutive data points above the mean. There is consistency in this being met and compliance maintained through professional clinical good practice and adherence to meeting professional standards in practice.	Effective processes in place for clinical governance, training & procedures to support clinical colleagues with clinical supervision. Inc; NHSE CPD funding investing in external trainers for clinical supervision/supervisor upskilling & refreshing. Available as a half day online offer at points across the year. The preceptorship programme further supports / promotes clinical supervision by mandating a clinical supervisor to be allocated and booking onto (not attending) the clinical supervision training within the first 2 weeks into post. Further work is underway to support digital recording, notifications to support clinical supervision infrastructure.	None to report.

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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



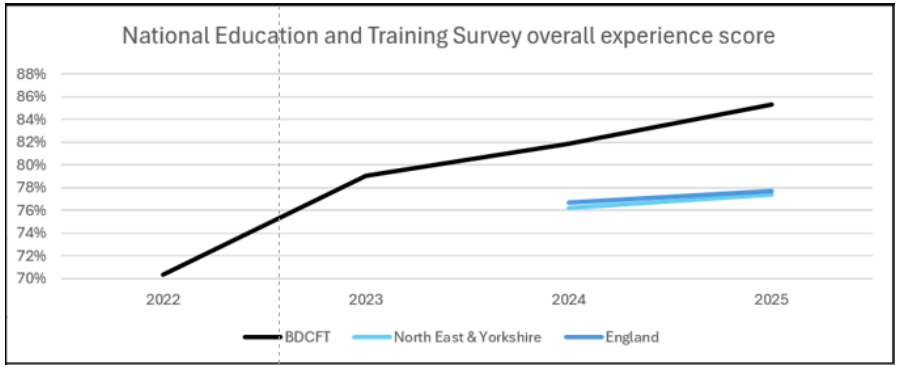
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
Monitoring mandatory training compliance in the NHS is important: mandatory training ensures that 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.

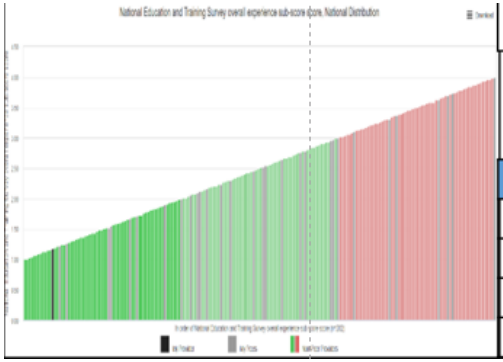
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Measure: National Education and Training Survey overall experience sub-score - new measure							
Domain:	People	NOF:	Yes	Accountable Exec:	Jo Harrison	Author: Naomi Fernandez	
Target:	-	Actual:	85.32% (NOF 1)	Data Period	2025	DQ Assessment	TBD





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		

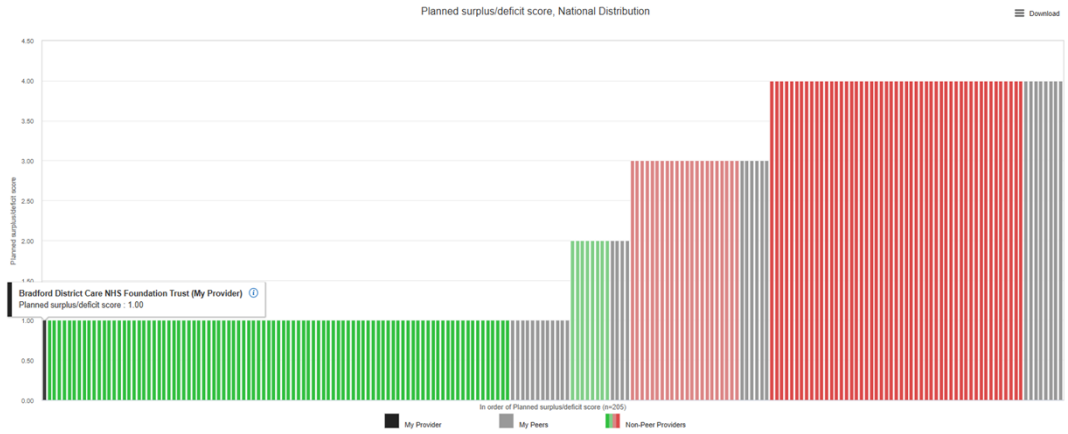
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This is a newly report NOF indicator for this quarter.	We are on Track, shown year-on-year improvement 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



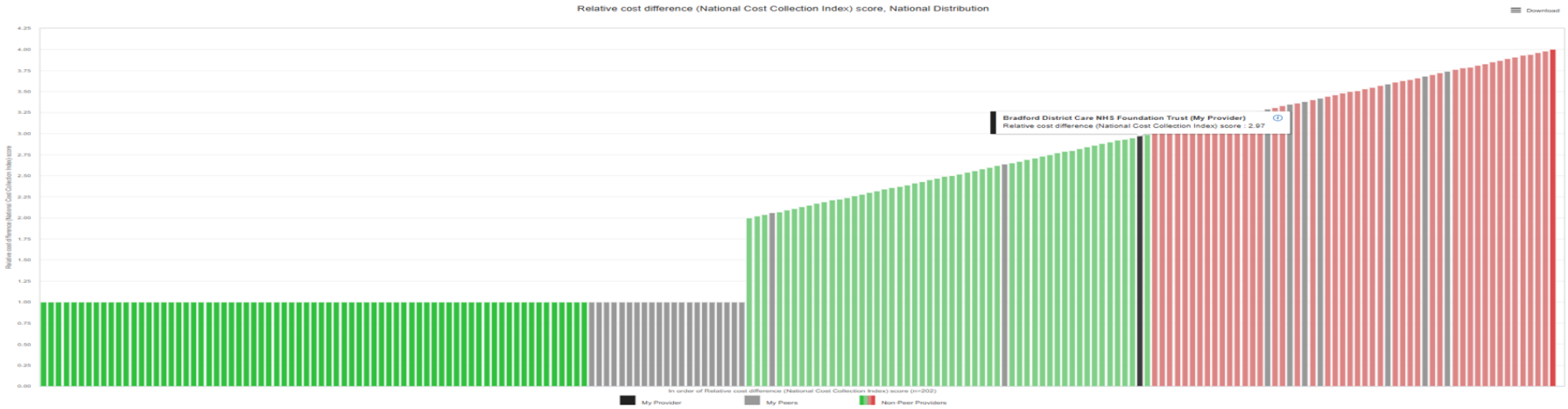
Why is this measure important?	Are we on track or off track? Why?	If we are off track what is the actions to remediate? If on track, how do we stay on track?	What are the risks to delivery and mitigations
This measure reflects the financial performance for the Trust and confidence that the Trust will 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.

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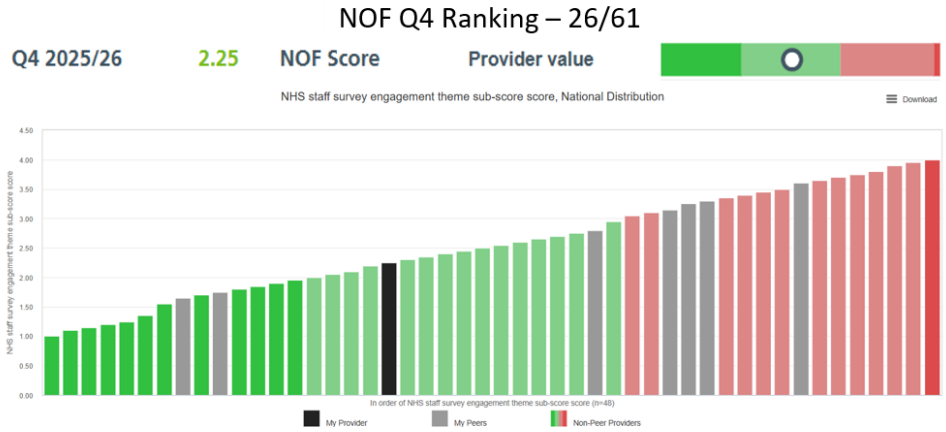
Appendix 3 – Annual Measures

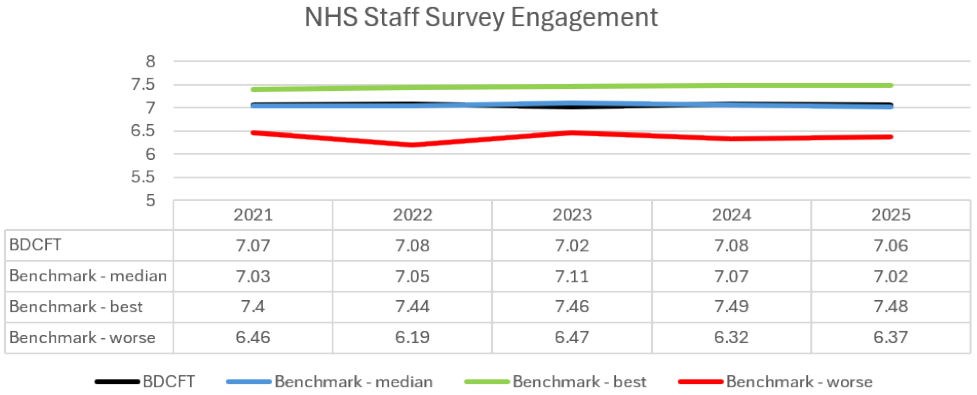
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Measure: NHS Staff Survey Engagement Sub Score					
Domain:	People	NOF: Yes	Accountable Exec:	Jo Harrison	Author: Naomi Fernandez
Target:		Actual: 7.06	Data Period: 2025		DQ Assessment TBD





	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.

Public Board 03 Feb 2026 10:55:32

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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