

BOARD OF DIRECTORS MEETING IN PUBLIC AGENDA

Date:	Thursday, 29 January 2026	Time:	10:00 – 12:30
Venue:	Conference Room, Field House, BRI	Chair:	Sarah Jones, Chair

10:30-10:40, Carly Stott, Bo.1.26.8 - Maternity and Neonatal Services update
12:10-12:20 – Laura Riach, Bo.1.26.15 – Bradford Hospitals Charity 12 month review

Observers: Imran Ellam and Dermot Bolton Governors

No.	Agenda Item	Lead	Outcome	Papers attached
10:00 Section 1: Opening matters				
Bo.1.26.1	Apologies for absence Tim Swift, Non-Executive Director	Chair	For information	Verbal
Bo.1.26.2	- Declarations of interest - Code of conduct	Chair	For information	Bo.1.26.2
Bo.1.26.3	Minutes of the meeting held on 27 November 2025	Chair	For approval	Bo.1.26.3
Bo.1.26.4	Matters arising	Chair	For information	Verbal

10:05 Section 2: Business Reports				
Bo.1.26.5	Report from the Chair	Chair	For assurance	Bo.1.26.5
Bo.1.26.6	Report from the Chief Executive	Chief Executive	For assurance	Bo.1.26.6

10:20 Section 3: Patient Care				
Bo.1.26.7	Report from the Chair of the Quality Committee a) January 2026	Chair of the Quality Committee	For assurance	Bo.1.26.7
Bo.1.26.8	Maternity and neonatal services update a) Maternity Incentive Scheme	Chief Nurse	For assurance For approval	Bo.1.26.8 Bo.1.26.8a
Bo.1.26.9	CQC Reports	Chief Nurse	For assurance	Bo.1.26.9

11:00 Section 4: People				
Bo.1.26.10	Report from the Chair of the People Academy a) January 2025 b) Workforce report	Chair of the People Academy	For assurance	Bo.1.26.10
Bo.1.26.11	Nursing & Midwifery staffing establishment review	Chief Nurse	For approval	Bo.1.26.11

BREAK 11:30 – 11:40

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11:40 5 Section 5: Finance and Performance

Bo.1.26.12	Report from the Chair of the Finance and Performance Committee a) January 2026 b) Finance Report c) Integrated Dashboard d) Performance Report e) Green Plan Progress Update	Chair of the F & P Committee	For assurance	Bo.1.26.12
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11:55 Section 6: Strategy & Partnerships

Bo.1.26.13	Strategy – Emerging issues	All	For information	Verbal
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12:00 Section 7: Governance

Bo.1.26.14	High-level risks	Chief Nurse	For assurance	Bo.1.26.14
Bo.1.26.15	Bradford Hospitals Charity 12 month review	Director of Strategy & Transformation	For assurance	Bo.1.26.15
Bo.1.26.16	Bradford Hospital Charity Draft Annual Report & Accounts 2024/25	Chief Finance Officer	For approval	Bo.1.26.16

12:25 Section 8: Board Meeting Outcomes

Bo.1.26.17	Any other business	Chair	For information	Verbal
Bo.1.26.18	Issues to refer to Committees or elsewhere	Chair	For approval	Verbal
Bo.1.26.19	Review of meeting	Chair	For information	Verbal
Bo.1.26.20	Date and time of next meeting: • 26 March 2025, 9.30am	Chair	For information	Verbal

Annexes for the meeting of the Board of Directors 29 January 2026

Annex 1: For Information

Bo.1.26.21	Board of Directors work plan	Associate Director of Corporate Governance/Board Secretary	For information	Bo.1.26.21
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Osbourne-Sheridan
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Employee	Role	Date Incurred	Year	Interest Type	Date Ended	Interest Description (Abbreviated)	Provider	Value £'s
Altaf Sadique	Non-Executive Director	01.12.2020	2020/21,2021/	Outside Employment		Industrial member	GS1	0
Altaf Sadique	Non-Executive Director	01.06.2021	2021/22,2022/	Outside Employment		ibox healthcare is working with healthcare providers across the UK and global markets to deliver dashboards & data visualisation solutions help optimise patient flow and operational efficiency.Key customers NG	ibox Healthcare (part of IHG Group ltd)	0
Altaf Sadique	Non-Executive Director	08.12.2021	2021/22,2022/	Loyalty Interests		Full member GG health institute (EU).	GG Health for Institute (EU)	0
Altaf Sadique	Non-Executive Director	01.09.2022	2022/23,2023/	Loyalty Interests		Known to myself as a personal friend of long standing	Hanif Malik	0
Altaf Sadique	Non-Executive Director	01.04.2024	2024/25	Loyalty Interests		Charity to help build better emergency healthcare in south east Asia region.My role is advisor to the board on bilateral relations with charitable hospitals in the subcontinent India & Pakistan	HALO Charity	0
Altaf Sadique	Non-Executive Director	01.05.2025	2025/26	Outside Employment		iboxhealthcare have agreed a commercial partnership with Avanade who could be a potential supplier for BTHFT.	ibox Healthcare Avanade Partnership	0
Benjamin Roberts	Chief Finance Officer	01.09.2006	2015/16 & befco	Loyalty Interests		Fellow of Chartered Institute of Management Accountants	Chartered Institute of Management Accountants	0
Benjamin Roberts	Chief Finance Officer	01.09.2006	2015/16 & befco	Loyalty Interests		Member of the HFMA (Healthcare Financial Management Association) and Chair the Associations Digital Council	HFMA (Healthcare Financial Management Association)	0
Benjamin Roberts	Chief Finance Officer	06.04.2025	2025/26	Nil Declaration				0
Bryan Machin	Non-Executive Director	04.02.2020	2019/20,2020/	Outside Employment		Trustee (Vice chair)	St Annes Community Services	0
Bryan Machin	Non-Executive Director	01.09.2020	2020/21,2021/	Outside Employment		Member of Disciplinary Committee. Typically hear 2-3 disciplinary cases per year against CIPFA members. Has been voluntary until 2025; now attracts small payment.	Chartered Institute of Public Finance and Accountancy	0
David Moss	Director of Estates	01.12.2022	2022/23,2023/	Loyalty Interests		Chair of Northern and Yorkshire HEFMA	HEFMA	0
David Moss	Director of Estates	01.12.2022	2022/23,2023/	Loyalty Interests		National Chair of HEFMA	HEFMA	0
Faeem Lal	Director of Human Resources	11.03.2025	2024/25	Nil Declaration				0
Geoff Hall	Non-Executive Director	11.12.2025	2025/26	Nil Declaration				0
Helen Lewis	Chief Digital & Information Officer	02.01.2017	2016/17,2017/	Outside Employment		Director of family owned company.	Vikmara Property Development Company	0
Helen Lewis	Chief Digital & Information Officer	02.01.2018	2017/18,2018/	Loyalty Interests		Son is a robotics engineer for Medtronic UK.	Medtronic UK	0
John Bolton	Medical Director	18.04.2019	2019/20,2020/	Loyalty Interests		I hold a commission in the British Army.	British Army	0
John Bolton	Medical Director	13.11.2023	2023/24,2024/	Outside Employment		I am an adult (criminal) court Magistrate sitting on the West Yorkshire bench.	HM Courts & Tribunal Service	0
Justine Andrew	Non-Executive Director	01.10.2024	2024/25	Outside Employment		Trustee of a charitable arts organisation	York Museums Trust	0
Justine Andrew	Non Executive Director	07.10.2025	2025/26	Nil Declaration				0
Karen Dawber	Chief Nurse	01.09.2022	2022/23	Loyalty Interests		Honorary Professor	University of Bradford	0
Karen Dawber	Chief Nurse	12.11.2022	2022/23	Loyalty Interests		Member of Professional Body, was previously the RCN but changed to MIP	Member of MIP - trade union / professional body	0
Karen Dawber	Chief Nurse	01.11.2021	2021/22	Loyalty Interests		Ellie is my daughter and a volunteer in the Trust	Ellie Dawber	0
Karen Dawber	Chief Nurse	14.03.2024	2023/24	Loyalty Interests		Mind in Bradford is a local mental health charity that provides free mental health support to everyone living in Bradford District and Craven. Trustee post.	MIND in Bradford	0
Karen Walker	Non-Executive Director	03.04.2025	2025/26	Nil Declaration				0
Karen Walker	Non-Executive Director	01.07.2022	2022/23	Outside Employment		Chair of WYCA Patient Experience and Strategy Group (voluntary NED role)	West Yorkshire Cancer Alliance	0
Laura Parsons	Associate Director of Corporate Governance/Bi	15.08.2025	2025/26	Nil Declaration				0
Mark Hindmarsh	Director of Strategy and Integration	08.04.2025	2025/26	Nil Declaration				0
Melany Pickup	Chief Executive	01.06.2020	2020/21,2021/	Loyalty Interests		Mel is Honorary Professor at the University of Bradford.	University of Bradford	0
Melany Pickup	Chief Executive	18.12.2023	2023/24,2024/	Loyalty Interests		Trustee	Bradford City of Culture 2025	0
Sajid Azeb	Chief Operating Officer	12.10.2020	2020/21,2021/	Loyalty Interests		Wife own optometry business which hold NHS England Contract	Optometry Business	0
Sajid Azeb	Chief Operating Officer	12.10.2020	2020/21,2021/	Loyalty Interests		Brother a GP and Primary Care Clinical Lead for Calderdale CCG	Calderdale CCG / Calderdale PCN	0
Sajid Azeb	Chief Operating Officer	12.10.2020	2020/21,2021/	Outside Employment		Family Property businesses	Directorship at Greenroyd Ltd and Skircoat Development Ltd	0
Sajid Azeb	Chief Operating Officer	12.10.2020	2020/21,2021/	Outside Employment		MBA Industry Advisory Board Chair	Bradford University	0
Sajid Azeb	Chief Operating Officer	01.12.2025	2025/26	Loyalty Interests		Nephew (Initials HM) is a resident doctor currently on rotation to BTHFT as part of his training with the Yorkshire Deanery.	BTHFT Resident Doctor	0
Sarah Jones	Chairman	01.10.2020	2020/21,2021/	Outside Employment	15.12.2025	Minority shareholder in Realise Education & Training	Realise Education & Training	0
Sarah Jones	Chairman	04.03.2024	2023/24,2024/	Loyalty Interests		Brother MD of the Cheshire & Merseyside Cancer Alliance	Cheshire & Merseyside Cancer Alliance	0
Timothy Swift	Non-Executive Director	01.05.2003	2015/16 & befco	Outside Employment		Elected councillor	Calderdale MBC	0
Timothy Swift	Non-Executive Director	01.04.2017	2017/18,2018/	Outside Employment		Board member and director - this is a voluntary position within a significant local and regional cultural organisation	Piece Hall Trust Ltd	0
Zafir Ali	Non-Executive Director	01.11.2016	2016/17,2017/	Outside Employment		Various roles including:Deputy Head of Internal Audit – Department of Health & Social CareHead of Internal audit for the NHS Counter Fraud AuthorityHead of Internal audit for the NHS Health Research Authorit	Government Internal Audit Agency	0

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BTHFT Inside Out Board Code of Conduct



BOARD OF DIRECTORS OPEN MEETING MINUTES

Date:	Thursday, 27 November 2025	Time:	09:30 – 12:40
Venue:	Meeting Room, Listening for Life, BRI	Chair:	Sarah Jones, Chair
Present:	Non-Executive Directors: - Sarah Jones (SJ) - Zafir Ali (ZA) - Justine Andrew (JA) - Professor Geoff Hall (GH) - Bryan Machin (BM) - Altaf Sadique (AS) - Tim Swift (TS) - Karen Walker (KW) (via MS Teams, agenda items Bo.11.25.1 – 13) Executive Directors: - Professor Mel Pickup, Chief Executive (MP) - Dr John Bolton, Chief Medical Officer (JB) - Professor Karen Dawber, Chief Nurse (KD) - Mark Hindmarsh, Director of Strategy and Transformation (MHi) - Ben Roberts, Chief Finance Officer (BR)		
In Attendance:	- Faeem Lal, Director of HR (FL) - Vikki Lewis, Chief Digital, and Information Officer - David Moss, Director of Estates and Facilities (DM) - James Taylor, Deputy Chief Operating Officer (JT) - Laura Parsons, Associate Director of Corporate Governance / Board Secretary (LP) - Deborah Earnshaw, Corporate Governance Manager (DE) - Daniel Balaz, Chief Executive Officer - Connecting Roma (for agenda item Bo.11.25.7) - George Reynolds, Patient Experience (for agenda item Bo.11.25.7) - Sara Hollins, Director of Midwifery (for agenda item Bo.11.25.9) - Kez Hayat, Head of Equality, Diversity and Inclusion (for agenda item Bo.11.25.12) - Carl Stephenson, Director of Planning & Performance (for agenda item Bo.11.25.16)		
Observing:	- Daniel Balaz, Chief Executive Officer - Connecting Roma - John Waterhouse, Governor - Andy Waller, Governor - Scott Benton Symonds, Graduate Trainee - Sarah Smith, Communications Manager		

No.	Agenda Item	Action
Section 1: Opening Matters		
Bo.11.25.1	Apologies for Absence - Sajid Azeb, Chief Operating Officer	
Bo.11.25.2	Declarations of Interest No declarations were raised in relation to the items on the agenda.	

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	Code of Conduct The code of conduct was noted by the Board.	
Bo.11.25.3	Minutes of the Meeting held on 25 September 2025 The minutes of the meeting held on 25 September 2025 were approved as a true and accurate record.	
Bo.11.25.4	Matters Arising The following actions were reviewed, outcomes noted and confirmed as closed: - <u>Bo250017 Report from the Chair of the Quality Committee: June & July 2025: Mental Health, Learning Disabilities and Neurodiversity Strategy update:</u> Work is ongoing with Sarah Turner and within the EXCEL programme / CQC action plan regarding additional training to staff on mental health and additional tracking of those patients presenting with mental health issues. <u>Action closed.</u> - <u>Bo250021 Partnerships: strategic view:</u> University of Leeds updates now included within the report to Board. <u>Action closed.</u> - <u>Bo250022 EPRR and NHSE Core Standards:</u> SJ has written to the team to express the Board's gratitude for their hard work. <u>Action closed.</u> - <u>Bo250023 EPRR and NHSE Core Standards:</u> Authority was delegated to the Finance and Performance Committee to sign off the final submission to meet the deadline requirement, and this was completed at the October meeting of the Committee. <u>Action closed.</u> - <u>Bo250024 Charitable Funds Committee – Chair's Report:</u> An assurance paper on the independence of the Charity will be included as part of the January Board meeting. <u>Action closed.</u>	
Section 2: Business Reports		
Bo.11.25.5	Report from the Chair SJ introduced the report from the Chair which was taken as read. She referred to the recent well-led CQC inspection during which there was a presentation by the Trust to the CQC attended by partner stakeholders, which was well received. The report was noted by the Board.	
Bo.11.25.6	Report from the Chief Executive MP introduced the report and highlighted the following: - It had been an incredibly busy couple of months with unannounced CQC inspections of several core services and a well-led inspection. - The expectation of NHS England (NHSE) during the recent resident doctor strike was for trusts to maintain 95% of planned activity. BTHFT achieved 93% of planned activity in relation to inpatients and 94% of outpatient activity, but this was the result of a significant increase of 'did not attends' rather than due to internal capacity constraints. In addition, there were no cancellations of cancer procedures nor any long wait patients. - In terms of the number of resident doctors undertaking strike action, this varied throughout the industrial action period to a maximum of 70%. MP thanked the operational teams for their support during this time and for a well implemented and executed command and control system. The Integrated Care Board (ICB) planned reduction in running costs is now to proceed within the current financial year. It is expected that a voluntary	

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	redundancy scheme will open shortly, with formal staff consultation on future structures beginning in January. The aim is to achieve the nationally mandated 50% reduction in running costs by 1 April 2026. The report was noted by the Board.	
Section 3: Patient Care		
Bo.11.25.7	Patient story (Roma Patients – Daniel Balaz) SJ welcomed DB, CEO of Connecting Roma, to the meeting. A video sharing DB's experience of attending A&E had been circulated to colleagues for viewing prior to the meeting, and Board members were invited to ask questions and share their observations with DB. Regarding cultural awareness, SJ asked what single message in relation to this should be shared with Trust employees to improve the experience of patients from the Roma community. DB advised that it is a complex community and culture, with members from various cities and countries, and therefore the level of education is varied. This needs to be considered in all interactions with these patients and visitors. KD apologised for the care received by DB. She assured the Board that several changes had been made following DB's experience, including pain relief now being provided by the triage nurse instead of waiting for a prescription by the Doctor. This has demonstrated improvements in patient feedback already. Regarding the cultural conversation, KD asked how to address the balance between explaining things in more detail to those that need it and not being patronising to those who have a higher level of understanding. DB recognised the challenge in balancing this and suggested that cultural advisors be appointed to help inform such discussions. ZA asked how the perception of the service by the Roma community has changed over time. DB responded that the Roma community in Bradford is open to sharing their feedback with DB and the Connecting Roma organisation but they are still being encouraged to share feedback with the Trust. He acknowledged that there is still an element of mistrust amongst the Roma community which often stops them seeking medical help when required. The Board thanked DB for attending the meeting and sharing his experience and advice in how the Trust can better support the Roma community.	
Bo.11.25.8	Report from the Chair of the Quality Committee: October & November 2025 TS gave an overview of the reports from the Quality Committee meetings in October and November 2025. There were several matters to alert to the Board: - The Trust is seeing an earlier than expected increase in Flu and Covid cases, which is causing operational issues as national modelling suggested increased numbers would be seen later in the year. The challenge is largely around side room capacity. The risk around ED overcrowding has reopened on the high-level risk register at a score of 20, with the constraints of the department posing a risk of major or catastrophic harm to patients.	

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	- There were 28 open high-level risks (scoring 15 or over). This is the highest total reported on the register in the last three years (2023/24 to 2025/26). Furthermore, no risks had reduced in score since the last report. - There were a cluster of risks associated with respiratory and service backlogs. It was proposed that the Quality Committee carries out a 'deep dive' into this area and reports back to the Board on further support and action that may be required. KD referred to the respiratory risks advising that a number of actions were being considered to improve the respiratory environment and experience, including a potential change in ward, but this would have consequences elsewhere and so this requires careful consideration. In relation to tuberculosis (TB) specifically, an analysis of the funding gap was being worked through as an element of the service is specialised commissioning. KD would keep the Board updated as relevant. AS queried whether those with airborne viruses can be isolated, and the process on contact tracing those that have been in contact with infected patients. KD advised that due to limited side room capacity, not all those with airborne viruses can be isolated and therefore a rapid risk review is undertaken for each patient and those with the most serious infections are prioritised for a side room. In relation to contact tracing for those that have been in contact with an infected patient, it was recognised this does create a burden on staff as there is no dedicated process for this or a singular lead, and the updated policy should help to address this. The Board received the report and noted the assurance provided. Digital Strategy bi-annual update: The Board received the report and noted the progress of the business plan and strategic objectives, and the risks towards delivery. Inpatient survey: SJ referred to the challenge around the inpatient survey only being available in the English language which doesn't always meet the needs of our patients. KD confirmed that this is a CQC-owned survey and whilst the Trust continues to raise these challenges, there is limited influence to change. The Trust does actively seek to obtain feedback by other routes to ensure that the views of those that are not English speaking are also received. The Board received the report and noted the summary of results and improvement action plan.	
Bo.11.25.9 Osbourne, Sheridan 26/01/2026 12:25:00	Maternity and neonatal services update SH provided an overview of the paper which sought to provide the Board with assurance that a review of maternity and neonatal quality and safety relating to September and October 2025 was presented, and key elements discussed, at the Quality Committee. SH highlighted the following points: - The number of harms occurring in September and October, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of Maternity Newborn Safety Investigations (MNSI) and Patient Safety Incident Investigation (PSII) cases.	

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	- There was 1 completed MNSI report in October, and 1 in November. Learning and recommendations from the investigations were shared with the Quality Committee. - The Trust has received notification that Baroness Amos and her investigation team will visit Maternity and Neonatal services on 1 and 2 December. Family engagement with the investigation is being co-ordinated by the Maternity and Neonatal Voices Partnership (MNVP) lead. The services continue to hold weekly preparation meetings and will respond to data requests as received. - As reported at the Quality Committee, the standard for safety action 1 of the Maternity Incentive Scheme, Year 7 had been met, or was on trajectory to be met, for standards A and B by the end of the reporting period in relation to the Perinatal Mortality Review Tool quarterly report. However, standard C is currently at 91%, falling short of the required 95% threshold. The service has submitted mitigation to MBRRACE-UK for one complex, multi-site case, including actions taken to prevent a recurrence of missed completion. This mitigation will be included in the self-declaration submission. A response is awaited from MBRRACE-UK as to whether the mitigation will be accepted. If declined, safety action 1 will be non-compliant, compromising overall compliance with the Year 7 scheme. - The Board was also informed of a possible non-compliance with Safety Action 8 of the Year 7 scheme. Compliance will only be achieved if all anaesthetic colleagues allocated to the final PROMPT training day, attend the session. All attendees are aware of the requirement to attend. - The CQC maternity report will be published on Friday 28 November. - This is a time of real digital change, including a singular reporting system for alerting MBRRACE and other organisations which should streamline reporting processes. There will also be implementation of a maternity sitrep, although there is no clarity on what submissions will be required as yet. - The Maternity Outcome Signals System (MOSS) was also shortly due to go live, this aims to highlight potential safety issues in intra-partum care using real time data and can trigger escalation to the ICB if required. There is some concern around the short response time and this will need to be worked through to ensure that any triggers are responded to appropriately. SJ thanked SH for the strong strategic detail in the report and demonstration of excellent leadership by SH. This was echoed by the Board. The Board: • confirmed that they were assured that the Quality Committee had reviewed and discussed the contents of the September and October 2025 Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority; and • noted the potential compromise in meeting compliance with the Maternity Incentive Scheme, Year 7, due to Safety Actions 1 and 8.	
Bo.11.25.10	CQC Action Plan – quarterly update KD provided an update to the Board on the delivery of the Medical Services, Maternity and Urgent and Emergency Care, Out-patient Services, Community Hospitals and Well Led actions in the Trust's CQC Improvement Plan. These were in varied stages of completion but KD assured the Board that services were giving due diligence to working through any open and outstanding actions. A CQC	

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	portal had been created on IRIS (the Trust's risk and incident management system) to support a more robust process for tracking actions and progress. BM highlighted the community hospitals feedback and reference to a lack of support for those patients that require help eating, which was also reflected in the inpatient survey. KD explained that the presence of the CQC had impacted on this; the CQC Inspector had also visited the next day and saw an improved position. KD noted that Westwood Park were an exemplar unit and regularly receive praise for their services, and it is hoped that these areas of good practice will be referenced in the draft report for community hospitals. SJ reflected that she has visited the ward on previous occasions and the care has been outstanding. The Board: - noted the progress to date; and - supported the continued delivery and resolution of outstanding actions.	
Section 4: People		
Bo.11.25.11	Report from the Chair of the People Academy: October & November 2025 KW gave an overview of the reports from the People Academy meetings held in October and November 2025. She alerted the Board to the dashboard which showed a decreased appraisal rate at 76.3%, absence at 6.1% and turnover at 9.6%. The development of dynamic conversations and manager support should remove the barriers to appraisal completion, the absence action plan has been revised and presented to the executive team for support, and turnover is stable. From the November meeting, KW alerted the Board to sickness absence which was 6.62% for September and seasonal viruses will likely push absence to above 7% for November. Despite a significant flu vaccination campaign, this is not driving the uptake of flu vaccines for staff. BM commented that sickness absence has been raised at a number of other committee meetings, and whilst there is significant information available around the data in relation to this, there is limited analysis. KW advised that she was assured by the actions being taken to mitigate sickness absence and a detailed analysis was received by the People Academy to help understand absence drivers. There was significant reliance on managers undertaking actions to help get their staff back to work or leaving the Trust if they are unable to return to their roles, but additional workload pressures makes this challenging. FL confirmed that the sickness absence plan had been refreshed and presented to the Academy and there was recognition that a culture change in relation to sickness absence was needed, including robust management training to help leaders address this. Policies were also being refreshed to ensure they were simple for managers to follow. However, there was acknowledgement that the Trust staffing is representative of the community and given that the community has health deprivation challenges, this is reflected in the health of Trust employees. Therefore the Trust may always benchmark negatively with peers, however comparison with Bradford District Care NHS Foundation Trust (BDCT), who have a similar staffing demographic, demonstrates a better sickness absence rate.	

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	FL provided an update on current flu vaccination figures and confirmed that uptake was 38.6%, which was an improvement on last year. The Board received the report and noted the assurance provided. Freedom to Speak Up (FTSU) quarterly report: KD highlighted the appointment of a second FTSU guardian to a total of 1 WTE. The Board received the report and noted the assurance provided. Workforce Report: The Board received the report and noted the assurance provided. The People Academy would review the report to identify what changes should be made in future iterations recognising the large amount of data included. Job Evaluation: The Board received the report and noted the assurance provided.	
Bo.11.25.12	Equality, Diversity and Inclusion (EDI) Strategy update KH gave a 6 monthly update on the Trust's approach and progress on EDI, including future direction, and progress on the EDI Strategy. With regards to the EDI conference, SJ made reference to the interactive live-action session led by Collingwood Learning, which was around professional behaviours in the workplace and the wider responsibilities and roles for those who witness inappropriate behaviours. This was well received and there was great engagement from this in the room calling out poor behaviours and 'clumsy' and inappropriate language. GH congratulated KH for his achievements and work in this space which should be used as an exemplar for the NHS. KW asked if a 'mini conference' could be developed with focus on professional behaviours in the workplace utilising a drama based approach, to enable more colleagues to attend. KH would take this into consideration to see if a belonging roadshow could be developed, but recognised resource limitations on this. KH had discussed with Cat Shutt (Head of Organisational Development) to identify if some smaller engagement offers could be developed for managers and staff. The Board thanked KH for his attendance at the Board and noted the update.	
Bo.11.25.13	Strategic Equality & Diversity Council (EDC) update – November 2025 MP presented the key highlights from the last EDC meeting held on 5 November 2025. MP made particular reference to the EDI Conference session led by the Yorkshire Women's Forum, which empowered colleagues to capture what belonging means to them by engaging in the development of an individual creative artwork piece. This prompted an invite from the Yorkshire Women's Forum for MP to join their event on 17 November. The full Executive Team had attended which resulted in connections being built that will be further explored. MP had also attended the Race Equality Network (REN) headquarters to meet with Professor Habib Naqvi around the progression of the Anti-Racist statement which will be brought back to a future Board meeting for endorsement and	

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	approval. This was also helping to increase the national profile and awareness of the work being undertaken by BTHFT in relation to the EDI agenda. The Board received the report and noted the assurance provided.	
Section 5: Finance and Performance		
Bo11.25.14	Report from the Chair of the Finance and Performance Committee: October & November 2025 BM gave an overview of the reports from the Finance and Performance Committee meetings in October and November 2025. He alerted the Board to the challenging financial position, and the addition of three new risks on to the high level risk register. Integrated Dashboard: There was a reflection on the large volume of information provided to the Committees and Board, and whether this provided the assurance sought by the relevant meeting members. JT advised that the detail is provided to the Board and Committees to ensure that there can be appropriate challenge and scrutiny of the information presented. SJ commented that the data provided to the Board is in the public domain and it can be challenging to understand due to the way it is presented. MP advised that the integrated dashboard would be refreshed with the aim of reflecting the areas which are tracked as part of the NHS Oversight Framework (NOF). JA commented that a level of detail can be helpful, but a clearer steer was needed to highlight the key issues requiring focus from the Board. GH supported this view. BM referred to the different balance of information required at operational, executive, committee and board level, which was acknowledged. The Board received the report and noted the assurance provided. Finance Report: BR gave an overview of the finance report and highlighted the following points: - The Trust is reporting a year to date I&E position worse than plan by £7.9m at Month 7, with an actual deficit of £16.3m, compared to a planned deficit of £9.3m. This is due to shortfalls against the cumulative Closing the Gap (CTG) savings target no longer being adequately offset by other run rate increases due to demand and policy pressures, and an increased Elective Recovery Fund (ERF) income risk. - The underlying position for Month 7 was a deficit of £2.6m which was a £0.7m deterioration on Month 6. This was mainly driven by increases in non-pay spend, such as drugs and consumables. - In the likely forecast scenario, based on the current Income & Expenditure forecast, the Trust may require up to £13m in cash support during the financial year, with the need expected to arise from December onwards, as pressures on working capital increase.	

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	The Board received the report and noted the assurance provided. Operational Performance Report: The Board received the report and noted the assurance provided. Premises Assurance Model (PAM) progress report The Board received the report and noted the assurance provided.	
Bo.11.25.15	Budget setting process & timetable BR presented the paper which summarised the approach that would be taken to develop and agree departmental income and expenditure budgets for 2026/27. The paper detailed a staged timetable for completion of the budget setting exercise and the governance route for sign off by the Executive Team and Finance & Performance Committee. The Board: - noted the approach to setting internal departmental budgets for 2026/27 set out in the paper; and - noted the timetable for completing the work.	
Bo.11.25.16	Annual Planning Framework CSt joined the meeting to provide an overview of the annual planning framework. The presentation detailed both the ask from the national team, and the Trust's approach to the response to this including the engagement plan. He highlighted a change from a short-term annual cycle to integrated, outcome planning for the next five years. SJ thanked CSt and his team for their work in establishing such a robust and detailed planned response to the national asks. JA queried the involvement of the Board in the planning process and how this links with the strategy development. BR commented that unlike in previous years, the guidance has been provided reasonably early but the initial submission requirement was also brought forward to December which caused a step up of planning response. The second submission was not due until February which would provide further opportunity for Board involvement and engagement in the planning process, including via the Committees. With regards to long term strategy planning, MHi recognised a need to progress this and ensure it aligns with the long term plans. The Board thanked CSt for attending the Board and confirmed their assurance around the annual planning framework and process.	
Section 6: Strategy & Partnerships		
Bo.11.25.17	Strategy – emerging issues MHi referred to the inaugural Strategic Advisory Forum meeting held on 24 October with external colleagues from partners such as Public Health England and the ICB in attendance. He advised that a number of similar sessions will be set up over the next year to engage partners with the strategy. MHi also referred to the upcoming Improvement Showcase on 3 December, noting that the National Director for NHS Impact would be in attendance to provide a keynote speech, and the event would showcase improvement initiatives	

No.	Agenda Item	Action
	from across the organisation. MHi encouraged all Board members register to attend if diaries permit.	
Bo.11.25.18	Partnerships – Strategic View MHi presented a summary of partnership working that the Trust was currently engaged with at place, across West Yorkshire and nationally. MHi made particular reference to: - The new Bradford District Strategy (2025-2035) had been approved by Bradford Metropolitan District Council. It will be overseen by the Health and Wellbeing Board, on which the Trust is represented by MP as Chief Executive. - The EXCEL programme has evolved strategically, recognising that a sustainable reduction in Emergency Department attendances can only be achieved through a system-wide, collaborative approach. To date, the programme has connected with over 42 distinct groups across the Bradford District and is working to continue strengthening these relationships to co-develop sustainable solutions. The Board: • noted the strategic view of partnership working and the links to the Strategic Framework, the strategic objectives and the 10 priority initiatives; • noted the publication of Bradford Council's "District Strategy 2025-2035"; and • noted the current opportunities and developments in partnership working.	
Bo.11.25.19	Anchor Institution MHi outlined the work carried out to date to fulfil the Trust's remit as an Anchor Institution in Bradford District and Craven, and further actions to be taken. The paper also made reference to a completed self-assessment to help identify areas of strengths and opportunities in the work of the Trust as an anchor institution, with an action plan developed in response. The Board noted the update and approved the work required to implement the self-assessment action plan.	
Section 7: Audit & Assurance		
Bo.11.25.20	Report from the Chair of the Audit Committee: 18 November 2025 ZA gave an overview of the reports from the Audit Committee meeting in November 2025. There were no matters to alert to the Board. The Board received the report and noted the assurance provided.	
Bo.11.25.21	Report from the Chair of the Charitable Funds Committee: 4 November 2025 AS gave an overview of the report from the Charitable Funds Committee meeting held in November 2025. The Board was alerted to a recent audit on the existing communication and marketing channels which highlighted that the charity website	

No.	Agenda Item	Action
	doesn't meet the Web Content Accessibility guidelines. MHi would take the proposal to the Charitable Operational Committee to discuss the functionality required and the Committee was assured that this would be addressed. MHi advised that the public phase of the neonatal 'Home from Home' appeal commences on 4 December by way of a launch event at the Bradford Science and Media Museum. MP referred to receipt of the first instalment of a £1m donation from the Harry and Mary Foundation to support the neonatal 'Home from Home' build, which was a fantastic boost for the appeal. Contact had also been made with local businesses to garner further support and donations. The Board received the report and noted the assurance provided.	
Section 8: Governance		
Bo.11.25.22	Board Assurance Framework and high-level risks KD introduced the paper which provided a profile of risks, controls and assurances related to the delivery of the Trust's strategic objectives. KD provided further comments on the high level risks as follows: - Risk 2478 (nuclear medicine service): There had been challenges in sourcing an alternate shield for the generator which was having a continuous impact on performance in relation to this service. Mitigations were in place and once a new shield was received the risk score should reduce. - Risk 2787 (maternity theatres): The maternity theatres do not meet the Association for Perioperative Practice (AFPP) standards in line with the main hospital theatres but this was being reviewed to ensure the staffing levels for maternity theatres were appropriate. KD and ZA would meet in February in anticipation of a Board Development session around the BAF and high level risks. The Board was assured that all risks on the High Level Risk Register and BAF were appropriately recognised and recorded, and that all appropriate actions were being taken within appropriate timescales where risks were not appropriately controlled.	
Bo.11.25.23	ToRs - People Academy, Quality Committee, Finance and Performance Committee and Charitable Funds Committee LP presented the revised Terms of Reference for the People Academy, Quality Committee, Finance and Performance Committee and Charitable Funds Committee. The Board approved the minor amendments to the Terms of Reference for the: - People Academy; - Finance and Performance Committee; - Charitable Funds Committee; and - Quality Committee.	

No.	Agenda Item	Action
Bo.11.25.24	Standing Financial Instructions (SFIs) and Scheme of Delegation BR presented the updated SFIs and Scheme of Delegation, noting that they had been previously presented at both ETM and more recently at the Audit Committee on 18 November where the proposed changes were approved. The Board approved the recommended changes. Board Standing Orders and Senior Independent Director (SID) appointment process LP presented the revised Board Standing Orders which have been reviewed from a legal perspective to ensure they are up to date and appropriate. The revised Board Standing Orders clarified that the same NED cannot be both Deputy Chair and Senior Independent Director, and that ideally neither should be the Audit Committee Chair. Therefore a SID appointment process document has been produced developed to clarify how the appointment of the SID will be made The Board approved the revised Board Standing Orders and the SID appointment process document.	
Bo.11.25.25	Modern slavery statement LP presented the proposed amendments to the Modern Slavery and Human Trafficking Statement. The revised Modern Slavery and Human Trafficking Statement was approved by the Board.	
Section 9: Board Meeting Outcomes		
Bo.11.25.26	Any Other Business No other business was discussed.	
Bo.11.25.27	Issues to Refer to Board Committees/Academies or Elsewhere There were no issues to refer elsewhere.	
Bo.11.25.28	Review of Meeting There were no comments in relation to review of the meeting.	
Bo.11.25.29	Date and Time of Next Meeting 29 January 2026 – 9.30-12.30	

Osbourne-Sheridan
26/01/2026 12:25:00

ACTIONS FROM BOARD OF DIRECTORS OPEN MEETING – 27 November 2025

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
Bo250016	Bo.5.25.17	Strategic Partnering Agreement Refresh 2024/25: A revised document reflecting the updated changes to be brought back to Board in November 2025.	Director of Strategy and Transformation	March 2026	The Strategic Partnering Agreement is currently being reviewed and an updated version will be agreed by the end of March 2026.
Bo250014	Bo.5.25.10	Report from the Chair of the People Academy: April & May 2025 – Guardian of Safe Working Hours Annual Report: Information on the Junior Doctoring gaps and where the fillers are being deployed to be included as part of the next iteration of the report.	Chief Medical Officer	May 2026	

Osbourne Sheridan
26/01/2026 12:25:00

Board of Directors				
Meeting Date:	29 January 2026		Agenda Reference:	Bo.1.26.5
Report Title:	Report from the Chair			
Presented by:	Sarah Jones, Chair			
Executive Lead:	Sarah Jones, Chair			
Author:	Jacqui Maurice, Head of Corporate Governance			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	This report provides an update to the Board on key items since my previous report provided in July 2025. The report covers: 1. Engaging with Partners and Stakeholders 3. Council of Governors - Feedback to the Council following Board of Directors meetings - NHS Oversight Framework and performance dashboards - Meetings of the Council 4. Governor elections update 5. Strategic Advisory Forum: Anchor Institutions 6. Key communications			
Recommendation/s: (including any decision/approval required)	The Board of Directors is asked to derive assurance from the report.			
Link to Strategic Objective:	N/A			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	N/A			
Legal/Regulatory:	N/A			
Quality & Patient Safety:	N/A			
Equality, Diversity and Inclusion and Health Equity:	N/A			
Resources:	N/A			
Environmental sustainability:	N/A			
Assurance Route				
Meeting/s where content has been discussed previously:	N/A			

Report from the Chair

1. Engaging with Partners and Stakeholders

In order to support the wider system, I have been appointed to the Chair role at Airedale NHS Foundation Trust from 1 February 2026 and from 1 March as Interim Chair in Common with Bradford District Care NHS Foundation Trust. As a result, I will need to step away from my day-to-day involvement here with Bradford Teaching Hospitals NHS Foundation Trust. In summary these are the changes that will take place locally:

- Karen Walker, Deputy Chair for Bradford Teaching Hospitals NHS Foundation Trust, will take over the role of acting chair
- I will take up the position of Chair for Airedale NHS Foundation Trust from 1 February 2026
- I will take up the position of Chair in Common at Bradford District Care NHS Foundation Trust from 1 March 2026

My appointment by Airedale's Council of Governors, together with being invited to take up the appointment of Chair in Common role at Bradford District Care NHS Foundation Trust, is a strong endorsement of the progress we have made in the governance of BTHFT in the past 12 months and also reflects well on the maturity of our partnership working across our organisations. My hope is that, through working together as a wider system, we can create opportunities for closer collaboration that will be to the benefit of the people of Bradford District and Craven.

2. Council of Governors

Feedback to the Council following Board of Directors meetings

On 2 December I provided a comprehensive update on items discussed and outcomes from our November Board meeting. The next feedback session is scheduled on the January Board is scheduled for 3 February from 4pm to 5pm. Our Interim Associate Director of Quality and, the 'Moving to Outstanding Lead' joined this session to provide an overview of the Trusts '15 Step Challenge' programme'.

NHS Oversight Framework and performance dashboards

Also on 2 December, Saj Azeb, Chief Operating Officer/Deputy Chief Executive and Ben Roberts, Chief Finance Officer delivered an engaging and information session for Governors in response to the publication of NHS England's oversight framework and performance dashboards. Saj and Ben aimed to provide Governors with clarity on what the information is communicating. This information is now routinely placed in the public domain.

Meetings of the Council

The last meeting of the Council took place on Thursday 15 January. As well as the in-depth discussions with the Academy/Committee Chairs, the Council received a comprehensive update on our 'five-year plan', 'digital strategy' and, up-to-date news items affecting the NHS (local and national). The council also approved the revised 'code of conduct' and the 'process for managing concerns'. The next meeting of the Council is scheduled for 15 April 2026 (times to be confirmed).

3. Governor elections update

Since my last report to the Board, unfortunately our staff governor representing the Medical and Dental group has, regrettably, stood down from the Council of Governors. An election process will therefore formally launch on 26 January for the following vacancies on our Council.

- Staff Governor Medical and Dental
- Public Governor Shipley
- Patient Governor (Out of Bradford)

The schedule for this election process is included below

Notice of Election published / nominations process open	Monday, 26 Jan 2026
Nominations deadline	Monday, 23 Feb 2026
Summary of valid nominated candidates published	Tuesday, 24 Feb 2026
Final date for candidate withdrawal	Thursday, 26 Feb 2026
Notice of Poll published	Monday, 16 Mar 2026
Voting packs despatched	Tuesday, 17 Mar 2026
Close of election	Thursday, 9 Apr 2026
Declaration of results	Friday, 10 Apr 2026

I would be grateful if board members would share news of these vacancies amongst their own networks / relevant staff and encourage self-nominations to these roles.

4. Strategic Advisory Forum: Anchor Institution

Our second 'Strategic Advisory Forum' covering 'Anchor Institutions' takes place on Thursday 5 February, 9.30am to 11.30am at the University of Bradford. William Hall, our Partner Governor from the University of Bradford has been instrumental in helping to develop the session which will focus on education and the role BTHFT has to play in supporting the population of Bradford to higher levels of educational achievement, particularly those aged 16+, and supporting people through alternative routes into healthcare roles. The agenda is just being finalised however it will include a focus on:

- Anchor institutions and why they are important
- Our Trust apprenticeships and social mobility
- 16+ Education and alternative routes into healthcare/university
- The University of Bradford - Social Mobility Champions

Key individuals from community organisations / institutions will also be attending. William and his team at the University have very kindly offered to host a tour of the simulated learning spaces after the meeting (approximately 1 hour), 11.30am to 12.30pm.

You will recall these sessions are scheduled to provide an opportunity for members of the Board and our Council of Governors to meet together, outside of the formal meeting structures. As with the previous event held in October, I expect this to be an extremely engaging and interactive session and would like to encourage as many of our Board members to attend as possible where diaries permit.

5. Key communications

Our Foundation Trust members have continued to be in receipt of 'Mel's monthly roundups' featuring news from across the Trust. The most recent communication is available online [here](#). Key communications also continue to be shared with Governors so that they remain in touch with developments here at our Trust. Governors also continue to have access to Let's Talk (staff newsletter) and global emails containing a range of updates to staff.

Board of Directors				
Meeting Date:	29/01/2026	Agenda Reference:	Bo.1.26.6	
Report Title:	Report from the Chief Executive Officer			
Presented by:	Professor Mel Pickup, Chief Executive			
Executive Lead:	Professor Mel Pickup, Chief Executive			
Author:	Executive Directors and Corporate Governance Manager			
Report Summary				
Purpose of the paper:	Decision ☐ (Approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (Review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	The report provides the Board with a summary position regarding our Patients, People, Place and Partners since the last report to the Board in November 2025.			
Recommendation/s: (including any decision/approval required)	The Board is asked to derive assurance from the content of the report.			
Link to Strategic Objective:	N/A			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	N/A			
Legal/Regulatory:	N/A			
Quality & Patient Safety:	N/A			
Equality, Diversity and Inclusion and Health Equity:	N/A			
Resources:	N/A			
Environmental sustainability:	N/A			
Assurance Route				
Meeting/s where content has been discussed previously:	N/A			

Report content
1. Patients The Quarter 2 position for the NHS Oversight Framework (NOF) was published in December. Overall performance for the indicators utilised by NHSE was relatively stable in this period, although some small deteriorations have meant the Trust's position has moved from 37 to 40 of 134. Each Trust is assigned a segment ranging from 1 (best) to 4 (worst) based on the average metric score across the performance domains which cover performance, quality, finance, and workforce. Our score moved from 2.00 to 2.08, although we remain in segment 3 as we can be no higher if reporting a financial deficit. As a Trust we continue to benchmark positively against the Emergency Care Standard (ECS), with our current position remaining in the upper decile of Acute Trusts in England. Attendances to our ED increased significantly during winter, above levels seen in previous years and higher than we forecast for this year, in particular this was linked to an earlier than anticipated rise in the influenza increase. The use

of patient streaming continued to provide the necessary resilience to manage periods of high demand, ensuring timely care for patients who would previously have experienced delays due to hospital pressures despite not requiring admission to a hospital bed. We also created additional capacity for patients requiring observation before same day discharge, which helped keep capacity available for treating new arrivals.

Alongside improvements within the Emergency Department (ED) the Trust is also working on initiatives to reduce overall bed occupancy and improve the ability to maintain adequate patient flow through the system. The impact of this will be improved patient experience throughout their time with the Trust and reduced frequency of long stays in ED which is a national priority. The EXCEL programme has this as one of its transformational objectives.

Collaborative work with Yorkshire Ambulance Service (YAS) continues and both handover and crew clear times improved as a result. Handover times are significantly shorter when compared to the same period last year following the implementation of the Transfer of Care Standard Operating Procedure (SOP) which requires crews to handover patients to the Ambulance Assessment Area (AAA) clinician after 45 minutes. The aim is to reduce delays for 999 callers by freeing up ambulance crews waiting at hospitals, improving response times, community safety, and patient experience. This work will help keep the organisation in line with stretching national expectations to have no handovers exceed 45 minutes.

Our winter plan is supporting the organisation to cope with seasonal pressures. This is an iterative process with the current plan based on attendance and admission modelling. Sustaining improvements in Urgent and Emergency Care (UEC) performance will be challenging during the winter period, particularly with the need to ensure financial balance, but daily oversight is in place to support timely response to pressures as they emerge. Some of the increased hospital attendance and admissions are associated with Influenza, which has impacted on flow and overall bed capacity. We continue to highlight the importance of vaccinations and have issued several communications to colleagues across the organisation on the importance of getting vaccinated to protect themselves and our patients.

Outpatient Transformation which utilises the model for improvement at a service and pathway level whilst enabling our digital offer to be modernised continued and several schemes are moving from test of change to scaled adoption across all services. The aim is to deliver outpatient services where patients can be seen more quickly and can access and interact with services in a way that better suits their lives. Clinical engagement with the case for change remains a priority whilst we scale up the concepts that have been evidenced as effective, this will be particularly important during Quarter 4 as we provide additional focus on shorter term productivity benefits in line with the Financial Recovery Board's priorities.

Referral to Treatment (RTT) performance dropped behind plan during Quarter 3. The overall waiting list has reduced to planned levels; recovery of the performance target is expected as we focus on several key services and have additional clinic capacity focussed on first appointments. This aligns perfectly with a national sprint related to increasing first outpatient attendance, demonstrating the challenges we face are mirrored across other providers. Engagement with this sprint has been extremely positive and will also potentially generate additional income to support the Trust's financial position. Our ambition is to be in line with the national ambition of achieving the 92% standard by 2029, subject to transformational change embedded towards the latter part of this period. The number of waits over 52 weeks is already better than the national target of 1% of total waits set for 2025/26 and improved further this month.

Work to improve productivity is being accelerated with the Data and Productivity work-stream established as part of the Financial Recovery Board. In addition to the work on outpatient transformation there will be a focus on Theatres and Day-case units where the opportunity to book and treat more patients per session will be explored. Progress has been made in making the data needed to progress this available to the operational teams. This work aims to improve our overall implied productivity rate, which is the level of activity per unit of spend, whilst also increasing treatments and the reducing the RTT waiting list as a result.

Improving the time to inform patients of whether they have cancer or not in no more than 28 days remains a priority. Performance for the related Faster Diagnosis Standard (FDS) measure is being sustained at levels above national and peer average. Treatment time remains below the 75% requirement time for patients being treated within 62 days. All tumour group improvement plans are being assessed as part of our response to the planning framework.

Work to meet the expectations set out in the Planning Framework continued at pace. The two asks being the production of a three-year numerical plan and a five-year narrative plan that support delivery of the three priority shifts, meet operational performance expectations, and deliver local change aligned to the needs of our population. Through the governance and processes needed to deliver this we have met each national deadline and engaged with external partners, and internal stakeholders to establish the baseline position against which we can produce and implement a final set of planning returns. These will be triangulated across strategy, finance, performance, workforce, and quality with clear alignment of digital strategy. Quality of care and patient outcomes will remain at the heart of these plans, and they will align to the wider plans across West Yorkshire, as well as the local Neighbourhood Health Plans as these develop.

Finance and Financial Recovery Programme

On 8 January 2026 the Trust submitted formal notification to Sir Jim Mackey and Elizabeth O'Mahoney to formally request a change to our forecast financial position for 2025/26. The Trust submitted a revised forecast of a £19.7 deficit, which is £17m worse than the planned deficit of £2.7m.

A Financial Recovery Board, led by the CEO, has been established that is meeting weekly. There is a clear recovery structure in place with all the Executive Directors taking leading roles on three workstreams to improve the financial position of the Trust.

Communications have been shared across the Trust regarding the financial position and the recovery actions that are being taken, with wider engagement taking place with the management teams across the organisation.

St Luke's Day Case Unit (SLH DCU) and Endoscopy Unit (BRI)

We are working with the contractor and NHSE estates colleagues to seek to resolve the delays relating to the St Luke's Day Case Unit; this is ongoing and I will keep the Board up to date on progress.

The Endoscopy Unit build continues to progress well and remains on budget. We are expecting completion at the end of January, the new unit will support improvements in the provision of this key diagnostic test, reduced waiting times, and the reattainment of JAG accreditation for the Trust

Industrial Action by BMA resident doctors – 14 to 19 November 2025

Another round of industrial action was undertaken by resident doctors in December. As per previous strike periods we established a full command and control infrastructure to ensure that our services remained safe, and we minimised the impact on patients as much as we possibly could. Unfortunately, there was some disruption to services with outpatient and theatre sessions cancelled to support other duties but over the period we were able to maintain activity volumes above the 95% national expectation compared to plan.

2. People

Flu Vaccination

The Flu vaccination programme started on 6 October with the aim of making at least a 5% improvement on last year's vaccine uptake of 33.8% of frontline staff having had the vaccine. This winter Joint Committee on Vaccination and Immunisation (JCVI) advised that frontline healthcare workers will not be eligible for COVID-19 vaccination under the national programme. There has been a downward trend in flu uptake across the Trust over the last 4 years, which reflects the national picture. Flu vaccination programme has been delivered by Rimmington Pharmacy, similar to the campaign last winter. The vaccine has been available from the static vaccination pods on the BRI main concourse and roving

vaccinators visiting all wards/departments across the Trust as well as across all community hospitals and sites. We are pleased that we have achieved a significant increase in the vaccination rates and according to the national figures we have had 46% of our frontline staff vaccinated which is an increase of over 12% from the previous campaign.

Staff Survey

The staff survey which is one of the largest workforce surveys in the world closed on 28 November. The final response rate for the survey was 42.82% with the average response rate for acute Trusts being 46%, this is lower than the 50% response rate last year. The results will be available with the benchmarking reports in March.

3. Place

Airedale NHS FT - New Hospital Programme

Plans have been submitted for the as part of Airedale's New Hospital Programme and Bradford Teaching Hospitals NHS FT continue to participate in the collaborative work at Place and West Yorkshire level.

To see the further information on the proposed new multi-storey car park and access road visit:
[proposed new multi-storey car park and access road](#)

Silsden care home

Following the successful work by Spellman Care to adopt the Care England adopt a grand-friend project the project will now be expanded to all other homes across West and North Yorkshire. The scheme fosters meaningful connections between young people and residents dedicated to tackling loneliness amongst older people. The intergenerational activities also aim to benefit a child's communication skills, social behaviour and increase confidence.

Further details of the scheme can be found here - ['adopt a grandfriend' scheme](#)

You're not alone campaign

On 1 December 2025 Bradford District and Craven launched the You're not alone campaign to support the mental wellbeing of residents in Bradford District and Craven Health and Care Partnership. The initiative aims to provide practical help and provide direct access to local support for those impacted by winter loneliness and mental health struggles.

To access further information see - ['You're not alone' campaign](#)

Bitesize guide to Place-based Health, Care and Wellbeing Strategy

The Bradford District and Craven Health and Care Partnership Strategy was published in September 2025 with the underlying aim to improve the health and wellbeing of the local population.

The Partnership has now published a simple bitesize guide to the plans and is available to access here - [Bitesize Guide](#)

Bradford District Care NHS Foundation Trust – New Purpose-Built Home for Community Mental Health Team (CMHT)

In November 2025 Bradford District Care NHS Foundation Trust announced the opening of its newly refurbished facility at New Mill in Saltaire. The relocation from Shipley provides an improved environment and supports the wellbeing, accessibility and continuity of care.

For further details - [new purpose built home for the Community Mental Health Team \(CMHT\) – North Bradford](#)

Yorkshire Asian Young Achievers Awards

I attended the Yorkshire Asian Young Achievers Award to represent the Trust. The Awards took place on 27 November 2025 at Cedar Court Hotel in Bradford and I am pleased to report that a resident doctor at BTHFT was crowned the overall winner.

Bradford District and Craven Talking Therapies – HSJ Award

Bradford District Care NHS FT won the Digitising Patient Care Award category. The service introduced AI powered tools to increase access, personalise care and optimise clinical capacity with the solution delivering significant benefits including reduction of inappropriate referrals.

Access the link to read more about the achievement - [HSJ Award](#)

Reducing Inequalities Alliance

Aamnah Rahman, Psychological Therapist for the trust's Clinical Health Psychology Team has published a case study profiling her work on supporting people from south Asian communities accessing cardiac health support. See the link for further information on the published case study - [case study](#)

Bradford Voluntary, Community and Social Enterprise Sector (VCSE) – Community Building Funds

Bradford's VCSE sector has benefited from various community building funds. At total of £800,000 is to be spread over two years. To read more about the successful groups see link below - [Community Building Funds](#)

City of Culture Legacy – Plans for Bradford

Plans have been revealed for Bradford to build on the City of Culture Legacy. The plans with support continuation of the successful event programming, fostering creative industries and driving physical regeneration projects across the district including funding and a capital grants programme.

Further information can be found via the link - [City of Culture Legacy](#),

4. Partners

West Yorkshire Association of Acute Trusts (WYAAT) Programme Executive Meeting, 2 December 2025 and 6 January 2026

I attended the WYAAT Programme Executive meeting on 2 December 2025, where opportunities to create a standardised medical job planning approach was discussed, and the benefits realisation and product scope for pharmacy aseptics. We also talked about the next steps for pathology, heard updates on radiology shared reporting and from the Integrated Care Board (ICB), and received the collaborative report. The transfer of WYHCA was communicated and we discussed 'Right Care Right Person'.

At the meeting on 6 January 2026, we had updates from both the ICB and Trusts, and around procurement. We had a detailed discussion on planning and heard updates on WYAAT organisational change and Health Innovation Network (HIN) review. We discussed the upcoming WYAAT Committee in Common including the agenda, system risks report and performance report. The usual collaborative report was received.

WYAAT System Leadership Executive Group Session, 20 January 2026

I will be attending the WYAAT System Leadership Executive Group session on 20 January, which post-dates this report, where organisations across the patch will provide a presentation on the future system from their perspectives, including the WY combined authority, local authority, VCSE, provider collaboratives, the ICB as strategic commissioner and provider partnerships. We will also discuss the timeframes for transition to end state and how we will work together in the future as a Health and Care Partnership.

5. National Reports

NHS England (NHSE) Maternity Signal System

On 8 December 2025 NHSE published news on a first of its kind safety signal system across NHS maternity services. The new tool rapidly analyses data being routinely recorded by maternity teams on wards to spot whether there are potential emerging safety issues which need urgent attention and action.

We are implementing processes across our maternity service to comply with the reporting requirements.

The publication can be accessed here - [NHS England » NHS maternity signal system will spot and stop emerging safety concerns](#)

NHSE Principles for Providing Patient Care in Corridors

The above guidance published on 11 December 2025 replaces the Principles for Providing Safe and Good Quality Care in Temporary Escalation Spaces, published on 16 September 2024. The guidance includes use of the term 'corridor care' and removes the term 'temporary escalation space' referred to in the earlier guidance.

The guidance includes five core principles to support the overarching corridor care principle which include Assessment and mitigation of risk, escalation, quality of care, raising concerns and data collection and measuring harm.

This work will be picked up by the EXCEL AED Improvement Programme with Sajid Azeb as its Senior Responsible Officer. Details of the full publication can be found here - [NHS England » Principles for providing patient care in corridors](#)

Acute Trust League Table Quarter 2 2025/26

As referred to earlier in the report, on 11 December NHS England released the Acute Trust League Table for Q2 2025/26. Details of the league table can be found here - [NHS England » Acute trust league table – Q2 2025/26](#)

NHSE Maternal Care Bundle

On 7 January 2026 a Maternal Care Bundle (MCB) for reducing maternal mortality and morbidity was published for NHS key stakeholders. The MCB requires co-ordinated action across NHS services and considers factors which extend beyond the score of maternity and neonatal care alone.

As background, the latest Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) Saving Lives, Improving Mothers' Care 2025 report shows that between 2021 and 2023, 611 women in the UK died during or within a year of pregnancy, 257 of whom during or within 6 weeks of the end of pregnancy, giving a UK maternal mortality rate of 12.82 deaths per 100,000 births.

<https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2021-2023>

The publication can be accessed here - [NHS England » The Maternal Care Bundle](#) and further details are included in the Maternity Services Update (agenda item Bo.1.26.8).

Improving postnatal care: a toolkit for integrated care boards, partners and providers

This toolkit supports integrated care boards (ICBs), their place-based partners, health and care providers to work with service users and professionals to improve the postnatal care experience and both short and long-term maternal and infant health. It shows ICB leaders what an effective, collaborative approach looks like and recommends evidence-based actions for ICBs and providers to consider taking.

The publication can be accessed here - [NHS England » Improving postnatal care: a toolkit for integrated care boards, partners and providers](#) and further details are included in the Maternity Services Update (agenda item Bo.1.26.8).

Meeting Title	Board of Directors		
Date	29 January 2026	Agenda item	Bo.1.26.7a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality Committee

Date of meeting: 22nd January 26

Key escalation and discussion points from the meeting

Alert:

- The executive continues to balance **financial constraints**, quality and safety across all activities. We were assured that safety remains a 'red line' in all considerations, but the board will need to consistently monitor and review decisions across all committees. We also need to consider a proportionate risk appetite as we focus on financial sustainability – for example in recruitment of clinical staff where cost needs to be balanced with increased workload and patient experience. We were assured by the CMO and chief nurse of the rigorous process where quality impacts are reviewed for all decisions.
- As previously advised, **renal capacity** remains a high-risk issue as the Trust approaches capacity. There is significant ongoing work to see what can be done in the short; medium and long term to mitigate this and reduce the risk of patients not being able to get the treatment they need. The quality committee will continue to monitor.

Advise:

- Whilst a significant amount of work is taking place, there remain ongoing **coding issues**, and a further update has been diarised for the quality committee for the clinical coding manager to provide a further update.
- There has been a higher incidence of **pressure ulcers** on some wards and the committee has asked for an update to track improvements.
- The committee continues to be assured by the transparency of **maternity and neonatal** data shared on a monthly basis; the assurance given by external reports and inspections, the significant reduction in still-births and the ongoing improvement work. There remain some gaps in middle grade clinical roles and also a consultant gap. This is being addressed with the CMO, and the committee will continue to monitor.
- Whilst we have many good examples of data analysis, there remains an ongoing requirement to **triangulate our data** better to give richer insight and also to centralise this reporting to ensure consistency. This is a common issue across all committees.

Meeting Title	Board of Directors		
Date	29 January 2026	Agenda item	Bo.1.26.7a

Assure:

- Sophie's Legacy**: We had a moving and impactful presentation from Charlotte Fairall, the mother of Sophie who has been campaigning to improve the experience of children in hospitals. We were assured by the Director of Estates and Facilities that Bradford is responding by taking steps to improve the quality of food available to children and providing catering facilities for parents alongside other food options.
- The committee had an overview of **Patient Safety Incident Investigation** (PSII) and also a deep dive into claims from the legal team. The committee was assured by the level of analysis that sits underneath the report and the detailed work of the QuoC (Quality of Care) panel in particular. There were some tangible examples of thematic reviews leading to changes in practice and the role of the patient safety partner was also highlighted.
- The committee received two reports on **safeguarding** covering both adults and children. The committee was assured by the detail shared and in particular by the closer working of the two teams and the collaborative work with BDCFT on mental health issues. It was noted that the increased prevalence of mental health issues across adults and children will be a key consideration for the Trust's 5-year plan.
- As part of a presentation on quality account improvement activities the committee received a deep dive into **Martha's Rule** implementation. This was the first time we were able to see some of the data now this has been rolled out Trust-wide. Whilst this remains and ongoing cultural change, the committee was assured both by the way it is being used and that the issues raised are dealt with appropriately, and do not raise any wider or thematic quality concerns.

Report completed by:

Justine Andrew
 Non-Executive Director

24th January 26

Osbourne-Sheridan
 26/01/2026 12:25:00

Board of Directors				
Meeting Date:	29.01.26	Agenda Reference:	Bo.1.26.8	
Report Title:	MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE, NOVEMBER/DECEMBER 2025			
Presented by:	Carly Stott, Head of Midwifery			
Executive Lead:	Professor Karen Dawber, Chief Nuse			
Author:	Sara Hollins, Director of Midwifery			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☒
Summary of Key Issues/Highlights:	The Director of Midwifery and the Chair of Quality Committee provide the Trust Board with assurance that a monthly review of maternity and neonatal quality and safety relating to November and December 2025 activity was presented and key elements discussed including: - The number of harms occurring in November and December, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of Maternity Newborn Safety Investigations (MNSI) and Patient Safety Incident Investigation (PSII) cases were discussed. - There were no completed MNSI reports in November and December. This paper also includes: - An update on the Amos Investigation; - Information regarding the roll out of the National Maternity Outcomes Signal System (MOSS); - Update on Maternity Incentive Scheme, Year 7, compliance; and - Assurance that action plans and audits required to declare compliance with safety Action 4 of the Maternity Incentive Scheme were presented to and approved by the People Academy in November 2025.			
Recommendation/s: (including any decision/approval required)	The Board is asked to: - Confirm that they are assured that the Quality Committee has reviewed and discussed the contents of the November and December 2025 Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. The full papers presented to the Quality Committee are available on request. - Note the intention to declare non-compliance with Safety Action 1 of the Maternity Incentive Scheme, and the impact this has on the overall self-declaration of the year 7 scheme. - To formally note in the Board minutes that November 2025 People Academy, received and approved the Neonatal medical and nursing staffing action plans, as stipulated in the Maternity Incentive Scheme. - To formally note in the Board minutes that November 2025 People Academy, received and approved the Obstetric Consultant attendance audit report as stipulated in the Maternity Incentive Scheme. - To note the reduction of stillbirths from 30 in 2024, to 16 in 2025.			

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Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness
Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	N/A
Legal/Regulatory:	The December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety. The requirements to strengthen and optimise Board oversight for maternity and neonatal safety includes: • That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board. • That all maternity Serious Incidents (SIs) are shared with Trust Boards and the Local Maternity and Neonatal System (LMNS), in addition to reporting as required to Maternity and Newborn Safety Investigation (MNSI) programme. • To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	November 2025 People Academy, January 2026 Quality Committee

Report content	
1. Purpose The December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety. The requirements to strengthen and optimise Board oversight for maternity and neonatal safety includes: • That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.	

- o That all maternity Serious Incidents (SIs) are shared with Trust Boards and the Local Maternity and Neonatal System (LMNS), in addition to reporting as required to Maternity and Neonatal Safety Investigations (MNSI).
- o To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

The monthly maternity and neonatal services report presented to Quality Committee (QC) ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that QC, as a committee of the Board has assurance of an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services.

The format of the monthly reports supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

The monthly paper also serves as the main mechanism for QC, as a committee of the Board, to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool (PMRT) reports, and monthly midwifery and obstetric staffing updates.

This bi-monthly Maternity and Neonatal (Perinatal) Board Assurance paper provides a summary of the key elements of the monthly paper presented and discussed at QC, including the approval of any reports required to demonstrate compliance with the annual Maternity Incentive Scheme (MIS).

2. Background/context

The November and December updates and associated appendices were both discussed at the Quality Committee meeting held on 22 January 2026, acknowledging that no Committee sat in December.

The key elements of the papers discussed included:

- The number of harms occurring in November and December, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of MNSI and PSSI cases were discussed.
- There were no completed MNSI report and learning/recommendations to share in November and December.
- The QC was asked to note that the Perinatal Leadership Quad joined the November bi-monthly perinatal safety Champion meeting, and that there were no safety escalations requiring support from the Board.
- The QC reported and recorded that they were assured by the papers, presentation, and discussion. There was nothing identified requiring escalation to the Board.

The full papers presented to the QC are available on request.

In addition to the papers presented to QC, the service would like to update the Board on specific items:

- National Maternity and Neonatal Investigation (Amos) update.

- o Baroness Amos and her team visited the perinatal services on 1 and 2 December. The team met with families, co-ordinated by the Maternity and Neonatal Voices Partnership (MNVP) Lead, received a presentation from the senior leadership team and executive colleagues, toured the clinical areas, and held staff forums.
 - o There was no service-related feedback which was as expected, and no immediate safety concerns were escalated as part of the visit.
 - o The service has responded to data requests during January.
 - o Individual interviews are planned or have taken place for members of the Executive and Perinatal Leadership teams.
- December also saw the rollout of the Maternity Outcomes Signal System (MOSS), a dashboard for NHS England's maternity services, designed to provide early warnings of safety issues by analysing routine data in near real-time, aiming to prevent harm to mothers and babies by detecting unusual patterns or trends, triggering traffic-light coded alerts (amber/red) for immediate investigation and corrective action by local trusts.
- How MOSS Works:
 - o Data Collection: Maternity teams input data during routine care.
 - o Analysis: MOSS rapidly analyses this data for unusual patterns or trends.
 - o Alerts: It generates traffic-light coded alerts:
 - o Amber: 95% certainty of increased safety events.
 - o Red: 99% certainty, requiring urgent attention.
 - o Action: The affected maternity unit must conduct a critical safety review within eight working days.
 - o Oversight: Data and signals are visible across trust, regional, and national levels for transparency.
- The maternity service has not received an amber or red alert at the time of writing this report.
- The QC received the final Perinatal Mortality Review Tool (PMRT) report, required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme.
 - o The service has met standards a and b, for all perinatal deaths between 1 December 2024 and 30 November 2025.
 - o However, we are declaring non-compliance with standard c, based on 2 cases which were not started within 2 months of the deaths, and 5 cases which did not meet the publication following completion deadline. Following conversations with NHS Resolution and MBRRACE, we will submit a mitigation document to MBRRACE to consider the reclassification of this declaration.
 - o This will result in an overall declaration of non-compliance with the Year 7 scheme, meeting 9 out of 10 safety actions. If the mitigation is accepted this will result in full compliance being declared after external review.
- In November 2025, the People Academy received and approved the Neonatal Medical and Nursing staffing paper and associated action plan outlining the actions required to meet the British Association of Perinatal Medicine (BAPM) standards. The paper demonstrates the progress made since 2024, and the ongoing actions required. The Board is asked to formally note that the relevant standard is not met, but that evidence of progress and ongoing actions have been approved by a committee of the Board. This is a requirement of the Maternity Incentive Scheme to support compliance with safety action 4.
- The People Academy also received and approved the Obstetric Consultant attendance audit report required to demonstrate compliance with Safety Action 4 of the Maternity Incentive Scheme. The audit demonstrated that there was over the required 80% of attendance by a

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Consultant Obstetrician at the applicable clinical situations as detailed by the Royal College of Obstetricians and Gynaecologists.

- The QC was informed of the improved stillbirth position at the end of 2025. There were 30 stillbirths in 2024 and 16 in 2025, one of these being a 16-week fetal loss delivered with its surviving twin at full term. The national data will not reflect this reduction until 2027. Further analysis of the annual data compared to previous years will be presented at women's speciality meeting in March.

3. Assessment

The monthly perinatal reports and associated appendices, and this overarching Board Assurance paper, meet the perinatal quality surveillance model requirements and recommendations to ensure that there is Board level oversight of perinatal clinical quality and safety.

4. Options analysis/Proposal

The service proposes that the Perinatal Update paper continues to be presented to the Quality Committee on a monthly basis with an assurance paper presented to Board bi-monthly.

This is to ensure that the Board receives timely information regarding perinatal quality and safety issues, in addition to quality improvement and transformation.

Any urgent concerns emerging outside of the monthly reporting arrangements will be escalated by the Trust Level Safety Champions to the Board Level Safety Champion.

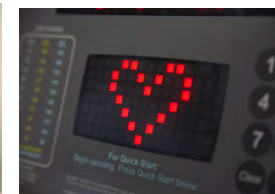
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Board of Directors

January 2026

Maternity Incentive Scheme Year 7 submission

*Sara Hollins, Director of Midwifery,
Carly Stott, Head of Midwifery*



Together, putting patients first

Maternity Incentive Scheme

- Year 7 of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS), intended to support the delivery of safer maternity care in all acute Trusts.
- BTHFT have declared full compliance with the scheme in the previous 6 years.
- The Board Declaration Form must be signed by the Chief Executive and the Accountable Officer for the Integrated Care System (ICS), and submitted no later than 12 noon on 3 March 2026.

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Board Reporting Process

- The Maternity and Neonatal Services Monthly Update Paper presented to Quality Committee with delegated authority of the Board, is used as the primary mechanism for updating on progress throughout the reporting year.
 - Quarterly PMRT reports.
 - Bi-annual Midwifery Workforce papers.
 - Progress with training compliance for PROMPT and Fetal Monitoring training.
- Throughout the year the evidence required to demonstrate compliance is also presented and discussed in a number of places.
 - ATAIN/PMRT/Early Notification Scheme (ENS)/MNSI cases discussed at joint obstetric/neonatal speciality meetings, core governance groups and at the bi-monthly Maternity Safety Champion Meetings.
 - Workforce Papers are discussed and approved at People Academy prior to presentation to Board.
 - Saving Babies Lives Progress quarterly meetings with LMNS.
- All papers are shared with the maternity leads at the ICS monthly Perinatal Quality Oversight Meetings attended by the LMNS.

Board Reporting Process

- An annual MIS summary and update paper is provided pre-submission including the MIS audit tool which shows, by each standard, the standard to be met, the evidence and location, and an assessment of compliance.
- Same summary is shared with the ICS Maternity Leads and the LMNS.
- Followed by a meeting with the CEO to complete the Board reporting form to enable CEO submission by 12 noon on 3 March 2026.

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Year 7 Position

- The Maternity Service believes that the standard for safety action 1 has not been met.
 - An action plan and supporting mitigation will be submitted with the Board declaration form.
 - There is a high probability that this information will result in the non-compliant position being overturned.
- The standards for each of the remaining 9 safety actions have been met and evidence for each safety action is available, including where additional action is required:
- Safety Action 4: Neonatal Staffing action plans and progress against previous action plans were approved at November 2025 People Academy, completing this standard.
- Safety Action 5: 1:1 care in labour risk assessment and improvement plan was approved at January Quality Committee, completing this standard.
- Safety Action 7: Formal escalation regarding the MNVP funding arrangements to the Trust/ICB and Regional level.
- All other safety actions met without the requirement of additional actions.

Year 4 Position

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 1 December 2024 to 30 November 2025 to the required standard?	N
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Y
3	Can you demonstrate that you have transitional care services in place and undertaking quality improvement to minimise separation of parents and their babies?	Y
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?	Y
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Y
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives care bundle version 3?	Y
7	Listen to women, parents, and families using maternity and neonatal services and coproduce services with users	Y
8	Can you evidence the following 3 elements of local training plans and 'in-house' , one day multi professional training?	Y
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Y
10	Have you reported 100% of qualifying cases to Maternity and Newborn safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?	Y

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26/01/2026 12:25:00

Questions?

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Board of Directors				
Meeting Date:	29.01.26	Agenda Reference:	Bo.1.26.8a	
Report Title:	Maternity Incentive Scheme (MIS), Year 7			
Presented by:	Carly Stott, Head of Midwifery			
Executive Lead:	Professor Karen Dawber, Chief Nurse			
Author:	Sara Hollins, Director of Midwifery			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☒
Summary of Key Issues/Highlights:	This paper is presented to ensure that the Board is fully sighted on the Maternity Incentive Scheme (MIS) and the requirement to sign off the submission prior to 12 March 2026 at 12 noon. The attached document, MIS Year 7, audit tool, (Appendix 1) provides an update against all ten criteria and confirms that we are proposing to declare non-compliance with standard 1 and compliance with standards 2 to 10, resulting in an overall recommendation of non-compliance for year 7 of the scheme. Discussions with MBRRACE-UK who externally validate Safety Action 1, Perinatal Mortality Review Tool (PMRT), suggest that there is a possibility that the decision to declare non-compliance for this standard, may be overturned, subject to the review and acceptance of the supporting action plan and the mitigation provided. The contents of the document and the plan to declare non-compliance with the scheme, will be discussed with the Accountable Officer (AO) for the Integrated Care System (ICS) and Lead Midwife for West Yorkshire and Harrogate Local Maternity and Neonatal System prior to signing the Board self-declaration form as a condition of the submission.			
Recommendation/s: (Including any decision/approval required)	The Board is asked to: - acknowledge the contents of the paper and attached appendices. - note that the contents of the document and support the decision to declare non-compliance with the scheme. - approve the action plan and mitigation for safety action 1, which will be submitted with the Board declaration form and is hoped to be accepted by the external reviewers and may change the overall submission to one of full compliance. - note that the audit tool and intention to declare non-compliance with the scheme, will be discussed with the Accountable Officer for the Integrated Care System and Lead Midwife for the on West Yorkshire and Harrogate Local Maternity and Neonatal System prior to completion of the Board Self-Declaration form.			
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness			
Link to Priority Initiatives 2025/26:	N/A			

Implications	
Risk:	Declaration of non-compliance will result in a significant financial penalty.
Legal/Regulatory:	Not applicable
Quality & Patient Safety:	Not applicable
Equality, Diversity and Inclusion and Health Equity:	Not applicable
Resources:	Not applicable
Environmental sustainability:	Not applicable
Assurance Route	
Meeting/s where content has been discussed previously:	The requirements required to demonstrate compliance with each of the safety standards have been presented to the Quality Committee and People Academy throughout the reporting period.

Report content
1. Purpose and Background The purpose of the report is to provide the Board and the Accountable Officer for the Integrated Care System with an update on the actions and evidence required to enable Board sign off, of MIS Year 7. This is the seventh year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS), intended to support the delivery of safer maternity care in all acute trusts. BTHFT was successful in achieving the ten safety actions in years one to six and recovered the 10% maternity premium and a share of the unallocated funds. The ten safety action titles remain unchanged in year 7. The monthly Maternity and Neonatal Services Update Papers presented to the Board and Quality Committee throughout the MIS reporting period, have served as the primary mechanism for providing Board/Committee with the necessary evidence required to demonstrate compliance. Including: - Quarterly Perinatal Mortality Review Tool (PMRT) reports. - Bi-annual Midwifery Workforce paper. - Progress meeting Fetal Monitoring, Newborn Life Support training, and PROMPT training. Many elements of the scheme are also included in the bi-monthly Maternity and Neonatal Safety Champion meetings as part of the standing agenda. These papers are shared monthly with the Integrated Care Partnership and the Local Maternity and Neonatal System, through the Perinatal Quality Surveillance Oversight Group process. Obstetric and Neonatal workforce information required for Safety Action 4, have been submitted to and approved by November 2025 People Academy, as an committee of the Board with delegated authority. 2. Assessment Challenges/Issues:

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?

The service has not met the required standard to declare compliance with this safety action.

PMRT quarterly reports have been shared with Quality Committee and the Perinatal Safety Champions during the reporting year.

In January 2026, the Quality Committee received the final PMRT report. The service has met standards a and b, for all perinatal deaths between 1 December 2024 and 30 November 2025.

However, we are declaring non-compliance with standard c, as the service achieved 93.5% compliance for reviews being started, which is below the 95% target and 68.8% of published reports of a 75% target. Following conversations with NHS Resolution and MBRRACE, appendices 1a and 1b, action plan and mitigation document, will be submitted as part of the self-declaration process. MBRRACE will then consider the reclassification of this declaration based on the information and assurance provided.

Safety actions 2-3: No concerns or actions required

Safety action 2: Maternity Services Data Set (MSDS) has been submitted to the required standard as evidenced on the MSDS national dashboard.

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

Standard met. TC services in place. The Quality Improvement (QI) project registered in MIS year 6, has continued into year 7. The QI project is the rollout of the electronic Neonatal Early Warning Tool (NEWTT 2) system which is anticipated to better identify babies at risk of deterioration. The Perinatal Safety Champions, and LMNS have been updated on progress throughout the reporting period.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

The service has met the required standard for the obstetric, anaesthetic, and neonatal elements.

The Neonatal Staffing updates paper and associated action plans were received and approved at November 2025 People Academy. The neonatal service does not currently meet the relevant British Association of Perinatal Medicine (BAPM) national standards for medical and nursing staffing. To achieve compliance, an action plan including progress against any previously developed action plans was presented to and approved by November 2025 People Academy, as a committee of the Board with delegated authority. The standard states that this must be formally recorded in the Board minutes. The same action plan was shared with the Neonatal Operational Delivery Network (ODN) and the LMNS, thus meeting the MIS standard for this safety action.

In November 2025, the People Academy also received the Consultant attendance audit, which requires a minimum of 80% Consultant attendance at a number of clinical situations determined by the Royal College of Obstetricians and Gynaecologists (RCOG).

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The service has met the required standard to declare compliance with this action, following Quality Committee, as a delegated committee of Board with authority, approval of the 1:1 care in labour risk/assessment action plan 22/01/26.

The risk assessment and associated actions were approved at Women's Core Governance Group, December 2025. This metric is monitored via the maternity dashboard and exception reported to Quality Committee. An improved staffing position, introduction, and use of a 4 hourly acuity app, and validation of occasions when 1:1 care is considered not to have been achieved, are anticipated to continue to improve the rate which has shown an improving position in the last quarter of 2025.

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version 3?

The service has met the required standard.

The service has continued to have quarterly implementation review meetings with the Director of Midwifery for West Yorkshire and Harrogate LMNS, throughout 2025 and Year 7 reporting period. Progress against implementation has been positive with no significant areas of concern and the overall assessment that the service is implementing the care bundle to the required standard. The Specialist Midwife for Saving Babies Lives has also participated in shared learning events.

Progress reports have been shared quarterly with the Quality Committee.

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

The service has met the required standard.

The service is unable to evidence that the Maternity and Neonatal Voices Partnership (MNVP) infrastructure is commissioned and funded as per national guidance. This is based on the MNVP lead having insufficient contracted hours to undertake the role as nationally described.

The position was formerly escalated to ICB Perinatal Quality Surveillance Oversight Group and the LMNS on 30 April 2025. The escalation was then noted at WY&H LMNS Board 21 May 2025. The Board was informed of the escalation on 29 May 2025. Evidence of the escalation of this position, meets the requirements of the safety action for year 7.

During the reporting year, the MNVP Lead has worked closely with the service, regularly attending core meetings such as Perinatal Services Forum and the Bi-Monthly Perinatal Safety Champion meetings. Her limited time and resource have focused on service user engagement particularly with women from Black, Asian, Minority Ethnicities and socially deprived community members, and the coproduction of the CQC Maternity Survey.

Safety actions 8-10: No concerns or actions required

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', 1-day multi-professional training?

Each relevant staff group has achieved 90% or above attendance compliance at PROMPT emergency training, Fetal Monitoring, and Newborn Life Support. Progress has been monitored and reported monthly throughout the reporting year and can be evidenced in training records.

Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

The monthly Maternity and Neonatal (Perinatal) update paper is prepared and presented to the Quality Committee as an appropriate Trust committee with delegated responsibility. The paper is written to include the minimum data set outlined in the national Perinatal Quality Surveillance Mode. A Bi-monthly assurance paper is presented to Trust Board, summarising the key points discussed at QC.

The same suite of papers is shared and discussed at regular meetings (minimum quarterly) with the LMNS and ICB leads.

The Executive Perinatal Safety Champion hosts a monthly Ward to Board meeting, which may be virtual or in the form of a unit walk round. Other members of the Executive and Non-Executive team regularly attend these meetings and engage directly with perinatal staff members.

Bi-monthly Perinatal Safety Champion meetings have continued during the Year 7 reporting period and are also attended by other members of the Perinatal Leadership team and the MNVP lead. Perinatal culture, claims scorecard are amongst the agenda items for discussion.

Safety Action 10: Have you reported 100% of qualifying cases to MNSI and NHS Resolution's Early Notification Scheme?

The service has met this standard. Appendix 3 provides an overview of all qualifying cases, including compliance with statutory duty of candour and assurance that families have received information regarding the role of MNSI and the EN scheme, including where this has been requested in a format that meets the requirements of the individual family.

Conclusion:

The maternity service believes that safety action 1 has not been met to the standard described, although there is supporting mitigation and an associated action plan which following external review, may overturn this position and result in compliance being declared. Safety actions 2-10 have been met to the required standard. Evidence to support compliance is predominantly contained in the monthly Maternity and Neonatal Update papers presented to and discussed at Quality Committee throughout 2026.

Unfortunately, the position of safety action 1 means that we are unable to declare full compliance with the year 7 scheme, although this position may be reversed following external review of the safety action 1 action plan and mitigation.

3. Options Analysis/Proposal:

The service proposes that the Trust Board and the Accountable Officer for the Integrated Care System, and the Director of Midwifery for West Yorkshire and Harrogate LMNS, have sufficient evidence to support the self-declaration of non-compliance with 1 Safety Action and compliance with the remaining 9 Safety Actions for the Year 7 scheme, as progress with the scheme has been discussed as a standing agenda item at the monthly Perinatal Quality Oversight meetings throughout 2026.

4. Appendices: (available in the Reading Room on Admincontrol via the links below)

1. [PMRT Mitigation report for MBRRACE-UK](#)
2. [Safety Action 1 action plan](#)
3. [MNSI/ENS qualifying cases 1 December 2024 to 30 November 2025](#)

Osbourne, Sheridan
26/01/2026 12:25:00

Board of Directors				
Meeting Date:	29.01.26	Agenda Reference:	Bo.1.26.9	
Report Title:	Care Quality Commission Report			
Presented by:	Professor Karen Dawber, Chief Nurse			
Executive Lead:	Professor Karen Dawber, Chief Nurse			
Author:	Byron Johnson, Interim Associate Director of Quality			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	- The unannounced Maternity 2025 CQC inspection reviewed elements of the Safe domain and all elements of the Effective, Caring and Responsive domains. The service was rated Good across all domains, resulting in an overall rating of Good. An action plan is currently being finalised to address identified improvements. - The Outpatients 2025 unannounced inspection, undertaken on 23 to 24 September 2025 as part of routine activity in preparation for the Trust level Well-Led inspection, resulted in a Good rating across all domains. Two regulatory breaches were identified (Regulations 15 and 17). A comprehensive action plan is in development. - The Urgent and Emergency Care CQC action plan remains in progress following the unannounced inspection conducted on 16 to 18 September 2025. Actions continue to be implemented as we await the final inspection report. - The initial draft report has been received for the Community Hospital inpatient services inspection undertaken on 22 to 23 October 2025. - The Well Led inspection was carried out between 3 to 6 November 2025. The draft report has not yet been received but is expected in early February 2026. - The majority of actions within the Medical Services CQC action plan (2024) have been completed. Three actions remain, relating to pharmacy workforce capacity, a quality improvement programme to address discharge delays, and the embedding of local CSU EDI action plans. Revised completion dates extend into 2026. - All actions for the Maternity CQC action plan 2024 have been completed with the exception of two actions relating to pharmacy, which are scheduled for completion in 2026. - Oversight continues through established quality governance arrangements. The CQC Improvement Steering Group is temporarily paused during the current inspection phase, with Exec to CSU meetings providing an alternative forum for assurance and escalation. - This report provides a confident level of assurance, with progress updates available in the associated improvement plans highlighted in the appendices.			

Osbourne, Sheridan
 26/01/2026 12:25:09

	The evidence for the Baroness Amos investigation into Maternity and Neonatal services was submitted on 15 January 2026 following the initial site visit. As a Trust, we await the outcome of the review which is expected to be reported in Spring 2026.
Recommendation/s: (including any decision/approval required)	The Board is asked to: 1. Note progress to date; and 2. Support the continued delivery and resolution of outstanding actions.
Link to Strategic Objective	Quality - To provide outstanding care for patients, delivered with kindness Improvement – to be continually learning organisation and recognised as leaders in research, education and innovation
Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	Supports mitigation of several risks identified in both strategic risk register and respective Clinical Service Unit (CSU) risk registers particularly those relating to patient safety, regulatory compliance, and workforce pressures. Progress against the CQC action plan directly addresses gaps previously identified by the CQC therefore strengthening assurance across key CQC quality statements.
Legal/Regulatory:	This update is aligned with regulatory requirements under CQC's single assessment framework and supports ongoing readiness for inspection. It provides evidence that the Trust is responding to CQC findings in a structured and accountable way, ensuring its legal duty to provide safe, effective, responsive, caring and well-led services.
Quality & Patient Safety:	Delivery of the improvement plans is designed to improve and assure key aspects of care, including medicines management, staffing levels, and governance. These directly impact on patient safety, effectiveness, and overall quality of care.
Equality, Diversity and Inclusion and Health Equity:	There will be future Equality Diversity and Inclusion (EDI) and health equity implications as the action plan evolves to incorporate key CQC quality statement requirements.
Resources:	Some actions have resource implications, including: - Workforce investment (e.g. therapy and pharmacy staffing plans); - Capital requirements (e.g. technology to support medicines tracking);
Environmental sustainability:	There will be future environmental sustainability implications as the action plan evolves to incorporate key CQC quality statement requirements.
Assurance Route	
Meeting/s where content has been discussed previously:	Clinical Service Unit (CSU) maternity governance meeting Weekly Oversight Meeting - Emergency Department CSU Driver Meetings

Report content	
Purpose	The purpose of this report is to provide the Board with assurance on the Trust's current position in relation to Care Quality Commission (CQC) inspections and associated improvement activity. The report summarises recent inspection outcomes, progress against agreed action plans, and the governance arrangements in place to oversee delivery.

Background/context

The Care Quality Commission has undertaken a number of unannounced service level inspections alongside the Trust level assessment under the Well Led framework. During 2024 and 2025, the Trust has been subject to multiple unannounced inspections across a range of services, including Maternity, Medical Care, Outpatients, Urgent and Emergency Care, Community Hospital inpatient services, and a Trust-wide Well-Led inspection.

The table below presents the current ratings for services where we have received feedback across the five key domains and compares these results with previous inspections:

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Neonatal Services	Good ↔ May 2024	Good ↔ May 2024	Outstanding ↑ May 2024	Good ↔ May 2024	Outstanding ↑ May 2024	Outstanding ↑ May 2024
Bradford Royal Infirmary (Medical Care)	Good ↔ Nov 2024	Requires Improvement ↔ Nov 2024	Good ↔ Nov 2024	Good ↔ Nov 2024	Good ↑ Nov 2024	Good ↑ Nov 2024
St Lukes Hospital (Medical Care)	Good ↔ Jan 2025	Good ↔ Jan 2025	Good ↔ Jan 2025	Good ↔ Jan 2025	Good ↔ Jan 2025	Good ↔ Jan 2025
St Lukes Hospital Outpatients	Good ↔ Jan 2026	Good ↔ Jan 2026	Good ↔ Jan 2026	Good ↔ Jan 2026	Good ↔ Jan 2026	Good ↔ Jan 2026
Maternity	Good ↔ Nov 2025	Good ↑ Nov 2025	Good ↔ Nov 2025	Good ↑ Nov 2025	Good ↔ May 2024	Good ↑ Nov 2025
Key	Same	Up one rating	Up to ratings	Down one rating	Down two ratings	
Symbol	↔	↑	↑↑	↓	↓↓	

Inspection outcomes to date have been positive, with services consistently rated Good, including across core domains of Safe, Effective, Caring and Responsive and Well-Led. Where regulatory breaches or areas for improvement have been identified, action plans have been developed and are being implemented, with the majority of actions either completed or on track for delivery.

16 to 17 September 2025 – Maternity Inspection. Complete. [Link to report](#)

The unannounced Maternity 2025 CQC inspection reviewed elements of the Safe domain and all elements of the Effective, Caring and Responsive domains. The service was rated Good across all domains, resulting in an overall rating of Good. An action plan is currently being finalised to address identified improvements. The assessment feedback for the Maternity inspection is available in the reading room on Admincontrol. [click here](#)

23 to 24 September 2025 - Outpatients Inspection, St Luke's Hospital. Complete. [Link to report](#)

The Outpatients 2025 unannounced inspection, undertaken on 23 to 24 September 2025 as part of routine activity in preparation for the Trust level Well-Led inspection, resulted in a Good rating across all domains. Two regulatory breaches were identified (Regulations 15 and 17). A comprehensive action plan

is in development. The assessment feedback for the Outpatients inspection is available in the reading room on Admincontrol. [click here](#)

16 to 18 September 2025 – Urgent and Emergency Care Inspection. Ongoing.
 Following the CQC inspection of Urgent and Emergency Care, the Trust responded to the CQC on 23 September 2025 having developed a comprehensive Urgent and Emergency Care improvement action plan addressing key findings across the service. The updated action plan (high level summary) is available in the reading room on Admincontrol. [click here](#)

22 to 23 October 2025 – Community Health Inpatient Services (Westwood Park Community Hospital and Westbourne Green Community Hospital). Ongoing. The initial draft report has been received for the Community Hospital inpatient services inspection undertaken on 22 to 23 October 2025. The assessment feedback is available in the reading room on Admincontrol. [click here](#)

The Well Led inspection was carried out between 3 to 6 November 2025.
 The draft report has not yet been received but is expected in early February 2026. The assessment feedback is available in the reading room on Admincontrol. [click here](#)

Progress is being monitored by the Executive Directors through meetings, governance processes and with updates logged in the improvement tracker.

Monitoring also continues for the Medical Services CQC Improvement Plan [click here](#) and the Maternity CQC Improvement Plan [click here](#), updated copies of which are available in the reading room on Admincontrol. A small number of actions remain outstanding, largely linked to system wide challenges such as pharmacy workforce capacity, quality improvement work to address discharge delays, and the embedding of equality, diversity and inclusion (EDI) plans at CSU level. These actions have revised completion timelines extending into 2026 and are subject to ongoing oversight.

During the current inspection phase, the Trust has adapted its governance arrangements to ensure continuity of assurance. While the CQC Improvement Steering Group is temporarily paused, oversight and escalation continue through quality governance structures and Exec to CSU meetings. This approach ensures that risks are identified and progress against CQC findings remains visible and assured.

Additionally, the evidence for the Baroness Amos investigation was submitted on 15 January 2026 following the initial site visit. As a Trust, we await the outcome of the review which is expected to be reported in Spring 2026. On 9 December 2025, Baroness Amos published her [reflections and initial impressions](#).

Next Steps

Continue with existing quality governance structures, including Exec to CSU oversight, until the conclusion of the current inspection cycle and receipt of outstanding draft and final CQC reports.

Resolve overdue items; support teams to close remaining open actions.

Internal self-assessment against the CQC single assessment framework with the CQC application on IRIS to ensure readiness for future inspections, particularly for those core services who have not.

Meeting Title	Board of Directors		
Date	29 January 2026	Agenda item	Bo.1.26.10

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 14th January 2026

Key escalation and discussion points from the meeting

Alert:

People dashboard – absence for November was 6.94%, slightly below the anticipated 7%. YTD is 6.41%. December data showed an upward trend to 7.12% as winter illnesses hit staff. Appraisal completion rate is showing progress with December data at 82%. Turnover remains stable at 10.41% in November. The dashboard narrative did not match the data presented and needs refreshing. The Chair asked for an action plan with milestone dates for absence reduction for February's Academy. They also suggested the HR Director work with the Head of Organisation Development to improve the reporting culture in relation to absence, appraisals and training as this was a consistent issue and needs addressing.

Patient Experience data – triangulating the data across the patient and people experience is key and the Patient Experience data was presented to the People Academy for the first time. A dashboard is in progress to collate the data in an accessible format. There has been an increase in complaints over the last 18 months as the Trust has made it easier for patients/families to voice their concerns and AI supports complaint writing although this has started to stabilise. There has been a focus on educating staff to de-escalate complaints early and face to face, addressing these informally where appropriate. Communication is the biggest issue, and there is a Patient Experience and Engagement strategy to address complaint themes. The Academy asked for the data to include such as complaints categorised by CSU, complaints as a % of the number of patients seen, etc to help identify outliers and good practice.

Advise:

Education dashboard – the dashboard has been streamlined, and the revised format was well received. Compliance with training was at 93% in December but Safeguarding Children training dropped to 70%, in part due to increased numbers of newly qualified staff. Did Not Attend rates for face-to-face training are high across all CSUs (326 in December), impacted by sickness, annual leave, high admission rates and recent industrial action. This is being monitored at CSU level.

Nursing and Midwifery Staffing Data Publication Report & Establishment Review - staffing fill rates improved from October to November 2025 across most staff groups however workforce shortages and associated safety risks remain. The staffing risk remains at 12 reflecting the ongoing risk to patient safety, staff wellbeing, and service quality if safe staffing cannot be maintained. There are shortages of 65 WTE Band 5 nurse vacancies and 167 WTE Band 2 HCA vacancies, increasing reliance on temporary staffing however fill rates are improving including strong night-shift coverage. Targeted recruitment includes monthly HCA campaigns, and conversion of bank HCAs to substantive roles to reduce vacancies. There are twice daily oversight meetings, increased red-flag reporting and robust escalation processes that strengthen real-time risk management and assurance. Workforce development includes Preceptorships, ward establishment reviews, and alignment with the National Quality Board safer staffing principles. The Academy heard the outcome of the six-monthly review of nursing and midwifery staffing establishments conducted to ensure safe, effective, and sustainable staffing. This

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assesses changes in bed capacity, skill mix, and workforce requirements across key services. Improvements to the number of beds, increased staffing and cover on some wards have been made, notably a proposal for more Band 5 Registered Nurses on the Emergency Department following the recent CQC visit and an uplift in Maternity Services to support 24 hour cover due to an increase in C-Section births. The risk score was reviewed in December and remains 12 and will be reassessed in February post recruitment.

Ethnicity and Disability Pay Gap report – the Head of EDI presented the Trust’s first publication of Disability and Ethnicity Pay Gap data (from March 2025); measuring pay gaps for both disabled staff and ethnically diverse staff. There is a disability pay gap of 7.7% between disabled and non-disabled staff and an ethnicity pay gap of 6.7% between ethnically diverse staff and white staff. These gaps highlight structural workforce inequalities rather than individual pay discrepancies. The findings will directly inform the WRES and WDES action plans, wider race and disability equality action plans and the work will align with the Trust’s EDI strategy and progress will be reported to the People Academy.

Assure:

Planning Framework – this was shared with the Academy to draw attention to the ask, cycle and next steps of the three-year numerical and five-year narrative plans that contribute to the NHS 10 year plan. Key to the Academy is the reduction in absence and bank and agency resource, increased partnership working and the evolution of roles. The Academy appreciated the increase in engagement with the planning process across the Trust.

Report completed by:

Karen Walker

Academy Chair and Non-Executive Director

25 January 2025

Osbourne, Sheridan
26/01/2026 12:25:00

Board of Directors				
Meeting Date:	29 January 2026	Agenda Reference:	Bo.1.26.10b	
Report Title:	Workforce Report			
Presented by:	Faeem Lal, HR Director			
Executive Lead:	Faeem Lal, HR Director			
Author:	Various Service Managers			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	The purpose of this paper is to outline key workforce themes and trends			
Recommendation/s: (including any decision/approval required)	The Board are asked to note the contents of this report.			
Link to Strategic Objective:	People - To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	Workforce risks remain primarily associated with vacancies, sickness absence and turnover in specific staff groups, particularly Nursing, AHPs, Healthcare Scientists and some specialist services. These pressures continue to be actively managed through recruitment, retention initiatives, workforce planning and use of temporary staffing. The principal staffing risk remains recorded on the Chief Nurse Risk Register and is subject to ongoing review and mitigation.			
Legal/Regulatory:	The Trust continues to meet its statutory and regulatory obligations in relation to workforce governance, including compliance with employment legislation, professional registration requirements and safe staffing expectations. No new legal or regulatory risks have been identified as a result of this report.			
Quality & Patient Safety:	Workforce availability and skill mix have a direct impact on the Trust's ability to deliver safe, high-quality care. While overall staffing levels have increased slightly, ongoing vacancies and reliance on temporary staffing in some areas may present risks to continuity of care. Mitigations include active recruitment, targeted retention actions, escalation through risk registers, and continued monitoring of staffing levels to maintain patient safety.			
Equality, Diversity and Inclusion and Health Equity:	The Trust remains committed to advancing equality, diversity and inclusion across the workforce. Progress continues through implementation of the Equality Delivery System 2, engagement with staff networks, inclusive recruitment practices, and initiatives to support retention and development for all colleagues. Workforce challenges and service reconfiguration are considered through an EDI lens to minimise disproportionate impacts on staff or patient groups.			
Resources:	Workforce pressures continue to have financial implications, particularly through the use of bank and agency staffing and investment in training and development. These are being managed within existing budgets where possible, supported by workforce planning, apprenticeship routes and external funding opportunities. Ongoing monitoring is required to ensure staffing solutions remain affordable and sustainable.			

Environmental sustainability:	While there are no direct environmental impacts arising from this report, workforce stability supports sustainable service delivery by reducing reliance on agency staff and unnecessary travel. Training and development initiatives, including digital systems such as e-Job Planning and e-Rostering, also contribute indirectly to more efficient and sustainable working practices.
Assurance Route	
Meeting/s where content has been discussed previously:	People Academy

Osbourne, Sheridan
26/01/2026 12:25:00

Board of Directors:

Agenda Item: Bo.1.26.10b

Report content

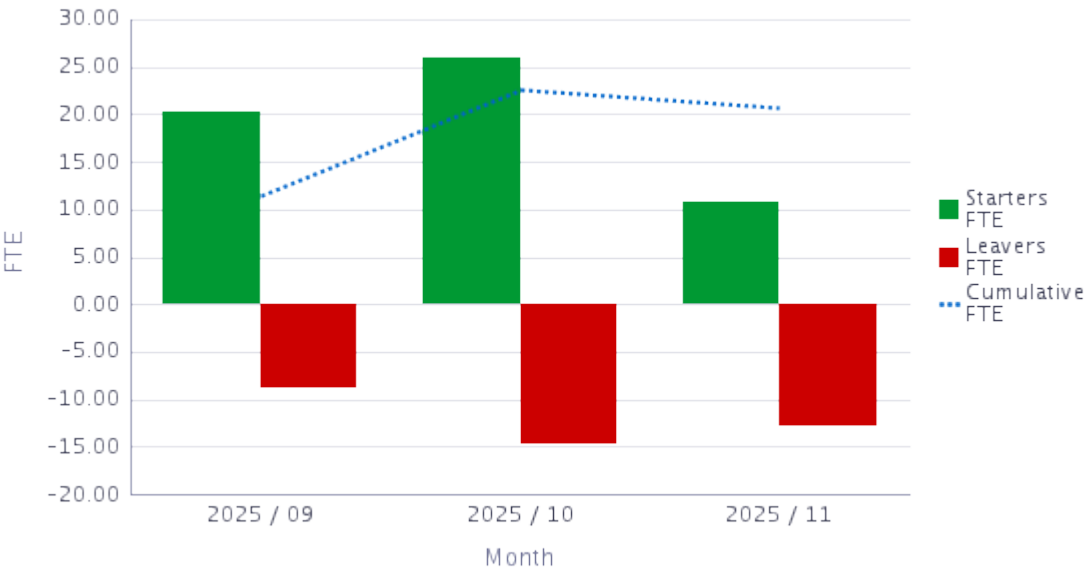
Staff in Post

Since the last report staff in post FTE has increased from 6,724.37 in September 2025 to 6,748.64 in November 2025 representing an overall increase across all staff groups of 24.27 FTE.

The largest increase in FTE over the period was in the Nursing & Midwifery Registered staff group (21.57 FTE) followed by the Medical and Dental staff group (7.22 FTE). The increase in the Nursing & Midwifery Registered staff group can be attributed to Newly Qualified Nurses obtaining their NMC registrations and moving from the Additional Clinical Services staff group.

The largest reduction in FTE over the period was in the Additional Clinical Services Staff Group (-14.18 FTE).

The table below shows the position with respect of qualified nursing / midwifery starters and leavers which demonstrates the position over the last three months. The cumulative position for the 3 months is 20.67 FTE with 56.92 FTE registered nurses / midwives joining the Trust and 36.25 FTE leaving. Please note that this only includes those Nurses/Midwives who join the Trust in that role and excludes any that joined as HCAs pending NMC Registration.



Osbourne-Sheridan
26/01/2026 14:05:00

Board of Directors:

Agenda Item: Bo.1.26.10b

Bank Staffing Nursing

In November the total number of requests sent to bank was 9741 compared with October's requests of 9864 a decrease of 123 requests. The November split is 4184 requests for registered staff and 5557 requests for unregistered staff. Of those 4184 registered requests a total of 2828 were filled by bank staff which is 67.6% compared with 66.9% in October a increase of 1.04%. Out of the 5557 requests for unregistered staff 3892 were filled by bank which is 70% compared to October which was 76% a decrease of 6%.

Agency Nursing

Agency shifts filled for November were 295. This is split 295 registered and 0 unregistered staff. Out of the 295 filled registered shifts, 154 were filled with registered theatre staff. In November Agency fill rates increased from October by 2.1% for registered staff, unregistered remains at zero usage.

Job planning - Medics

There are currently 453 Medics registered within the system. 269 are signed off which is 59%.

Job Planning – AHP

There are currently 429 AHP registered within the system. 252 are signed off which is 59%.

Job Planning – Specialist Nursing

There are currently 215 CNS registered within the system. 5 are signed off which is 2%.

Turnover

Turnover has shown a slight increase to 10.41% in November 2025 from 9.99% in September 2025. Turnover has increased slightly across all staff groups apart from Nursing & Midwifery Registered where it has reduced by 0.09%.

Nursing and Midwifery

Background

Data from the Model Hospital Portal can be used to benchmark against peer organisations, locally and nationally. For the Registered Nurse vacancy position as reported via the Model Health Hospital there continues to be an increase in the vacancy rate for registered nurses from 6.7% in August 2025 to 6.8% in September 2025 (Figure 1)

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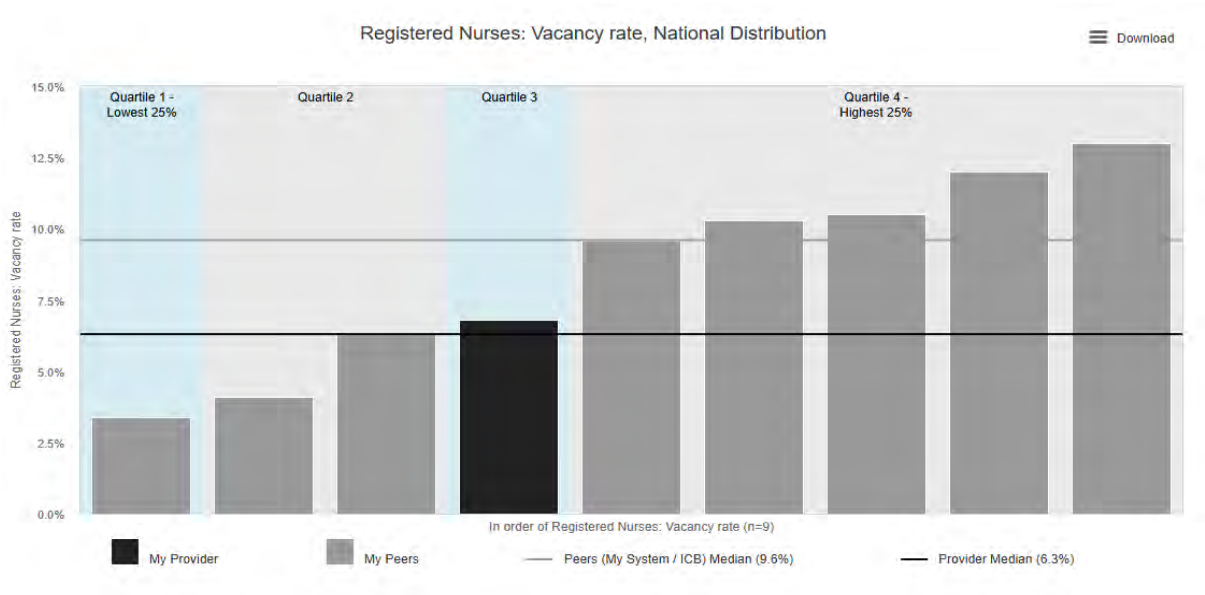
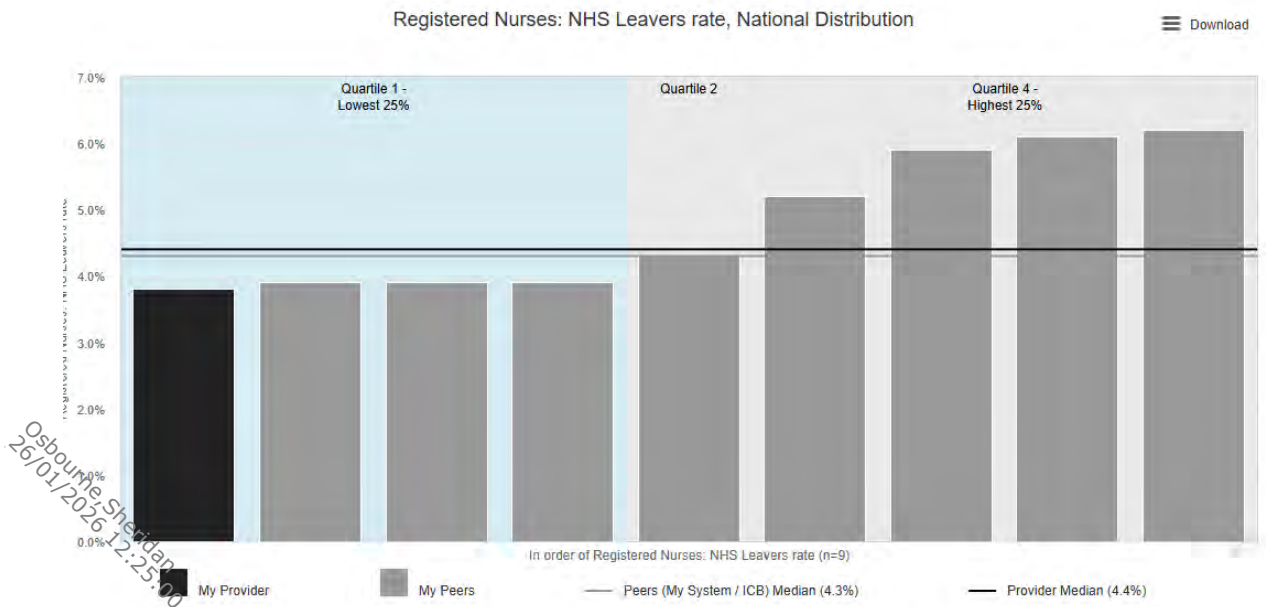


Figure 1 (Registered Nurse Vacancy position)

The turnover rate as defined by Model Health Systems is the percentage of Registered Nurses that left to join another NHS organisation or left the NHS over the previous 12 months. Since August 2024, the nurse leaver's rate continues to decrease, 7.3% August 2024, 6.8% in March 2025, 3.9% in August 2025 and 3.8% in September 2025 (Figure 2).



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Figure 2 (Registered Nurse Turnover rate within the West Yorkshire ICB)

Risks and Recruitment

The staff shortage risk on the Chief Nurse Risk Register (Risk ID 187/3732). There is a risk of harm to patient's, staff and visitors within the Trust if the trust is unable to maintain safe staffing levels; potentially resulting in poor patient experience of care, potential patient harm, increased staff and patient dissatisfaction, complaints, incidents, increased sickness levels, claims and poor retention of staff and a negative impact on the reputation and financial status of the Trust. The risk was reviewed in November 2025 and remains as a risk score of 12 (3x4). The risk will have a further review as the position improves with a deeper dive into areas with higher sickness or unavailability (January 2026).

To ensure consistency of reporting, the total Band 5 vacancy position from finance in November 2025 across the organisation is 65 Whole Time Equivalent (WTE). The total nurse vacancy position as reported by Model Hospital has increased to 6.7% in August 2025. Our Band 2 healthcare assistant vacancy position is reported at 167 WTE vacancies across our wards (including theatres).

Recruitment

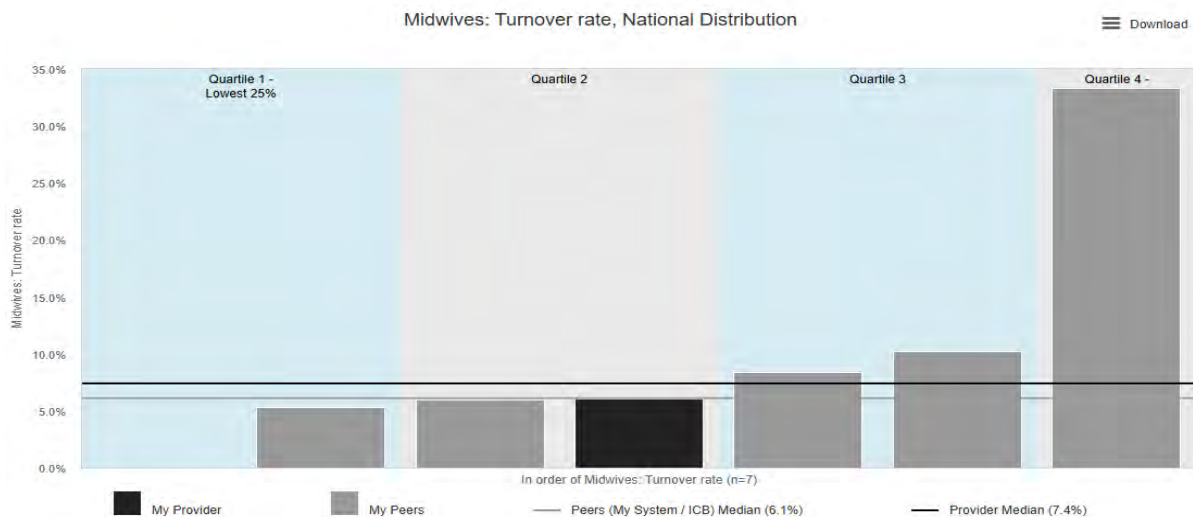
The Trust continues to actively recruit into Registered Nurse vacancies in line with workforce forecasts. Despite targeted efforts, recruitment outcomes have not met expectations. A key challenge has been the current employment landscape, where the number of newly qualified nurses exceeds available posts nationally. This has led to increased instability in retaining newly appointed candidates, with some individuals accepting offers but subsequently withdrawing or leaving shortly after commencement, having secured alternative employment. Additional recruitment activity took place in December 2025 and efforts will remain proactive and continuous, focusing on safe staffing and improved retention. To address the Health Care Assistants (HCA) workforce gaps, current vacancies are supported by temporary staffing, and we will continue with monthly HCA recruitment. In addition, all bank HCA colleagues who do not have a substantive contract in the Trust have been asked to express an interest if they would like to be considered for a substantive HCA position within the Trust. Interviews are planned in early January 2026.

Midwifery

Midwifery recruitment will continue to be coordinated via the LMNS process (Local Maternity and Neonatal Services) for Newly qualified midwives. This process is hosted by Leeds Teaching Hospitals NHS Trust. Model Hospital data shows midwifery turnover rate continues to decrease to 6.1% in September 2025 from 9.5% in January 2025 (Figure 3 Midwifery turnover rate within the West Yorkshire ICB provider organisations).

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(Figure 3 Midwifery turnover rate within the West Yorkshire ICB provider Trusts)

Retention

The retention of staff is a key objective of the NHS People Promise and an important step in providing safe staffing. We continue to be engaged in several initiatives to improve recruitment including;

- Learning career conversations and mapping career opportunities.
- Recognition of staff via DAISY Awards and NHS England's Chief Nurse Awards.
- Benchmarking our position with NHS Employers and NHS England's retention toolkits.

Allied Health Professionals

Physiotherapy vacancies on B6 line, however all vacancies are being recruited into. We've had approval to over recruit to B5's due to high turnover on this line.

Current staffing challenges in Intermediate Care because of vacancies and long-term sickness. We're currently utilising agency staff to fill the gap.

A stroke business case has been approved which will result in an additional 15 staff members across Physiotherapy, Occupational Therapy and Speech and Language Therapy. Recruitment into these posts is ongoing with the first cohort of new staff starting in January 2026.

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Occupational Therapy has had significant turnover on B5 line, but all vacant posts have been recruited into. Service is carrying a number of maternity leaves and staff on long term sickness.

Speech & Language Therapy vacancies have reduced with new B6 staff coming into post. Two new Band 7's have been recruited, one for head and neck services who will start in January and the other for the acute inpatient wards who is undergoing pre-employment checks.

The Rehabilitation Team at Y AIS, consisting of Speech & Language Therapists and Teachers of the Deaf, currently has a Lead Rehabilitation post vacant (Band 8a). The paediatric rehabilitation has adjusted their support for children and families until the posts can be filled. The adult service is fully staffed with 2 Speech and Language Therapists.

All Therapists have completed job plans. The teams continue to support undergraduate Speech and Language Students.

Dietetics

No current vacancies. Since the last report new roles have been established in provider-to-provider contracts for Children's Eating Disorder Service, Proactive care team (Keighley) and for inpatient MH care. Registered Dietetic staffing is now 77.75wte. 4 substantive staff are undertaking part-time funded Masters, research roles or secondments, these hours will be backfilled to ensure clinical capacity is retained for service delivery whilst skills are developed in the workforce.

Our 6 apprentice dietitians are progressing well and undertaking placements alongside students from Leeds Beckett university.

Development and application of our departmental Professional Development Framework is supporting staff in all bandings to develop and progress and supports retention of staff in BTHFT.

Orthoptics have no current vacancies.

Orthotics are fully staffed.

Sonographers currently have 5 band 7 vacancies which we are struggling to fill.

We have increased student training and have 4 trainees on the post grad course, 1 at Leeds and 3 Sheffield. In addition, we have a 1st year undergraduate on the new BSc ultrasound course at Leeds University.

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We employed a practice educator last year to help co-ordinate their training and support the students.

We have provided opportunities for development of existing staff by creating 3 band 8a clinical specialist roles. As part of their role they perform interventional procedures previously performed by radiologists.

Healthcare Scientists

Audiology

A 5 Year workforce plan has been agreed and there is a plan to develop a 5-10 Year workforce plan collaboratively with Airedale NHS Trust. The service has started to appoint to the posts identified in the workforce plan but this is being done in a gradual manner so as to not overload the service with new starters. It is hoped all positions will be filled by April 26.

An accreditation benchmarking visit has taken place which has also identified the lack of capacity but also highlighted the need for additional resource to take forward the work that would need to be done to enable accreditation.

The service continues to support a number of students at different levels i.e. 2 STP students, up to 3 PTP students per year group, Band 2 apprentice and 2 staff undergoing specialist training. The support of all these posts required resource which has a significant drain on the service but is beneficial overall.

Medical Illustration

Band 5 x 1 trainee (annex 21) – Studying post grad course Staffordshire University in Clinical Photography - due to complete March 26

Band 6 x 2 and Band 7 x 1 - All qualified Clinical Photographers AHCS registered.

Seniors all registered with Good Clinical Practice for Ophthalmic Research studies.

Clinical Engineering

1x HC Scientist Assistant - Vacancy.

1x HC Scientist Specialist – Vacancy

1x HC Scientist Specialist – Maternity leave anticipated return end Nov 2025.

1x HC Scientist Trainee (Band 5 Annex 21) enrolled onto 3rd year BSc Medical Engineering Apprenticeship PTP programme (University West of England).

Board of Directors:

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No NHSE 25/26 funding to support Clinical Engineering CPD & manufacturer technical training opportunities for existing HC Scientists/ Specialists.

Unable to utilise additional Apprenticeship levy as no supporting salary to implement substantive trainee posts.

Clinical Engineering supporting 2x voluntary (unpaid) UoB student rotation placements through 25/26.

Clinical Engineering supporting 1x voluntary Project Search admin/ stock control role.

Cardiac and Respiratory Scientists

Have continued to struggle to recruit experienced staff at all levels and have therefore concentrated on growing our own. Continue to make use of NHSE funding support for trainees at Level 2, Level 4, Level 6 and Level 7. We now have a total of 14 trainees on programmes from Level 2 to Level 7, as well as four Level 6 students on placement from Leeds University. This is a huge training burden which is being managed by 0.5wte dedicated Training & Education Lead. More resources are needed for this to be successful.

In the absence of dedicated CPD funding, monies from income streams is being utilised to support the development of existing staff in order to increase retention.

Recent UKAS benchmarking assessment highlighted the necessity of trying to recruit to all vacant posts within the existing structure, as well as recommendations to have additional 1.5wte Band 7/8a posts with the specific remit of quality assurance. Currently have 3 Band 7 posts vacant and have been unable to recruit to these.

Medical Physics – Clinical Technologists

Nuclear Medicine

- Team of 8 Clinical Technologists (6.8 WTE) – currently 1 vacancy.

Clinical Physics

- Team of 4 Clinical Technologists (1.6 WTE) – currently no vacancies or staffing issues.

Osbourne, Sheridan
26/01/2026 12:25:00
DXA

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- Team of 3 Clinical Technologists (2.24 WTE) – currently no vacancies, but the current staffing level is not adequate for the service. A business case has been written to increase the establishment by 1 band 6 (1.0 WTE).

Clinical Neurophysiology

- Team of 2 Clinical Physiologists (1.92 WTE) – currently no vacancies or staffing issues

Radiation Physics

Nuclear Medicine –

2 x Clinical Scientists

Diagnostic Radiology & Non- ionising –

3 (2.8WTE) x Clinical Scientists

2 x pre-registration clinical scientists.

2 x Clinical Technologists.

0.8WTE Clinical scientist has been working at 1 WTE since Jan 2025.

Additional clinical scientist post recently recruited to pending HR process.

1 WTE clinical scientist off long term.

Other Clinical Professions

Optometry team of 11 x B7 plus a Head Optometrist and Deputy Head optometrist are fully recruited. Recruitment is OK at B7 but very few applicants have previous hospital experience, which means recruiting and training relatively inexperienced applicants for what is a specialist clinical role. Majority of applicants are not wanting more than 2-day per week roles due to better pay in the private sector. Retention is not currently a concern.

Clinical Health Psychology

The team is now fully established with no vacancies. We currently have no staff on long term sickness following 2 staff returning to work recently. We have 3 staff (around 10% of our workforce) on maternity leave, two of whom are due to return early in the New Year. We have reconfigured our service offer during these absences to ensure minimal service disruption. We have secured NHSE funding for 3 full time training placements for 2026, two are for CBT therapists and one is for a learning disability and autism practitioner. These are band 6 training

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posts funded for 12 months and will increase our clinical capacity during that time period by around 5% at no cost. We continue to host Clinical Psychology trainees for 6 or 12 month placements (around 4 at any one time) which also adds to our clinical capacity at no cost to the Trust. We remain committed to improving the diversity of our team at all levels of seniority and continue to make good progress in this area.

Pharmacy

- Recruitment to vacancies continues and the current staff in post as a percentage of funded positions is the highest it has been in the last 18 months at over 90%.
- Sickness absence rates spiked to around 10% over the latest two months (Oct and Nov 2025) following a sustained period of reduced sickness absence to Trust target levels.
- Long Term sickness is the main driver for high sickness absence rates. Pharmacy are working hard to ensure Return to Work conversations take place and are recoded in e-Roster, to support effective return to work, some with Occ Health referral and advice and a phased return plan. Also managing cases as efficiently as possible through the formal routes when required with the help of HR colleagues.
- 12-month rolling turnover rates are around 6% over the past 3 months, which is much better than national benchmarking levels for Pharmacy at 15% and good compared to Trust turnover rates.

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Board of Directors:

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Organisational Development (OD)

NHS Staff Survey 2025

The NHS Staff Survey closed on 28 November 2025. The overall response rate for BTHFT was 43%. This is a decrease of 7% since 2024 which appears to follow the national trend of fewer colleagues responding to the survey. Initial results will be shared with CSUs / Corporate Services in mid-January, and full management results are expected back early February 2026 which will enable an organisational level action plan to be developed.

Leading at A Higher Level

Six new dates have been arranged for 2026 and are now available on ESR for colleagues to book. Invitations have now been sent directly to colleagues at a Band 6 level who have been identified as line managers or having supervisory responsibility via ESR.

Progression Hub (STEP)

Work has focused on refining the organisational mapping of roles and progression pathways and aligning the platform with existing workforce and leadership development frameworks. Colleagues from Nursing and Midwifery, and Administrative and Clerical pilot groups have been engaged to co-produce the user journey and validate the accuracy of role-specific information. Preparatory work has also been undertaken to scope external support for brand identity development.

Equality, Diversity and Inclusion

Equality Delivery System 2

The EDI team are currently working on implementing the Equality Delivery System 2 and will be working with colleagues across the People Directorate to help prepare for our submission in relation to Domain 2 and Domain 3. As with previous years this will be implemented with key departments such as Organisational Development, HR, Health and Wellbeing and corporate governance. A report will be presented to People Academy in terms of our progress and current position in February 2026.

Black History Month Celebrations

Excel and the RESIN staff equality network worked in partnership to host a special event at the Sovereign Lecture Theatre celebrating our local African Caribbean community and the profound legacy of the Windrush generation.

Board of Directors:

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As part of the event, colleagues welcomed Bradford filmmaker, Tom Harmer, to present a special viewing of his 30-minute documentary painted to members of our local community and partnering organisations. Rooted in Bradford, painted explores heritage, identity, and racism through the lens of portraiture.

The event attracted a wide range of people from our local community, providing valuable opportunity to come together.

EDI Strategic Objectives/priorities

The current EDI objectives as part of the Trust's EDI strategy are currently being reviewed and refreshed, as part of this process, the team are currently planning a range of engagement/listening sessions with a range of teams and colleagues so we can identify a set of strategic EDI priorities.

Recommendation

The Board is asked to note the contents of this report.

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Board of Directors				
Meeting Date:	29/01/2026	Agenda Reference:	Bo.1.26.11	
Report Title:	Nursing and Midwifery Strategic Staffing Review January 2026			
Presented by:	Professor Karen Dawber, Chief Nurse			
Executive Lead:	Professor Karen Dawber, Chief Nurse			
Author:	Jo Hilton, Deputy Chief Nurse Laura Loveday, Associate Chief Nurse for Workforce and Quality Saj Hussain, Finance Business Partner- Unplanned Care (Appendix 2) Lucy Godden, Finance Manager (Appendix 2)			
Report Summary				
Purpose of the paper:	Decision ☒ (approve)	Assurance ☐	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	The Chief Nurse is required to review and agree the nursing and midwifery staffing establishments on a 6 monthly basis to ensure safe, effective, and sustainable staffing in the right place, at the right time with the right skills. The establishment review process was undertaken with consideration given to NHS England's Professional Judgement Framework for Safe Staffing.			
Recommendation/s: (Decision/approval/assurance required)	The Chief Nurse's recommendations are: Support the skill mix changes outlined in Appendix 1. Ward F5 The bed base has increased from 20 beds to 25 beds; current ratio 1:12 additional Registered Nurse (RN) on day shifts (ratio improves to 1:8). Options: Recruit additional RN (Increase of 2.4 WTE). Reduce bed base to 20. Emergency Department Business Case presented to Executive Team Meeting (ETM) in December 2025. Proposal: Increase in establishment by: 21 WTE Band 5 RNs. Maternity Establishment uplift on M4 only (24-hour cover) (increase of 5.37 WTE).			
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	The staff shortage risk on the Chief Nurse Risk Register (Risk ID 187/ 3732). There is a risk of harm to patient's, staff and visitors within the Trust if the trust is unable to maintain safe staffing levels; potentially resulting in poor patient experience of care, potential patient harm, increased staff and patient dissatisfaction, complaints, incidents, increased sickness levels, claims and poor retention of staff and a negative impact on the reputation and financial status of the Trust. The risk was reviewed in December 2025 and remains as a risk score			

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	of 12 (3x4). It will be reviewed again in February 2026 following recruitment into vacancies.
Legal/Regulatory:	This report fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB) 2016 and 2018): How to ensure the right people, with the right skills, are in the right place at the right time and 'Safe, sustainable and productive staffing.
Quality & Patient Safety:	There is a risk to patients and staff is safe staffing levels are not maintained resulting in poor patient experience of care, potential patient harm, increased staff and patient dissatisfaction, complaints, incidents, increased sickness levels, claims and poor retention of staff.
Equality, Diversity and Inclusion and Health Equity:	There is a continued focus on recruitment and progression of the nursing and midwifery workforce to be reflective of the local community and to offer opportunities for growth and development in the organisation as an anchor institution.
Resources:	Where risks are identified there are processes in place to identify and report staffing gaps and where possible, ensure mitigation is in place to provide safe patient care. There continues to be recruitment of new nurses, retention of existing staff and efficiency of staff deployment.
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	Executive Team Meeting – 12/01/2026 People Academy – 14/01/26 Finance and Performance Committee - 21/01/2026

Report content
1. Purpose This paper is the bi-annual Nursing and Midwifery Strategic Staffing Review. It fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB) 2016 and 2018): How to ensure the right people, with the right skills, are in the right place at the right time and 'Safe, sustainable and productive staffing. The Chief Nurse is required to review and agree the nursing and midwifery staffing establishments on a 6 monthly basis to ensure safe, effective, and sustainable staffing in the right place, at the right time with the right skills. The establishment review process was undertaken with consideration given to NHS England's Professional Judgement Framework for Safe Staffing. This review focuses on the requests made and reviewed in December 2025. All areas have been reviewed in line with national quality board standards, however only the areas where a change has been recommended are included. 2. Background/context A triangulated approach to nurse workforce establishment planning is used in line with NQB recommendations. This includes: - Twice-yearly review of nursing establishments using an evidence-based acuity tool such as the Safer Nursing Care Tool (SNCT). - Daily analysis of the Allocate E Roster Safe Care results, which provide three times a day breakdown of patient acuity, completed by a Senior Nurse. - Annual Chief Nurse led review of staffing establishments. - Monthly analysis of Care Hours Per Patient Day (CHPPD).

- Daily monitoring of staffing capacity versus demand with triangulation against harms/quality metrics and the relationship to staffing.

3. Assessment

Workforce Review and Staffing Assurance

For inpatient wards, the staffing model of one Band 7 nurse providing 0.5 WTE supervisory time alongside two Band 6 registered nurses to ensure clinical leadership and support. Nursing establishments include headroom allowances of 21.5% across all areas, with a higher rate of 24.3% applied to maternity services to reflect their specific needs.

To optimise staff availability and ensure effective rostering, Confirm and Challenge meetings have been embedded within the CSUs. These meetings ensure ongoing scrutiny to ensure effective safe rostering within their allocated budgets.

In addition, clear recommendations have been developed regarding Clinical Nurse Specialist (CNS) job planning and the workforce principles applicable to this group. These guidelines support consistent role definition and workforce planning across the Trust.

Robust processes are in place to monitor workforce metrics alongside patient safety indicators, enabling early identification of potential risk areas.

Where gaps in workforce establishments are identified, recruitment efforts are prioritised accordingly to address these shortfalls. Shift fill rates and their impact on patient care and service delivery are proactively managed through twice daily staffing call with Matrons, the Command Centre, Deputy Divisional Directors of Nursing and on-call teams to ensure timely mitigation and safe staffing numbers. While all areas remain under ongoing review, those without specific recommended changes will receive enhanced oversight. Quality Impact Assessments will be completed to assure that service quality and safety are maintained.

This comprehensive approach ensures that staffing levels remain aligned with national standards and operational demands, supporting the delivery of safe, effective, and patient-centred care across the Trust.

Safer Nursing Care Tool (SNCT):

In line with NQB recommendations, the Safer Nursing Care Tool (SNCT) was developed to ensure the right staff, with the right skills are in place to support safe patient care.

Evidence based tools are available for:

- Adult Inpatient Wards in Acute Hospitals.
- Adult Acute Assessment Units.
- Children and Young People's Inpatient Wards in Acute Hospitals.
- Emergency Department Safer Nursing Care Tool.

The tools were updated 2024 to include two additional categories,
 1c: Patients requiring continuous observations (Enhanced care).
 1d: Patients requiring continuous observation by two members of staff.

It is recommended adult ward data collections should be undertaken twice yearly. The twice daily data collection is entered into the SNCT calculator which indicates the number of staff required for patient care based on acuity and dependency and this will be updated to include calculations of the new acuity scores of 1c and 1d.

NQB recommends the Safer Nursing Care Tool (SNCT) is used to assist senior nurses to ensure safe nurse staffing levels are applied for the patients in their care. Professional judgement must be used alongside triangulation of data from Nurse Sensitive Indicators (NSIs) such as infection rates, complaints, pressure ulcers and falls. Additionally, when reviewing staffing levels skill mix, competence, leadership, morale, and compliance is considered.

Implementation of Updated Staffing Tools

All relevant clinical areas are receiving comprehensive training on the updated staffing tools and the using safecare and the SNCT has been embedded in the twice daily staffing meetings which commenced in October 2025 with Matrons, Deputy Directors of Nursing and the Nursing and Midwifery Lead – Workforce and Safe Staffing overseeing the accuracy and proper recording of data.

The results generated by the new tool will be reviewed in conjunction with Professional Judgement (PJ) and Outcomes (OC) data. Findings and recommendations will then be presented as part of the forthcoming six-monthly establishment review to inform future staffing decisions.

Enhanced Therapeutic Observations of Care (ETOC)

Enhanced Therapeutic Observations of Care (ETOC) provides focused and continuous observation to patients requiring additional therapeutic support. This targeted approach enhances patient safety by ensuring close and consistent monitoring, allowing clinical teams to respond promptly to changing patient needs.

ETOC is often referred to as enhanced care, 1:1's or specialising, is an intervention which is intended to reduce the factors that contribute towards increased risk to and from an individual or others. ETOCs should promote recovery and wherever possible, preserve dignity. Demand for ETOC has increased due to our aging population and complexity of patient presentation. Nursing leaders report the need to identify innovative workforce models to ensure that patient safety and experience can be maintained in the most appropriate way. These complexities are presenting in three key issues:

- Poor patient experience: this can be down to patients being in the wrong environment, experience longer waits in emergency departments, not receiving therapeutic care, incorrect care if using agency staff (unaware of policies, care plans, ways of working).
- Longer lengths of ETOC and/or stay: Incorrect assessment and care plan can mean ETOC requirements are longer, leading to workforce inefficiencies.
- Increased spend - this may be due to:
 - Incorrect training calling for need of additional staffs.
 - Last minute bookings/reliance on temporary staffing.

Incorrect workforce models, and unnecessary ETOC time, is ultimately leading to patient dissatisfaction, and impacting trusts spend and staff productivity.

ETOC aligns with national guidance, including NHS England's recommendations on safe staffing and the National Institute for Health and Care Excellence (NICE) quality standards related to patient observation and care for vulnerable patients. These frameworks emphasise the importance of tailored care plans and vigilant observation to reduce harm and improve outcomes.

By supporting tailored care based on individual patient requirements, ETOC contributes significantly to improving overall patient outcomes and safety. Alongside the safer staffing principles, ETOC enables more effective allocation of staff to ensure responsive and supportive approach to patients requiring ETOC.

Following the NHSE launch of ETOC in June 2025, a working group has been established with the Trust including, nursing workforce team and the additional needs team to progress this valuable work. ETOC self-assessment was completed in July 2025 and this work continues through a working group with support from NHSE.

Outcomes from Nursing and Midwifery Strategic Staffing Review (July 2025)

- 7.75 WTE Band 5 posts to sustain the improvements achieved and address ongoing pressures within the Emergency Department (approximately £421,000 for a year).
- funding for a 1.0 WTE Band 8b Consultant Midwife role dedicated to leading efforts to reduce inequalities within maternity services.

Requests from the Establishment Reviews in December 2025

■ Ward 6 & Ward 9

Increase Band 7 supervisory role to 1.0 WTE with protected management time for quality improvement, staff development, Expected impact: reduced incidents, improved care quality, and enhanced stroke/neuro expertise.

Outcome - not supported. 0.5% WTE supervisory time in line with other inpatient areas.

■ Emergency Department

Current Challenges within the department:

- Risk to safe care: ED occupancy regularly exceeds the footprint capacity, creating delays and stress on staffs.
- CQC feedback: concerns regarding oversights and safe staffing in Resus, lack of proactive coordination.
- Workforce mismatch: nurse in charge is often pulled into direct patient care, losing 'helicopter' view of department.
- Patient safety risks: complaints about long waits, poor pain management and communication issues.
- Performance Impact: Ambulance handover delays; difficulty in meeting 45 min standard.
- Benchmarking: BTHFT ranks 2nd lowest in WYAAT for FTE/WTE; establishment unchanged since 2019 despite complexity rising.
- Matron Role Overload: current matron responsibilities are reactive due to competing demands, limiting proactive leadership and flow management, an additional matron would strengthen resilience and safety.

Business case has been presented to ETM requesting an increase in the ED nursing workforce.

Request for nursing establishment from the business case:

- Increase Nursing establishment: additional 26.25 WTE Band 5 RNs.
- Additional Leadership Capacity: New Matron (Band 8a) for operational oversight and flow
Outcome – Not supported at this present time

(Appendix 2 AED Business Case for Nursing workforce – available in the Board reading room on Admincontrol [here](#)).

■ AMU Wards 1 & 4

Ward 1: Increase HCAs from 3 to 4 per shift to meet rising patient dependency and mental health needs.

Ward 4: Increase RNs from 4 to 5 per shift to maintain safe 1:6 ratio.

Rationale: AMUs now function as high-acuity unit; longer stays, complex admissions, and monitoring requirements have escalated. **Outcome**- review with SNCT data at next review.

- **Ward 16**

Additional RN 24/7 to ensure Band 6's presence on every shift. **Outcome-** review with SNCT data at next review.

- **Ward 28**

At the January 2025 establishment review it was agreed to increase the ward establishment by one healthcare assistant per shift. The budget for the uplift 8.48 WTE HCAs has not yet been added to the wards overall finance budget.

- **Critical Care Unit**

Convert Band 2 monies to Band 4 monies, to retain the staff that have completed their NA training. The current establishment is for two Band 2 HCAs on a day shift and one on a night, The move will change this to one HCA on a day shift and one night. This is cost neutral and will give additional resilience to flex capacity depending upon levels of care at the bedside. **Outcome** - supported skill mix within budget.

- **Ward 18**

Additional 1.0 WTE RN early shift Monday to Friday requested to support proposed assessment area aimed at reducing A&E pressure **Outcome** – pathway to be developed first.

- **Ward 22**

Reallocate Band 4 vacancies to create additional Band 6 posts for senior presence across all shifts. **Outcome** - supported skill mix within budget.

- **Ward 3**

Convert Band 4 posts to Band 5 to maintain safe registrant numbers and enable acute admission/assessment care. **Outcome** - supported skill mix within budget. Request for housekeeper to be approved as requested in previous staffing review. **Outcome-** will need to be funded within CSU.

- **Ward 29**

Convert Band 4 posts to Band 5 to maintain safe registrant numbers and enable acute admission/assessment care. **Outcome** - supported skill mix within budget.

- **Ward 31**

Convert Band 4 posts to Band 5 to maintain safe registrant numbers and enable acute admission/assessment care. **Outcome** - supported skill mix within budget.

- **WBG & WWP**

Dedicated full-time supernumerary management time for Band 7. **Outcome** - not supported continue 0.5 WTE supervisory.

- **Maternity Services**

Maternity Services are seeking consideration for an increase to the staffing establishment to include an additional Band 3 Maternity Support Worker (MSW) on wards M3 (mixed antenatal & postnatal ward) and M4 (postnatal ward). Current BirthRate Plus acuity data shows these areas are

consistently operating in the red, indicating that the existing staffing levels are insufficient to safely meet patient acuity. Service-user feedback further highlights concern regarding limited support for essential care needs for both mothers and babies, reinforcing the impact of the current staffing shortfall.

To address this, the following options are presented for review:

- **Establishment uplift on both M3 and M4:** An additional 1 WTE Band 3 MSW on each ward, providing 24-hour cover.
- **Establishment uplift on M4 only (24-hour cover):** While both wards show negative acuity, M4 demonstrates more significant and sustained deficits.
- **Night-shift uplift on M4 only:** An additional 1 WTE Band 3 MSW on nights, recognising that M4's night staffing was reduced approximately 18 months ago when midwifery establishment increased.

▪ **Ward F5**

Bed base increased from 20 beds to 25 beds; current ratio 1:12.5. Proposal: additional RN to day shifts (ratio improves to 1:8.4) to enhance care quality. **Outcome** – consider additional RN on a long day or reduce bed base.

▪ **Ward 27**

Move Band 3 rehab support workers into Band 2 HCA line; establish SNA line with 2.65 WTE. **Outcome** - supported skill mix within budget.

▪ **Ward 21**

Additional Nursing Associates required for high-dependency post-op patients and monitored beds. Proposal to redeploy Band 3 & 4 posts from Ward 20. **Outcome** - supported skill mix within CSU budget.

Children's Services

▪ **Ward 30**

Convert 3.61 WTE Band 2 vacancies to 1.0 WTE housekeeper and 2.61 WTE play assistants. **Outcome** – recruit to the vacant HCA posts and incorporate these roles to enhance patient experience and operational efficiency.

▪ **Paediatric Urgent Care**

Increase 2.72 WTE Band 5 nurses for twilight shifts; Increase 5.44 WTE Band 3 HCAs for ED observations and CCDA support. **Outcome-** to undertake a workforce skill mix review.

▪ **NNU**

No change; consider substantive funding for NEP Band 7 post beyond March 2026. **Outcome:** This post cannot be substantively funded.

Theatre Workforce Review and Future Planning

The current theatre establishment was proposed to support 19 theatres, covering both acute and elective surgical activities. Presently, the working model operates predominantly from 8:00 am to 6:00 pm, with acute services providing 24/7 cover to meet urgent demands.

However, the existing working pattern does not accommodate overruns or extended surgical times, which are increasingly necessary to manage complex patient interventions. To address this gap, a workforce review is underway to consider extending the length of the working day to include overruns and potentially a third operating session.

A detailed modelling exercise has been conducted to explore potential new working patterns and assess their impact on service delivery and organisational resources. This work was undertaken in collaboration with the Workforce team, focusing on reviewing and allocating theatre templates and implementing the use of the roster management system to optimise staffing. A further review is currently underway.

Additionally, the option of introducing flexible rostering will be evaluated to enhance workforce management in alignment with surgical activity demands. These initiatives aim to improve operational efficiency, support complex surgical workloads, and ensure sustainable staffing models that can respond to evolving clinical needs.

Clinical Nurse Specialist (CNS) teams

The development of the Clinical Nurse Specialist (CNS) establishment review is being approached through a structured, two-phase programme designed to strengthen role clarity, standardise practices, and optimise service delivery in line with patient need and national expectations.

Phase 1: Foundation and Structure

The first phase focuses on establishing a clear foundation for the CNS workforce across the organisation. This includes:

- **Job Planning:** is being undertaken to define CNS roles and responsibilities. This ensures alignment with service priorities and avoids role drift, while recognising the specialist expertise CNSs bring to clinical care.
- **Data Collection:** Detailed information is being gathered on current CNS activities, workload, and variation across services. This will inform decisions about role and workforce requirements.
- **Standardisation:** Uniform protocols and guidelines are being developed to ensure consistency in the scope of practice, clinical responsibilities, and processes across all specialties.
- **Policy Development:** Clear rules and policies are being established to support safe, consistent clinical practice and accountability within the CNS workforce.

Phase 2: Optimisation and Delivery

Building on the foundations established in Phase 1 (currently underway), Phase 2 will then focus on service optimisation and improving patient access:

- **Demand and Capacity Analysis:** A structured review of patient need, service demand, and CNS workload is underway to ensure resources are deployed effectively and equitably.
- **CNS-led Clinics:** Expansion and formalisation of CNS-led outpatient clinics is a key objective, enhancing patient experience and access to specialist care while supporting medical colleagues.
- **Implementation of GIRFT Principles:** The service will align with the national *Getting It Right First Time (GIRFT)* programme to embed best practices, reduce variation, and improve clinical outcomes and efficiency across pathways.

This phased approach is intended to deliver a sustainable, standardised CNS model that maximises the contribution of this vital workforce group, improves patient outcomes, and supports service transformation. The non medical job planning policy is completed and going through ratification process, which will provide a robust framework to support job planning.

Update on Business Case Development for Key Service Areas

Several service areas have been identified as requiring business case development to support the ongoing establishment review and address workforce challenges associated with increased activity, complexity, and service expansion:

- **Women's Health Unit:** A business case to request 1.0 WTE Band 7 has been recruited to.
- **ENT and Ophthalmology Outpatients:** Both services have experienced increased activity, treatment complexity, and patient volume. Consequently, a business case is being finalised to support service delivery.
- **Endoscopy:** A new endoscopy unit is planned for early 2026, as an initial 'lift and shift' model. 4.6 WTE RN posts were approved in December 2025 by the ETM, a business case summary is underway for an increase in staffing to open the two additional rooms.
- **Critical Care:** The critical care network for Intensive Care Units (ICU) recommends a 35% uplift to the unit's staffing budget, increasing from 21.5%, to create sufficient headroom for mandatory training requirements. However, this recommendation has not yet been adopted by Trusts within the West Yorkshire Association of Acute Trusts (WYAAT).
- **Skipton Dialysis Unit:** Band 3 workforce model has been reviewed, and Band 3 monies has been moved to Band 5 line to ensure a safe workforce, this is cost neutral. A business case is underway to support the opening of four additional rooms in March 2026.

Additional workforce reviews remain ongoing in the following areas and will inform future business case developments as required:

- Theatre Workforce.

4. Options Analysis/Proposal

The Board of Directors is asked to note the content of this report and provides sufficient assurance of the process undertaken. The Board of Directors is asked to support the Chief Nurse recommendations.

The Chief Nurse's recommendations:

Support the skill mix changes outlined in Appendix 1 and the body of this report.

Ward F5

Bed base has increased from 20 beds to 25 beds; current ratio 1:12 additional RN on long day shifts (ratio improves to 1:8).

Options:

Recruit additional RN (Increase of 2.4 WTE, costing £124,256).

Reduce bed base to 20.

Emergency Department

Business Case presented to ETM in December 2025.

Proposal: Increase establishment by: additional four Band 5 RNs on every shift (21 WTE including uplift) Total costing - £1,161,355.

Maternity

Establishment uplift on M4 only (24-hour cover) (increase of 5.37 WTE, costing £214,643).

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Extra staff requested per shift vs. current funded establishment – 2025/26

				40.22	68.99	28.77	1,598,823	3,099,348	1,500,525	1,500,525	
Service Area	Specialty		Ward - Current	Current WTE	Final New Total	Change - WTE	Current Budget	Proposed Budget	Change - £	Staffing Review Request	Comments
Unplanned Services	UEC Eld IMC	Emergency Care	Accident & Emergency Dept RN 24/7	0.00	21.00	21.00	0	1,161,355	1,161,355	1,161,355	ED 4RN 24/7
Unplanned Services	UEC Eld IMC	Intermediate Care Services	Ward F5	40.22	42.62	2.40	1,598,823	1,723,349	124,526	124,526	Extra RN nurse on LD
Unplanned Services	Obs and Gynae	Obs and Gynae	M4 - Maternity	0.00	5.37	5.37	0	214,643	214,643	214,643	Proposed change is 1.00 WTE MSW 24/7
TOTAL				40.22	68.99	28.77	1,598,823	3,099,348	1,500,525	1,500,525	

5. Appendices

Appendix 1

Strategic Staffing Review PowerPoint presentation

Appendix 2

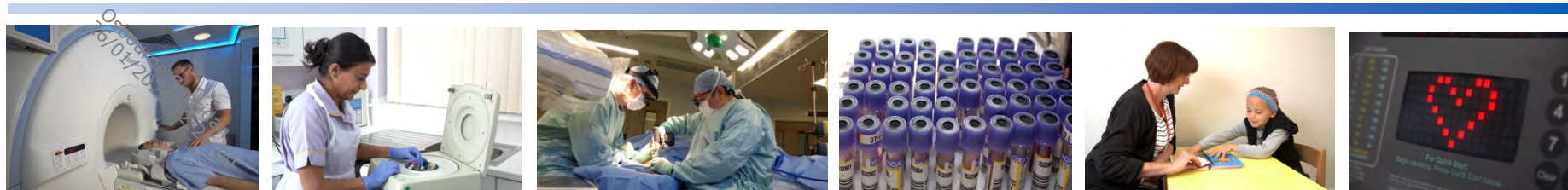
AED Business Case Nursing Workforce (available in the Board reading room on Admincontrol [here](#))

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Appendix 1

Strategic Nurse and Midwifery Staffing Review

Karen Dawber
Chief Nurse
January 2026



Introduction

The establishment review paper focused on two areas:

1. Acuity, dependency and risk.
2. Business case development.

The slides describes the detail where there has been a request for change in nursing establishments and the recommended action of the Chief Nurse.

This review has focused on requests made in November 2025 for inpatient ward areas.

It will also update on the ongoing establishment review made in July 2025 for outpatient and day case areas and the Clinical Nurse Specialist (CNS) workforce.

The areas identifying a requirement to produce a business case will do this in line with the Trust process outside of the establishment review.

Principles

- All areas have been reviewed in line with national quality board standards, however only the areas where a change has been recommended are included.
- The principle of one Band 7 with 0.5% WTE supervisory time and two band 6 registered nurses remains in place for in-patient wards.
- The headroom applied to nursing establishments is 21.5% for all areas and 24.3% for Maternity.
- Confirm and Challenge meetings in place to support effective rostering and optimise staff availability.

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Principles

- Processes are in place to monitor workforce and patient safety metrics to identify any specific areas of risk.
- Processes are in place to proactively manage staffing, escalate concerns and mitigate risks via twice daily staffing meetings, Matrons, Command Centres and on call teams.
- Where workforce gaps are identified in the current establishment recruitment will be prioritised for those areas.
- To continue to monitor and report shift fill rates and impact on patient care and delivery.
- All areas remain under review but where specific requests have not been recommended through this review there will be enhanced focus and oversight with Quality Impact Assessments completed.

Safer Staffing Principles

- Professional Judgement (PJ)
- Outcomes (OC)
- Evidence Based Tools. (EBT, eg SNCT, Birthrate Plus)

Figure 1: Principles of safe staffing



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Safer Staffing Principles and Quality Impact Assessments

Safer Staffing Principles

- Ensure safe, effective, and patient-centered staffing levels
- Balances clinical needs, staff skill mix, and patient acuity
- Utilizes data on patient outcomes, incidents, and feedback
- Flexible Staffing Model can adapt to fluctuating demand and ward-specific needs

Quality Impact Assessments (QIAs):

- Evaluate risks related to staffing changes before implementation
- Assess potential effects on patient safety, experience, and clinical outcomes
- Include multidisciplinary input for comprehensive review
- Use real-time data and staff feedback to adjust staffing dynamically
- Align with NHS standards, regulatory bodies, and CQC requirements
- Aim to reduce adverse events, improve care quality, and enhance workforce wellbeing

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Safer Nursing Care Tool

Evidence based tools are available for;

- Adult Inpatient Wards in Acute Hospitals
- Adult Acute Assessment Units
- Children & Young People's Inpatient Wards in Acute Hospitals
- Emergency Department Safer Nursing Care Tool

The tools were updated 2024 to include two additional categories,

1c: Patients requiring continuous observations (Enhanced care).

1d: Patients requiring continuous observation by two members of staff.

Plan:

- All areas are receiving training on the updated tools.
- SNCT data collection will be undertaken twice in the next 12 months.
- Results will be reviewed alongside PJ and OC and recommendation put forward as part of the next 6 monthly review.

Enhanced Therapeutic Observations of Care (ETOC)

ETOC

- Provides focused and continuous observation to patients needing extra therapeutic support
- Enhances patient safety through close monitoring
- Supports tailored interventions based on patient needs

Together, ETOC and Safer Staffing:

- Improve patient outcomes and safety
- Enable effective resource allocation
- Foster a supportive care environment

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- Phase 1: job planning, gathering detail, standardisation, rules
- Job planning establishes a structured process for creating, reviewing, and monitoring electronic job plans (e-Job plans) for clinical staff groups such as Nursing, Allied Health Professionals, Healthcare Scientists, and others. These job plans are prospective agreements outlining duties, responsibilities, and objectives to align workforce capacity with service needs, improve efficiency, and support professional development. It aims to ensure consistency, fairness, and compliance with national standards, contributing to high-quality patient care and optimal use of staff time.
- Phase 2: Focus areas include outpatient transformation through GIRFT principles, clinic optimisation and capacity modelling.
- The non medical job planning policy is completed and going through ratification process, which will provide a robust framework to support job planning.

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Business Case Development updates:

Bradford Teaching Hospitals

NHS Foundation Trust

Update on the areas requiring business case development to support the review:

- **Women's Health Unit:** A business case to request 1.0 WTE WTE Band 7 has been recruited to.
- **ENT and Ophthalmology Outpatients:** Increase in activity, treatment and complexity, business case required for increase in HCA's – business case is being finalised
- **Endoscopy:** New unit opening on 14th January 2026 as an initial 'lift and shift' model. Business case summary for the additional two rooms is underway. 4.6 WTE RN has already been approved by ETM in Dec 2025.
- **Critical Care:** critical care network for ICU recommend a 35% uplift to unit budget from 21.5% to create sufficient headroom for all training requirements. This has not been adopted by Trusts in WYAAT.
- **Skipton Dialysis Unit:** Band 3 workforce model has been reviewed, and Band 3 monies has been moved to Band 5 line to ensure a safe workforce, this is cost neutral. Business case underway for four additional rooms (March 2026).
- **Theatre workforce review-** further review being undertaken.

Current Challenges

Risk to safe care: ED occupancy regularly exceeds the footprint capacity, creating delays, overcrowding resulting in poor patient and staff experience.

CQC feedback: concerns regarding clinical oversight of the department and safe staffing in Resus, lack of proactive coordination.

Workforce mismatch: nurse in charge is often pulled into direct patient care, losing 'helicopter' view of whole department.

Patient safety risks: complaints about long waits, poor pain management and communication issues.

Performance Impact: Ambulance handover delays; difficulty in meeting 45 min standard.

Benchmarking: BTHFT ranks 2nd lowest in WYAAT for FTE/WTE; establishment unchanged since 2019 despite complexity and attendances rising.

Matron Role Overload: current matron responsibilities are reactive due to competing demands, limiting proactive leadership and flow management, an additional matron would strengthen resilience and safety.

- Business case has been presented to ETM requesting an increase in the ED nursing workforce

Request for nursing establishment from the business case:

- **Increase Nursing establishment:** additional four Band 5 RN's on every shift (21 WTE including uplift) Total costing - £1,161,355.
- **Additional Leadership Capacity:** New Matron (Band 8a) for operational oversight and flow. Total costing - £71,579 **Outcome** – not supported at this present time

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Summary of Key Changes and Requests:

- **Ward 6 & Ward 9**

Increase Band 7 supervisory role to 1.0 WTE with protected management time for quality improvement, staff development, Expected impact: reduced incidents, improved care quality, and enhanced stroke/neuro expertise. **Outcome** - not supported. Continue 0.5% WTE supervisory time in line with other inpatient areas

- **Emergency Department**

Business case presented to ETM in December 2025 – to increase establishment to additional 21 WTE Band 5 RN's and 1.0 WTE Band 8a Matron. **Outcome** – Matron post not supported at this present time.

- **AMU Wards 1 & 4**

Ward 1: Increase HCAs from 3 to 4 per shift to meet rising patient dependency and mental health needs.

Ward 4: Increase RNs from 4 to 5 per shift to maintain safe 1:6 ratio.

Rationale: AMUs now function as high-acuity unit; longer stays, complex admissions, and monitoring requirements have escalated. **Outcome**- review with SNCT data at next review

- **Ward 16**

Additional RN 24/7 to ensure Band 6 presence on every shift. **Outcome**- review with SNCT data at next review

- **Ward 28**

At the January 2025 establishment review it was agreed to increase the ward establishment by one healthcare assistant per shift. The budget for the uplift 8.48 WTE HCAs has not yet been added to the wards overall finance budget

- **Critical Care Unit**

Convert Band 2 monies to Band 4 monies, to retain the staff that have completed their NA training. The current establishment is for two Band 2 HCAs on a day shift and one on a night, The move will change this to one HCA on a day shift and one night. This is cost neutral and will give additional resilience to flex capacity depending upon levels of care at the bedside. **Outcome** - supported skill mix within budget

Summary of Key Changes and Requests:

- **Ward 18**

Additional 1.0 WTE RN early shift Monday to Friday requested to support proposed assessment area aimed at reducing A&E pressure **Outcome** – pathway to be developed first.

- **Ward 22**

Reallocate Band 4 vacancies to create additional Band 6 posts for senior presence across all shifts. **Outcome** - supported skill mix within budget.

- **Ward 3**

Convert Band 4 posts to Band 5 to maintain safe registrant numbers and enable acute admission/assessment care. **Outcome** - supported skill mix within budget. Request for housekeeper to be approved as requested in previous staffing review. **Outcome**- will need to be funded within CSU.

- **Ward 29**

Convert Band 4 posts to Band 5 to maintain safe registrant numbers and enable acute admission/assessment care. **Outcome** - supported skill mix within budget.

- **Ward 31**

Convert Band 4 posts to Band 5 to maintain safe registrant numbers and enable acute admission/assessment care. **Outcome** - supported skill mix within budget.

- **WBG & WWP**

Dedicated full-time supernumerary management time for Band 7. **Outcome** -not supported continue 0.5 WTE supervisory

Summary of Key Changes and Requests:

- **Ward F5**

Bed base increased from 20 beds to 25 beds; current ratio 1:12.5. Proposal: additional RN to day shifts (ratio improves to 1:8.4) to enhance care quality. **Outcome** – consider additional RN on a long day or reduce bed base

- **Ward 27**

Move Band 3 rehab support workers into Band 2 HCA line; establish SNA line with 2.65 WTE. **Outcome** - supported skill mix within budget

- **Ward 21**

Additional Nursing Associates required for high-dependency post-op patients and monitored beds. Proposal to redeploy Band 3 & 4 posts from Ward 20. **Outcome** - supported skill mix within CSU budget.

Children's Services

- **Ward 30** Convert 3.61 WTE Band 2 vacancies to 1.0 WTE housekeeper and 2.61 WTE play assistants. **Outcome** – recruit to the vacant HCA posts and incorporate these roles to enhance patient experience and operational efficiency.

- **Paediatric Urgent Care:** Increase 2.72 WTE Band 5 nurses for twilight shifts; Increase 5.44 WTE Band 3 HCAs for ED observations and CCDA support. **Outcome-** to undertake a workforce skill mix review

- **NNU** No change; consider substantive funding for NEP Band 7 post beyond March 2026. **Outcome:** This post cannot be substantively funded.

Summary of Key Changes and Requests:

Maternity services

Maternity Services are seeking consideration for an increase to the staffing establishment to include an additional Band 3 Maternity Support Worker (MSW) on wards M3 (mixed antenatal & postnatal ward) and M4 (postnatal ward). Current BirthRate Plus acuity data shows these areas are consistently operating in the red, indicating that the existing staffing levels are insufficient to safely meet patient acuity. Service-user feedback further highlights concern regarding limited support for essential care needs for both mothers and babies, reinforcing the impact of the current staffing shortfall.

- **Establishment uplift on both M3 and M4:** An additional 1 WTE Band 3 MSW on each ward, providing 24-hour cover.
- **Establishment uplift on M4 only (24-hour cover):** While both wards show negative acuity, M4 demonstrates more significant and sustained deficits.
- **Night-shift uplift on M4 only:** An additional 1 WTE Band 3 MSW on nights, recognising that M4's night staffing was reduced approximately 18 months ago when midwifery establishment increased.

Outcome:

Establishment uplift on M4 only (24-hour cover) (increase of 5.37 WTE, costing £214,643)

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Summary:

The total changes recommended and to be considered by the Board as part of the establishment review is:

Support skill mix changes outlined in slides.

Ward F5

Bed base has increased from 20 beds to 25 beds; current ratio 1:12 additional RN on long day shifts (ratio improves to 1:8)

Options:

Recruit additional RN (Increase of 2.4 WTE, costing £124,526)

Reduce bed base to 20

Emergency Department

Business Case presented to ETM in December 2025.

Proposal: Increase establishment by:

Increase Nursing establishment: additional four Band 5 RN's on every shift (21 WTE including uplift) Total costing - £1,161,355.

Maternity

Establishment uplift on M4 only (24-hour cover) (increase of 5.37 WTE, costing £214,643)

Recommendations

- The Board is assured of the process undertaken and asked to support the recommendation of Chief Nurse. Where there are areas that have requested a change, and this has not been recommended the Board is assured of the ongoing oversight and review in line with the National Quality Board recommendations.

Osbourne, Sheridan
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Meeting Title	Board of Directors		
Date	29 January 2026	Agenda item	Bo.1.26.12

Committee Escalation and Assurance Report

Report from the: Finance and Performance Committee

Date of meeting: 21 January 2026

Key escalation and discussion points from the meetings

Alert:

Financial position

The Committee was advised the forecast adverse variance to plan was in the range £15.1m (best case) to £27.1m (worst case). The liquidity position was described as “constrained” with close monitoring required for the remainder of the financial year. Detailed papers were provided in support of the reported revenue and cash position. As the Board will receive either the same or updated information at its meeting on 29 January, detail is not provided here.

The Chief Executive was in attendance for a discussion of the Financial Recovery Plan detailed in the Finance Report which outlined the actions being taken and the risks and mitigations to delivery. Committee members had the benefit of an in depth consideration of the financial challenges facing the Trust in the Private Board Meeting on 15 January in the context of planning for future years. The Committee focussed on the challenge for the remainder of 25/26 but were acutely aware of the impact on future years of the planned recovery action that have been put in place not fully delivering. The Committee particularly noted that some of the actions were “one-offs.” The Committee also explored the change in financial culture required across the Trust to address the current and future financial challenge and welcomed the observations of the Chief Executive and Chief Financial Officer on the approach being taken and initial responses they had received.

High Level Risks

The Committee noted that the two ‘red’ risks concerning capacity and length of stay in the Emergency Department were past both their review and mitigation dates. An increased risk concerning hospital haemodialysis was noted.

Operational Performance

The Committee received updates on the KPI performance exceptions:

- DM01 6-weeks: Performance for December has reduced to 79.71% following a circa 15% performance on previous months this is due to challenges in Audiology, Neurophysiology and Urodynamics. Rating remains at amber as recovery to 95% is challenging.
- Elective Activity: Deviation from plan relates to capacity challenges in Plastics and Pain Management, alongside the delay to the opening of the DCU which has only

Meeting Title	Board of Directors		
Date	29 January 2026	Agenda item	Bo.1.26.12

been partially mitigated. Recovery requires productivity gains and work is ongoing to accelerate this as part of the financial recovery.

- Outpatient Transformation: Follow up activity remains high whilst new appointments are static. Recording of OPPROC is being improved with service specific actions now on track. Longer term pathway transformation and an expectation that the growth in follow ups is a short-term requirement aligned to RTT waiting list reductions may reverse the trend but full recovery to plan remains difficult.

The Committee debated whether the DM01 KPI was amber or red for recovery to plan but was assured that there was continued focus on achieving the improvement required.

Advise:

Operational Performance

At its November meeting the Committee was advised of the following in month exceptions / early warnings:

- Cancer 28-day FDS: Performance impacted by deterioration in histology reporting and ongoing challenges across key tumour groups. Year-end position remains a forecasted pass and YTD performance is above target.
- Cancer 62-day FT: Diagnostic delays are also impacting on this standard, although slower than hoped for improvement across other sites can also be noted. Recovery is a combination of tighter oversight and pathway reform (this is specific to different tumour groups).
- 18 Weeks Incomplete RTT: Performance remains below plan which will impact on two NOF metrics. Activity and productivity in terms of clock stops is improving, with efforts to ensure the longest waits are prioritised - continuing we should be able to recover to plan if these trends are sustained

The Board will receive the detail underpinning the in-month exceptions / early warnings at its January meeting and can expect the Finance and Performance Committee to continue to scrutinise whether the reported work to deliver the planned performance is successful.

Nursing and Midwifery Staffing Review

The Committee received a presentation from the Chief Nurse outlining the rigour of the process undertaken in this six month review. The proposed cost of the ELT supported staffing increases is £1.5m which the CFO said had been included in the 25/26 draft planning figures presented to the Private Board on 15 January. The Committee discussed how this was an immediate example of the difficult choices that the Board faced in balancing financial performance, operational performance, quality, safety, and the impact of staff.

Meeting Title	Board of Directors		
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Assure:

Referral to Treatment improvement work

The Committee has received a detailed presentation on Referral to Treatment improvement work in the Trust. The Committee was assured by the work being done, the improvements in care and performance actually delivered whilst noting the challenges remaining.

Estates Assurance Map

The Director of Estates and Facilities presented the outcome of work to date to develop an Estates Assurance Map. The Committee welcomed the work done as a major step forward and looked forward to its continued development as a significant contribution to how the Committee could receive assurances about the Estate and improve its reporting to the Board.

Capital Plan

The Committee was assured by process and prioritisation work to develop a draft capital plan for approval by the Board. The Committee will seek assurances that the planned capital spend on the estate will address, as far as resources allow, the highest estate risks that have been reported to recent Committees.

Other matters

The Committee was assured by the quality of the work presented on a range of important issues:

- Progress against the Trust's Green plan; a very comprehensive report was received.
- An update on progress against the Violence Prevention and Reduction Standards.
- Financial Grip and Control work – good progress against the actions in the plan.

Report completed by:

Bryan Machin
 Committee Chair and Non-Executive Director
 22 January 2026

Osbourne-Sheridan
 26/01/2026 12:25:00

Board of Directors				
Meeting Date:	29/01/2026		Agenda Reference:	Bo.1.26.12b
Report Title:	Month 9 Finance Report			
Presented by:	Ben Roberts, Chief Finance Officer			
Executive Lead:	Ben Roberts, Chief Finance Officer			
Author:	Amy Denning, Assistant Director of Finance, Michael Quinlan, Deputy Director of Finance, Chris Smith, Deputy Director of Finance			
Report Summary				
Purpose of the paper:	Decision ☐	Assurance ☒	Action ☐	Information ☐
Summary of Key Issues/Highlights:	- As agreed by the Board of Directors in December 2025, the Trust has formally submitted an off plan forecast for the financial year to NHS England at Month 9 reporting. The forecast to NHSE was originally that the Trust will post a year end deficit of £19.7m, which is £17.7m behind its £2.7m deficit plan for the year. - The Trust has subsequently been notified by NHSE that £1.9m of non-recurrent funding will be allocated in Quarter 4 to offset the costs of industrial action in November and December. BTHFT is required to improve its recovery plan forecast by a commensurate amount. This means the revised recovery plan forecast is a deficit of £17.8m, which is £15.1m off plan. - This forecast is dependent on the delivery of £12m of recurrent and non-recurrent mitigations in Quarter 4 via the CEO-led Financial Recovery Plan. The worst case “do nothing” forecast is a deficit of £29.8m which would be £27.1m off plan. - There remains risk to full delivery of the targeted £12m recovery plan mitigations. The forecast adverse variance to plan is therefore in the range from £15.1m in the best case to £27.1m in the worst case. - The Trust is reporting a year to date I&E position worse than plan by £16.1m at Month 9, with an actual deficit of £22.3m compared to a planned deficit of £6.2m. This is due primarily to shortfalls against the cumulative Closing the Gap (CTG) savings target and other expenditure run rate increases due to pressures arising from demand and policy requirements. - The December in-month position was a deficit of £2.7m which is £3.8m adverse to the £1.1m planned surplus. However, the in-month position was £1.35m better than the £4.1m deficit forecast included in the Financial Recovery Plan forecast submitted to NHSE. - The capital programme is currently £5.6m behind plan, with year-to-date expenditure concentrated on the Endoscopy Programme (£14.3m) and Outstanding Maternity improvements (£5.1m). The variance is due to timing delays in other planned schemes, with the year to date (YTD) underspend mainly driven by slippage in MRI Scanner and Estates Critical Infrastructure projects.			

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	- At Month 9, the closing cash balance is £4.5m, which is £6.5m below the planned position. The shortfall is primarily driven by an Income and Expenditure cash deficit of £7.1m, which is higher than anticipated. This reflects the ongoing operational pressures impacting revenue performance. The adverse variance has been partially mitigated by stronger than expected capital cash flows, contributing £0.6m above plan. Despite this offset, the overall liquidity position remains constrained and will require close monitoring over the remainder of the financial year to ensure sufficient cash availability to meet obligations. - The forecast closing cash position is projected to be £7.8m, contingent upon delivering the revised recovery plan forecast of £17.8m, the receipt of £3.6m in Capital Cash Support (application submitted in January) and £9.4m in Revenue Cash Support, for which the application is due by 4 February. These additional cash injections are critical to maintaining liquidity and ensuring operational stability. If received as planned, this will enable the Trust to sustain an I&E cash balance of approximately £3.0m at year end. - It should be noted that the timing and approval of these support applications represent a key risk to the forecast. Any delay or shortfall in funding would significantly impact the Trust's ability to meet its financial obligations and could necessitate further escalation to the regional team. Close monitoring of cash flows and proactive engagement with NHSE will therefore remain essential throughout Q4. - The CTG efficiency programme is £7.7m behind plan at Month 9, with £18.2m of efficiencies reported against a year-to-date target of £25.9m. The latest risk adjusted forecast is that £23m of savings will be delivered in 2025/26 against the overall £38.3m CTG target (distinct from the Quarter 4 Recovery Plan target), resulting in a shortfall of £15.3m in transacted CTG. - The current working forecast is that the recovery plan will be delivered in full. In this scenario, the Trust is projecting a year-end cash balance of £7.8m including cash support. An application for £9.4m of revenue cash support from NHSE will be submitted in February to support ongoing day to day expenditure in March. - NHS West Yorkshire Integrated Care System's (the ICS) formal consolidated month 9 position is not yet available. However, it is known that at least three of the other acute providers in the West Yorkshire system have submitted off-plan forecasts to NHSE at Month 9.
Recommendation/s: (including any decision/approval required)	The Board is asked to: 1. Note the content of this report
Link to Strategic Objective:	Sustainability - To deliver our financial plan and key performance targets
Link to Priority Initiatives 2025/26:	Closing the Gap 2025/26
Implications	
Risk:	Provides an update relevant to Strategic Objective 2 on the Board Assurance Framework, Reference no 6.

	Strategic Risk: If we and/or our Integrated Care System (ICS) partners in aggregate fail to deliver our financial plan in the short and medium term, including failure to secure an adequate capital funding allocation, then we may fail to maintain financial stability and sustainability, we may have insufficient internal cash and liquidity to support ongoing day to day expenditure and to support the necessary revenue and capital investments required to maintain safe and sustainable services and to support the corporate strategy, resulting in reduced ability to meet demand, develop services and to maintain / improve the safety and quality of care, impaired patient experience, an increased likelihood of system intervention and / or regulatory action including the potential loss of decision making autonomy and a negative impact on the Trust's reputation.
Legal/Regulatory:	Requirement from NHSE to deliver the financial plan
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/a
Assurance Route	
Meeting/s where content has been discussed previously:	N/A

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Board of Directors				
Meeting Date:	29/01/26	Agenda Reference:	Bo.1.26.12c	
Report Title:	Integrated Dashboard			
Presented by:	Mel Pickup, CEO			
Executive Lead:	Vikki Lewis, Chief Digital & Information Officer			
Author:	Vikki Lewis, Chief Digital & Information Officer			
Report Summary				
Purpose of the paper:	Decision ☐	Assurance ☒	Action ☐	Information ☐
Summary of Key Issues/Highlights:	The integrated Board dashboard is developed by combining the individual performance reports that are received and scrutinised by the Committees: (1) Finance and Performance Committee (2) People Academy (3) Quality Committee Historically, the individual metrics have been agreed with the Executive leads for these Committees and updated on a rolling basis as policy, planning and performance imperatives require. Following the recent publication of the National Oversight Framework (NOF) and other key planning documents, the organisation is working towards developing the reporting suite for inclusion in the IPR. Prior to recently published national guidance on the NOF, the organisation had confirmed its intentions to adopt the principles of the NHS England Making Data Count programme and this intention remains a guiding principle throughout this period of transition.			
Recommendation/s:	The Board is invited to receive and review the document attached. The Board is asked to note the progress to date and be assured of continued progress to create a comprehensive, detailed and informative performance dashboard going forward.			
Link to Strategic Objective:	Sustainability - To deliver our financial plan and key performance targets			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	N/A			
Legal/Regulatory:	N/A			
Quality & Patient Safety:	N/A			
Equality, Diversity and Inclusion and Health Equity':	N/A			
Resources:	N/A			
Environmental sustainability:	N/A			
Assurance Route				

Meeting/s where content has been discussed previously:	N/A
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26/01/2026 12:25:00

Integrated Dashboard

Board of Directors

December 2025

Osbourne Sheridan
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Key to KPI Variation and Assurance Icons

Variation			Assurance			
Special cause of <u>(H)igher or (L)ower</u> values indicating areas of concern	Special cause of (H)igher or (L)ower values indicating improving performance	Common cause - no significant change	'Pass' variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	Fail' Variation indicates consistently - (F)ailing of the target	Data Current unavailable or insufficient data points to generate SPC

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) specialty cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Special Cause Improvement - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) specialty cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls

Further Reading / other resources

The NHS England website has a range of resources to support Boards using the Making Data Count methodology. This includes a number of videos explaining the approach and a series of case studies – these can be accessed via the following link - <https://www.england.nhs.uk/publication/making-data-count/>

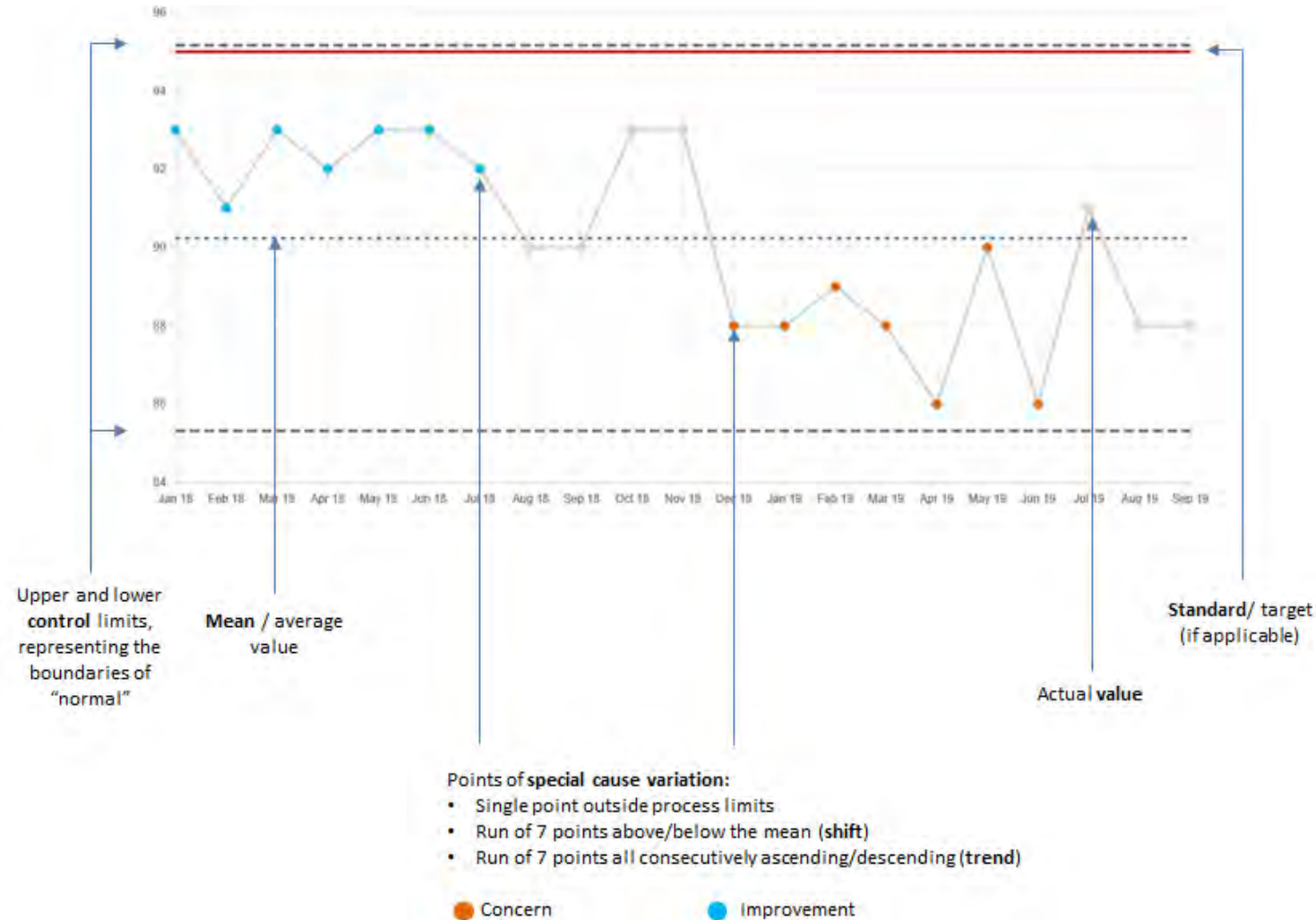
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Interpreting Statistical Process Control Charts

Guidance notes

Reporting within this document uses a combination of chart types. Where appropriate, Statistical Process Control (SPC) charts have been used to aid analysis.

SPC charts



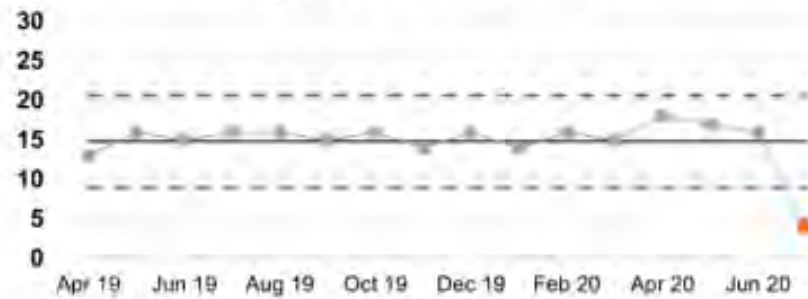
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Interpreting Statistical Process Control Charts

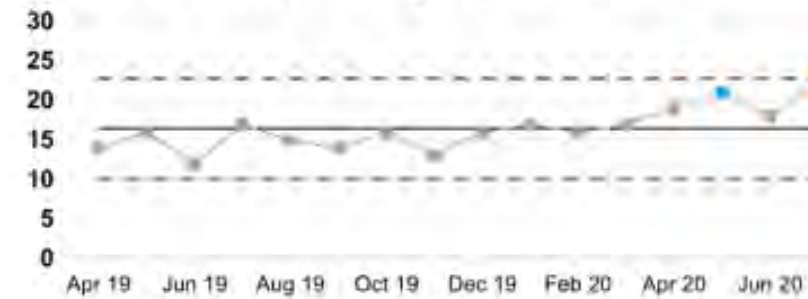
SPC rules : special cause variation



A single point outside the process limits



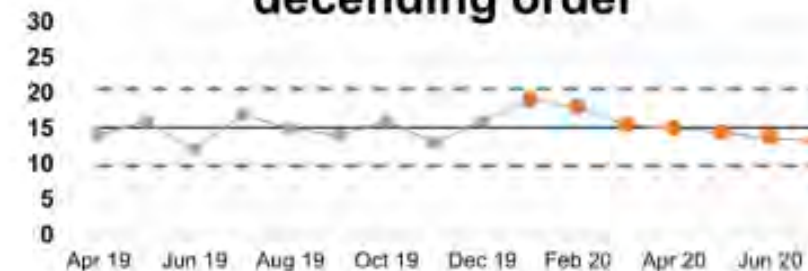
Two out of three points close to a process limit



A shift of points above / below the mean



A run of points in consecutive ascending or descending order



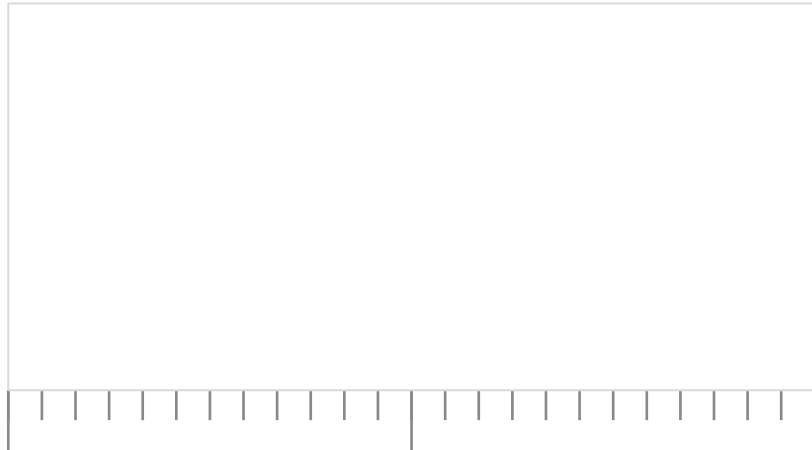
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Metric	Period	Latest Value	Target	Variation	Assurance	Mean
% Ambulance Handover <15 Mins - * All	Dec-25	50.0%				56.40%
% Ambulance Handover <30 Mins - * All	Dec-25	84.0%				85.80%
% Ambulance Handover <60 Mins - * All	Dec-25	99.0%				96.50%
Ambulance Arrivals - * All	Dec-25	3,636				3,200
Bed Occupancy - * All	Dec-25	90.76%	93%			90.70%
Cancer 2 Week Wait - * All	Nov-25	95.82%				93.80%
Cancer 28 Day Faster Diagnosis	Nov-25	75.53%				81.6%
Cancer 31 Day 1st Treatment	Nov-25	93.85%				92.6%
Cancer 62 Day Wait - * All	Nov-25	74.40%	75%			74%
Day Case Rate - * All	Dec-25	88.27%				88.90%
Diagnostic Waiting List - * All	Dec-25	7,071				10,236
Diagnostic Waiting List (% < 6 Weeks) - * All	Dec-25	70.70%	95%			72.50%
DTA to Admission > 12 Hours	Dec-25	1.9%				2.01%
DNA Rate - All	Dec-25	9.10%				8.85%
ED - Time to Initial Assessment - * All	Dec-25	18.69				24.4
ED Attendances (% < 4hr) - * All	Dec-25	79.95%	77.30%			75.60%
Elective Ordinary and Daycase Admissions	Dec-25	4,530				4,190
Elective Theatre Sessions Volume Completed	Oct-24	616				520
Length of Stay 21+ Days - * All	Dec-25	83				103.5
Not Meeting Criteria to Reside - * All	Dec-25	10.79%	14.79%			13.06%
Outpatient Attendances	Dec-25	44,548				41,567
Outpatient Attendances % New or with Procedure	Dec-25	56.35%				56%
Outpatients Discharged to PIFU	Dec-25	4.72%				2.14%
Patients Discharged on/before DRD	Dec-25	82.3%				81.90%
Patients in ED >12 Hrs - * All	Dec-25	707				680.1
RTT 18 Weeks (%) - * All	Dec-25	64.83%				68.90%
RTT 18 Weeks (Total Pathways) - * All	Dec-25	31,932	30,571			35,619
RTT 52 Week Breaches - * All	Dec-25	80				613.3
RTT 65 Week Breaches - * All	Dec-25	0				81.6
Theatre Capped Utilisation	Oct-24	85.30%				82%

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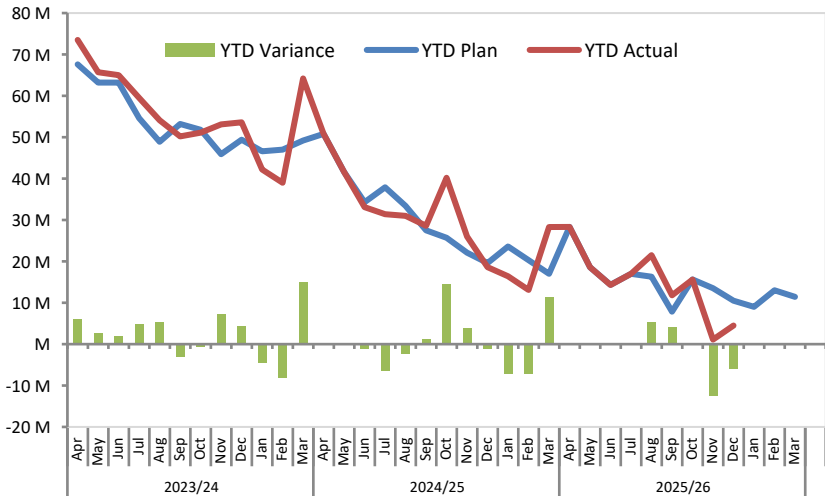
Finance – To deliver our key performance targets and finance plan

December 2025 – (£22.2)



December 2025 – £10.5m

Delivery of Cash Plan



Analysis

The Trust is reporting a year to date I&E position worse than plan by £16.1m at Month 9, with an actual deficit of £22.3m compared to a planned deficit of £6.2m. The Trust has formally submitted an off plan forecast for the financial year to NHS England at Month 9 reporting. The forecast to NHSE is that the Trust will post a year end deficit of £17.8m, which is £15.1m behind its £2.7m deficit plan for the year. This forecast includes £1.9m of industrial action funding notified in January 2026.

Year to date cash has decreased by £27.3m, reducing from an opening balance of £31.8m to £4.5m. This reduction reflects a net cash outflow of £12.8m on the capital programme, £19.8m relating to the I&E deficit, partially offset by £5.3m generated through working capital improvements driven by increases in deferred income.

The year to date cash balance of £4.5m is £6.0m below plan. This variance is primarily due to lower than planned cash impact from the I&E deficit (£15.9m), partially offset by favourable working capital movements (£8.8m), which include higher deferred income (£10.0m) and an additional £0.6m relating to capital.

The Trust is forecasting a closing cash balance of £7.8m, based on the anticipated I&E delivery. This forecast assumes £3.6m of capital cash support in January and £9.4m of revenue cash support in March. An application for the capital cash support has already been submitted, and if revenue cash support is required in March, an application will need to be made by early February. The level of cash support required will be dependent on achieving the updated I&E forecast.

Note: From August 2025 onwards the plan has been updated to reflect the revised I&E position agreed with NHSE and other known changes.

The CTG efficiency programme is £7.7m behind plan at Month 9, with £18.2m of efficiencies reported against a year to date target of £25.9m. The latest forecast is that £23m of savings will be delivered in 2025/26 against the overall £38.3m CTG target (distinct from the Quarter 4 Recovery Plan target), resulting in a shortfall of £15.3m. Focus is now shifting to delivery of the £12m mitigations targeted via the the Recovery Plan, some of which will be categorised as CTG savings, while others will be non-recurrent income streams and technical adjustments. Delivery of the full £12m mitigations is not fully confirmed at Month 9 and there is significant risk to this forecast.

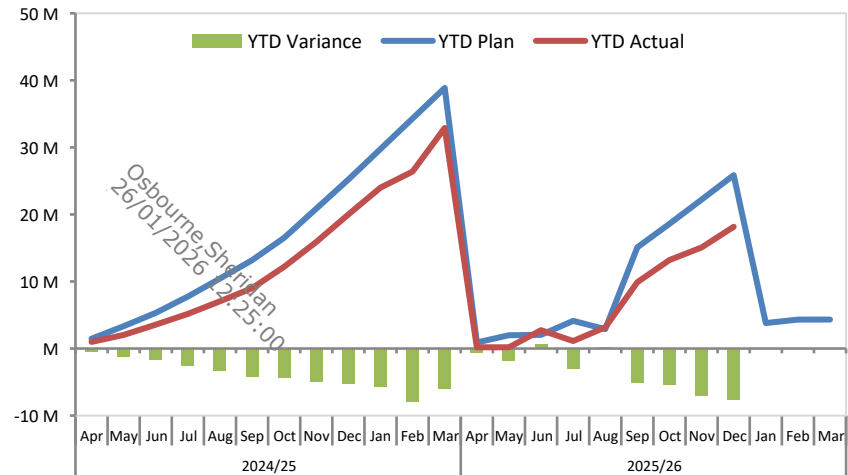
Year to date capital expenditure totals £24.6m, which is £5.6m below the revised plan. The majority of this spend relates to the Endoscopy scheme (£14.3m) and the Outstanding Maternity scheme (£5.1m).

The full-year capital plan is £45.1m, funded by £24.0m of internal resources, £1.7m in donations, and £19.5m of external PDC funding. The programme is currently forecast to underspend by £1.6m, primarily due to lower costs on the SLH DCU scheme. The Trust is actively exploring opportunities to mitigate the risk of an underspend in the current financial year.

Year to date capital expenditure is £24.6m, which is £5.6m below the revised plan. This variance is primarily due to the MRI scanner not being purchased (£2.0m) and the Outstanding Maternity Scheme (OMS) being slightly behind plan (£1.1m).

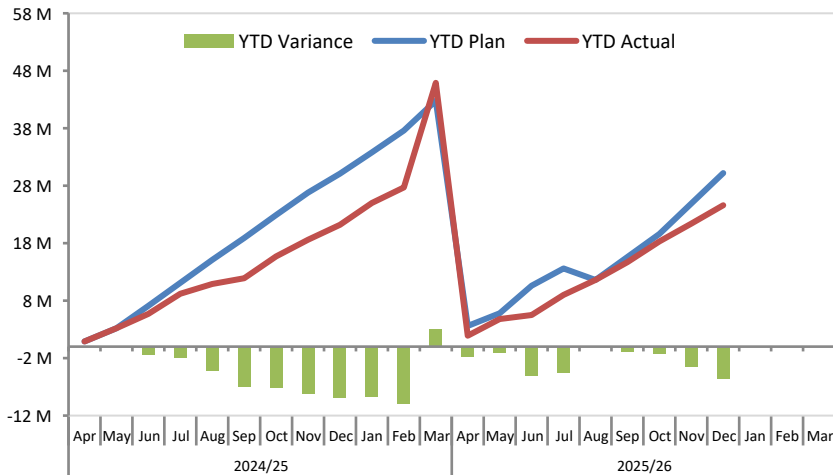
December 2025 - £18.1m

Closing The Gap



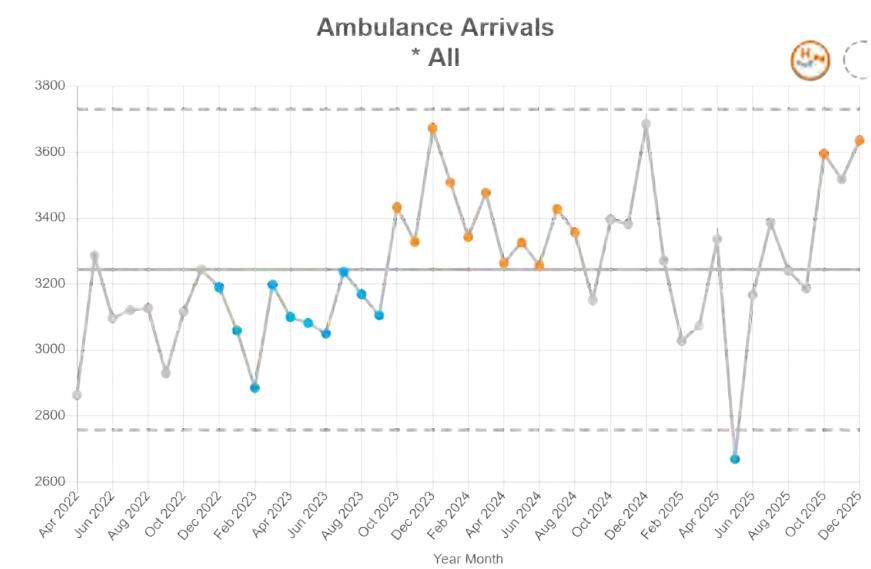
December 2025 – £21.4m

Delivery of Capital Plan

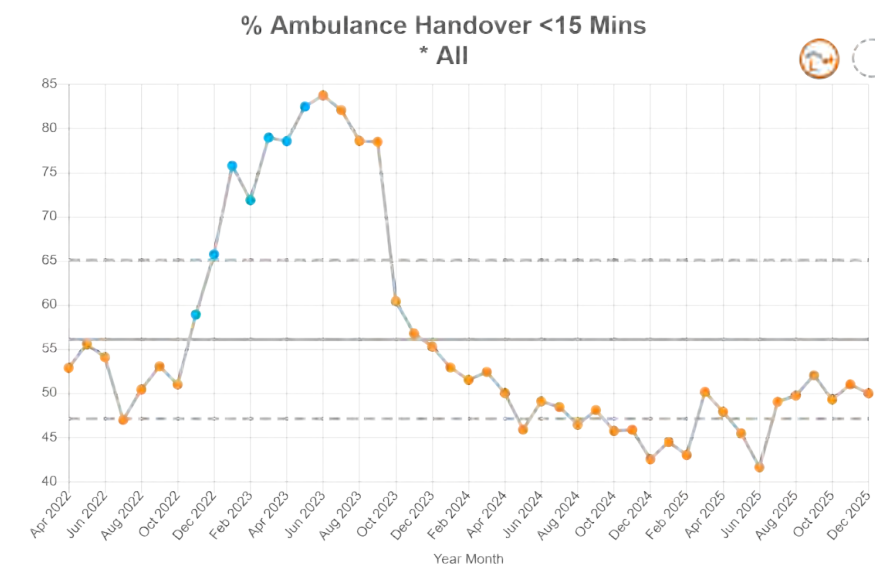


Performance – To deliver our key performance targets and finance plan

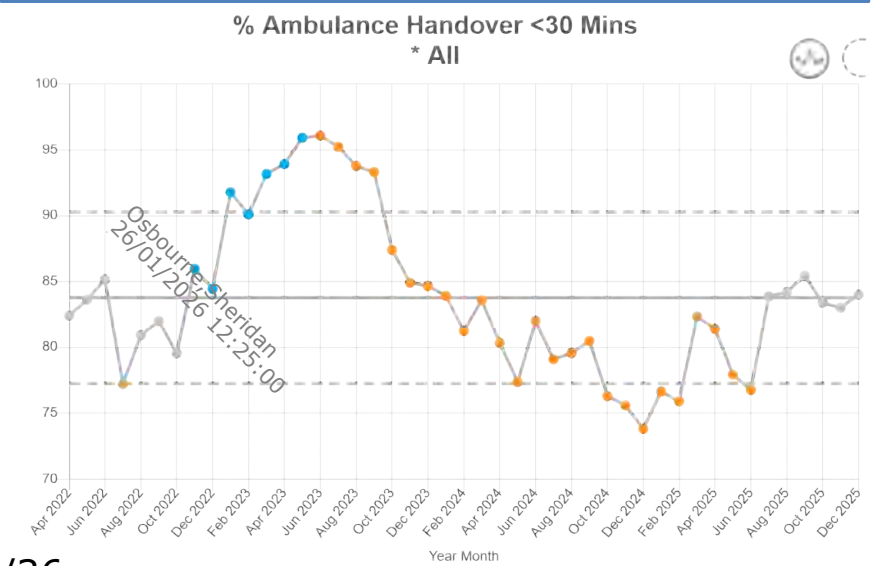
December 2025 – 3,636 Ambulance arrivals
Common cause variation



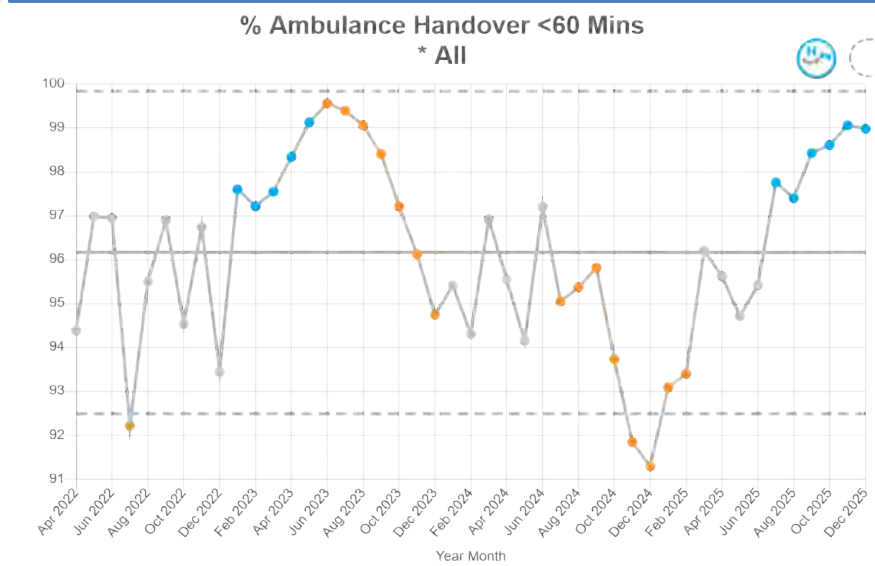
December 2025 – 50.00% ambulance arrivals
Special cause variation of an improving nature



December 2025 84.00% ambulance arrivals
Common cause variation



December 2025 – 98.98% ambulance arrivals
Common cause variation



Analysis

Performance for 15-minute handovers, as reported by Yorkshire Ambulance Service (YAS), was 50.66% in December compared with 51.42% in November.

Risks, Mitigations and Assurance

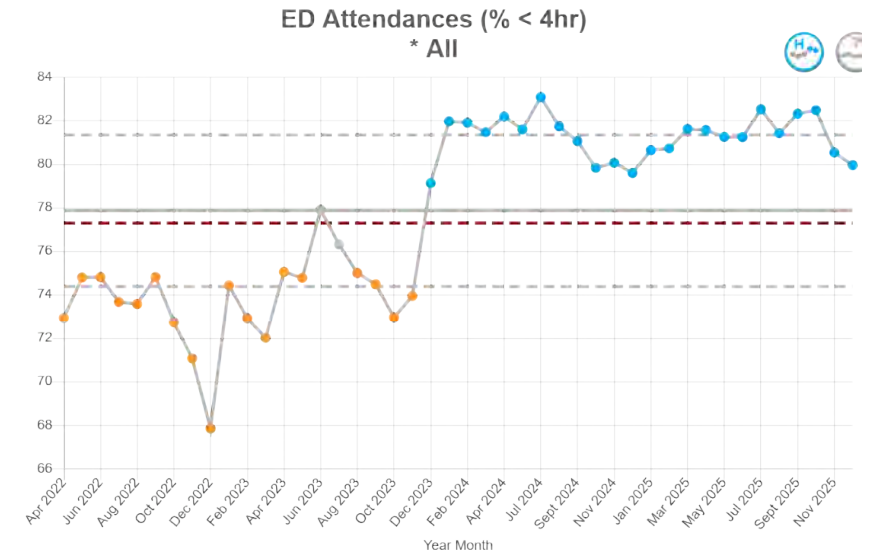
Despite an increase in Ambulance arrivals during both November and December, BTHFT's average handover time improved to 18:44, representing an approximate 8-minute (30%) reduction compared to the same period last year and demonstrating the positive impact of the Transfer of Care SOP implementation. Similar improvements in Crew Clear times have also contributed to a sustained improvement in the overall turnaround performance with ~60% being delivered within 45 minutes. As of Mid December, YAS have introduced a same-day handover data validation process to improve data accuracy further and reduce reported 45-minute handover breaches ahead of NHSE submission. A YAS HALO remains on site to support the adoption of the new Transfer of Care SOP and to increase the number of self-handovers.

Benchmarking

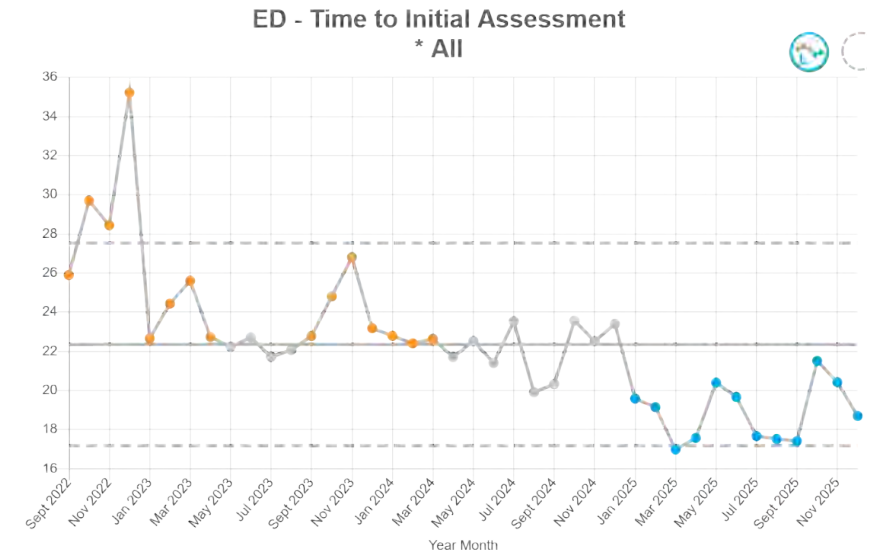
Compared to peer we have sustained a better than average position.

Performance – To deliver our key performance targets and finance plan

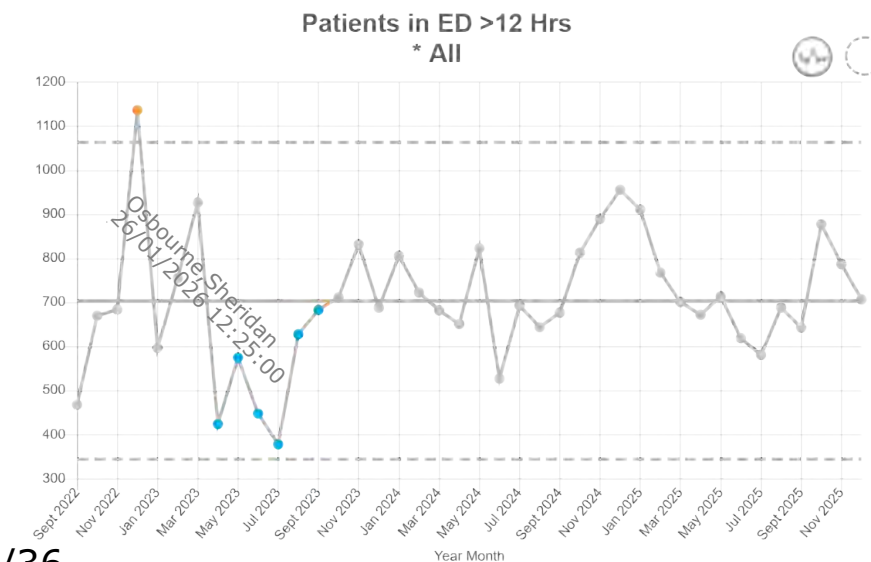
December 2025 – 79.95% - Year end target 77.3%
Common cause variation



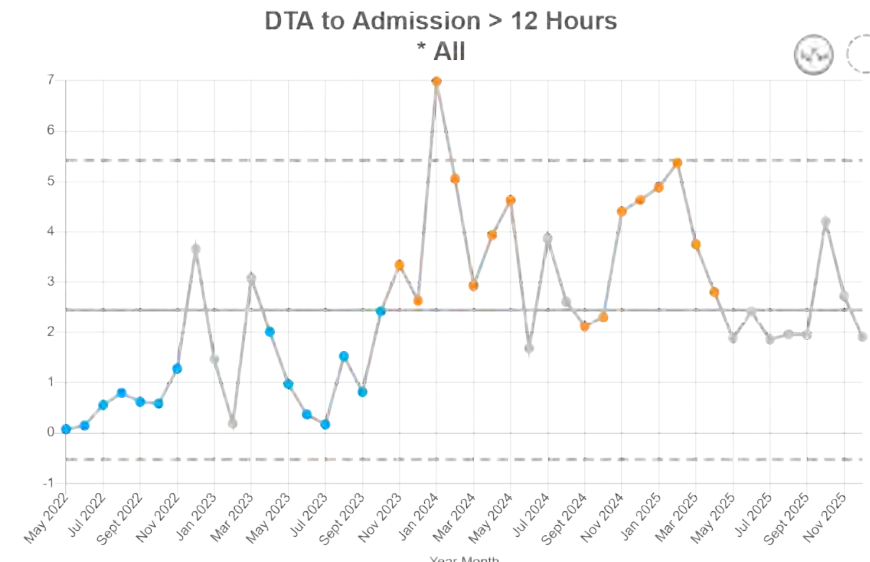
December 2025 –18.691 minutes
Commo cause variation of an **improving** nature



Decmber 2025 – 707 patients
Common cause variation



December 2025 – 1.91
Common cause variation



Analysis

Daily attendances during December returned to predicted levels despite higher than planned demand in October and November. ECS performance for November and December improved to 82.45%, up from 81.16% in the same period in 2024 representing a 1.29% increase despite a slight increase in ED attendances. During November and December 2025, performance against ED length-of-stay measures improved compared to the same time last year with the percentage of Type 1 attendances exceeding 12 hours reducing from 10% to 8% (a reduction of 372 patients) over same the two-month period.

Risks, Mitigations and Assurance

ECS performance is reflective of the enhanced streaming to UTC, AECU and the newly opened medical SDEC, alongside increased 24/7 consultant cover. The continued utilisation of patient streaming provides the necessary resilience to manage periods of high demand, ensuring timely care for patients who would previously have experienced delays due to hospital pressures despite not requiring admission to a hospital bed.

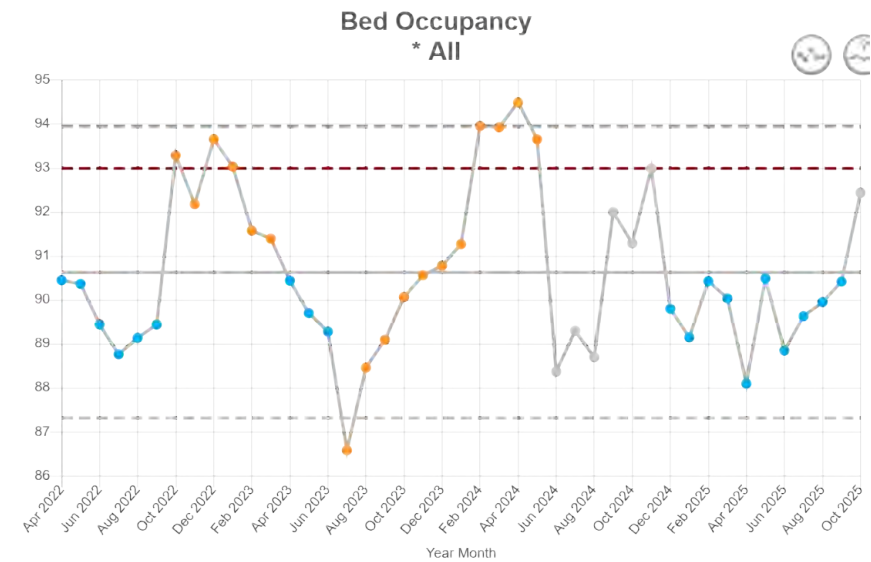
The EXCEL programme is progressing. It aims to reduce overcrowding and enhance patient experience through a collective approach. Key initiatives will focus on reducing demand on UEC Services, decreasing length of stay, and improving the staff experience. Discussions with patient groups, system partners, and other stakeholders have already shown an appetite for change and participation.

Benchmarking

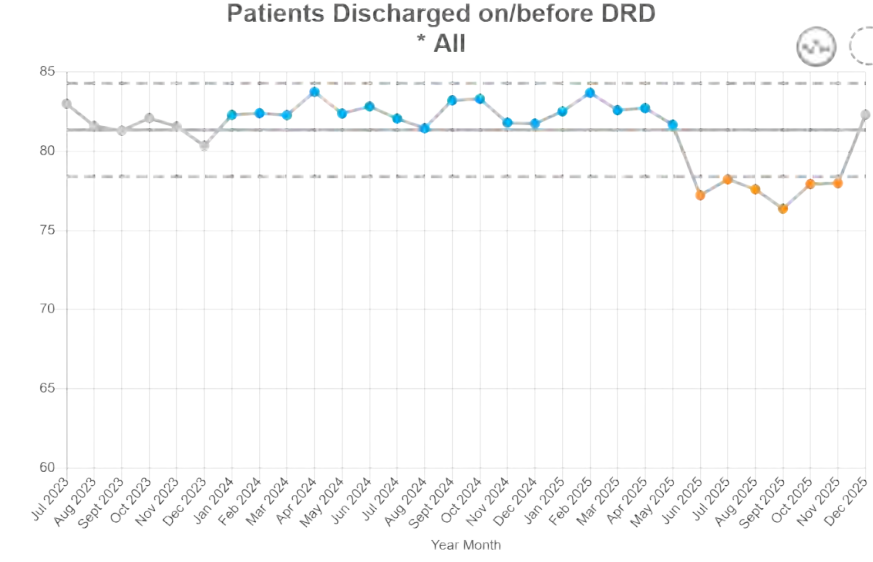
Performance is above national, peer and WY averages. For ECS the Trust performs in the upper decile of Acute Trusts in England.

Performance – To deliver our key performance targets and finance plan

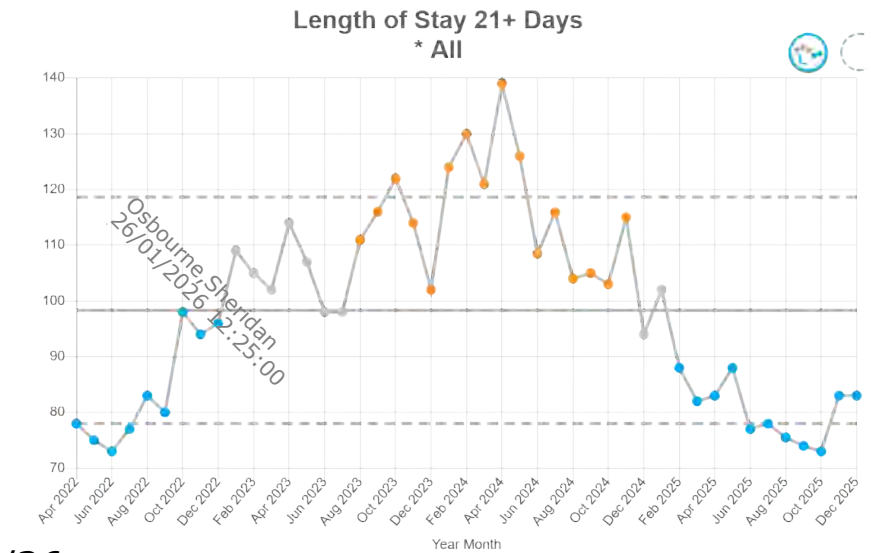
December 2025 – 90.76% occupancy – Year end target 93%
Common cause variation of a **concerning** nature



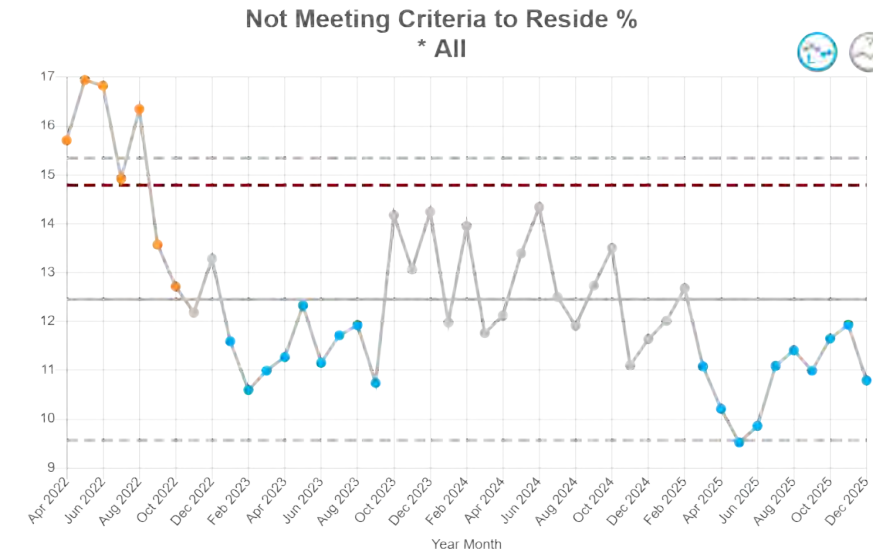
December 2025 – 82.32% occupancy – Year end target 93%
Common cause variation



December 2025 – 83 patients
Special cause variation of an **improving** nature



December 2025 – 10.79% – Year end target 14.79%
Common cause variation of an **improving** nature



Analysis

Total G&A bed occupancy reduced in December to 90.8% delivering below planned levels with increased NEL discharges observed. Patients with No Criteria To Reside (NCTR) has reduced in December with the average delays post Discharge Ready Date (DRD) showing a similar reduction.

Risks, Mitigations and Assurance

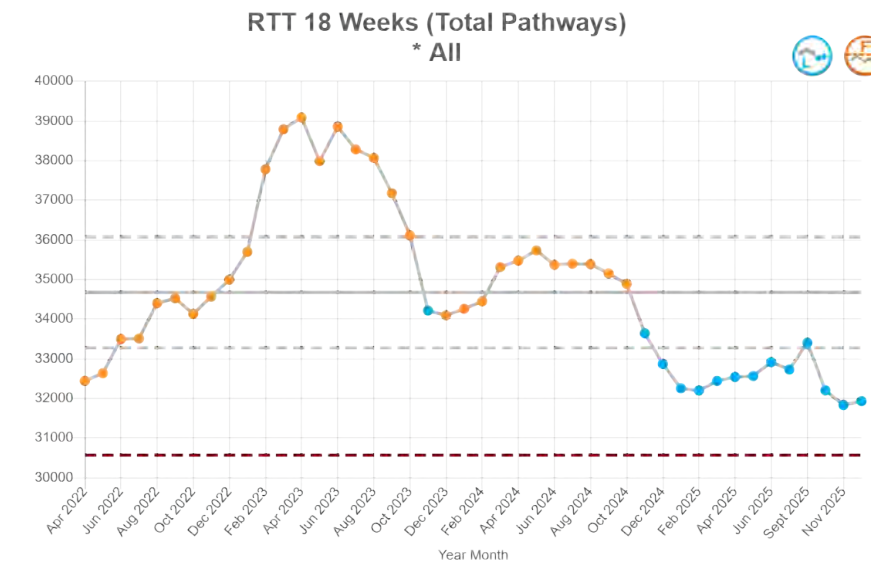
Work is ongoing with Local Authority partners to reduce delays for patients discharged on Pathway 1 (non-H-FAST), with CBMDC introducing a new programme aimed at minimising delays and increasing the number of discharges via H-FAST. Collaborative work with ASC, Bevan, and housing teams is also underway to address discharge delays linked to homelessness. A quality improvement project is underway within the Trust to improve Discharge plans, capture of data, and targeting of resource to reduce delays.

Benchmarking

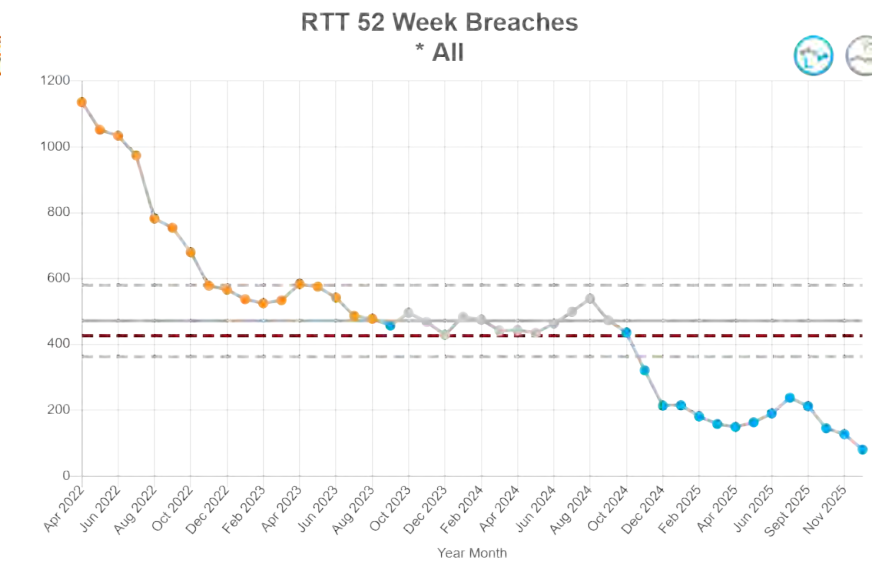
As a % of emergency spells the number of 21-day LoS for BTHFT continues to benchmark better than the national and peer averages and close to the best quartile nationally despite the increases.

Performance – To deliver our key performance targets and finance plan

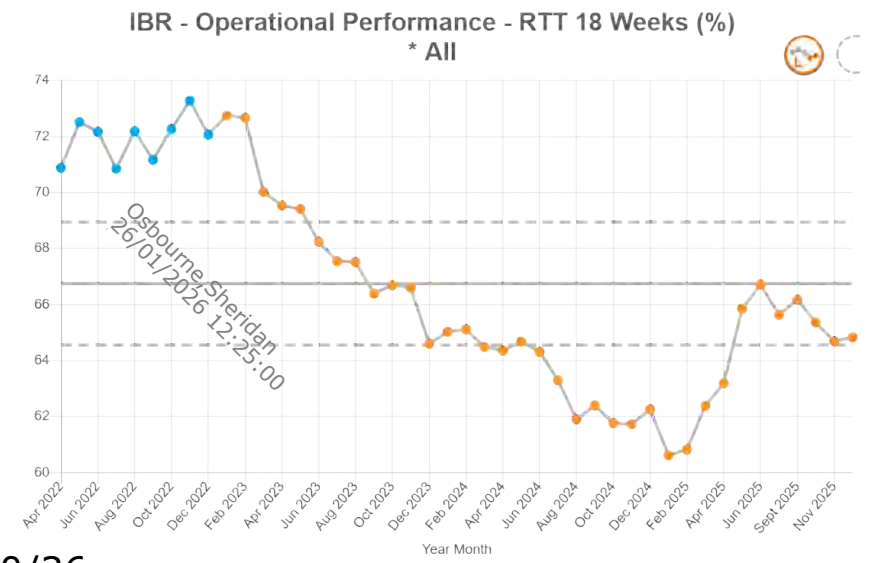
December 2025 – 31932 pathways – Year end target 30,571
Special cause variation of a **concerning** nature



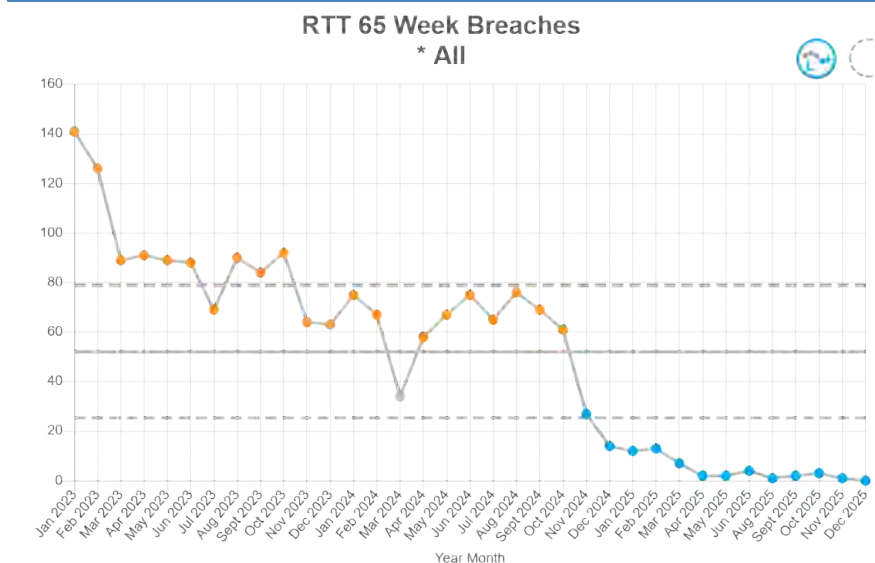
December 2025 – 80 pathways – Year end target 426
Special cause variation of a **concerning** nature



December 2025 – 64.83%
Common cause variation



December 2025 – 0 patient
Special cause variation of an **concerning** nature



Analysis

The RTT waiting list size rose slightly in December with reduced activity over the holiday period and due to strike action but is expected to resume falling in January as activity increases. The number of patients waiting over 52 weeks reduced in December due to a significant improvement in the Respiratory position, along with sustained improvement in Trauma and Orthopaedics who have 2 additional consultants now backfilling cancelled theatre session. No patient waited over 65 weeks, with the Trust meeting the national timescales set for clearance of this cohort.

Risks, Mitigations and Assurance

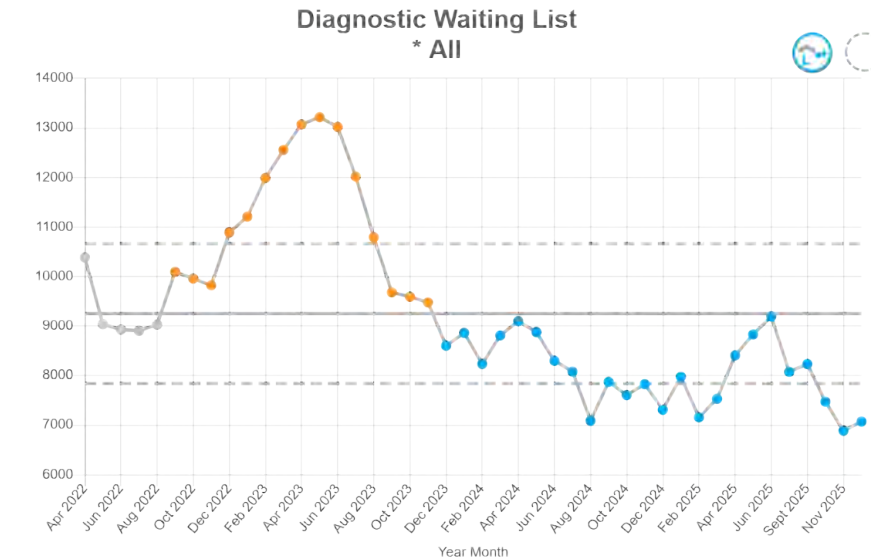
A Q4 outpatient sprint is expected to deliver 1500 extra new appointments and will positively impact the RTT position. Two new clinicians in Pain service will help stabilise their current capacity challenges delivering extra sessions each week. Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.82% in December 2025, this is the best position ever reported for the Trust. The number of DQ errors on RTT PTL reported on LUNA Dashboard remain low at 456 i.e. 1.40% of total waiting list size.

Benchmarking

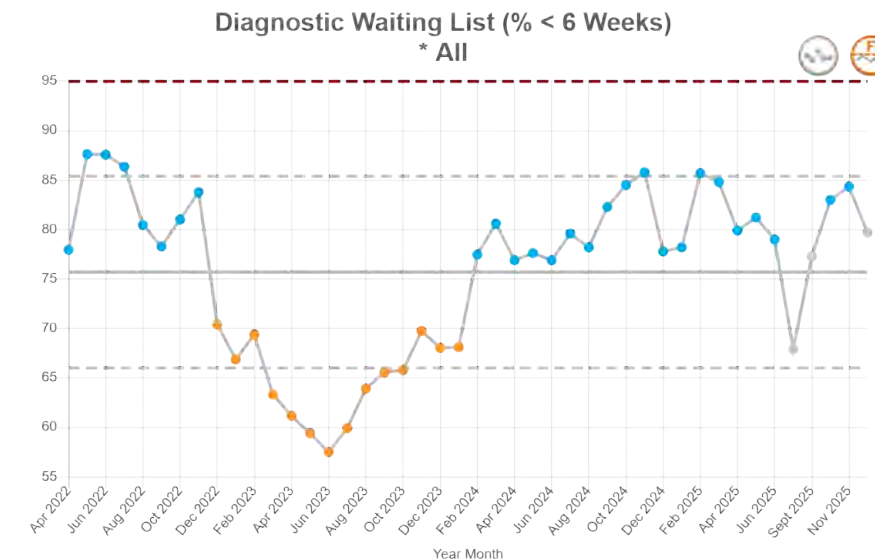
52-week performance benchmarks in the best quartile nationally whilst we are just below the best quartile for 18 weeks, although at the lower end compared to WYAAT.

Performance – To deliver our key performance targets and finance plan

December 2025 – 7071 pathways
Special cause variation



December 2025 – 70.7% <6 Wks – Year end target 95%
Common cause variation



Analysis

DM01 performance for December has reduced to 79.71% due to ongoing challenges in Audiology, Neurophysiology and Urodynamics. Insourcing remains in place for Non-Obstetric Ultrasound, but the unavailability of the locum has resulted in a temporary drop of activity and is delaying recovery.

Risks, Mitigations and Assurance

All recovery and long-term sustainability plans have been reviewed since last meeting and additional assurance sought from the operational leads for each area on the associated timescales. In Audiology, recruitment is ongoing while the service is continuing to offer overtime weekend clinics. The service remains closed to new adult referrals. Furthermore, insourcing has been approved and is now at the point of award. Neurophysiology continues to face staffing challenges, with no option to provide additional clinics due to costs. The service has now gone out to tender. In Urodynamics, partial booking was introduced and increased capacity is planned into the new year. Staff have now also had additional training to ensure attendance and discharges are accurately recorded in all systems.

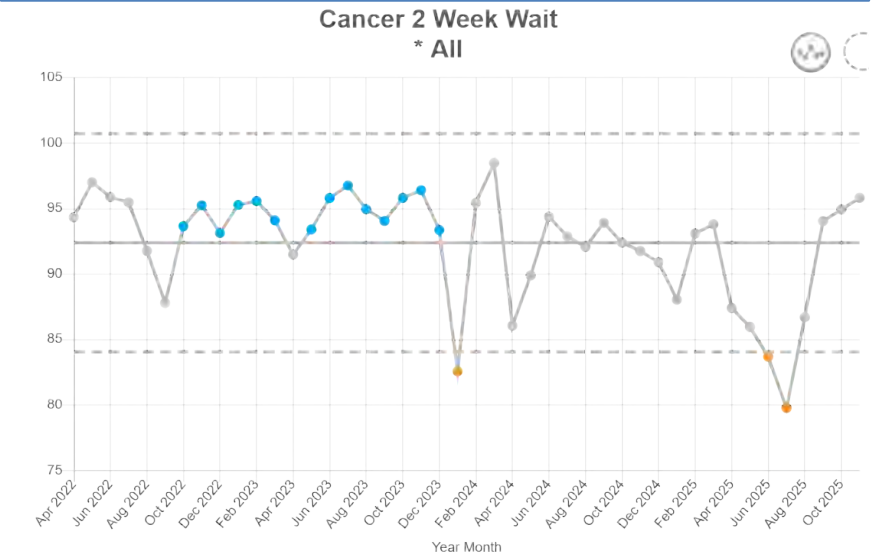
Benchmarking

Performance was improving towards national and peer average.

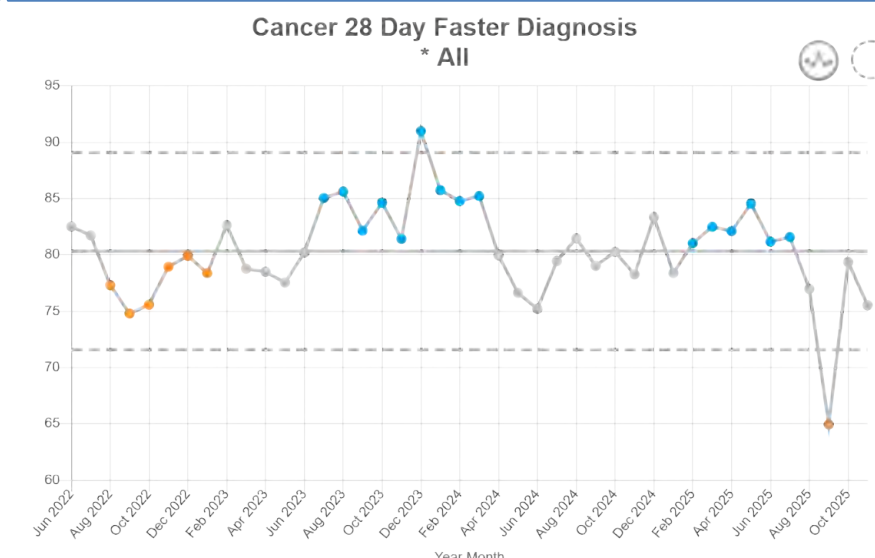
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Performance – To deliver our key performance targets and finance plan

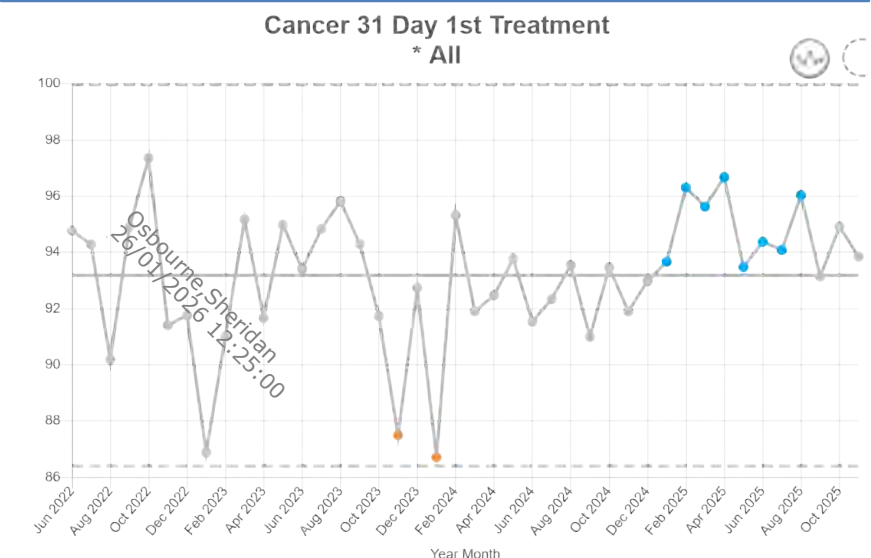
November 2025 – 95.82%
Common cause variation



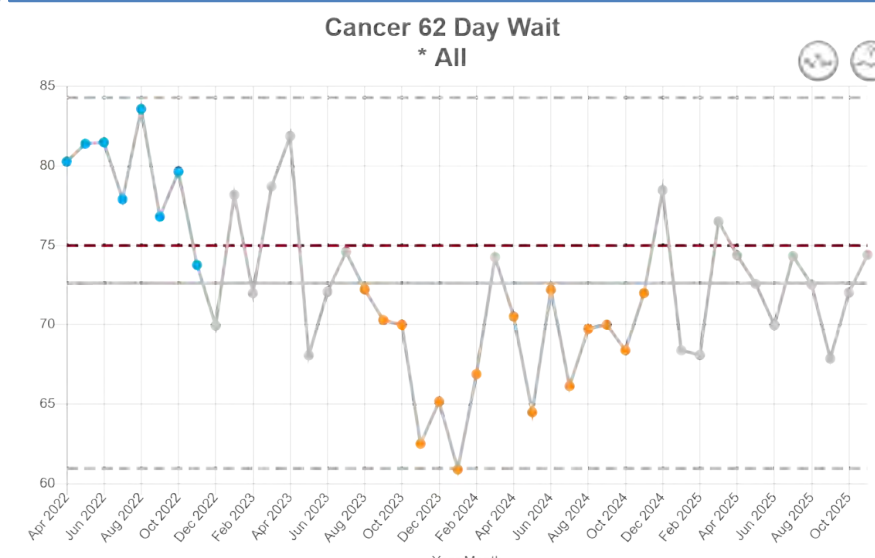
November 2025 – 75.53%
Common cause variation



November 2025 – 93.85%
Common cause variation



November 2025 – 74.4%
Common cause variation



Analysis

Two week wait (2WW) performance is predicted to improve on the November position of 94.4% in December. The FDS performance for December is forecast to be below the 80% target. December performance against the 62 Day standard is also forecast to remain below plan.

Risks, Mitigations and Assurance

The Skin and Gynaecology pathways continue to be impacted by histology reporting backlogs. For Lower GI, capacity is being strained by a combination of the Bowel Cancer Screening age reduction and increased referrals, coupled with reduced capacity due to retirement; however, related typing backlogs have now been addressed.

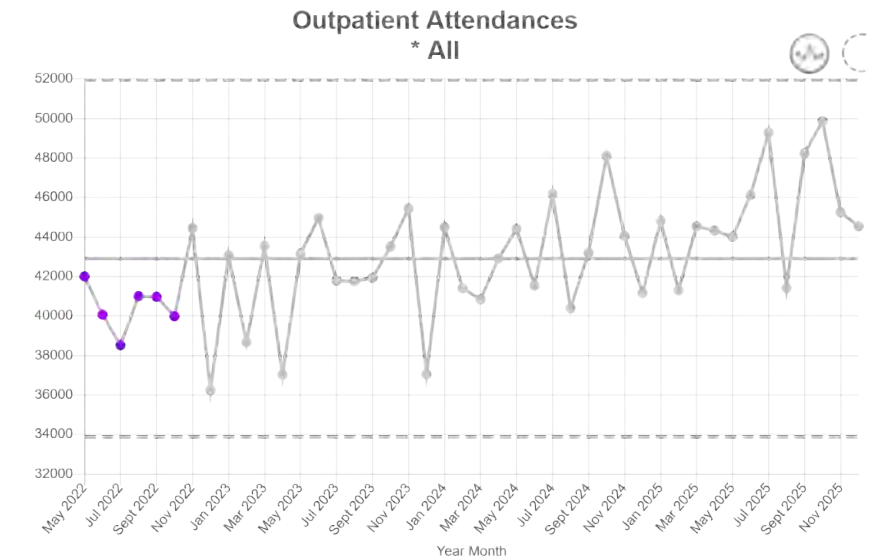
Across all pathways, patient compliance issues are noted as an overarching challenge. Initiatives such as proactive phone calls to patients likely to DNA, bus tickets to encourage attendance and targeted engagement work in Endoscopy remain in place. Work on MDT streamlining continues with the MDT Programme which is targeting objectives to improve this stage of the patient pathway along with a system wide focus on improvements for notifying patients of a benign cancer diagnosis and improving reporting processes.

Benchmarking

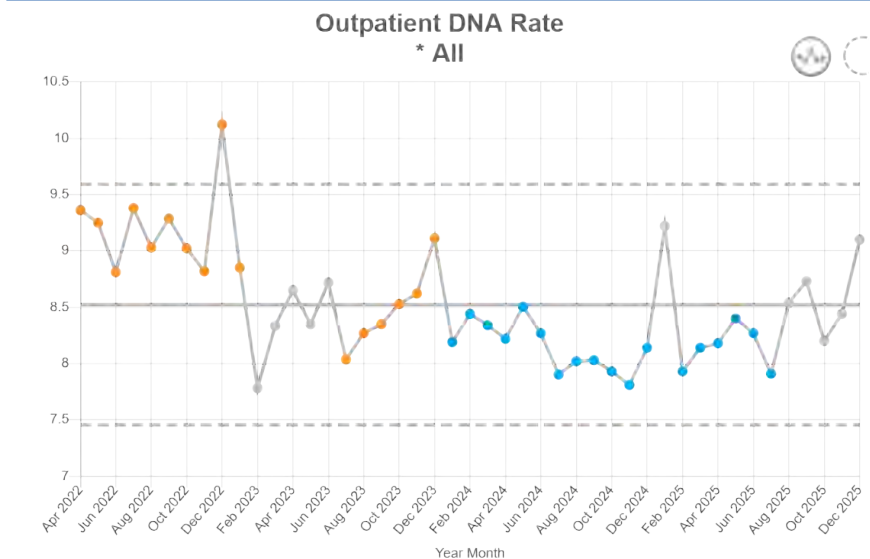
Despite challenges the Trust continues to benchmark above national and peer averages.

Performance – To deliver our key performance targets and finance plan

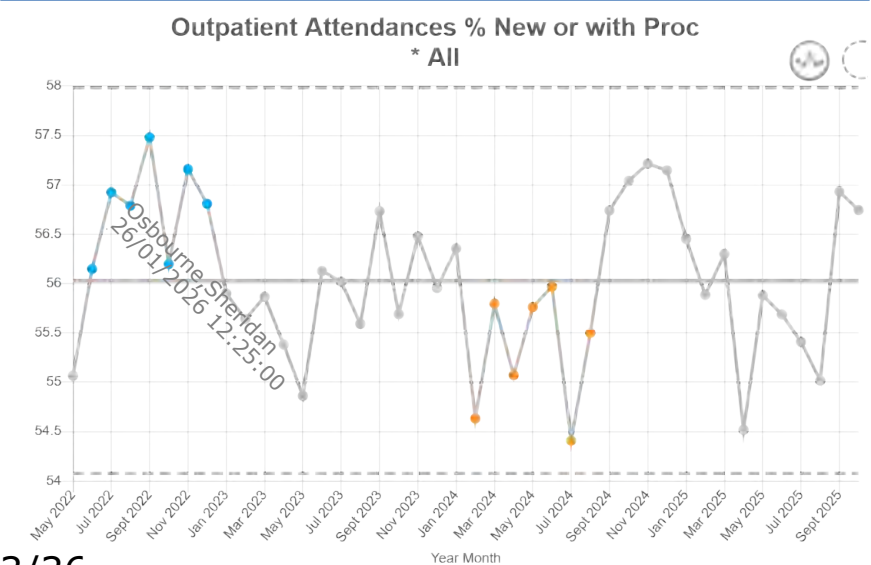
December 2025 – 44,548
Common cause variation



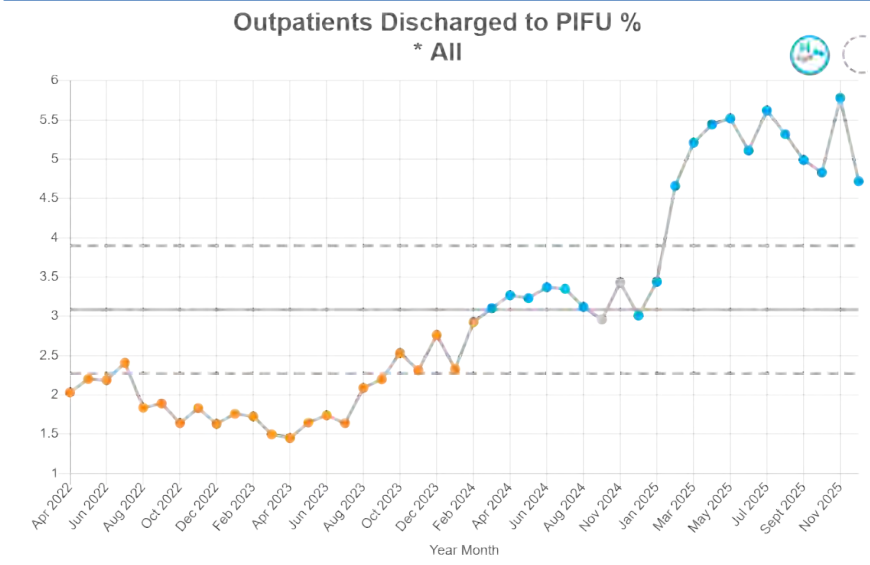
December 2025 – 9.1%
Common cause variation



December 2025 – 56.35%
Common cause variation



December 2025 – 4.72%
Special cause variation of an **improving** nature



Analysis

Outpatient activity delivered slightly above plan, although the percentage that are new or with procedure remained behind plan. PIFU use continues to improve but increasing follow up demand remains an issue although the number of RTT clock stops increased.

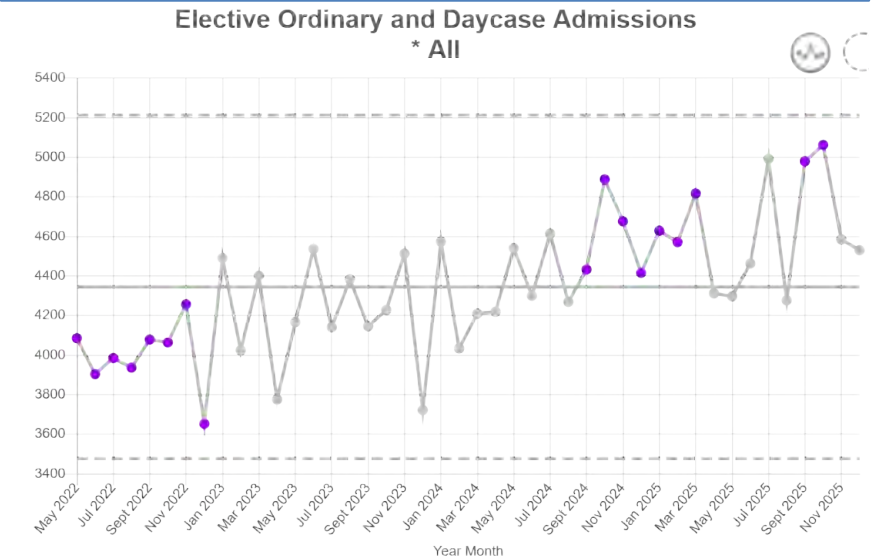
Risks, Mitigations and Assurance

We are addressing these trends though Outpatient Transformation which is focussed on service led pathway redesign supported by digital advancement and alignment of support processes. A straight to Advice & Guidance trial with Paediatrics is underway with LMC support and several other services ready to follow. This will increase A&G revenue whilst also reducing demand for new appointments. Service Improvement are setting up training, engagement and drop-in sessions to mobilise the use of model for improvement at a service level. This will move us from further faster action plans to PDSA cycles for specific change ideas. Clinical engagement is planned for the next Hospital Management Group. EPR and RTT training plans are being developed alongside this engagement strategy, supported by expert teams.

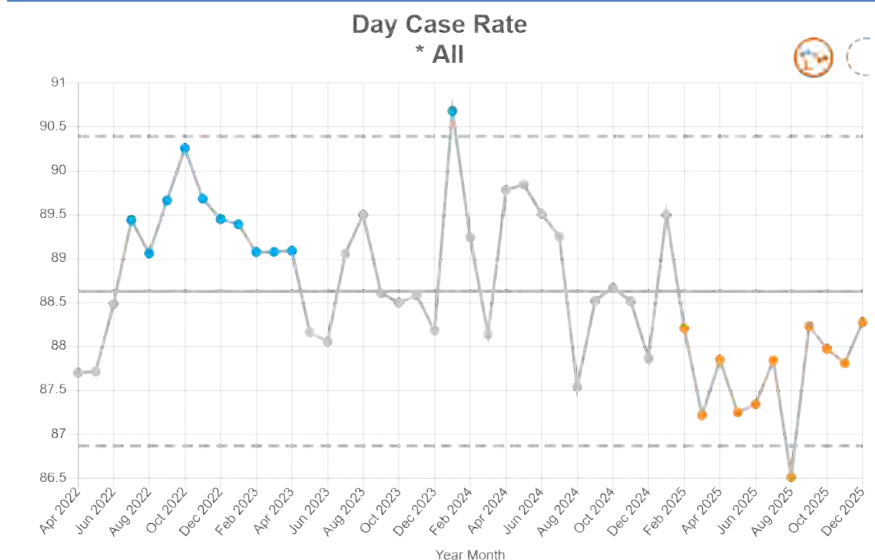
Benchmarking

Performance – To deliver our key performance targets and finance plan

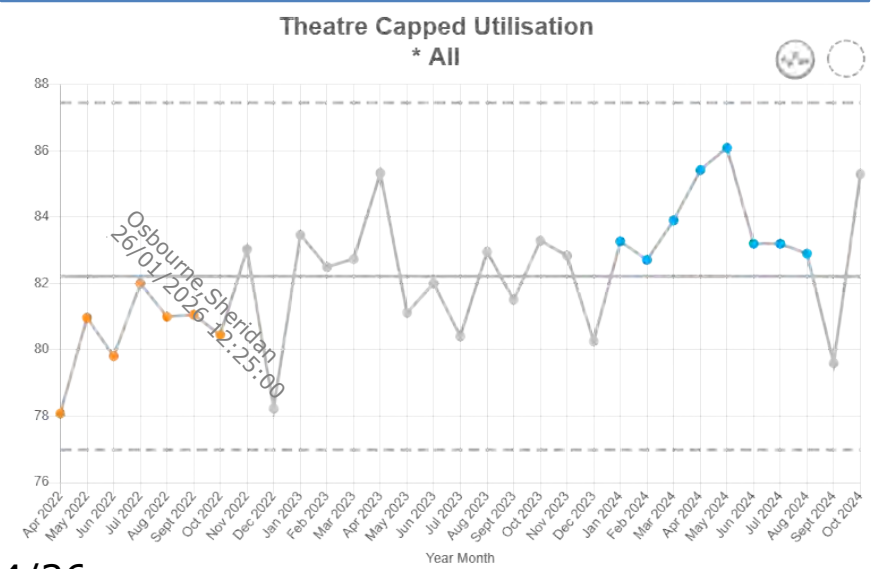
December 2025 – 4530
Common cause variation



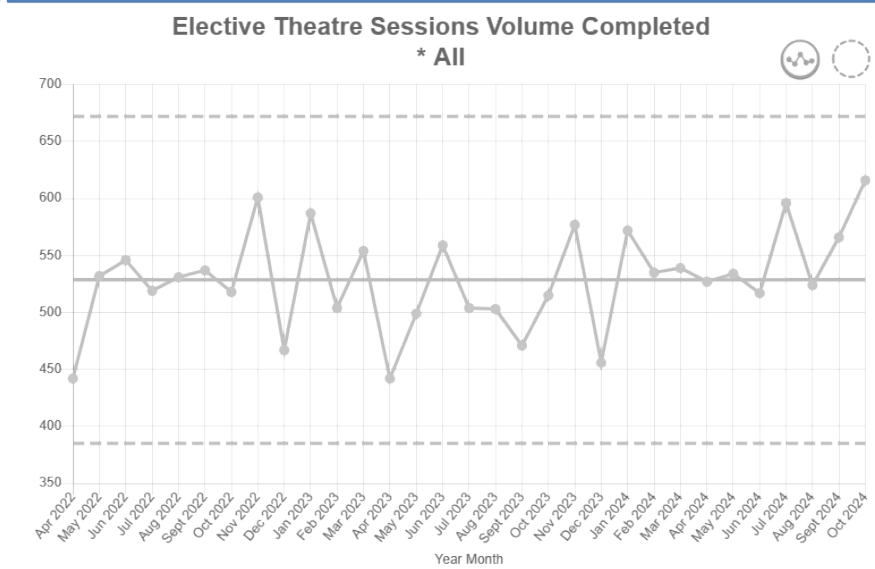
December 2025 –88.27%
Common cause variation



October 2024 – 85.3%
Common cause variation



October 2024 – 616
Common cause variation



Analysis

Activity remains behind plan due primarily to the Day Case Unit delay. Mitigation includes weekend lists, but activity is forecast to remain slightly below plan in January.

Risks, Mitigations and Assurance

Theatre efficiencies aiming to increase the number of lists run and the number of patients per list continue to progress into 2025/26 as a key part of our operational excellence plan with productivity targets aligned to national analysis and the operational planning trajectories set with NHSE. Weekend lists are running to mitigate the DCU delays. Theatre productivity data is being provided in support of financial recovery.

Benchmarking

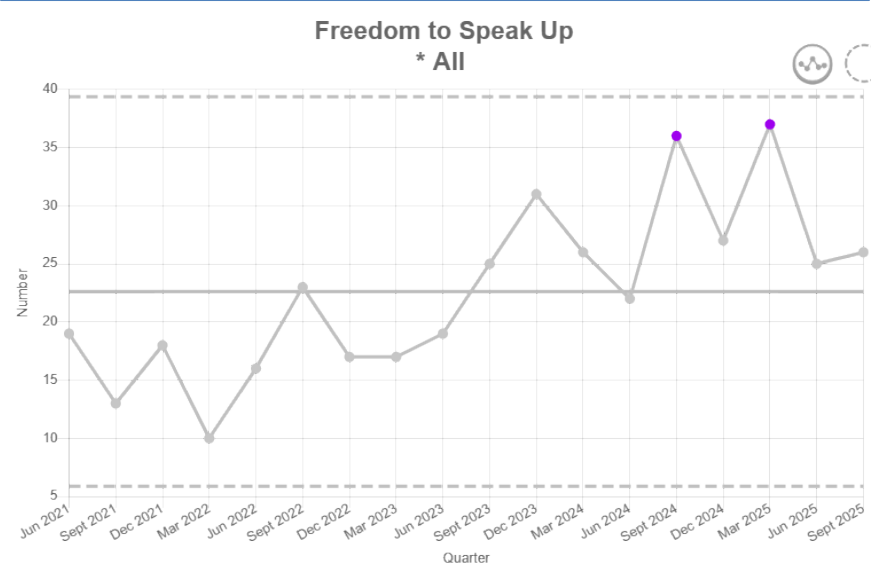
Benchmarking not available due to the issues with reporting post TACC implementation.

Metric	Period	Latest Value	Target	Variation	Assurance	Mean
Agency - %	Nov-25	0.72%				2.10%
Appraisal Rate - Non-Medical	Nov-25	81.0%				75.36%
BAME Split - Band 8+	Sep-25	21.1%				17.45
BAME Split - Bands 1-5	Sep-25	52.9%				43.91
BAME Split - Bands 6-7	Sep-25	31.3%				25.57
BME - * All	Sep-25	45%				38.47
Core Mandatory Training - * All	Nov-25	92.7%				90.90%
Disability Declaration - * All	Sep-25	6.0%				3.9%
Freedom to Speak Up - * All	Jul 25 - Sep 25	26.00				21.00
Harrassment and Bullying - Disciplinary Action	Apr25 - Sep 25	1				0.67
Harrassment and Bullying - Informal Action	Apr25 - Sep 25	0				3.00
Harrassment and Bullying - In-progress	Apr25 - Sep 25	11				7.00
Harrassment and Bullying - No Case To Answer	Apr25 - Sep 25	5				3.00
Harrassment and Bullying - Resigned	Apr25 - Sep 25	0				0.67
Harrassment and Bullying - Total Investigations	Apr25 - Sep 25	17				14.33
Job Planning - Allied Health Professionals	Dec-25	60.0%				49%
Job Planning - Medics	Dec-25	59.0%				25%
Job Planning - Nurses	Dec-25	2%				60%
Nursing Agency Fill Rate - %	Dec-25	7.0%				11.8%
Nursing Bank Fill Rate - %	Dec-25	64.8%				50.6%
Staff Advocacy - Contacts	Apr25 - Sep 25	12				14.00
Staff Advocacy - Contacts Not Resolved	Apr25 - Sep 25	0				0.00
Staff Advocacy - Formal Complaints/Investigations	Apr25 - Sep 25	0				0.67
Staff Advocacy - In-progress	Apr25 - Sep 25	3				0.67
Staff Advocacy - Outcome Unknown	Apr25 - Sep 25	3				0.33
Staff Advocacy - Resolved Informally	Apr25 - Sep 25	6				9.00
Staff Sickness - * All	Nov-25	6.41%				6.3%
Staff Stability - * All	Nov-25	99.25%				98.8%
Staff Turnover - * All	Nov-25	10.41%				11.1%

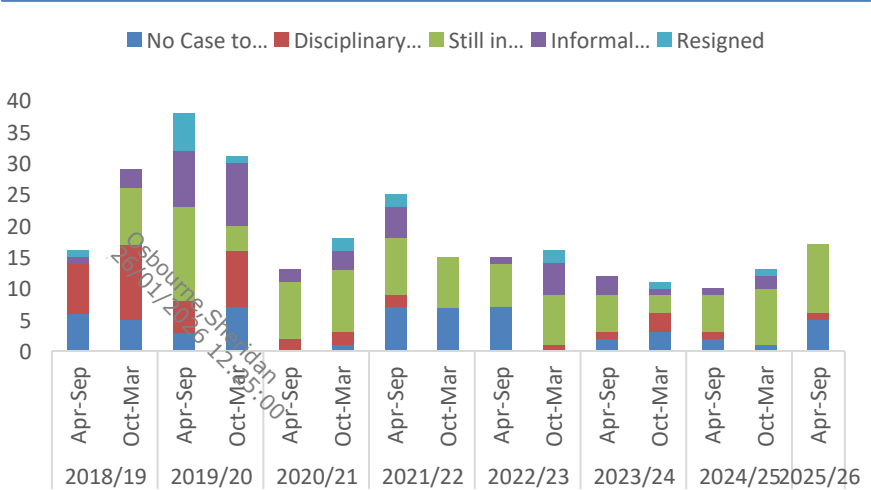
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People – Engagement – To be in the top 20% Employers

2025/26 Quarter 2 - 26



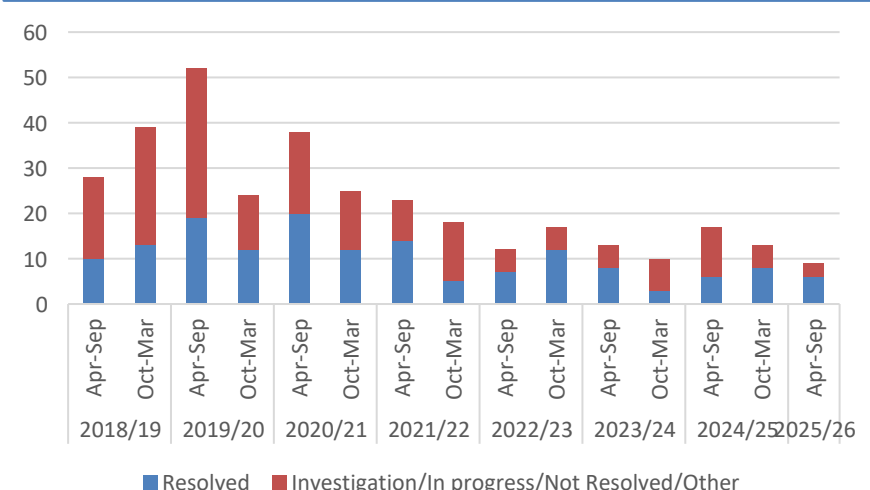
2025/26 Quarter 2 Harassment and Bullying



2025/26 April to September– Staff Advocacy

Month	Contacts	Formal complaint/ investigation	Resolved Informally	In Progress	Contacts not resolved	Outcome unknown
Apr 18 - Sep 18	28	5	10	6	3	4
Oct 18 - Mar 19	39	18	13	5	3	6
Apr 19 - Sep 19	52	11	19	6	4	12
Oct 19 - Mar 20	24	3	12	2	1	8
Apr 20 - Sep 20	38	4	20	5	1	8
Oct 20 - Mar 21	25	1	12	2	1	9
Apr 21 - Sep 21	23		14			
Oct 21 - Mar 22	18	5	5	4	0	4
Apr 22 - Sep 22	12		7			
Oct 22 - Mar 23	17		12			
Apr 23 - Sep 23	13	2	8	2		1
Oct 23 - Mar 24	10	0	3	3	1	3
Apr 24 - Sep 24	17	1	6	4		6
Oct 24 - Mar 25	24	0	8	5	0	11
Apr 25 - Sep 25	12	0	6	3	0	3

2025/26 April to March –Staff Advocacy



Analysis

Harassment & Bullying Outcomes: An increase in the number of formal cases (with 8 new cases in the last 6 months). 3 of the ongoing cases are delayed due to long term sickness. Also, there has been an increase in investigations resulting in 'no case to answer'. Limited activity in terms of informally resolved cases and 1 case was withdrawn by the complainant. Just 1 case resulting in disciplinary action during the last 6 months.

Contacts with staff Advocacy Service: Despite the rise in formal cases, we have seen reduced contacts with the Staff Advocacy Service in the last 6 months (from 24 to 12 cases). However, the proportion of cases being supported that were resolved informally increased from 33% to 50%.

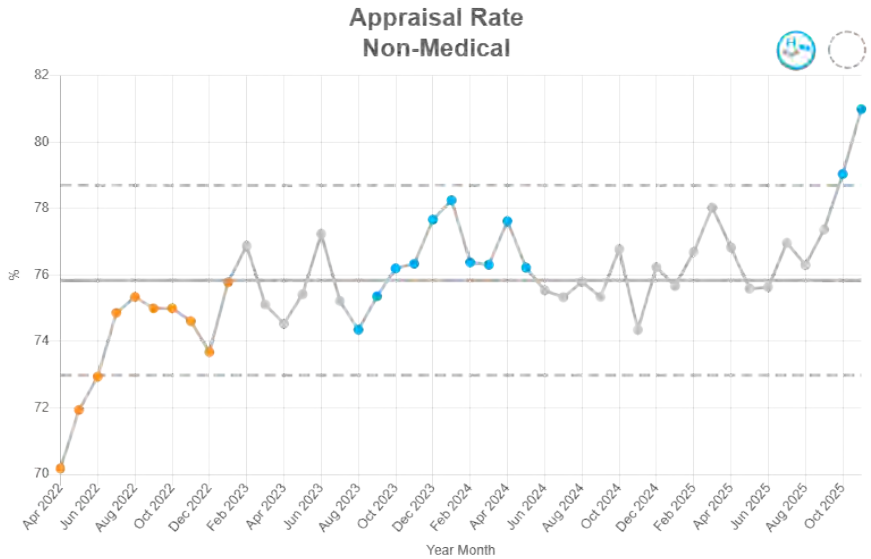
Freedom To Speak Up: There were 26 concerns raised to the FTSU team in Q2. The highest category of concerns (15) had an element of worker safety or wellbeing and there were 8 concerns raised that had an element of other inappropriate attitudes or behaviours. This quarter, the highest group of staff raising concerns were registered nurses and midwives (9). There were 5 concerns reported anonymously in Q2 via the FTSU App

Risks, Mitigations and Assurance

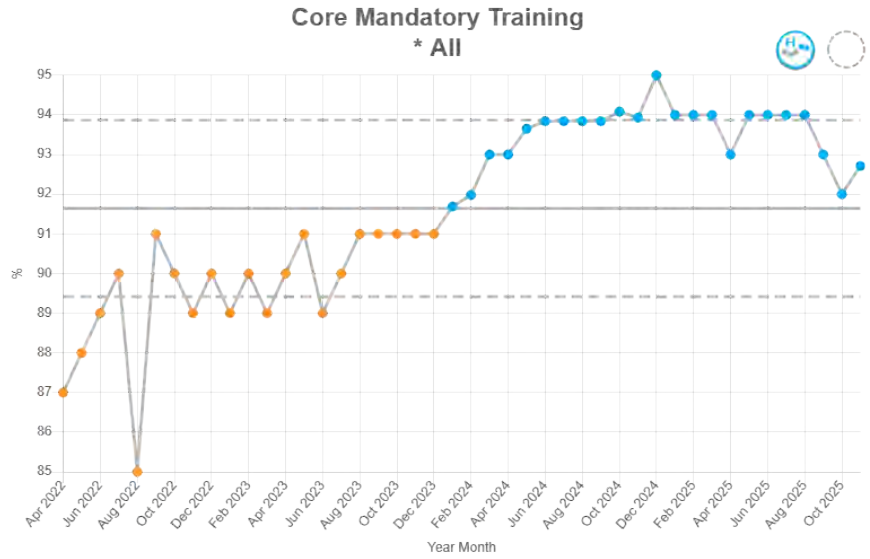
Harassment & Bullying Outcomes: Further focus and efforts are required in terms of raising awareness around informal conflict resolution. This will be a key area of focus in the next 12 months as we launch the newly developed Respect, Civility & Resolution policy. This will involve a targeted implementation plan, with emphasis on training managers in workplace facilitated discussions and also refreshing existing mediators and recruiting further mediators. Further work will develop in raising the profile of the Staff Advocacy service including recruiting and training new advocates. At the recent EDI Belonging conference there was a session provided by Collingwood Learning which provided a creative form of live interactive theatre. Actors adopted various personas to reflect and act out common workplace experiences of incivility, encouraging audience reflection and participation. Feedback around this session has been extremely positive, which will be explored in relation to potential future learning opportunities.

People – Engagement – To be in the top 20% Employers

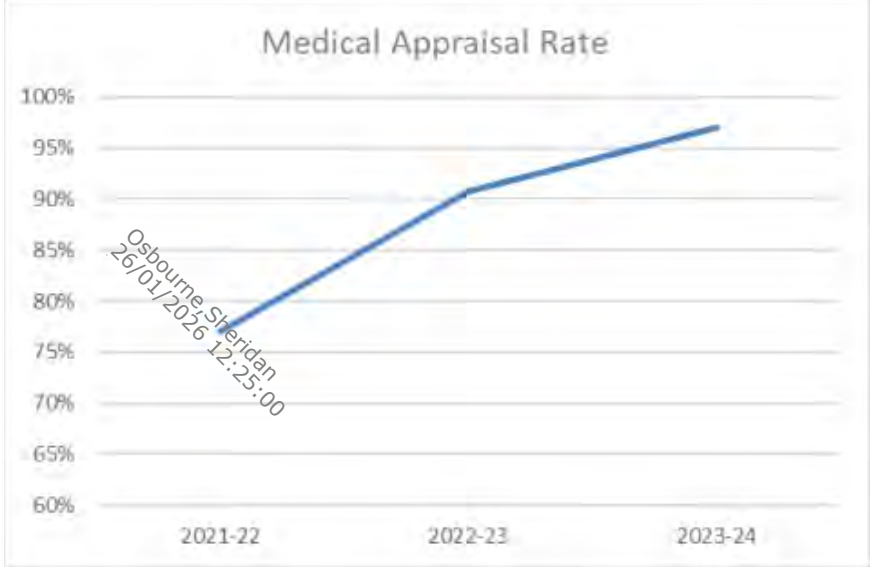
November – 80.99%
Common cause variation of an **improving** nature



November 2025 – 92.7%
Common cause variation



March 2024 – 97%



Analysis

Core Mandatory Training

- Overall Trust compliance continues to be above the Trust target of 85%, staying above 90% over the last several months.
- All CSU's continue to achieve above the 85% target, with several achieving an increase of 1% or more over the last quarter.

Appraisal

Since April 2024 the target for non-medical appraisal has been set at 85%. Appraisal compliance has increased slightly during September 2025, to 77.4%.

Medical Appraisal Rate

Medical Appraisal year from 1st April 2024 to 31st March 2025: 488 (92.9%) doctors received an Outcome Measure 1 (Completed appraisal). 37 (7.1%) doctors were allocated an Outcome Measure 2 (Approved Missed appraisal).

Risks, Mitigations and Assurance

Core Mandatory Training

Overall compliance for December was 93%, no change from November. The majority of subjects maintained their compliance % from last month. Safeguarding Children Level3 compliance dropped by 3% to 70%. Increased numbers of newly qualified staff have contributed to the drop over the last few months.

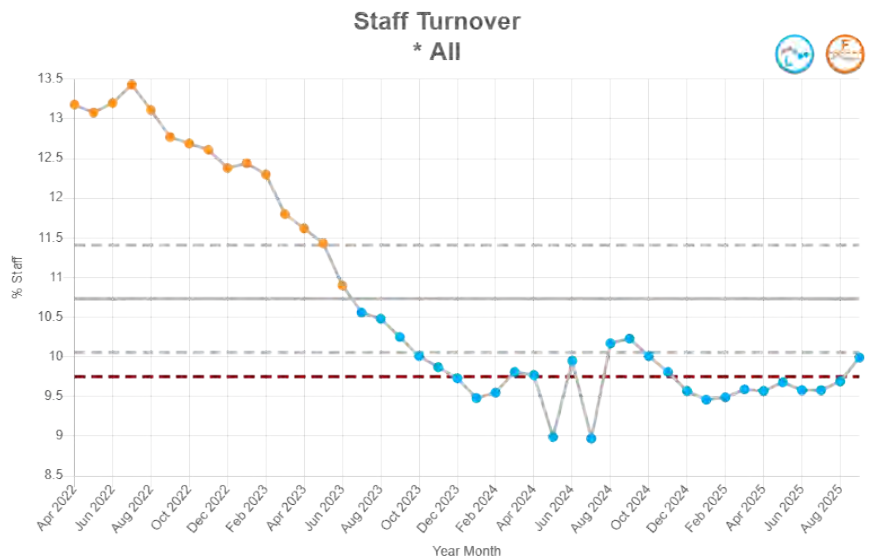
Estates & Facilities compliance % for Infection Prevention for both L 1 & L2 dropped by 2% from November.

Targeted actions continue for subjects below 85% to improve compliance across all areas.

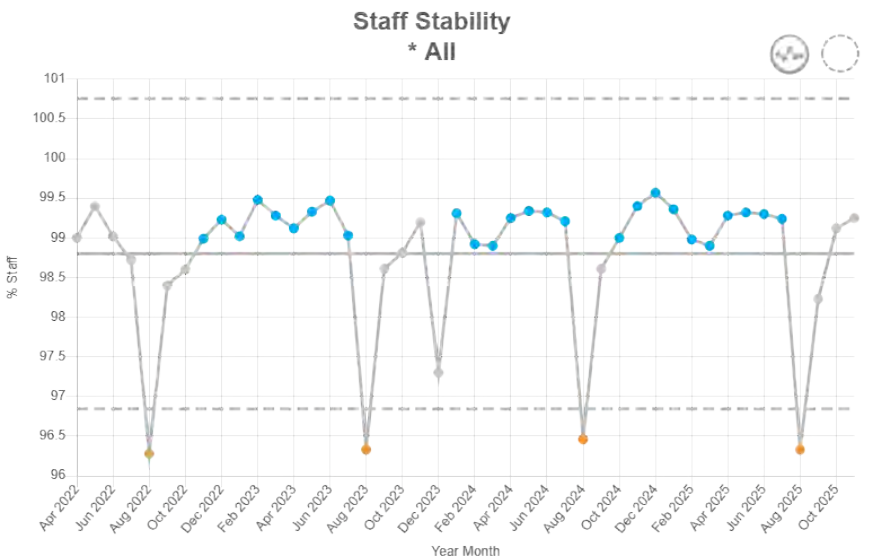
Appraisals are central to creating an environment of continuous learning and improvement; they unlock the potential of our people, developing individual performance and driving personal and professional development. Appraisals ensure everyone is working towards our Trust Strategic Objectives; understand how they contribute to achieving our Vision and are clear of what is expected of them. Our new 1-1 framework, 'Dynamic Conversations' and new appraisal approach 'Dynamic Conversation Appraisals' were launched in July 2025. Paperwork, a useful video and a supportive guide are available via the Thrive portal, and participants at Leading at a Higher Level are given an opportunity to explore and practice the new approach. In addition, the OD team are currently meeting with every service to offer a bespoke training package around what a great appraisal looks like, how to hold a quality, coaching style conversation and how to update ESR.

People – Engagement – To be in the top 20% Employers

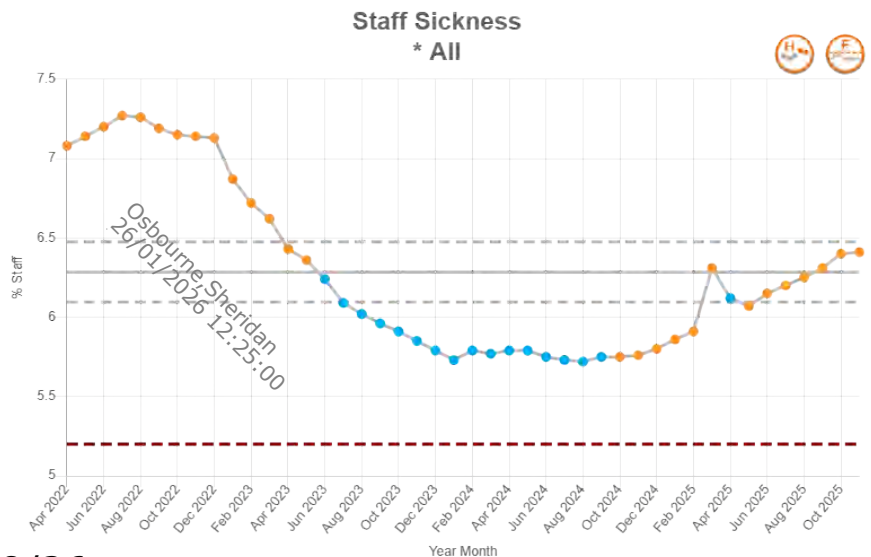
November 2025 – 10.41%
Special cause variation of an **improving** nature



November 2025 – 99.25%
Common cause variation



November 2025 (rolling 12 months) – 6.41%
Special cause variation of a **deteriorating** nature



Analysis

Sickness in November 2025 is 6.94% and the YTD figure is 6.41%, in comparison with September 2025 where the monthly sickness rate was 6.62% and the YTD figure was 6.31%.

The staff groups with the highest sickness rates in November 2025 are Additional Clinical Services at 9.87%, Estates & Ancillary at 8.95%, Add Prof Scientific and Technic at 8.25%, Admin and Clerical at 7.22%, Allied Health Professionals at 6.95%, Nursing & Midwifery at 6.91%, Healthcare Scientists and Medical & Dental are below target for the month of November with the rates of 4.32%, 2.32% respectively. The overall YTD sickness % has remained consistently above 5.5%. In August 2024, we saw a steady increase in monthly sickness absence rates with a peak in March and then a slight drop in April and May 2025 with further increases in subsequent months in 2025.

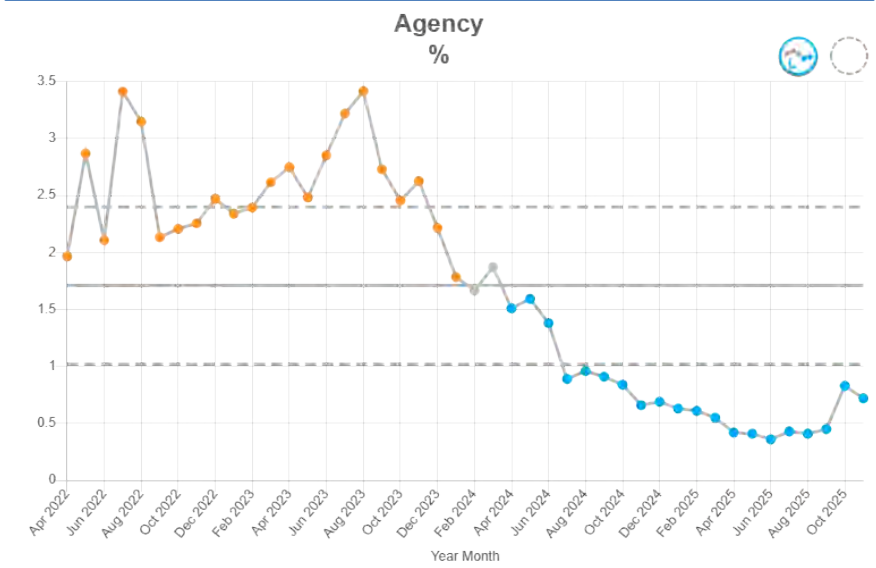
Turnover - The monthly turnover rate in November 2025 is 10.41%, compared to September 2025 which was 9.6%, however this remains below the Mean of 10.8%
The stability index shows the percentage of all colleagues including rotational doctors and fixed-term appointments who are still in post at the end of the month and who were in post at the start of the month.

Risks, Mitigations and Assurance

Since July 2022 sickness rates were on a downward trajectory, however, since August 2024, we are seeing a steady rise, month on month in those rates.
The following measures have been implemented to improve rates;
Sickness action plans have been designed to support CSU's to reduce their sickness rates, with key strategies and timeframes. As part of these plans be-spoke service level training will be provided as and when required.
Briefing sessions have been undertaken regarding manager roles and responsibilities in relation to the Health, Wellbeing and Management of Attendance Policy; including promotion of the support the Trust can provide to employees and managers.
Regular monthly meetings are scheduled for managers and members of the HRBP team to review sickness cases and obtain assurance that cases are being progressed in a timely manner, and in accordance with policy.
The HRBPs continue to attend monthly CSU Triumvirate and Performance meetings where sickness rates are discussed alongside ward/department turnover rates.
Feedback and improvement plans from staff surveys are also a critical element of the process and need to be considered alongside other action plans.
The HRBP team will continue with the work regarding 'deep dives' in relation to high Bradford Factor Scores, and where CSU sickness rates remain consistently above target, with minimal reduction in sickness levels; assessing reasons for absences, common themes and what preventative and proactive measures can be put in place.
Whilst turnover rates have improved over the last 2 years, we have seen a slight increase in turnover since July 2025. As at November 2025, the highest turnover rate was within Estates and Facilities at 11.67%, followed by Unplanned Care Services at 11.01%, Diagnostics and Corporate Operational Services at 10.51% and then Planned Care at 10.26%.

People – Engagement – To be in the top 20% Employers

November 2025 – 0.72%
Special cause variation of an improving nature

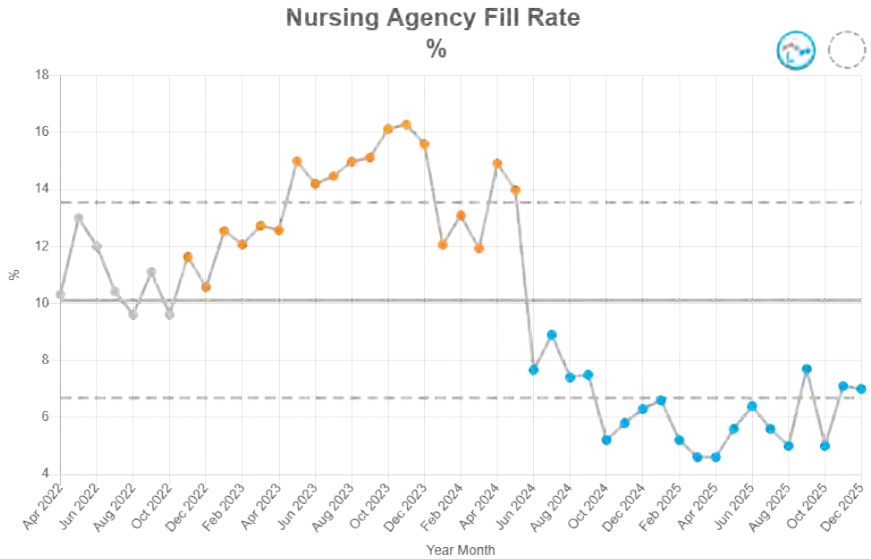


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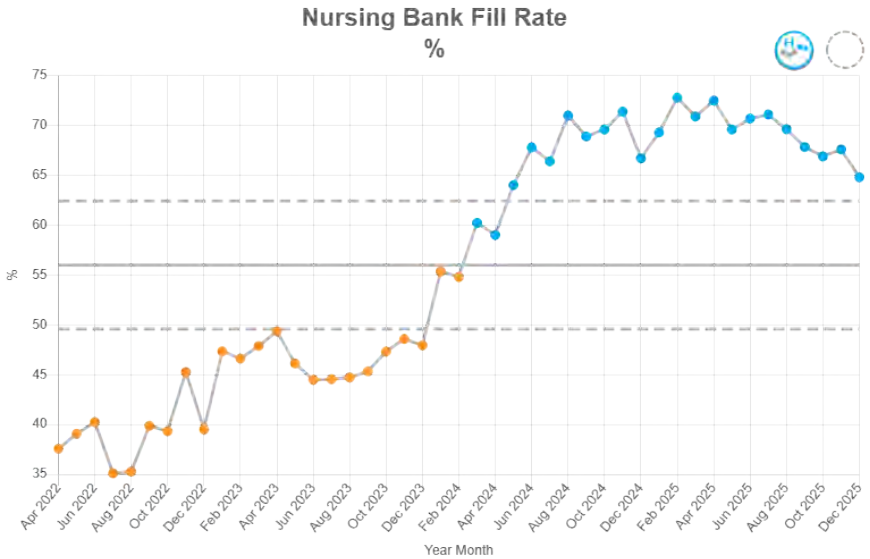
Analysis
There has been an overall increase in agency paid in September 2025 (worked in August 25). The decrease has been in the following staff group Medical and Dental. Increases in agency have been in the following staff groups, Nursing and Midwifery, Professional Scientific & Technical and AHP's. Admin and Clerical remain the same as last month. Estates and Facilities, Additional clinical services and Healthcare scientists have used no agency during September 2025.
Risks, Mitigations and Assurance
The Trust wide bank is working across the Trust to reduce the reliance on agency. CSU's are working to remove agency where it is safe to do so. No risks have been identified by the removal of agency.

People – Engagement – To be in the top 20% Employers

December 2025 – 7.0%
Special cause variation of an improving nature



December 2025 – 64.8%
Special cause variation of an improving nature



Analysis

Bank Staffing Nursing
In November the total number of requests sent to bank was 9741 compared with October's requests of 9864 an increase of 123 requests. This is split as 4184 requests for registered staff and 5557 requests for unregistered staff. Of those 4184 registered requests a total of 2828 were filled by bank staff which is 67.6% compared with 69.9% in October with a decrease of 1.04%. Out of the 5557 requests for unregistered staff 3892 were filled by bank which is 70% compared to October which was 76% a decrease of 6%.

Agency Nursing
Agency shifts filled for November were 295. This is split 295 registered and 0 unregistered staff. Out of the 295 filled registered shifts, 154 were filled with registered theatre staff. In November Agency fill rates increased overall from October by 2.1% for registered staff, unregistered remains at zero usage. This is due to increased demand from A &E.

Risks, Mitigations and Assurance

From the 20th November 2023 a new nursing agency approval process was put in place to give assurance around agency use for nursing. Reports are being shared on a monthly basis with Nursing workforce lead.

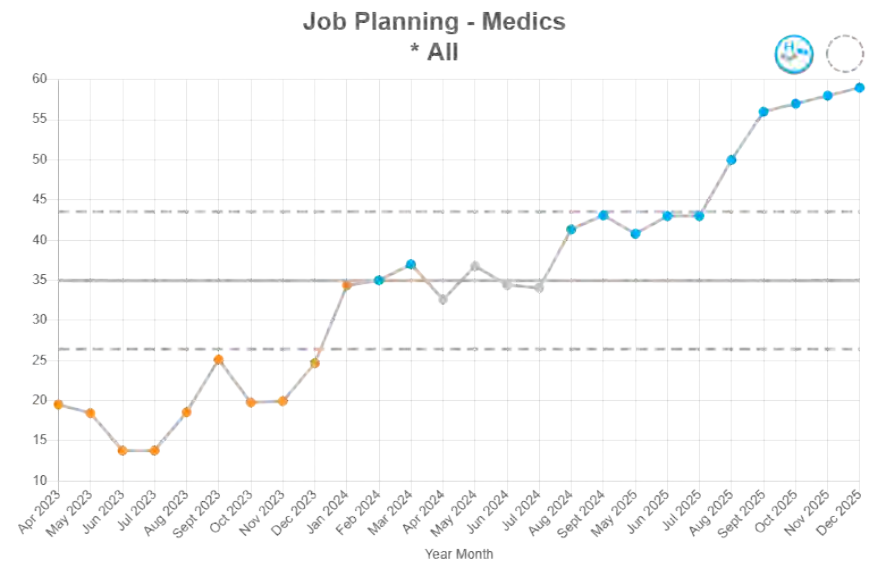
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People – Engagement – To be in the top 20% Employers

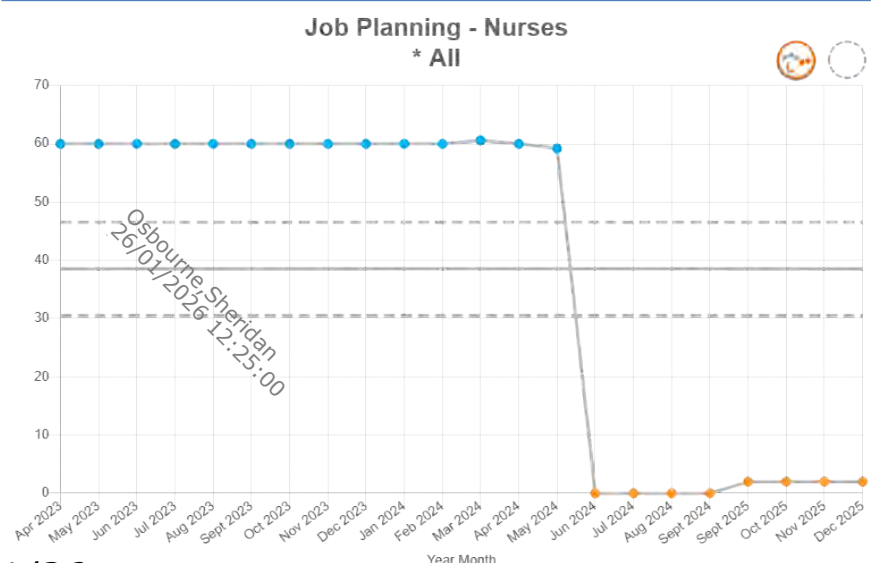
December 2025 – 60%
Special cause variation of an **improving** nature



December 2025 – 59%
Special cause variation of an **improving** nature



December 2025 – 2.0%
Special cause variation of a **deteriorating** nature



Analysis

Job planning - Medics
There are currently 452 Medics registered within the system. 270 are signed off which is 60%.

Job Planning – AHP
There are currently 429 AHP registered within the system. 252 are signed off which is 59%.

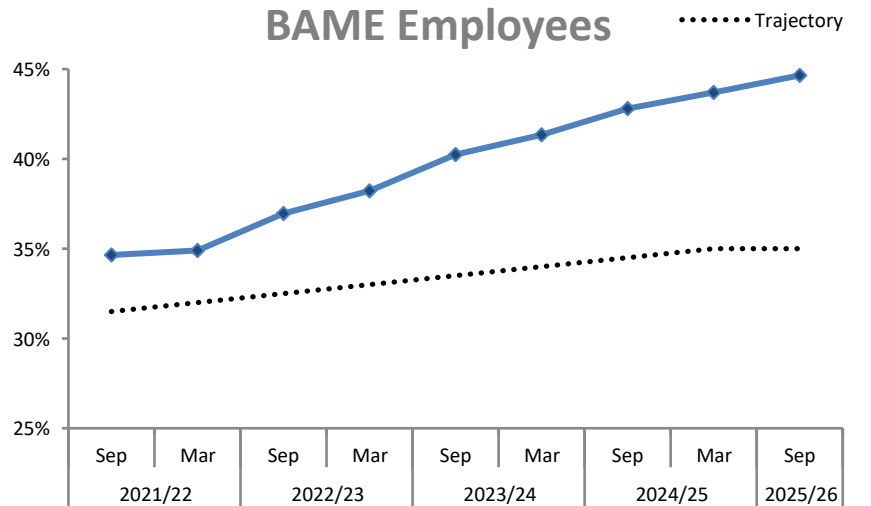
Job Planning – Specialist Nursing
There are currently 215 CNS registered within the system. 5 are signed off which is 2%.

Risks, Mitigations and Assurance

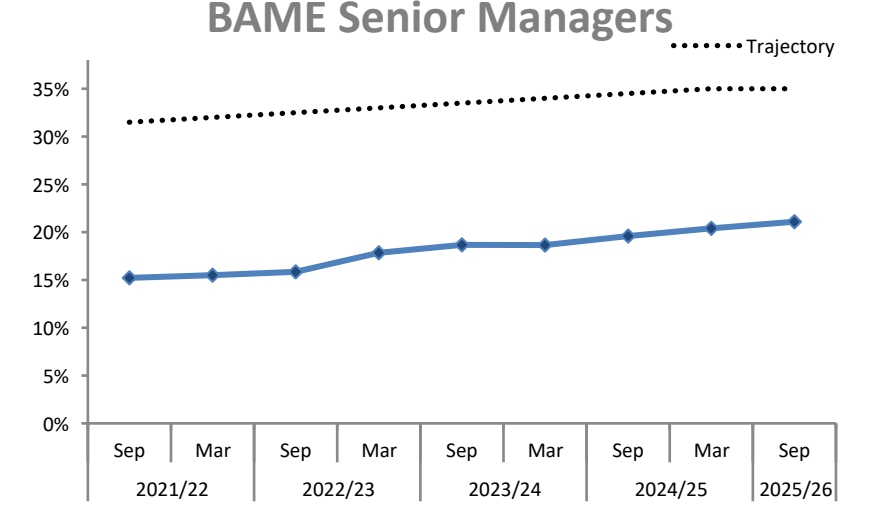
Non-medical job planning guidance will provide support with completion of CNS and AHP job plans.
Ongoing support to Medics colleagues to achieve 90% signed off job plans.

People – Engagement – To be in the top 20% Employers

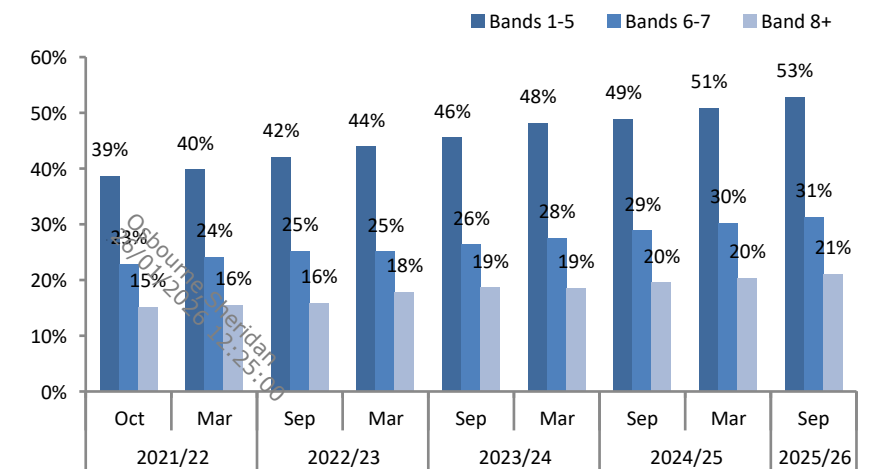
2025/26 Quarter 2 - 44.65%



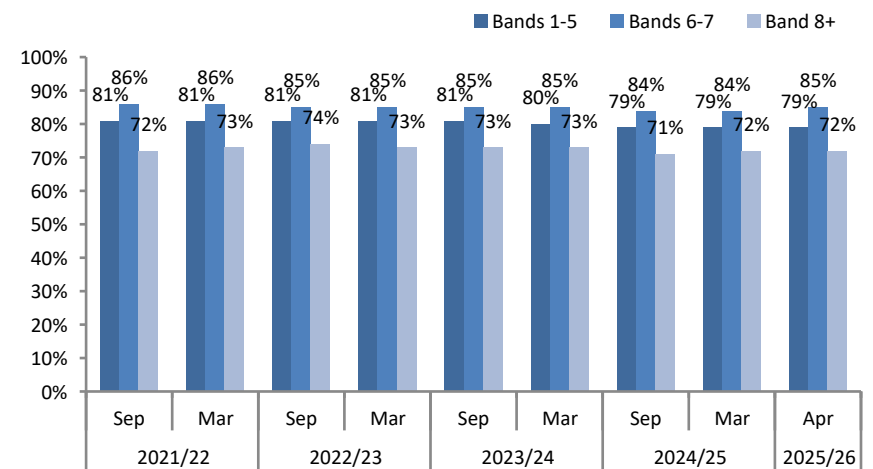
2025/26 Quarter 2 – 21.09%



2025/26 Quarter 2 – BAME employee % by band



2025/26 Quarter 2– Female workforce by band group



Analysis

The proportion of Ethnic Minority employees in the workforce continues to increase rising from 44% to 45% in the last 6 months as we continue to exceed our target of having an overall workforce reflective of the local population (35%). Representation at Senior Management level (Band 8+) has also increased by 1% in the last 6 months from 20% to 21%. In addition, we have seen a 1% increase at Bands 6&7 (to 31%), which is encouraging. However Ethnic minority staff continue to be over-represented at lower levels in the organisation (a 1% increase to 52% for Bands 1-5). With 77% women in the workforce as a whole; women continue to be over-represented in the lower to middle bands (but with a 1% decrease over the last 6 months to 79% representation at Bands 1-5). There is no real change at Bands 6&7 (still 85% representation). Women continue to be proportionately under-represented at senior management levels (Band 8a+/ VSM) where there is still 72% representation (only a 0.2% increase in the last 6 months)

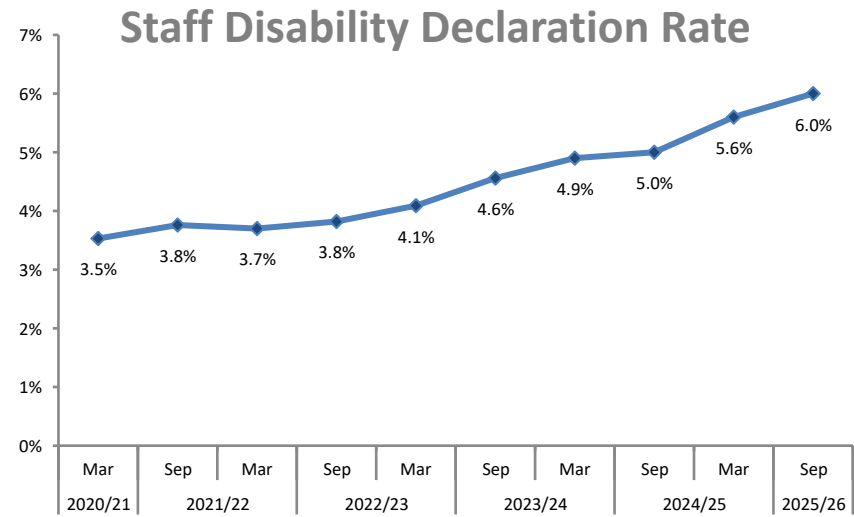
Risks, Mitigations and Assurance

We know that achieving our ambitions around senior leadership representation continues to an area of focus. In 2025 (as part of the new People Strategy Launch) we set ourselves a refreshed target of 28% representation at Bands 8a+ by Sept 2027 and our activity over the next 12 months will be pivotal in achieving this target. This will remain a key element in our refreshed WRES action plan for 2025/2026, as we continue to focus our efforts on providing development opportunities for aspiring leaders from an ethnic minority background and in ensuring we consider more innovative positive action approaches to recruitment for senior level roles (as they arise), engaging with the race equality staff inclusion network in ensuring that development offers meet the needs of our ethnically diverse staff. The Recruitment & Selection policy and training has been reviewed and refreshed with EDI included as a golden thread throughout, with particular emphasis on conscious/ unconscious bias, including discrimination in recruitment.

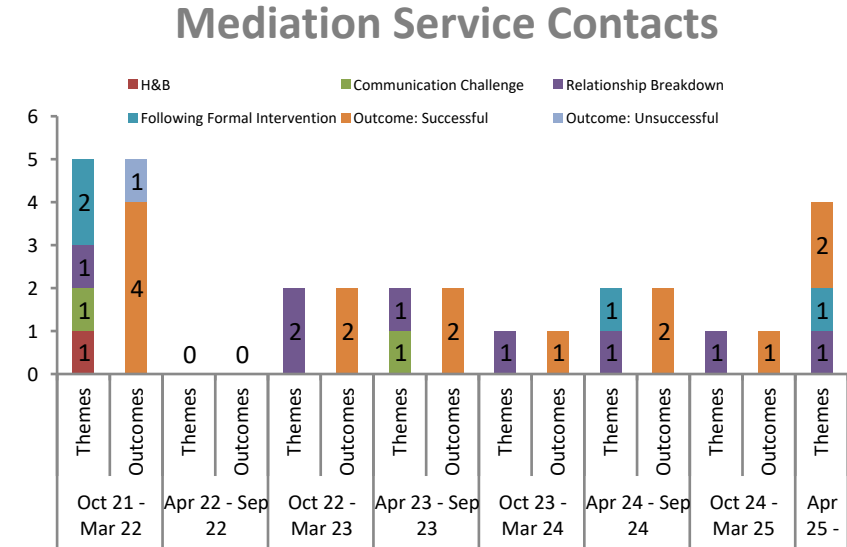
Our Gender Equality Network are fast becoming a thriving network and keen to work collaboratively with other staff equality networks, recognising the intersectionality of colleagues and some of their shared goals. The Gender Equality network presented their work plan at the July EDC meeting, including a number of key areas of focus around “women in leadership, addressing potential blockages to development, with particular focus on flexible working for front line workers and including focus on encouraging more men into traditionally female roles”.

People – Engagement – To be in the top 20% Employers

2025/26 Quarter 2 - 6%



2025/26 Quarter 2



Analysis

Our disability declaration rate (as recorded in the Electronic Staff Record/ ESR) continues to rise very slowly with a small, but positive increase of 0.5% in the last 6 months but remains round to 6%.

2 mediations have taken place since the last update (with successful outcomes for all parties). 1 further case was arranged but didn't go ahead. There are 2 cases currently pending with a further case in discussion.

Risks, Mitigations and Assurance

Disability Declaration: Whilst the 2024 staff survey results only represent 50% of our workforce, there continues to be a much higher proportion of staff survey respondents (c. 24% in 2024) who declared a disability/ long term health condition, indicating there may be a number of staff who are not declaring their status in ESR. In 2025 we set ourselves some challenging but achievable targets for the next 5 years to improve declaration rates, and we continue to work with our Enable staff network in increasing confidence to declare a disability . Our refreshed WDES action plan (presented at the November 2025 People Academy) will continue to provide focus to improving the experience of colleagues with a disability or long-term health condition, which we hope will drive up declaration rates. We will have renewed focus over the next 12 months as we embark on a more detailed review of our disability equality policy and pursue the achievement of Disability Confident (level 3) leader accreditation, which will require a number of improvements in how we raise the profile of disability equality, how we report on our activity and how we support colleagues across the Trust.

Mediation continues to provide a crucial role in supporting staff to deal with any workplace disagreements/conflict and is an important tool for 'nipping issues in the bud' and repairing relationships that may have been damaged by long standing issues or formal processes. The mediation service will become a key component of the newly developed Respect, Civility and Resolution policy and process when it is finalised over the next couple of weeks and whilst the EDI team are working to raise the profile of mediation through the EDI Managers training, the service should benefit from a re-launch as part of the implementation phase of the new policy.

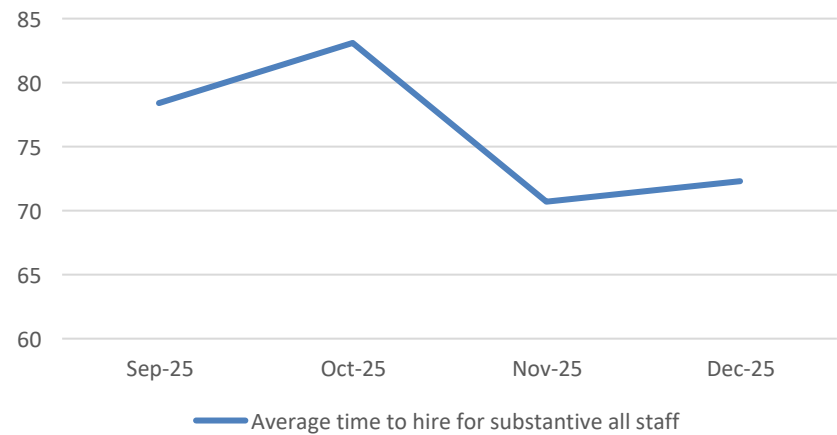
We are mindful that some trained mediators have now left the Trust. We are developing plans around recruiting new mediators and also providing refresher training for existing mediators.

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People – Engagement – To be in the top 20% Employers

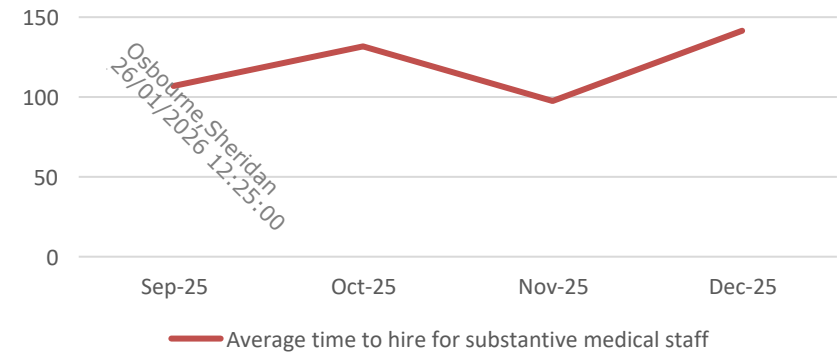
December 2025 Total substantive staffing – 72.3 working Days
Special cause variation of an **improving** nature

Average time to hire for all staff (not Bank)



December 2025 Medical – 141.5 working days
Special cause variation of a detrimental nature

Average time to hire for medical staff (not Bank)



December 2025 Recruitment – 69.7 Working Days
Special cause variation of an **improving** nature

Average time to hire for non-medical staff (not Bank)



Analysis

Time to hire for December (AfC) has decreased from 77.5 in October to 69.7 in December. This data reflects Advert Close to Candidate Start date. December saw 101 AfC candidates move through from Conditional Offer to Contract Sent with some starting within month and others with agreed start dates in the future. Pre-employment checks were completed for AfC staff in 28.9 days in December.

December’s Time to Hire for Medical has increased by Data shows delays outside Trust control including new starters who could not start in post for a significant length of time due to maternity leave and living overseas. Several overseas candidates requiring sponsorship have also affected this figure. Whilst Rotational Doctors are not included in our time to hire figures, we would like highlight the impact this has on the figures with so much resource assigned to preparing the Doctors for that rotation start date with >95% starting on induction day.

To note that there were 2 Bank Holiday’s in December which will inflate the figures due t these still being counted as working days within the system (report).

Risks, Mitigations and Assurance

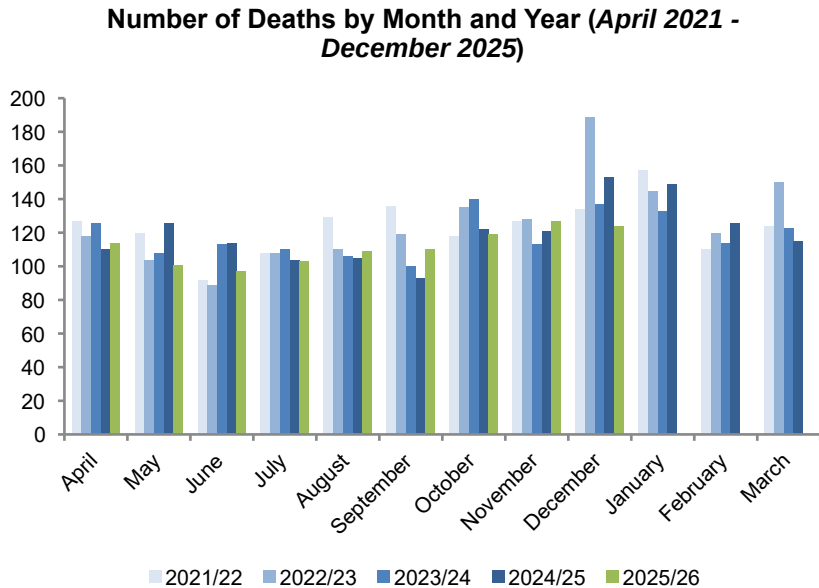
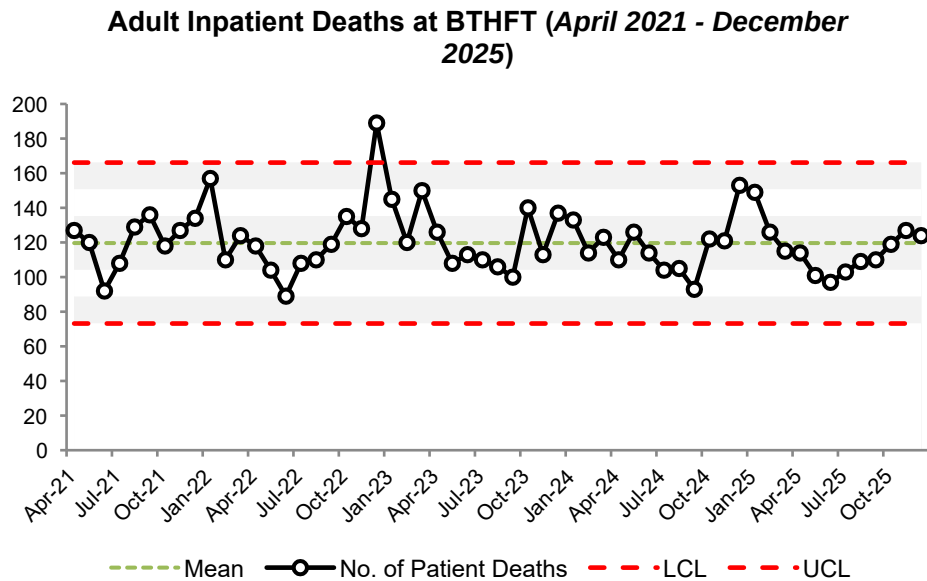
Despite showing continuous improvements in our overall time to hire figure, we are still striving to further reduce figures where we have direct influence over the time to hire. We are continuing to review and monitor our processes and seek improvements. The Recruitment team has introduced “chasing workflows” whereby each member of the team will concentrate their efforts on an individual area of the dashboard to engage with recruiting managers and support them with further learning and knowledge. The aim is that with the additional support we will empower the RM’s to be able to proactively look after their own recruitment and therefore reduce time to hire and provide a better candidate experience.

As part of this continued improvements in the Medical Recruitment team, they have introduced a rota-based system similar to that currently used in the non-medical recruitment team. The new rota system will dedicate time to each workflow daily; therefore, meaning that all activities will be actioned in a timely manner. It will also allow for future planning for Doctors rotations allowing sufficient resources to be allocated to the rotational Doctors whilst still maintaining active work on all non-rotational Doctors. The rota will allow recourses to be manipulated in reaction to any identified bottlenecks.

We are also looking to revise the Time to Hire targets for those waiting GMC/CCT compared to generic medic recruitment as this recruitment has a longer turn around time due to static time scales. This review will begin January 2026.

Clinical Effectiveness - To provide outstanding care for patients

December 2025 – 124 Adult Inpatient Deaths



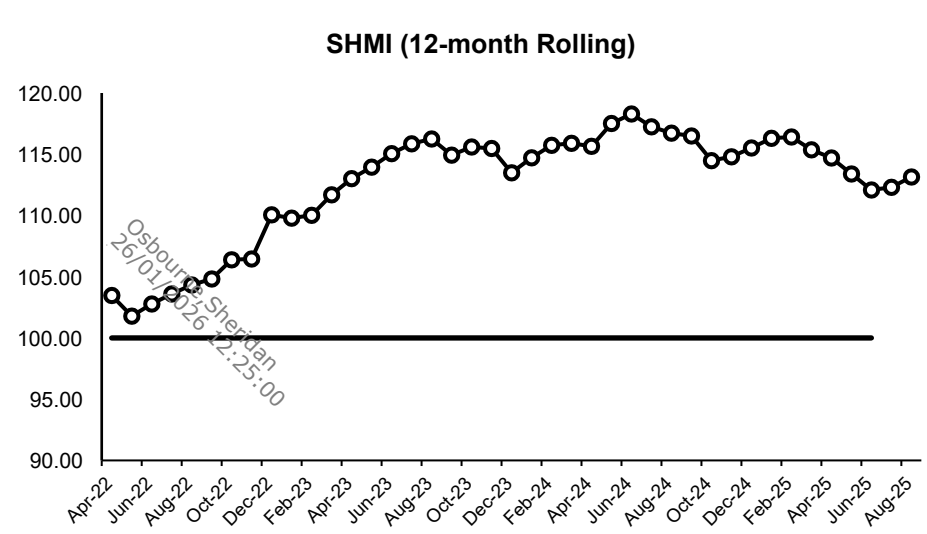
Analysis

The Summary Hospital-level Mortality Indicator (SHMI) shows the ratio of the observed to the expected number of deaths up to 30 days after discharge from hospital, multiplied by 100. The SHMI reports on mortality at trust level for acute trusts across the NHS in England and is evaluated over all diagnosis groups in a specified patient group. It excludes stillbirths, and a death is counted only once and to the last discharging acute provider. The SHMI value is not an indication of avoidable deaths or a measure of the quality of care delivered.

Learning, Improvement, Assurance

In December 2025, the Trust saw 124 adult inpatient deaths. This is the lowest number of deaths for a December period in 5 years and is no doubt a testament to the efforts of our clinicians during an unprecedented time of increased activity in the Trust.

SHMI 12-month Rolling – 113.15 (figure covering September 2024 – August 2025: Reported December 2025)

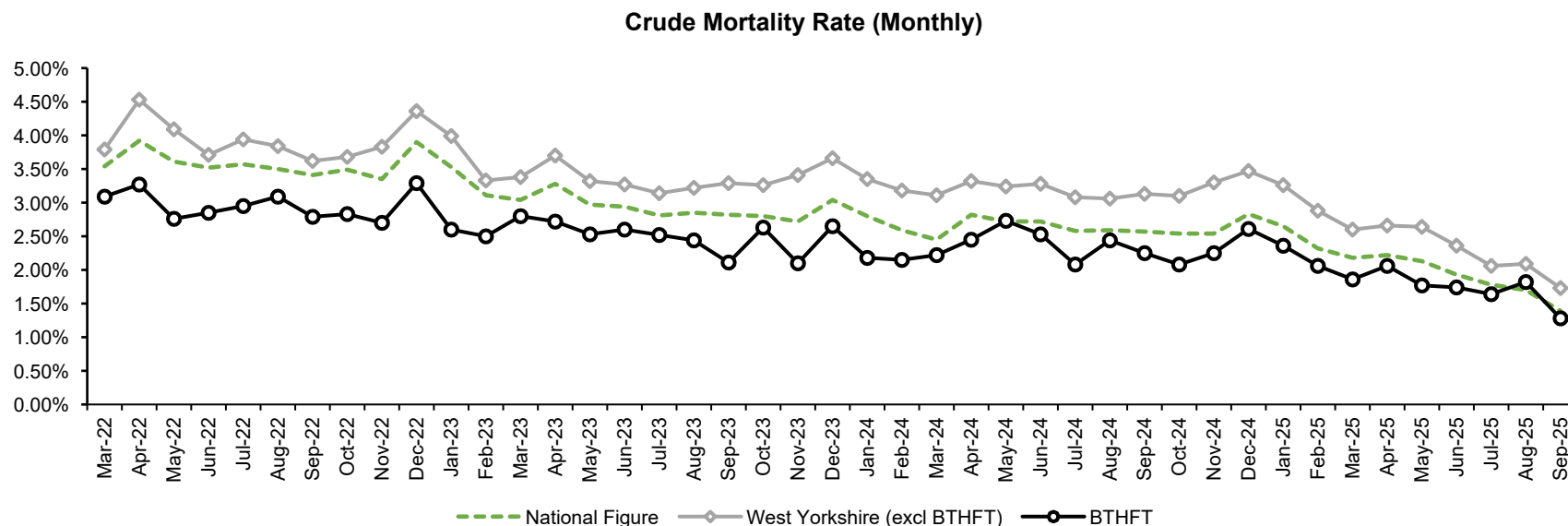


SHMI has increased slightly to 113.15 but is still within expected range.

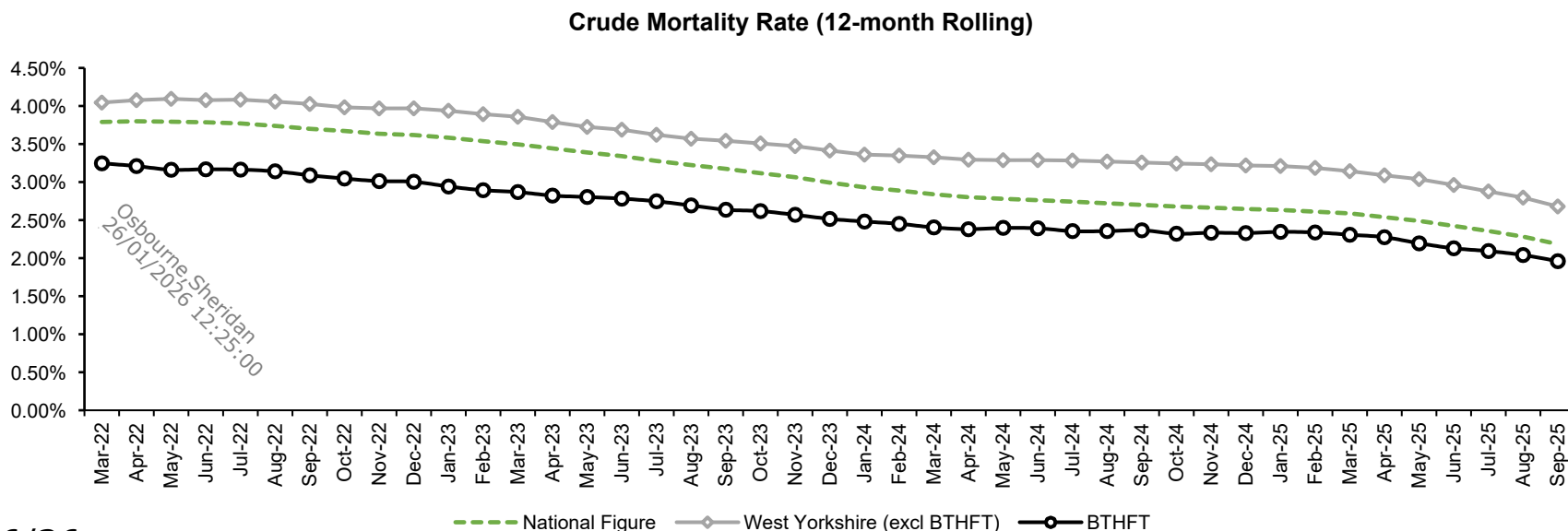
Having identified the main issue surrounding submission of historical coding data, along with continued efforts from the Coding Team to eliminate any backlog, our SHMI has been updated by NHS England to reflect these changes.

Clinical Effectiveness - To provide outstanding care for patients

Crude Mortality Rate (monthly) – 1.28% (figure for September 2025: Reported December 2025)



Crude Mortality Rate (12-month Rolling) – 1.96% (figure covering October 2024 – November 2025: Reported December 2025)



Analysis

Our crude mortality rate decreased to 1.28% for the month of September, the latest reported figure (*reported in December 2025*). This rate is lower than the national figure (1.39%) and is the lowest crude mortality rate in West Yorkshire for the month. As a 12-month rolling average, BTHFT currently has a mortality rate of 1.96%, lower than the national average of 2.18% and well below the average for the rest of the West Yorkshire region, which has an average rate of 2.68%.

Learning, Improvement, Assurance

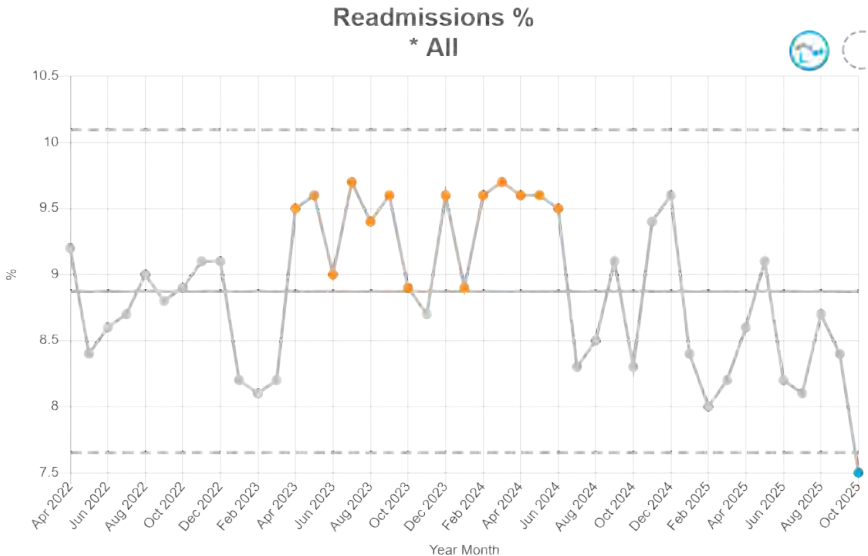
Crude mortality rate is a measure of the number of patient deaths as a proportion of overall patient activity. Crude Mortality Rate is an excellent way of looking at the rate of patient deaths as it takes into account the activity of the hospital by using the number of patient discharges as the denominator.

Since the discontinuation of HSMR by NHS England, the Learning from Deaths Team at BTHFT have chosen to focus on our crude mortality rates to balance against SHMI.

Our Crude Mortality Rate provides assurance that we continue to see very low rates of mortality at BTHFT despite a high SHMI value.

Clinical Effectiveness - To provide outstanding care for patients

October 2025 – 7.5%
Common cause variation



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Analysis

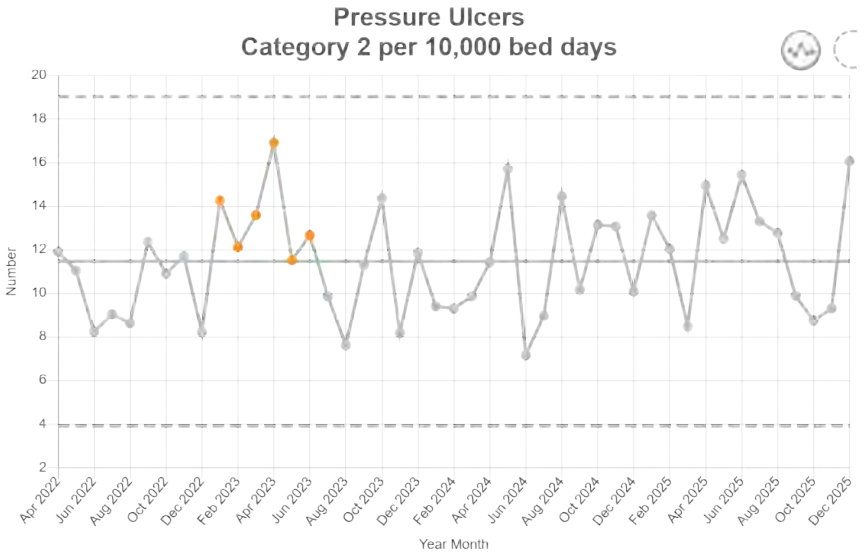
On average re-admissions for October 2025 are lower than the same period last year and are trending at their lowest levels in three years. Data analysis indicates that this reduction is down to improved correct coding of patients who are brought back for a planned follow-up after an initial Non-Elective spell (e.g. GATU/EPAU, paediatrics and general surgery)

Learning, Improvement, Assurance

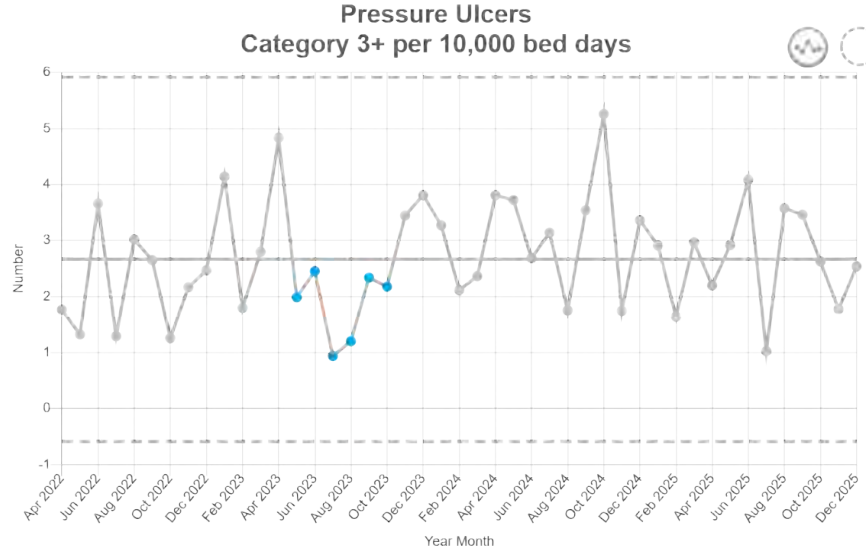
There is on-going work with BI, performance and CSUs to to continue to improve coding for planned returners following an initial NEL spell.

Clinical Effectiveness - To provide outstanding care for patients

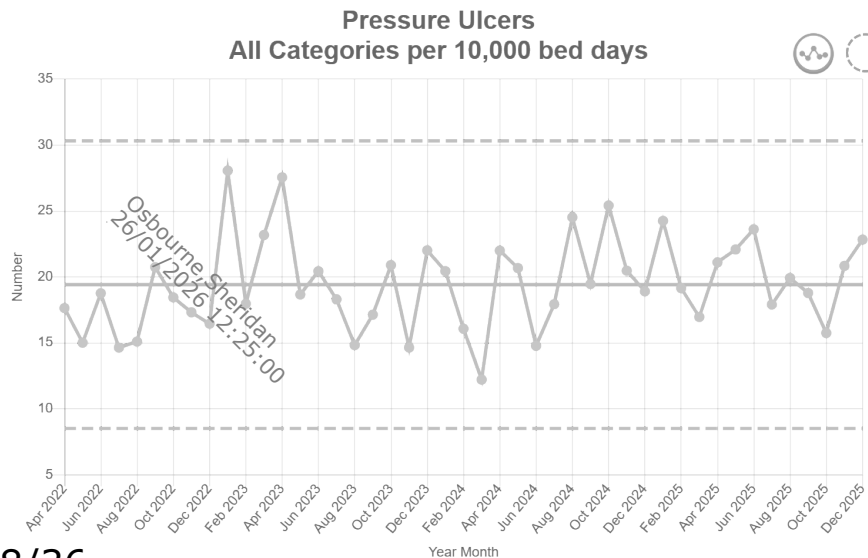
December 2025 – 16.06
Common cause variation



December 2025 – 2.53
Common cause variation



December 2025 – 22.83
Common cause variation



Analysis

In December the number of pressure ulcers per 10,000 bed days remained above the control limit. Category 3+ incidents decreased but category 2 incidents increased above the control limit.

Risks:

1. Ward 23 & 26 had the highest number of incidents which is a consistent pattern.
2. Recent increase in incidents in ED, AMU 4 & wards 29 & 31.

Learning, Improvement, Assurance

Mitigations:

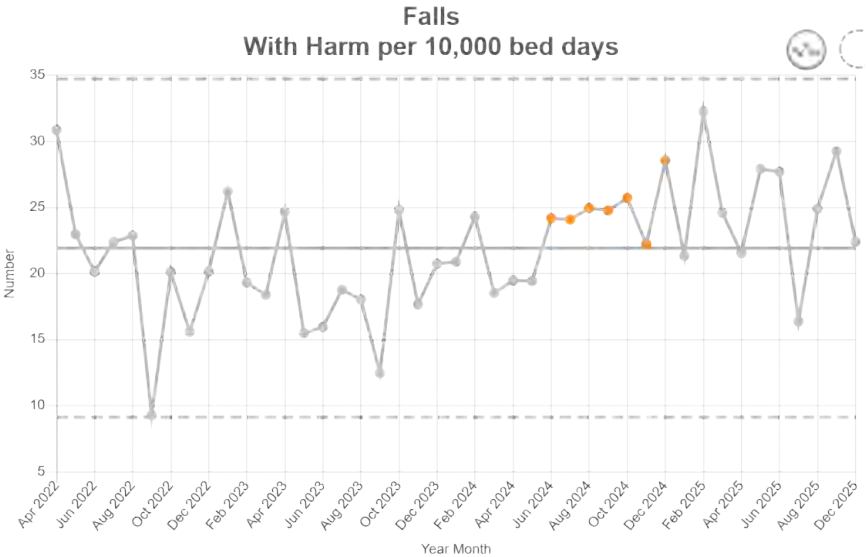
1. Planned collaboration with Calderdale and Huddersfield NHS Trust is planned regarding improving the accurate completion of the risk assessment tool on EPR (PURPOSE T).
2. Quality improvement support has been provided to wards 23, 26, ED & 17 by TVN. Planning is underway for a pressure ulcer collaborative with wards 23, 26, 4, 29, 31 & ED.
3. Pressure ulcer prevention is one of the ward accreditation standards – feedback and recommendations are provided to the ward teams following audit and the ward assessment visit.

Assurance:

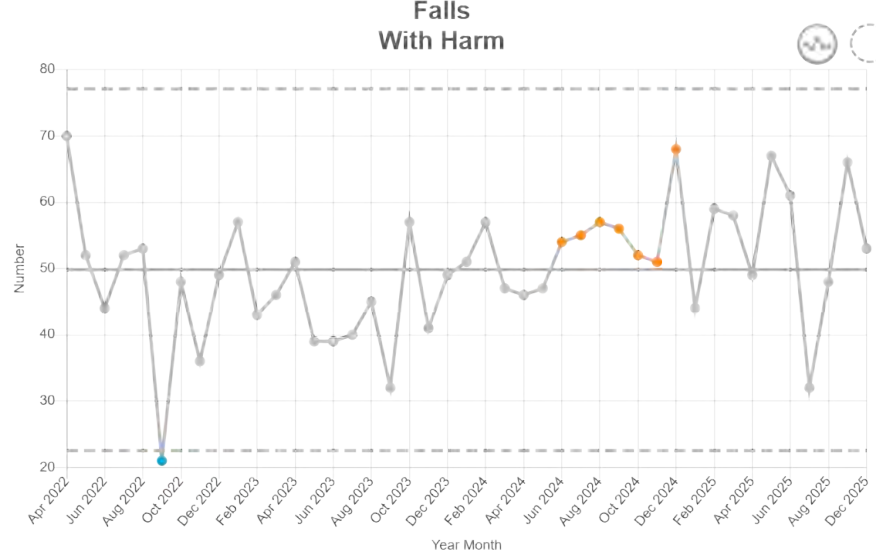
1. Education and training is being delivered to new starters and existing staff (e.g. HCA bootcamp, e-learning modules) and bespoke training to clinical areas e.g. stroke & neurology and specialist medicine.
2. The pressure ulcer improvement group meets monthly. and ward teams share their data (pressure ulcers, training figures), learning from incidents and improvement plans. Most ward areas have presented to the group at least once.
3. Ward 26 is continuing work on visual prompts for repositioning using the Model for Improvement methods. ED have developed a QI storyboard and improvement plan. First steps are to raise awareness and completion of initial skin assessments and pressure ulcer risk assessment within amber zone and HDU within 6 hours of triage. Testing role of HCA champion.
4. Ward 23 are focusing on repositioning, use of slide sheets and supervision of care.
5. Ward 29 have run a 'Perfect Pressure Ulcer' week but this needs revisiting this year.

Clinical Effectiveness - To provide outstanding care for patients

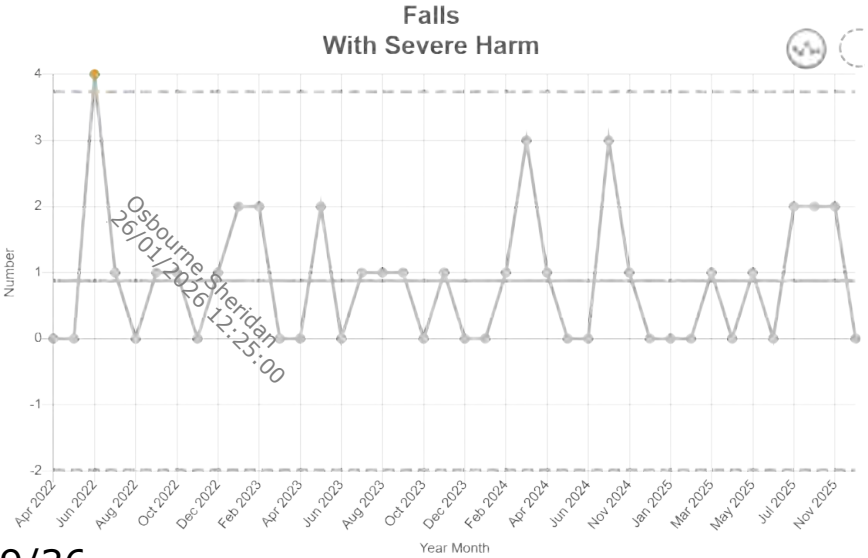
December 2025 – 22.40
Common cause variation



December 2025 – 53
Common cause variation



December 2025 - 0
Common cause variation



Analysis

Learning, Improvement, Assurance

- Every fall that occurs within the Trust continues to be reviewed by the lead Nurse for Falls to ensure that all appropriate post falls care has been provided and learning identified.
- All falls are reviewed using the Royal College of Physicians hot debrief and after action review process in line with PSIRF with referral to SEG where appropriate should a PSII need to be considered.
- CSU's are requested to attend the falls improvement group to discuss ward data and themes from learning.
- There is focused bespoke support and training provided by the Lead Nurse to wards and areas who's falls rates are in the top 3 highest falls across the Organisation or where there have been specific issues or challenges identified.
- Key worker training dates continue and have been well attended to provide ongoing focused support to staff fulfilling those roles.
- The annual falls equipment review audit was completed in January 2025 to support wards to identify if they have sufficient resources to manage the falls risks. This is in line with the new contract for falls sensors which will be rolled out in 2025.
- Volunteers have been recruited to looking at supporting patients to be occupied and engaged on specific wards to reduce the risk of patients attempting to stand unsupervised. This is being monitored with a view to rolling this out to other high risk wards.
- We have launched our 'mission statement, and 'Get the 6 pack' for ward areas.
- The National Audit for In Patient falls now monitors all fractures and head injuries within the Trust.

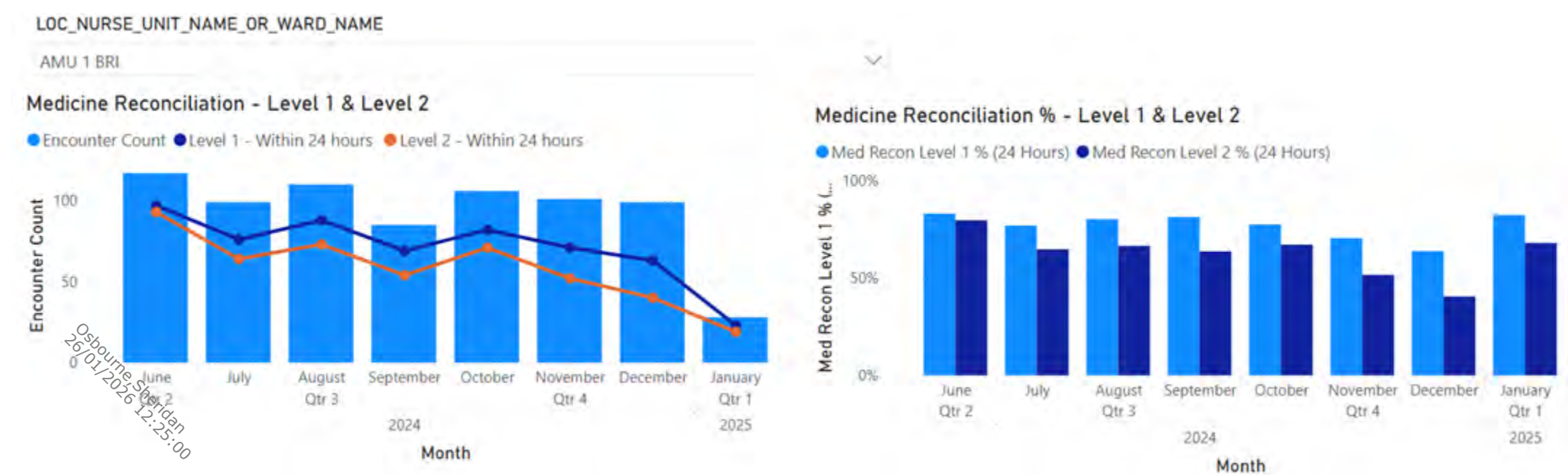
Analysis

Following discussions held between the Quality Team, Medicines Management Team and Business Intelligence, there is ongoing work to bring new, measurable metrics for Medicines Management.

These metrics are being actively worked on by Business Intelligence and the Pharmacy Team. Progress is being made on ward-by-ward basis with data quality checks and validation being undertaken by the Pharmacy Team each time a ward is added into the metrics. This is to ensure accuracy of the data being produced by the Power BI dashboard.

Whilst wards can be added quickly by the BI Team, the validation process by Pharmacy is time consuming. Once all wards have been stress-tested and data validation completed to ensure the metrics are working as they should, Trust-wide reporting will begin.

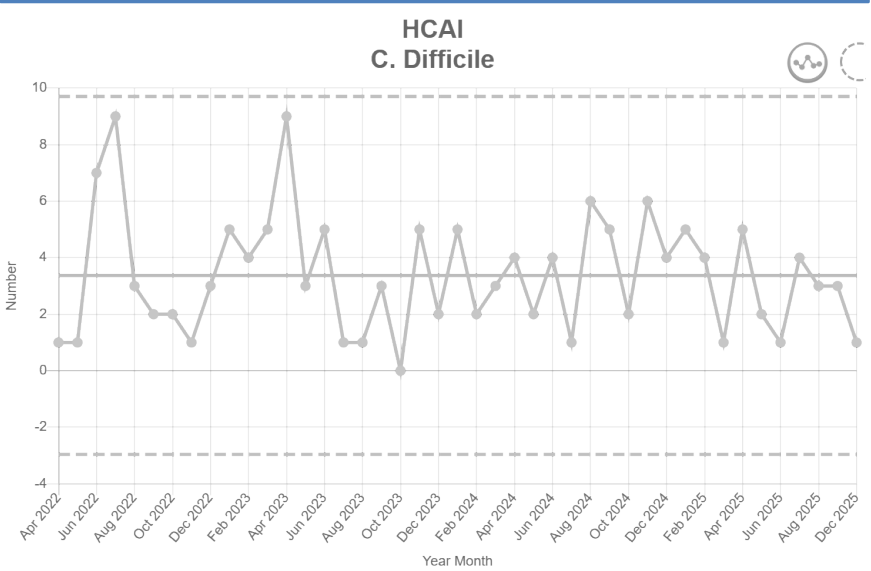
Business Intelligence have supplied an example image of how the data may be presented upon completion of the project:



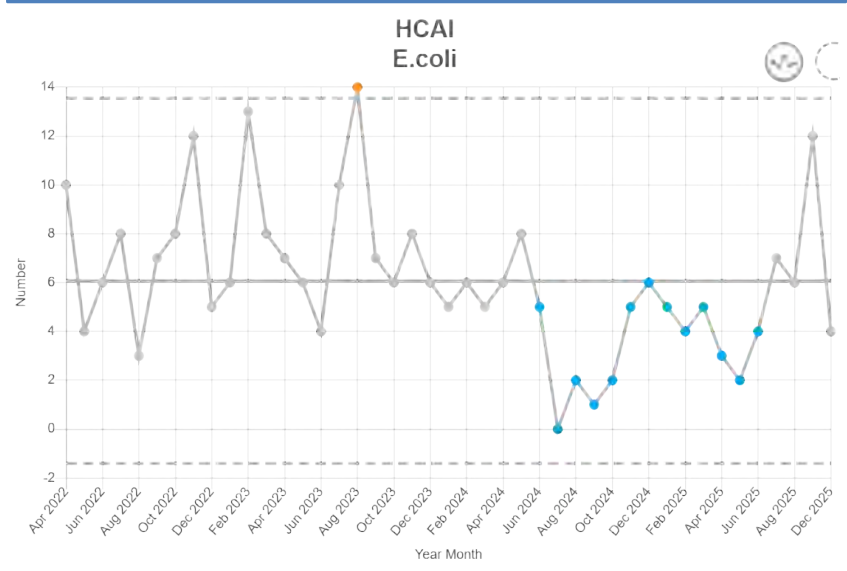
Please note that the data used for this representation is still undergoing validation and is not representative for this ward.

Clinical Effectiveness - To provide outstanding care for patients

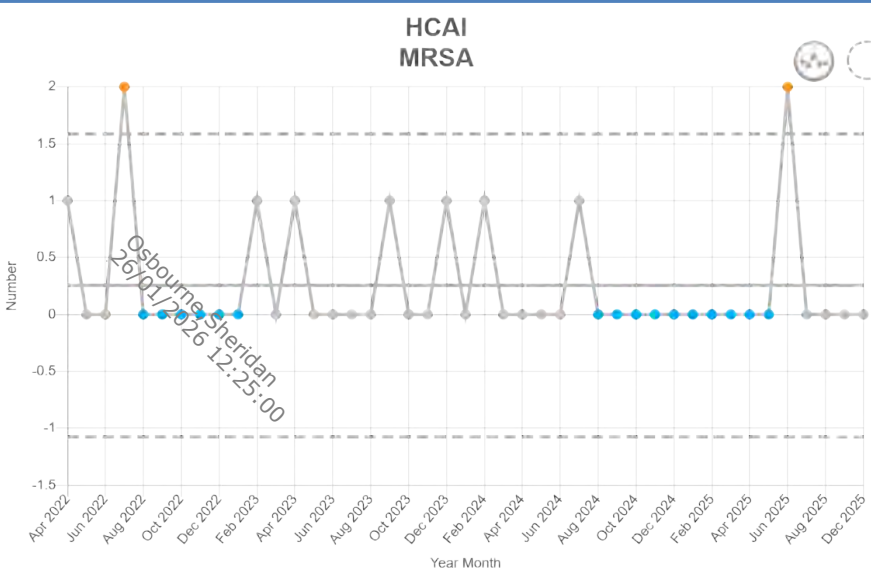
December 2025 – C. Diff Cases - 1



December 2025 – E. Coli Cases - 4



December 2025 – MRSA Cases - 0



Analysis

E. Coli Bacteraemia
An improvement in E. coli bacteraemia has been after a peak in November.

Clostridioles difficile Infection
A decrease in the number of C. diff infection cases has been observed since July 2025. The review of cases was carried out. Different ribotypes have been identified in the recent cases which means no transmission between patients has occurred. Majority of the cases had multiple antibiotics resulting in C. diff infection. A comprehensive review of antibiotics was carried out by the antimicrobial pharmacist to identify any learning in antimicrobial prescribing practice. More efforts are being put to improve the practice of switching from IV to oral antibiotics.

MRSA Bacteraemia
No MRSA bacteraemia cases have been observed in last four months. Only one case has been observed in the last 12 months.

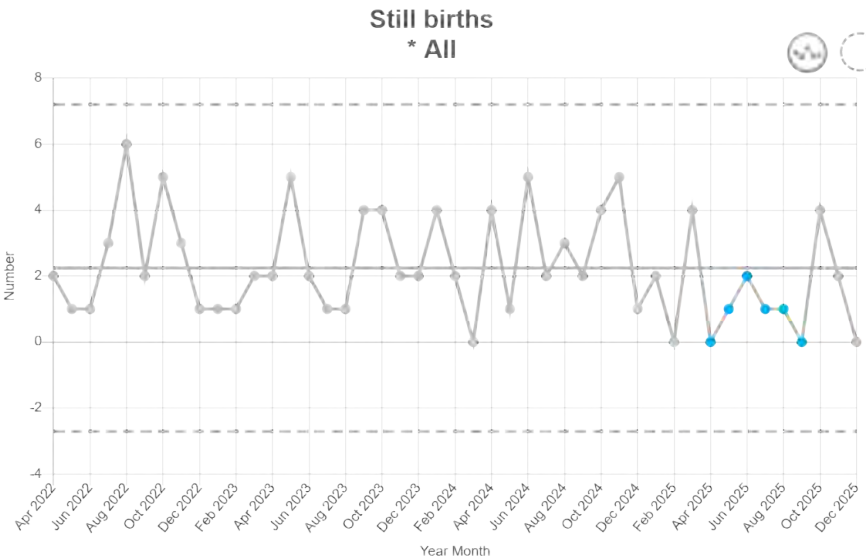
Learning, Improvement, Assurance

- Clostridioles diff Infections reduction plan.**
- CDI Improvement plan in place with regular updates.
 - Immediate review of cases for quick learning
 - Triangulation of cases using PSIRF
 - Multidisciplinary team meeting in case of increase in the cases
 - Adhoc and regular environmental audits
 - Commode audits with IRIS on non-compliance
 - Dedicated antimicrobial Stewardship pharmacist
 - Data collection on compliance to Start Smart and Focus

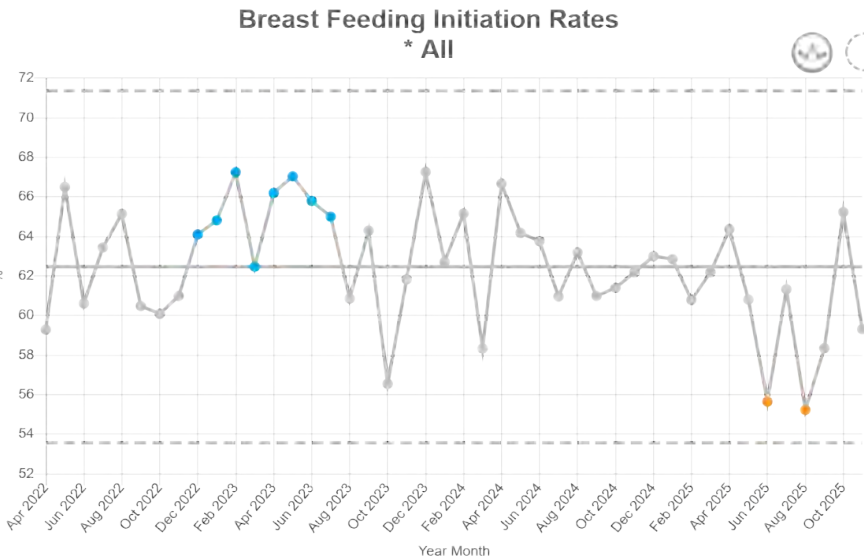
- Bacteraemia Reduction plan**
- A comprehensive improvement plan updated regularly
 - Immediate review of bacteraemia cases for quick learning
 - Triangulation of cases using PSIRF
 - Preparing for ANTT accreditation
 - Updated SOP for Central Venous Access devices (CVAD)
 - Support Gloves off Campaign
 - Hydration improvement project
 - Audits of Octenisan compliance (IRIS on non-compliance)
 - Addition of a tool to ask patients about Octenisan bath

Clinical Effectiveness - To provide outstanding care for patients

December 2025 - 0
Common cause variation



November 2025 – 59.31%
Common cause variation



Analysis

Stillbirths are monitored and reported on a monthly basis, with a thematic approach if more than 4 are reported in any month. Each baby is subject to a Perinatal Mortality Review Tool (PMRT) and any intrapartum stillbirth of a term baby is referred to MNSI for independent investigation.

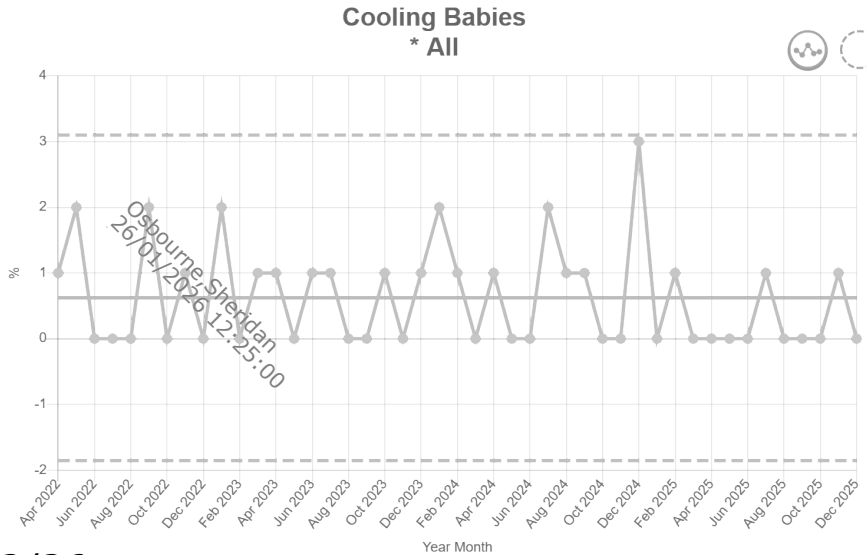
All cooled babies meeting MNSI criteria are referred for independent investigation.

Cooled babies not meeting MNSI criteria are reviewed as an MDT case review and after action review/PSSI as required.

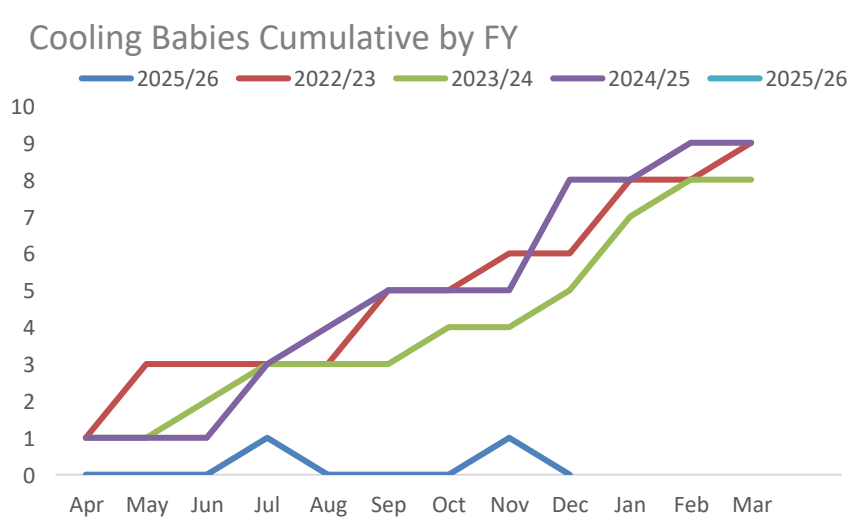
Learning, Improvement, Assurance

The service is meeting the MIS saving babies lives version 3 standards and continues to progress a number of initiatives to reduce inequalities which continues to be a theme within the PMRT reviews.

December 2025 - 0
Common cause variation



Cooling Babies Cumulative by FY



Academy Dashboard Quality

Appendices

Osbourne Sheridan
26/01/2026 12:25:00

Key to KPI Variation and Assurance Icons

Variation			Assurance			
						
Special cause of <u>(H)igher or (L)ower</u> values indicating areas of concern	Special cause of (H)igher or (L)ower values indicating improving performance	Common cause - no significant change	'Pass' variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	Fail' Variation indicates consistently - (F)ailing of the target	Data Current unavailable or insufficient data points to generate SPC

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) specialty cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Special Cause Improvement - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) specialty cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls

Further Reading / other resources

The NHS England website has a range of resources to support Boards using the Making Data Count methodology. This includes a number of videos explaining the approach and a series of case studies – these can be accessed via the following link - <https://www.england.nhs.uk/publication/making-data-count/>

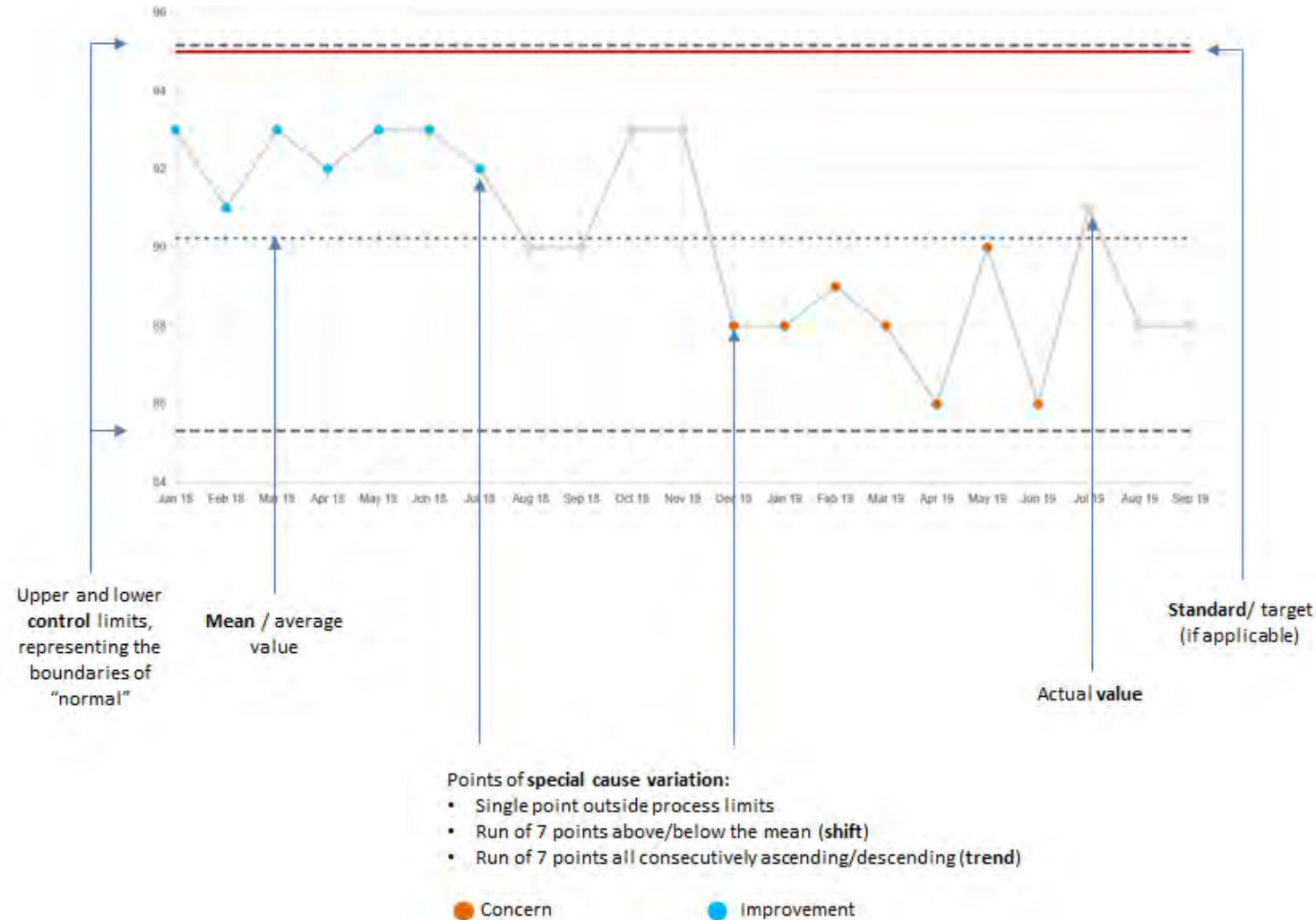
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Interpreting Statistical Process Control Charts

Guidance notes

Reporting within this document uses a combination of chart types. Where appropriate, Statistical Process Control (SPC) charts have been used to aid analysis.

SPC charts



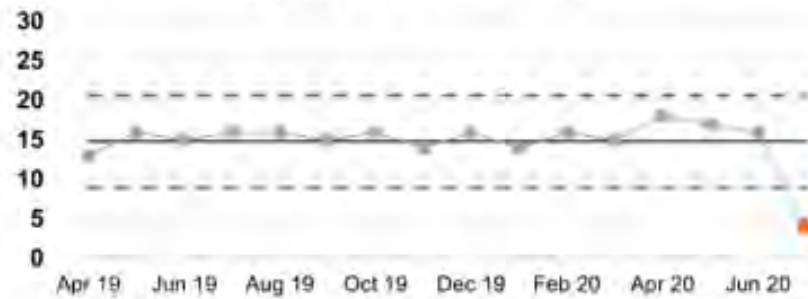
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Interpreting Statistical Process Control Charts

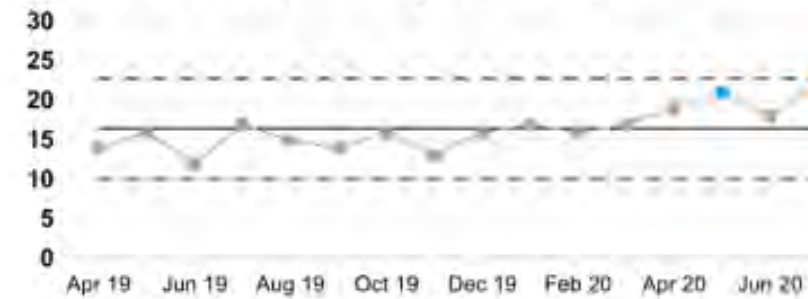
SPC rules : special cause variation



A single point outside the process limits



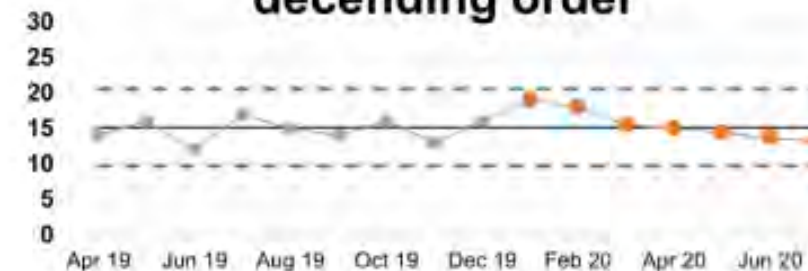
Two out of three points close to a process limit



A shift of points above / below the mean



A run of points in consecutive ascending or descending order



Osbourne Sheridan
26/01/2026 12:25:00

Board of Directors				
Meeting Date:	29/01/26	Agenda Reference:	Bo.1.26.12d	
Report Title:	Operational Performance Highlight Report			
Presented by:	Bryan Machin, Chair of F&P Committee			
Executive Lead:	Sajid Azeb, Chief Operating Officer & Deputy Chief Executive			
Author:	Carl Stephenson, Director of Planning and Performance			
Report Summary				
Purpose of the paper:	Decision ☐	Assurance ☒	Action ☐	Information ☐
Summary of Key Issues/ Highlights:	Headline KPI summary page: - In month and YTD performance presented in the context of 2025/26 planning commitments and the latest benchmarking from the NHS Oversight Framework where available. - Year-end forecasts are derived from current performance, trends, and the measurable actions that are planned and will impact on the KPI within these timescales. Assurance provided through the exception report and the recovery actions being progressed. Headline KPI exceptions: - DM01 6-weeks: Performance for December has reduced to 79.71% following a circa 15% performance on previous months this is due to challenges in Audiology, Neurophysiology and Urodynamics. Rating remains at amber as recovery to 95% is challenged. - Elective Activity: Deviation from plan relates to capacity challenges in Plastics and Pain Management, alongside the delay to the opening of the DCU which has only been partially mitigated. Recovery requires productivity gains work is ongoing to accelerate this as part of financial recovery. - Outpatient Transformation: Follow up activity remains high whilst new appointments are static. Recording of OPPROC is being improved with service specific actions now on track. Longer term pathway transformation and an expectation that the growth in follow ups is a short-term requirement aligned to RTT waiting list reductions may reverse the trend but full recovery to plan remains difficult. In month exceptions/ early warning metrics: - Cancer 28-day FDS: Performance impacted by deterioration in histology reporting and ongoing challenges across key tumour groups. Year-end position remains a forecasted pass and YTD performance is above target. - Cancer 62-day FT: Diagnostic delays are also impacting on this standard, although slower than hoped for improvement across other sites can also be noted. Recovery is a combination of tighter oversight and pathway reform (this is specific to different tumour groups). 18 Weeks Incomplete RTT: Performance remains below plan which will impact on two NOF metrics. Activity and productivity in terms of clock stops is improving, with efforts to ensure the longest waits are prioritised continuing we should be able to recover to plan if these trends are sustained.			

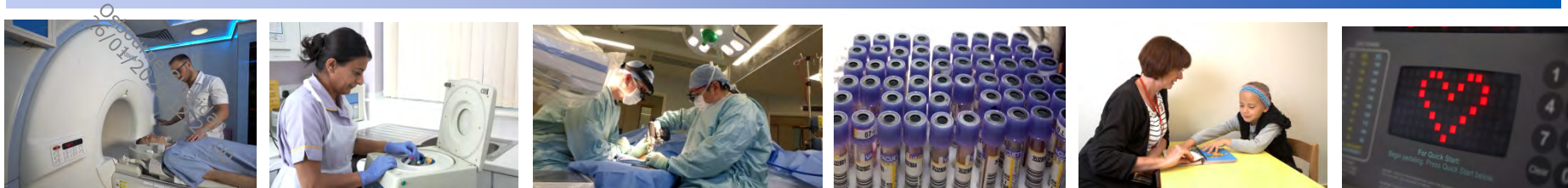
Osbourne, Sheridan
 26/01/2026 12:25:00

	65-week and 52-week RTT: National deadline to eliminate over 65-week waits was achieved and we continue to track ahead of national and peer average for the number of 52-week waits. This has been achieved through waiting list management processes and targeted support to services. Additional information to aid the understanding of current and forecast positions and support the assurance provided by the exception report is included in appended highlight reports.
Recommendation/s: (including any decision/approval required)	<i>The Board is asked to:</i> - Receive assurance that overall delivery against performance indicators is understood. - Note the escalation of areas of underperformance and review the improvement actions.
Link to Strategic Objective:	Sustainability - To deliver our financial plan and key performance targets
Link to Priority Initiatives 2025/26:	Choose an item.
Implications	
Risk:	This paper demonstrates our understanding of the KPI that underpin our short-term response and shape our longer-term plans related to delivering improvement within item 7 of the BAF.
Legal/Regulatory:	The operational priorities covered by this report include those which form part of NHSE contract, annual planning, and performance assessment frameworks.
Quality & Patient Safety:	Failure to deliver improvements in the KPI covered by this report in line with our agreed plans will have a direct impact on patient experience and outcomes related to timely access to services.
Equality, Diversity and Inclusion and Health Equity:	Failure to address issues or deliver the improvements outlined for 2025/26 may have a disproportional impact on some communities and demographics where access to services correlates with poorer long-term health outcomes.
Resources:	
Environmental sustainability:	
Assurance Route	
Meeting/s where content has been discussed previously:	This report aligns to the performance and accountability framework and specifically the operational performance domain of the balanced scorecard. This report has been informed by and the content discussed at the various meetings set out in this framework for overseeing and improving performance.

Osbourne, Sheridan
26/01/2026 12:25:00

Operational Performance Highlight Report

Board of Directors
December 2025 Performance



Headline KPI Summary

Headline KPI	Latest Month	BTHFT Plan	Perf.	3-Month Trend	Q2 NOF Rank	Year To Date	Year End Target	Year End RAG
Avg. Ambulance Handover	Dec-25	24:58	18:36	↓	N/A	20:04	21:23	G
4-Hour Emergency Care Standard	Dec-25	81.00%	82.57%	↓	11 of 123	82.99%	82.01%	G
12-Hour Length of Stay in ED	Dec-25	9.49%	7.40%	↓	44 of 119	7.54%	7.99%	G
Length of Stay ≥21days	Dec-25	90	82	↑	N/A	N/A	82	G
Avg. Delay Post Discharge Ready Date	Dec-25	3.8	3.9	↑	N/A	3.7	3.8	G
18-Week Referral To Treatment (RTT)	Dec-25	66.00%	64.83%	↓	29 of 131	N/A	66.70%	G
18-Week RTT Incomplete vs Plan	Dec-25		-1.17%	↓	52 of 131	N/A	-	-
52-Week RTT Incomplete	Dec-25	0.65%	0.25%	↓	20 of 131	N/A	0.66%	G
52-Week Community Waits	Nov-25		0.00%	-	1 of 79	N/A	-	-
%age New & OPPROC of all outpatients	Dec-25	46.56%	44.10%	↓	N/A	44.28%	46.56%	A
Elective Activity vs Plan	Dec-25	100.00%	100.67%	↑	N/A	95.59%	100.00%	A
6-Week Diagnostic Standard (DM01)	Dec-25	92.38%	79.71%	↓	N/A	N/A	95.00%	A
Cancer 28-Day Faster Diagnosis Standard	Nov-25	80.02%	77.52%	↓	53 of 118	80.70%	80.00%	G
Cancer 31-Day General Treatment	Nov-25	93.00%	93.85%	↑	N/A	94.50%	93.00%	G
Cancer 62-Day General Treatment	Nov-25	74.92%	74.33%	↑	55 of 118	72.47%	75.25%	G

Red performance = not meeting plan; **Green** performance = meeting or exceeding plan

Red arrow = trend is a deterioration; **Green** arrow = trend is an improvement

NOF rank: **Red** =worst quartile; **Amber** = 2nd worst quartile; **Light Green** = 2nd best quartile; **Green** = best quartile

Year end: **Red** = unlikely to meet target; **Amber** = recovery planned but not certain; **Green** = expected to meet target

Headline KPI – Year End Forecasts

↔ DM01 6-weeks:

Performance for December has reduced following a 15% improvement over the past few months to 79.71% due to challenges in Audiology, Neurophysiology and Urodynamics. Rating remains at amber as recovery to 95% is challenged.

↔ Elective Activity:

Deviation from plan relates to capacity challenges in Plastics and Pain Management, alongside the delay to the opening of the DCU which has only been partially mitigated. Recovery requires productivity gains, work is ongoing to accelerate this as part of financial recovery.

↔ Outpatient Transformation:

Follow up activity remains high whilst new appointments are static. Recording of OPPROC is being improved with service specific actions now on track. Longer term pathway transformation and an expectation that the growth in follow ups is a short-term requirement aligned to RTT waiting list reductions may reverse the trend but full recovery to plan remains difficult.

Headline KPI – In Month

Cancer 28-day FDS:

Performance impacted by deterioration in histology reporting and ongoing challenges across key tumour groups. Year end position remains a forecasted pass and YTD performance is above target.

Cancer 62-day FT:

Diagnostic delays are also impacting on this standard, although slower than hoped for improvement across other sites can also be noted. Recovery is a combination of tighter oversight and pathway reform (this is specific to different tumour groups).

18 Weeks Incomplete RTT:

Performance remains below plan which will impact on two NOF metrics. Activity and productivity in terms of clock stops is improving, with efforts to ensure the longest waits are prioritise continuing we should be able to recover to plan if these trends are sustained.

Sub-metrics / Early Warnings

65-week and 52-week RTT:

National deadline to eliminate over 65-week waits was achieved and we continue to track ahead of national and peer average for the number of 52-week waits. This has been achieved through waiting list management processes and targeted support to services.

Appendix A

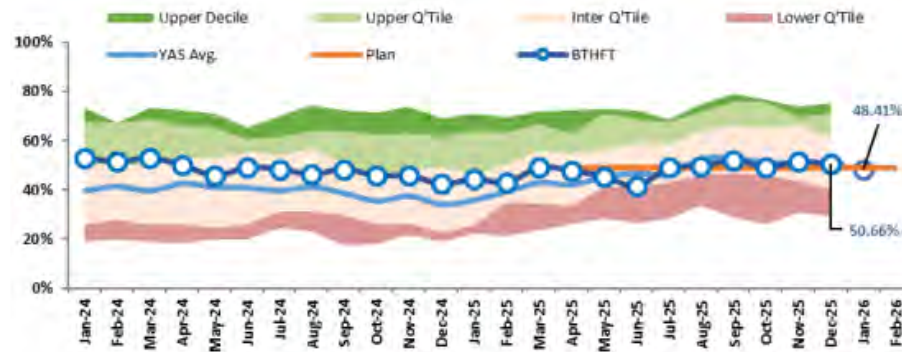
Headline KPI Highlight Reports

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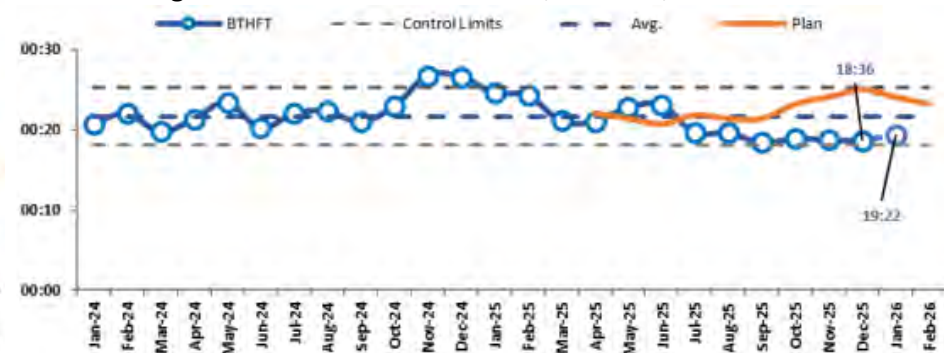
1. Ambulance Handover Performance

Objective: Reduce Ambulance Turnaround Time

1.1 Ambulance Performance Benchmarked (Source: YAS)



1.2 Average Ambulance Handover Time (Source: YAS)



1.3 Additional Ambulance Metrics

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Avg. Daily Arrivals	113	114	108	112	108	111	111	106	108	118	119	120
Avg. Handover Time (MM:SS)	24:33	24:19	21:05	21:01	22:48	23:06	19:39	19:40	18:25	18:56	18:45	18:36
Avg. Crew Clear Time (MM:SS)	30:08	29:00	28:03	29:20	28:24	27:30	26:28	27:02	26:50	26:36	25:22	24:43
Total Turnaroud Time (MM:SS)	54:33	53:09	49:04	50:16	51:05	50:20	45:57	46:34	45:04	45:18	43:50	43:01
% <60 mins	95.0%	94.6%	96.6%	95.9%	96.1%	95.8%	98.0%	97.5%	98.5%	99.2%	99.1%	99.0%
% Handover <45 Mins				91.5%	90.2%	89.8%	94.4%	93.8%	95.3%	94.9%	94.1%	95.8%
% Turnaround <45 Mins	43.1%	42.4%	50.2%	45.3%	45.5%	45.4%	54.2%	52.6%	54.6%	55.1%	58.0%	60.3%

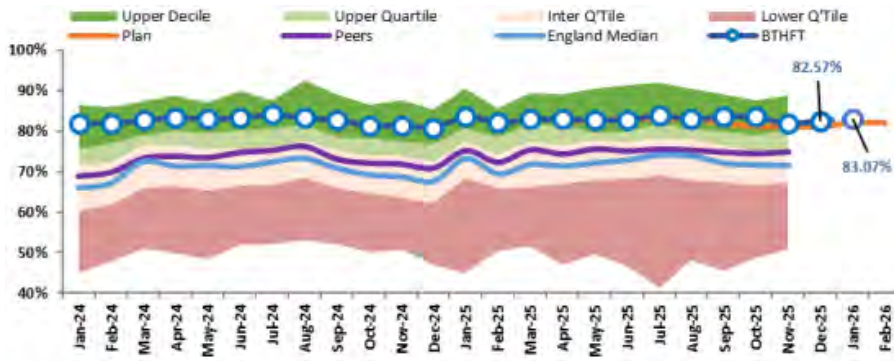
Latest position

- Performance for 15-minute handovers, as reported by Yorkshire Ambulance Service (YAS), was 50.66% in December compared with 51.42% in November.
- Despite an increase in Ambulance arrivals during both November and December, BTHFT's average handover time improved to 18:44, representing an approximate 8-minute (30%) reduction compared to the same period last year and demonstrating the positive impact of the Transfer of Care SOP implementation.
- Similar improvements in Crew Clear times have also contributed to a sustained improvement in the overall turnaround performance with ~60% being delivered within 45 minutes.
- As of Mid December, YAS have introduced a same-day handover data validation process to improve data accuracy further and reduce reported 45-minute handover breaches ahead of NHSE submission.
- A YAS HALO remains on site to support the adoption of the new Transfer of Care SOP and to increase the number of self-handovers.

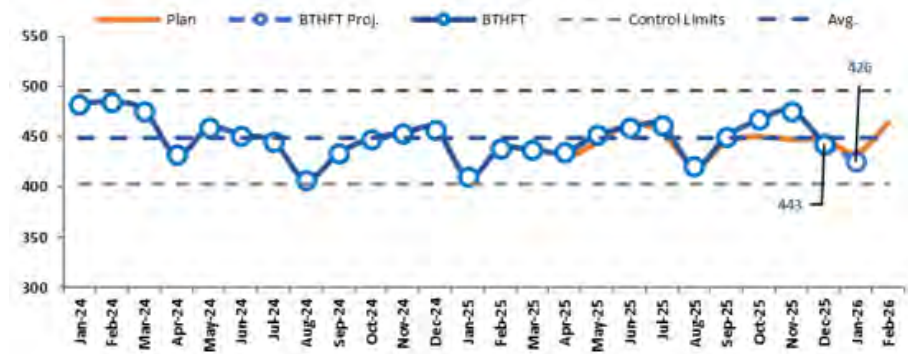
2. Emergency Care Standard (ECS)

Objective: Sustain ECS performance

2.1 ECS Performance Benchmarked (Source: NHSE for Acute & Combined Trusts)



2.2 Average Daily Attendances (Type 1, 2 & 3) (Source: EPR)



2.3 Additional Emergency Department Metrics

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Type 1 Performance	74.3%	74.7%	75.1%	74.8%	74.3%	74.7%	76.2%	74.7%	75.9%	76.0%	74.1%	75.3%
Arrival to Assessment	00:19	00:19	00:16	00:17	00:20	00:19	00:17	00:17	00:17	00:21	00:20	00:18
Assessment to Treatment	02:51	03:15	02:50	02:45	02:56	03:02	03:07	03:18	02:42	03:04	03:03	02:54
Treatment Length	02:57	02:53	03:47	02:40	02:43	02:36	02:30	02:42	01:53	01:59	01:57	02:53
% Patients Streamed	46.3%	45.1%	89.2%	46.6%	46.6%	46.2%	47.0%	47.1%	47.0%	47.9%	44.4%	52.1%

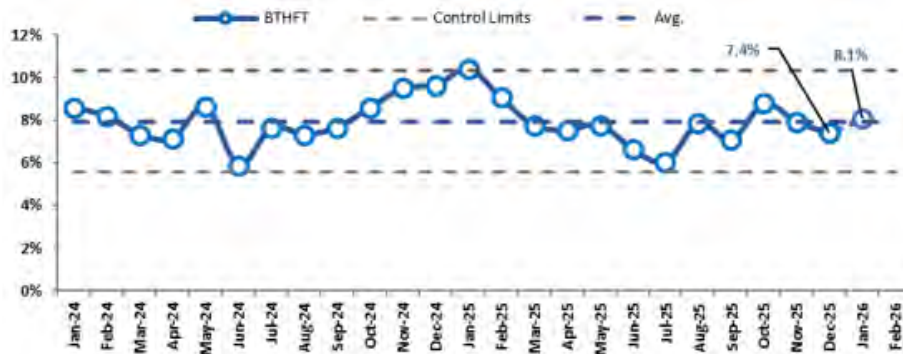
Latest position

- Daily attendances during December returned to predicted levels despite higher than planned demand in October and November.
- ECS performance for November and December improved to 82.45%, up from 81.16% in the same period in 2024 representing a 1.29% increase despite a slight increase in ED attendances.
- The improvement in ECS performance is reflective of the enhanced streaming to UTC, AECU and the newly opened medical SDEC, alongside increased 24/7 consultant cover.
- The continued utilisation of patient streaming provides the necessary resilience to manage periods of high demand, ensuring timely care for patients who would previously have experienced delays due to hospital pressures despite not requiring admission to a hospital bed.
- Following shared learning with Calderdale and Huddersfield NHS Foundation Trust (CHFT), ECS performance gains have been observed, and a similar streaming model is now being trialled, with associated metrics under ongoing review.
- BTHFT is also exploring the potential benefits of implementing FirstNet Model Content, which is now expected to be rolled in February 2026.

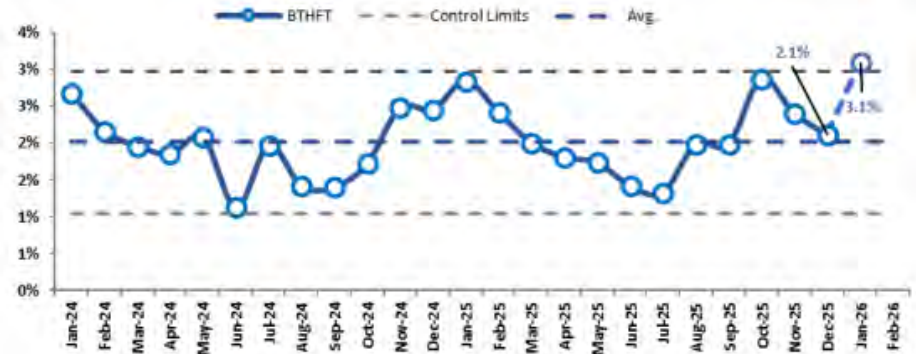
3. Emergency Department (ED) Length of Stay

Objective: Improve Patient Experience in ED

3.1 Patients with a 12 Hour LoS (as % of Type 1 Attendances)



3.2 % >12 Hour DTA to Admit



3.3 Additional Admission Metrics

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Avg. # Daily Admissions	81	83	84	84	84	87	86	81	89	88	87	81
Avg. Wait DTA to Admit	06:22	05:36	05:15	04:53	05:02	04:32	04:30	05:06	05:04	06:21	06:02	05:38
LoS (Admitted P'ts)	08:35	08:07	07:21	07:09	07:27	07:06	06:47	07:31	07:14	08:10	08:18	07:30
LoS (Discharged Pts)	03:05	03:09	03:01	03:03	03:05	03:02	02:53	02:50	02:56	03:08	03:09	03:03
LoS (Admitted & Discharged Pts)	04:15	04:10	03:55	03:53	03:58	03:52	03:40	03:49	03:51	04:09	04:08	03:57
% Patients Admitted	21.2%	20.3%	20.9%	20.5%	20.2%	20.6%	20.4%	21.0%	21.3%	20.0%	19.4%	21.4%

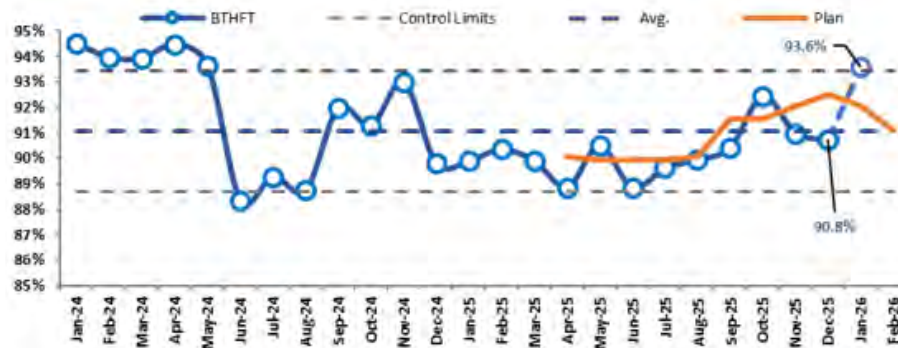
Latest position

- Recruitment to support AECU and ED in-reach is progressing to plan.
- During November and December 2025, performance against ED length-of-stay measures improved compared to the same time last year with the percentage of Type 1 attendances exceeding 12 hours reducing from 10% to 8% (a reduction of 372 patients) over same the two-month period.
- This was accompanied by a 50% reduction in 12-hour DTA breaches. The average length of stay for admitted ED patients also improved, reducing by ~25 minutes. These improvements reflect enhancements to medical SDEC, the implementation of a revised winter model focused on overnight assess-to-discharge and strengthened social care pathways.
- ED attendances exceeded plan in October and November before returning to plan in December, with 12-hour waits aligning with the higher demand profile. A slight increase is forecast for December, which may be influenced by increased bed occupancy.
- The EXCEL programme is progressing. It aims to reduce overcrowding and enhance patient experience through a collective approach. Key initiatives will focus on reducing demand on UEC Services, decreasing length of stay, and improving the staff experience.
- Discussions with patient groups, system partners, and other stakeholders have already shown an appetite for change and participation.
- Delivery work programme currently being reviewed in line with new executive sponsorship which will seek to better align the work of the CSU and the Excel programme.

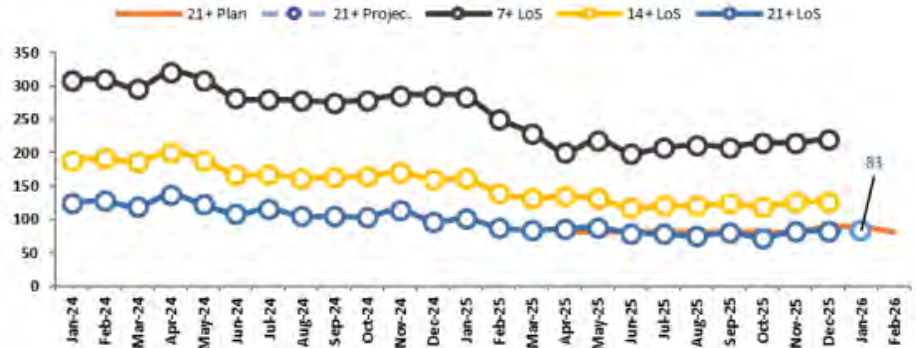
4. Inpatient Length of Stay (LoS)

Objective: Maintain Hospital capacity for daily admissions

4.1 Bed Occupancy



4.2 Patient LoS Profile (Source: EPR)



4.3 Additional Inpatient LoS Metrics

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Bed Occupancy	89.90%	90.35%	89.91%	88.88%	90.49%	88.86%	89.63%	89.95%	90.42%	92.44%	90.98%	90.76%
Avg. Inpatient LoS	5.0	4.5	4.3	4.9	4.3	4.2	4.5	4.7	4.7	4.4	4.5	4.9
% Patients Discharged <4PM	40.4%	40.4%	41.6%	40.0%	39.6%	38.5%	39.6%	38.8%	40.7%	38.1%	37.8%	42.6%
# NEL Admissions	3,380	3,792	4,152	3,958	4,183	4,072	4,149	3,872	4,036	4,244	4,078	4,131
7+ LoS	283	250	229	200	219	199	207	211	208	214	214	221
14+ LoS	162	140	133	135	132	117	121	121	124	120	127	127
21+ LoS	101	87	84	86	88	79	79	75	81	73	82	82

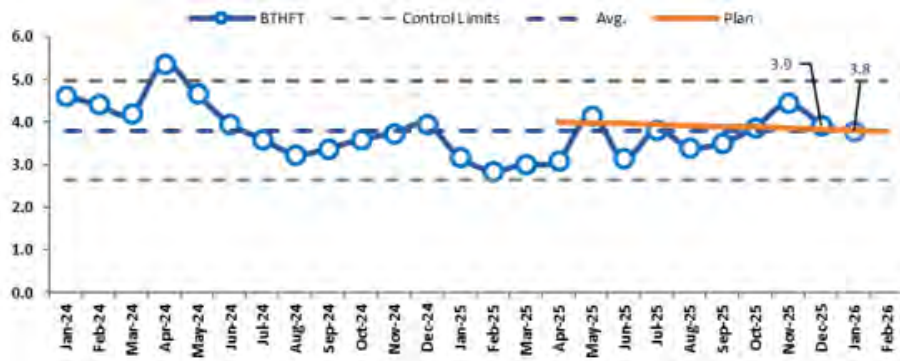
Latest position

- Total G&A bed occupancy reduced in December to 90.8% delivering below planned levels with increased NEL discharges observed.
- Bed occupancy increased in early January and is currently forecast to exceed plan for the month. Adult occupancy has risen from approximately 92% to 95% month to date, driven by increased ED admissions across multiple wards, including Surgical Assessment, Frailty, and Care of the Elderly.
- H-FAST capacity remains at four discharges per day, although eligibility criteria has reduced suitability increasing reliance on the BEST pathway (which carries a seven-day delay). The recent introduction of the LA bed bureau has also contributed to discharge delays. Short-term mitigations are in place, with a DTA gap analysis shared with the ICB and system-wide workshops underway to deliver longer-term improvements across all discharge pathways.
- Collaboration with ASC, Bevan, and housing teams is progressing to address discharge delays linked to homelessness. A mapping session in Nov '25 identified further commissioning needs for complex housing and care support – a further update is expected in February.
- A feasibility review is underway with VRI to identify suitable patient cohorts for discharge – further update expected in late February.
- A new Length of Stay process trialled to support earlier discharge has been placed on hold due to a lack of demonstrable benefit.
- The onboarding of the Optica system to enhance integrated discharge coordination and reporting is progressing with further work needed to assess cost and technical feasibility - go live date expected by Feb 26, subject to data validation and training requirements/resource.

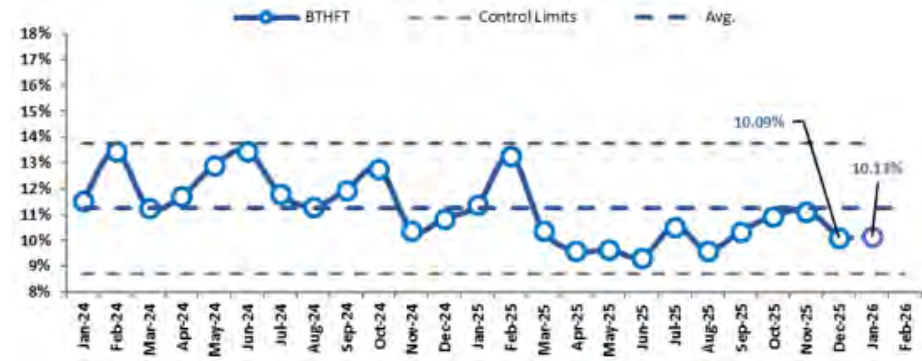
5. Discharge Processes

Objective: Ensure Timely Discharge

5.1 Average Delay Past Discharge Ready Date



5.2 % Patients Not Meeting Criteria to Reside



5.3 Additional Inpatient LoS Metrics

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
% of Pts with Discharge Ready Date	96.6%	94.2%	94.5%	93.0%	93.0%	93.9%	93.8%	93.6%	94.9%	95.8%	95.4%	94.5%
% of Pts Discharged on/before DRD	78.3%	80.4%	80.1%	79.8%	79.4%	79.2%	80.3%	79.7%	78.3%	79.4%	79.0%	76.5%

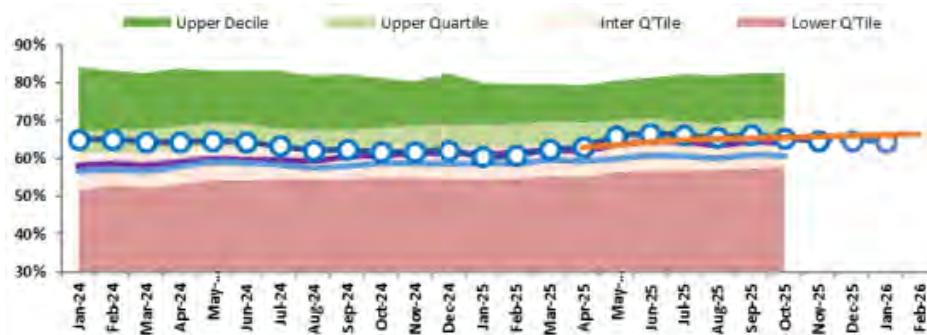
Latest position

- Patients with No Criteria To Reside (NCTR) has reduced in December with the average delays post Discharge Ready Date (DRD) showing a similar reduction.
- Due to staffing constraints in the Local Authority enablement provider services H-FAST cannot accept patients who require the attention of 2 resulting in some patients on pathway 1 experiencing discharge delays
- The LoS post medical and therapy optimisation for pathway 1 continues to reduce. Inpatient therapy does remain a challenge, and a review of capacity and demand has been completed; a paper on capacity and demand was submitted to ETM to understand and acknowledge the gaps and is expected to be followed by a business case.
- A review of discharge data has identified issues stemming from the use of "virtual chairs" and records left open post patient discharge - a 2-3 month project is underway to ensure wards enter accurate discharge dates and times once documentation is complete. (SM)
- Two Band 3 posts have been approved for a nine-month trial to support discharge delays and challenges, with HR processes now underway.
- BTHFT continues to work with Local Authority partners although capacity issues within the assessment and support teams and provider services have resulted in increased delays across pathways 1-3 impacting timely discharges.

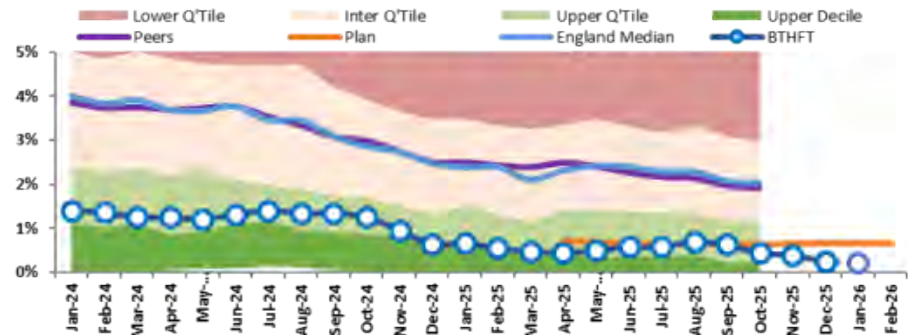
6. Referral to Treatment (RTT)

Objective: Deliver RTT Improvements

6.1 18 Week RTT Benchmarked (Source: NHSE for Acute & Combined Trusts)



6.2 52 Week RTT Benchmarked (Source: NHSE for Acute & Combined Trusts)



6.3 Additional RTT Metrics

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Waiting List Size	32,254	32,200	32,438	32,541	32,563	32,915	33,149	33,728	33,405	32,204	31,832	31,932
Waiting List Change		-54	+238	+103	+22	+352	+234	+579	-323	-1,201	-372	+100
% New RTT Within 18 Weeks	65.0%	64.3%	65.5%	66.5%	69.2%	68.2%	68.6%	68.4%	67.5%	68.0%	67.7%	67.8%
Incomplete (52+)	215	181	158	149	163	190	193	238	212	145	127	80

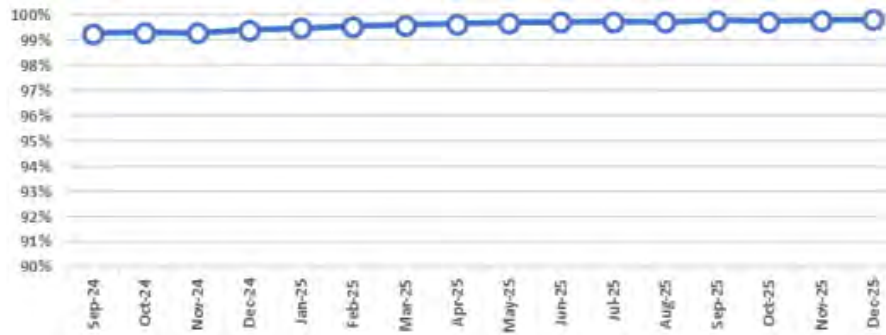
Latest position

- The RTT waiting list size rose slightly in December with reduced activity over the holiday period and due to strike action but is expected to resume falling in January as activity increases.
- The number of patients waiting over 52 weeks reduced in December due to a significant improvement in the Respiratory position, along with sustained improvement in Trauma and Orthopaedics who have 2 additional consultants now backfilling cancelled theatre session. No patient waited over 65 weeks, with the Trust meeting the national timescales set for clearance of this cohort.
- A Q4 outpatient sprint is expected to deliver 1500 extra new appointments and will positively impact the RTT position.
- Two new clinicians in Pain service will help stabilise their current capacity challenges delivering extra sessions each week.
- A support services improvement programme has been launched with the aim to improve understanding and compliance with the Referral to Treatment (RTT) policy across support services to strengthen their role in overall delivery. This will be achieved through the standardisation of processes, targeted staff training, and the implementation of robust, data-driven monitoring systems. The four area in scope are Pre assessment, Theatres and the Central Patient Booking Service.

7. Waiting List Management and Validation

Objective: Reduce Errors to Improve Wait Times

7.1 RTT Waiting List Confidence Level



7.2 Correction Rate



7.3 Additional WL Management and Validation Metrics

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
RTT LUNA DQ Metrics	19,551	19,583	20,237	20,562	21,442	21,960	21,960	22,136	22,108	21,050	20,591	20,700
Correction Rate - Non RTT	22.67%	14.00%	19.00%	33.92%	6.23%	7.36%	41.97%	23.36%	14.94%	15.28%	20.20%	23.09%
Non-RTT DQ Process Failures	12,703	12,617	12,201	11,979	11,121	10,955	11,189	11,592	11,297	11,154	11,241	11,232

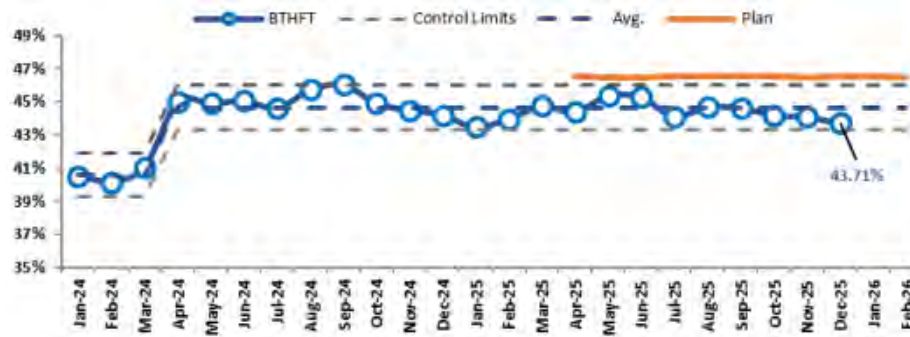
Latest position

- Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.82% in December 2025, this is the best position ever reported for the Trust. The number of DQ errors on RTT PTL reported on LUNA Dashboard remain low at 456 i.e. 1.40% of total waiting list size.
- The significant reduction in the number of DQ metrics on the RTT waiting list, this is due to targeted validation of incomplete pathways and improvement in staffing capacity in the Corporate Access Team (CAT).
- Technical validation of process failures is ongoing with 14193 pathways corrected and 24894 pathways removed in the last 12 months by CAT.
- The Data Quality Intervention Specialist (DQIS) team is supporting with high DQ errors on RTT pathways including Urology, ENT, Gastroenterology, Gynaecology and Cardiology. This includes RTT training of clinicians and ward staff.
- Text based validation of RTT and long waiting Non-RTT patients is being automated via the waiting list management tool.
- New structure of managing same day operations cancellations has been rolled out on the web-based waiting list management tool, this has provided services real time data to manage cancellations and rebook patients quicker.

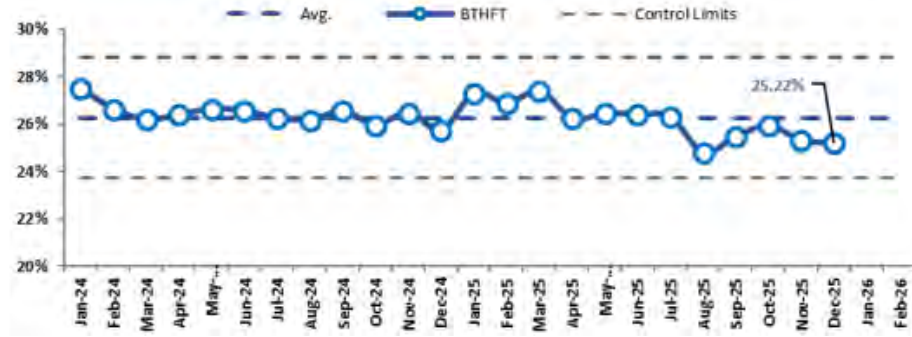
8. Outpatient Productivity

Objective: Improve Non-Admitted Productivity

8.1 % OPA that are New or with Procedure (Source: EPR)



8.2 Clock Stops /DTAs per Outpatient Appointment



8.3 Additional Outpatient Metrics

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
% New vs Plan	99%	101%	108%	103%	101%	107%	102%	102%	100%	98%	101%	103%
% Follow Up vs Plan	114%	117%	119%	116%	108%	113%	109%	113%	107%	106%	110%	115%
DNA Rate	9.04%	7.55%	7.52%	7.80%	7.90%	7.74%	7.64%	8.01%	8.18%	7.81%	8.43%	8.88%
Follow Up Orders	27,658	25,509	27,347	27,525	28,293	27,328	29,064	24,059	29,800	30,490	27,789	27,360
PIFU %	2.87%	3.80%	4.27%	4.50%	4.49%	4.43%	4.64%	4.36%	4.91%	4.74%	5.73%	4.65%
PIFU % (including Therapies)	3.44%	4.66%	5.24%	5.44%	5.52%	5.19%	5.67%	4.88%	5.16%	5.63%	6.50%	5.35%
First to Follow Up Ratio	2.7	2.7	2.6	2.8	2.7	2.6	2.7	2.8	2.7	2.7	2.7	2.8

Latest position

- The percentage outpatient appointments that are new or with procedure remain behind plan. Work continues to identify areas achieving below plans and improve the position through Robotic Process Automation where possible.
- PIFU use reduced slightly in December and increasing follow up demand remains an issue. These will remain a focus throughout 2025/26.
- Outpatient activity delivered slightly above plan in December and is expected to continue to do so with a focus on new appointments for Q4.
- Outpatient Transformation is focussed on service led pathway redesign supported by digital advancement and alignment of support processes. A straight to A&G process has been rolled out in several areas already with promising reduction in referrals and is expected expand further with Gynaecology next.
- Service Improvement training and clinical engagement efforts continued, and these are integral to long term transformational objectives.
- In the more immediate term, we are accelerating productivity related improvements, particularly relating to DNA rates and clinic template configuration as part of the Financial Recovery Board's plan.

9. Inpatient Productivity

Objective: Increase Elective Ordinary and Day Case Volumes

9.1 Elective Activity (day cases and ordinary) (Source: EPR)



9.2 Elective Activity in Theatre



9.3 Additional Inpatient Metrics

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Admitted Clock Stops	1,521	1,496	1,647	1,247	1,231	1,275	1,425	1,100	1,315	1,391	1,245	1,226
Daycase Rate	89.6%	88.4%	87.5%	89.8%	89.0%	88.5%	88.0%	86.9%	88.6%	88.2%	87.8%	88.3%
Number of Lists Run	634	628	662	599	582	635	632	564	666	714	607	594
Patients Per List	1.9	2.0	2.1	1.9	2.0	2.0	2.1	2.0	2.0	2.0	2.1	2.0
Reportable Cancellations	77	45	31	35	46	31	66	45	45	56	44	
28-day Rebooking Breaches	20	21	11	9	9	8	7	13	17	7	4	

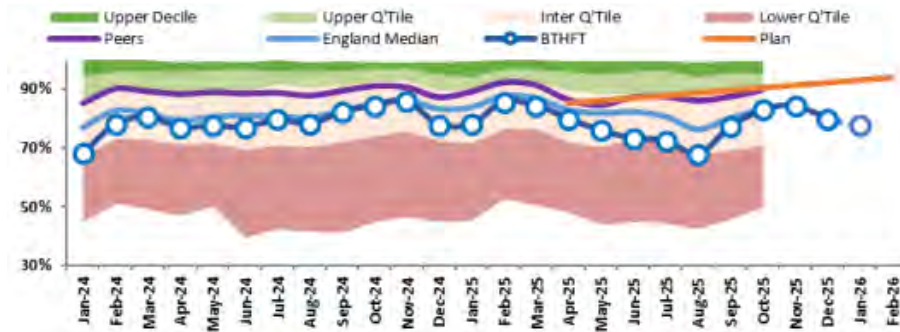
Latest position

- Activity remains behind plan due primarily to the Day Case Unit delay. Mitigation includes weekend lists, but activity is forecast to remain slightly below plan in January.
- The T&O improvement programme is now up-and-running and should identify productivity opportunities. Despite this, recovery remains slow and options to run Medinet lists or use the independent sector are being explored for 26/27.
- Plastics are in the process of agreeing an SLA with Airedale and beginning to use the Theatre Forward Wait area to increase operating lists and drive admitted recovery.
- A Theatre and Critical Care (TACC) module was added to our EPR in late November 2024 and services successfully migrated from Galaxy to this build. Reporting was impacted as a result but has now partially resumed. Work on developing a full theatre reporting suite continues.
- Early indications suggests utilisation has dropped during this period. Theatre efficiency improvement aiming to increase the number of lists run and the number of patients per list are a key part of our operational excellence plan with productivity targets aligned to national analysis and the operational planning trajectories set with NHSE.
- The Support Services improvement programme should also support improvements in coming months.

10. Diagnostic Waiting Times

Objective: Increase Activity to Reduce Delays for Diagnostic Tests

10.1 DM01 6-week Performance (Source: NHSE for Acute & Combined Trusts)



10.2 Diagnostic Activity vs Plan



10.3 Additional Diagnostic Metrics

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
(Phys. M'ment) Activity	1,386	1,425	1,428	1,461	1,403	1,686	1,872	1,711	1,862	2,035	1,740	1,539
(Phys. M'ment) Performance	69.7%	76.5%	74.9%	69.2%	62.6%	56.6%	59.1%	60.5%	70.2%	70.8%	69.1%	58.3%
(Imaging) Activity	9,182	8,516	9,070	9,147	9,148	9,081	9,792	9,174	10,270	10,536	9,577	9,262
(Imaging) Performance	79.3%	87.9%	86.9%	83.8%	81.2%	78.8%	76.3%	68.4%	77.7%	85.2%	87.7%	84.5%
(Endoscopy) Activity	1,625	1,537	1,546	1,484	1,455	1,437	1,714	1,437	1,807	1,682	1,594	1,520
(Endoscopy) Performance	87.9%	91.9%	90.7%	85.4%	83.9%	80.6%	82.7%	82.5%	92.8%	92.4%	92.6%	89.5%

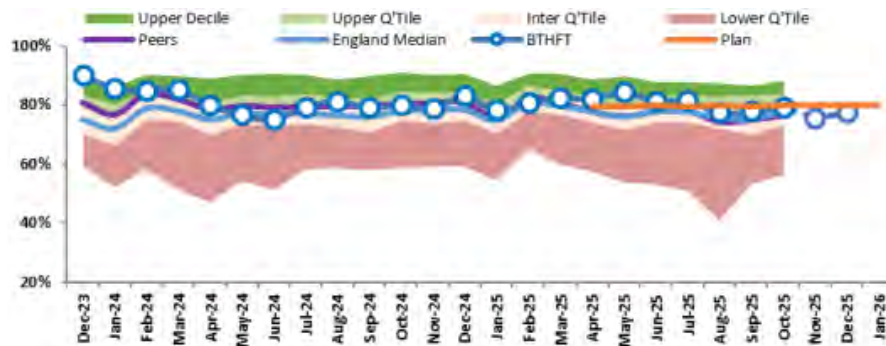
Latest position

- DM01 performance for December has reduced to 79.71% due to ongoing challenges in Audiology, Neurophysiology and Urodynamics.
- Despite insourcing remaining in place for Non-Obstetric Ultrasound, the unavailability of the locum has resulted in a temporary drop of activity and is delaying recovery.
- In Audiology, recruitment is ongoing while the service is continuing to offer overtime weekend clinics. The service remains closed to new adult referrals. Furthermore, insourcing has been approved and is now at the point of award.
- Neurophysiology continues to face staffing challenges, with no option to provide additional clinics due to costs. The service has now gone out to tender.
- In Urodynamics, partial booking was introduced and increased capacity is planned into the new year. Staff have now also had additional training to ensure attendance and discharges are accurately recorded in all systems.
- Cardiology performance will also be impacted going forwards, due to the increase in Stress Echo referrals as per GIRFT recommendations (previously referred as Myoview), until a business case can be approved for additional capacity.

11. Cancer Diagnostic Phase

Objective: Deliver the Faster Diagnosis Standard (FDS)

11.1 28 Day FDS Benchmarked (Source: NHSE for Acute & Combined Trusts)



11.2 28 Day Performance by Tumour Group vs 80% Target (Source: PPM)

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Trust	81.2%	81.6%	75.5%	77.8%	79.4%	75.5%	77.5%
Breast	93.6%	92.5%	93.9%	96.2%	97.8%	97.4%	96.1%
Gynae	71.5%	69.7%	76.1%	64.9%	77.8%	68.3%	70.0%
Haematology	30.0%	54.5%	54.6%	59.1%	75.0%	72.7%	63.6%
Head & Neck	79.6%	84.4%	83.0%	80.1%	80.8%	77.1%	81.4%
Lower GI	65.4%	66.4%	56.0%	61.7%	63.4%	59.6%	70.7%
Lung	85.7%	94.3%	83.3%	91.9%	86.0%	89.7%	88.4%
NSS	95.7%	90.3%	76.0%	100.0%	94.4%	94.1%	94.7%
Upper GI	81.8%	78.8%	72.7%	77.3%	77.7%	87.1%	80.2%
Skin	87.1%	85.4%	71.3%	74.6%	67.9%	62.2%	65.4%
Urology	71.9%	67.1%	65.0%	68.6%	84.6%	77.8%	67.8%

11.3 Additional Cancer Diagnostic Metrics

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
# 2WW Refs	1,596	1,823	1,900	1,800	1,819	1,963	2,050	2,068	1,737	2,123	1,977	1,828
% 2WW Performance	90.9%	88.0%	93.1%	93.8%	87.4%	82.3%	83.7%	79.8%	86.7%	94.0%	94.9%	94.8%
28 Day FDS Performance	83.4%	78.4%	81.0%	82.5%	82.1%	84.5%	81.2%	81.6%	77.0%	77.8%	79.4%	75.5%
# Total Patients Seen FDS	1,466	1,568	1,598	1,782	1,705	1,727	1,917	2,106	1,941	2,080	2,020	1,872
# Undiag, unbooked >28 days	264	300	228	244	267	261	213	340	264	288	337	282

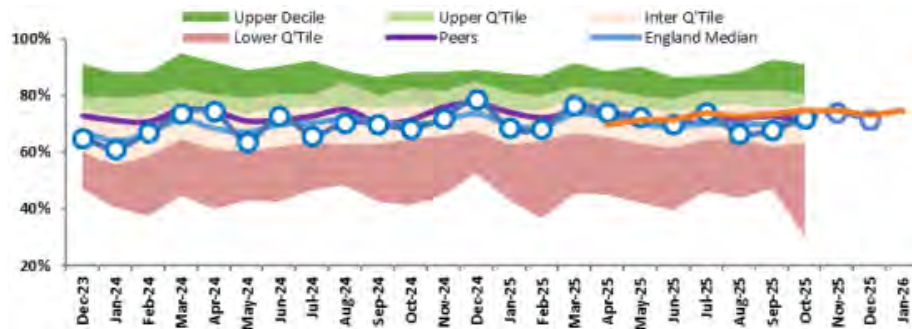
Latest position

- Two week wait (2WW) performance is predicted to improve on the November position of 94.4% in December. The estates work on the additional room to provide additional one-stop capacity on a regular basis should be complete by the beginning of February 2026
- The FDS performance for December is forecast to be below the 80% target.
- The Skin and Gynaecology pathways continue to be impacted by histology reporting backlogs.
- For Lower GI, capacity is being strained by a combination of the Bowel Cancer Screening age reduction and increased referrals, coupled with reduced capacity due to retirement; however, related typing backlogs have now been addressed.
- Across all pathways, patient compliance issues are noted as an overarching challenge. Initiatives such as proactive phone calls to patients likely to DNA, bus tickets to encourage attendance and targeted engagement work in Endoscopy remain in place.
- Work on MDT streamlining continues with the MDT Programme which is targeting objectives to improve this stage of the patient pathway along with a system wide focus on improvements for notifying patients of a benign cancer diagnosis and improving reporting processes.

12. Cancer Treatment

Objective: Deliver the 62 Day Treatment Standard

12.1 62 Day Treatment Benchmarked (Source: NHSE for Acute & Combined)



12.2 62 Day Performance by Tumour Group vs Plan (Source: PPM)

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Trust	70.0%	74.3%	75.0%	67.9%	72.0%	74.3%	71.9%
Breast	84.8%	82.1%	83.7%	85.9%	83.7%	92.6%	84.8%
Gynae	40.0%	46.7%	100.0%	20.0%	87.5%	77.8%	27.3%
Haematology	63.6%	46.7%	52.9%	66.7%	72.7%	73.9%	83.3%
Head & Neck	52.4%	51.9%	100.0%	39.3%	35.0%	35.9%	30.0%
Lower GI	60.0%	44.4%	40.0%	33.3%	31.0%	70.0%	62.5%
Lung	14.3%	30.8%	69.6%	10.5%	42.1%	63.6%	43.8%
Upper GI	81.8%	76.2%	87.5%	88.0%	77.8%	77.8%	75.0%
Skin	93.5%	90.2%	97.2%	84.7%	83.0%	80.5%	86.7%
Urology	59.6%	86.2%	74.6%	72.1%	74.7%	68.2%	75.9%

12.3 Additional Cancer Treatment Metrics

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
# 31 Day Treatments	228	221	217	229	241	230	249	254	232	277	295	260
31 Day Performance	93.0%	93.7%	96.3%	95.6%	96.7%	93.5%	94.4%	94.1%	95.7%	93.1%	94.9%	93.8%
62 Day Performance	78.5%	68.4%	68.1%	76.7%	74.4%	72.6%	70.0%	74.3%	75.0%	67.9%	72.0%	74.3%
62 Day Backlog	67	102	96	58	70	84	63	60	99	97	73	60

Latest position

- December performance against the 62 Day standard is projected to remain below plan.
- Complex diagnostic pathways are still impacting performance across most 62-day pathways, with Lower GI most affected. Provider delays are prevalent across all pathways with late inter provider transfers being a particular issue with Lung.
- The Skin pathway continues to struggle with a backlog and operational issues due to the loss of a Lead/substantive Consultant and lack of senior-decision makers.
- Other significant concerns include addressing patient compliance issues, reporting delays and some outpatient and elective and preassessment capacity constraints
- Civica go live remains on hold but should be announced soon. Benefits include Personalised Stratified Follow Up (PSFU) and digital remote monitoring system (RMS) for patients after cancer treatment, which will reduce unnecessary follow-ups.
- This will also provide the data needed to better review our services against best practice time pathways and identify areas for further improvement, building on existing pathway improvement and MDT optimisation workstreams.

F&P Committee				
Meeting Date:	29/01/26		Agenda Reference:	Bo.1.26.12
Report Title:	Green Plan Progress Update			
Presented by:	David Moss – Director of Estates & Facilities			
Executive Lead:	David Moss – Director of Estates & Facilities			
Author:	Robert Dadzie, Head of Sustainability			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	• The Trust’s Green Plan was updated and approved by the Board in July 2025. Since approval, a number of priority actions have been delivered in support of the Trust’s sustainability objectives. • Progress over the past year includes the roll-out of NHS carbon awareness training, delivery of Board-level sustainability training, implementation of a dedicated communications strategy, and completion of a Trust-wide staff travel survey. • The carbon footprint assessment for FY 2024/25 has also been drafted in preparation for Annual Report submission, with the assessment boundary expanded to include emissions from revenue and capital purchases. Preparations are presently underway for TCFD disclosure. • External funding has been secured to support the removal of the Trust’s remaining nitrous oxide manifolds. In addition, PSDS Phase 4 funding has been awarded to enable the planned connection of St Luke’s Hospital to the Bradford Energy Network. • The Trust’s sustainability engagement programme continues to develop, with 28 Green Champions recruited across the organisation following last year’s sustainability drive. Assurance provided: The report provides assurance that the Trust is making demonstrable progress in delivering the commitments set out in its Green Plan, that appropriate governance and oversight arrangements are in place, and that key actions are being advanced in line with national NHS net zero requirements and local sustainability priorities.			
Recommendation/s: (including any decision/approval required)	The Board is asked to note the requirement for climate-related financial disclosure as part of TCFD submissions in the Annual Report. Additionally, Board is asked to support this development by endorsing the inclusion of climate-related financial risks and opportunities into the Trust’s financial planning, risk management, processes, in line with emerging NHS and regulatory expectations.			

Link to Strategic Objective:	Sustainability - To deliver our financial plan and key performance targets
Link to Priority Initiatives 2025/26:	Green Plan
Implications	
Risk:	N/A
Legal/Regulatory:	The Task Force on Climate-related Financial Disclosures (TCFD) is a framework that helps organisations understand and disclose how climate change may affect their finances, assets, and long-term sustainability. It focuses on identifying climate-related risks and opportunities, such as the impact of extreme weather, energy costs, supply chains, and future regulation. Within the NHS, TCFD is becoming an expected part of good financial governance and supports better long-term decision-making in areas such as capital investment, procurement, and risk management. TCFD is built around four core areas that describe how climate change may affect the Trust's financial sustainability: • Governance – how the Board and Executive oversee climate-related risks. • Strategy – how climate impacts are considered in future planning, estates and investment decisions. • Risk Management – how climate-related risks are identified and managed alongside other financial and procurement risks. • Metrics and Targets – how impacts such as emissions and energy use are measured and monitored.
Quality & Patient Safety:	The actions outlined support improved estate resilience, safer clinical infrastructure and greater organisational preparedness for climate-related risks, helping to enhance quality and protect safety of patient care. There are no identified adverse impacts on quality or patient safety.
Equality, Diversity and Inclusion and Health Equity:	The Green Plan supports efforts to reduce health inequalities in Bradford by contributing to improved air quality and reduced travel-related emissions, in line with the Bradford Clean Air Zone. Initiatives such as remote consultations and delivery of care closer to home improve access to services and support more equitable health outcomes for local communities.
Resources:	The following resources will be essential to the success of the Plan: • Financial investment – Continued access to capital funding is required to deliver infrastructure and estate improvements, with some reliance on external funding sources. • Staff capacity – Delivery depends on sufficient dedicated time across Estates and Facilities, Procurement, Informatics, clinical leadership and the Green Champions network. • Training – Ongoing investment is needed to upskill the workforce and embed sustainability and Net Zero principles into routine practice. • Governance and oversight – Clear governance arrangements and Exec Board oversight are required to ensure effective delivery of the Green Plan.
Environmental sustainability:	The Green Plan is expected to deliver a significant positive impact on environmental sustainability by reducing the Trust's carbon footprint, improving air quality, cutting waste, and enhancing biodiversity across the estate.

	Through targeted actions such as energy efficiency upgrades, fleet decarbonisation, sustainable procurement, and improved waste management, the Trust will reduce both direct and indirect emissions in line with NHS Net Zero targets. The plan also supports climate adaptation by making buildings and services more resilient to extreme weather, while green space enhancements will promote biodiversity and contribute to a healthier environment for patients, staff, and the wider community.
Assurance Route	
Meeting/s where content has been discussed previously:	The Trust's Green Plan was updated and approved by the Board in July 2025.

Report content	
1. Purpose The purpose of this paper is to provide the Board with an update on progress against the Trust's Green Plan, including recent sustainability achievements, secured external funding, and the recalculation of the Trust's greenhouse gas (GHG) assessment to include emissions from revenue and capital purchases. The paper also seeks Board support for the continued development of climate-related financial disclosures and associated governance arrangements. 2. Background/context The Green Plan is a strategic requirement aligned with national NHS Net Zero commitments and sets out actions that will have implications for the Trust's operations, finances and clinical activity. Delivery of the Plan requires coordinated action across the organisation, supported by clear governance and sustained Board oversight. This paper responds to NHS guidance requiring all Trusts to maintain an up-to-date Green Plan and builds on previous sustainability activity, stakeholder engagement and an assessment of the Trust's environmental risks and opportunities. 3. Assessment The Trust's Green Plan sets out a structured response to the increasing financial, operational and regulatory impacts of climate change on NHS organisations. Key drivers include rising energy costs, exposure of estates and supply chains to climate-related disruption, national NHS Net Zero commitments, and emerging expectations around climate-related financial disclosure. The recalculation of the Trust's greenhouse gas (GHG) footprint to include emissions from both revenue and capital purchases reflects improved data maturity and alignment with national guidance. This expanded boundary provides a more accurate understanding of the Trust's emissions profile, particularly in relation to procurement and capital investment decisions, which represent a significant proportion of NHS emissions. 4. Level of assurance This paper provides moderate assurance that the Trust is making appropriate progress in delivering its Green Plan, that key sustainability actions and funding have been secured, and that arrangements are being developed to strengthen climate-related financial risk management and disclosure. Further assurance will be provided as this work matures and is embedded within routine governance and reporting processes.	

5. Options analysis/Proposal

In the short term, the Trust will set out a practical approach to climate-related financial disclosure in line with TCFD, agree clear leadership and oversight arrangements, and use the updated GHG assessment to help focus Green Plan priorities. Over the medium term, climate-related risks will be built into existing financial planning, risk and procurement processes, supported by better data and staff capability. Over time, these considerations will become part of routine decision-making and capital planning, with progress overseen through existing governance arrangements.

Osbourne, Sheridan
26/01/2026 12:25:00

Green Plan 2025-2028

Bradford Teaching Hospitals NHS Foundation
Trust

May 2025

Osbourne Sheridan
26/01/2026 12:25:00

Issue and Versions Control

Revision	Date	Originator	Checker	Approver	Description

Document reference:

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Introduction

The climate emergency is a health emergency. Climate change is a profound public health challenge that directly impacts the wellbeing of patients and our communities. From heatwaves causing heat-related illnesses to flooding disrupting healthcare services, the consequences are far-reaching and severe.

By prioritising carbon emission reductions and integrating environmentally sustainable practices, the environmental impact of healthcare delivery can be reduced.

In 2020, the NHS became the world's first health system to commit to reaching net zero emissions, publishing the [Delivering a 'Net Zero' National Health Service](#)¹ report. The NHS then embedded net zero into legislation through the Health and Care Act 2022; following which the [Delivering a 'Net Zero' NHS](#) report is now statutory guidance.

Classification: Official



Delivering a 'Net Zero' National Health Service



Achieving net zero and embracing sustainability are not just ethical imperatives but practical necessities for the NHS.

It is imperative that action is taken now to mitigate these impacts and safeguard the health of future generations.

By transitioning to renewable energy sources, reducing waste, and promoting sustainable procurement, healthier environments can be created for our patients and staff. These actions will help combat climate change and enhance the resilience of our healthcare system.

¹ <https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/>

NHS Green Plans

Trusts and Integrated Care Boards (ICBs) are expected to meet the climate challenge and address their duties and statutory responsibilities through the delivery of board-approved Green Plans.

Green Plans focus on the environmental aspects of the health system at an organisational level, to improve sustainable operations and increase the positive contributions to the wider populations health.

Following NHS England's update to its Green Plan guidance in February 2025², this document is our, Bradford Teaching Hospitals NHS Foundation Trust (BTHFT), Green Plan 2025-2028, defining our programme of sustainable activity for the next three years.

With specific alignment to the guidance, we have:

- Reviewed our progress to date and engaged with key stakeholders, in particular clinical and staff groups, who underpin green plan delivery to identify our priorities;
- Considered the NHS national carbon emissions targets;
- Set SMART objectives and associated actions for each Green Plan area of focus;
- Revised governance for our Green Plan to measure and report on progress; and
- Ensured compliance with any applicable legal duties, including the duty to reduce inequalities, the Public Sector Equality Duty and the duty to have regard to all likely wider effect of decisions.

Our strategic objectives are supported by focus area action plans outlining how we intend to reach our sustainable aspirations.

² <https://www.england.nhs.uk/long-read/green-plan-guidance/>

Our Journey So Far

The Green Plan 2025-2028 is not the beginning of our sustainability journey. Whilst developing the Green Plan we have reflected on our journey to date, our vision and our current carbon footprint. The 'look back' has allowed us to identify our successes so far, and further areas for improvement.

Bradford Teaching Hospitals NHS Foundation Trust

BTHFT is responsible for providing hospital and community services for the people of Bradford and beyond. We employ approximately 6,400 members of staff and have an annual revenue of £500m.

We operate over several sites including:

- **Bradford Royal Infirmary (BRI)** which provides the majority of our inpatient services, has one of the busiest single site A&E departments in the country with up to 400 daily attendances, and one of the busiest maternity units, delivering more than 6,000 babies each year
- **St Luke's Hospital (SLH)** which predominantly provides outpatient and rehabilitation services

We collaborate with various academic institutions and research organisations to conduct clinical trials and studies. This commitment to research ensures that our patients have access to the latest medical advancements and evidence-based care.

We are deeply embedded in our local community and strive to reflect and represent its diverse population. As an anchor institute, BTHFT exists to support the wider Bradford goal of helping our people to stay happy, healthy and at home.

We are extremely conscious of the impact our activities can have on the local community, economy and environment, and of the role we play as a responsible healthcare provider.

Our Vision

The **Our Patients, Our People, Our Place and Our Partners – Our Corporate Strategy 2022-2027**³ describes our vision:

“To be an outstanding provider of healthcare, research and education and a great place to work.”

We are proud to be part of the Bradford District and Craven Health and Care Partnership (BCDHCP). In our local health and care partnership (HCP), we have a joint vision to **act as one to keep people happy, healthy at home.**

Through the delivery of this vision and by working with our local HCP partners to nurture our workforce and manage our finances and resources wisely, we can provide new and innovative services to address inequalities.

Our strategy shapes our ambitions around four themes:

- **Our Patients** – we are committed to making a difference to everyone who needs our care. We recognise that we will best do this by developing high quality, innovative services and by continuing to develop and embed a culture of kindness to ensure a positive patient experience.
- **Our People** – we will continue to develop and nurture our people to create an environment where they can thrive and deliver outstanding care. We will value diversity and create a culture that is inclusive of all.
- **Our Place** – we are committed to making a difference for every member of our community who needs our care, wherever possible meeting them where they are and helping them to live longer in good health.
- **Our Partners** – we will work with partners across West Yorkshire; tackling problems together that cannot be resolved by individual organisations alone.

³ <https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2022/06/Our-Corporate-Strategy-2022%E2%80%932027.pdf>

Our corporate strategy explains that our ambitions are not simply a list of things we want to do; they are coherent and mutually reinforcing and will ensure that we meet our Trust strategic objectives through the delivery of the objectives.



Our 2020-2025 Green Plan

We created our first Green Plan in 2020⁴ prior to the NHS mandate for Green Plans. Our 2020-2025 Green Plan outlined our commitment to sustainability and highlighted the specific challenges Bradford faces in terms of climate change and environmental pollution.

The 2020-2025 Green Plan set the following key objectives:

1. **Carbon reduction** – achieve significant reductions in carbon emissions through energy efficiency, renewable energy, and sustainable practices.
2. **Waste management** – improve waste segregation, recycling, and reduce overall waste production.
3. **Water conservation** – implement measures to reduce water consumption and enhance water efficiency.

⁴ <https://www.bradfordhospitals.nhs.uk/green-plan/>

4. **Sustainable travel** – promote sustainable travel options for staff and patients, including cycling and public transport.
5. **Biodiversity** – enhance green spaces and biodiversity within hospital grounds.

The plan included a robust governance structure to ensure accountability and monitor progress and outlined the intention for regular reviews and updates. The actions we had taken prior to 2020 were detailed, using the now expired Sustainable Development Assessment Tool (SDAT) headings with actions for implementation and governance arrangements.

Developing our Green Plan 2025-2028 is one of the ways in which we are demonstrating our commitment to improving our sustainability credentials.

Our Successes So Far

Since the publication of our 2020-2025 Green Plan, significant effort has gone into a range of initiatives.



Developing our Green Plan 2025-2028

Following the updated guidance from NHS England, we have developed our Green Plan 2025-2028, building on our previous successes and aligning with the new areas of focus.

We held interviews with key stakeholders to discuss progress over the last 5 years and their vision for the Green Plan 2025-2028.

The interviews were followed with a workshop to discuss the requirements of the guidance and how that aligns with our own ambitions. The workshop enabled our teams across the Trust to collaborate on ideas for the Green Plan and highlight challenges that they may face during implementation.

The following stakeholders were consulted on the development of the Green Plan 2025-2028 and supporting action plan:

- | | |
|---|--|
| • Director of Estates and Facilities | • Head of Facilities |
| • Deputy Director of Estates and Facilities | • Anaesthetic and Renal Consultants |
| • Head of Sustainability | • Partnership Lead |
| • Energy Manager | • Director of Pharmacy |
| • Operational Head of Procurement | • Emergency, Planning, Resilience and Response manager |
| • Senior Procurement Manager Non-Clinical | • Director of Strategy and Transformation |
| • Senior Head of Facilities | • Chief Finance Officer |
| • Policy Manager, Strategy and Integration | • IT Programme Manager |
| • Catering Manager | • Head of Portering |
| • Chief People and Purpose Officer | • Chief Digital and Information Officer |
| • Chief Medical Officer (CMO) | • Operating Officer/ Deputy CEO |

We've invested in **secure cycle shelters, locker rooms and showers**, alongside running a **bike loan scheme**. We also **subsidise public transport season tickets** for staff

Following the heatwave of summer 2022, we have **upgraded our servers** to combine 5 units into a single system to **improve efficiency**.

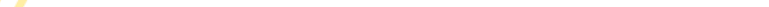
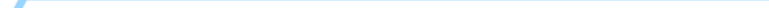
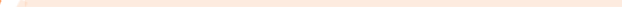
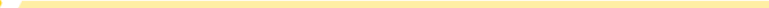
We have **removed desflurane** (an anaesthetic gas with a significant carbon footprint) from our theatres

A **10% social value levy** is now included in all our contracts

We have implemented an auditing system that manages existing stock to **reduce ordering**. So far, we have **saved around £200,000**

We've **improved waste streaming** in our theatres

We are rolling out **segregated waste bins** across the Trust estate



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What you told us

To ensure staff across the Trust were able to input into the sustainability agenda, a survey form was shared to capture initiatives and ideas for the Trust and provide the opportunity for staff to become involved with the Green Plan as a ‘Green Champion’.

Director of E&F	•"The emerging Green Plan should be based on Actions".
Head of Sustainability	•"The Green Plan should be a prominent strategy that's integrated by the Trust and which underpins our decision making process".
Nurse	•"Focus should be on Recycling and using less energy".
Support Manager	•"The plan should ensure that older buildings are viable to run and operate efficiently. It should aim to design better places including green space".
Senior Administrator	•"Focus should be placed on green spaces and encouraging relaxed mowing to promote wildflowers and insect diversity".
General Manager	•"Focus should be on direct carbon emissions i.e. those within our immediate control: utilities, energy, waste, consumables, prescriptions, virtual appointments, travelling to and from the hospital".
Head of Education	•"The plan should promote better transport links to the hospital sites and car pooling. Consider shuttle bus from the train station during peak hours to promote use of public transport. Provide better vegetation options in catering and consider Meat Free Mondays. Focus on recycling".

Emerging Themes

The following Themes have emerged following review of staff survey responses:

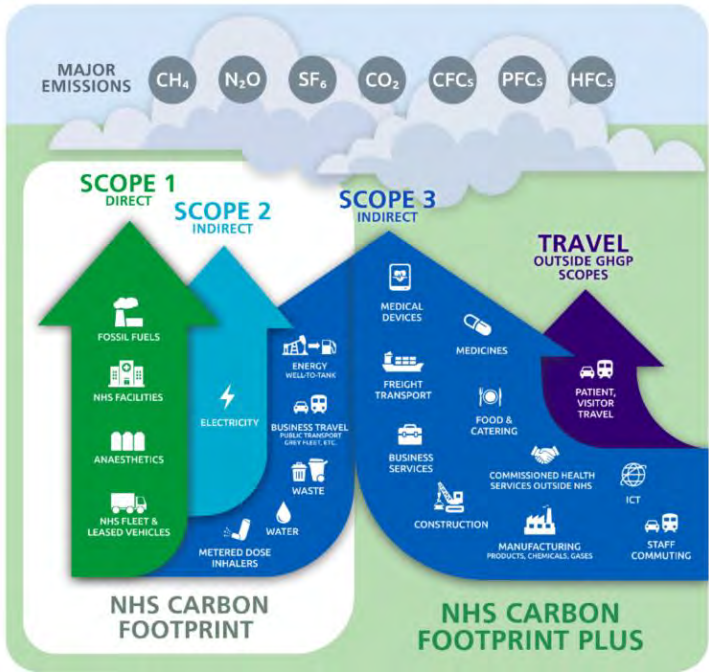
- **Integration** – The Green Plan should be closely aligned with the Trust’s corporate objectives and strategic ambition.
- **Waste management** – Further efforts should be made to prioritise the segregation of clinical waste and to promote recycling. Opportunities to limit single use materials should also be sought in an effort to promote circular economies.
- **Energy efficiency and Net Zero** – Operational energy efficiency should support the decarbonisation targets for the Trust. Buildings should be designed to maximise optimisation and occupant comfort.
- **Green Spaces and Biodiversity** – The Trust should work to enhance its existing Green Spaces whilst also identifying opportunities to develop new areas of natural habitats.
- **Green Travel and Transport** – A Green Travel Plan should be developed which encourages active modes of travel, whilst further promoting the uptake of public transport and car-pooling.
- **Sustainable Catering** – Efforts should be made to align our catering contracts with the Green Plan, by aligning nutritional guidance with both seasonal menus and meat-free options.



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Our Carbon Footprint

As part of our commitment to NHS net zero targets, we undertake annual carbon reporting for our NHS Carbon Footprint⁵. Historically, it has been challenging to quantify many of our scope 3 emissions, however we have an ambition to expand and improve our data capture and reporting, enabling further reductions of our carbon emissions.



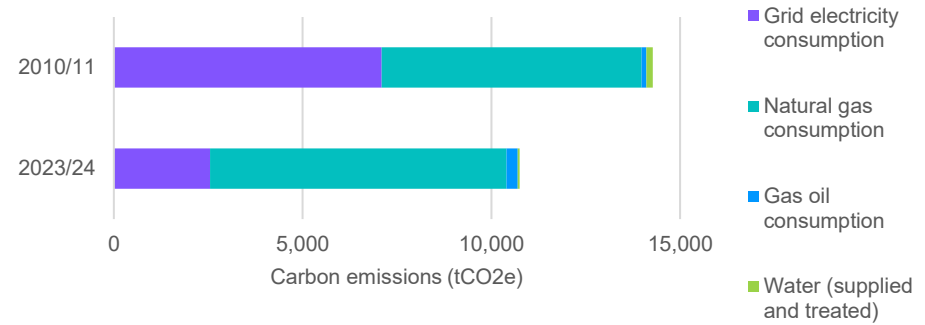
We have data available for several emissions sources from 2010/11. Therefore, we use 2010/11 data as our baseline year.

Comparing the energy and water use from 2010/11 to our 2023/24 data we have reduced these carbon emissions by 25% from our baseline year.

⁵ As defined in the 'Delivering a Net Zero National Health Service' report

There has been a 14% increase in total gas consumption, when compared with the baseline year, which has resulted from the installation of Combined Heat and Power (CHP) units at BRI and St Luke's. These units use natural gas to produce heat and electricity, which has contributed to a 64% reduction in the amount of electricity we need to import from the national grid. Historically, CHPs have reduced our operational energy costs and carbon emissions. However, these units are still dependant on fossil fuels, and as such, will need to be replaced as the national electricity grid decarbonises. Our heat decarbonisation plans (HDPs) will support this challenge.

Emission source (tCO ₂ e)	2010/11	2023/24	Percentage change
Grid electricity consumption	7,090	2,549 ⁶	-64%
Natural gas consumption	6,894	7,850	14%
Gas oil consumption	121	298	146%
Water (supplied and treated)	175	48	-73%
Total	14,280	10,745	-25%



Our gas oil consumption shows the largest percentage rise (146%) due to an increase in purchased fuel. However, total emissions from this energy source remain below 3%. Emissions from this backup fuel, are significantly lower than the emissions associated with grid electricity and natural gas.

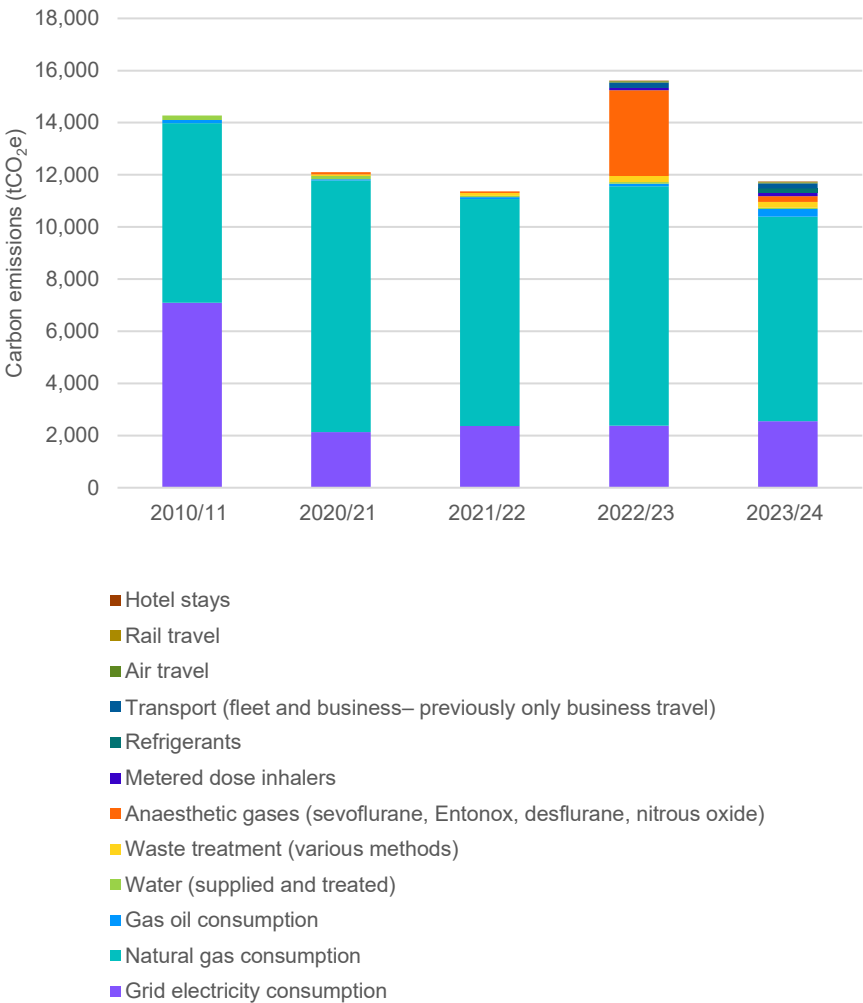
⁶ Grid electricity emissions are reported using 'location based' factors in line with NHS guidance. These do not capture the reduction in emissions through the procurement of renewable energy guarantees of origin (REGO) backed electricity.

We have worked across our sites to reduce our water usage and associated emissions, as a result we are currently 73% below our baseline.

As more data becomes available, we're able to improve the accuracy of our analysis and the scope of our assessment boundary, which provides a more accurate picture of our carbon footprint. One emissions source, which has experienced considerable improvement in data availability has been Anaesthetic gases. The 2022/23 assessment saw a significant rise in reported emissions from anaesthetic gases, which can be attributed to improved visibility of data from this category. The subsequent reduction in emissions experienced throughout the 2023/24 reporting period demonstrates the impact of desflurane use, which we have now removed.

NHS Carbon Footprint emissions (tCO ₂ e)	2010/11	2020/21	2021/22	2022/23	2023/24
Grid electricity consumption	7,090	2,137	2,372	2,382	2,549
Natural gas consumption	6,894	9,651	8,695	9,179	7,850
Gas oil consumption	121	44	74	105	298
Water (supplied and treated)	175	129	52	55	48
Waste treatment (various methods)	-	62	107	229	219
Anaesthetic gases (sevoflurane, Entonox, desflurane, nitrous oxide)	-	74	68	3,299	216
Metered dose inhalers	-	-	-	81	122
Refrigerants	-	-	-	-	176
Transport (fleet and business– previously only business travel)	-	-	-	216	189
Air travel				39	49
Rail travel				11	18
Hotel stays				8	14
Total	14,280	12,181	11,441	15,605	11,747

When comparing the extended dataset against our baseline total emissions from 2010/11 we have reduced our NHS Carbon Footprint by 18%.



Moving forwards, we will continue to expand our data collection to improve the understanding of our NHS Carbon Footprint and expand into calculating our NHS Carbon Footprint Plus. The objectives and actions within our Green Plan will support the reduction of the emissions associated with our Footprint Plus.

Our areas of focus

The Green Plan 2025-2028 is aligned to the nine key focus areas within the NHS England Green Plan Guidance.



To ensure there is equal importance placed on biodiversity and nature, we have added this as a tenth focus area.

For each area of focus, we have provided descriptions of what they entail and information on where we currently are and where we intend to be.

We have also developed an objective for each area of focus to define the progress that we intend to make in the next 3-years.

We have applied SMART methodology (please see below) to each of the 9 objectives to ensure we effectively can gauge progress and priorities:

- **Specific** – what is the objective?
- **Measurable** – an increase or reduction by amount or percentage, or a change in behaviour.
- **Assignable** – can this be assigned to a team or individual.
- **Realistic** – the objective must be achievable in the current environment, what challenges could impact progress.
- **Time** – when will the objective be achieved.

The SMART objectives for each of our 10 focus areas can be found in Appendix A.

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Workforce and Leadership

The transition to a net zero BTHFT will be driven by our people.

We are committed to improving engagement to ensure everyone is involved on the journey to deliver our net zero and wider sustainability goals.

We will work together to learn, innovate and embed sustainability into everyday actions.

Our workforce and leadership objective is to:

Create a culture of sustainability through comprehensive training, leadership development, and active engagement in carbon reduction initiatives, ensuring all staff are empowered to contribute to net zero goals.

Where we are

- We recently appointed our new Head of Sustainability who will work with our Senior Responsible Officer (SRO) to implement the Green Plan 2025-2028 and drive our net zero and sustainability journey;
- Our SRO is the dedicated lead on the Executive Board for the Green Plan.

Where we want to be

- Establish Green Champions across the Trust to promote awareness and engagement of our sustainability initiatives and generate new ideas;
- Introduce a sustainability category at our staff awards to encourage and recognise sustainable behaviours;
- Align and provide training with our sustainability goals, potentially including sustainability as part of mandatory training and providing role specific training to invest in our teams;
- Improve our communications for sustainability issues to increase visibility and engagement;
- Introduce Board level training on sustainability.

We have identified the following actions to enable achievement of our workforce and leadership objective:

Action	Trust lead	Delivery date
Assess workforce capacity and skill requirements for delivering the Green Plan.	Head of Sustainability	End of 2025
Promote, and consider setting uptake targets for, core training offers set out on the Greener NHS Training Hub	Head of Sustainability	End of 2025
Promote specialist training for staff groups who underpin the delivery of green plans, such as board members, procurement, finance, estates and facilities staff and clinicians	Head of Sustainability	End of 2025
Introduce Green Champions to promote awareness of the agenda across the Trust	Head of Sustainability	Mid 2026
Improve Green Plan communications by developing a communication strategy to support the promotion of sustainability development to staff and learning through existing Trust channels	Head of Sustainability	End of 2025
Implement a sustainability category at the staff awards to encourage and recognise sustainable staff behaviours	Green Plan SRO	Mid 2026

Net Zero Clinical Transformation

Clinical transformation is fundamental in delivering a sustainable NHS. The majority of healthcare emissions are driven by clinical activity and decision-making, transforming the way we design and deliver care is essential to reaching net zero.

Achieving this requires rethinking care pathways through the lens of sustainability, placing environmental responsibility alongside quality and safety.

By embedding the four principles of sustainable clinical practice, prevention, patient empowerment, lean delivery, and low-carbon alternatives⁷ into everyday care, clinicians can lead a shift toward models of care that reduce carbon, improve outcomes, and build a healthier future for patients and the planet.

Our net zero clinical transformation objective is to:

Reduce emissions from clinical activity and redesign care pathways through the principles of sustainable clinical practice, driven by clinical leadership, continuous improvement, and system-wide collaboration to deliver high-quality, low carbon care.

Where we are

- Renal services have delivered a range of high-impact improvements in virtual care, digital records, and efficient dialysis—resulting in significant carbon emissions reductions.
- Waste streaming in theatres has begun, looking at ways of recycling equipment and medicines.

Where we want to be

- Net zero clinical lead appointment and net zero clinical working group formed with representation from each Clinical Service Unit (CSU).

⁷Towards net zero healthcare | The BMJ

- Care is increasingly delivered closer to home, supported by digital consultations and integrated with primary and preventive care, reducing hospital-based interventions.
- Appropriate and safe switches from single use to reusable medical items have been made.
- Reduced inappropriate Personal Protective Equipment (PPE) usage.

We have identified the following actions to enable achievement of our net zero clinical transformation objective:

Action	Trust lead	Delivery date
Appoint a clinical lead with oversight of net zero clinical transformation	Green Plan SRO	End of 2025
Introduce a net zero clinical transformation group, chaired by the net zero clinical lead and with representation from each CSU to identify initiatives (e.g., reducing inappropriate PPE usage; reusable medical items; switching from IV to oral antibiotics) and a targeted focus on improving quality of care for at least one clinical area (as per the NHS England guidance)	Clinical Lead	End of 2025
Consider net zero principles in future service changes, reconfiguration programmes and pathway redesign initiatives, with a targeted redesign of at least one care pathway, engaging with local and national Trusts (as appropriate)	Clinical Lead	End of 2028
Identify and implement/switch from single-use to reusable medical items	Clinical Lead and Head of Sustainability	End of 2028

Digital Transformation

Utilising digital solutions is an integral part of the Green Plan's overarching aims to reduce waste and better manage resources, as well as improving patient care.

The digital transformation area focuses on streamlining clinical and non-clinical processes and enhancing the Trust's operations where possible. This may include changing how patients order food to the steps taken between information transfers across the Trust.

Our digital transformation objective is to:

Leverage digital technologies to enhance patient care, improve operational efficiency, and reduce carbon emissions through the integration of innovative digital solutions and robust data management, ensuring a sustainable and resilient healthcare system.

Where we are

- The Trust has a Virtual Ward and "baby view" initiatives in the neonatal ward, reducing staff and patient travel.
- The Trust has remote working software to allow staff to work from home where possible.

Where we want to be

- Complete a review to optimise our approach to laptop/PC usage
- Continue our expansion of virtual wards and virtual appointment initiatives
- Review working from home policy and desk booking system in place following trials
- Reduce printing (and remove colour printing), letters and paper usage across the Trust using streamlined information sharing processes
- Increase the frequency of our 'data purges' to reduce back-ups

We have identified the following actions to enable achievement of our digital transformation objective:

Action	Trust lead	Delivery date
Review the working from home policy and the Trust's virtual desktop arrangements to encourage, where appropriate and proportionate, remote working to reduce staff travel	Green Plan SRO	End of 2026
Supported by the Digital Maturity Assessment, explore opportunities to expand virtual wards and appointments. Engage with our digital suppliers and review our supply of hardware (e.g., laptops, servers, PCs) to understand if higher spec devices can extend their life reducing the need for replacement and any other circular economy initiatives	CDIO	2028
Review the existing PC power down arrangements to understand if they are working correctly and can be improved/expanded	CDIO	End of 2027
Complete a review to optimise our approach to laptop/PC usage and ordering	CDIO	2027
Improve operational energy demands associated with our hardware (e.g. by replacing inefficient equipment and reducing cooling demands in server rooms)	CDIO	2028
Continue to maximise the benefits of digital transformation to reduce emissions and improve patient care, for example, by expanding our virtual pathways	Clinical Lead, CDIO and Head of Sustainability	2028
Explore and digitise more Trust processes and policies, for example, annual leave booking	Head of Sustainability	2028

Medicines

Medicines contribute around 25% of the NHS’s carbon footprint, driven by manufacturing, supply chains, anaesthetic gases, inhalers, and waste.

Sustainable medicines management is essential to achieving net zero and requires:

- Optimising prescribing,
- Reducing overuse,
- Switching to lower-carbon alternatives, and
- Improving storage and disposal.

By embedding patient-centred, evidence-based prescribing into clinical pathways, and tackling high-impact areas such as anaesthetic gases and metered dose inhalers, we can reduce emissions while improving outcomes and reducing harm.

Our medicines objective is to:

Reduce the environmental impact of medicines by embedding sustainability into prescribing practice, optimising use, minimising waste, and promoting low-carbon alternatives to deliver safer, lower carbon, and more effective patient care.

Where we are

- Removed desflurane and replaced with this sevoflurane from use ahead of the NHS target removal date.
- Strategies in place for removing piped nitrous; funding has been obtained to remove the remaining nitrous manifolds across the Trust.
- Adopted e-prescribing.
- Included design specifications for mobile Entonox destruction as part of development plans for our new Endoscopy department at BRI.

Where we want to be

- Review Entonox and anaesthetic gas usage and implement targeted strategies to reduce nitrous oxide (N₂O), with defined goals and timelines

for elimination. Whilst key milestones have been achieved with respect to N₂O removal, the gas remains a constituent component within the use of Entonox, which typically consists of a 50/50 mix of N₂O and oxygen. A focus on Entonox is therefore important in order to address emissions from N₂O, which is a potent greenhouse gas.

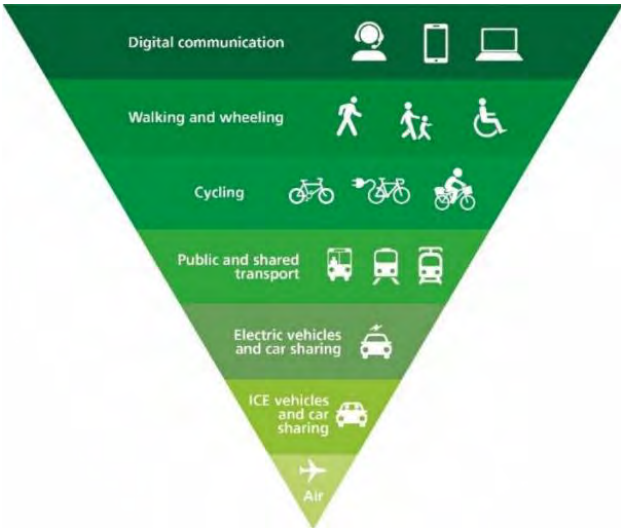
- Review waste (ordering, use & storage) in medicines and implemented improvement strategies.
- Review disposal of pharmaceutical waste and implemented improvement strategies.
- Identify and implement appropriate switches from intravenous (IV) to oral medications, with a focus on antimicrobials
- Support usage of lower carbon inhaler devices, through a system wide approach.

We have identified the following actions to enable achievement of our medicines objective:

Action	Trust lead	Delivery date
Complete decommission of nitrous oxide infrastructure	Estates and Facilities	End of 2026
Identify opportunities to decommission Entonox Manifolds	Clinical Lead	End of 2027
Review medicines and pharmaceutical wastage, with a focus on returns to pharmacy and waste streams	Pharmacy Lead	End of 2028
Implement initiatives to increase the use of oral medication as an alternative IV, with a focus on antibiotics and pre-operative medicines	Clinical Lead and Pharmacy Lead	End of 2028
Support high-quality, lower-carbon respiratory care, including supporting patients to choose the most appropriate inhaler(s) in alignment with clinical guidelines, engaging with system wide approaches (as appropriate)	Pharmacy Lead	End of 2028

Travel and Transport

The NHS published the Net Zero Travel and Transport Strategy in 2023⁸, recognising the NHS’s necessity as an anchor institution, to decarbonise its fleet. The strategy applies the sustainable travel hierarchy and sets targets for Trust owned vehicles, staff travel and leased vehicle emissions



Our travel and transport objective is to:

Measure and reduce emissions associated with all staff and patient travel, as well as rationalising our fleet and journeys around our sites. Encourage active travel and low carbon options where possible, providing facilities and programmes to support this transition.

Where we are

- We have installed secure cycle facilities, lockers and showers at BRI for staff to use. We have a Bicycle Users Group that are a community of cyclists at the Trust.

⁸ NHS Net Zero Travel and Transport Strategy

- Currently engaged with Yorkshire Trams and the council on buses.
- We have two EV charging points installed on site.
- Annual Travel Survey carried out.

Where we want to be

- Develop a Sustainable Green Travel Plan in line with the NHS Net Zero Travel and Transport Strategy and expected guidance from NHS England in 2025.
- Increase number of staff cycling to work or using public transport.
- Increase the number of EV chargers installed for staff and patient use.
- Review WFH policy to reduce staff travel.
- Review and have implemented changes to our fleet to improve its sustainability and reduce number of journeys to and around our sites, looking to centralise fleet management with our Partners.
- Continue to work with our partners to provide low carbon travel solutions to our staff
- Use digital solutions to better understand our business travel and its associated carbon emissions

We have identified the following actions to enable achievement of our travel and transport objective:

Action	Trust lead	Delivery date
Develop a Sustainable Green Travel Plan in line with the NHS Net Zero Travel and Transport Strategy and expected guidance from NHS England in 2025	Head of Sustainability/ Green Plan SRO	End of 2026
Increased number of staff cycling to work or using public transport	Head of Sustainability	End of 2028
Increase the number of EV chargers installed for staff and patient use	Deputy Director of Estates and Facilities	End of 2028

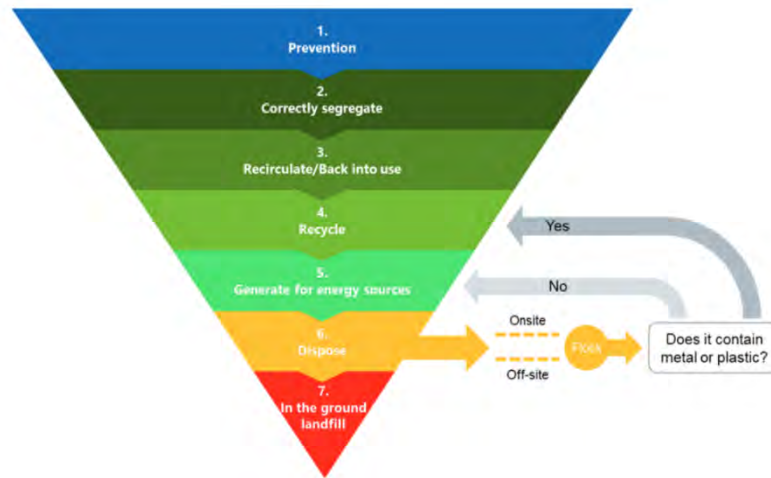
Continue work with our partners (Local Authorities, etc.) to provide low carbon travel solutions to our staff	Head of Sustainability	End of 2028
Use digital solutions to better understand our business travel and its associated carbon emissions	Head of Sustainability	End of 2026
Review and improve our fleet and make arrangements to purchase, or enter into new lease arrangements for, zero-emission vehicles only from December 2027 onwards	Deputy Director of Estates and Facilities	End of 2028
Offer only zero-emission vehicles through vehicle salary sacrifice schemes from December 2026 onwards (for new lease agreements)	Deputy Director of Estates and Facilities	End of 2028
Continue to monitor new taxi arrangement to ensure all journeys are being completed with EVs	Deputy Director of Estates and Facilities	End of 2028
Complete a staff travel survey	Head of Sustainability	End of 2025
Explore collaboration with neighbouring Trusts to reduce mileage and support transition to more sustainable travel	Head of Sustainability	End of 2028

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Estates and Facilities

The NHS estate accounts for approximately 15% of the total carbon emissions of the NHS; this includes energy consumption, water and waste.

In January 2023 the NHS clinical waste strategy⁹ was published, including the waste hierarchy which sets out in order of priority, the waste management options as defined by the Department for Environment, Food and Rural Affairs (DEFRA), adapted for clinical waste.



Efforts are also underway to improve air quality across the city, which is aligned to the Trust's core ambition to improve public health and reduce inequalities.

The Health Technical Memorandum 07-01: safe and sustainable management of healthcare waste¹⁰ details best practice for waste management, the environmental benefits and identifies potential opportunities for cost savings and carbon emission reductions.

⁹ [B2159i-nhs-clinical-waste-strategy.pdf](#)

Our estates and facilities objective is to:

Operate an efficient estate with detailed understanding of our resource consumption and waste generation, delivering our plans to decarbonise and reduce waste.

Where we are

- We have developed a heat decarbonisation plan (HDP) focussing on the removal of fossil fuels as primary energy sources across our sites
- We secured £600k funding for LED lighting to enable us to achieve 100% LED across the estate
- We have received funding to install more solar PV panels to increase our renewable energy generation
- We have an energy manager who monitors the energy consumption across our sites and is responsible for identifying reduction opportunities
- Our new buildings are served by non-fossil fuel sources

Where we want to be

- Remove fossil fuels as primary energy sources, switching to heat pumps or district heat networks where possible
- Install submetering to understand and ultimately reduce our energy consumption
- Reduce waste across the estate using the waste hierarchy and providing training to staff
- Improve the performance of our building with better controls and fabric upgrades

¹⁰ [NHS England » Health Technical Memorandum 07-01: Safe and sustainable management of healthcare waste](#)

We have identified the following actions to enable achievement of our estates and facilities objective:

Action	Trust lead	Delivery date
Improve energy usage and reporting, develop business case(s) for submetering, water efficiency and steam surveys, and, where possible and affordable, purchase green energy	Head of Sustainability / Energy Manager	End of 2025
Implement our HDP (and review annually) to support the removal of fossil fuels and our move to electrifying our hot water and heating solutions	Director of Estates and Facilities	From 2025 to 2028
Continue to explore and submit bids for grants and funding opportunities to support our transformation to a net zero estate	Director of Estates and Facilities	From 2025 to 2028
Complete studies on theatre energy usage and consider initiatives such as setback, lights, anaesthetic gas scavenging and automatic shutdowns	Deputy Director of Estates and Facilities	End of 2025
Support the periodic monitoring of internal and external air quality through joint efforts between Estates, Occupational Health, and Facilities teams.	Head of Sustainability	End 2026
Ensure all applicable new building and major refurbishment projects are compliant with the NHS Net Zero Building Standard and BREEAM Healthcare methodology	Director of Estates and Facilities	Immediately
Explore opportunities to reduce on-site water consumption	Deputy Director of Estates and Facilities	End of 2025
Continue to install and increase usage of renewable energy by investing in on- or near-site renewable energy generation, such as solar panels, solar thermal, etc.	Energy Manager/ Deputy Director of Estates and Facilities	From 2025 to 2028

Improve our waste segregation and waste management through the introduction of waste training for the waste hierarchy and installing a waste compactor to reduce our number and volume of collections	Deputy Director of Estates and Facilities	End of 2028
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Supply Chain and Procurement

The purchasing and supply of medicines, medical equipment and other consumables accounts for over half of the NHS Carbon Footprint. Influencing the supply chain and procurement process therefore has the potential to greatly impact scope 3 emissions and the journey to a net zero NHS.

The NHS net zero supplier roadmap¹¹ sets out the NHS requirements for procurements until 2028. We have implemented the 2022 requirement of 10% net zero and social value in all competed procurements and implements the requirements for carbon reduction plans and application of the Evergreen sustainable supplier assessment¹² where possible.

To extend beyond these targets, further engagement across the Trust is needed to understand where single use products can be reduced, and sustainability considerations can be built into procurement as a standardised item. This is a particular challenge within clinical operations, with work needed to ensure the safety and clinical functionality of products.

Our supply chain and procurement objective is to:

Provide information and training across the Trust to embed sustainability considerations into all our procurement decisions and business processes, from end users to board members.

Where we are

- Inclusion of 10% net zero social value weighting in all our competed procurements.
- Encourage our suppliers to have a carbon management plan in place

Where we want to be

- Work with the Green Plan Implementation Group to encourage staff and signpost to sustainability training to encourage end users to consider sustainability in procurement decisions.

- Further promotion of carbon reduction plans from our suppliers, and encourage suppliers to be compliant with the Evergreen Framework.
- Reduce our reliance on single-use products
- Continue the roll-out of a digitised inventory management solution (SupplyX) where suitable

We have identified the following actions to enable achievement of our supply chain and procurement objective:

Action	Trust lead	Delivery date
Embed NHS net zero supplier roadmap requirements into all relevant procurements and ensure they are monitored via KPIs	Head of Sustainability	2028
Reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects	Head of Sustainability	2028
Explore and implement a digitised inventory management solution across the Trust	Procurement Lead and CDIO	2028
Promote PPN 006 (formerly PPN 06/21) to ensure carbon reduction plans are in place for key suppliers	Procurement Lead	2028
Collate case studies from other NHS organisations on projects to reduce single-use items to support with their implementation	Head of Sustainability	End of 2025
Explore and implement sustainability-specific training to supply chain and procurement professionals	Procurement Lead and Head of Sustainability	End of 2026

¹¹ [NHS-Net-Zero-Supplier-Roadmap-2024.pdf](#)

¹² [NHS England » Evergreen sustainable supplier assessment](#)

Food and Nutrition

Providing nutritional food to patients is an important part of supporting their health and recovery, and the overall health and wellbeing of the public. Nutritional food is also beneficial to the health and wellbeing of our staff.

Providing and promoting seasonal fruit and vegetables as well as avoiding heavily processed foods has the potential to offer healthier and low carbon options to patients and staff.

In addition to what healthier and more sustainable food options we provide to patients and staff, it's also important for us to understand our food waste and identify innovative methods to reduce this in line with NHS guidance.

Our food and nutrition objective is to:

Provide and promote healthier and lower carbon food to staff and patients, working to quantify and then reduce our food waste.

Where we are

- In the process of developing digital menus for patients, promoting vegetation and vegan options.
- Completing annual food wastage (in tonnes) as part of ERIC.

Where we want to be

- Implement digital menus across the Trust.
- Reduce food waste, with methods to quantify and understand our food waste and where it's come from.
- Measure food waste in line with the Estates Returns Information Collection (ERIC) and set reduction targets.
- Reduce single use plastics used across the site.
- Provide and promote healthy food options to staff, even at out of hours times. This includes supporting the provision of seasonal menus high in fruits and vegetables and low in heavily processed foods.

We have identified the following actions to enable achievement of our food and nutrition objective:

Action	Trust lead	Delivery date
Continue to measure food waste in line with the Estates Returns Information Collection (ERIC) and set reduction targets to drive a reduction in food waste - both plate waste and ordered meals	Food and Nutrition Lead	2028
Explore opportunities to make menus healthier and lower carbon by introducing digital menu ordering, introducing seasonal menus and, where possible, utilise local food producers	Food and Nutrition Lead, CDIO and Head of Sustainability	Mid 2026
Explore circular economy opportunities, e.g., recycling used cooking oil into biodiesel	Food and Nutrition Lead	Mid 2026
Reduce single use plastics and packaging, e.g., all food comes in plastic containers. Engagement with procurement contract(s).	Food and Nutrition Lead	2028
Explore out of hours menu options	Food and Nutrition Lead	Mid 2026
Explore cold storage options at BRI to support a reduction to deliveries to site and emissions.	Food and Nutrition Lead and Estates and Facilities	Mid 2026

Adaptation

Climate change poses a risk to the operation of healthcare facilities, and places additional demands on services if not mitigated effectively.

The threats posed by climate change include increases in the intensity of heatwaves, more frequent storms and flooding, and increased spread of infectious diseases.

We have experienced the effects of recent heatwaves and are working to adapt our operations to prepare for anticipated challenges such as extreme heat and increased admissions due to heat stroke and respiratory illnesses.

New buildings on site are incorporating measures to reduce flood risks, including sustainable drainage solutions where possible.

Our adaptation objective is to:

Understand the risks posed by climate change to both our infrastructure and clinical operations, implementing processes to ensure the wellbeing of staff and patients.

Where we are

- We have upgraded our servers to perform better in high temperatures
- We are including features for resilience in our new buildings, such as flood alleviation tanks
- We have an Adverse Weather Plan, alongside all the required business contingency plans.

Where we want to be

- Identify flood risks and opportunities for sustainable urban drainage design implemented where possible
- Carry out climate adaptation, risk and resilience assessments in line with UK climate projections

- Define overheating risks and improved management of summer high temperatures for both clinical and infrastructure systems with staff and patient support
- Understand the clinical implications from climate events (e.g. increased admissions from heat exhaustion and respiratory diseases)

Using the Climate Change Risk Assessment (CCRA) tool to bring stakeholders together and provide a baseline and understanding of our risks, complete the maturity assessment in the recently released NHS England Climate Adaptation Framework¹³.

We have identified the following actions to enable achievement of our objective:

Action	Trust lead	Delivery date
Create, and get Board approval for, an Adaptation Plan linked to the Green Plan, ensuring this identifies interdependencies between partners and services and the necessary mutual aid requirements to prevent service disruptions	Director of Estates and Facilities/ Green Plan SRO	End of 2026
Use the CCRA Tool to carry out climate adaptation, risk and resilience assessments to define risks to the Trust	Green Plan SRO	End of 2026
Complete the NHS England climate adaptation framework maturity assessment	Green Plan SRO	End of 2026
Explore the roll-out of climate-specific adaptation training to the required professionals, e.g., Head of EPRR, Green Plan SRO, Medical Director, etc.	Director of Estates and Facilities/ Green Plan SRO	End of 2026
Ensure all future infrastructure decisions and the designing of new facilities factor in the effects of climate change, including	Director of Estates and Facilities/ Green Plan SRO	End of 2026

¹³ <https://www.england.nhs.uk/long-read/a-climate-adaptation-framework-for-nhs-organisations-in-england/>

enhancements like improved drainage systems and passive cooling solutions		
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Biodiversity and Green Spaces

Green spaces can be an important asset to healthcare facilities, both from a biodiversity and nature perspective.

Green spaces provide places for patients and staff to come for fresh air and rest, and there is a growing body of evidence linking biophilic design considerations to improvements in health outcomes¹⁴.

We currently have wildflower gardens at BRI (shown below) and St Luke’s; however the ambition of this Green Plan is to help identify opportunities and programmes to develop additional spaces that patients and staff can use, that also enhance the biodiversity on site.



Our biodiversity and green spaces objective is to:

¹⁴ <https://www.mentalhealth.org.uk/sites/default/files/2022-06/MHAW21-Nature-research-report.pdf>

Continue to maintain and improve our current green space, looking to identify opportunities for new spaces and enhance biodiversity on site.

Where we are

- We have two wildflower gardens at BRI and St Luke’s and practice “No Mow May” each year.

Where we want to be

- Continue to improve and maintain our greenspaces.
- Identify and develop any spaces that could be turned into greener spaces or with more natural light e.g. yards behind Unwin Place.
- Identify opportunities to extend the “No Mow May” and other initiatives currently on site.
- Establishment of green roofs on new builds / existing buildings.

We have identified the following actions to enable achievement of our objective:

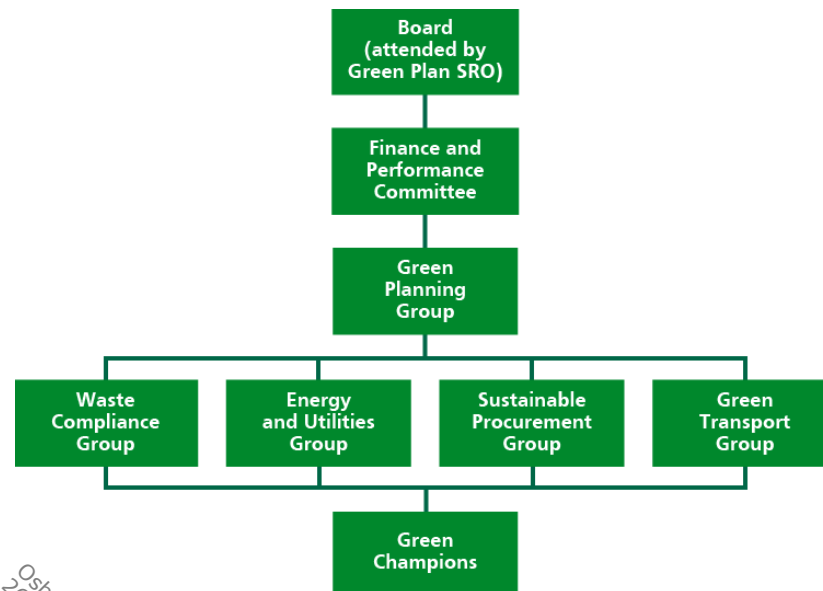
Action	Trust lead	Delivery date
Protect and enhance our green spaces and biodiversity (e.g., Wild Gardens at both BRI & SLH) by ensuring they are not built on or disturbed	Head of Sustainability	2028
Ensure any new buildings or projects have dedicated green spaces (e.g., green roofs/walls) included and that, where possible, biophilic design principles are weaved into their design	Head of Sustainability	2028
Explore rainwater harvesting for use on our Wild Gardens	Head of Sustainability	End of 2026

Our Delivery Plan

Governance

The current governance structure to manage and drive delivery of our 2020 Green Plan requires a refresh due to changing personnel and updated priorities, in line with the publication of this 2025 Green Plan.

As part of developing this 2025 Green Plan, we have considered what our Green Plan governance should consist of, ensuring there is a link between our proposed Green Champions through to our Board. Subject to a full review, we envisage our governance structure to look similar to:



The suggested members of the Green Plan Group (GPG) are:

- Executive Director of Estates and Facilities, Green Plan SRO – representing Workforce and Leadership (Chair)
- Head of Sustainability (Deputy Chair)

- Deputy Director of Estates and Facilities – representing Estates and Facilities
- Green Plan Clinical Lead – representing Net Zero Clinical Transformation
- Catering Manager – representing Food and Nutrition
- Director of Pharmacy – representing Medicines
- Operational Head of Procurement – representing Supply Chain and Procurement
- Energy Manager – representing Utilities and Consumption
- EPRR Manager – representing Adaptation
- Bicycle Users Group Lead – representing Travel and Transport
- Digital Lead – representing Digital Transformation

Following approval and publication of this Green Plan, we will periodically review and refresh membership of the GPG to ensure appropriate governance.

Tracking and Reporting Progress

To support the successful delivery of this Green Plan, a range of report and collection methods will be used to monitor and track progress.

These reports and data collection methods will consist of a mixture of quantitative and qualitative and be both internal and external.

The frequency and type of reports we will utilise are:

Bi-Monthly

- Verbal and written updates against Green Plan actions to our refreshed Green Planning Group

Quarterly

- Greener NHS Data Collection – including fleet emissions
- Written report(s) against Green Plan SMART objectives

Bi-annually

- Business travel mileage/emissions

Annually

- Trust Sustainability Report – including report(s) against Green Plan SMART objectives
- Greener NHS Green Plan Support Tool
- NHS Premises Assurance Model
- Estates Return Information Collection – including waste tonnage/emissions, medical gas emissions, and heating/flooding (i.e., adaptation) occurrences
- Annual staff survey for travel and modal shift

Our approach may be subject to change following any changes in local, regional or national requirements.

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Appendices

A. SMART Objectives

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A. SMART Objectives

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Focus area	Objective	Specific	Measurable	Assignable	Realistic	Time	Baseline
Workforce and leadership	Cultivate a culture of sustainability within the Trust, through comprehensive training, leadership development, and active engagement in carbon reduction initiatives, ensuring all staff are empowered to contribute to net zero goals	Introduce board level training	100% of board members to attend training	Green Plan SRO	Subject to small investment	End of 2025	No training delivered to date
		Introduce green champions	Identify >25 green champions	Head of Sustainability	Dependent on strong engagement	Mid 2026	Currently zero green champions
		Identify sustainability training gaps/ opportunities and implement where applicable across Trust – Review and roll out NZ training	Completion of review and roll out of training	Head of Sustainability	Subject to investment	End of 2025	None
		Increase comms for Green Plan	Issue quarterly newsletter	Head of Sustainability	Comms and engagement support	Following Green Plan approval	None
		Review of improvement methods and training to establish where sustainability can be incorporated	Review undertaken		Transformation and Improvement lead support	End of 2026	
Net zero clinical transformation	Embed sustainability into clinical transformation by reducing emissions from clinical activity and redesigning care pathways through the principles of sustainable clinical practice, driven by clinical leadership, continuous improvement, and system-wide collaboration to deliver	Recruit a clinical lead	Clinical lead in post	Green Plan SRO	Investment for 0.5 PA required	End of 2025	No clinical lead in post
		Introduce net zero clinical transformation group with representation from each CSU	Net zero clinical transformation group created with representation from each CSU	Clinical lead	Requires clinical lead recruitment	End of 2025	No group yet exists
		Redesign another care pathway	Care pathway redesigned	Clinical lead	Requires clinical lead recruitment	2028	LKD pathway
		Identify and implement switch from	At least three high-volume single-use items switched	Clinical lead	Requires clinical lead recruitment	2028	No data on volume yet

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Focus area	Objective	Specific	Measurable	Assignable	Realistic	Time	Baseline
	high-quality, low-carbon care.	single-use to reusable medical items					
		Reduce expenditure on PPE	10% reduction in PPE procurement	Clinical lead	Requires clinical lead recruitment	2028	No baseline procurement data
Digital transformation	Leverage digital technologies to enhance patient care, improve operational efficiency, and reduce carbon emissions through the integration of innovative digital solutions and robust data management, ensuring a sustainable and resilient healthcare system.	Review procurement policy to promote sustainable purchases	Development of Procurement Policy for Informatics which promotes energy efficient or low carbon purchases	CDIO	Requires Procurement input	2027	Presently no existing sustainable Procurement Policy in Informatics
		Improve cooling efficiency in server rooms and removal of older hardware that are less tolerant of heat (eg EI PACS)	Maintain server room temperatures within the recommended 19°C -23°C limit and promote free cooling. Complete the infrastructure replacement program in 2026	CDIO	Needs careful monitoring during heatwave conditions. May require investment into hot/cold aisle containment and upgraded HVAC systems.	2028	Server rooms are currently chilled to 21°C.
		Encourage behavioural change through PC power-downs to reduce operational energy consumption from IT equipment left on standby	Develop communications strategy in support of switch-off campaign and carry out audit of computers left on standby	CDIO	Staff engagement / Investment into power management solutions such as Certero to support audit, with a potential ROI of 6 months	2027	No current communication campaign relating to switch-off strategy, however, PC Power downs already take place.
		Continue expansion of virtual wards and appointments	Virtual wards to increase by 20%	Transformation team / Clinical Lead	Requires digital and clinical colleagues	2028	Capacity as of 23/01/25 – 80 patients
		Implement automated hot desking platform and space sensors	Implementation of the platform across the Trust	Estates	Successful implementation	End of 2026	Hot desking trial implemented

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Focus area	Objective	Specific	Measurable	Assignable	Realistic	Time	Baseline
		Remove coloured printing	No colour printing at the Trust	CDIO	Engagement with Digital/ need exec lead	End of 2025	N/A
		Data purge to reduce back ups	Plan for regular deletion of old medical records	CDIO	Requires agreement on periodic deletion of records	2028	No data purge completed
Medicines	Reduce the environment impact of medicines by embedding sustainability into prescribing practice, optimising use, minimising waste, and promoting low-carbon alternatives to deliver safer, lower carbon, and more effective patient care.	Complete decommission nitrous oxide infrastructure	0% piped nitrous oxide across Trust	E&F	Engagement with E&F	End of 2026	Process started
		Identify opportunities to decommission Entonox Manifolds	Feasibility report produced for the removal of Entonox manifolds.	Pharmacy Lead/ Clinical lead/ E&F	Clinical lead/ E&F engagement	End of 2026	No current feasibility assessment carried out for Entonox decommissioning.
			Increased usage of low carbon alternatives to Entonox	Pharmacy Lead/ Clinical lead/ E&F	Clinical lead/ E&F engagement	End of 2027	No baseline data on procurement of low carbon alternatives i.e. Methoxyflurane.
		Reduce medicines wastage - returns to pharmacy	10-20% increase in volume of returns recycled for patient use as opposed to disposed	Pharmacy Lead	Pharmacy lead engagement	2028	Baseline position to be determined
		Increase use of oral antibiotic medication as an alternative to IV	80% of eligible patients to receive antibiotics or pre-operative medicines	Pharmacy Lead	Pharmacy lead engagement	2028	No baseline
		Increase use of oral medication pre-operatively	from oral medication as opposed to intravenous in line with national guidance	Clinical Lead	Clinical Lead appointment	2027	0% of oral medication given at pre-op
		To reduce emissions from MDI through	To target reduction of inhaler emissions	Pharmacy Lead	Pharmacy Lead	End of 2028	Baseline position to be determined

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Focus area	Objective	Specific	Measurable	Assignable	Realistic	Time	Baseline
		adoption of DPI, soft mist inhalers (SMI).	by 50% through effective prescribing				
Travel and transport	To measure and reduce emissions associated with all staff and patient travel, as well as rationalising our fleet and journeys around our sites. Encourage active travel and low carbon options where possible, providing facilities and programmes to support this transition	Develop a sustainable green travel plan	Develop a sustainable green travel plan	Head of Sustainability/ Director of Estates and Facilities	In line with NHS England guidance due soon	End of 2026	No travel plan currently
		Transition to zero emissions fleet	100% fleet are zero emissions	Deputy Director of Estates and Facilities	Existing leases to be reviewed	2028	Presently only one electric vehicle within the Estate.
		Increase staff's active travel	Carry out annual travel surveys and target 15% increase in active travel by staff	Head of Sustainability	Staff engagement and infrastructure upgrades required	2025-2028	A staff travel survey has not recently been carried out to determine active travel uptake
		Increase EV charging infrastructure	Implement an Electric Vehicle Charging Point (EVCP) strategy which targets a minimum number of additional chargers c.25	Deputy Director of Estates and Facilities	Investment required	2028	No 2 EV chargers
Estates and facilities	Operate an efficient estate with detailed understanding of our resource consumption and waste generation, delivering our plans to decarbonise and reduce waste.	Improve the Lord Carter metric of utilisation of non-clinical space	To increase to 65%	Director of Estates and Facilities		By 2030	51%
		Implement projects based on our HDP to remove fossil fuels	At least 1 per annum	Director of Estates and Facilities	Projects to be linked to Trust capital plan	From 2026 to 2028	No projects currently
		Increase renewable energy usage	At least 3% energy from on-site renewable sources	Head of Sustainability / Energy Manager		2028	Energy usage from renewables currently contributes to 0.5% of Total Energy

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Focus area	Objective	Specific	Measurable	Assignable	Realistic	Time	Baseline
Osbourne, Sheridan 26/01/2026 12:25:00							Consumption across the Trust.
		Reduce waste volumes	Improve waste segregation ratios – targeting 20% HTI, 20% infectious, 60% offensive.	Head of Sustainability / Waste Manager		2028	Current segregation ratio for FY24-25 is 6% HTI, 61% infectious, 32% offensive and 1 % Pharmacy.
		Energy monitoring	Ensure that at least 80% of our individual buildings are sub metered.	Head of Sustainability / Waste Manager	Projects to be linked to Trust capital plan to maximise budget	From 2026 to 2028	Individual buildings are largely not sub metered across the Trust.
		Reducing water consumption	Identify opportunities for leak detection technology / alarms, low-flow fittings, direct flush toilets, or rainwater harvesting.	Head of Sustainability / Waste Manager	Projects to be linked to Trust capital plan to maximise budget	From 2025 to 2028	No baseline position.
		Carbon footprint	Recalculate carbon footprint to determine emissions across all applicable Scope 3 emissions sources	Head of Sustainability / Energy Manager		2027	Scope 3 emissions reporting is presently limited
		Ensure compliance with NHS standards for new buildings and refurbished projects	All applicable projects to be compliant with NZBS and BREEAM Healthcare methodology, which targets “excellent” for new builds and “very good” for	Deputy Director of Estates – Capital & Strategic		Immediately	No baseline – new guidance

Focus area	Objective	Specific	Measurable	Assignable	Realistic	Time	Baseline
			major refurbishments under HTM 07-07				
		Air Quality	Ensure the Trust carries out periodic monitoring of internal and external air quality	Net Zero Clinical Transformation Lead / Head of Sustainability	Requires support from occupational health to ensure IAQ assessment	End of 2026	No baseline position.
Supply chain and procurement	Provide information and training across the Trust to embed sustainability considerations into all our procurement decisions and business processes, from end users to board members.	Reduce reliance on single-use products	Engage with top 10 suppliers by spend to identify at least one single-use product that can be reduced or replaced	Head of Sustainability	May be challenging to measure	2028	Currently no supplier engagement carried out
		Ensure compliance with the NHS Net Zero Roadmap	By April 2027, 100% of new suppliers into the Trust will publicly report Scope 1, 2, and 3 emissions.	Head of Procurement	Will require dedicated supplier engagement and careful monitoring	April 2027	At present only suppliers with a contract value above £5m are required to comply with the NHS Net Zero Roadmap
		Roll-out sustainable procurement training	>50 staff to complete sustainable procurement	Head of Sustainability	Requires training to be rolled out	2028	Zero for procurement
		Inclusion of environmental considerations in procurement applications	Amendment to SFIs	Green Plan SRO/ CFO	Annual refresh – check timescales	End of 2026	Standing Financial Instructions (SFIs) do not presently include environmental considerations
		Continue roll out of digitised inventory management solution (SupplyX)	Implement a digitised inventory management solution	Procurement/ Digital	Requires investment and resource	2028	Currently in several departments

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Focus area	Objective	Specific	Measurable	Assignable	Realistic	Time	Baseline
Food and nutrition	Providing and promoting healthier and lower carbon food to staff and patients, working to quantify and then reduce our food waste.	Reduce food waste	Reduce food waste volumes as to 3.5% as a proportion of total waste.	Green Plan SRO	Patient and staff comms required	2028	Food waste is presently 5% of total waste.
		Introduce seasonal ingredients as part of a digital menu that also provides meat-free options as a part of a nutritionally balanced catering service	Introduction of a digital menu	Green Plan SRO	Collaboration with digital and catering	End of 2025	No digital menu in place
Adaptation	Understand the risks posed by climate change to both our infrastructure and clinical operations, implementing processes across the Trust to ensure the wellbeing of staff and patients.	Create an adaptation plan linked to the green plan	Adaptation plan created	Director of Estates and Facilities/ Green Plan SRO	Internal approvals	Mid 2026/ End of 2026	No adaptation plan in place
		Identification of flood, heat, drought and other risks	Complete NHS climate change risk assessment tool	Green Plan SRO	Requires engagement with EPRR colleagues	End of 2026	None carried out to date
		Roll-out climate-specific adaptation training	At least 100% of board members to have training	Director of Estates and Facilities/ Green Plan SRO	Time constraints and coordination	End of 2026	No training currently in place
Biodiversity and greenspace	Continue to maintain and improve our current green space, looking to identify opportunities for new spaces and enhance biodiversity on site.	Identify and develop any spaces that could be turned into greener spaces or with more natural light e.g. yards behind Unwin Place.	Establishment of at least 2 new spaces on site.	Head of Sustainability	Constrained site	Mid 2027	The Trust has wild gardens at both hospital sites. These have been designed to encourage flora and wildlife - adjacent to B Block, Horton Wing at SLH, and the rear of Estates Offices at BRI.
		Identify opportunities to extend the no mow	Establish working group and identify	Head of Sustainability	Constrained site	End 2026	Two wildflower gardens on site and

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Focus area	Objective	Specific	Measurable	Assignable	Realistic	Time	Baseline
		May and other initiatives currently on site.	and run three programmes for biodiversity				no mow May implemented.
		Establishment of green roofs on new builds / existing buildings.	At least one green roof/ wall installed on site	Head of Sustainability	Challenges with existing structures. Cost prohibitive.	End 2028	Presently no green roof or green walls across the Estate.

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Acknowledgements

This Green Plan has been developed with the support of Mott MacDonald, who were commissioned to lead its preparation. The work instructed involved engaging stakeholders across the organisation through various interviews and workshops. Following which, the analysis of feedback contributed to this written strategy. The Green Plan is informed by a wide range of operational insights and aligned with current sustainability priorities.



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Board of Directors Open				
Meeting Date:	29 January 2026	Agenda Reference:	Bo.1.26.14	
Report Title:	High Level Risk Report			
Presented by:	Karen Dawber, Chief Nurse			
Executive Lead:	Karen Dawber, Chief Nurse			
Author:	Laura Parsons, Associate Director of Corporate Governance/Board Secretary/ Deborah Earnshaw, Corporate Governance Manager			
Report Summary				
Purpose of the paper:	Decision ☐ (Approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (Review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	All operational risks scoring 15 and above (high level risks) are escalated to the Executive Team Meeting (ETM) monthly and reported to the relevant Committees and the Board. At its monthly meetings held in December 2025 and January 2026, ETM considered a summary of all high level risks including any new risks, closures and changes in score, and those risks which had passed their review date. The Committees reviewed the high level risks within their remit at their meetings held during January 2026 (there were no Committee meetings held in December 2025). Since the last high level risk report presented to the Board of Directors on 27 November 2025 – - There are two risks past the target mitigation date (risks 2612 and 2756). - No new risks have been accepted onto the high level risk register. - No risks were closed. - One risk has increased in score from 15 to 20 (2753). - One risk has reduced in score from 15 to 12 and is no longer on the high level risk register (2727). - There are four risks past their review date (risks 2612, 95, 2756 and 2677) The HLRR, showing all high-level risks rated 15+ for January 2026, is attached at Appendix 1.			
Recommendation/s: (including any decision/approval required)	The Board is asked to confirm whether it is assured that all risks on the high-level risk register are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.			
Link to Strategic Objective:	N/A			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	This report details the strategic risks which are reviewed and updated by Executive leads prior to quarterly reporting to ETM, and then to Committees and the Board.			

Legal/Regulatory:	N/A
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	Executive Team Meeting: 1 December 2025 and 12 January 2026 People Academy: 14 January 2026 Finance and Performance Committee: 21 January 2026 Quality Committee: 22 January 2026

Report content
1. Purpose This paper provides a profile of risks, controls and mitigations related to the High Level Risk Register (HLRR) (see Appendix 1). 2. Background/context The Board of Directors has a responsibility to understand the level and type of risks being taken within the organisation. 3. Assessment All operational risks scoring 15 and above (high level risks) are escalated to the Executive Team Meeting (ETM) on a monthly basis and then to the relevant Committees and the Board. At its meetings on 1 December 2025 and 12 January 2026, ETM considered a summary of all high level risks, including any new risks, closures and changes in score, and those risks which had passed their review date. The Committees reviewed the high level risks within their remit at their meetings held during January 2026 (there were no Academy/Committee meetings during December 2025). The HLRR, showing all high level risks rated 15+ for January 2026, is attached at Appendix 1. High Level Risks Report on a Page The document at Appendix 2 provides a visual overview of all high level risks as at January 2026, and shows trends over a number of cycles and flags areas that the Board may wish to consider. The following information is included: • An overview of the risk profile, with details of the total number of high level risks. • An overview of whether scores are increasing, decreasing or staying static. • A graph showing the changing number of risks on the register. • Static risks which demonstrates over time how long risks have remained static for. A risk that remains static over a number of months may be an indication that further work is required to control the risk.

Target Mitigation Dates

There are two risks beyond the target mitigation date.

Risk ID:	Current Score:	Target Score:	Risk Description:	Lead Director:	Target date:	Committee:
2612	15	10	There is a risk that, due to the increased numbers of patients requiring enhanced diagnostic tests under the care of the Emergency Department that the significance of some results might get missed and there may be delays actioning the results. This may result in harm to patients and delays in treatment / diagnosis.	Chief Medical Officer	30 November 2025	People Academy & Quality Committee
2756	20	12	If we are unable to see, treat and admit or discharge patients within 4 hours then patients will increasingly experience a long length of stay in the A&E department. Consequently, they are more likely to experience increased mortality and morbidity.	Chief Operating Officer	31 December 2025	Quality Committee & Finance & Performance Committee

Changes to target mitigation dates

The document at Appendix 3 provides a detailed overview of all current high level risks and the number of changes made to the target mitigation date for each risk since it was created.

New risks to the High Level Risk Register (HLRR)

Since the last report to the Board no new risks have been added to the high level risk register.

Risks closed since the last report

No risks have been closed since the previous report.

Risks which have changed in score

One risk has increased in score since the last report to the Board:

Risk ID:	Current Score:	Previous Score:	Risk title:	Risk Description:	Lead Director:	Reason for increased score	Committee/ Academy:
2753	20	15	Renal Dialysis Capacity	There is a risk that there is insufficient capacity for in-centre (hospital) haemodialysis, meaning we will not be able to provide timely dialysis for new patients potentially resulting in death or serious harm.	Chief Medical Officer	30/12/25 - Building work for Skipton expected to be complete by May 2026. Capacity remains an ongoing challenge and concern for the CSU. Currently 98% of available dialysis slots across St Luke's and Skipton are booked, as such the CSU has increased the risk score to 20.	Quality Committee & Finance and Performance Committee

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One risk has reduced in score since the last report to Board:

Risk ID:	Current Score:	Previous Score:	Risk title:	Risk Description:	Lead Director:	Reason for reduction in score	Committee/ Academy:
2727	12	15	Logistical Communication failure in the Portering Service due to failing IT / Capacity Management Software and subsequent iPod failure for allocation of portering tasks resulting in delayed patient transfers and potential harm.	The portering team use iPods to receive task allocation from the CAPMAN system – the system is used for transfer of patients and other portering tasks. If unable to use iPods, then pen and paper or radios is the alternative which impacts on quality, and efficiency of service delivery and this would require porters to return to a central point and limit the amount of information provided to the porter and could increase the risk of incidents.	David Moss, Director of Estates and Facilities.	8.12.25 – BIA & BCP in place which cover 'loss of systems' this includes ipods. The timeframe is 7 days to be back up and running. D Moss reduced score following ETM discussion.	Finance and Performance Committee & Quality Committee

Risks beyond their review date

There are four risks beyond their review date.

Risk ID:	Current Score:	Target Score:	Risk Description:	Lead Director:	Review Date:	Committee/ Academy:
95	15	6	If we are unable to provide a sufficient number of middle and senior grade doctors that meets the 24 hour capacity and demand of the Emergency Department then there may be a mismatch of patient acuity and demand versus the number and competencies of clinical decision makers on duty at any one time resulting in an increased risk of patient harm, compromised quality and performance and a negative impact on efficiency and patient flow.	Chief Medical Officer	31 October 2025	Quality Committee & People Academy
2612	15	10	There is a risk that, due to the increased numbers of patients requiring enhanced diagnostic tests under the care of the Emergency Department that the significance of some results might get missed and there may be delays actioning the results. This may result in harm to patients and delays in treatment / diagnosis.	Chief Medical Officer	30 November 2025	People Academy & Quality Committee
2677	20	5	There is a risk that if we do not increase respiratory inpatient activity including appropriate side room provision, ensuite and appropriate ventilation, then it will lead to infection control break outs, long stays in AED, inappropriate use of ICU capacity and a large number of respiratory outliers resulting in avoidable harm to patients and extended length of stay.	Chief Medical Officer	31 December 2025	Quality Committee

2756	20	12	If we are unable to see, treat and admit or discharge patients within 4 hours then patients will increasingly experience a long length of stay in the A&E department. Consequently, they are more likely to experience increased mortality and morbidity.	Chief Operating Officer	31 December 2025	Quality Committee & Finance & Performance Committee
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4. Options analysis/Proposal

As outlined in the Risk Management Strategy, the Board's role is as follows:

Seek assurance from the Executive Team and Committees that all risks on the High Level Risk Register and BAF are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.

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All Open Operational Risks with a current scoring of 15 or over (as at 06/01/2026)

Consequence	Likelihood	Rating
(1) Negligible	(1) Cannot believe that this will ever happen again	15 to 25 Extreme
(2) Minor	(2) Do not expect it to happen again but it is possible	8 to 12 - High
(3) Moderate	(3) May recur occasionally	4 to 6 - Moderate
(4) Major	(4) Will probably recur, but is not a persistent issue	1 to 3 - Low
(5) Catastrophic	(5) Will undoubtedly recur, possibly frequently	

Risk Register Id	Date of Entry	Lead Director	Risk Lead	Source of risk	Assuring Committee or Academy Summary	Risk Title	Description of Risk	Next review date	Rating (initial)	Consequence (initial)	Likelihood (initial)	Rating (residual)	Consequence (residual)	Likelihood (residual)	Summary of Risk Treatment Plan	Target date for implementation of mitigation	Consequence (current)	Likelihood (current)	Rating (current)
30	30 Aug 2023	Karen Dawber	Hannah Ackroyd	Risk Assessment	Quality Committee	USS capacity	There is a risk that the service cannot achieve the 72 hour timeframe for undertaking fetal ultrasound scans due to a lack of scan capacity	lørdag 28. februar 2026	10	(5) Catastrophic	(2) Do not expect it to happen again but it is possible	5	(5) Catastrophic	(1) Cannot believe that this will ever happen again	19.11.2025 - there has been an increase in the number of urgent scans (both NWD and 72 hour scans) that have escalated for further triaging due to booking issues due to capacity. This increase workload on the EL LSCS consultant has been escalated as affecting the safety of the EL LSCS lists resulting lists not being triaged. It has been uncovered that the recent issues with urgent capacity is relating to urgent lists are being utilised for non-urgent scans i.e. anatomy scans. This has been escalated to the Radiology team who advised they will work with the admin team to assure scans are booked into the designated lists.	30 Apr 2026	(5) Catastrophic	(3) May recur occasionally	15
70	29 Mar 2023	Sajid Azeb	Osman Chohan	Risk Assessment	Finance and Performance Committee People Academy	Pharmacy Accommodation - Cramped and not fit for purpose	If we are unable to improve the pharmacy accommodation, then staff will not be able to undertake their roles efficiently and safely. Staff may also suffer harms to their wellbeing from working in unfit accommodation. The result of this could be an increased risk to patient care, staff wellbeing and trust finance. Note - The pharmacy aseptic unit is listed as a separate risk - risk 3696.	01 Jul 2026	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	6	(2) Minor	(3) May recur occasionally	03.07.2025, Entry by Sannah Khan, MSO 1. Air conditioning unit installed and currently operational in Pharmacy reception area on Floor 1. 2. Carpet replaced with linoleum floor. Still awaiting tables/desks and chairs. 3. Standing down of OPS has made an office available, giving the opportunity to have a re-organisation of the placement of different aspects of the service. 4. Relocation to the SLH temporary Aseptic unit completed in April 2025. 5. Risk assessment reviewed and submitted to Director of Pharmacy for review before uploading to Iris. This risk is discussed regularly at CSU to Exec meetings.	31 Jul 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
95	14 Sep 2023	John Bolton	Mayada ME Elsheikh	Risk Assessment	People Academy Quality Committee	Emergency Department Medical Staff Coverage - weekend and evenings	If we are unable to provide a sufficient number of middle and senior grade doctors that meets the 24 hour capacity and demand of the Emergency Department then there may be a mismatch of patient acuity and demand versus the number and competencies of clinical decision makers on duty at any one time resulting in an increased risk of patient harm, compromised quality and performance and a negative impact on efficiency and patient flow	31 Oct 2025	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	02/10/2025 Update- CQC arrival delayed completion of workforce establishment review Rearranged (ME)	31 Mar 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15

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290	10 Feb 2021	David Moss	Chris Davies	Business Continuity	Quality Committee Finance and Performance Committee	Estates Critical Infrastructure	There is a risk of Estates Critical Infrastructure Failure due to backlog maintenance resulting in a potential loss of premises, harm and reputation damage.	lørdag 31. januar 2026	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	15	(5) Catastrophic	(3) May recur occasionally	November 2025 - Field House roof replacement has begun, C&D bridge link is now removed as work continues to install the new projects. BRI duct progresses, the boiler house leg is now a live project	30 Apr 2026	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
901	07 Dec 2016	Vikki Lewis	Daniel Kay	Business Continuity	Quality Committee	Cyber Exploitation and Incidents	Cause: The rising frequency and sophistication of cyber-attacks across different sectors such as retail, banking and the health sector including the NHS, combined with known vulnerabilities in legacy clinical systems, critical third-party integrations, and growing regulatory obligations significantly increases the likelihood of service disruption at BTHFT. This evolving threat environment heightens the Trust's exposure to operational instability, loss of digital continuity, and potential failure to meet statutory and contractual obligations under the NHS England guidance and UK GDPR/Data Protection Act 2018. Event: A successful cyber-attack (such as ransomware, data breach/exfiltration, or denial-of-service) compromises critical BTHFT digital infrastructure, resulting in the disruption of clinical and administrative systems, such as patient records, appointment scheduling, internal communications, and community services. This operational breakdown impairs care continuity, reduces organisational resilience, and exposes the Trust to increased scrutiny from regulatory and commissioning bodies due to unmet service obligations. Effect: Inadequate implementation of controls may result in delayed access to critical clinical systems or patient records, directly affecting care continuity and placing patient safety	mandag 19. januar 2026	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	12	(4) Major	(3) May recur occasionally	Sept 25 - Initial retng taken to 20. Shortfalls in cyber resources and gaps in 3rd party management require treatment. New digital assurance model in development to adequately resource cyber governance and protection	01 Apr 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16
979	02 Jul 2018	Karen Dawber	Yaseen Muhammad	Business Continuity	Quality Committee People Academy	Surge in respiratory illness - Linked to National RR	If we experience a surge in respiratory illness, this will result in services being impacted due to increase demand and staff absence resulting in a potential for loss of life or illness to staff and patients.	28 Sep 2026	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	16	(4) Major	(4) Will probably recur, but is not a persistent issue	September 2025 Risk reviewed - Please note this risk has an annual review. Please note that the staff flu uptake has been historically low and this will impact on our ability to fully mitagate. October 2024 Risk has been re-reviewed and approved at IPCC. As this risk is based on a national risk and regional risk from the North East & Yorkshire risk register GR1, the Trust score will stay the same. FOR INFORMATION- As there is no intelligence at present for a new strain of influenza and if it wasn't a national risk, this risk would be scored at 2x5 and would revert back to 4x5 If a new strain alert is received. As this is based on a national risk, the score will stay at 16.	29 Jan 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16

2509	16 Feb 2024	Karen Dawber	Louise Lacy	Business Continuity	Quality Committee	Children's Autism pathway - System wide risk	There is a risk that children will not be assessed for autism in a timely manner leading to a delay in diagnosis and avoidable harm due to the delay in treatment.	onsdag 25. mars 2026	16	(4) Major	(4) Will probably recur, but is not a persistent issue	12	(4) Major	(3) May recur occasionally	No change to current score. Review Dec 25	27 Dec 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16
2549	05 Apr 2024	Sajid Azeb	Jen Green	Risk Assessment	People Academy Quality Committee	Workforce Constraints within Non-Surgical Oncology (NSO)	There is a risk that the current NSO workforce within BTHFT and also WYAAT can't continue to support the current NSO model of care within the region, which will delay cancer treatment causing harm to patients.	fredag 27. februar 2026	16	(4) Major	(4) Will probably recur, but is not a persistent issue	8	(4) Major	(2) Do not expect it to happen again but it is possible	26/11/25 - business case for AOS workforce has been approved by ETM, in addition a new AOS pathway using SDEC has also been agreed. There will be AIM consultant oversight of Oncology SDEC and out of hours for Oncology admissions in order to release Oncology consultants from weekend ward rounds. Adaptation and innovation within AOS will aim to improve patient safety and experience for patients with acute complication of cancer and SACT.	31 Mar 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16
2588	24 May 2024	John Bolton	Nada Sabir	CQC Visit	Quality Committee	Currently unable to consistently staff MAC and ANDU with middle grade obstetric doctors	The service must ensure medical staffing for maternity triage and Antenatal Day Unit (ANDU) is reviewed so there are sufficient numbers of suitably qualified, competent staff to deliver the service in line with national guidance. Regulation 18 (1) The Maternity service within the Women's CSU in Bradford is one of the busiest maternity services in the UK. There are approximately 5300 births per year. We have 24/7 maternity assessment centre (MAC) comparable to the Emergency Department structure. In our MAC and ANDU we see an average of 1125 unplanned women per month, and 600 planned. This is equivalent to around 60 patients per day.	30 Apr 2026	12	(4) Major	(3) May recur occasionally	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	17.10.25 Partial 2 tier rota remains implemented, but service currently unable to move to a 19 person rota due to challenges in recruitment, trajectory shows that this might be achieved in Sept 2026 . Dr Sabir, CD shared challenges with recruitment and plans that they have to train MIT and SAS doctors in the longer term.	30 Sep 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16
2601	28 Jun 2024	John Bolton	Jen Green	Risk Assessment	Quality Committee	Cath Lab Equipment Failure	Downtime of current equipment is preventing optimal numbers of patients being seen, leading to longer waits for elective PCI and pacing work, and pressure on beds due to acute waits. Resulting in the potential for increased patient harm and poor patient experience.	27-feb-26	15	(5) Catastrophic	(3) May recur occasionally	9	(3) Moderate	(3) May recur occasionally	26/11/25 Cath Lab paper presented at ETM on 03/11/25, a further discussion with Airedale is required.	31 Mar 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15

2604	04 Jul 2024	Sajid Azeb	Mayada Elsheikh	Risk Assessment	Quality Committee Finance and Performance Committee	Emergency Department Overcrowding	There is a risk that the number of patients in the emergency department will exceed its designed capacity and available resources meaning providing safe, timely, and efficient care to current and incoming patients becomes challenging resulting in a potential for unsafe care delivery and increased stress on staff.	28-feb-26	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	12	(4) Major	(3) May recur occasionally	1. Immediate actioning of Trust-wide comms and social media campaign to inform parents of one carer policy once surge commences and SOP triggered 2. Develop an OPEL scoring system for escalation to alert the Executive team when we are under significant pressure. (Adults and Paeds) 3. Agreement from speciality teams to accept direct referrals and for ED teams to be able to send these patients directly to specialty receiving areas on their arrival to ED, including tertiary referrals and semi-elective admissions. 4. Develop business case for 24/7 consultant cover. 5. AED Pharmacist/Tech must ensure adequate stock, assist with complex prescriptions, and suggest alternatives to reduce the burden on nursing and medical staff for medication checks, issuing of TTOs, prescription reviews, and bed waits. 6. Long term Excel project launched	31-mar-27	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
2612	15 Jul 2024	John Bolton	Mayada ME Elsheikh	Risk Assessment	People Academy Quality Committee	Emergency Department (ED) Consultant review of pathology and radiology results	There is a risk that, due to the increased numbers of patients requiring enhanced diagnostic tests under the care of the Emergency Department that the significance of some results might get missed and there may be delays actioning the results. This may result in harm to patients and delays in treatment / diagnosis	30 Nov 2025	15	(5) Catastrophic	(3) May recur occasionally	10	(5) Catastrophic	(2) Do not expect it to happen again but it is possible	02/10/2025 Plans in place to adjust staffing allocation to account for increased numbers of reports to review at certain times of the week eg Monday mornings.	30 Nov 2025	(5) Catastrophic	(3) May recur occasionally	15
2628	31 Jul 2024	John Bolton	Jen Green	National Target	Quality Committee	TB Backlog	If we are unable to see TB referrals within the required 1-2 weeks there will be delayed assessment, investigation and treatment for active or latent TB resulting in increased morbidity and mortality for patients under the care of the TB service, increased admissions to hospital of unwell patients with infectious TB and an increased risk to Public health due to spread of infection and increased cases.	27-feb-26	9	(3) Moderate	(3) May recur occasionally	9	(3) Moderate	(3) May recur occasionally	26/11/25 - Clinical Fellow that was appointed and gave back word, post re-advertised and interviews held again. Appointment made on 12/11/25, now awaiting HR checks. In the interim, extra clinics that the consultants agreed to undertake are also being used to book the longest TB patients. Work is being undertaking in the service as Performance are currently unable to assess demand and capacity/	27-mar-26	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
2667	05 Dec 2024	John Bolton	Simon Kirk	Escalated from Division	Quality Committee	Insufficient Radiation protection advisor(RPA) and medical physics expert (MPE) for diagnostic imaging - Legal Compliance and Patient safety	If we fail to have qualified and adequate provision for MPE and RPA we will not be in line with legislation leading to regulatory sanction and potential harm to patients and staff.	22-mar-26	16	(4) Major	(4) Will probably recur, but is not a persistent issue	4	(2) Minor	(2) Do not expect it to happen again but it is possible	update feb 2025- single point of failure has failed- (temp in sourcing to keep hospital operational with xrays) Both roles are legally required. There is a single point of failure with current workforce- There is a risk to regulatory compliance, patient safety, reputation and business continuity. When bench marking against workforce calculator we have less than 1.00 WTE against a requirement of 7.2. As a result we have incidents where dose optimisation had not been completed. Diagnostic Reference Levels have not been completed. not complete. DRL audits have not been completed. - critised at experal inspection (CQC/SQAS).	01 Feb 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16

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2677	23 Dec 2024	John Bolton	Rebecca Kidd	Risk Assessment	Quality Committee	Respiratory Inpatient Capacity	There is a risk that If we do not increase respiratory inpatient capacity including appropriate side room provision, ensuite and appropriate ventilation, then it will lead to infection control out breaks, long stays in AED, inappropriate use of ICU capacity, large number of respiratory outliers. Resulting in avoidable harms to patients and extended length of stay.	31 Dec 2025	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	5	(5) Catastrophic	(1) Cannot believe that this will ever happen again	10.11.2025 - Reviewed as part of a review of the high level risk register. New SOP for POCT swabbing prior to transfer to ward 23. Since implementation. 1x official flu outbreak since this date and 1x further pop up on wd 23. However all mitigations are not yet in place 10/11/2025 - Target mitigation date updated to fit with next review date.	30 Apr 2026	(5) Catastrophic	(3) May recur occasionally	15
2725	26 Mar 2025	John Bolton	Leah Richardson	Risk Assessment	Quality Committee	The physical condition of the environment where pathology slides and blocks are stored at St Luke's Hospital poses a risk to the material stored. There is further risk to staff safely accessing the material for retrieval due to the location of the storage space.	If we are unable to find a suitable location with the correct environmental considerations for the storage and retrieval of pathology slides and blocks, then we will be in potential breach of legislation (HTA / MHRA / HSE etc) resulting in reduced specimen integrity, non compliance with regulations, reputational damage and harm to staff.	31 Jan 2026	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	3	(3) Moderate	(1) Cannot believe that this will ever happen again	02/10/2025 - The risk remains the same we have a draft tender and plan to finalise this to put to market in November.	31 Oct 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
2748	23 Jun 2025	Sajid Azeb	Mike Page	Escalated from Division	Finance and Performance Committee Quality Committee	Loss of NM Service - As of September 2025, redesigned Tc99m generator no longer fits	From 30 September 2025, the supplier is changing the shape of the Tc99m generator, meaning it will no longer fit the lead housing within the isolator. This renders the generator unusable and will result in loss of Tc99m supply. Without a viable solution, this will cause a Nuclear Medicine service failure	02-mar-26	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	4	(4) Major	(1) Cannot believe that this will ever happen again	The Business Continuity Plan is to source supply from an alternative provider if the issue remains unresolved.	31 Jan 2026	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
2753	11 Jul 2025	John Bolton	Jen Green	Risk Assessment	Quality Committee Finance and Performance Committee	Renal Dialysis Capacity	There is a risk that there is insufficient capacity for in-centre (hospital) haemodialysis, meaning we will not be able to provide timely dialysis for new patients potentially resulting in death or serious harm.	31-mar-26	25	(5) Catastrophic	(5) Will undoubtedly recur, possibly frequently	5	(5) Catastrophic	(1) Cannot believe that this will ever happen again	30/12/25 - Building work for Skipton expected to be complete by May 2026. Capacity remains an ongoing challenge and concern for the CSU. Currently 98% of available dialysis slots across St Luke's and Skipton are booked, as such the CSU has increased the risk score to 20.	31 Mar 2026	(5) Catastrophic	(4) May recur occasionally	20

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2756	16 Jul 2025	Sajid Azeb	Mayada ME Elsheikh	Risk Assessment	Quality Committee Finance and Performance Committee	AED Long Waits	If we are unable to see, treat, and admit or discharge patients within 4 hours then patients will increasingly experience a long length of stay in the A&E department. Consequently, they are more likely to experience increased mortality and morbidity	31 Dec 2025	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	12	(4) Major	(3) May recur occasionally	02/10/2025- ME Ongoing works with interprofessional standards and EXCEL programme will hopefully help with this. Interprofessional standards currently being updated by CMO/Deputy Director of Operations. Aim to increase review of patients by specialties in AED and divert GP referrals to specialties direct to appropriate areas.	31 Dec 2025	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
2758	18 Jul 2025	Karen Dawber	Melanie Stack	Risk Assessment	Quality Committee Finance and Performance Committee	Violence and Aggression on AMU	If we continue to see patients in acute crisis there is a potential for violence and aggression towards staff and patients resulting in staff and patient harm.	02-feb-26	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	8	(4) Major	(2) Do not expect it to happen again but it is possible	02/12/25 - KK Ongoing collection of evidence was presented at establishment review. awaiting outcome from final establishment review.	31 Jul 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16
2764	30 Jul 2025	Sajid Azeb	Jen Green	Risk Assessment	Finance and Performance Committee Quality Committee	Respiratory RTT Backlog	There are 670 unbooked RTT patients on the waiting list, of whom 177 are TB latent patients (see risk entry for TB). 23/670 are over a 40 week wait, and 150 between 30 and 39 weeks, undated, with first available appointment in December 2025	31-mar-26	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	30.12.25 - Due to the additional clinics, good progress has been made to reduce the backlog and long waiters. There are now 14 patients over 52 weeks compared to 86 patients over 52 weeks in September 2025. ETM have also approved 1.00 WTE substantive consultant and 1.00 WTE locum consultant for 6 months. Additional capacity for TB will be a provided by a Clinical Fellow from March 2026	31 Mar 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
2770	19 Aug 2025	Karen Dawber	Laura Chadwick	Risk Assessment	Quality Committee	Neonatal Videolaryngoscope	Endotracheal intubation is a lifesaving, highly skilled and complex procedure that is often done in emergency situations in neonatal intensive care. The role of video laryngoscope in neonatal intubation is being increasingly recognised. There is evidence to suggest that Video laryngoscopy improves the intubation success rate in neonates when compared to direct visualisation and is being used increasingly for emergency and elective intubations. In addition, it is helpful as a teaching / training tool for less experienced professionals. It is an important tool for addressing difficult airways and on multiple occasions, has helped us manage challenging airways in babies of extremely low gestation and birth weight. Videolaryngoscope is recommended as the gold standard technique for administering surfactant to preterm babies through Less Invasive Surfactant treatment (LISA), a common procedure in neonatal intensive care. The BAPM neonatal airway safety standard strongly recommends the use of videolaryngoscopy in routine clinical practice and for supervising inexperienced intubators. and in training neonatal staff in delivering airway interventions in neonates. Recently, the existing provider of our current video laryngoscope (ACUTRONIC) has stopped making any replacement blades. We currently have 2 size 00 and 2 size 0 blades that are being used regularly. Currently, the blades	22-jan-26	15	(5) Catastrophic	(3) May recur occasionally	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	Dec - 25: New videolaryngoscope purchased. In use. Risk assessment score to reduce for next Core Group Governance meeting.	22-jan-26	(5) Catastrophic	(3) May recur occasionally	15

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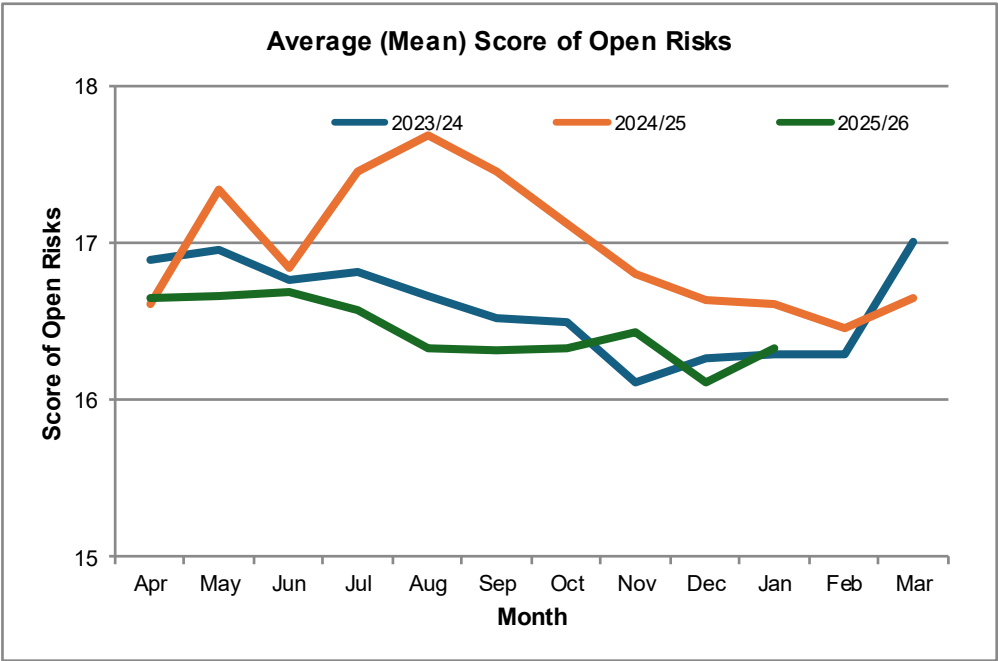
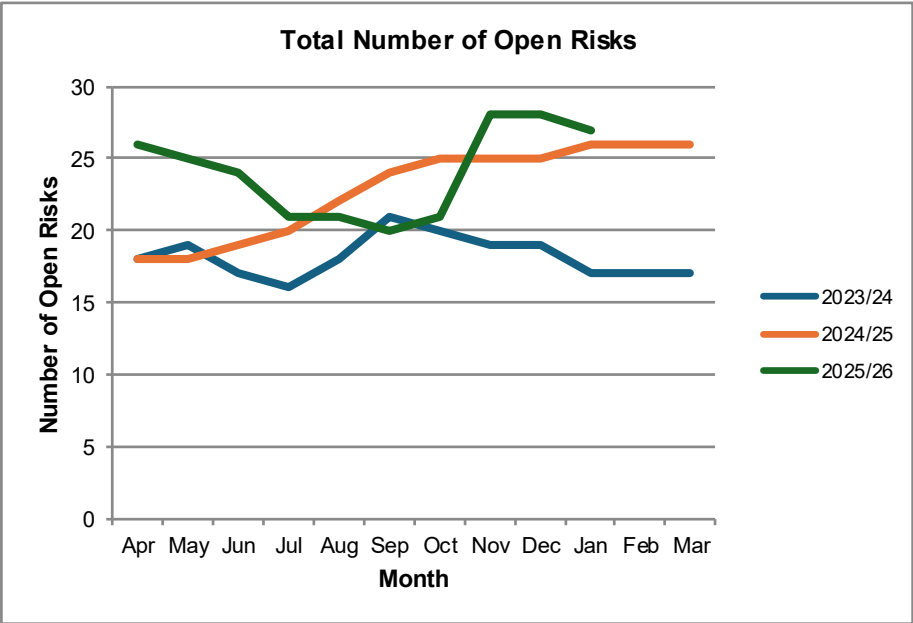
2773	20 Aug 2025	Karen Dawber	Kay Rushforth	Risk Assessment	People Academy Quality Committee	Children and Young People with Medical Complexity	IF staffing resource is not commissioned to deliver higher level care to children with medical complexity when they require this THEN care for CMC remains at a nurse to patient ratio of 1:4 and untimely medical supervision RESULTING IN substandard care, for all children irrespective of care level needs, reduced flow and possible closure of beds.	20 Apr 2026	12	(4) Major	(3) May recur occasionally	12	(4) Major	(3) May recur occasionally	1. Aim to provide 1:1 where child in cubicle or 1:2 care. Immediate care on arrival to ED and CCDA to aim for continuity of care. 2. Increased nurse to patient ratios and recognition of HDC level 2 status. Increased medical staff hours with expertise to provide care. Non recurrent money (winter surge November 2024 - 25 for 6 months) provided to keep some complex needs children out of hospital. Pilot study only. Study a success but must continue. 2. As above. Greater discussion required nationally and regionally. Children should be cared for closer to home with the expertise necessary 3. Focus group for parents/CMC to share ideas thoughts needs	20 Apr 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16
2787	23 Sep 2025	Karen Dawber / John Bolton	Alastair Hughes	National Guidance	Quality Committee	Maternity theatres	The maternity theatres do not meet the AFPP standards in line with the main hospital theatres.	30 Jan 2026	12	(3) Moderate	(4) Will probably recur, but is not a persistent issue	4	(1) Negligible	(4) Will probably recur, but is not a persistent issue	19.12.25- Core governance unable to proceed due to national junior Dr Strike. All available Consultants covering clinical activity , Not Quorate. RA extended to January 2026.	31 Mar 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
2810	01 Oct 2025	Ben Roberts	Chris Smith	Corporate Objective	Finance and Performance Committee	Revenue Financial Position	IF Trust doesn't deliver its financial plan THEN it will not achieve it's statutory duty to achieve financial balance RESULTING IN additional sanctions being placed on the Trust by NHS England and reducing its ability to invest in services and being unable to maintain liquidity to meet its financial obligations.	30 Jan 2026	12	(4) Major	(3) May recur occasionally	12	(4) Major	(3) May recur occasionally	Identification of further financial mitigations, approvals is in place with NHS E to appoint external turnaround support jointly with Airedale.	31 Jan 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16

High Level Risks Report on a Page - January 2026

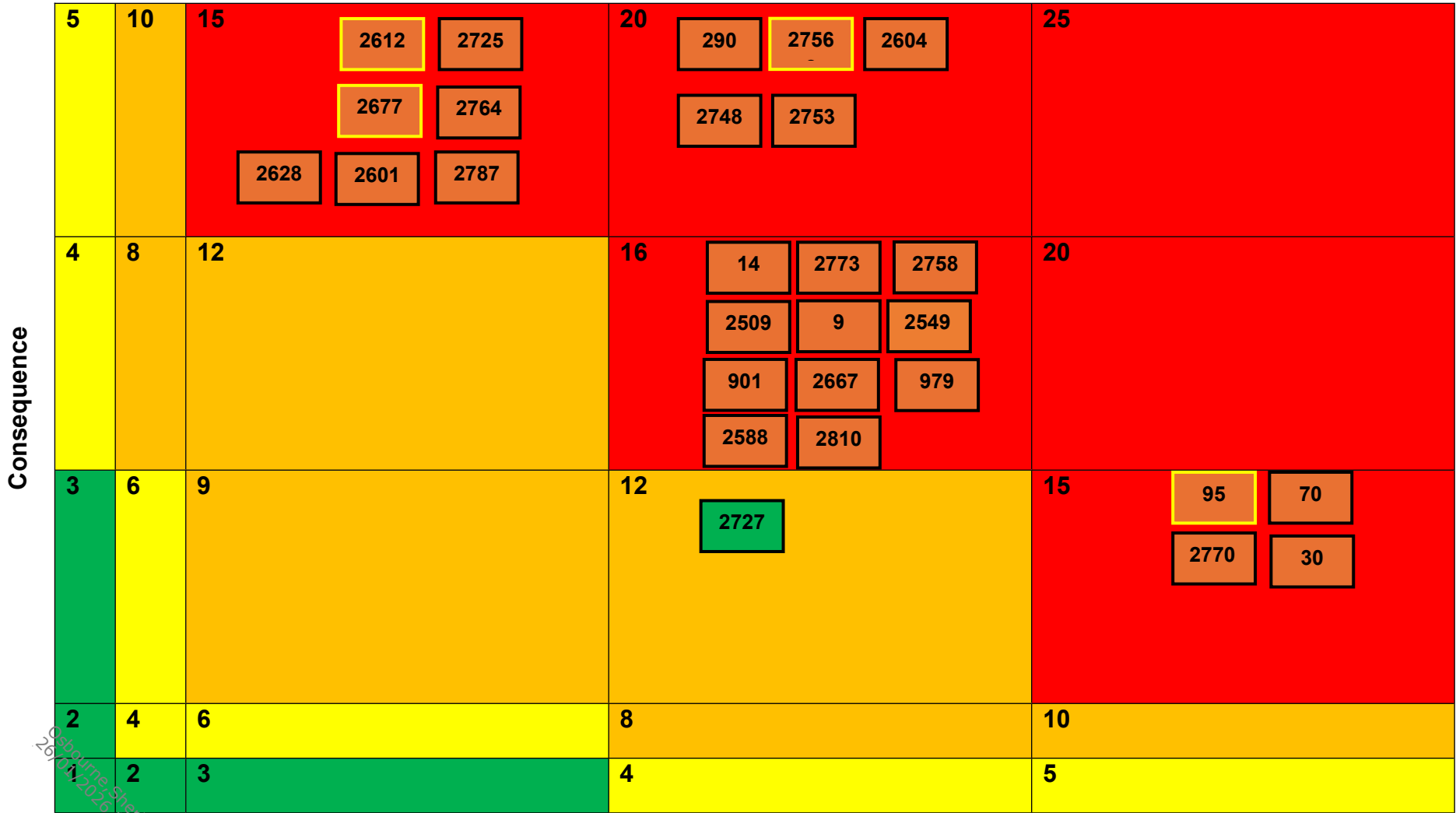
Total High Level Risks	27*
Aligned to F&PA	9
Aligned to QA	23
Aligned to PA	6
Aligned to Board	2

*Note some risks are aligned to more than one Academy/Committee

Movement of Risks	
New	0
Marked for closure	0
Risk score increased	1
Risk score static	26
Risk score decreased	1

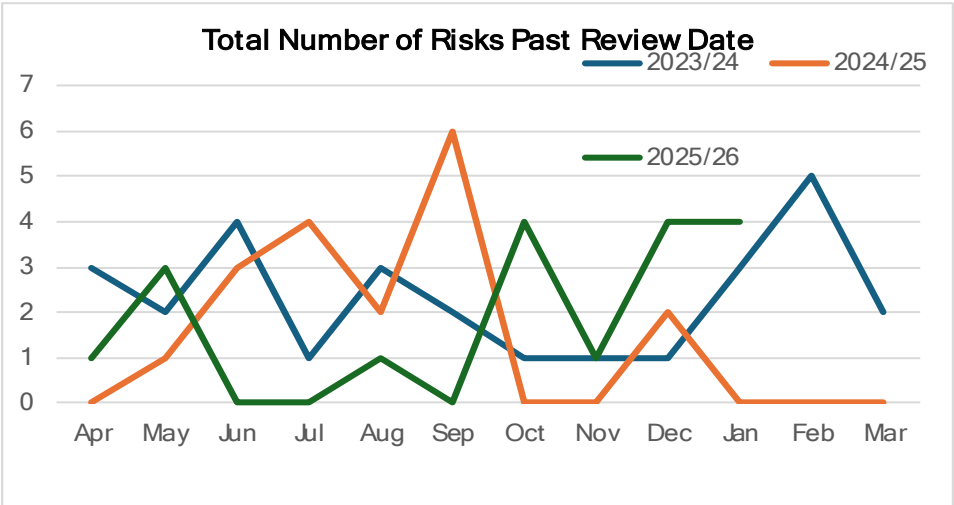
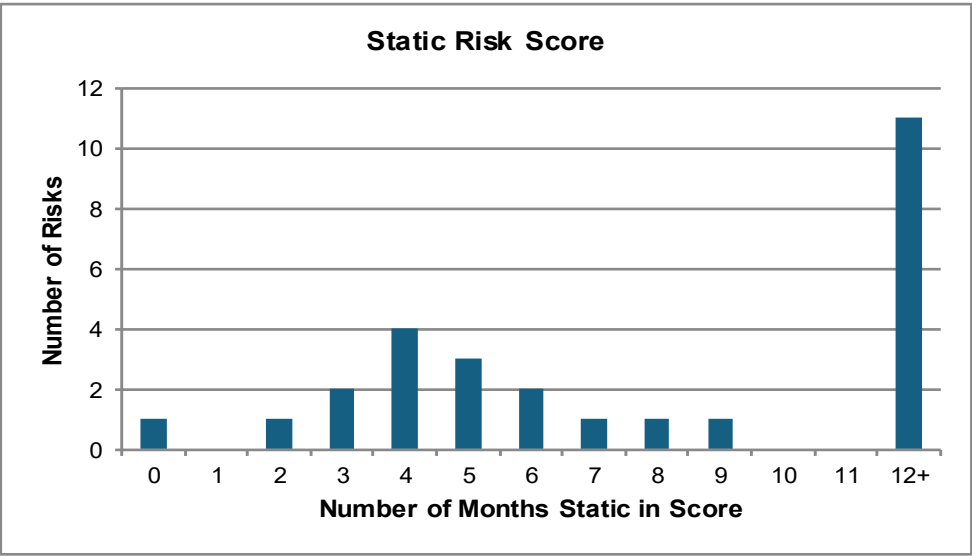


Risk Overview



Likelihood

Key: New Closed Increase Decrease Static Past Review Date



Changes to Target Mitigation Date of Current High Level Risks - January 2026

IRIS ID	Date of entry	Academy/ Committee	Current Score - December 2025	Target Score	Original	1st Change	2nd Change	3rd Change	4th Change	5th Change	6th Change	7th Change	8th Change	9th Change	10th Change
290	10/02/2021	QC, F&P	20	10	30/04/2021	31/05/2021	31/03/2023	31/03/2025	30/04/2026						
14	17/10/2023	Board	20	10	30/11/2023	31/03/2024	30/09/2024	31/03/2025	31/12/2025	31/12/2026					
2549	05/04/2024	PA & QC	16	4	31/03/2025	31/05/2024	31/10/2024	31/03/2025	31/03/2026						
95	14/12/2022	PA & QC	15	6	28/02/2024	31/08/2024	31/10/2024	31/03/2025	31/03/2026						
2612	15/07/2024	PA & QC	15	6	30/09/2024	03/12/2024	28/02/2025	31/07/2025	06/10/2025	30/11/2025					
2601	28/06/2024	QC	15	8	31/12/2024	31/01/2025	31/07/2025	31/03/2026							
901	07/12/2016	QC	16	9	30/04/2024	30/03/2025	30/08/2025	30/09/2025	01/04/2026						
9	10/11/2023	Board	16	8	30/09/2024	31/03/2025	31/12/2025	30/04/2026							
70	29/03/2023	F&P & PA	15	6	01/04/2025	31/05/2025	31/12/2025	31/07/2026							
2509	16/02/2024	QC	16	9	01/04/2024	27/12/2025	27/12/2026								
2677	23/12/2024	QC	15	5	01/09/2025	30/04/2026									
2667	05/12/2024	QC	16	16	07/05/2025	07/09/2025	01/12/2025	01/02/2026							
2725	26/03/2025	QC	15	3	31/10/2025	31/10/2026									
2628	31/07/2024	QC	16	8	30/05/2025	30/06/2025	29/08/2025	31/10/2025	27/03/2026						
2756	16/07/2025	QC, F&P	20	12	31/12/2025										
2758	18/07/2025	QC, F&P	16	8	31/07/2026										
2753	11/07/2025	QC, F&P	20	5	31/03/2026										
2773	30/08/2025	PA & QC	16	16	20/04/2026										
2604	04/07/2024	QC, F&P	20	12	01/10/2024	30/06/2025	30/09/2025	31/03/2027							
30	30/08/2023	QC	15	5	31/08/2024	31/05/2024	30/09/2024	31/12/2024	31/03/2025	30/04/2026					
2748	13/06/2025	QC, F&P	16	4	31/01/2026										
2588	24/05/2024	QC	16	6	01/11/2024	01/04/2025	01/10/2025	28/09/2026							
2787	23/09/2025	QC	15	4	31/03/2026										
979	29/09/2025	PA & QC	16	16	29/01/2026										
2764	30/07/2025	QC, F&P	15	6	31/03/2026										
2770	19/08/2025	QC	15	6	19/09/2025	19/12/2025	22/01/2026								
2810	04/11/2025	F&P	16	12	31/01/2026										

Key: Past target mitigation date
 Target mitigation date changed

Osbourne Sheridan
26/01/2026 12:25:00

Board of Directors				
Meeting Date:	29/01/26	Agenda Reference:	Bo.1.26.15	
Report Title:	Bradford Hospitals Charity 12-month review			
Presented by:	Mark Hindmarsh, Director of Strategy & Transformation, Altaf Sadique, Chair of Charitable Funds Committee & Laura Riach, Charity Director			
Executive Lead:	Mark Hindmarsh, Director of Strategy & Transformation			
Author:	Laura Riach, Charity Director			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	Executive Summary A year of transition, growth, and increasing strategic relevance to the Trust. The charity enters 2026 with strong leadership, financial momentum, and a flagship capital campaign advancing at pace. The Senior Leadership Team (SLT) is now fully in place and operating effectively, delivering record fundraising and programme impact. The charity's alignment with Trust priorities is strengthened further by closer integration with the Finance team, with the Charity Finance Manager now reporting directly to the Charity Director, ensuring robust financial oversight and governance. Key highlights: Leadership and governance: SLT fully operational; Independence Committee established; Chair of Trustees recruitment underway. Building relationships with major donors and key Trusts and Foundations. Fundraising and income generation: Significant contributions through major campaigns, including: private and public phases of the Home from Home Campaign launched, resulting in the charity's first £1m gift from the Harry & Mary Foundation as well as numerous pledges of support from individuals, organisations and trusts and foundations. Big Give 2025: £51,094 raised in just one week, leveraging match-funding and gift aid. Christmas Appeal 2025: Over 4,000 presents delivered to 40 wards, community events at Bradford Royal Infirmary and St Luke's, and significant engagement with the local community and business. Snowflake Appeal relaunch: Approx. £10,000 raised from key partners following hiatus since 2021. This year, we included recognition labels to motivate corporate partners to get involved. 100 Club relaunch: Secured new corporate support as well as a £30,000 donation from Sovereign Healthcare to fund a new digital oral scanner.			

Osbourne, Sheridan
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	Impact delivered (Apr25-Dec25): 125 charitable expenditure application forms received from April to December. 123 approved to date. Home from Home campaign momentum: Private phase launched May 2025 and public phase launched November 2025 resulting in coverage on BBC Look North, BBC Radio Leeds, BBC Online, and Telegraph and Argus. Follow up pitch to Sovereign Healthcare for £250-300k at the end of January. Key community and corporate initiatives planned for the duration of 2026, including targeted social media advertising (Facebook and Instagram), and the 'Buy a Brick' campaign launching in February. Strategic direction: Next 12 months are critical to deliver our share of the £3m Home from Home campaign, progress independence, and working towards securing £30,000/month unrestricted income.
Recommendation/s: (including any decision/approval required)	As we prepare for independent status, we ask Board Members to please consider the following: 1. Trustee Recruitment: Please consider if you wish to become a Charity Trustee when we transition to independence. Your existing knowledge of our organisation would be invaluable in this new structure. 2. External Trustee Recommendations: We warmly welcome suggestions for external independent trustees who could strengthen our board. We are particularly seeking: • Key decision makers within the Bradford community • Individuals with strong networks across the region who are willing to make introductions and open doors • Those with a demonstrated passion for healthcare in Bradford • People with complimentary skills in fundraising, finance, governance, charities and strategic development For support and advocacy: Please champion the charity with your teams and networks, to help us grow unrestricted income and support more patients, families and staff members across the Trust • Please attend / support community & corporate engagement events For Decision / Endorsement: • Endorse independence timeline and governance arrangements • Support Home from Home 'Buy a Brick' launch in February and ambassador engagement throughout the year • Please share Chair of Trustee role with networks Your active participation in this transition period will be crucial to establishing a strong foundation for our independent future, ensuring we can maximise our impact for staff and patients across Bradford Teaching Hospitals Foundation Trust.

Osbourne, Sheridan
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Link to Strategic Objective:	N/A
Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	N/A
Legal/Regulatory:	N/A
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	Charity Operational Committee 20.01.26

Report content

Forward look and review: The charity is well-governed, strategically aligned, and delivering tangible value. Board-level advocacy and support will be pivotal as we move to independence and scale the Home from Home programme to fruition.



Pictured: She-Donna and baby Sheariah – they spent nearly 4 months on the unit. She-Donna and her sons stayed in one of the rooms on the Neonatal Unit. She-Donna was pivotal in launching the campaign by kindly sharing her experiences on film.

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Pictured: Families that have used the Neonatal Unit supporting the 'Home from Home' campaign.

B. Key numbers – April 2025-December 2025.

Metric	April-Dec	Insight
Number of applications funded	123 out of 125	Across wards, departments, and Trust-wide initiatives
Number of donors / supporters	6000 +	Community, corporate, and individual engagement
Number of events / campaigns delivered	55	100 Club relaunch, Big Give Campaign, Winter Ball, Snowflake relaunch

Key insight:

The charity has grown significantly over the past year, in monetary donations, gifts in kind and impact across the Trust. In December 2025 the charity saw a significant increase in income compared to December 2024.

Momentum is particularly strong in major campaigns and high-profile community engagement initiatives, which will feature a PR campaign in February, encouraging Sadaqah-related giving during Ramadan, while strengthening trust and commitment with Bradford's Muslim communities.

C. Charitable impact and expenditure

Impact on patients and families

- Children's ward improvements – cinema room (first in Yorkshire region) and sensory room

Holly's three-year-old daughter, Isabella, was a patient on the children's ward at Bradford Royal Infirmary when the hospital cinema room opened. The 22-year-old, from Allerton, said: "In a room it's all the same four walls, so it's pretty boring, and she also associates it with getting the medical treatments, that obviously stress her out quite a lot..."

"I think it takes some of the stress off, of trying to keep a child entertained during long stays. It's also more relaxing to watch a film as a parent in a different space."



Pictured: Isabella enjoying the cinema on the children's ward



Pictured: Little boy playing in the sensory room on the children's ward. The sensory room was funded by Claire Walker with her 'Sparkle for Axel' fund in memory of her precious son.

- Applications from ICU, children's, maternity, neonatal, stroke, renal were all approved

Louise Gee lost her son Alfred in 2025; he was a patient on the Neonatal Unit at Bradford Royal Infirmary. In memory of Alfred she's been a huge supporter of the 'Home from Home' appeal and often donates items to the ward, most recently Zaky hands (weighted, hand-shaped cushions that mimic a parent's touch), she said: "We will never stop supporting you, you made such a difference to us and to Alfred and we're so pleased that future babies in (the Neonatal Unit's) care are able to benefit from these in his memory." Louise kindly shared her story on film which formed part of the public phase launch.



Pictured: A baby on the neonatal unit with a Zaky hand.

Laura's son was born sleeping at 25 weeks. The Izzard family helped raise funds to refurbish the snowdrop suite, a private and homely room for families facing the loss of their baby. The entire Izzard family were invited back to open the refurbished suite, she said: "We haven't been back in there since that day, and it was incredibly moving to see how the money we raised from our Walk for Louie has transformed the space..."

"It was overwhelming (in the best way) to see how much love and care went into every detail, and to know the funds raised in Louie's name have helped make a difference for families, who heartbreakingly, may find themselves there in the future."



Picture: The suite was officially unveiled by Ruby and George Izzard at a small, private event held for bereaved families, in loving memory of their brother Louie.

- Giggle Doctors / Baggins the Bear

Orla raised £320 for Baggins the Bear after he brought her comfort during her visit to Bradford Royal Infirmary. Orla's mum, Sophie, said: "It was such a lovely way to distract the children from what could be a very daunting experience." Our beloved Baggins Mascot has gone down very well and is helping to raise awareness everywhere he goes.



Pictured: Baggins the Bear mascot with a child (left). Picture of Orla and her parents with Baggins (right).



Pictured: Giggle Doctors on the concourse at Bradford Royal Infirmary.

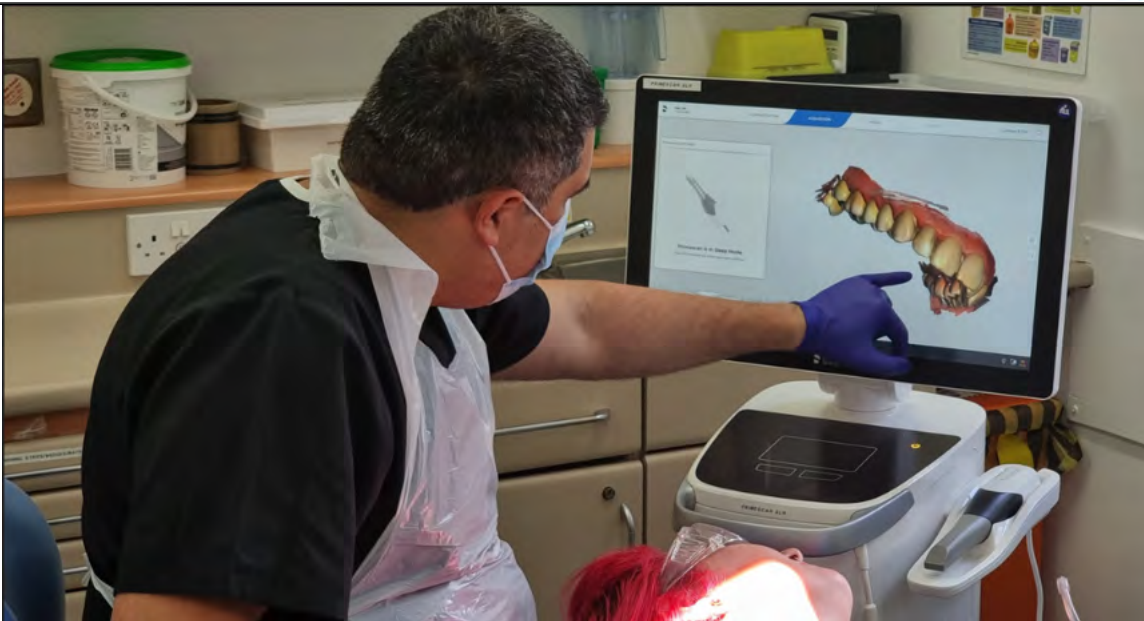
Impact on Staff

- Brilliant Bradford Staff Awards
- Long Service Awards
- Ramadan Allies and wellbeing initiatives, including the garden at Field House

A woman with long brown hair tied back, wearing a purple t-shirt with the Bradford City NHS Foundation Trust logo, is smiling and handing a white plastic bag labeled 'RAMADAN PACK' to a person in a dark uniform. In the background, a man in a light blue short-sleeved shirt and grey trousers stands near a window. A sign on the window reads 'RAMADAN Fast Packs' and mentions '16 Free Ramadan Fast Packs' and 'Thank you'.

3. Strategic Infrastructure and Equipment Investment

- Osbourne, Sheridan
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Pictured: Ahmed, Consultant and Specialist in Restorative Dentistry & Oral/Facial Rehabilitation showcasing the intra-oral 3D scanner at the relaunch of our 100 Club Event. This led to a £30,000 donation from Sovereign Healthcare to fund an additional scanner and 3D Printer.

- Facilities improving supporting patient, family and staff experience



Pictured: Field House staff garden where staff can have a break from their busy days to relax and unwind a little.

Every investment demonstrates the charity's ability to deliver outcomes beyond NHS-funded activity.

D. Fundraising and key partnership highlights

Key partnerships: The Harry & Mary Foundation, Sovereign Healthcare, Compass Group, Dunelm, Ken & Edna Morrison Foundation, ACS Group and others.

Community campaigns and events:

- o Big Give 2025 (£51,094 raised)
- o Christmas Appeal 2025 (over 4,000 presents across 40 wards and departments)
- o Snowflake Appeal relaunch (£9,750 raised)
- o Winter Ball and Winter Wonderland (£18,000 raised)

Grants & Philanthropy:

Grants of £1,044,279 have been received or pledged towards the Home from Home appeal.



Pictured: Mel Pickup, BTHFT Chief Executive and The Harry and Mary Foundation Trustees (Robert, Bob and John) at the signing of the £1m gift agreement.

We were also successful in our pitch to become one of seven beneficiary charities for the Yorkshire Charity Clay Days event in May 2026 for the Home from Home appeal, which raised £575,000 for selected charities last year.

Further grants have also been secured to continue providing visits from The Giggle Doctors to the children's wards through-out 2026, and a number of grants from Sovereign Health Care.

Innovation and engagement: The [events calendar](#) to engage staff and corporates to fundraise on behalf of the Charity has been finalised and will include favourites such as the Great North Run and Dragon Boat race and a new Inflatable 5K challenge this year. Market Mondays are well established at BRI and in 2026 will be extended to St Lukes and possibly outside the neonatal unit to boost regular unrestricted income further.

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Why it matters:

Why it matters
Every week, 1
(NICU) at Brac

Every night, their parents face an impossible choice: stay close in uncomfortable chairs or return home to rest, knowing they are far away if their baby needs them.

“You can’t underestimate that when you’ve given birth everything in your body is telling you that you should be with your baby. Any distance at all feels unnatural, a nightmare if I’m honest. If you’re separated you don’t feel whole – it’s awful having to walk away, even for one night.” – Helen, Beatrice & Emmeline’s mum.

The need for a ‘Home from Home’

Prematurity is the leading cause of death in children under the age of five, with one premature baby born every eight minutes in the UK. At Bradford Royal Infirmary NICU we care for up to 31 poorly and sick babies at any one time, seeing around 500 babies on the Neonatal Intensive Care Unit each year.

Currently, we can only offer overnight accommodation to a maximum of five families, meaning that other parents must go home at night, leaving their precious miracle in hospital. This places a huge amount of emotional and financial stress on families who have already found themselves in the most traumatic of situations.

“A ‘home from home’ would mean that I could enjoy every precious little moment that I have with my baby that I otherwise wouldn’t have had the opportunity to.” – Mohammed, whose son Ahmad was cared for in the Neonatal Intensive Care Unit.

The premature baby charity, Bliss, estimate that it costs approximately £405 extra per week in costs for parents with a premature or poorly baby in the Neonatal Intensive Care Unit. They will also forfeit, on average, £3,000 in lost income from giving up work or taking unpaid leave. This additional financial burden has a disproportionate impact on those from poorer, more deprived, backgrounds and may result in one or both parents not being able to visit or stay with their baby as often as they would like. 75% of parents do not have access to overnight accommodation when their baby is critically ill, and 87% said this impacted their ability to take part in their baby’s care.

One of their families told them, *“It was very hard to walk away while she was critically ill at times, but because there was nowhere to stay [at the hospital] we had no choice but to go home.”*

We know that babies have the best developmental outcomes when their parents can deliver hands-on care. This includes:

- Feeding
- Kangaroo care (also known as skin-to-skin contact)
- Administration of (some) medications
- Dressing and changing baby
- Bathing and comforting

But to do this, parents need to present at their baby’s side, ideally 24 hours a day. Parental involvement in care is also critical for forming secure attachments and developing the parent-infant bond, increasing parental confidence, reducing stress and anxiety, and improving the perception of ‘feeling like a parent’.

What your support will help us achieve

This transformative project will see the development of a dedicated 'Home from Home' family accommodation unit next to the Neonatal Intensive Care Unit at Bradford Royal Infirmary. The 'Home from Home' will provide five additional bedrooms for families whose babies are admitted to the unit, along with a communal kitchen, dining area, lounge and private garden space for all families to utilise. This will also allow the reconfiguration of existing internal spaces to provide an end-of-life care room for families with babies too poorly to survive, counselling rooms, and prayer room.

Key dates and programme milestones

Planning permission for the build was formally approved by Bradford Council on 1 October 2025, and the project is now at RIBA Stage 4. We have begun the tender process for a contractor, using the Procure Partnerships Framework and four companies have been invited to tender. It is expected that the contractor will be appointed in January 2026, with work on-site due to start later that month.

The project will be approximately a 12-month build, with several elements produced off-site to minimise noise and disruption to babies and families on the unit. It is acknowledged that the building is in close proximity to the Neonatal Intensive Care Unit, which will continue operating as normal during the build time.

Where we are now:

To date, 28% of the capital campaign target has been received, with a further 30% formally pledged and we are in the process of building a robust pipeline. This provides a strong foundation for the campaign and reflects early confidence in the project. However, there is still more work to do, and continued momentum will be essential. Achieving this transformative build will require the full support of the Bradford community, and active fundraising efforts will continue to engage supporters and secure further investment to deliver the project in full.

Ambassador Programme – strategic update:

Ishfaq Farooq (one of the directors of MyLahore and WunderCrumble) has supported Bradford Teaching Hospitals for over a decade and has been appointed Bradford Hospitals Charity first-ever ambassador, he brings a wealth of knowledge, experience and strategic connections.

He is actively raising awareness and aiming to raise £30,000 towards the kitchen and dining facilities in the 'Home from Home'. His engagement has already generated significant visibility and excitement within key community networks and garnered lots of media interest.

Ishfaq said it was a "great honour" to take up the role, adding: "I'm so grateful that we are in this position where we can help and support this amazing charity. We're a community-led business and we feel it is a vehicle to do good. We've personally seen and experienced the difference that the charity makes and it's a bridge between the community and the hospital."

In early discussions with **Adeeba Malik**, Lord Lieutenant of West Yorkshire, about becoming an ambassador for the 'Home from Home' appeal - providing prestige, strategic advocacy, and credibility at Board and community level.

Both appointments enhance campaign reach, community engagement, and fundraising credibility, demonstrating a proactive approach to engaging high-profile and strategic supporters.



Pictured: Ishfaq Farooq at Wunder Crumble raising awareness and funds at their Winter Wonderland event.

Next steps:

Over the coming months, we will continue to build momentum through sustained media coverage and community engagement, supported by board advocacy at key milestones in the campaign. On the estates side, mobilisation is planned for late January, with a formal ground-breaking anticipated in late February or early March. In parallel, Memoranda of Understanding and lease agreements are progressing with legal support to ensure the project remains on track.

Please click on the links below to hear directly from several parents about their experiences and why the creation of a Home from Home is so important to families receiving care at Bradford hospitals.

- [Alfred's story - Home from Home](#)
- [Sheariah's story - Home from Home](#)
- [Ahmad's story - Home from home appeal](#)
- [Emmeline's story - Home from Home](#)

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[Images / slides: Home from Home concept render, ambassador events or headshots, campaign highlights]

We would like to thank all Board Members for their support for our Snowflake campaign and would like to warmly encourage all board members to participate in upcoming NNU events to demonstrate leadership commitment to this critical project.

F. Case for Independence

The move towards independence will enable the charity to operate as a fully autonomous, professionally governed organisation, while remaining firmly aligned to NHS values.

This transition will support greater agility in fundraising, decision-making, programme delivery, strengthens financial controls and governance, and enhances the charity's long-term sustainability, while maintaining a clear focus on improving outcomes and experiences for patients, families, and staff. The Senior Leadership Team is now fully operational, and an Independence Committee established to oversee delivery. Interviews for the Chair of Trustees are scheduled for the

week commencing 23 February 2026, followed by trustee recruitment, which is expected to be completed by Q3 2026.

Timeline and milestones:

Milestone	Target Date
Chair of Trustees appointed	Feb/March 2026
Trustee recruitment completed	Apr-June 2026
Full operational independence	Within 12–18 months

Board involvement:

As the charity progresses towards independence, its alignment with Trust priorities, close partnership with clinical teams, and unwavering focus on patient, family, and staff impact will remain unchanged. The Trust Board will be kept regularly informed of progress through scheduled updates and key decision points and will play an active role in shaping the charity’s future relationship with the Trust, including contributing to the development of a formal partnership charter to underpin ongoing alignment. The Board will also be invited to recommend potential trustees and to support advocacy for the charity within both Trust and external networks. Board endorsement is sought for the proposed independence timeline and governance arrangements, recognising the strategic benefits of independence in strengthening impact, long-term sustainability, and donor confidence, whilst also opening new routes to funding not currently available.

G. Workforce and Capacity Update

Investment in the team is starting to pay dividends. The Senior Leadership Team is fully in place and delivering a strong performance, supported by the wider team across all operational areas. The finance function is now fully integrated, with the Charity Finance Manager reporting directly to the Charity Director. While there is still important work to do in changing hearts and minds across the Trust, we are excited to be joining the Big Health Lotto, run by NHS Charities Together, with the first draw anticipated in April. This initiative will engage staff, patients, families, and the wider community, supported by monthly “payday stalls” and alongside ongoing fundraising activity through MicroHive and regular giving. We are also expanding our grateful patient schemes and in memory and legacy giving, with the launch of Much Loved in February, enabling supporters to make a lasting difference to the hospital and the families we care for.

Thank you for reading and for your interest and support for Bradford Hospitals Charity.

Osbourne, Sheridan
26/01/2026 12:25:00

Board of Directors				
Meeting Date:	29/01/26	Agenda Reference:	Bo.1.26.16	
Report Title:	Final Annual report and accounts 2024/25			
Presented by:	Jonny Scholtz, Assistant Director of Finance			
Executive Lead:	Ben Roberts, Chief Financial Officer			
Author:	Jonny Scholtz, Assistant Director of Finance			
Report Summary				
Purpose of the paper:	Decision ☒ approve	Assurance ☐	Action ☐	Information ☐
Summary of Key Issues/Highlights:	- The draft annual report and accounts for Bradford Hospital Charity have been independently examined by the audit firm Moore Kingston Smith. - The annual report and accounts have been updated for changes recommended through the audit process and are ready to be signed and submitted to the Charity Commission. - The final accounts have been reviewed and approved by the Charitable Fund Committee and Audit Committee.			
Recommendation/s:	The Trust Board is asked to: - Approve the Bradford Hospital Charity 2024-25 report and accounts. - Approve the annual report and accounts to be electronically signed by the Chair, Chief Executive and Chief Financial Officer			
Link to Strategic Objective:	N/A			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	N/A			
Legal/Regulatory:	Charities must comply with the Charities Act 2011 and submit annual accounts to the Charity Commission.			
Quality & Patient Safety:	N/A			
Equality, Diversity and Inclusion and Health Equity:	N/A			
Resources:	N/A			
Environmental sustainability:	N/A			
Assurance Route				
Meeting/s where content has been discussed previously:	The draft annual accounts were reviewed by the Charitable Fund Committee in August.			

Osbourne, Sheridan
 26/01/2026 12:25:00

Report content

1. Purpose

To seek the Board’s approval to sign off the charity’s Annual Report and Accounts for the financial year ended 31 March 2025, following completion of the independent examination.

2. Background/context

Under the requirements of the Charity Commission the Trust’s Board, acting as a Corporate Trustee, is responsible for approving the Annual Report and Accounts prior to submission. The accounts have been prepared in accordance with the Charities Statement of Recommended Practice (SORP) and applicable legal requirements.

An independent examination has been carried out by Moore Kingston Smith, who has confirmed that the accounts comply with the necessary standards and that no material issues have been identified. The independent examiner’s report is included within the Annual Report and Accounts.

3. Assessment

The independent examination has confirmed that:

- The Annual Report and Accounts present a true and fair view of the charity’s financial position and activities for the year.
- The independent examiner has provided an unqualified report, confirming compliance with statutory and regulatory requirements.
- No significant risks or concerns have been raised during the examination process.

A summary of the key values in the accounts is provided in the table below.

	2024/25 – final £000	2024/25 - draft £000	2023/24 £000
Net Assets	1,645	1,638	1,979
Income	357	357	472
Expenditure	(712)	(719)	(720)
Gain / (Loss) on investment	21	21	(89)
Net movement in funds	(334)	(341)	(159)

The following adjustments were made through the audit process:

- Reduction in the external audit fee to reflect an independent examination (£15.6k less expenditure)
- Inclusion of additional expenditure relating to staff lottery refunds which were due in 2024/25 but have been paid in 2025/26 (£8.6k more expenditure).
- An update to the number of staff paid salaries in excess of £60k. The draft accounts included one member of staff but this was updated to nil as a change of post holder in year meant no individual exceeded the £60k reporting limit.

4. Options analysis/Proposal

The Trust Board is asked to:

Approve the Bradford Hospital Charity 2024-25 report and accounts.

Approve the annual report and accounts to be electronically signed as follows:

Chairperson	Statement of Trustee responsibilities, page 17
Chief Executive	Statement of Trustee responsibilities, page 17
Chief Financial Officer	Balance sheet, page 20

Following the sign off by Board the accounts will be signed by the independent examiner and then submitted to the Charity Commission.

Appendices

Appendix 1: BHC Annual Report and Accounts 2024/25

Osbourne, Sheridan
26/01/2026 12:25:00



Annual Report and Accounts 2024 – 2025

Bradford Hospitals Charity
Daisy Bank
Duckworth Lane
Bradford
West Yorkshire
BD9 6RJ

Bradford Hospitals Charity is the official NHS charity for Bradford Teaching Hospitals NHS Foundation Trust

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Prepared by: Sheridan
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The Trustee Report below aims to provide sufficient information to understand the Charity, its purpose, and how it has performed during the year.

1. Chair and Board Members Foreword

On behalf of the Trustee of Bradford Hospitals Charity ("the Charity"), we are pleased to present the Charity's Annual Report and Accounts for the year ended 31 March 2025.

This document provides an overview for stakeholders and interested parties of what the Charity has achieved during 2024/25. This Annual Report, including the Trustee Report and Accounts has been prepared in accordance with accounting policies set out in the notes of the accounts and complies with the Charity's governing document (the Trust Deed) the Charities Act 2011 and the Statement of Recommended Practice ("SORP") "Accounting and Reporting by Charities" ("FRS 102").

The Charity is committed to enhancing the care and treatment of patients and improving the health of local people. The Charity works with Bradford Teaching Hospitals NHS Foundation Trust ("the Trust") to improve health and healthcare across the Bradford City Region. We are proud that the general public trust us to invest in projects that are over and above the responsibility of the NHS and exchequer.

Thanks to the support of our donors, Bradford Hospital Charity has been able to make a meaningful impact on the health and well-being of our community. From funding critical medical equipment to supporting innovative healthcare initiatives that support children in a caring and meaningful way to aid their mental health and well-being, through to internal campaigns for staff, each contribution has played a vital role in enhancing the quality of care provided by Bradford's healthcare professionals.

I want to express my deepest gratitude to our invaluable supporters - including individuals, trusts, foundations, and corporate partners. Your generosity and commitment have enabled us to deliver vital services throughout the year. The support shown to our staff has been particularly meaningful and has strengthened our ability to provide exceptional care to our patients.

With sincere thanks.

2. Review of activities

2.1. Review of the year

During the 2024/25 year Bradford Hospitals Charity delivered the projects summarised below to enhance service provision for the benefit of both patients and staff:

- The Charity has supported the creation of a Reflection Garden in the grounds of Bradford Royal Infirmary, with a grant of £42,000. This dedicated space will provide a tranquil space for staff and patients to reflect, connect with nature and be an environment suitable for a place of remembrance where bereaved families will feel safe and hold ceremonies for loved ones.
- The Charity has supported St Luke's Hospital with a grant of £23,675 to purchase five fistula scanner devices to improve the quality of care for patients with a dialysis fistula (the patient's lifeline for dialysis). This equipment helps ensure our patients receive gold standard care and meet national guidance for best practice.

- The Children's Ward has been improved with the addition of a new sensory room, which will provide psychological and social support to children and young people with medical and emotional conditions. It will provide both a relaxing space for children with anxieties and a stimulating environment for children with more complex health needs.
- The Children's waiting area in the Children's Emergency Department has been enhanced with the addition of new furniture and decoration. The replacement of hard, wooden seating with padded covered seating and backrests make the area more appropriate and comfortable for those who have a long wait or observation period before transfer to the ward or their next appointment. While the new display and notice boards will include both public health information and patient discharge information leaflets.
- Ensuring inclusivity and equality for staff during the month of Ramadan, while ensuring continuity of high class service delivery during this time of fasting, we have provided £7,455 towards the Ramadan Allies project. This award-winning project provides 'Fast Packs' and 'Prop Packs' to ensure staff morale and wellbeing are supported, enhance productivity during fasting and supporting their religious rights at work.
- Funds have been invested across the board to support patients, their families, and our staff through the purchase of equipment, training, research and projects which go over and above what the NHS provides.

2.2. Our Strategic Objectives

The Charity has as its sole objective to use its funds:

For any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by Bradford Teaching Hospitals NHS Foundation Trust

The Corporate Trustee considers that this objective does not unreasonably restrict access to charitable benefits within the scope of the Declaration of Trust. The Corporate Trustee of the Charity seeks to achieve this objective, considering general guidance, by two main routes:

1. The Corporate Trustee works to identify significant projects to which it can contribute or which it can wholly fund. It actively enhances the refurbishment of wards and clinical areas from basic specifications to higher quality.
2. Staff throughout the organisation identify small but valuable differences where the fund monies can deliver benefits to patients and staff, such as attendance at extra training courses or conferences.

2.3. Activities for public benefit

Thanks to the continued generosity of our supporters, the Charity has continued to develop and during 2024/25 the Charity spent £711,744 (£720,304 in 2024) in the following ways:

	2025	2024
	£000	£000
Medical equipment	52	130
Staff education and welfare	135	119
Patient welfare	277	166
Other activities	34	21
Raising funds	214	284
Total	712	720

2.4. Fundraising

As a Charity we are committed to the highest standards of fundraising practice and all our activities are carried out in an ethical manner. The Charity is registered with the Fundraising Regulator and abides by their codes of conduct and their fundraising promise, which ensures that our fundraising is legal, open, honest, and respectful. The Charity has a fundraising team that is compliant with the recognised standards of fundraising as well as those required under charity law and wider law. Controls are in place to ensure any fundraising is within the Fundraising Code of Practice. It is inevitable that fundraisers will come into contact with people who may be in a vulnerable circumstance or need additional support to make an informed decision. If a staff member reasonably believes that an individual is unable to decide, then they will not accept a donation from that person. The fundraising team use a checklist to help identify signs that an individual may be in a vulnerable circumstance.

The fundraising team will get to know their donors by sending out relevant and often personalised communications. They also give individuals clear information and opportunities to change how, when and if they want to hear from the Charity and follow the General Data Protection Regulation (GDPR) principles. The Charity raises funds to enhance the care and treatment of local patients and those who care for them. The Charity has not used any professional fundraising agencies and has not received any complaints. Fundraising record-keeping and monitoring are coordinated through the Harlequin Customer Relationship Management (CRM) system.

The Charity has never and will never sell, share or swap details of our supporters.

In 2024/25 the Charity continued to raise its profile within the local community, including businesses and trusts & foundations. The Charity has also had a key focus on increasing audiences across each of our digital channels. The Charity has had a successful year and to maintain this needs to build continuous support from the communities the hospitals serve.

As a charity we continue to work in, and alongside, our local community to increase our profile and support the Bradford community to raise funds for the charity. We have increased community engagement through a series of fundraising activities at local supermarkets, carnivals and galas. We have also held a number of community campaigns including our knitted hearts campaign to support the children's ward, palliative care and bereavement services. We have also seen an increase in internal fundraising among NHS staff, with bake sales, tombolas and participation in challenge events.

Donations from Corporate supporters and Trusts and Foundations provide a much valued contribution to our work, including the introduction of Baggins the Bear to the children's radiology department, a 1-year programme to bring The Giggle Doctors to our children's wards and a rockin R Nintendo Switch gaming cart. Distraction projects like these for children in hospital are so important, helping them to cope with the daily worries and stress of being in hospital, the many tests and interventions they receive during their stay, and often all while being hungry, bored and in pain. A few moments of fun, imagination and delight can make all the difference, and can make treatment and waiting that little bit more bearable.

We hope to continue expanding the diverse income streams and increasing income in all the key areas, such as Community, Corporate Giving and Trusts and Foundations. It is also essential to focus on 'in aid of giving' and regular giving. This is an exciting time for the Charity with our focus being on:

- Delivering for our beneficiaries
- Maximising fundraising opportunities
- Creating new opportunities through our existing and new networks.

The Charity will work with the Trusts volunteer service to provide opportunities for volunteers to support the Charity's work such as supporting fundraising events. Volunteers are the backbone of any charity, and a great

area of support for the Charity. The Charity will create a robust volunteer process, with clear guidelines and make internal adjustments to onboard the volunteers promptly and safely.

The Fundraising team will continue to raise awareness of the Charity through its digital channels; social media will be our focus next year and something we look forward to developing as we grow. Understanding the Charity's work is critical to building a strong following in these current times. We have had many articles and local PR stories in the local press. There is an expectation of a high online presence with many public followers, and we have made some improvements in some critical areas. We now have 'Facebook Giving', a valuable and accessible platform for supporters to donate and we have introduced QR codes, making it easy for people to access our website's donate page.

3. Financial Review

3.1. Summary

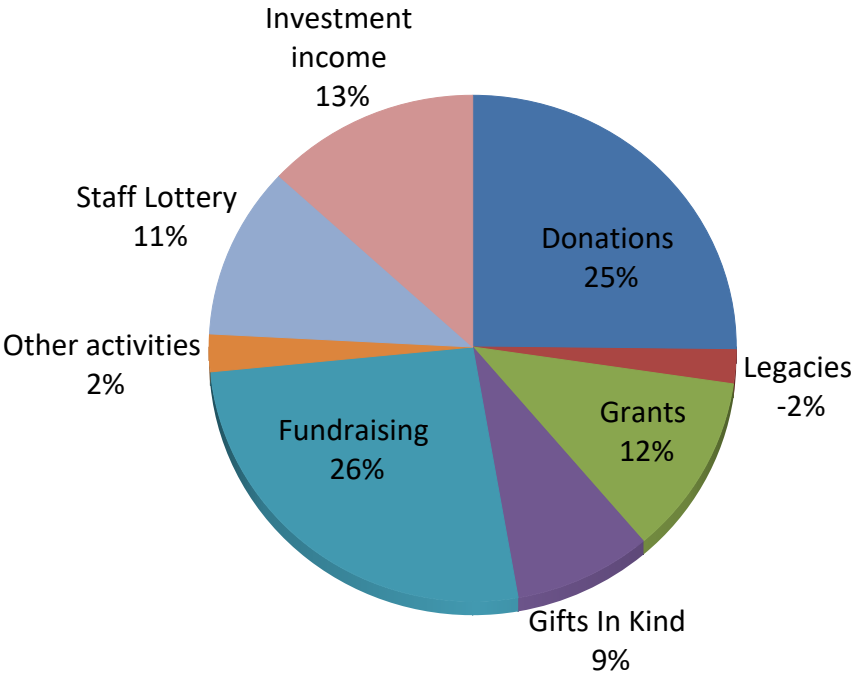
The net assets of the Charity as at 31 March 2025 were £1,645,636 (compared to £1,979,472 in 2024). This is a reduction of £333,835 during the year.

During the year, income (excluding unrealised and realised investment gains) was £357,272, a reduction of £115,371 on the previous years total of £472,643. This is mainly due to a reduction in the donations and legacies received. Total expenditure for the year was £711,743, which represents a decrease of £8,561 on the previous years total of £720,304. This resulted in excess expenditure over income of £354,471 which, together with realised and unrealised gains and losses from the investment portfolio totalling £20,636, has led to an overall decrease in net assets of £333,835. The Charity will only fund items when it has cash available. It also has funds in reserves to cover operating costs.

	2024/25 £000	2023/24 £000
Income	357	472
Expenditure	(712)	(720)
Net income / (expenditure) before investments	(355)	(247)
Net gain / (loss) on investment	21	89
Net movement in funds	(334)	159

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3.2. Sources of Income for the Charity 2024/25 (£000)

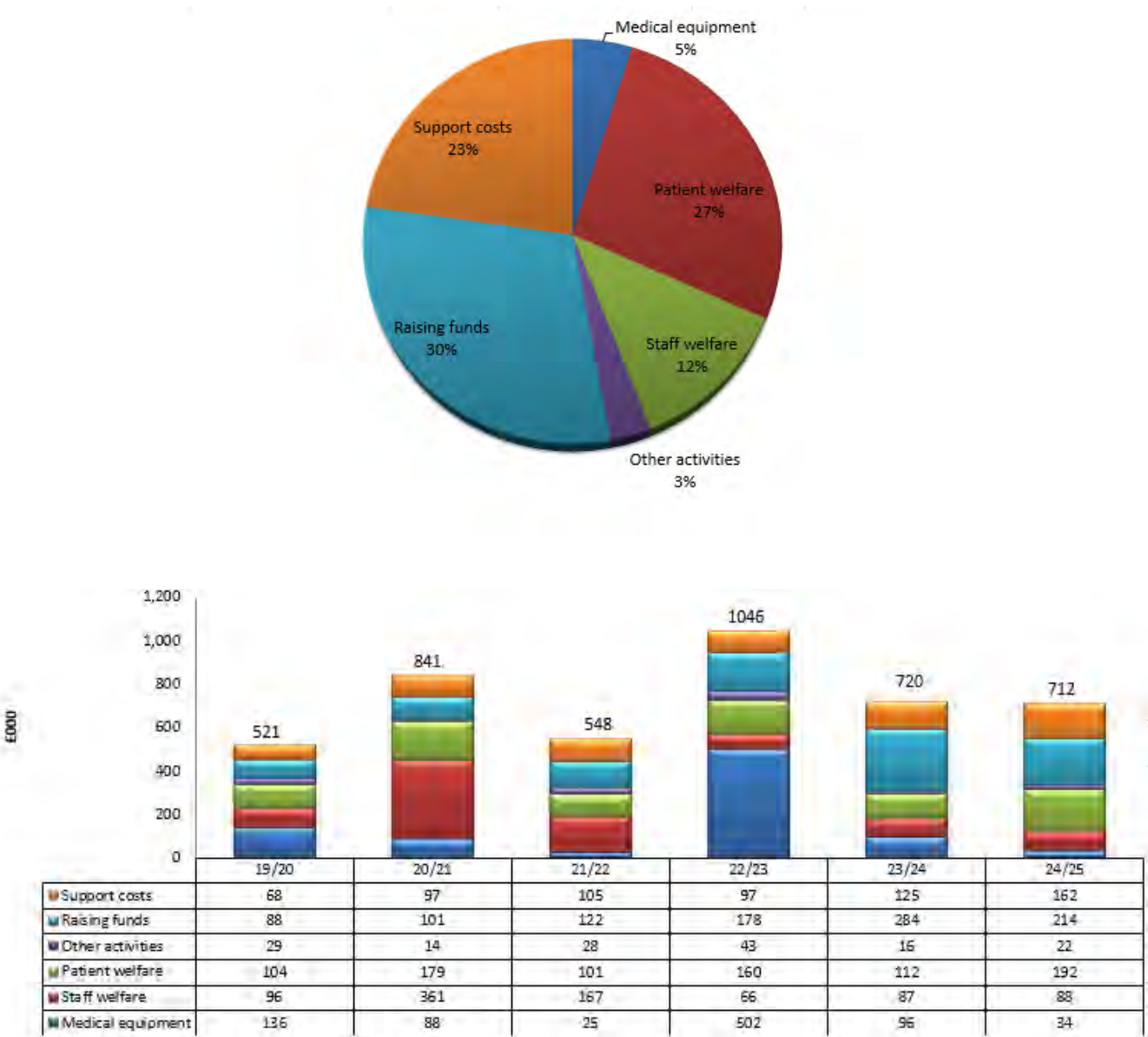


	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Investment income / bank interest	15	17	36	37	52	65	49
Staff Lottery	49	48	48	42	40	39	41
Other activities	1	1	0	0	0	0	9
Fundraising	98	144	76	65	104	132	98
Gifts In Kind	0	0	171	25	26	20	32
Grants	0	50	203	7	81	135	43
Legacies	35	60	114	54	180	5	-8
Donations	148	116	309	72	574	76	94

The primary sources of income for the Charity are donations, fundraising, and investment income. Income reduced in 24/25 due to reductions in fundraising and grant income due to vacancies in the fundraising team. The Charity is investing in its fundraising team to secure long term sustainable income.

The Charity uses Rathbones Investment Management to manage its investments and also holds an investment with The Charles and Elsie Sykes Trust. For this financial year, there has been an unrealised gain on investments of £20,636 (£89,581 unrealised gain in 2024).

3.3. How funds were spent 2024/25 (£000)



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Total Charity expenditure has remained consistent with 2023/24 and patient and staff welfare continuing to be the largest area of charitable activity. The Charity is continuing to encourage spend in year by asking departments to identify projects to utilise the designated funds held. The Charity aims to maximise public benefit by ensuring individual funds are spent in line with the purpose of the fund. Expenditure is limited to total donations received and is spent on needs when opportunity arises. The Corporate Trustee considers that there are no material uncertainties that could cast doubt over the Charity's ability to continue as a going concern for a period of at least twelve months from the date of signing the accounts.

4. Structure, governance, and management

4.1. Corporate Trustee

The Trust is the Corporate Trustee of the Charity and is governed by the law applicable to NHS Trusts, principally the Trustee Act 2000 and the Charities Act 2011. The Trust Board of Directors has devolved responsibility for the on-going management of funds to the Charitable Fund Committee ("the Committee"), which administers the funds on behalf of the Corporate Trustee. No trustee remuneration was paid in the year by the Charity.

Members of the Trust Board of Directors are not individual Trustees under Charity Law but act as agents of the Corporate Trustee. The Board of Directors approves which members become the agents of the Corporate Trustee and are introduced to the Charity through Board standing orders / Executive Leads.

The following members of the Board of Directors served on behalf of the Corporate Trustee during the year:

Sarah Jones (Chair)
Altaf Sadique (Non-Executive Director)
Bryan Machin (Non-Executive Director)
Mel Pickup (Chief Executive)
Matthew Horner (Director of Finance)
Ben Roberts (Chief Finance Officer)
Mark Hindmarsh (Director of Strategy and Transformation)
Mohammed Hussain (Non-Executive Director)

The Charity General (unrestricted) Fund was established using the model Declaration of Trust, and all funds held on trust as at the date of registration (April 1997) were either part of this unrestricted fund or registered as separate designated funds within the Charity. Subsequent donations and gifts received by the Charity that are attributable to the original funds are added to those fund balances within the existing Charity. The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of each fund, and by designating funds the Corporate Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, carers, and staff.

4.2. Charity Operational Committee

The Charity Operational Committee meets every three months and is a Committee of the Charitable Funds Committee. Its purpose is to give additional assurance to the Committee that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales and to ensure compliance with the Charity's own governing document. It does not remove from the Committee the overall responsibility for this area but provides a forum for a more detailed consideration of charitable matters and allows for direct contact with the Charity Commissioners where necessary.

Membership:

Chair:

Director of Strategy & Transformation¹

Chief Operating Officer / Deputy Chief Executive²

Members:

Charity Director (Deputy Chair)

Associate Director of Corporate Governance / Board Secretary

Deputy Finance Director

Assistant Director of Finance

Head of Fundraising

Charity PR and Communications Officer

AHP Representative

Nurse Representative

Doctor Representative

Manager Representative

HR Representative

Estates and Facilities Representative

Representative of each of the Four Funds (Sunshine, Dementia and Elderly, Cancer and Children's)

4.3. Structure of funds

The primary issue to be considered in any expenditure decision is whether the expenditure is within the scope of the objects of the Charity. Charitable purposes within the NHS translate to prevention or relief of sickness, disease or human suffering of patients served by the NHS. This does not preclude expenditure on staff as long as the benefit to staff translates demonstrably to relief of sickness of NHS patients.

The Charity has a decision making and approval process whereby an expenditure form needs to be completed. The expenditure form is structured in sections covering the key principles that fund holders need to consider and includes the requirement for the appropriate authorised signatories.

The Charity has started an exercise to rationalise the existing trust funds into four main funds - Sunshine, Children's, Cancer and Dementia & Elderly. A fifth fund ('Other') has also been set up for funds that are related to governance and admin. Over the next two years, the intention is to merge the existing trust funds into one of the four new funds.

The General Fund

This comprises of gifts received by the Charity where no preference as to their expenditure has been expressed by donors.

Designated (earmarked) Funds

Under the new structure, this will be the Children's, Cancer, and Dementia & Elderly. These usually contain donations where the donor expressed a preference to benefit a particular department or activity of the Trust at the time of making the donation. This preference can also include benefit to staff welfare, thereby enhancing both patient care and public benefit.

¹ .Director of Strategy and Transformation was the Chair from January 2025.

² Chief Operating Officer was the Chair until January 2025

Whilst the donor's preference is not binding on the Corporate Trustee, the designated funds reflect these preferences. The designated funds are overseen by fund holders who can make recommendations on how to spend the money within their designated area. Fund holders' recommendations are generally accepted, and these funds can be spent at any time.

The funds available for spending are allocated to specialties within the Trust's clinical management structure.

Restricted Funds

This comprises of gifts received by the Charity where a specific instruction as to their expenditure has been expressed by donors. These funds must only be used in accordance with specific restrictions imposed by the donor. At present, the Charity has one restricted fund, which was primarily established for the grants received from NHS Charities Together.

Endowment Funds

The Charity has "Capital in Perpetuity" (CIP) funds, which consist of five expendable endowment funds and one permanent endowment fund (which cannot be spent). These funds provide investment income.

4.4. Public benefit

The Corporate Trustee conducts its activities with regard to the Charity Commission guidance on Public Benefit in section 4 of the Charities Act 2011.

The key principles of public benefit are:

- there must be identifiable benefit(s); and
- benefit must be to the public or to a section of the public.

The Corporate Trustee seeks to meet these principles in a number of ways. It has established a system of expenditure approval that ensures proper consideration is given to what the benefits of its activities are and who will benefit. The Corporate Trustee considers that, because its activities are patient focussed and contribute to the health of NHS patients, it clearly provides public benefit. In providing public benefit the Corporate Trustee is careful to ensure that its activities do not unreasonably restrict access to charitable benefit within the scope of Declaration of Trust or cause any detriment or harm. Charitable funds may be used to partially fund staff welfare and professional education / training, where this is in addition to the provision ordinarily afforded by the NHS. As professional education / training can also be a personal benefit, care has been taken to establish that this is incidental to the patient benefit. These requests demonstrate a direct link between professional education / training and the benefit for Bradford patients. To minimise risk and restrict harm, medical equipment purchases are made through the Trust's procurement processes, which help to ensure compliance with legislation, including Health and Safety and Equality and Diversity.

Staff appointments are subject to the Trust's policies and procedures to reflect good practice in recruitment and retention. The members of the Board of Directors receive a comprehensive induction upon their appointment to the Trust; this includes relevant information regarding the Charity and the Committee.

4.5. Governance

The Charity is constituted by trustees incorporated as a body and is governed by a Declaration of Trust of 25 March 1997. This is the formal document which sets out information on what the Charity is set up to do (objects), how the Charity will do this (powers) and administrative provisions.

Acting for the Corporate Trustee, the Committee is responsible for the overall management of the Charity and is required to:

- Ensure that the Charity complies with current legislation
- Review new legislation and its impact on the Charity
- Set and review an investment policy for the Charity.
- Appoint brokers to manage the Charity's funds if required.
- Review the performance of the Charity's investments as managed by its brokers.
- Set and review an investment policy including the use of investment gains.
- Review individual fund balances within the overall Charity on a regular basis.
- Seek expenditure plans from individual fund holders where funds are currently not being used.
- Agree guidance and procedures for fund holders.
- Review audit recommendations.
- Review the Annual Accounts for the Charity and
- Review the Annual Reports for the Charity.

These are all included in the Committee's terms of reference. The accounting records and the day-to-day administration of the Charity are dealt with by the finance department of the Trust. These costs are re-charged to the Charity. The Charity has policies on expenditure, investments and reserves as well as guidelines for fund holders.

4.6. Day to day management of the Charity

The Chief Operating Officer, Sajid Azeb had day to day responsibility for the management of the Charity up to January 2025. From January 2025 this passed to the Director of Strategy and Transformation, Mark Hindmarsh.

Sharon Milner, Charity Director, acted as the principal officer overseeing day to day operations and fundraising for the Charity until May 2024. Laura Riach was subsequently appointed and has undertaken this role since November 2024

Matthew Horner, Director of Finance, was the Executive Director with overall responsibility for financial management and accounting for the Charity until July 2024. Chris Smith, Interim Chief Finance Officer undertook this role during July and August 2024. Since September 2024 the role has been undertaken by Ben Roberts, Chief Finance Officer. The Chief Finance Officer can personally approve, on behalf of the Corporate Trustee, all expenditure over £500, with an upper limit of £10,000, using their delegated authority. For expenditure from £10,000 to £50,000, approval must be obtained from the Chief Executive of the Trust. For any expenditure over £50,000, approval needs to be obtained from the Chairperson of the Trust. For any expenditure over £100,000, approval needs to be obtained from the Corporate Trustee.

Michael Quinlan, Deputy Director of Finance, acted as the principal officer overseeing the day-to-day financial management and accounting for the Charity during the year.

Principal office

Bradford Hospitals' Charity
Daisy Bank
Duckworth Lane
Bradford
West Yorkshire
BD9 6RJ

Principal professional advisers:

Independent Examiner	Investment Advisors	Bankers
Moore Kingston Smith LLP 6 th Floor 9 Appold Street London EC2A 2AP	Rathbone Investment Management Port of Liverpool Building Pier Head Liverpool L3 1NW	HSBC 47 Market Street Bradford BD1 1LW

4.7. Board of Directors

The Charity has a Corporate Trustee, the Trust. The members of the Trust Board of Directors who served during the financial year and up to the date of signing of the financial statements were as follows:

Executive directors:

Name	Role	Appointed	To
Professor Mel Pickup	Chief Executive	01/11/2019	Present
Mr Sajid Azeb	Chief Operating Officer / Deputy Chief Executive	12/10/2020	Present
Renee Bullock	Chief People and Purpose Officer	02/04/2024	30/09/2025
Professor Karen Dawber	Chief Nurse	29/08/2016	Present
Mark Hindmarsh	Director of Strategy and Transformation	14/04/2024	Present
Mr Matthew Horner	Director of Finance	01/08/2012	7/07/2024
Mr David Moss	Director of Estates and Facilities	05/08/2024	Present
Ben Roberts	Chief Finance Officer	01/09/2025	Present
Dr Paul Rice*	Chief Digital and Information Officer	01/01/2021	30/05/2025
Vikki Lewis	Chief Digital and Information Officer	09/06/2025	Present
Chris Smith	Acting Chief Finance Officer	08/07/2024	31/08/2024
Dr Ray Smith	Chief Medical Officer	01/01/2021	31/05/2025
Dr John Bolton	Chief Medical Officer	01/06/2025	Present

*Non-voting Executive Director

Non - executive directors:

Name	Role	Term start	Term end
Sarah Jones	Chair	04/03/2024	03/03/2027
Professor Louise Bryant	Non-Executive Director	01/06/2023	31/05/2024
Mr Mohammed Hussain	Non-Executive Director	01/09/2019	31/08/2025
Ms Julie Lawreniuk	Non-Executive Director	01/09/2019	31/08/2025
Mr Bryan Machin	Non-Executive Director	01/02/2024	31/01/2027
Ms Sughra Nazir	Non-Executive Director	20/01/2022	19/01/2025
Mr Altaf Sadique	Non-Executive Director	01/12/2020	31/11/2026
Ms Karen Walker	Non-Executive Director	01/01/2021	31/12/2026
Ms Zafir Ali	Non-Executive Director	01/02/2024	31/01/2027

Reference and administrative details

The Charity, registered charity number 1061753, was entered on the Central Register of Charities on 09 April 1997. The name of the charity changed from 'Bradford Teaching Hospitals NHS Foundation Trust Charitable Fund' in August 2014 to 'Bradford Hospitals Charity', with no change being made to the objectives of the Charity.

The Charity consists of 141 funds as of 31 March 2025 (2024: 143), and the notes to the accounts distinguish the types of funds held and disclose separately all material funds (funds with balances over £50,000). The funds received by the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the Health Service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990, and these funds are held on trust by the Corporate Trustee.

4.8. Investments policy and performance

The Charity uses Rathbone Investment Management to invest the funds of the Charity. The assets of the Charity must be invested in accordance with the declaration of Trust and are governed by the Trustee Act 2000. The investment policy addresses the needs of the Charity and its beneficiaries in the short, medium, and long term by aiming to balance both capital growth and income generation. The Charity has an investment policy which is reviewed annually.

The overall objectives are to generate sufficient income and capital growth to enable the Charity to carry out its purposes consistently year on year with due and proper consideration for future needs and the maintenance of and, if possible, enhancement of the value of the invested funds while they are retained. The Charity recognises that every investment carries risk. Equally, not investing at all carries the risk of lost asset value in real terms, and the consequent reputational risk of poor stewardship.

The Charity has considered the types of risk identified by the Charity Commission in its guidance Charities and investment matters: a guide for trustees (CC14), namely:

- Capital risk – loss of capital and volatility
- Market risk - loss due to fluctuations in the financial markets
- Valuation risk
- Sector risk – loss from having too many investments in one sector
- Currency risk – loss from changes to exchange rates of an investment valued in a different currency
- Environmental, social and governance– loss due to poor ESG practice by a company you have invested in
- Regulatory risk – loss because of investing in unregulated investments, or in markets where regulation of financial services is less rigorous, or compensation schemes are not in place.

Other risks to be considered include:

- Reputational risk – reduced support for the charity or harm to its reputation as a result of the investment approach
- Risk posed to the achievement of the charity's purposes from investments which conflict with them.

The Charity has decided that to mitigate risk it will have a diversified portfolio of investments, both in asset class and individual investment, and will be invested such that the overall risk profile of the funds is 'medium' with the specific investment strategy to be agreed with our investment manager.

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The Charity permits investments in the following assets:

- Listed UK equities
- International equities quoted on a recognised stock exchange
- Government gilts
- Corporate bonds
- Alternative / Diversifier investments e.g., property, infrastructure, gold, absolute return funds
- Interest bearing cash deposits in UK banks or building societies
- Cash

The Charity has appointed professional investment managers to oversee its investments. In addition to managing the Charity's portfolio of investments, they provide the Charity with advice on specialist areas including market risk. The Charity does not pay tax on investment income as it is applied to a charitable purpose. The investment managers also ensure the Charity's portfolio reflects environmental, social and governance concerns such as ceasing investments with Russian companies since the start of the war in Ukraine.

Ethical considerations are included which in general terms seek to obtain the best financial return from the Charity's investments consistently and with commercial prudence. The Charity will not invest directly in companies which are primarily involved in the production of alcohol, tobacco, armaments, or gambling. Our investment manager is encouraged to monitor the collective investments held, in so far as is practicable, such that any indirect exposure in these areas is minimised.

In the year to 31st March 2025, the investment portfolio of the Charity, managed by Rathbones, produced a total return (the combination of capital growth and income) of 3.5%. This was broadly in line with the benchmark (MSCI PIMFA Income Index) total return of 4.0%. While the global economic outlook is currently uncertain our investment manager continues to actively manage our portfolio, balancing both our return aspiration as well as our risk tolerance, in order to meet our long term objectives. The performance of the Charity investments are closely monitored by the trustees.

The Charity has a capital in perpetuity fund (Elsie Sykes CIP fund) that is held for investment, with income generated to be used for charitable purposes, as specified in the endowment terms. This is currently invested with the Charles and Elsie Sykes Trust and was valued at £253,000 as of 31 March 2025.

4.9. Reserves policy

The Charity has a reserves policy requiring reserves to be maintained at a level equivalent to the cost of maintaining the Charity team for one year. The Charity has total funds of £1,645,000 of which, £70,000 is restricted and not available to fund general purposes and £316k which is held in the permanent endowment funds and are excluded from reserves. The Charity holds £1,259,000 of unrestricted and designated funds as its reserves. This is equivalent to approximately 2 years of expenditure. As at 31 March 2025, there are no material commitments, with the cost of the Charity team for the forthcoming year planned to be £477,000. In addition to the unrestricted and designated funds held in reserves, the Trustee has the power, if it so wishes, to spend any of the expendable endowment. However, the expendable endowment is used to generate income, supplementing the income from donations and legacies. The Trustee will therefore only spend the expendable endowment on an exceptional basis.

It is not anticipated that the Charity will deploy funding towards any projects before donations have been received which mitigates the risk of any planned commitments, or designations, that cannot be met by future income alone. In other words, commitment is made by the Charity after funding has been identified / receipted.

Osbourne-Sheridan
26/01/2026 12:25:00

4.10. Risk management

The Corporate Trustee has considered any major risks to which the Charity is exposed. The Corporate Trustee aims to mitigate the risk that income will fall by engaging with the Fundraising department. The fundraising department works with the Charity and engages with the local community to raise funds through a programme of events and encouraging donations. The Charity seeks to generate income from multiple sources to help mitigate shortfalls in any one area. This includes a programme of fundraising activity, fundraising appeals, legacies and, applying for grants.

The Corporate Trustee has agreed to invest in a fundraising strategy, with a long-term ambition to engage with the public and to further enhance the environment of the Trust.

The investment portfolio is well diversified to help protect the Charity against any fall in value of a particular market. The Investment Manager holds a discretionary mandate which enables them to make investment and divestment decisions on the Charity's behalf. The Charity works closely with the Investment Manager to ensure that the investment policy is reviewed regularly.

The investment strategy is to protect the long-term value of the portfolio in absolute terms and in terms of purchasing power once the impact of inflation is considered. To achieve this, the Investment Managers have inevitably invested a substantial amount of the portfolio in equities, both in the UK and overseas.

Any investment gains and losses, although reflected in the Charity's accounts are not, realised as such unless and until the investments concerned are actually sold.

4.11. Partnership working and networks

The Trust is the main beneficiary of the Charity and is a related party by virtue of being the Corporate Trustee of the Charity. Effective partnership with the Trust ensures that the funds are used to best effect. When deciding upon the most beneficial way to use the Charity funds, the Corporate Trustee has regard to the main activities, objectives, strategies and plans of the Trust.

5. Future plans

The Charity's priorities are those set out in the Trust's mission statement: 'to provide the highest quality healthcare at all times'. The vision for the Trust that describes its ambition and where it wants to be as an organisation in five years' time is 'to be an outstanding provider of healthcare, research and education, and a great place to work'. Meeting this mission and vision will maximise the impact of the Charity and its benefits to the beneficiaries of the Charity who are primarily the NHS patients of Bradford, through three core values:

- We care.
- We value people; and
- We are one team.

In order to enhance and improve the current levels of care for NHS patients throughout the Trust, the Charity has planned expenditure in a number of areas. The Charity will also continue to enhance the refurbishment of wards and clinical areas from basic specification to higher quality.

The Charity plans to expand its fundraising activities in line with its goal to meet its priorities of increasing income and raising its profile over the next five years. In the 2025/2026 financial year this will include a significant investment in Charity staff and infrastructure. The Charity will also begin to explore becoming an independent charity registered with the Charity Commission.

The Charity is continuing to encourage spend in year by asking departments to identify projects to utilise the designated funds held. The Charity aims to maximise public benefit by ensuring individual funds are spent in line with the purpose of the fund. Expenditure is limited to total donations received and is spent on needs when opportunity arises.

6. Financial Statements for the year ended 31 March 2025

The accounts of the funds held on trust by the Trustee appointed as stated below:

6.1. Foreword

The Corporate Trustee present their report and the audited financial statements of the Charity for the year ended 31 March 2025. The Trustee has adopted the provisions of the Statement of Recommended Practice ("SORP") "Accounting and Reporting by Charities" (FRS 102) in preparing the annual report and financial statements of the Charity.

The financial statements have been prepared in accordance with the accounting policies set out in the notes to the accounts and comply with the Charity governing document, the Charities Act 2011 and Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable to the UK and Republic of Ireland published on 16 July 2014, updated with the second edition released in October 2019.

6.2. Statement of Trustee responsibilities in respect of the Trustee annual report and the financial statements

The Trustee is responsible for preparing the Trustee Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), including FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland".

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period.

In preparing these financial statements, the Trustee is required to:

- select suitable accounting policies and then apply them consistently.
- observe the methods and principles in the Charities SORP.
- make judgements and estimates that are reasonable and prudent.
- state whether applicable accounting standards have been followed; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable it to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the Trust Deed. It is also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

By order of the Trustee

Signed:

_____	_____
Chairperson of the Corporate Trustee	Date

_____	_____
Chief Executive of the Corporate Trustee	Date

Osbourne, Sheridan
26/01/2026 12:25:00

6.3. Independent Examiner's Report to the Trustees of Bradford Hospitals Charity

Independent examiner's report to the trustee of Bradford Hospitals Charity

I report to the Trustee on my examination of the accounts of Bradford Hospitals Charity (the Charity) for the year ended 31 March 2025.

Responsibilities and basis of report

As the Trustee of the Charity you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act'). You are satisfied that your charity is not required by charity law to be audited and have chosen instead to have an independent examination.

I report in respect of my examination of the Charity's accounts carried out under section 145 of the 2011 Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the Act.

Independent examiner's statement

Since the Charity's gross income exceeded £250,000 your examiner must be a member of a body listed in section 145 of the 2011 Act. I confirm that I am qualified to undertake the examination because I am a member of the ICAEW, which is one of the listed bodies.

I have completed my examination. I confirm that no material matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. accounting records were not kept in respect of the Charity as required by section 130 of the Act; or
2. the accounts do not accord with those records; or
3. the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Adam Fullerton (FCA DCHA)
For and on behalf of Moore Kingston Smith LLP

6th Floor
9 Appold Street
London
EC2A 2AP:

Date: 29 January 2026

Osbourne-Sheridan
26/01/2026 12:25:00

6.4. Statement of financial activities for the year ended 31 March 2025

	Notes	Unrestricted funds 2025 £000	Restricted funds 2025 £000	Endowment funds 2025 £000	Total funds 2025 £000	Total funds 2024 £000
Income from:						
Donations and legacies	4	160	9	0	169	236
Other trading activities	5	139	0	0	139	171
Investment income	7	49	0	0	49	65
Total incoming resources		348	9	0	357	472
Expenditure on:						
Raising funds	8	(214)	0	0	(214)	(284)
Charitable activities:	9					
Medical equipment		(52)	0	0	(52)	(130)
Staff education & welfare		(131)	(4)	0	(135)	(119)
Patient welfare		(238)	(39)	0	(277)	(166)
Other expenditure		(34)	0	0	(34)	(21)
Total charitable activities		(455)	(43)	0	(498)	(436)
Total expenditure		(669)	(43)	0	(712)	(720)
Net gains / (losses) on investments	15	12	0	9	21	89
Net income/(expenditure)		(309)	(34)	9	(334)	(159)
Net movement in funds		(309)	(34)	9	(334)	(159)
Reconciliation of funds						
Total funds brought forward	21	1,568	104	307	1,979	2,138
Total funds carried forward		1,259	70	316	1,645	1,979

The statement of financial activities includes all gains and losses recognised during the year.

The notes on pages 22 to 37 form part of these accounts and the comparative Statement of financial activities on page 26.

6.5. Balance Sheet as at 31 March 2025

	Note	Unrestricted funds 2025 £000	Restricted funds 2025 £000	Endowment funds 2025 £000	Total funds 2025 £000	Total funds 2024 £000
Fixed assets						
Investments	15	1,252	0	253	1,505	1,496
Total fixed assets		1,252	0	253	1,505	1,496
Current assets						
Debtors	16	40	0	0	40	110
Cash and cash equivalents	17	111	70	63	244	901
Total current assets		151	70	63	284	1,011
Liabilities						
Creditors due within one year	18	(144)	0	0	(144)	(528)
Net current assets		7	70	63	140	483
Total assets less current liabilities		1,259	70	316	1,645	1,979
Total net assets		1,259	70	316	1,645	1,979
The funds of the Charity:	21					
Unrestricted funds		5	0	0	5	5
Restricted funds		0	70	0	70	104
Designated funds		1,254	0	0	1,254	1,563
Endowment funds		0	0	316	316	307
Total Charity funds		1,259	70	316	1,645	1,979

These accounts together with notes on pages 22 to 37 were approved and authorised for issue by the Corporate Trustee on:

Chief Financial Officer

Date

Osbourne-Sheridan
26/01/2026 12:25:00

6.6. Statement of Cash Flows for the year ending 31 March 2025

	Note	Total funds 2025 £000	Total funds 2024 £000
Cash flows from operating activities:			
<i>Net cash provided by / (used in) operating activities</i>	19	(718)	247
Cash flows from investing activities:			
Dividends and interest from investments	7	49	65
Proceeds from sales of investments	15	131	268
Purchase of investments	15	(119)	(278)
<i>Net cash provided by / (used in) investing activities</i>		61	55
<i>Change in cash and cash equivalents in the reporting period</i>		(657)	302
Cash and cash equivalents at the beginning of the reporting period	17	901	599
<i>Cash and cash equivalents at the end of the reporting period</i>	17	244	901

The Charity had no cash equivalents and no net debt as at 31 March 2025(2024: None)

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26/01/2026 12:25:00

Notes to the accounts

1.0 Accounting policies

a. Basis of preparation of the financial statements

The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) issued in October 2019 and the Charities Act 2011 and UK Generally Accepted Practice. The Charity constitutes a public benefit entity as defined by FRS102.

The significant accounting policies are set out below.

b. Accounting convention

The financial statements are prepared under the historic cost convention, except for investments which are held on a revaluation basis, and are rounded to the nearest thousand. The Corporate Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future as it does not intend to liquidate the Charity or to cease its operations. The Corporate Trustee considers that there are no material uncertainties that could cast doubt over the Charity's ability to continue as a going concern for a period of at least twelve months from the date of signing the accounts. A robust reserve policy, strengthened by the fact the Charity has no material long term commitments, and having internal governance to ensure the Charity is only spending funds that are available, allows the Corporate Trustee to consider the Charity to be a going concern.

c. Income

Income is recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of income can be measured with sufficient reliability.

Where there are terms or conditions attached to income, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met, or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

d. Accounting for legacies

Legacies are accounted for as income either upon receipt or where the receipt of the legacy is probable. Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted.
- The executors have established that there are sufficient assets in the estate to pay the legacy; and
- All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all the conditions for income recognition are met.

e. Investment income

Dividends are included in the Statement of Financial Activities when they are declared and at an amount which includes the tax credit recoverable from HM Revenue and Customs.

f. Recognition of liabilities

Liabilities are recognised on an accrual's basis in accordance with generally accepted accounting practice.

g. Expenditure

Expenditure is accounted for on an accruals basis and has been classified under appropriate headings.

Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the appropriate heading for the expenditure on which it was incurred.

h. Commitments

Expenditure is recognised as a commitment liability where a recipient has a reasonable expectation that they will receive the assets or services in lieu of a grant.

i. Fundraising costs

Fundraising costs are those costs attributable to generating income for the Charity and are distinct from costs incurred in undertaking charitable activities.

j. Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration and internal audit and external independent examination (audit) costs. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the basis of apportionment applied are shown in note 12.

k. Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 9.

l. Realised and unrealised gains and losses

Realised gains and losses are included in the accounts at the date on which a contractual obligation is entered.

Unrealised gains and losses are computed by reference to the market value of the investments at the balance sheet date as compared to the brought forward cost or valuation, and gains and losses arising on similar categories of investments are netted off.

This includes cash and short term highly liquid investments with a short maturity of three months or less from the date of acquisition or opening of the deposit or similar account.

s. Critical accounting judgements and key sources of estimation uncertainty

In the application of the Charity's accounting policies, which are described in note 1, the Corporate Trustee is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The Corporate Trustee does not consider there are any critical judgements or sources of estimation uncertainty requiring disclosure.

t. Gifts in kind

Gifts of tangible assets such as microwaves and fridges are recognised as a donation at fair value (market price) on receipt and charitable expenditure when they are distributed. Where gifts in kind are held before being distributed to beneficiaries, they are recognised at fair value as stock until they are distributed. Gifts in kind, such as food and care packages are not accounted.

2.0 Prior year comparatives by type of fund

The primary statements provide prior year comparatives in total; this note provides prior period comparatives for the Statement of Financial Activities and the Balance Sheet for each of the three types of funds that the Charity manages.

2.1 Unrestricted funds – Statement of Financial Activities for the year ended 31 March 2025

	Notes	2025 £000	2024 £000
Income from:			
Donations and legacies	4	160	114
Other trading activities	5	139	171
Investments	7	49	65
Total incoming resources		348	350
Expenditure on:			
Raising funds	8	(214)	(283)
Charitable activities	9		
Medical equipment		(52)	(105)
Staff education & welfare		(131)	(97)
Patient welfare		(238)	(166)
Other activities		(34)	(15)
Total charitable activities		(455)	(383)
Total expenditure		(669)	(666)
Net gains / (losses) on investments	16	12	75
Net expenditure		(309)	(241)
Net movement in funds		(309)	(241)
Reconciliation of funds			
Total funds brought forward	22	1,568	1,809
Total funds carried forward		1,259	1,568

Unrestricted funds – Balance Sheet as at 31 March 2025

	Notes	As at 31 March 2025 £000	As at 31 March 2024 £000
The assets and liabilities of the Charity:			
Fixed Assets			
Investments	16	1,252	1,252
Total fixed assets		1,252	1,252
Current assets			
Debtors	17	40	110
Cash and cash equivalents	18	111	234
Total current assets		151	344
Liabilities: -			
Creditors due within one year	19	(144)	(28)
Net current assets		7	316
Total assets less current liabilities		1,259	1,568
Total net assets	22	1,259	1,568
Total assets for unrestricted funds		1,259	1,568

2.2 Restricted funds – Statement of Financial Activities for the year ended 31 March 2025

	Notes	2025 £000	2024 £000
Income from:			
Donations and legacies	4	9	122
Other trading activities	5	0	0
Income from investments	7	0	0
Total incoming resources		9	122
Expenditure on:			
Raising funds	8	0	(1)
Charitable activities	9		
Medical equipment		0	(25)
Staff education & welfare		(4)	(22)
Patient welfare		(39)	0
Other activities		0	(6)
Total charitable activities		(43)	(53)
Total expenditure		(43)	(54)
Net gains/(losses) on investments	16	0	0
Net expenditure		(34)	68
Net movement in funds		(34)	68
Reconciliation of funds			
Total funds brought forward	22	104	36
Total funds carried forward		70	104

Restricted funds – Balance Sheet as at 31 March 2025

	Notes	As at 31 March 2025 £000	As at 31 March 2024 £000
The assets and liabilities of the Charity:			
Fixed Assets			
Investments	16	0	0
Total fixed assets		0	0
Current assets			
Debtors	17	0	0
Cash and cash equivalents	18	70	604
Total current assets		70	604
Liabilities: -			
Creditors due within one year	19	0	(500)
Net current assets		70	104
Total assets less current liabilities		70	104
Total net assets	22	70	104
Total assets for restricted funds		70	104

2.3 Expendable Endowment funds – Statement of Financial Activities for the year ended 31 March 2025

The Charity has five expendable endowment funds (capital in perpetuity funds (CIP)), with a combined balance of £62,290 (2024: £62,290) and one permanent endowment fund, with a balance of £253,000 (2024: £244,037), that have been brought forward from previous years. During 2024-25, any income received has been recognised within the investment income.

The permanent endowment fund has been invested with the Charles and Elsie Sykes Trust.

3.0 Related party transactions

The Trust (which succeeded Bradford Teaching Hospitals NHS Trust on 1 April 2004) is the Corporate Trustee of the Charity and is governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011. The Trust Board of Directors has devolved responsibility for the on-going management of funds to the Committee, which administers the funds on behalf of the Corporate Trustee. No trustee remuneration was paid in the year by the Charity from the Trust. None of the trustees or members of the Trust or parties related to them has undertaken any transactions with the Charity or received any benefit from the Charity in payment or kind.

Related party expenditure transactions relate to items such as salary recharges and internal audit fees with the Trust.

Osbourne, Sheridan
26/01/2026 12:25:00

Payables

	2025 £000	2024 £000
The following amounts were owed by the Charity to the Trust as at 31 March	98	500
	98	500

Expenditure

	2025 £000	2024 £000
Value of transactions during the year with the Trust	200	313
	200	313

4.0 Income from donations and legacies

	Unrestricted funds £000	Restricted funds £000	Total 2025 £000	Total 2024 £000
Donations	93	9	102	76
Grants	43	0	43	135
Legacies	(8)	0	(8)	5
Gifts in Kind	32	0	32	20
Total	160	9	169	236

Donations are from corporates, the community, patients and relatives of patients and staff. Donations of gifts in kind have been valued at their market value. All these donations have been distributed during the year.

5.0 Analysis of income from other trading activities

	Unrestricted funds £000	Restricted funds £000	Total 2025 £000	Total 2024 £000
Staff lottery	41	0	41	39
Fundraising	98	0	98	132
Total	139	0	139	171

The staff lottery is operating within the guidelines set out by the Gambling Commission.

6.0 Role of volunteers

The Charity does not have any general volunteers, but it does have approximately 100 fund holders. The fund holders are Trust staff members who manage how the Charity's designated funds should be spent, as part of their day-to-day duties. These funds are designated (or earmarked) to be spent for a particular purpose or in a particular ward or department. Each fund holder has delegated powers to approve spend for the designated funds that they manage, subject to the scheme of delegation as approved by the Corporate Trustee.

7.0 Gross investment income

The Charity earned interest and investment income of £49,332 (2024: £65,244).

8.0 Analysis of expenditure on raising funds

	Unrestricted funds	Restricted funds	Total 2025	Total 2024
	£000	£000	£000	£000
Fundraising costs	30	0	30	69
Support costs	184	0	184	215
Total	214	0	214	284

9.0 Analysis of charitable expenditure

The Charity did not make any grant funding to third parties. All the charitable expenditure incurred was directly with third parties or reimbursed expenditure.

Unrestricted funds	Direct charitable activities	Support costs	Total 2025	Direct charitable activities	Support costs	Total 2024
	£000	£000	£000	£000	£000	£000
Medical equipment	34	18	52	71	34	105
Staff education & welfare	84	47	131	65	32	97
Patient welfare	153	85	238	112	54	166
Other activities	22	12	34	10	5	15
	293	162	455	258	125	383

Restricted funds	Direct charitable activities	Support costs	Total 2025	Direct charitable activities	Support costs	Total 2024
	£000	£000	£000	£000	£000	£000
Medical equipment	0	0	0	25	0	25
Staff education & welfare	4	0	4	22	0	22
Patient welfare	39	0	39	0	0	0
Other activities	0	0	0	6	0	6
	43	0	43	53	0	53

10.0 Analysis of grants

The Charity did not make any grants to individuals or other institutions.

Osbourne-Sheridan
26/01/2026 12:25:00

11.0 Movements in funding commitments and liabilities

	Current liabilities £000	Non-current liabilities £000	Total 2025 £000	Total 2024 £000
Opening balance as at 01 April	528	0	528	531
Additional commitments made during the year	712	0	712	720
Amounts paid during the year	(1,096)	0	(1,096)	(723)
Closing balance as at 31 March	144	0	144	528

The Charity has expenditure that has been approved but not yet delivered or services not yet provided. Most expenditure is paid out in the same financial year. As the Charity has control over the expenditure, there is little uncertainty around these payments.

12.0 Allocation of support costs and overheads

	Raising funds £000	Charitable activities £000	2025 Total £000	Raising funds £000	Charitable activities £000	2024 Total £000	Basis
Internal audit	0	0	0	0	0	0	Salaries
Independent examination	3	2	5	2	1	3	Salaries
Other	12	14	26	10	7	17	Salaries
Governance	15	16	31	12	8	20	
Salaries	166	144	310	200	115	315	Hours
Computer expenses	3	2	5	3	2	5	Salaries
Total	184	162	346	215	125	340	

Salaries: this is proportionate to staff salaries where costs are related to the employed staff

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2025 Total £000
Raising funds	184	0	0	184
Charitable activities	162	0	0	162
	346	0	0	346

	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2024 Total £000
Raising funds	214	1	0	215
Charitable activities	125	0	0	125
	339	1	0	340

13.0 Trustees' remuneration, benefits, and expenses

The Corporate Trustee receives no remuneration for the work it undertakes as trustee and claims no expenses from the Charity.

14.0 Analysis of staff costs and remuneration of key management personnel

The key management personnel of the Charity comprise the Charity Director and Deputy Director of Finance. The total cost of employing the charity's key management personnel during the year, including employer's social security and pension contributions was £66,770 (2023/24: £109,053).

The Charity does not employ members of staff. The administration and fundraising are carried out by staff from the Trust and recharged to the Charity as a single cost. No employee had emoluments in excess of £60,000 (2024: one staff member had emoluments in excess of £60,000).

	2025 £000	2024 £000
Salaries and wages	272	265
National insurance costs	17	23
Employer's pension contribution	21	27
Total	310	315

15.0 Fixed asset investments

Investments held with Rathbones Investment Management:

	2025 £000	2024 £000
Market value at 01 April	1,252	1,188
Add: additions at cost	102	278
Less: disposals at carrying value and in year gain / (loss) on disposals	(131)	(257)
Add: net gain / (loss) on revaluation	9	64
Add: net gain / (loss) on disposals	3	12
Less: Movements in broker held bank accounts	17	(33)
Market value at 31 March of unrestricted investments	1,252	1,252

Fixed asset investment by type

	2025 £000	2024 £000
Fixed Interest	281	173
UK Equities	184	280
Overseas Equities	453	428
Alternatives	280	296
Total listed investments	1,198	1,177
Cash	55	75
Market value at 31 March of unrestricted investments	1,252	1,252

The historic cost of investments held with Rathbones Investment Management is £1,150,000 (2024: £1,150,000).

Investments held with the Charles and Elsie Sykes Trust:

	2025	2024
	£000	£000
Market value at 01 April	244	230
Add: additions at cost	0	0
Add net gain (loss) on revaluation	9	14
Market value at 31 March of the permanent endowment fund	253	244

Fixed asset investment by type

	2025	2024
	£000	£000
Equities	182	182
Bonds	49	49
Real Estate	5	5
Alternatives	6	6
Total listed investments	242	224
Cash	2	2
Market value at 31 March of the permanent endowment fund	253	244

Total value of investments held at 31 March

1,505	1,496
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The historic cost of investments held with Charles and Elsie Sykes Trust is £228,365 (2024: £228,365).

Included in the above figures, are investment management charges of £10,706 (2024: £10,706).

16.0 Analysis of current debtors

	Unrestricted funds	Restricted funds	Total 2025	Total 2024
	£000	£000	£000	£000
Prepayments and accrued income	40	0	40	110
NHS Debtor	0	0	0	0
Total	40	0	40	110

17.0 Analysis of cash and cash equivalents

	Unrestricted funds	Restricted funds	Endowment funds	Total 2025	Total 2024
	£000	£000	£000	£000	£000
Cash in hand	111	70	63	244	901
Total	111	70	63	244	901

No cash or cash equivalents were held in non-cash investments or outside of the UK. The Charity had no cash equivalents as at 31 March 2025 (2024: None).

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18.0 Analysis of liabilities

	Unrestricted funds £000	Restricted funds £000	Total 2025 £000	Total 2024 £000
Creditors due within 1 year				
NHS Creditor	110	0	110	513
Accruals	21	0	21	3
Other creditors	13	0	13	12
Total	144	0	144	528

The Charity has no creditors falling due after more than 1 year and has no contingent liabilities. An amount of £109,924 is owed to the Trust.

19.0 Reconciliation of net expenditure to net cash flow from operating activities

	2025 £000	2024 £000
Net (expenditure) / income (as per the statement of financial activities)	(334)	(159)
Adjustments for:		
Interest from Investments	(49)	(65)
Loss / (profit) on the sale of fixed assets investments	3	33
(Gains) / losses on investments	(18)	(89)
Investment fees	(11)	(11)
Decrease / (increase) in debtors	68	(541)
(Decrease) / increase in creditors	(377)	(3)
Net cash used in operating activities	(718)	247

20.0 Transfers between funds

There has been no transfer of funds between restricted and unrestricted funds.

21.0 Analysis of charitable funds

a) Analysis of unrestricted and material designated fund movements

	2025 Balance b/f £000	2025 Income £000	2025 Expenditure £000	2025 Gains and losses £000	2025 Fund c/f £000
NNU Appeal	163	57	(116)	0	104
Bradford Cardiac	147	0	(53)	0	94
Sunshine Fund	94	303	(127)	0	270
The HJ Gajdecki Fund	56	0	0	0	56
ICU Fund	54	(6)	(22)	0	26
Other designated funds	1,054	(6)	(351)	12	709
Total	1,568	348	(669)	12	1,259

	2024 Balance b/f £000	2024 Income £000	2024 Expenditure £000	2024 Gains and losses £000	2024 Fund c/f £000
NNU Appeal	93	115	(45)	0	163
Bradford Cardiac	199	0	(52)	0	147
Sunshine Fund	261	47	(214)	0	94
The HJ Gajdecki Fund	70	0	(15)	0	55
ICU Fund	63	8	(17)	0	54
St Lukes Renal Dialysis	38	3	(8)	0	33
Bradford Disaster Memorial	35	2	(8)	0	29
Oncology / Cancer	35	1	(9)	0	27
Vascular Surgery Research	31	0	(7)	0	24
Bradford Hospital Childrens Charity	19	12	(9)	0	22
Cancer Fund	26	2	(7)	0	21
Other designated funds	939	160	(275)	75	899
Total	1,809	350	(666)	75	1,568

An exercise to reduce the number of trust funds to four main funds will be taking place over the next two years.

b) Analysis of restricted fund movements

	2025 Balance b/f £000	2025 Income £000	2025 Expenditure £000	2025 Gains and losses £000	2025 Fund c/f £000
Covid Fund	104	9	(43)	0	70
Total	104	9	(43)	0	70

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	2024 Balance b/f £000	2024 Income £000	2024 Expenditure £000	2024 Gains and losses £000	2024 Fund c/f £000
Covid Fund	36	122	(54)	0	104
Total	36	122	(54)	0	104

c) Analysis of endowment fund movements

	2025 Balance b/f £000	2025 Income £000	2025 Expenditure £000	2025 Gains and losses £000	2025 Fund c/f £000
Bradford Teaching Hospitals NHS Trust CIP	54	0	0	0	54
Elsie Sykes Permanent Endowment Fund	244	0	0	9	253
Orthopaedic CIP	7	0	0	0	7
Paediatric CIP and 2 other CIPs	2	0	0	0	2
Total	307	0	0	9	316

In 2019/20, the permanent endowment fund was invested with the Charles and Elsie Sykes Trust. The funds are held by the Charles and Elsie Sykes Trustees on trust for the Charity.

	2024 Balance b/f £000	2024 Income £000	2024 Expenditure £000	2024 Gains and losses £000	2023 Fund c/f £000
Bradford Teaching Hospitals NHS Trust CIP	54	0	0	0	54
Elsie Sykes Permanent Endowment Fund	230	0	0	14	244
Orthopaedic CIP	7	0	0	0	7
Paediatric CIP and 2 other CIPs	2	0	0	0	2
Total	293	0	0	14	307

22.0 The Charity as a subsidiary

The Trust, its patient's and its staff are the main beneficiaries of the Charity. The Trust is a related party by virtue of being the Corporate Trustee of the Charity. For accounting purposes, this means that the Charity is deemed to be a subsidiary of the Trust as it is 'controlled' by another entity through the trusteeship arrangements.

All Trusts are required to have a constitution, containing detailed information about how that Trust will operate. The purpose of the Trust is set out in its Constitution as follows:

The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

The Trust may provide goods and services for any purposes related to:

- the provision of services provided to individuals for or in connection with the prevention, diagnosis, or treatment of illness, and
- the promotion and protection of public health.

The Trust accounts are available to the public online at the following web address:

<https://www.bradfordhospitals.nhs.uk>

They are also available by request from the Trust Secretary, using the details below:

Trust Secretary
Trust Headquarters
Bradford Royal Infirmary
Bradford
BD9 6RJ

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BOARD OPEN 2025-27

Item	Lead	29 Jan 26	31 Mar 26	21 May 26	23 Jul 26	24 Sep 26	26 Nov 26	28 Jan 27	30 Mar 27	Notes
STRATEGY										
Corporate Strategy / Strategic Framework	Director of Strategy & Transformation		x			x			x	
Mental Health Strategy	Chief Nurse		x			x			x	
Green Plan	Director of Estates & Facilities	x			x			x		
Communications - Annual Update	Chief Executive		x			x				
Digital Strategy	CDIO			x			x			
Improvement Strategy	Chief Medical Officer	x	x		x			x		
Patient Experience & Engagement Strategy	Chief Nurse	x			x			x		
EDI Strategy	Chief Operating Officer		x			x			x	
People Strategy	Director of HR									Date TBC
Strategy - Emerging Issues	All	x	x	x	x	x	x	x	x	
QUALITY										
		29 Jan 26	31 Mar 26	28 May 26	23 Jul 26	24 Sep 26	26 Nov 26	28 Jan 27	30 Mar 27	
CQC Reports/Action Plan	Chief Nurse									Only when there is relevant information to report July/Nov - quarterly updates on action plan. Review frequency in November.
Infection Prevention & Control Q4 Report (Annual Report)	Chief Nurse			x						
Maternity and Neonatal Services Update	Chief Nurse	x	x	x	x	x	x	x	x	
Maternity Incentive Scheme	Chief Nurse	x						x		
Inpatient Survey	Chief Nurse						x			
Adults & Children Safeguarding Annual Reports	Chief Nurse				x					
Research Activity in the Trust	Chief Medical Officer		x			x*			x	*Presentation from Research Team
PEOPLE										
		29 Jan 26	31 Mar 26	28 May 26	23 Jul 26	24 Sep 26	26 Nov 26	28 Jan 27	30 Mar 27	
Equality, Diversity & Inclusion Update (WRES, WDES)	Chief Operating Officer		x							Presentation
Equality & Diversity Council (quarterly reporting - update)	Chief Executive		x	x		x	x		x	
Staff Survey Results	Chief Executive			x						
Freedom to Speak Up	Chief Nurse			x			x			
Nursing & Midwifery Staffing Establishment Review	Chief Nurse	x			x			x		
Guardian of Safe Working Hours annual report	Chief Medical Officer			x						
Medical Appraisal & Revalidation Annual Report & Statement of Compliance	Chief Medical Officer					x				
Gender Pay Gap Report	Chief Operating Officer		x						x	
Workforce Report	Director of HR	x		x	x		x	x		Quarterly - goes to People Jan, April, July, Nov
Healthcare Worker Flu Vaccination Best Practice Assurance	Director of HR	x						x		Item now included in CEO report
Apprenticeships	Chief Medical Officer		x						x	Presentation
Education Annual Report	Chief Medical Officer			x						
Education Self Assessment Report (SAR)	Chief Medical Officer					x				
FINANCE & PERFORMANCE										
		29 Jan 26	31 Mar 26	28 May 26	23 Jul 26	24 Sep 26	26 Nov 26	28 Jan 27	30 Mar 27	
Finance Report (inc Closing the Gap)	Chief Finance Officer	x	x	x	x	x	x	x	x	
Performance Report	Chief Operating Officer	x	x	x	x	x	x	x	x	
Integrated Dashboard	All	x	x	x	x	x	x	x	x	
Operational Plan Submission	Chief Operating Officer / Chief Finance Officer		x						x	
Financial Plan	Chief Finance Officer		x						x	
Capital Programme	Chief Finance Officer		x						x	

BOARD OPEN 2025-27

Item	Lead	29 Jan 26	31 Mar 26	21 May 26	23 Jul 26	24 Sep 26	26 Nov 26	28 Jan 27	30 Mar 27	Notes
Budget setting process & timetable	Chief Finance Officer						x			
Winter Plan	Chief Operating Officer						x			
Charity Annual Report & Accounts	Chief Finance Officer	x						x		
PARTNERSHIPS		29 Jan 26	31 Mar 26	28 May 26	23 Jul 26	24 Sep 26	26 Nov 26	28 Jan 27	30 Mar 27	
Health Inequalities	Director of Strategy & Transformation		x			x			x	
Partnerships - strategic view	Director of Strategy & Transformation		x		x		x		x	
GOVERNANCE / ASSURANCE		29 Jan 26	31 Mar 26	28 May 26	23 Jul 26	24 Sep 26	26 Nov 26	28 Jan 27	30 Mar 27	
Board Assurance Framework	Chief Nurse	x	x	x	x		x	x		
High Level Risk Register	Chief Nurse	x	x	x	x	x	x	x	x	
Review of Standing Orders/SFIs/Scheme of Delegation	Chief Finance Officer						x			
Constitution - annual review	Chief Operating Officer	x	x				x			
Self Certification of Provider Licence	Chief Operating Officer			x						
NED Independence Test	Chief Operating Officer			x						
Compliance with NHS Code of Governance	Chief Operating Officer			x						
Well Led Review & Board Self Assessment	Chief Operating Officer									Date TBC
Annual Report from Academies and Committees	Committee/Academy Chairs			x						
Risk Appetite Review	Chief Nurse			x						
Annual Fire Safety Report	Director of Estates & Facilities			x						
Annual Health & Safety Report	Director of Estates & Facilities				x					
Premises Assurance Model Progress Report	Director of Estates & Facilities						x			
Annual Security Report	Director of Estates & Facilities					x				
Violence Prevention & Reduction Standard	Director of Estates & Facilities			x		x				Sept - part of Annual Security Report
Data Security & Protection Toolkit	CDIO			x						
DPO Annual Report	DPO					x				
Emergency Preparedness, Resilience & Response & NHSE Core Standards	Chief Operating Officer					x				
Use of the Trust Seal	Chief Operating Officer					x				
NED Champion Roles - annual review	Chair			x						
Fit and Proper Person Test - annual review	Chair			x						
Modern Slavery Statement	Chief Operating Officer						x			
COG Engagement Policy	Chief Operating Officer	x	x							
STANDING ITEMS		29 Jan 26	31 Mar 26	28 May 26	23 Jul 26	24 Sep 26	26 Nov 26	28 Jan 27	30 Mar 27	
Patient Story	Chief Nurse		x		x		x		x	
Getting to know the CSUs	Chief Operating Officer/Chief Medical Officer/Chief Nurse	x		x		x		x		
Chair's Report	Chair	x	x	x	x	x	x	x	x	
Chief Executive's Report	Chief Executive	x	x	x	x	x	x	x	x	
Chair's report from Academies and Committees	Committee/Academy Chairs	x	x	x	x	x	x	x	x	
Key:										
Planned item										
Planned item deferred to future meeting										
Planned item cancelled and not re-planned in / state reason in notes										
Item discussed at the meeting										