

Board of Directors public

Tue 31 March 2026, 09:30 - 12:00

Conference Room, Field House, BRI

Agenda

09:30 - 09:30 **Agenda**

0 min

 Bo.3.26.0 - Open Board Agenda 31.3.26.pdf (2 pages)

09:30 - 09:30 **Bo.3.26.1 - Apologies for absence**


0 min

Information *Chair*


09:30 - 09:30 **Bo.3.26.2a - Declarations of interest**

0 min

Information *Chair*

 Bo.3.26.2 - Declarations of Interest.pdf (1 pages)


Bo.3.26.2b - Code of Conduct

 Bo.3.26.2b - Code of conduct.pdf (1 pages)

09:30 - 09:30 **Bo.3.26.3 - Minutes of the meeting held on 29 January 2026**

0 min

Approval *Chair*

 Bo.3.26.3 - Unconfirmed minutes of the BoD Open Meeting 29.01.26 - chair approved.pdf (9 pages)

09:30 - 09:35 **Bo.3.26.4 - Matters arising**

5 min

Information *Chair*

09:35 - 09:40 **Bo.3.26.5 - Report from the Chair**

5 min

Assurance *Chair*

 Bo.3.26.5 - Report from the Chair March 2026.pdf (3 pages)

09:40 - 09:50 **Bo.3.26.6 - Report from the Chief Executive**

10 min

Assurance *Chief Executive*

 Bo.3.26.6 - CEO Report.pdf (7 pages)

09:50 - 10:05 **Bo.3.26.7 - Patient story**

15 min

Assurance *Chief Nurse*

10:05 - 10:15 **Bo.3.26.8 - Report from the Chair of the Quality Committee**

10 min

Assurance *Chair of the Quality Committee*

8a - February & March 2026

Osbourne
30/03/2026 10:08:30
Sheridan

Assurance Chair of the Quality Committee

📄 Bo.3.26.8a - Report from the Chair of the Quality Committee - February 2026.pdf (2 pages)

📄 Bo.3.26.8a - Report from the Chair of the Quality Committee - March 2026.pdf (1 pages)

8b. Improvement strategy update

Assurance Chair of the Quality Committee

📄 Bo.3.26.8b - Improvement Strategy update.pdf (9 pages)

8c. Mental Health strategy update

Assurance Chair of the Quality Committee

8d. Research Activity in the Trust

📄 Bo.3.26.8d - Research Activity in the Trust (presentation).pdf (5 pages)

10:15 - 10:25 **Bo.3.26.9 - Maternity and neonatal services update**

10 min

Assurance Chief Nurse

📄 Bo.3.26.9 - Mat Neo(Perinatal) Board Assurance (cover paper).pdf (4 pages)

10:25 - 10:35 **Bo.3.26.10 - CQC Well Led inspection report**

10 min

Assurance Chief Nurse

📄 Bo.3.26.10 - Care Quality Commission Well Led Inspection Report (cover).pdf (1 pages)

📄 Bo.3.26.10 - Appendix 1.20260318 Bradford Teaching Hospitals NHS trust Final report letter.pdf (3 pages)

10:35 - 11:00 **Bo.3.26.11 - Report from the Chair of the People Academy**

25 min

Assurance Chair of the People Academy

11a - February & March 2026

Assurance Chair of the People Academy

📄 Bo.3.26.11a - Report from the Chair of the People Academy - February 2026.pdf (2 pages)

📄 Bo.3.26.11a - Report from the Chair of the People Academy - March 2026.pdf (2 pages)

11b - Gender Pay Gap review 2025/26

Assurance Chair of the People Academy

📄 Bo.3.26.11b - Gender Pay Gap Review 2026.pdf (17 pages)

11:00 - 11:15 **Bo.3.26.12 - Report from the Chair of the Finance and Performance Committee**

15 min

Assurance Chair of the F&P Committee

12a - February & March 2026

Assurance Chair of the F&P Committee

📄 Bo.3.26.12a - Report from the Chair of the F&P Committee - February 2026.pdf (3 pages)

📄 Bo.3.26.12a - Report from the Chair of the Finance and Performance Committee March 26.pdf (3 pages)

12b - Integrated Dashboard

Assurance Chair of the F&P Committee

Osbourne, Sheridan
30/03/2025 10:18:30

- 📄 Bo.3.26.12b - Integrated Dashboard (Cover).pdf (2 pages)
- 📄 Bo.3.26.12b - Integrated Dashboard February 2026.pdf (36 pages)

12c - Finance Report

Assurance *Chair of the F&P Committee*

- 📄 Bo.3.26.12c - Finance Report Month 11.pdf (2 pages)

12d - Performance Report

Assurance *Chair of the F&P Committee*

- 📄 Bo.3.26.12d - Operational Performance Report (cover).pdf (2 pages)
- 📄 Bo.3.26.12d - Operational Highlight Report.pdf (16 pages)

11:15 - 11:20 **Bo.3.26.13 - Strategy - emerging issues**

5 min

Assurance *All*

11:20 - 11:25 **Bo.3.26.14 - Health Inequalities**

5 min

Assurance *Director of Strategy & Transformation*

- 📄 Bo.3.26.14 - Health Equity and Inequalities v2.pdf (8 pages)

11:25 - 11:35 **Bo.3. 26.15 - Strategic Framework**

10 min

Approval *Director of Strategy & Transformation*

- 📄 Bo.3.26.15 - Strategic Framework 2025 26.pdf (6 pages)

11:35 - 11:40 **Bo.3.26.16 - Report from the Chair of the Audit Committee - 10 February 2026**

5 min

Assurance *Chair of the Audit Committeee*

- 📄 Bo.3.26.16 - Report from the Chair of Audit Committee Feb 2026.pdf (2 pages)

11:40 - 11:45 **Bo.3.26.17 - Report from the Chair of the Charitable Funds Committeee - 3 February 2026**

5 min

Information *Chair*

- 📄 Bo.3.26.17 - Report from the Chair of the Charitable Funds Committee - Feb 2026.pdf (1 pages)

11:45 - 11:50 **Bo.3.26.18 - Board Assurance Framework & High-level risk register**

5 min

Assurance *Associate Director of Corporate Governance/Board Secretary*

- 📄 Bo.3.26.18 - BAF and HLRR - March (cover paper).pdf (6 pages)
- 📄 Bo.3.26.18 - Appendix 1 - Updated Q3 2025-26 BAF v2.pdf (18 pages)
- 📄 Bo.3.26.18 - Appendix 2 - Board March_All Open Operational Risks_15 or over (as at 04.03.2026).xlsx (7 pages)
- 📄 Bo.3.26.18 - Appendix 3 - BoD Risk on a Page Report March 26.pdf (1 pages)
- 📄 Bo.3.26.18 - Appendix 4 Target Mitigation Dates.pdf (1 pages)

11:50 - 11:55 **Bo.3.26.19 - Communications Strategy**

5 min

Approval *Strategic Communications and Engagement Lead*

- 📄 Bo.3.26.19 - Communications Strategy (cover).pdf (3 pages)
- 📄 Bo.3.26.19 - Appendix 1 - Communications Strategy 2026.pdf (26 pages)

11:55 - 11:55 **Bo.3.26.20 - Any other business**

Osborne
30/03/2026 10:48:30

0 min

Information

Acting Chair

11:55 - 11:55 Bo.3.26.21 - Issues to refer to Committees or elsewhere

0 min

Information

Acting Chair

11:55 - 11:55 Bo.3.26.22 - Review of meeting

0 min

Information

Acting Chair

11:55 - 11:55 Bo.3.26.23 - Date and time of next meeting

0 min

Information


Acting Chair

11:55 - 12:00 Bo.3.26.24 - Board of Directors work plan

5 min

Information

Associate Director of Corporate Governance/Board Secretary

 Bo.3.26.24 - Board Open Work Plan 2025-26 - v6.pdf (2 pages)

BOARD OF DIRECTORS MEETING IN PUBLIC AGENDA

Date:	Tuesday 31 March 2026	Time:	09:30 – 12:00
Venue:	Conference Room, Field House, BRI	Chair:	Karen Walker, Acting Chair

Attending for specific items only:

- 09:50-10:05 – Razwana Bashir, Renal Matron - Bo.3.26.7
- 10:15-10:25 - Sara Hollins, Director of Midwifery - Bo.3.26.9
- 11:50-11:55 – Shak Rafiq, Strategic Communications and Engagement Lead – Bo.3.26.19

Observers:

- Fiona Thompson and John Waterhouse, Governors

No.	Agenda Item	Lead	Outcome	Papers attached
09:30 Section 1: Opening matters				
Bo.3.26.1	Apologies for absence <ul style="list-style-type: none"> • Justine Andrew, NED • Geoff Hall, NED • Zafir Ali, NED • Saj Azeb, Chief Operating Officer (James Taylor, Deputy COO representing) 	Acting Chair	For information	Verbal
Bo.3.26.2	a. Declarations of interest b. Code of Conduct	Acting Chair	For information	Bo.3.26.2
Bo.3.26.3	Minutes of the meeting held on 29 January 2026	Acting Chair	For approval	Bo.3.26.3
Bo.3.26.4	Matters arising	Acting Chair	For information	Verbal

09:35 Section 2: Business Reports				
Bo.3.26.5	Report from the Chair	Acting Chair	For assurance	Bo.3.26.5
Bo.3.26.6	Report from the Chief Executive	Chief Executive	For assurance	Bo.3.26.6

09:50 Section 3: Patient Care				
Bo.3.26.7	Patient Story	Chief Nurse	For assurance	Bo.3.26.7
Bo.3.26.8	Report from the Chair of the Quality Committee <ul style="list-style-type: none"> a. February & March 2026 b. Improvement Strategy update c. Mental Health Strategy update d. Research Activity in the Trust 	Chair of the Quality Committee	For assurance	Bo.3.26.8
Bo.3.26.9	Maternity and Neonatal services update	Chief Nurse	For assurance	Bo.3.26.9
Bo.3.26.10	CQC Well Led inspection report	Chief Nurse	For assurance	Bo.3.26.10

10:35 Section 4: People				
Bo.3.26.11	Report from the Chair of the People Academy <ul style="list-style-type: none"> a. February & March 2026 b. Gender Pay Gap review 2025/26 	Chair of the People Academy	For assurance	Bo.3.26.11

BREAK 10:50 – 11:00

11:00 Section 5: Finance and Performance				
Bo.3.26.12	Report from the Chair of the Finance and Performance Committee a. February & March 2026 b. Integrated Dashboard c. Finance Report d. Performance Report	Chair of the Finance and Performance Committee	For assurance	Bo.3.26.12

11:15 Section 6: Strategy & Partnerships				
Bo.3.26.13	Strategy – emerging issues	All	For assurance	Verbal
Bo.3.26.14	Health Inequalities	Director of Strategy & Transformation	For assurance	Bo.3.26.14
Bo.3.26.15	Strategic Framework	Director of Strategy & Transformation	For approval	Bo.3.26.15

11:35 Section 7: Audit & Assurance				
Bo.3.26.16	Report from the Chair of the Audit Committee – 10 February 2026	Chair of the Audit Committee	For assurance	Bo.3.26.16
Bo.3.26.17	Report from the Chair of the Charitable Funds Committee – 3 February 2026	Chair of the Charitable Funds Committee	For assurance	Bo.3.26.17

11:45 Section 8: Governance				
Bo.3.26.18	Board Assurance Framework & High-level risk register	Associate Director of Corporate Governance/Board Secretary	For assurance	Bo.3.26.18
Bo.3.26.19	Communications Strategy	Strategic Communications and Engagement Lead	For approval	Bo.3.26.19

11:55 Section 9: Board Meeting Outcomes				
Bo.3.26.20	Any other business	Acting Chair	For information	Verbal
Bo.3.26.21	Issues to refer to Committees or elsewhere	Acting Chair	For approval	Verbal
Bo.3.26.22	Review of meeting	Acting Chair	For information	Verbal
Bo.3.26.23	Date and time of next meeting: • 21 May 2026	Acting Chair	For information	Verbal

Annexes for the meeting of the Board of Directors 31 March 2026

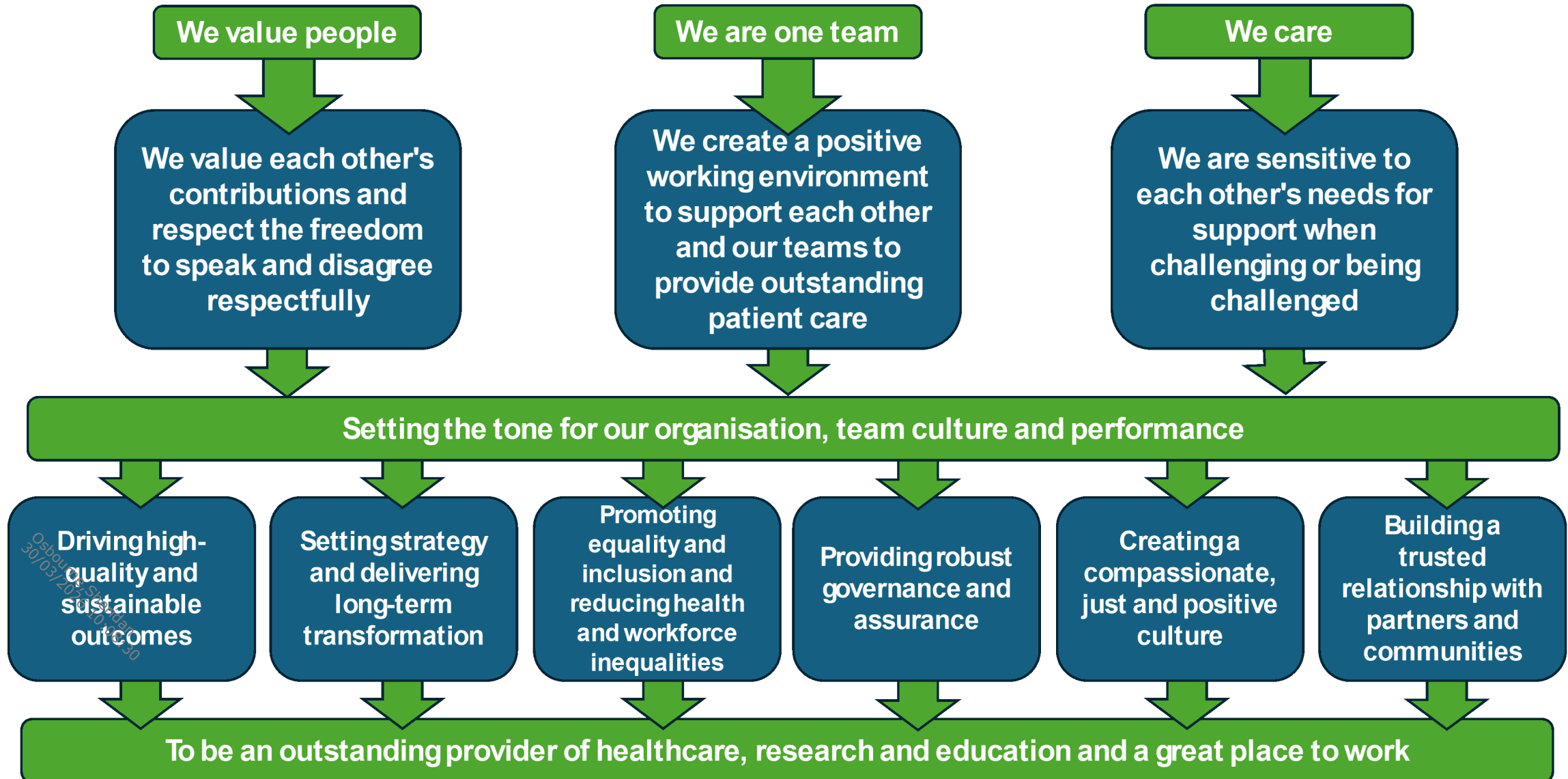
Annex 1: For Information				
Bo.3.26.24	Board of Directors work plan	Associate Director of Corporate Governance/Board Secretary	For information	Bo.3.26.24

Osbourne-Sheridan
30/03/2026 10:08:30

Employee	Role	Date Incurred	Year	Interest Type	Date Ended	Interest Description (Abbreviated)	Provider	Value £'s
Ataf Sadique	Non-Executive Director	01.12.2020	2020/21,2021/	Outside Employment		Industrial member	GSI	0
Ataf 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
Ataf Sadique	Non-Executive Director	08.12.2021	2021/22,2022/	Loyalty Interests		Full member of health institute (EU).	IG Health for Institute (EU)	0
Ataf 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
Ataf 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
Ataf 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 & befo	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 & befo	Loyalty Interests		Member of the HFMA (Healthcare Financial Management Association) and Chair the Associations Digital Council	HFMA (Healthcare Financial Management Association)	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 hand 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
Faem Lal	Director of Human Resources	18.12.2024	2024/25	Shareholdings and other ownership interests		£1	F&R Group limited	0
Faem Lal	Director of Human Resources	01.09.2025	2025/26	Outside Employment		I volunteer at my local mosque, as an unpaid volunteer and unofficial helper in the mosque committee.	JTI Shearbridge	0
Faem Lal	Director of Human Resources	01.01.2026	2025/26	Outside Employment		I volunteer with the scouts association and chair the a local scouts group.	Volunteer with The Scouts Association	0
Geoff Hall	Non-Executive Director	01.03.2001	2015/16 & befo	Outside Employment		Professor of Digital Health and Cancer Medicine	University of Leeds	0
Geoff Hall	Non-Executive Director	01.03.2001	2015/16 & befo	Outside Employment		Consultant Medical Oncology	Leeds Teaching Hospitals	0
Geoff Hall	Non-Executive Director	01.03.2015	2015/16 & befo	Outside Employment		Chief Clinical Information Officer	Leeds Teaching Hospitals	0
Geoff Hall	Non-Executive Director	01.01.2021	2020/21,2021/	Outside Employment		Director, Health Data Research Hub for Cancer	DATA CAN	0
Geoff Hall	Non-Executive Director	01.06.2024	2024/25,2025/	Outside Employment		Member of Research and Innovation committee	Leeds Hospitals Charity	0
Geoff Hall	Non-Executive Director	01.09.2021	2021/22,2022/	Outside Employment		Chief Clinical Data Officer	Health Data Research UK	0
Geoff Hall	Non-Executive Director	01.09.2021	2021/22,2022/	Sponsored Research		Curation of real world data for cancer patients	Flairion Health	100000
Geoff Hall	Non-Executive Director	01.09.2014	2015/16 & befo	Sponsored Research		Use of real world data to improve cancer care	K2VIA	100000
Geoff Hall	Non-Executive Director	01.09.2020	2020/21,2021/	Sponsored Research		Multimodal AI in ovarian cancer	Bramall Foundation	1400000
Geoff Hall	Non-Executive Director	01.09.2023	2023/24,2024/	Outside Employment		Speaker at national meetings	Pfizer	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
Helen Lewis	Chief Digital & Information Officer	18.11.2025	2025/26	Hospitality		One day Cisco AI Infrastructure Exec Advisory Board meeting at McLaren Tech Centre in Woking, Surrey. Including 2 nights accommodation, car transfer to venue and meals.	Cisco	1221
Helen Lewis	Chief Digital & Information Officer	10.12.2025	2025/26	Hospitality		Lunch at the Three Fishes in Whalley with Darren from Penpole.	Penpole Consulting	25
Helen Lewis	Chief Digital & Information Officer	27.02.2026	2025/26	Hospitality		Lunch at the Hilltop Brasserie, Grimsburgh, Preston.	SCC UK	28
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
John Bolton	Deputy CMO & Operations Medical Director	22.05.2024	2024/25	Hospitality		Train fare to conference in London and lunch while there.	Intuitive Medical	515
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 Dawber	Chief Nurse	01.09.2025	2025/26	Loyalty Interests		Ellie is my daughter and a volunteer in the Trust, during the year Ellie has transitioned, through a competitive process, into an as and when paid role as an Oliver McGowan co facilitator.	Ellie Dawber	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/B	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
Timothy Swift	Non-Executive Director	01.05.2003	2015/16 & befo	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 Authority	Government Internal Audit Agency	0

Osbourne Sheridan
30/03/2026 10:08:30

BTHFT Inside Out Board Code of Conduct



UNCONFIRMED - BOARD OF DIRECTORS OPEN MEETING MINUTES

Date:	Thursday, 29 January 2026	Time:	10:00-12:30
Venue:	Conference Room, Field House, BRI	Chair:	Sarah Jones, Chair
Present:	<p>Non-Executive Directors:</p> <ul style="list-style-type: none"> - Sarah Jones (SJ) - Zafir Ali (ZA) - Justine Andrew (JA) - Professor Geoff Hall (GH) - Bryan Machin (BM) - Altaf Sadique (AS) - Karen Walker (KW) <p>Executive Directors:</p> <ul style="list-style-type: none"> - Professor Mel Pickup, Chief Executive (MP) - Sajid Azeb, Chief Operating Officer (SA) - 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:	<ul style="list-style-type: none"> - Faeem Lal, Director of HR (FL) - Vikki Lewis, Chief Digital, and Information Officer - David Moss, Director of Estates and Facilities (DM) - Laura Parsons, Associate Director of Corporate Governance / Board Secretary (LP) - Deborah Earnshaw, Corporate Governance Manager (DE) - Carly Stott, Head of Midwifery (CSt) <i>for item Bo.1.26.8 only</i> - Laura Riach, Charity Director (LR) <i>for item Bo.1.26.15 only</i> - Tabitha Lawreniuk, Personal Business Manager as Secretariat 		
Observing:	<ul style="list-style-type: none"> - John Waterhouse, Governor - Dermot Bolton, Governor 		

No.	Agenda Item	Action
Section 1: Opening Matters		
Bo.1.26.1	<p>Apologies for Absence</p> <ul style="list-style-type: none"> - Tim Swift, Non-Executive Director 	
Bo.1.26.2	<p>Declarations of Interest No additional declarations were raised in relation to the items on the agenda.</p> <p>Code of Conduct The code of conduct was noted by the Board.</p>	
Bo.1.26.3	<p>Minutes of the Meeting held on 27 November 2025</p> <p>The minutes of the meeting held on 27 November 2025 were approved as a true and accurate record.</p>	

No.	Agenda Item	Action
Bo.1.26.4	<p>Matters Arising</p> <p>There were no matters arising.</p> <p>SJ thanked colleagues for arranging the pre-meeting tour of the new Endoscopy unit.</p>	
Section 2: Business Reports		
Bo.1.26.5	<p>Report from the Chair</p> <p>SJ introduced her report which was largely taken as read. SJ highlighted that this was her last meeting of the BTHFT Board as she takes up the Chair role at Airedale NHS Foundation Trust (AFT) from 1 February and Bradford District Care NHS Foundation Trust (BDCT) on 1 March, and during this period will temporarily step back from BTHFT. Karen Walker, Deputy Chair, will act up into the Chair post during this absence.</p> <p>SJ also highlighted the forthcoming Strategic Advisory Forum at the University of Bradford and encouraged attendance.</p> <p>The report was noted by the Board.</p>	
Bo.1.26.6	<p>Report from the Chief Executive</p> <p>MP introduced the report and highlighted the following:</p> <ul style="list-style-type: none"> - The strike action concluding on 22 December had not been included in the paper; mitigation enabled maintenance of urgent and emergency care and 95% of planned elective activity. - Planning submissions for finance, performance, and workforce for the next three years are due on 12 February. This would be discussed in further detail during the course of the meeting. - The Trust hosted Baroness Amos and her team on 1 and 2 December as part of the national maternity review, with preliminary feedback about the process as a whole received and more formal, Trust specific findings expected in Summer. <p>KD updated the Board on maternity record sharing challenges. A temporary portable electronic record solution was now in place.</p> <p>The report was noted by the Board.</p>	
Section 3: Patient Care		
Bo.1.26.7	<p>Report from the Chair of the Quality Committee: January 2026</p> <p>JA gave an overview of the report from the Quality Committee meeting held in January. The report highlighted the continued financial pressure and the need for Board-wide monitoring of decision-making to protect safety. The report also alerted the Board to an ongoing high level risk relating to renal capacity, with work underway to identify short-, medium- and long-term mitigations.</p> <p>ZA raised longstanding issues with coding accuracy. JB confirmed progress is being made through joint work across Digital, Medical and Performance teams</p>	

No.	Agenda Item	Action
	<p>but is taking time to resolve given it is a multifaceted issue. MP noted that AI-supported analysis is also being explored to more rapidly improve coding accuracies.</p> <p>The Board noted the report and the assurance provided.</p>	
<p>Bo.1.26.8</p>	<p>Maternity and Neonatal services update and Maternity Incentive Scheme, Year 7</p> <p>CSt joined the meeting to present the paper which sought to provide the Board with assurance that a monthly review of maternity and neonatal quality and safety activity relating to November and December 2025 was presented at the Quality Committee in January, and key elements were discussed. The paper also included assurance that action plans and audits required to declare compliance with safety Action 4 of the Maternity Incentive Scheme (MIS) were presented to, and approved by, the People Academy in November 2025. The People Academy also received and approved the Obstetric Consultant attendance audit report.</p> <p>CSt also presented the MIS Year 7, audit tool, which provides an update against all ten MIS criteria and confirmed that the Trust is 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.</p> <p>KD noted that the Trust has met the MIS Scheme every year since implementation. She was hopeful that with this strong track record, MBRRACE would look favourably on the Trust with regards to the overturning of the non-compliance.</p> <p>In relation to the Maternity and Neonatal services update, the Board:</p> <ul style="list-style-type: none"> • confirmed they were assured that the Quality Committee had 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; • noted 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; • noted that in November 2025, the People Academy received and approved the Neonatal medical and nursing staffing action plans, as stipulated in the Maternity Incentive Scheme; and • noted that in November 2025, the People Academy received and approved the Obstetric Consultant attendance audit report as stipulated in the Maternity Incentive Scheme; and • noted the reduction in stillbirths from 30 in 2024, to 16 in 2025. <p>In relation to the Maternity Incentive Scheme, Year 7, the Board:</p> <ul style="list-style-type: none"> • acknowledged the contents of the paper and attached appendices; • supported the decision to declare non-compliance with the scheme; • approved the action plan and mitigation for safety action 1, which would be submitted with the Board declaration form and was hoped to be accepted by 	

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	<p>the external reviewers, and noted that this may change the overall submission to one of full compliance; and</p> <ul style="list-style-type: none"> noted 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 West Yorkshire and Harrogate Local Maternity and Neonatal System, prior to completion of the Board Self-Declaration form. 	
Bo.1.26.9	<p>CQC Reports</p> <p>KD gave an overview of the paper which sought 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 summarised recent inspection outcomes, progress against agreed action plans, and the governance arrangements in place to oversee delivery.</p> <p>KD advised that the A&E inspection report was still awaited but was expected to reflect areas of improvement already familiar to the Board. She confirmed that, following the visit in September 2025, the service had developed an action plan addressing the immediate issues identified, and this is being monitored through the Executive Team Meeting. The action plan will be updated upon receipt of the draft report to incorporate any further required improvements.</p> <p>A further report to the Board would be brought back in four months time including an overarching action plan responding to all elements of the CQC reports. This would also be presented to the Council of Governors (CoG) for assurance.</p> <p>The Board:</p> <ul style="list-style-type: none"> noted the progress to date; and supported the continued delivery and resolution of outstanding actions. 	
Section 4: People		
Bo.1.26.10	<p>Report from the Chair of the People Academy: January 2025</p> <p>KW gave an overview of the report from the People Academy meeting held in January, alerting the Board to the continuous challenge around staff absence which, whilst lower than anticipated in November (6.94% against an anticipated 7%), did increase in December as winter illnesses became prevalent. KW has asked for an action plan with milestone dates for absence reduction for February's Academy meeting. She had also suggested that the Director of HR work with the Head of Organisational Development to improve the reporting culture in relation to absence, appraisals and training as this was a consistent issue.</p> <p>KW also alerted the Board to the progress made on the triangulation of patient and people experience data, noting that a dashboard is in progress to collate the data in an accessible format.</p> <p>The Board discussed the need for a realistic sickness absence target reflecting the local population and representation of the population within the workforce profile. MP commented that whilst the NHS England Regional Director had acknowledged that the Trust's workforce profile results in higher than average sickness absence, there was still a need to reduce the overall absence figure.</p>	

No.	Agenda Item	Action
	<p>The Board received the report and noted the assurance provided.</p> <p>Workforce Report: The Board noted the report. BM felt it would be helpful for a clearer analysis of the data to be included within the narrative, and FL would include this in future reports.</p> <p>The Board noted the contents of the report.</p>	<p>Bo26001 Director of HR</p>
<p>Bo.1.26.11</p>	<p>Nursing & Midwifery staffing establishment review</p> <p>KD presented the bi-annual Nursing and Midwifery Strategic Staffing Review. The Board was asked to consider the assurance that a robust review process had been undertaken, and support the recommendations of the Chief Nurse as below:</p> <ul style="list-style-type: none"> - Ward F5: Recruit an additional Registered Nurse (RN), increase of 2.4 WTE, costing £124,256. - Emergency Department: Increase establishment by an additional four Band 5 RNs on every shift (21 WTE including uplift), at a total cost of £1,161,355. A business case relating to this had been put forward to the Executive Team meeting in December for consideration. - Maternity: Establishment uplift on ward M4 only (24-hour cover), increase of 5.37 WTE, costing £214,643. <p>BM queried how the approval of these additional roles would impact the headcount of the Trust recognising the need to reduce the workforce overall. FL confirmed that plans allow for some headroom around approval of these posts, however there is an intent to reduce temporary staffing and increase into substantive posts which will help to address this.</p> <p>With regards to the emergency department Matron cover, the initial establishment review suggested the addition of a Matron to ensure oversight of the department. This was rejected by the Executive Team and KD confirmed that she would review her existing Chief Nurse team roles and responsibilities to identify a lead for providing this oversight to the department.</p> <p>The Board:</p> <ul style="list-style-type: none"> • supported the skill mix changes as outlined in Appendix 1 to the report; and • approved the recommendations of the Chief Nurse outlined above. 	
<p>Section 5: Finance and Performance</p>		
<p>Bo.1.26.12</p>	<p>Report from the Chair of the Finance and Performance Committee: January 2026</p> <p>BM gave an overview of the report from the Finance and Performance Committee meeting held in January 2026. He alerted the Board to the significantly challenging financial position, including the forecast adverse variance to plan which is now in the range of £15.1m (best case) to £27.1m (worst case). The Chief Executive had attended the meeting to discuss the Financial Recovery Plan which outlined the actions being taken and the risks and mitigations to delivery, and this was well received by the Committee.</p>	

No.	Agenda Item	Action
	<p>BR also referred to the updates received by the Committee relating to KPI exceptions and performance challenges, including the mitigations in place to help recover.</p> <p>The Board received the report and noted the assurance provided.</p> <p>Finance Report: BR highlighted the notification by NHS England that £1.9m of non-recurrent funding will be allocated to the Trust in Quarter 4 to offset the costs of industrial action in November and December, however the Trust is required to improve its recovery plan forecast by a commensurate amount.</p> <p>The Board received the report and noted the assurance provided.</p> <p>Integrated Dashboard: The Board received the report and noted the assurance provided.</p> <p>Performance Report: The Board received the report and noted the assurance provided.</p> <p>Green Plan Progress Update: The Board received the report and noted the assurance provided.</p>	
Section 6: Strategy & Partnerships		
Bo.1.26.13	<p>Strategy – emerging issues</p> <p>MHi informed the Board that he and MP had been working with partners to develop a Place Provider Partnership and MP has now taken up Chair of a meeting to ensure progress on this. The alignment of this work with existing collaboration structures will be considered as it progresses. MP and MHi will keep the Board updated.</p> <p>JA suggested that a clearer overview of how governance structures across Place interconnect would be helpful as the work is established.</p> <p>SJ reminded colleagues of the importance of keeping Governors informed and engaged.</p> <p>The Board noted the update provided.</p>	
Section 7: Governance		
Bo.1.26.14	<p>High-level risks</p> <p>KD presented the paper which provided a profile of risks, controls and mitigations related to the High Level Risk Register (HLRR). She advised that Internal Audit time was set aside to look at how the organisation reviews risks and opportunities to improve, including the implementation of a risks and issues log.</p> <p>KD highlighted the increasing pressure on renal dialysis capacity. Short-term measures are in place, supported by capital investment for expansion; longer-term solutions must be incorporated into the new hospital programme. KD</p>	

No.	Agenda Item	Action
	<p>assured the Board that the executive team were fully aware of the challenges and had been fully briefed at the recent Executive Team Meeting on 26 January.</p> <p>BR advised that capital monies has been set aside to increase capacity at current sites, including expansion of Skipton Renal Unit, and this was expected to provide sufficient capacity until 2030.</p> <p>The Board confirmed it was assured that all risks on the high-level risk register were appropriately recognised and recorded, and that all appropriate actions were being taken within appropriate timescales where risks were not appropriately controlled.</p>	
Bo.1.26.15	<p>Bradford Hospitals Charity 12 month review</p> <p>LR joined the meeting to present the Bradford Hospitals Charity 12 month review, including key achievements in 2025, progress on the Home from Home appeal, and the timeline for moving to Independence. AS reflected on the positive return on earlier investment in the Charity team.</p> <p>MHi noted the Charity's success in being named Broadway Bradford's Charity of the Year, which was expected to bring in additional funds for the Charity as well as helping to raise the local profile.</p> <p>The Board thanked LR and her team for their work in driving progress of the Charity.</p> <p>The Board noted the update and assurance provided.</p>	
Bo.1.26.16	<p>Bradford Hospitals Charity Draft Annual Report & Accounts 2024/25</p> <p>BR gave a brief overview of the paper which sought the Board's approval of the charity's Annual Report and Accounts for the financial year ended 31 March 2025, following completion of the independent examination. Following approval by Board, the accounts will be signed by the independent examiner and then submitted to the Charity Commission.</p> <p>The Board:</p> <ul style="list-style-type: none"> • approved the Bradford Hospitals Charity 2024-25 report and accounts; and • approved the annual report and accounts to be electronically signed by the Chair, Chief Executive and Chief Financial Officer. 	
Section 8 Board Meeting Outcomes		
Bo.1.26.17	<p>Any Other Business</p> <p>No other business was discussed.</p>	
Bo.1.26.18	<p>Issues to Refer to Board Committees/Academies or Elsewhere</p> <p>There were no issues to refer elsewhere.</p>	

No.	Agenda Item	Action
Bo.1.26.19	<p>Review of Meeting</p> <p>There were no comments in relation to review of the meeting.</p> <p>MP thanked SJ for her leadership and contributions during her time as Chair of BTHFT, recognising the progress the Board has made with her support. This was echoed by the Board and SJ would be missed during her temporary absence from the Trust. In turn, SJ thanked KW for acting up as Chair during this interim period.</p>	
Bo.1.26.20	<p>Date and Time of Next Meeting</p> <ul style="list-style-type: none"> 26 March 2026 – 9.30am 	

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ACTIONS FROM BOARD OF DIRECTORS OPEN MEETING – 29 January 2026

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
Bo26001	Bo.1.26.10	Report from the People Academy – Workforce Report: BM felt it would be helpful for a clearer analysis of the data to be included within the narrative, and FL would include this in future reports.	Director of HR	March 2026	
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	April 2026	The Strategic Partnering Agreement is currently being reviewed in light of Place Provider Partnership arrangements and an updated version will be presented to the Board in April 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	

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Board of Directors				
Meeting Date:	31 March 2026	Agenda Reference:	Bo.3.26.5	
Report Title:	Report from the Acting Chair			
Presented by:	Karen Walker, Acting Chair			
Executive Lead:	Karen Walker, Acting Chair			
Author:	Jacqui Maurice, Head of Corporate Governance			
Report Summary				
Purpose of the paper:	Decision <input type="checkbox"/> (approve/recommend/ support/ratify)	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> (review/discuss/ comment)	Information <input type="checkbox"/>
Summary of Key Issues/Highlights:	<p>This report provides an update to the Board on key items since the previous Chair Report provided in January 2026. The report covers:</p> <ol style="list-style-type: none"> 1. Council of Governors 2. Governor Elections 3. Strategic Advisory Forums 4. Team of the Year Selection Panels 5. Annual Members Meeting 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			

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Report from the Acting Chair

1. Introduction

Welcome to my first report as Acting Chair in the absence of Sarah Jones, our Chair.

My thanks to the Non-Executive Directors who have each stepped up to take on more responsibility while I am Acting Chair and in the absence of one of our NED colleagues who is suffering a period of absence.

2. Council of Governors

Feedback to the Council following Board of Directors meetings

I held my first feedback session with the Council on 3 February from 4pm to 5pm where I shared key items from our Board meeting in January.

Meetings of the Council

The next meeting of the Council is scheduled for 15 April 2026 (times to be confirmed).

3. Governor elections

The election process formally launched on 26 January; for one governor vacancy in each of the following seats.

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

Following the deadline for nominations we received one nomination each for our public and patient constituencies. These were from Daniel Balaz and Zulfiqar Hussain respectively and they have been elected unopposed. Both Daniel and Zulfiqar are currently undergoing our usual pre-appointment checks. Once complete they will formally be welcomed and inducted into the Council.

There were no nominations received in respect of our Medical and Dental staff group.

4. Strategic Advisory Forum: Anchor Institution

Our second 'Strategic Advisory Forum' covering 'Anchor Institutions' took 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 was instrumental in helping to develop the session which focussed 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 focussed 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 also attended. Following the session William and his team at the University very kindly hosted a tour of the University's simulated learning spaces.

You will recall these sessions are scheduled to provide an opportunity for members of the Board and our Council of Governors to meet outside of the formal meeting structures. As with the previous event held in October, this was an extremely engaging and interactive session. Mark Hindmarsh, Director of Strategy and Transformation is now co-ordinating our third forum, scheduled for Thursday 7 May, 9.30 to 11.30am. This will cover 'Digital tech and innovation'. Further details will be published nearer the time. I would like to encourage Board members to attend where their diaries permit.

5. Selection Panel Team of the Month Award

Our Public, Patient and Partner Governors have responded favourably to an invitation to join the selection panels which have been taking place monthly since mid-January 2026. This is a good opportunity for our Governors to get to know more about our Trust.

6. Annual Members Meeting 2024/25

Our Annual Members Meeting takes place on Tuesday 24 March in the Sovereign Lecture Theatre from 5pm to 6pm. The agenda and papers are all available on our website [here](#). Whilst we are almost at the end of 2025/26 it will be good to formally present the Annual Report and Accounts 2024/25 to our staff, the Council of Governors, Foundation Trust Members and the Public.

7. 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.

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Board of Directors				
Meeting Date:	31 March 2026	Agenda Reference:	Bo.3.26.6	
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 <input type="checkbox"/> (Approve/recommend/ support/ratify)	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> (Review/discuss/ comment)	Information <input type="checkbox"/>
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 January 2026.			
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
<p>1. Patients</p> <p>Work to meet the expectations set out in the Planning Framework continued at pace and we submitted a set of three-year numerical plans 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. The governance and processes we established to deliver this supported a broader level of engagement with external partners, and internal stakeholders, which in turn produced aligned and triangulated plans with a high degree of board assurance. Quality of care and patient outcomes remain at the heart of these plans. The Trust continues to work with NHSE on plan acceptance with all parties working to ensure we are targeting credible but stretching shifts in key areas.</p>

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. This trend continued until February and has since remained at expected averages. 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.

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 and has been establishing the work plan to deliver this during 2026/27, including stakeholder engagement and baseline data exercises during recent months.

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.

Outpatient Transformation has continued, which uses the model for improvement at a service and pathway level whilst enabling our digital offer to be modernised. Several schemes are moving from test of change to scaled adoption across all services. A particular improvement we are focussing on is the optimisation of referrals using triage and advice & guidance, alongside the ability to undertake or order diagnostic tests in advance of first appointments. The overall 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, and will be particularly important as we now focus on some of the shorter-term productivity benefits which will ensure resource utilisation increases, which has both a patient and financial benefit. Reducing the occurrences when patients are unable to attend is a scheme we will look to accelerate, and improvements here will also have a direct impact on health equity as our data shows those not attending are more likely to be from communities with poorer health outcomes.

The work to improve outpatient productivity is being supported by the Data and Productivity work-stream established as part of the Trust's Recovery Board. In addition to data recording there is also a focus on Theatres and Day-case units where the opportunity to book and treat more patients per session will be progressed at pace. This work-stream aims to improve our overall implied productivity rate, which is the level of activity per unit of spend, whilst also increasing treatments and then reducing the Referral to Treatment (RTT) waiting list as a result.

RTT performance is slightly behind plan and this will increase the level of improvement required next year. Some schemes planned to support improvement during Q4 have only commenced in March and these will continue into 2026/27 as part of the productivity focus previously described. This includes a continued focus on increasing first outpatient appointments, and the delivery of additional theatre sessions and higher treatment numbers in key specialties where waiting lists have grown. Despite the overall waiting list challenges, the number of waits over 52 weeks remained better than the national target of 1% of total waits set for 2025/26 and improved further this month, evidencing the successful processes that continue to minimise the longest delays.

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, but slightly below our previous best. 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, and there will be a dual focus on ensuring capacity matches demand and pathways are managed optimally so that this capacity is allocated without delay to the patients likely to need it.

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

The Endoscopy Unit has been handed over having achieved practical completion with first patients through the unit taking place during the week of 9 March 2026. 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.

CQC rates maternity services as 'Good'

The Trust's maternity services have achieved a 'Good' rating from the Care Quality Commission (CQC) following an unannounced full inspection carried out in September 2025.

The CQC found the services were well-led, were responding to the needs of the communities they serve and demonstrated evidence of a commitment to continuous improvement. The report highlighted how people working in the services are working hard to learn from the experiences of families accessing maternity care. The report has highlighted most mothers and babies received good care and had complimentary feedback to give on their birth experiences. This included support provided in a timely manner and the use of an electronic interpreting tool available in different languages to ensure any information given to women and their families was accessible. Inspectors also recognised the focused efforts being made to improve outcomes for women, especially considering deprivation level and ethnic background which can often impact negatively on birthing experiences.

National Maternity and Neonatal Investigation

Baroness Amos and her team visited perinatal services at the Trust on 1 and 2 December 2025. The team met with families, co-ordinated by the Maternity and Neonatal Voices Partnership (MNVP) Lead.

The interim report by Baroness Valerie Amos was published on 26 February 2026 and included the engagement undertaken to date. The investigation is midway and final conclusions and recommendations are yet to be made. The link to the interim report is provided here - [Independent Investigation into Maternity and Neonatal Services in England - Interim Report - National Maternity and Neonatal Investigation](#)

The report at this stage is not trust specific, as it shares general findings from inspections and interviews that have taken place with all 12 Trusts. We understand at the conclusion of the investigation, trusts will receive individual reports, and we very much look forward to understanding the findings of the review in respect of the services provided by our Trust.

2. People

LGBT+ History Month – February 2026

The Trust LGBTQ+ staff network teamed up with the Bradford District Care Trust's LGBTQ+ staff network to celebrate LGBTQ+ History Month. An event was held in Bradford Royal Infirmary's Sovereign Lecture Theatre on 25th February, and provided an opportunity for colleagues to connect, learn together and celebrate the contributions of LGBTQ+ communities and people throughout history, with a particular focus on science and innovation. Examples included Barbara Burford, a medical researcher who established NHS equality and diversity guidelines; Jemma Redmond, a biotechnologist who developed 3D bioprinters to create tissues and organs; and the 'founder of modern chemistry', Robert Boyle. Chair of the Trust's LGBTQ+ staff equality network bought the event to a close with a LGBTQ+ quiz.

International Women's Day 2026 – March 2026

International Women's Day 2026 was celebrated with an event at Bradford Royal Infirmary's Sovereign Lecture Theatre. Colleagues from across the Trust came together to reflect, celebrate and challenge us to go further in advancing gender equality across the Trust.

BTHFT Community Iftar – February 2026

We proudly hosted our first community Iftar for colleagues and their families to come together and break their fast. We were delighted to welcome over 100 colleagues in a powerful demonstration of what inclusion looks and feels like in practice — creating space for understanding, shared experience, and genuine connection. The evening included a short overview of the significance Ramadan within the Islamic faith, helping colleagues better understand why this month holds such importance for Muslims here at the Trust, in our communities and worldwide. We also provided context around the importance of prayer, reflection, charitable giving and community during this sacred month.

We also took the opportunity to provide a brief update on the Trust's Home from Home charity appeal, reinforcing the strong link between Ramadan and charitable giving, compassion, and service to others — values that align closely with our organisational purpose. The feedback from colleagues has been overwhelmingly positive. Colleagues have shared how much they appreciated the opportunity to come together, learn, reflect, and feel seen. Many spoke about the sense of belonging the event fostered — not just for Muslim staff, but for allies and colleagues from all backgrounds who attended in solidarity and curiosity.

2025 NHS Staff Survey

On behalf of the Board, I would like to thank staff who completed the 2025 NHS Staff Survey. Our response rate was 43%, meaning that 3,236 of staff completed the survey and we will share our commitment to carry out more focused listening exercises across the Trust and work collaboratively on the things that matter the most.

It has been reassuring to see that we continue to generally score above average across all the NHS People Promise themes. This is relatively better than many of our peers across the country as we have, over the last five years, seen a steady improvement across the NHS People Promise themes. Staff specifically highlighted how the organisation supports career progression and flexible working. It is important that we maintain momentum, while doing more in the focused areas. Staff felt engaged and felt that morale has improved despite all the ongoing challenges we are collectively facing.

It is however disheartening and unacceptable to hear that some colleagues in our organisation experience discrimination and we will work with colleagues to understand how we can challenge this. Every single colleague coming to work for our Trust should be respected for who they are, their life experiences and we should be celebrating diversity to foster a sense of belonging. This is especially important at a time when we are witnessing the impact of division and the distressing events across the world.

Three specific themes have been identified, and we will be launching a series of listening events over the coming months. These safe space events will focus on:

- Creating a sense of belonging by tackling any forms of discrimination
- Improving how we hear from our colleagues (listening and learning)
- Further developing our wellbeing support

The action plan to support the findings of the staff survey will be monitored by the Trust's People Academy and Board of Directors.

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3. Place

National organisational change updates

The DHSC and NHSE merger timetable has now been published. A new target operating model is being developed and is expected to be published by the end of May 2026. The DHSC plans to launch a 45-day consultation from October on the detailed design proposals for the new DHSC and on any potential future downsizing. This operating model will be aligned with both the Model ICB and Regional Blueprints, both of which have changed over time, as new information has come to light or decisions on changes reversed. Both DHSC and NHSE have already started to manage their own resizing separately, reflecting the aim of reducing the collective workforce by around 50%. It has been confirmed that the process is not a merger but creating a new DHSC. It looks likely that this will become a reality some time in 2027/28.

West Yorkshire ICB

In December, Rob Webster CBE, Chief Executive of NHS West Yorkshire Integrated Care Board and Lead Chief Executive of the West Yorkshire Health and Care Partnership, informed colleagues of his decision to step down from his role during 2026. After more than 35 years in health and care leadership, including over a decade leading the West Yorkshire partnership, Rob indicated that this decision reflects the organisation's transition into a new operating model and his intention to take a break from NHS leadership. Jonathan Webb, ICB Director of Finance, has been announced as interim CEO until a permanent appointment of CEO is made.

Following the departure of Cathy Elliott, Professor Nadira Mirza has been serving as Acting Chair. Interviews for the substantive ICB Chair have now been completed and Mark Chamberlain has been announced as the new incoming Chair commencing 1st April 2026. The ICB will also shortly begin recruitment for three Non-Executive Member roles, as a number of current terms come to an end. This is to ensure continuity, with new appointments expected to commence from 1 April 2026.

ICB organisational change update

The first cohort of colleagues leaving under the voluntary redundancy (VR) scheme will begin to exit the organisation shortly. The final leaving date for staff approved in round one of the schemes is 30 April 2026, with most departures expected to take place by the end of March 2026. More than 250 applications were approved in the first round of the scheme.

A formal consultation with staff commenced on 14 January 2026. This consultation covers the proposed organisational structures, including job descriptions, the appointments to post process, the implications for office bases, and changes to first and second on-call arrangements. The consultation period will run for 45 days and conclude on Friday 27 February 2026.

Bradford District & Craven Partnership

Partners across Bradford District and Craven have agreed to form a formal **Place Provider Partnership**, marking a significant step forward in strengthening how organisations work together to deliver joined-up care. This will be known as the Act as One Committee. Chief executives and sector leaders are now actively working together to design the partnership, with a shared ambition to improve outcomes for local people, tackle inequalities, and make better use of collective resources. This work builds on existing collaboration but moves it into a more formal, accountable arrangement. Good progress has been made in shaping how the partnership will operate in practice. Six core workstreams are under way, covering leadership, governance, finance, resourcing, clinical leadership, and delivery capacity, with the aim of establishing a shadow provider committee by April 2026. This shadow year will allow partners to test decision-making arrangements, strengthen relationships, and prepare for formal operation from April 2027, while continuing to work closely with the ICB during the transition.

Key next steps focus on moving from design to delivery. This includes agreeing which services and budgets will transfer into the partnership in shadow form during 2026 ahead of formal delegation to the Committee in April 2027, finalising governance arrangements, completing a readiness self-assessment, and setting out clear decision-making routes. This work is essential to ensure the partnership is ready to

take on greater responsibility as the ICB's role evolves, and to support the delivery of neighbourhood health and other shared priorities in a more coordinated and sustainable way.

Integrated Neighbourhood Health

Work is progressing to put the right structures in place to support integrated neighbourhood health across Bradford District and Craven. Most neighbourhood teams now have agreed boundaries (86%), with the remaining areas on track to be confirmed by February, and teams in the **National Neighbourhood Health Implementation Programme (NNHIP)** areas are already delivering practical support for defined population groups. While some activity has been slowed by ICB capacity pressures, partners are actively exploring how additional support can be provided, and engagement remains strong, with well-attended workshops, positive feedback from across health and care, growing national interest in the work, and new joint arrangements in place to support future neighbourhood estates development. **Minal Bakhai, NHS England Director for Primary Care and Community Transformation and the NNHIP, is visiting Bradford in March 2026 to see how our NNHIP work is progressing.**

Integrated Acute (ABCAS)

Good progress is being made across the programme, with project prioritisation completed for 11 specialties and detailed plans now being developed for the first phase. Additional capacity has been secured through KPMG to maintain momentum and align delivery with national timescales, and a quality and equality impact assessment has been drafted and is due for sign-off later this month. Alongside this, agreement has been reached on next steps for collaborative working in stroke, midwifery and radiology/MSK, and demand and capacity modelling is under way in ENT, max fax and ophthalmology to improve use of theatres and outpatient clinics.

Lynfield Mount redevelopment

Plans to redevelop Lynfield Mount Hospital have been approved, enabling significant investment to modernise mental health inpatient facilities in Bradford. The redevelopment will improve the quality, safety and dignity of care for patients, including better therapeutic spaces and upgraded wards, while supporting staff to deliver care more effectively. This marks an important step in strengthening local mental health services and responding to long-standing estate and capacity challenges. [Lynfield Mount Hospital given green light for redevelopment - Bradford District Care NHS Foundation Trust](#)

Local Authority Children's Services (ILACS) inspection

The Ofsted Inspection of Local Authority Children's Services or ILACS took place in the Bradford district from 12 January 2026. The focus is on the effectiveness of local authority services, leadership and arrangements. Colleagues from across health services supported the process. Information about ILACS: [Inspecting local authority children's services - GOV.UK](#) A joint CQC/Ofsted reinspection of SEND services is anticipated for Bradford District soon.

4. Partners

West Yorkshire Association of Acute Trusts (WYAAT) Programme Executive Meeting, 10 February 2026 and 3 March 2026

Unfortunately, I was unable to attend the WYAAT Programme Executive meeting on 10 February, but Saj Azeb deputised on my behalf. The meeting included an ICB update and a focused discussion around planning including individual Trust updates and mid-year reviews. Attendees also received updates on Non Surgical Oncology (NSO), FIPP and on the WYAAT organisational change. There was also a discussion on scaling up of people services and the usual collaborative report was received.

At the meeting on 3 March, we had an update from the ICB and on research, innovation and improvement. We also reviewed the Health Innovation Network. We had a detailed discussion on planning and on the WYAAT organisational change. We talked about Right Care, Right Person and received the usual collaborative report.

WYAAT Committee in Common, 3 February 2026

I was unable to attend the WYAAT CiC on 3 February due to annual leave, but Saj Azeb joined on my behalf. The Committee had feedback from individual organisations to set operational context before a strategic context discussion led by each place provider collaborative. The committee discussed any risks or issues for escalation before receiving a bundle of documents relating to strategy and case for change delivery, including programme risks and escalations, and the Clinical Services Board terms of reference. The meeting was held at Calderdale and Huddersfield NHS Foundation Trust.

West Yorkshire Partnership Board Meeting, 3 February 2026

The Partnership Board on 3 February was attended by Saj Azeb and included an update from the Partnership CEO lead and a section dedicated to patient and public voice. The Board also discussed the ambition to strengthen the local economy by focusing on the NHS England Health and Growth Accelerator and WorkWell.

5. National Reports**NHS Oversight Framework – NHS Trust Performance League Tables Process and Results**

On 18 March 2026, NHSE published the Quarter 3 2025/26 segmentation results. The trust is ranked 58th out of 134 acute trusts. The league table can be found via the link below -

[NHS England » Acute trust league table – Q3 2025/26](#)

NHS England (NHSE) Additional actions to virtually eliminate corridor care

On 4 March 2026, NHSE published a letter from Sarah-Jane Marsh CBE, National Priority Programme Director, Urgent and Emergency Care, NHS England. The letter outlines the work undertaken with the Corridor Care Coalition which represents patients, staff and public on the issue. In response, NHSE have identified further national actions in addition to the existing work led by the Getting It Right First Time (GIRFT) programme. On 26 February, CEOs, Chairs, chief operating officers, medical directors and chief nurses along with directors of communications from 30 trusts assessed as facing the biggest challenges on corridor care met to discuss and develop additional actions for trusts to support the eradication of corridor care which are more amenable to local ownership rather than national direction.

The publication can be accessed here [NHS England » Additional actions to virtually eliminate corridor care](#)

This publication follows the national report included in my January report to board, which outlined the principles for providing patient care in corridors. [NHS England » Principles for providing patient care in corridors](#)

UK Covid-19 Inquiry – Module 3 report

The Inquiry published its third report and recommendations following its investigation into 'the impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom' on Thursday 19 March 2026. It examines the governmental and societal response to Covid-19 as well as dissecting the impact that the pandemic had on healthcare systems, patients and healthcare workers.

[Module 3 full report](#)

[Module 3 'In-brief' summary](#)

The Trust's former Chief Medical Officer submitted a witness statement as part of the Inquiry, and it is referenced within the full report on page 58, paragraph 2.35 relating to visiting restrictions.

Osbourne, Sheridan
30/03/2026 10:08:30

Meeting Title	Board of Directors		
Date	31 st March 2026	Agenda item	B.3.26.8a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality Committee

Date of meeting: 19th February 2026

Key escalation and discussion points from the meeting

Alert:

- **Risk 2759 (Histopathology Staffing):** The service is currently operating with a 25% reduction in the consultant workforce due to vacancies, which is negatively impacting cancer turnaround times. The Committee agreed this raises important issues regarding workforce planning and has escalated it to the People Academy for further review.
- **Internal Audit – Falls (Limited Assurance):** An internal audit regarding Falls resulted in a 'Limited Assurance' opinion. The Committee was advised that historical failings in documentation and data availability are being addressed through the embedding of the Quality Committee Dashboard across wards, and the planned recruitment of a Falls Improvement Lead.

Advise:

- **ExCEL Programme Reprioritisation:** Following the recent CQC inspection, the programme is being reprioritised to focus on A&E decompression and integration with neighbourhood networks. Focused work on staff and patient experience is scheduled to commence in April 2026.
- **Maternity Homebirth Oversight:** In response to a national Prevention of Future Deaths report, the Trust is reviewing its homebirth service provision. The existing Maternity dashboard will be enhanced to include data on women transferred from home to hospital care.
- **Data Triangulation:** There is an ongoing requirement across all Committees to better triangulate data (e.g., mapping patient experience against sickness and staffing levels). This remains a manual exercise, and work with Business Intelligence is required to create a more effective dashboard of key indicators.
- **Clinical Coding:** Strategic work continues to address depth of coding issues which impact mortality (SHMI) metrics. A strategic piece of work is ongoing to improve recording in the EPR system.
- **Renal Case Reviews:** Three case reviews requested by HM Coroner following a cluster of issues on a ward in 2024 are being re-drafted as individual reports. A summary of the learning will be presented to the Committee in March.

Meeting Title	Board of Directors		
Date	31 st March 2026	Agenda item	B.3.26.8a

Assure:

- **National Maternity Benchmarking:** BTHFT has been highlighted nationally for having the lowest rates of post-partum haemorrhage (PPH) and the lowest rate of pre-term births for Black, Asian, and minority ethnic women and those from deprived areas, demonstrating a decade of progress in addressing health inequalities.
- **Mortality and Performance Trends:** The crude mortality rate continues to fall and remains below the national average. The Trust’s strategic "Quality" progress dial indicates an overall slight improvement over the last six-month period.
- **Medical Physics Achievement:** The Trust has successfully become a higher specialist training centre for doctorate-level scientists in Medical Physics, significantly reducing related workforce risks.
- **Infection Prevention and Control (IPC):** An internal audit of IPC Blood Cultures resulted in a ‘Significant Assurance’ opinion. Overall IPC benchmarking data continues to compare favourably with national peers.
- **Quality Account 2025/26:** Production is on schedule, with five meaningful improvement priorities identified for the coming year, including Learning Disability/Autism and Workforce Planning.

Report completed by:

Tim Swift

Committee Chair and Non-Executive Director

22nd March 2026

Osbourne, Sheridan
30/03/2026 10:08:30

Meeting Title	Board of Directors		
Date	31 st March 2026	Agenda item	Bo.3.26.8a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality Committee

Date of meeting: 26th March 2026

Key escalation and discussion points from the meeting
<p>Alert:</p> <ul style="list-style-type: none"> • Children’s ward escalation: The committee was advised of a red-rated assurance visit to Ward 30-32. Staff pressure, high capacity and patient acuity had contributed to concerns. A number of actions are in place, including weekly support meetings and daily supportive visits from external staff. There is also an NMC inquiry regarding student placements which is being managed and responded to with care and consideration.
<p>Advise:</p> <ul style="list-style-type: none"> • The committee was advised of two new high-level risks relating to maternity services. These concern personalised care plans and maternal antibody testing. The former is linked to the lack of a digital solution after two unsuccessful procurements, whilst the latter is being addressed through system and process improvements. • The committee received a report on the thematic cluster of three cardiac arrest incidents on Ward 15. The incidents were linked to concerns about unexplained low blood sugars. These have been reported previously but further reports had been triggered by the coroner. Learning focused on earlier recognition of dying patients and improving communication with families.
<p>Assure:</p> <ul style="list-style-type: none"> • Maternity and Risk Progress: The committee was fully assured relating to the maternity and neonatal services activity for October 2025. Compliance with the Saving Babies Lives Care Bundle Version 3 remains at 94%. • The committee received a report on the strategic shift aimed to deliver improved first-time structured coding across ED, outpatients and inpatient activity. The report included information on the significant financial implications for the Trust from inaccurate coding. Committee was assured by the work underway and will receive further reports. • Research and innovation update: The committee received a comprehensive report on the Trust’s research programme, the continuing national leadership in recruitment to trials, the strength of Connected Bradford, new national collaborations, and multiple significant grants awarded. Discussions throughout the meeting emphasised how research is used to underpin and strengthen the quality of our services. • Quality Oversight and Assurance Profile and Patient Safety Incident Investigation Report: The structure and presentation of this report has been improved to give the committee greater clarity and insight. Views from other Board members on the revised report would be welcomed.

Report completed by:

Tim Swift

Committee Chair and Non-Executive Director

29th March 2026

Board of Directors				
Meeting Date:	31 March 2026		Agenda Reference:	Bo.3.26.8b
Report Title:	Improvement Strategy (Annual Progress Report)			
Presented by:	Chair of the Quality Committee			
Executive Lead:	Mark Hindmarsh, Director of Strategy and Partnership			
Author:	Liz Tomlin, Head of Improvement			
Report Summary				
Purpose of the paper:	Decision <input type="checkbox"/> (approve/recommend/ support/ratify)	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> (review/discuss/ comment)	Information <input checked="" type="checkbox"/>
Summary of Key Issues/Highlights:	<p>This paper reports on the progress on implementing the Trust's Improvement Strategy (2023-2028). It includes a summary of work to date and considers the short-term plan proposed in July 2025 paper. The Board is asked to take note of the progress and plan for next steps.</p> <p>There has been good progress since July 2025 to provide a clear framework for improvement for the organisation, with measures to indicate the number of people who have attended training, network and celebration events.</p> <p>From January to December 2025, the Improvement Team have provided improvement training to over 500 members of clinical and non-clinical and corporate staff groups. Since July 2025 we have renewed the Improvement Network and there are now over 500 members across the Trust. Members receive monthly updates on opportunities for training - internal and external, peer learning on improvement work, intranet links to key tools and resources.</p> <p>The next step for Q4 2025/26 are:</p> <ul style="list-style-type: none"> To continue to deliver our in-house training programme and seek external offers via NHS IMPACT free at the point of access. <ul style="list-style-type: none"> To continue building a climate for improvement within services and teams by enabling staff to lead on meaningful improvement work via the peer network for improvement <ul style="list-style-type: none"> To provide a named improvement specialist from the Improvement Team for each CSU to foster closer working relationships and support improvement activity <ul style="list-style-type: none"> To measure improvement training, activity and impact by capturing details centrally about small scale improvement projects. This will be shared with wards, teams and CSUs so that there is a broader understanding of what is going on across the organisation. <p>An end of year annual report (2025/26) for the Improvement Strategy will be presented to Quality Committee in May 2026 to provide assurance against on-going progress.</p>			
Recommendation/s: (including any decision/approval required)	<p><i>The Board is asked to:</i></p> <ol style="list-style-type: none"> Note the progress against the Improvement strategy to date. 			
Link to Strategic Objective:	Improvement - To be a continually learning organisation and recognised as leaders in research, education and innovation			

Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	Not associated with any risks.
Legal/Regulatory:	N/A
Quality & Patient Safety:	The Improvement Strategy provides a framework to ensure our quality management system is linked to quality control, planning, assurance and improvement.
Equality, Diversity and Inclusion and Health Equity:	Ensuring all staff have an equitable access to training and support for improvement work.
Resources:	No additional resources required at this time.
Environmental sustainability:	No direct impact on environmental sustainability.
Assurance Route	
Meeting/s where content has been discussed previously:	ETM 22 January 2026 Quality Committee 19 Feb 2026

Report content
<p>1. Purpose</p> <p>This paper reports on the progress on implementing the Trust’s Improvement Strategy (2023-2028). It includes a summary of work to date and considers the short-term plan proposed in July 2025 paper. The Board is asked to take note of the progress and plan for next steps.</p> <p>2. Background/context</p> <p>The Improvement Strategy (2023-2028) provides a framework to develop a culture of continuous improvement to support meeting the Trusts’ strategic objectives. There are five components that underpin NHS IMPACT’s systematic approach which have been incorporated into the Trust’s Improvement Strategy (2023-2028) key objectives:</p> <ol style="list-style-type: none"> 1. Building a shared purpose and vision 2. Investing in people and culture 3. Developing leadership behaviours 4. Building improvement capability and capacity 5. Embedding improvement into management systems and processes <p>The strategy sets out our improvement method, training plan and resources required to build improvement capability and capacity across the organisation.</p> <p>From 1 April 2025, the Quality Improvement Team and Transformation Team were joined together to create a centralised single Improvement Team within the Strategy and Transformation corporate service. Prior to this move, quality improvement work and transformational programmes had been managed separately which made oversight of activity complex and complicated. The new structure provides an opportunity to align our approach and thinking about <i>how</i> we improve. This is to ensure that we all use a common methodology and a standardised set of tools and techniques to achieve and sustain successful changes.</p> <p>The short-term plan outlined in a previous update to the Board identified the following steps: <u>Short term plan – July to September 2025</u></p>

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- a. **Complete a plan for delivering each objective, with engagement from key stakeholders.**
- b. Develop a measurement plan to demonstrate tangible progress and outcomes from improvement efforts.
- c. **Launch of Bradford's 'Way of Improvement' with refreshed training offer and coaching programme**
- d. **Develop our local QI community of practice network to support peer learning and sharing best practice.**
- e. **Design our feedback recognition mechanisms and celebration events for all our stakeholders.**

The following update will focus on items a, c, d, and e above and with plans for item b detailed in next steps section.

3. Assessment

a) **Complete the detailed plan for delivering each objective, with engagement from key stakeholders**

A more detailed plan for each of the five objective is set out in Appendix 1. This has been informed by NHS IMPACT's components underpinning a systematic approach to improvement and how this is demonstrated in practice. We will use this plan to assess progress at the end of the reporting year (2025/26).

However, we have conducted a high-level self-assessment of current progress using key activities identified by NHS IMPACT, summarised in Appendix 2. We have made progress to provide a clear improvement methodology with a standard set of tools and coaching support. The next steps are to:

- Determine how success will be measured at an early stage, use appropriate tools and frameworks, and include feedback from people working at the point of care and people with lived experience.
- Demonstrate the impact of co-producing quality improvements with people who use services as an integral part of daily work.
- Set an expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplace.

We are working towards a more robust and systematic approach to improvement across the Trust. This also entails building new links between corporate teams such as Quality Governance and Business Intelligence to ensure work is joined up to address pressures being faced by teams and the Trust to meet regulatory, contractual and commissioning requirements.

c) **Launch of Bradford's 'Way of Improvement' with refreshed training offer and coaching programme**

Creating a firm foundation of improvement capability has been the main focus of work for the improvement team since August 2025. The improvement team are also supporting priority initiatives identified by the organisation for 2025/26. This includes, the EXCEL programme, Martha's Rule, Digital Strategy and Outpatients Transformation Programme.

Launch of Bradford's 'Way of Improvement'

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As set out in our Improvement Strategy we are building a shared purpose and vision for improvement. Enabling our workforce to use our improvement methodology and associated tools is vital to creating a continual learning environment to enhance the quality of care. From July 2025, we refreshed and standardised our in-house improvement training offer and re-built our local network of improvers. This activity is essential to develop leadership behaviours to support improvement activity and a commitment to investing in our people and culture at BTHFT. This activity is summarised below:

- In-house improvement training

We use the IHI Model of Improvement (Mfi) as our approach to improvement which is complemented by a 7-week service improvement training (SIT) programme. We also run a shorter 2 hour SIT course ('Good-to-Go') which provides an easy introduction to the Mfi and key tools to get started with a local project. We are also upskilling our colleagues in the Education Team who are delivering the 2-hour SIT course as part of the preceptorship programme for newly qualified staff and the Bronze, Silver and Gold programme for clinical colleagues.

From January to December 2025, the Improvement Team have collectively provided formal improvement training to over 500 members of clinical and non-clinical and corporate staff groups (See Table 1).

Table 1 Improvement training from January to December 2025

In-house Improvement Training Jan to Dec 2025	Number of staff
SIT 7-week programme	n=119
SIT 'Good-to-Go' 2-hour course	n=118
QI Foundation*	n=273
External Training	
NHS Impact	n=16
Total	n=526

**The QI Foundation was delivered by the Quality Improvement team up until July 2025 and was similar content to the 2 hour Good-to-Go training.*

- External improvement training
 - NHS IMPACT Operational Improvement Training Programme

The 'Operational Improvement Training Programme' developed by NHS IMPACT¹ aims to empower clinical and operational staff (Bands 6-8a) to lead on meaningful improvement activity. This programme is also designed to support the development of future leaders to help deliver change at scale as part of the 10 Year Health Plan². The programme consists of a one day face-to-face 'core' session led by external facilitators, followed by a ½ day pathway specific virtual session and on-going peer-learning groups. The programme is aligned to our way of improvement and seen to compliment in-house training programme.

To date, we have hosted one full day core session at the BRI on 28/11/15. The course content focussed on team building, tools to understand problems, how to make improvements and sustaining gains and aligns with our in-house improvement training content. There were 17

¹ <https://www.england.nhs.uk/nhsimpact/nhs-impact-operational-improvement-training-programme/>

² <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-executive-summary>

people who attended with a range of staff from different CSU's, aligning with the pathways identified by NHS IMPACT that included, Urgent Care, Cancer Services, Outpatients, Theatres & Perioperative Care, Diagnostics and Elective Care.

Bradford District Care Trust (BDCT) will be hosting a further four core one day sessions in Q4 2025/26. We have directed staff to attend the next sessions at BDCT which supports more effective use of system level resources and help to foster relationships with our partner organisations, thorough sharing best practice and networking opportunities.

Formal feedback from NHS IMPACT in November 2025 stated that of the 267 operational managers and clinicians that have attended the training across the region to date, 93% of the respondents said they 'left with a clear understanding of how to apply what they learned' and 89% agreed their 'skills and knowledge improved' because of the training. Site level feedback is currently not available, but informal feedback from staff also suggested that people had benefitted from sharing their experiences and knowledge from different services.

- Northeast Yorkshire LIN (NEY LIN) - Improvement Sprint, January 2026

Following a successful application to our regional NHSE Learning and Improvement Network (LIN) we have joined an improvement sprint focussing on the 18-week RTT performance metric. There is also up to £10K of funding to support improvement activities for the team.

Children's Services have taken up this opportunity and will be specifically looking at the Autism referral pathway. This is an area of concern for the service with a significant waiting list for referrals which is impacting subsequent care, treatment and support for children, young people and their families. A small team clinically led by Dr Thopte, are undertaking this rapid improvement sprint. This includes a face-to-face launch event (in York) with other regional organisations on 07/01/2026, three one-hour virtual 'learning sets' in February and March and a final celebration event on the 27/03/26. The output and outcomes of this work will be reported upon in the annual report in May 2026.

d) Develop our local QI community of practice network to support peer learning and sharing best practice

Since July 2025 we have renewed the Improvement Network and there are now over 500 members across the Trust. Members receive monthly updates on opportunities for training - internal and external, peer learning on improvement work, intranet links to key tools and resources.

We have held two virtual Network meetings with over 100 people attending. Teams have shared their learning from small scale improvement projects, and we have provided updates on our priority initiatives.

The Network has generated requests for support, bespoke training sessions and allowed the team to provide improvement coaching to enable staff to lead and run independent projects. We are now capturing this activity to measure and understand the impact of the training.

e) Design our feedback recognition mechanisms and celebration events for all our stakeholders

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Improvement Showcase Event

The Improvement Team held a showcase event on the 3 December 2025, with over 100 members of staff and people from partner organisations attending the day.

Our guest keynote speaker was John Ashcroft (Director of NHS IMPACT and Pathways, NHS England) who provided a national overview about improvement in the NHS and reminded the audience that improvement is most often most valuable when being driven and conducted by people who know the work and service (staff and patients).

We heard from a wide range of services and staff about improvement activity being undertaken and demonstrating how we use the model for improvement as a framework to support change. There were 22 presentations over the day with 11 as part of the 'lightning round' highlighting small scale improvement projects.

Formal and informal feedback of the day to the Improvement team was positive with people learning about the breadth and depth of improvement activity taking place (See comments below):

Feedback from 3 Dec Showcase Event

That there is lots of improvement going on across the trust - small scale and larger scale work.

Was not aware of all the improvement work that was being done within the Trust

How much amazing work our trust has done, and is planning to do, remarkable considering the stresses across the estate

Never give up.

Keep it simple

Improved patient outcomes

Lots of great improvement activity going on across the organisation, sometimes we do not see what the good work others are doing. It demonstrates lots of creativity and innovative thoughts being put into practice, utilising the SIT.

As part of the event, we also shared our approach to rewards and recognition for improvement efforts which include, certificates for undertaking training, completion of projects, visits from the Director of Strategy and Transformation and the senior leadership team to wards and departments and events to share learning with each other and celebrate successes. This is an opportunity to share work with the Executive Team, raising the profile and importance of improvement work that may be unseen and recognition of work being undertaken by individuals and teams.

The Improvement team will also run a midyear mini showcase event in June 2026 and a repeat full event in December 2026. It is anticipated that we will be able to demonstrate increased maturity of our methodology and more rigorous application of improvement tools and techniques, linked clearly to the Trust's strategic objectives.

4. Next steps

b) Develop a measurement plan to demonstrate tangible progress and outcomes from improvement efforts

There has been timely progress since July 2025 to provide a clear framework for improvement for the organisation, with measures to indicate the number of people who have attended training,

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network and celebration events. This activity is currently reported via the Executive Team Meeting (ETM).

Therefore, the next step for Q4 2025/26 are:

- To continue to deliver our in-house training programme and seek external offers via NHS IMPACT which are cost neutral/free at the point of access
 - To continue building a climate for improvement within services and teams by enabling staff to lead on meaningful improvement work, as well as sharing work via the peer network for improvement
 - To provide a named improvement specialist from the Improvement team for each CSU to foster closer working relationships to help understand key issues and support improvement activity.
 - To measure improvement training, activity and impact by capturing details centrally about small scale improvement projects. This is to understand what worked and why and monitoring to ensure sustainability. This will be shared widely so that everyone has a broader understanding of what is going on across the organisation. This will require better communication and connection with our CSUs and corporate services to ensure useful information reaches 'floor to board' and with our patients, carers, families and local population.

An end of year annual report (2025/26) for the Improvement Strategy will be presented to Quality Committee in May 2026 to provide assurance against on-going progress.

Appendix 1 Detailed plan for Improvement Strategy Objectives

1. Building a Shared Purpose and Vision

- Co-create an organisational improvement vision with staff, patients, and partners to ensure shared ownership and alignment.
- Communicate the vision consistently across all levels through onboarding, team meetings, leadership walkabouts, and digital channels.
- Align the vision with national priorities identified by the National Improvement Board to ensure consistency with NHS-wide goals.
- Translate the vision into strategic objectives and define measurable outcomes that teams can work toward.
- Use case studies and stories from NHS organisations to demonstrate what the vision looks like in practice.
- Ensure continuous dialogue so staff can question, refine, and reinforce purpose and vision as improvement practices evolve.

2. Investing in People and Culture

- Develop a culture of psychological safety, enabling staff to raise issues, test ideas, and learn from failure.
- Prioritise staff engagement, ensuring people at all levels are involved in improvement activity.
- Offer continuous development opportunities, such as improvement workshops, masterclasses, and NHS IMPACT lunch-and-learn events.
- Invest long-term in improvement infrastructure, recognising that cultural maturity requires several years of support.

- Build mechanisms for organisational learning, including learning events, cross-team knowledge sharing, and capturing lessons from pilots.
- Promote diversity and inclusion to ensure all voices shape improvement priorities and solutions.

3. Developing Leadership Behaviours

- Build leadership capability at all levels.
- Model improvement behaviours, such as curiosity, humility, coaching, and encouraging evidence-based testing.
- Protect time for improvement, mirroring examples such as Leeds leaders dedicating time to speak with staff about improvement methods.
- Champion a learning mindset, recognising complexity rather than framing outcomes as simple success or failure.
- Promote visible leadership through walkarounds, active participation in QI teams, and celebrating improvement wins.
- Strengthen “strategic ambidexterity,” balancing short-term operational pressures with long-term improvement goals.

4. Building Improvement Capability and Capacity

- Provide structured improvement training for staff at all levels, from beginners to advanced practitioners.
- Utilise NHS IMPACT learning resources, courses, tools, and the NHS IMPACT Improvement Guide for programme assessment.
- Develop internal improvement coaches to sustain local capability and provide on-the-ground support.
- Create multidisciplinary improvement teams with protected time to run testing cycles and scale successful changes.
- Embed improvement skill assessment into workforce planning and professional development processes.
- Ensure capability building is linked to organisational priorities, not generic or theoretical training.

5. Embedding Improvement into Management Systems and Processes

- Integrate improvement into performance management, governance, and strategic planning systems.
- Use standard management routines such as huddles, visual management boards, and regular improvement reviews.
- Adopt the NHS IMPACT Improvement Guide to self-assess programme maturity and ensure best-practice implementation.
- Develop quality management systems that align leadership, culture, capability, and strategic priorities.
- Use data transparently, enabling teams to track progress, identify variation, and make timely improvements.
- Ensure improvement governance connects frontline tests to organisational decision-making.

Appendix 2 Improvement Capability Progress -Self-assessment January 2026

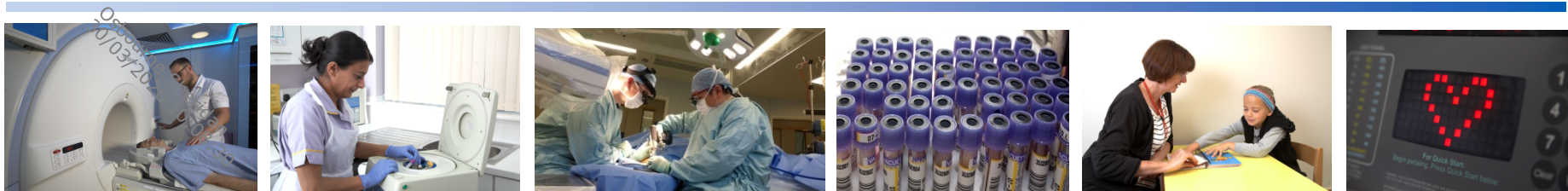
Building Improvement Capability	Self-Assessment
Identify or create an improvement methodology to use across your entire organisation, ensuring a local and systemic way of practising improvement	✓ Achieved 2026/27 - Ensure embedded into routine practice by teams and services
Give all people access to improvement training and support, so that everyone can run improvement projects and continuously improve their daily work.	✓ Achieved

	2026/27 - Ensure equality of access by monitoring staff groups and services undertaking training opportunities
Determine how success will be measured at an early stage, use appropriate tools and frameworks, and include feedback from people working at the point of care and people with lived experience.	2026/27 - Working towards
Demonstrate the impact of co-producing quality improvements with people who use services as an integral part of daily work.	2026/27 - Working towards
Set an expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplace.	2026/27 - Working towards
Create and embed a training strategy to increase improvement capability.	✓ Achieved 2026/27 - Measurement to understand actual impact on improving quality and productivity of care delivery
Leaders attend teams daily huddle boards and work to unblock issues which teams are facing.	Daily Trust wide huddle in place Daily Executive Team Huddle in place 2026/27 To understand service/ward/department level daily huddles taking place to tackle immediate issues. Roll out of Ward Quality Boards to drive Quality Assurance, learning and improvement activities that are aligned to Quality, People and Performance agendas

Osbourne, Sheridan
30/03/2026 10:08:30

Research Activity in the Trust

Michael McCooe
Deputy Director of Research



Report Highlights

- **Top recruiting trust in the country!**
- CQC visit
- Alan Milburn visit – Connected Bradford
- Huge NIHR Infrastructure at BTHFT
- IRL Trial (world first) – social media and teenage mental health
- AIM – adolescent interventions for mental health
- NIHR Yorkshire and Humber Applied Research Collaboration
- Secure Data Environment Research estate expansion
- Yorkshire Quality and Safety Research team performing a national evaluation of Martha's Rule

Osbourne, Sheridan
30/03/2026 10:08:30

Funding

- £1.2 million Wellcome funding for IRL
- £8 million from UKRI for Healthy Urban Places
- £500,000 EPSRC AI solutions to Urban Health (HUP)
- £1.3 million NIHR clinical research facilities funding
- NIHR funding of £2.2 million for research on Safe Use of Medicines
- £12 million funding for the NIHR YHARC

Osbourne, Sheridan
30/03/2026 10:08:30

Our Trust & People

- BiB – 60,000 Bradford residents
- BaBi – 60,000 mothers and babies across UK
- Age of Wonder - 30,000 Bradford teenagers
- BiBBS achieve – addressing inequalities of 5500 children
- JUMP – Join Us: Move Play – world leading results
- Pregnancy and Early Years – MuM-PrediCT, MIREDA, BaBi, MEaCC, PSC
- Electronic Frailty Index
- Special Educational Needs
- Working together for our citizens and our wider teams

Osbourne, Sheridan
30/03/2026 10:08:30

Thank you

Osbourne, Sheridan
30/03/2026 10:08:30

Board of Directors			
Meeting Date:	31.03.26	Agenda Reference:	Bo.3.26.9
Report Title:	MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE, JANUARY/FEBRUARY 2026		
Presented by:	Sara Hollins, Director of Midwifery		
Executive Lead:	Professor Karen Dawber, Chief Nurse		
Author:	Sara Hollins, Director of Midwifery		
Report Summary			
Purpose of the paper:	Decision <input type="checkbox"/> (approve/recommend/ support/ratify)	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> (review/discuss/ comment) Information <input checked="" type="checkbox"/>
Summary of Key Issues/Highlights:	<p>The Director of Midwifery and the Chair of Quality Committee (QC) provide the Board with assurance that a monthly review of maternity and neonatal quality and safety activity relating to January and February 2026, was presented and key elements discussed including:</p> <ul style="list-style-type: none"> • The number of harms occurring in January and February, 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 two completed MNSI reports and recommendations in January, and none in February. • There were no Maternity Outcomes Signal System (MOSS) triggers received in January or February. <p>This paper also includes:</p> <ul style="list-style-type: none"> • An update on the Amos Investigation and interim report published in February. • An update on the National Prevention of Future Deaths report in relation to Home Birth services. 		
Recommendation/s: (including any decision/approval required)	<p>The Board is asked to:</p> <ol style="list-style-type: none"> 1. Confirm that they are assured that the Quality Committee has reviewed and discussed the contents of the January and February 2026 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 Admincontrol. 2. Note that in February, the Quality Committee received and acknowledged the service response to the Prevention of Future Deaths report regarding Home Birth services. 3. Note that in March, the Quality Committee received the Saving Babies Lives Care Bundle quarterly Local Maternity and Neonatal System (LMNS) peer review report, and acknowledged sustained compliance of 94%. 		
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness		

Osbourne, Sheridan
30/03/2026 16:16:30

Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	N/A
Legal/Regulatory:	<p>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.</p> <p>The requirements to strengthen and optimise Board oversight for maternity and neonatal safety includes:</p> <ul style="list-style-type: none"> • 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:	Quality Committee – 19 February 2026 & 26 March 2026

Report content
<p>Purpose</p> <p>The monthly maternity and neonatal services report presented to the Quality Committee (QC) ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the QC, as a Committee of the Board with delegated authority has assurance of an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. A summary of incidents is provided to the QC, in addition to any completed Maternity and Neonatal Safety Investigations (MNSI) and internal Patient Safety Incident Investigation (PSII) reports.</p> <p>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.</p> <p>The monthly paper also serves as the main mechanism for the 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.</p>

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 the QC, including the approval of any reports required to demonstrate compliance with the annual Maternity Incentive Scheme (MIS).

Background/context

The January and February updates and associated appendices were discussed at the Quality Committee meetings held in February and March 2026 respectively.

The key elements of the papers discussed included:

- The number of harms occurring in January and February, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of MNSI and PSSI cases were discussed.
- There were two completed MNSI reports and learning/recommendations to share in February and none in March.
- In February, the QC was asked to note that the Perinatal Leadership Quad joined the January bi-monthly perinatal safety champion meeting, and that there were no safety escalations requiring support from the Board.
- In February and March, the QC reported and recorded that they were assured by the papers, presentation, and discussion. There was nothing identified requiring escalation to the Board.

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 and interim report:
 - All data requests were submitted to the investigation team and no further enquiries or requests for further information have been received to date.
 - The service promoted the link for staff to contribute to the investigation.
 - All requested interviews with the senior leadership team have taken place.
- Baroness Amos published an interim report in February. The report sets out the background and changing context in which maternity and neonatal care is provided. Six factors have been identified:
 - Capacity pressures
 - Culture and leadership
 - Racism and discrimination
 - Poor responses and lack of accountability when things go wrong
 - The quality of estates
 - Workforce
 - The investigation is still collecting evidence so further themes and issues may yet emerge. There are currently no firm conclusions or recommendations in the report. The final report is expected in June.

Following the publication of a Prevention of Future Deaths Report, regarding the deaths of a mother and baby following a home birth in Manchester, the service was asked by the National Chief Midwifery Officer to review its home birth service provision including:

- The operational running of the home birth service
 - Care planning and risk assessment
 - Governance and oversight

- In February, the QC received and acknowledged the service's position response and that the service considers the provision of homebirth meets the standard described. Further work is planned around the review of 'rest' arrangements prior to an on-call, and the inclusion of additional homebirth metrics to the existing maternity dashboard. The latter will provide additional oversight for the QC as a committee of the Board.
- Breastfeeding initiation rates and breastfeeding rates at 6-8 weeks (not included on the maternity dashboard) were raised as an area of concern at the February Quality Committee.
 - BTHFT Maternity services discharge women from maternity care between 10-28 days postnatal, where care is then handed over to Health Visiting colleagues in Primary care, which is where the 6-8-week data is held. Our plan is to collect and include 'method of feeding at discharge from maternity care', which will be a more accurate reflection of breastfeeding rates within the service.
- Tables were provided to the QC demonstrating the services' 'first feed of breastmilk' position at LMNS, regional, and other level 3 units, indicating that we are distinctly average, particularly in comparison to peers in the North East and Yorkshire region. The Specialist Midwife for Infant Feeding continues to lead the teams towards UNICEF baby accreditation, with an assessment date planned for November 2026.
- In March, the QC received the Saving Babies Lives Care Bundle Version 3, quarterly peer review report, required to demonstrate compliance with Safety Action 6 of the Maternity Incentive Scheme. The service has continued to follow Year 7 reporting standards until the Year 8 scheme is published. Peer review concluded that the Trust's overall compliance has been sustained at 94% for Q3 25-26, that the evidence was of high quality and demonstrated sustained improvement, and that there was evidence of shared and continuous learning.

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 Trust Board level oversight of perinatal clinical quality and safety.

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 Trust 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.

*Osbourne, Sheridan
30/03/2025 10:08:30*

Board of Directors				
Meeting Date:	31.3.26	Agenda Reference:	Bo.3.26.10	
Report Title:	Care Quality Commission (CQC) Well Led Reports			
Presented by:	Professor Karen Dawber, Chief Nurse			
Executive Lead:	Professor Karen Dawber, Chief Nurse			
Author:	Professor Karen Dawber, Chief Nurse			
Report Summary				
Purpose of the paper:	Decision <input type="checkbox"/> (approve/recommend/ support/ratify)	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> (review/discuss/ comment)	Information <input type="checkbox"/>
Summary of Key Issues/Highlights:	<ul style="list-style-type: none"> The CQC Well Led reports arrived into the Trust on Wednesday, 18 March 2026. The associated letter received from the CQC is attached at Appendix 1. The reports were published on the CQC's website on 27 March 2026 and are available at the links below: <ul style="list-style-type: none"> AP2750 (first assessment): 16-18 April 2024 <ul style="list-style-type: none"> Overview Report AP15671 (second assessment): 4, 5 and 6 November 2025 <ul style="list-style-type: none"> Overview Report 			
Recommendation/s: (including any decision/approval required)	<p>The Board is asked to:</p> <ul style="list-style-type: none"> Note the CQC Well Led report. Agree that a detailed action plan will be submitted to the Board in May 2026, following presentation at the Quality Committee in April 2026. 			
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:	N/A			
Legal/Regulatory:	CQC Statutory Requirement			
Quality & Patient Safety:	CQC Standards			
Equality, Diversity and Inclusion and Health Equity:	CQC Standards			
Resources:	N/A			
Environmental sustainability:	CQC Standards			
Assurance Route				
Meeting/s where content has been discussed previously:	N/A			

Professor Mel Pickup
Chief Executive
Bradford Teaching Hospitals NHS Foundation Trust
Trust Headquarters
Bradford Royal Infirmary
Bradford
BD9 6RJ

Via email mel.pickup@Bhft.nhs.uk
Karen.dawber@bthft.nhs.uk

Cc Reports at NHS England North East

18 March 2026

**Care Quality Commission
Health and Social Care Act 2008**

Trust name: Bradford Teaching Hospitals NHS Foundation Trust
Provider ID: RAE
Our reference: AP2750 (first assessment) and AP15671 (second assessment)

Dear Professor Pickup

Following our recent well led assessments at Bradford Teaching Hospitals NHS Trust we have enclosed our report of the findings from our March 2024 and November 2025 inspections. We have used our internal report template through this process. This template is not published but is attached to give you prior notice of our findings. This document will be used by our website team to populate the relevant sections of our website. The report's content will be published on our website shortly.

Please make this report readily available for people who use the service.

We have reviewed your comments relating to any factual inaccuracies in the draft report and enclose our response in the attached factual accuracy template.

Any changes made as a result of your comments relating to factual accuracy did not impact on the ratings contained within the second final report.

We will publish this report on our website.

Once published, you can see the report at any time by following these steps:

- Go to the CQC website www.cqc.org.uk .
- Select the appropriate tab for your type of service.
- Type in the name of your trust.
- Click on your trust and follow the links to find your report.

Now that you have received your rating following our recent inspection, you must display it by law to meet Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. If you provide activity that is not regulated by CQC, you should be clear about what service(s) the rating relates to. Find out what you have to display and where by reading information contained on our website using this link: [Regulation 20A: Requirement as to display of performance assessments - Care Quality Commission](#)

Challenging the ratings

A rating review involves checking whether or not CQC followed its process for making ratings decisions, as explained in the guidance published on our website. If you think that we have not followed the process you can request a review. You cannot ask for a review of ratings on the basis that you disagree with our judgements.

You must submit your request for review, using the online form, within 15 working days of the publication of your report(s). You must say in what way we have not followed the process, and which ratings you think have been affected.

Please use the following link to access the form:

[Requesting a review of one or more CQC ratings - Care Quality Commission](#)

Please note that a rating review does not involve a reconsideration of the evidence and ratings awarded, unless we find the process has not been followed.

You can only request a review of ratings once after each inspection. Please note that requests for reviews of ratings can lead to ratings going down as well as up, or they can remain the same.

If you have any questions about this letter, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Compliance@cqc.org.uk

Write to: CQC HSCA Compliance

Citygate

Gallowgate

Newcastle upon Tyne

NE1 4PA

If you do get in touch, please quote our reference number AP15671 and AP2750 to avoid delays in processing your request.

Yours sincerely

Yours sincerely,

A handwritten signature in black ink, appearing to read 'KR' followed by a stylized flourish.

Karen Knapton
Deputy Director of Operations
Network North

Attached

First final report and factual accuracy
response

Second final report

Osbourne-Sheridan
30/03/2025 10:08:30

Meeting Title	Board of Directors		
Date	31 March 2026	Agenda item	Bo.3.26.11a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: **People Academy**

Date of meeting: 11th February 2026

Key escalation and discussion points from the meeting

Alert:

Sickness absence within the Trust remains stubbornly high. An updated plan was presented to the Academy. Whilst there are several notable positive actions, such as the introduction of an online Occupational Health referral system, which has reduced assessment waiting times from 5 to 6 weeks to 3 to 4 days, there is more to be done.

The Academy welcomed the plan but also noted the importance of this issue for financial sustainability; the 5-year plan and also staff wellbeing and therefore also noted the need for a more comprehensive and joined up sickness reduction plan (looking at root cause, prevention, wellbeing as well as policy and tracking data) with measurable targets and timelines. This should align to Closing the Gap (CTG) plans and reporting and requires a multi-disciplinary team (MDT) approach across the Trust.

The Academy asked for an updated approach to be brought back to the April Academy meeting.

Advise:

- The **People Dashboard** requires a refresh as there is some outdated commentary and data that needs reviewing to enable adequate assurance to be given.
- Whilst our overall **BAME representation** should be applauded, the challenge remains to ensure representation at senior levels, and this will be the focus of monitoring moving forward.
- **Job Planning** (as indicated in other committees) is critical across all staff and remains below targets. The Academy will continue to monitor as part of the dashboard.
- **Education dashboard** - Did Not Attend (DNA) rates for face-to-face training remain high across all CSUs. It was noted that the education team could not manage this alone and needed the CSUs to recognise the importance of training and also the impact of DNA.
- It was noted, as part of the **Nursing and Midwifery Staffing Data Publication Report** that Band 2 vacancies remain challenging, with 180 healthcare assistant vacancies across the organisation, though assurance was given that overall, there has not been a detrimental impact on patient experience. This is an example of where bringing together different **data sets** across staff and patient data, would provide a greater level of evidence-based assurance to the Academy.

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30/03/2025 17:08:30

Meeting Title	Board of Directors		
Date	31 March 2026	Agenda item	Bo.3.26.11a

Assure:

- **Education dashboard** – the dashboard has been streamlined, and the revised format was well received, noting the addition of KPIs to track progress. Compliance with training remains good at 92% against a target of 85%, though there are some areas of lower compliance (such as Estates and Facilities) support is being offered to improve and will be monitored by the Academy.
- The Academy was assured by the **quarterly FTSU report**. There has been a marked increase in incidents, which are at their highest level (51 Freedom to Speak Up concerns in Q3, compared with the usual average of 27). This is reflective of a lot of effort across the organisation to raise awareness; promote successes and increase routes to report, including anonymous. The Academy will need to continue to monitor the rates and also ensure the team has support and capacity to respond in a timely and effective manner.
- The Academy was assured by a comprehensive **Gender Pay Gap** report supported by data-led evidence. It was noted that whilst there were many excellent supporting activities, including those focused on intersectionality, the pay gap had improved by just 0.1% on the prior year. The identified focus was on representation at more senior levels across the organisation, including at clinician level. The Academy supported the work of the team and asked for a mid-year update on progress. The report will be publicly available.
- The Academy received the **Violence Prevention and Reduction Standards progress update**. Against national measures there has been a clear improvement across the organisation, with red indicators reduced from 18 to 10, amber indicators reduced from 15 to 11, and green indicators increased from 10 to 22. The Academy understood that this reflects system-wide strengthening rather than isolated progress. The Academy also discussed how important this was – that everyone felt safe in the Trust – and agreed to continue to monitor closely.

Report completed by:

Justine Andrew
Academy Chair and Non-Executive Director

4th March 2026

Osbourne-Sheridan
30/03/2026 10:08:30

Meeting Title	Board of Directors		
Date	31 March 2026	Agenda item	Bo.3.26.11a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 11th March 2026

Key escalation and discussion points from the meeting
Alert:
<ul style="list-style-type: none"> • There were no red alert items to raise this month.
Advise:
<ul style="list-style-type: none"> • Again, we discussed dashboard quality. The dashboard contains good data but requires further development, including clearer targets, benchmarking, and stronger links to the five-year workforce plan. This will evolve over the next few months, but a starting point will be to add in targets (where they exist) to the dashboard so we can track progress. • Medical job planning: whilst compliance had improved to c.64%, it was acknowledged that the national target of 90% was unlikely to be achieved within the current year. Members were assured that NHS England support had been requested and external advice was being explored. • Quality Impact and Financial Recovery: the Academy received an overview of the use of Equality and Quality Impact Assessments (EQIAs) to mitigate potential risks arising from financial recovery measures. Members stressed the need for triangulation across workforce, sickness, vacancy, and quality data to identify emerging hotspots early but were broadly assured by the rigour of the processes in place. • Guardian of Safe Working Hours: The Guardian of Safe Working Hours report was presented. Key themes included: <ul style="list-style-type: none"> ○ An increase in exception reports, particularly in surgery and medicine at junior grades. ○ Recognition that workload intensity at the Trust was high compared to national benchmarks. ○ Assurance that additional administrative and operational support was being put in place to stabilise the reporting process. ○ Positive early outcomes from balanced rostering pilots were noted, including reduced sickness and improved work-life balance. <p>It was requested that future reports include clearer mitigations and actions, rather than descriptive data alone.</p> • Staff Survey 2025 Results: The Staff Survey was presented in depth. Key findings included: <ul style="list-style-type: none"> ○ A 43% response rate, slightly lower than the previous year. ○ The Trust scored above the national average across all nine People Promise themes and all 21 sub-themes, a significant achievement. ○ Strong improvements were seen in appraisals, flexible working, and work-life balance. <p>Areas of concern included:</p> <ul style="list-style-type: none"> ○ Physical violence reporting.

Meeting Title	Board of Directors		
Date	31 March 2026	Agenda item	Bo.3.26.11a

- Discrimination, particularly related to race, religion, and sex.
- A high proportion of staff reporting musculoskeletal issues linked to work.
- A five-year trend analysis highlighted risks around quiet disengagement, recognition, and learning momentum plateauing if not addressed.

*There are many positives that the Trust should welcome and build on in the survey. However, there are also some areas of concern that require more time to understand and more time for the Academy to consider. It was therefore agreed that a focused People Academy action plan, concentrating on three key areas of **colleague voice, wellbeing, and discrimination**, would be brought back in May, with dedicated agenda time.*

Assure:

- Following on from the last meeting we had identified a number of lower band (band 3) colleagues who managed people but had not had sufficient training to enable them to fulfil the breadth of the role requirements, and this was having a knock-on effect. It was confirmed that a **new leadership and management programme**, jointly developed by Operational and OD teams, would be rolled out and prioritised in high-risk areas such as Estates and Facilities. This was welcomed by the Academy.
- Given some of the wider issues coming to People Academy the revised **Civility and Respect / Resolution Policy** will be rolled out in Q1 of the next financial year and this update on timing was welcomed by the Academy.
- As with so many of the core issues discussed, successful **appraisals** underpin many of the Academy's other measures including progression, sickness, and retention. As part of the dashboard, we were assured and informed by a more detailed presentation and discussion on appraisals and dynamic conversations across the Trust. Appraisal compliance is at 81%, just below the 85% target – however the staff survey data suggests 87% of staff believed they had received an appraisal, indicating confusion between appraisals and dynamic conversations. The Academy welcomes the focus on this area and the further use of internal and external assurance (e.g. internal audit) to monitor progress.
- The Academy finished the meeting with a survey of effectiveness with some positive comments but also helpful feedback that will be considered in detail and brought back to members.

Report completed by:

Justine Andrew
Academy Chair and Non-Executive Director

23rd March 2026

Osbourne, Sheridan
30/03/2026 10:08:30

Board of Directors			
Meeting Date:	31 March 2026	Agenda Reference:	Bo.3.26.11b
Report Title:	Gender Pay Gap Review 2025/ 2026		
Presented by:	Kez Hayat, Head of Equality, Diversity & Inclusion		
Executive Lead:	Saj Azeb, Chief Operating Officer/ Deputy Chief Executive		
Author:	Ruth Haigh, Equality, Diversity & Inclusion Manager		
Report Summary			
Purpose of the paper:	Decision <input type="checkbox"/> (approve/recommend/ support/ ratify)	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> (review/discuss/ comment)
Information <input type="checkbox"/>			
Summary of Key Issues/Highlights:	<p>The purpose of this report is to:</p> <ul style="list-style-type: none"> To inform Board of Directors of the Trust's Statutory Gender Pay Gap report that will be published for 30th March 2026 deadline in line with our contractual and legal obligations. <p>It is a legal requirement for all employers with 250 or more employees to annually publish their gender pay data and report within one year of the 'snapshot date' (31 March).</p> <p>The gender pay gap analysis shows the differences in the average pay between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with and the individual calculations and any subsequent analysis may help to identify what those issues are.</p> <p>Progress is being made with our gender pay gap data since 2017. Despite 0.1% increase in our mean gender pay gap this year to 22.2%), over all it is decreasing and has reduced by 9.1% since we started reporting in March 2017. However, when it comes to pay; <u>although there are more women employed in the organisation, women continue to earn less than men.</u> Analysis of the data has revealed:</p> <ul style="list-style-type: none"> A 22.2% mean average gender pay gap (including a very slight increase this year of just 0.1%) <p>Whilst benchmarking data suggests that we are not outliers this does indicate an inequality between the pay for men and women and there is still work to do to address the issues in the following key areas:</p> <ul style="list-style-type: none"> Women continue to be proportionately under-represented at senior levels and over-represented at supervisory and middle management levels. Men continue to be significantly under-represented in nursing & midwifery roles <p>The report provides some further focus and areas for targeted action on gender equality at the Trust. By actively working towards reducing inequalities for our diverse staff ensures that BTHFT, as a Trust, is meeting the requirements of the Equality Act 2010 Public Sector Equality Duty (specific Duties and Public Authorities).</p>		

Osbourne-Sheridan
30/03/2026 10:08:30

Recommendation/s: (including any decision/approval required)	It is recommended that Board of Directors: <ol style="list-style-type: none"> 1. Note the contents of the report and the gender pay gap data submissions 2. Approve the data, as set out in section 3 3. Support the next steps to reduce the Trusts' gender pay gap (section 4) 4. Agree to receive annual updates on our gender pay gap and any progress made.
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:	Thrive
Implications	
Risk:	There is a risk that, if we are unable to achieve our ambitions on EDI, including tackling health inequalities due to ingrained attitudes that persist in society and across our health and care organisations, or if we are unable to recruit, retain and develop a workforce at all levels that is representative of the population we serve, then we may have low levels of staff engagement and morale, resulting in an adverse impact on patient safety and experience, staff experience and wellbeing, and a failure to attract diverse staff to work for our Trust. There is a requirement to ensure the Trust is compliant with a whole range of NHS equality frameworks, including the Equality Act 2010, and specifically the Public Sector Equality Duty. This paper sets out our continued progress to mitigate this risk and to meet our Public Sector Equality Duty, along with other contractual requirements.
Legal/Regulatory:	Our activity around Equality, Diversity & Inclusion (EDI) helps us to meet the requirement of the Equality Act 2010 and more specifically our responsibilities under the Public Sector Equality Duty (as part of the act). Progress on gender equality and implementation of the Gender Pay Gap analysis is a key measure for success in the well-led element of the CQC framework around workforce diversity and the fair and equitable treatment of staff.
Quality & Patient Safety:	Our progress in recruiting, retaining and developing a workforce that is representative of the population we serve has a direct impact on the quality of patient care.
Equality, Diversity and Inclusion and Health Equity:	EDI has been a key area of activity within BTHFT over the last 5 years, including the development of a dedicated EDI Strategy " We are Bradford: we value diversity and champion inclusion ", which was launched in 2023 following extensive engagement with our key stakeholders. The strategy is aligned to both our local ambitions around EDI, including regional and national EDI priorities, and our legal and contractual obligations such as WRES, WDES, the national EDI Improvement plan (6 high impact actions), gender pay gap, and our approach to EDS22. Reduction in our diversity pay gaps is essential in ensuring the Trust is reducing the gap in some of the workforce inequalities that are evident. We have a good infrastructure and strong foundations in place which will enable us to improve our performance over the next 12 months.
Resources:	Activity to raise the profile of EDI across both the Trust will require some level of investment for optimum success.
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	The March 2025 gender pay gap review was taken to People Academy in February 2026. This report provides an update to Board of Directors on the most recent gender pay gap data (data as at March 2025).

Report content

1. Purpose

The purpose of this report is to inform the Board of Directors of the Trust's Statutory Gender Pay Gap report that will be published prior to the 30th March 2026 deadline in line with our contractual and legal obligations.

2. Background/context

What is Gender Pay Gap Reporting?

It is a legal requirement for all public sector employers (with 250+ employees) to annually publish their gender pay gap data, analysis and recommendations within one year of the 'snapshot date' (31 March). Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) is committed to reducing our gender pay gap and this will be our 8th mandatory publication against this standard.

Gender pay reporting is different to equal pay. The gender pay gap is the average difference between the average gross hourly earnings for all men and women which is expressed as a percentage of men's earnings (as set out in the table below). Equal pay refers to men and women being paid the same for like work; work rated as 'equivalent' or 'work of equal value' as set out in the Equality Act 2010. It is unlawful to pay people unequally purely because they are a man or a woman.

If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

By actively working towards reducing inequalities for our diverse staff this ensures that BTHFT, as a Trust, is meeting the requirements of the Equality Act 2010 Public Sector Equality Duty (specific Duties and Public Authorities).

Gender Pay Gap Indicators – Overview

The legislation requires employers to publish the results of six calculations:

Proportion women in each pay quartile
Ranking all our employees from highest to lowest paid, dividing this into four equal parts ('quartiles') and working out the percentage of men and women in each of the four
Mean gender pay gap in hourly pay (ordinary pay)
Adding together the hourly pay rates of all male or female full-pay and dividing this by the number of male or female employees. The gap is calculated by subtracting the results for females from results for males and dividing by the mean hourly rate for males, then multiplied by 100 to give a percentage
Median gender pay gap in hourly pay (ordinary pay)
Arranging the hourly pay rates of all male or female employees from highest to lowest and find the point that is in the middle of range. The median helps to show where the mean value has potentially been skewed by an outlier (a few individuals at the very top or bottom of the range).
Proportion of males and females receiving a bonus payment
Total males and females receiving a bonus payment divided by the number of relevant employees.
Mean gender bonus pay gap
Add together bonus payments for all male or female employees and divide by the number of male or female employees. The gap is calculated by subtracting the results for females from results for men and dividing by the mean hourly rate for men. This number is multiplied by 100 to give a percentage.
Median gender bonus pay gap
Arranging the bonus payments of all male or female employees from highest to lowest and find the point that is in the middle of the range.

Progress on Gender Equality at the Trust

Celebrating International Women's Day and Launch of a new Gender Equality Staff Network:

In March 2025 we celebrated **International Women's Day** with an event that generated a lot of focus in this area. The event was an opportunity for a diverse range of colleagues to share their inspiring lived stories, including perspectives from men, women and non-binary colleagues and bringing into the discussion the issue of intersectionality and additional challenges that can come with that. The event also provided a platform for the launch of a newly developed **Gender Equality Staff Network**, with a focus on inclusivity and allyship, as well as progress. As with other staff equality networks terms of reference and a core group has been established, and the network have appointed to key roles to drive this agenda forwards. The chair of the network, Shaheen Kauser (Health Equity Project Manager) is now a member of both the **Equality & Diversity** and **People Academy** (providing a voice for gender equality at a strategic level). Shaheen has also joined the **Chair of Chairs** Network, ensuring all our staff networks are working collaboratively and with focus on the **intersectionality**.

Gender Equality Work Plan: Network members co-produced a Gender Equality Workplan which they presented to the Equality & Diversity Council in July 2025. This was developed in response to last years' gender pay review but also exploring in more detail some of the Trust data and their own lived experiences. The network meet on a bi-monthly basis to maintain momentum against this work plan against which the following progress has been made:

1. The network has **developed its own logo/ identity** and is in the process of working with the Equality & Diversity Team to develop comms materials aligned to the other three staff equality networks.
2. The network has worked with the Digital Comms Officer to develop a **Gender Equality Video** which was shared at the BTHFT EDI Conference in October to raise the profile of the network. The core group have plans to develop a number of smaller video clips to raise the profile of gender equality.
3. The network was keen to **influence the introduction of better flexible working approaches for front-line staff**. They invited Sarah Freeman (Director of Nursing, Operations) to their meeting October 2025 to provide an update. Sarah confirmed that flexible working for frontline staff remains a significant challenge. While the Trust already offers a range of options such as part-time, set shifts, term-time, and annualised hours, these arrangements do not always meet everyone's needs. Balancing individual requests with fairness, service needs, and patient care can create tension within teams, particularly in smaller services with limited staffing. Although progress has been made, achieving true flexibility while maintaining service delivery is an ongoing journey. Importantly, flexibility should be inclusive of all staff, recognising that caring and family responsibilities affect men as well as women.
4. Network members were keen to **support the work of the Trust Breast-feeding working group** (led by Rea Halstead), who are working to develop better support for colleagues who are breast/ chest feeding and ensure the Trust is meeting legal responsibilities under the Equality Act 2010. In collaboration with senior colleagues, there has been significant progress with providing a fully equipped space in the staff lounge at BRI allocated for development to incorporate secure access off the main corridor and a booking system to ensure appropriate use. An application for money from charities should provide the resources needed to make this a real success and the group are now exploring how this model can also be implemented at St Lukes, with other areas to follow.

5. The group have been exploring some of the Trust data around senior leadership representation and have highlighted the impact 'intersectionality' can have to compound the inequalities already identified for female colleagues. They are keen to **Influence the development of a positive action development opportunity for aspiring female leaders** (encouraging uptake from ethnically diverse colleagues) and have set up a task & finish group, with support from Cat Shutt (Head of OD) to look at development offers for women, especially diverse women. As a starting point, EDI colleagues are working with the OD team to take a paper to People Academy to recommend the establishment of a '**Shadow Board**' initiative that will benefit aspiring leaders from diverse backgrounds.
6. The group are keen to **influence the use of gender-neutral language across the Trust** and have plans to invite Laura Loveday (Associate Chief Nurse, Quality & Workforce)/ Jo Hilton (Director of Nursing/ Deputy Chief Nurse) to a future meeting to start this conversation.
7. Plans are already in place for this years '**International Women's Day**' celebration. Network colleagues are working collaboratively with the EDI team and other colleagues to hold a face-to-face event on 3rd March 2026, 12pm – 2pm in the Sovereign Lecture theatre. The theme for 2026 is "**#Give to Gain**", focusing on giving support, calling out stereotypes, challenging discrimination, questioning bias, and celebrating women's successes.
8. The EDI team are in the process of setting up a task & finish group with dedicated network members to further explore some of the available data, to understand what it is telling us in relation to gender equality and explore what actions we can take as a Trust to address any gaps or areas for improvement.

EDI Conference:

There has been a great deal of focus, not only on instilling "Inclusion and Belonging" in line with the NHS National People Plan, but also in creating a culture at BTHFT of Civility and Respect with a view to improving the experience of both staff and patients. On 22nd October 2025 we held our first ever Equality, Diversity & Inclusion Conference at the Cedar Court Hotel in Bradford. The conference provided a great opportunity to showcase our four staff equality networks and saw network chairs take to the stage to lead a Q&A discussion where they shared their lived experience with colleagues from across the Trust. This has helped us to raise the profile of the gender equality network.

Celebrating Diversity:

We have continued to work collaboratively with colleagues in each of our four staff equality networks to celebrate the diversity of our workforce and raise the profile of EDI across the Trust. On 14th May 2025 we celebrated **National Staff Equality Networks Day**, where employee networks across the United Kingdom rise up as a community to raise the profile of staff equality networks and lead the way for change in the workplace. Our staff equality networks organised a lunch time event taking place on the concourse where representatives from all four of our staff networks were represented allowing an opportunity for staff and colleagues to learn more about the role of the networks and how staff can join as members and allies. Colleagues also had the opportunity to meet the Executive Sponsors for each network.

3. Overview of Key Data Highlights: Assessment of Current Position





Data for the year up to and including 31st March 2025

In March 2025 there were proportionately more women (**76.8%**) employed by the Trust than men (**23.2%**). If we are to have gender pay equality, the same proportion of men and women should be represented at all levels of the organisation. The following analysis shows that this is not the case at BTHFT, and women continue to be proportionately under-represented at the most senior levels of the organisation and proportionately over-represented at supervisory and middle management levels.




Proportion of women in each pay quartile:

Nb. *Some* bank staff are included in the data calculation if they have worked on an assignment during the reference period up to and including the snapshot date (31st March). Agency staff are not included.



Nb. A key to symbols used can be found at appendix 1

-  Upper pay quartile: **65.25%** (1.5% decrease from last year - negative)
-  Upper middle pay quartile: **82.3%** (0.1% decrease from last year - positive)
-  Lower middle pay quartile: **79.9%** (0.2% decrease from last year – positive)
-  Lower pay quartile: **77.7%** (0.3% increase from last year – negative)

When we break down each staff group by gender:




-  Women are proportionately under-represented in Estates & Ancillary roles (at 47% compared to 76.8% women in the organisation as a whole) with a decrease of 5% from last year.
-  Women are proportionately under-represented in Medical & Dental roles (at 49% compared to 76.8% women in the organisation as a whole) with a slight decrease of 2% from last year.
-  Men are under-represented in Nursing & Midwifery roles (at 8% compared to 23.2% men in the organisation as a whole), with no change from last year.

Gender pay gap (ordinary pay):

-  Our mean average gender pay gap was **22.2%** (increase of 0.1%)
-  Our median average gender pay gap was **4.9%** (decrease of 1.2%)

Gender pay gap (bonus pay):

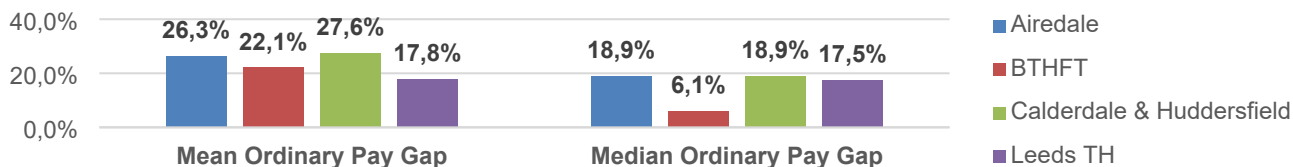
The only bonus payments made in the Trust are Clinical Excellence Awards (CEA's) paid to medical & dental consultants. In recent years efforts to create greater equity in these payments has reduced our bonus pay gap slightly. However, this will not be fully eliminated until legacy (old style) local CEA payments are reduced/ eliminated through colleagues retiring or leaving the Trust and/ or through a greater proportion of female consultants applying for higher value national CEA awards – changes which are very difficult to influence.

-  **0.6%** of women and **4.1%** of men across the Trust received a bonus payment
-  Our mean average gender bonus pay gap was **35.9%** (decrease of 6.3%)
-  Our median average gender bonus pay gap was **33.3%** (decrease of 8.6%)

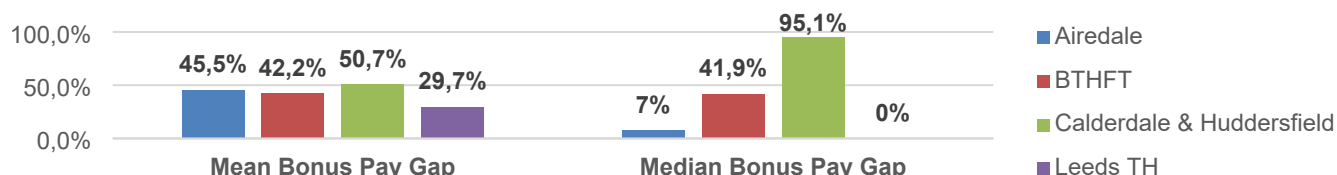
Benchmarking Data:

Whilst data for the March 2025 submission is not yet available, the government website allows a comparison of data submissions for the previous year. To provide some context to our gender pay gap position it is helpful to compare our March 2024 data with that of other local NHS Trusts. This comparison shows that, whilst we continue to have a gender pay gap, we are not outliers, in fact we compare quite favourably (BTHFT in red below).

Comparison of Gender Pay Gap (ordinary pay) – March 2024 data
(March 2025 data comparison not yet available)



Comparison of Gender Pay Gap (bonus pay) – March 2024 data
(March 2025 data comparison not yet available)



The gender pay gap data and detailed analysis can be found at [Appendix 2](#)

4. Next Steps

The Trust gender pay gap data will be published by 30th March 2026 in line with our legal requirements.

Our gender pay gap analysis, along with other workforce data will help to inform some targeted approaches for the next 12-months. In collaboration with our Gender Equality Staff Network we will consider developing new actions and developing existing actions further (aligned to both our [EDI strategy](#) and the [NHS EDI Improvement Plan.](#)) This should ensure we are working towards not only improving the experience of our diverse staff in the workplace but also challenging some of the barriers to personal development and progression.

These actions will continue to be developed around three key themes with an overall aim of ensuring we recruit, retain and support the right staff and develop excellent leaders who will have the skills to empower our people and create a positive culture where our people feel valued, can take responsibility for their actions and flourish. The main focus of our action plan to reduce our gender pay gap will be:

- **Representation of women in Leadership:** further increasing our engagement with aspiring females and further exploring some of the ‘barriers to senior level development’ with particular focus on intersectionality, personal development and talent management.
- **Continued focus on improving the working lives of women at BTHFT,** addressing some of the barriers to retention and progression.
- **Raising the profile of Gender Equality across the Trust,** with focus on addressing the under-representation of men in traditionally female roles and challenging gender stereotypes in the workplace.

Monitoring and Evaluation

Progress on gender equality will be monitored by the Trust People Academy and through the Board of Directors on a 6-monthly basis as part of their Equality, Diversity & Inclusion update.

We will continue to review our gender pay gap data on an annual basis going forward to monitor progress and ensure the findings are influencing some of this activity.

5. Proposal






It is recommended that Board of Directors:

5. Note the contents of the report and the gender pay gap data submissions
6. Approve the data, as set out in section 3
7. Support the next steps to reduce the Trusts' gender pay gap (section 4)
8. Agree to receive annual updates on our gender pay gap and any progress made.

Osbourne Sheridan
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Appendix 1

Key for symbols used in the data tables:

	<i>A higher % or score is better and this has shown an increase this year</i>		<i>A lower % or score is better and this has shown an increase this year</i>
	<i>A lower % or score is better and this has shown a decrease this year</i>		<i>The score has stayed the same from the previous year</i>
	<i>A higher % or score is better and this has shown a decrease this year</i>		

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Gender Pay Gap Data and Analysis 2026

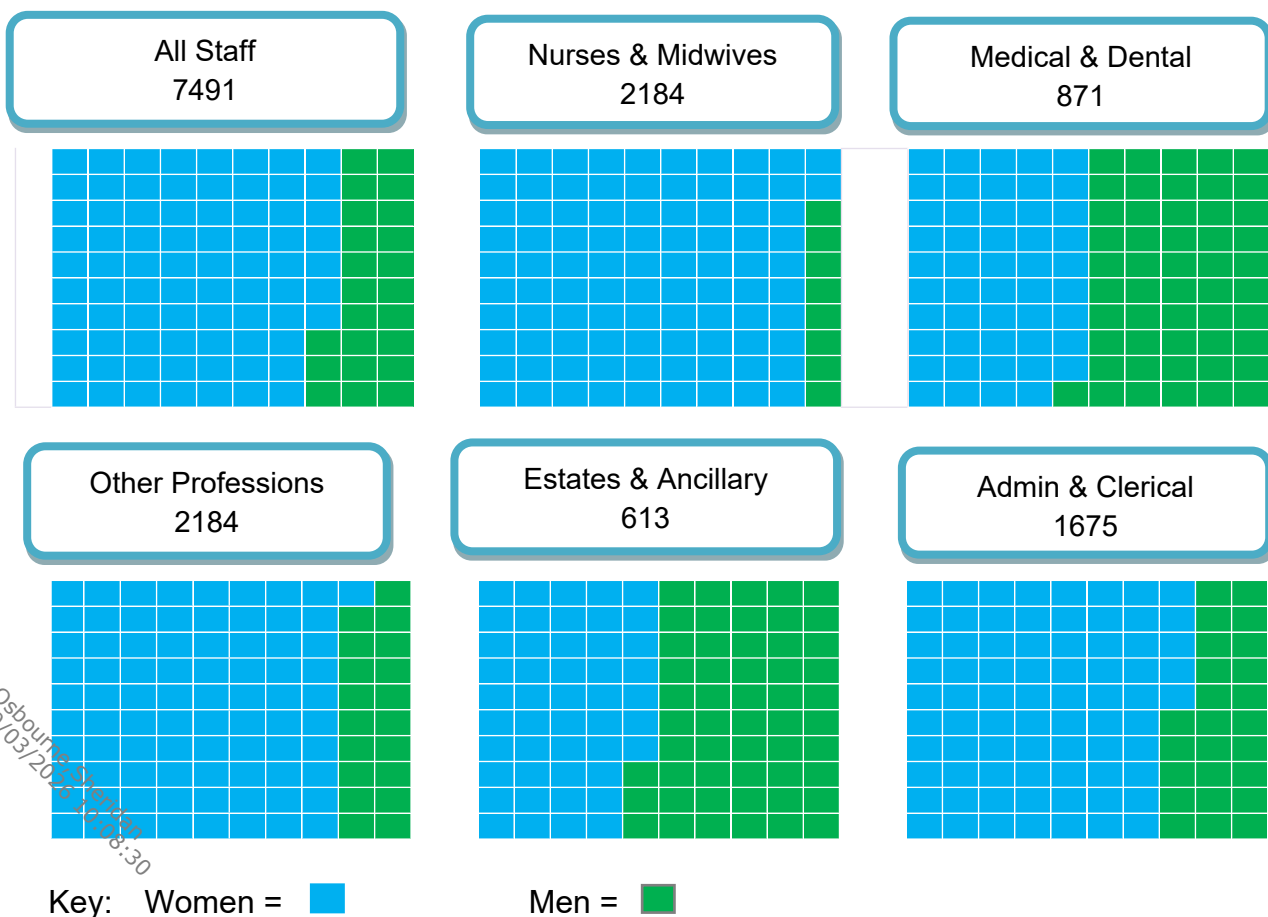
The following data was collected on 31 March 2025 when our workforce comprised **7,491 staff**, of which; **5,753 (76.8%) were women** and **1,738 (23.2%) were men**.

Throughout this report, where appropriate, data for March 2023 and/or March 2024 has been included to show a comparison and evidence our progress over the last three years.

Workforce by Gender

The table below illustrates how our workforce was made up by gender as at 31st March 2025.

- ➡ The green squares represent men and the blue squares represent women. Women make up a significant proportion of our workforce (76.8%) and this has remained fairly static over the last 12 months, but with a 0.2% increase of women in the workforce as a whole since March 2024.
- ⬇ Women are proportionately under-represented in Estates & Ancillary roles (at 47% compared to 76.8% women in the organisation as a whole) with a decrease of 5% from last year.
- ⬇ Women are proportionately under-represented in Medical & Dental roles (at 49% compared to 76.8% women in the organisation as a whole) with a slight decrease of 2% from last year.
- ➡ Men continue to be significantly under-represented in Nursing & Midwifery roles and Other Professions. Whilst no change for Nursing & Midwifery roles there is a 1% increase in men in other professions over the last 12 months which is positive.



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Quartile Reporting

The pie charts below show the proportion of males and females when divided into four groups ordered from the highest to the lowest pay. The data below ranks our whole-time equivalent employees from highest to lowest paid, divided into four equal parts (quartiles). The lower quartile (red) represents the lowest salaries in the Trust and the upper quartile (green) represents the highest salaries.

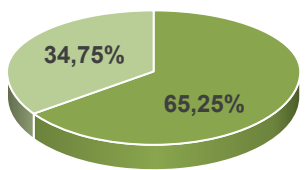
In March 2025 there were proportionately more women employed by the Trust (76.8%) than men (23.2%). If we are to have gender pay equality, the same proportion of men and women should be represented at all levels of the organisation. The following analysis shows that this is not the case at BTHFT, and **women continue to be proportionately under-represented at the most senior levels and proportionately over-represented at supervisory and middle management levels. Despite minor fluctuations in this data year on year, there has been little change in this metric since March 2021:** ➡

At 65.25%; Women continue to be proportionately under-represented in the Upper quartile (higher paid staff) by 11.6% (compared to 76.8% women in the organisation overall).

- ↓ The proportion of women in the upper quartile has fluctuated over the last three years. However, after a 2.5% increase last year, we have seen a **1.5% decrease in the proportion of women in the upper quartile this year.**
- ↓ Women continue to be proportionately over-represented in the Upper Middle quartile (82.3%), but with a slight reduction again (0.1%) in this inequality from last year.
- ↓ Women continue to be proportionately over-represented in the Lower Middle quartile (79.9%) but with a slight reduction (0.2%) in this inequality from last year.
- ↑ Women remain just slightly over-represented (proportionately) in the lower quartile (lowest paid staff) at 77.7% and with a 0.3% increase this year.

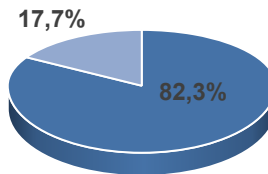
The charts below show the percentage of males and females who fall into each quartile:

Upper Quartile



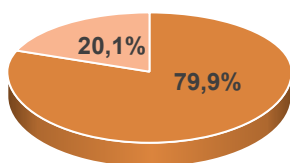
■ Female % ■ Male %

Upper Middle Quartile



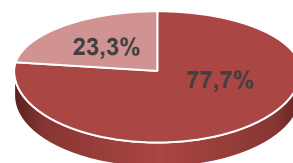
■ Female % ■ Male %

Lower Middle Quartile



■ Female % ■ Male %

Lower Quartile



■ Female % ■ Male %

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Average Gender Pay Gap as a Mean Average

The mean is calculated as the sum of all values (hourly pay rate) divided by the number of staff. The difference in these values for men and women is expressed as a percentage.

Table 1

Mean Average Hourly Rate	2023	2024	2025
Male	£24.19	£24.23	£26.05
Female	£18.28	£18.87	£20.26
Gap	24.4% ↓	22.1% ↓	22.2% ↑

↑ When it comes to pay, although there are more women employed in the organisation; women earn less. The mean average pay gap has been steadily reducing over the last few years, but this year has increased slightly (by 0.1%) from **22.1%** to **22.2%**. Despite 0.1% increase in our mean gender pay gap this year to 22.2%), over all it is decreasing and has reduced by 9.1% since we started reporting in March 2017



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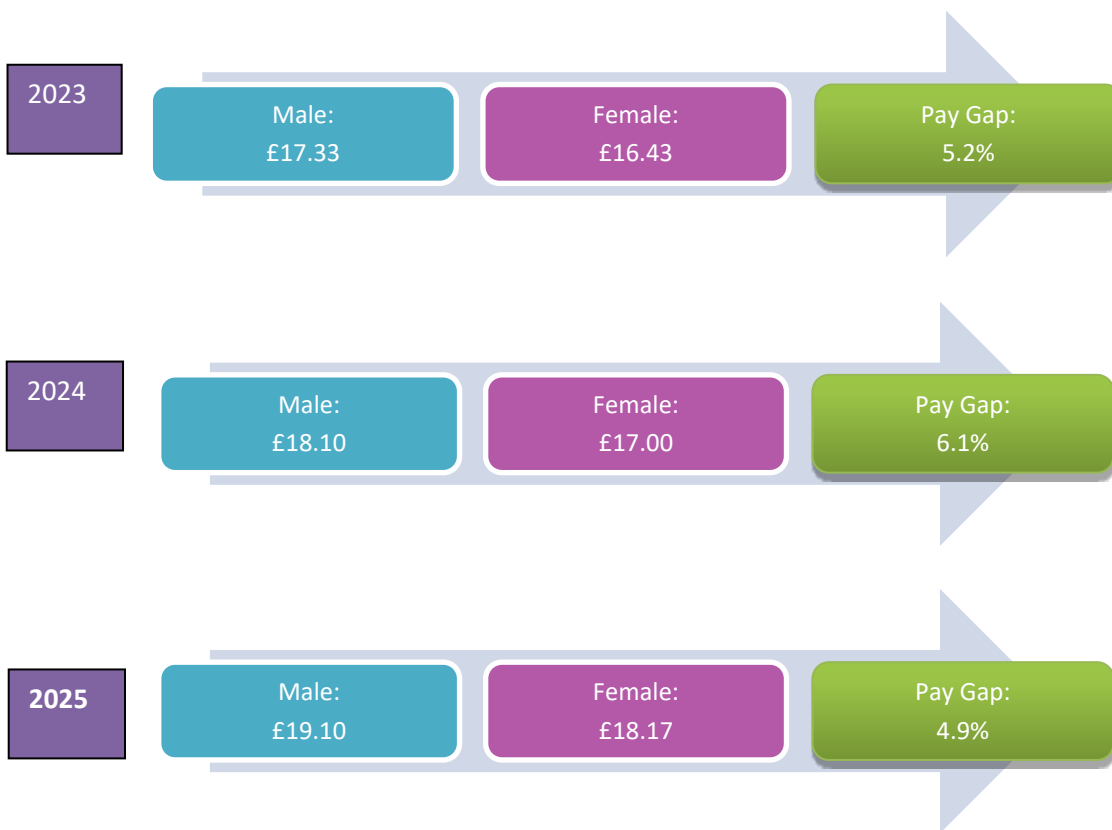
Average Gender Pay Gap as a Median Average

Median is calculated by separating each pay list by gender and then putting each list in order from lowest to highest. The Median is the middle number in each list. The difference in these values for men and women is expressed as a percentage.

Table 2

Median Average Hourly Rate	2023	2024	2025
Male	£17.33	£18.10	£19.10
Female	£16.43	£17.00	£18.17
Gap	5.2% ↓	6.1% ↑	4.9% ↓

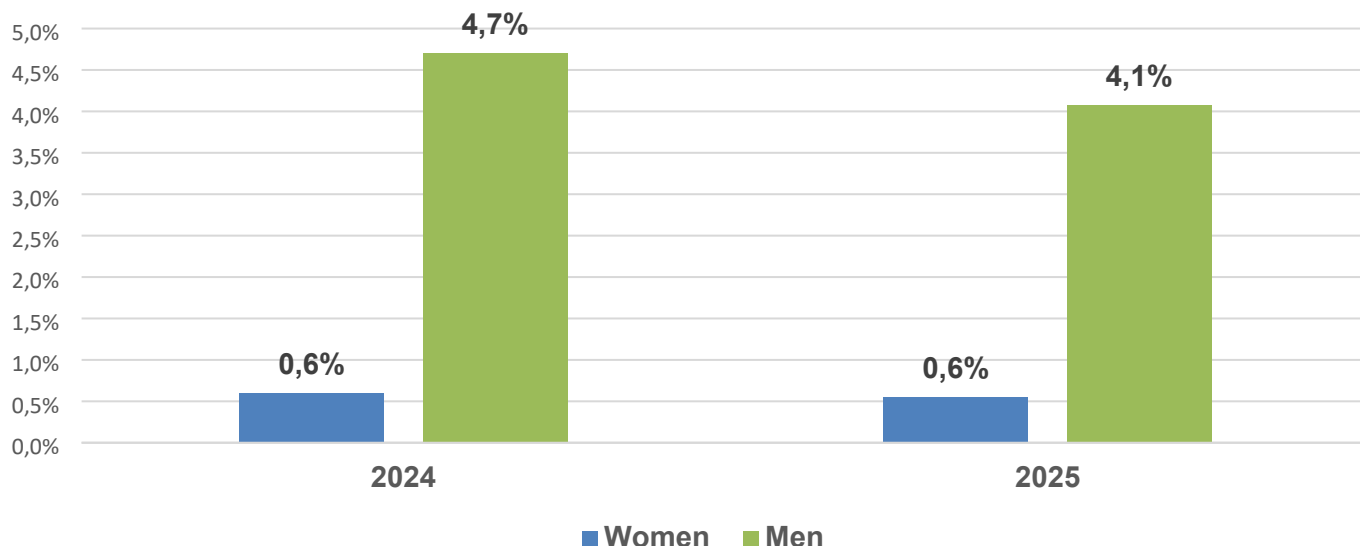
↓ There has been a year-on-year increase in women’s median average hourly pay rate for the last 3 years and although the median average hourly pay rate for men continues to be higher, this year the median pay gap has decreased slightly (by 1.2%) from **6.1%** in **2024** to **4.9%** in **2025**.



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Percentage of Men and Women receiving a Bonus Payment at BTHFT

↓ There continues to be a lower proportion of women in the Trust receiving a bonus payment, although this gap has decreased slightly with 0.6% of the women and 4.1% of men at BTHFT receiving a bonus payment in March 2025 (compared to 0.6% women and 4.7% of men in 2024).



Is it right that a smaller proportion of women in the Trust are paid bonuses?

As identified in previous years, for the purposes of the national gender pay gap requirements this data is calculated as a proportion of the workforce as a whole (where we know that proportionately there is an over-representation of women). However, the only bonus payments made in the Trust are clinical excellence awards (CEA) paid to medical & dental consultants, where we know that we employ more men than women. This exaggerates the gap.

A more useful comparison would be to compare the proportion of male and female consultants receiving a bonus payment (CEA) compared to the proportion of male and female consultants in the workforce:

- As at 31st March 2025 **39%** of the consultant workforce were women and **61%** were men. Further analysis of the snapshot data shows that **30%** of bonus payments were made to female consultants and **70%** were made to male consultants. This does still show a **slightly higher proportion of male consultants receiving a bonus payment compared to female consultants (when compared to the proportion of males and females in the consultant workforce)**, although there is a 1% reduction in this disparity from last year.

Some background information into the reason for the bonus pay gap:

Historically, there has been a higher proportion of male consultants in the workforce, with a greater length of service and seniority, which were previously success factors in receiving a local CEA (an award paid in varying amounts) and although this award has now been phased out some of these staff continue to receive legacy payments on a mark-time basis. There is no longer opportunity for anyone to apply for the 'old style' CEA (and continuation of this legacy award will be subject to a formal review in the future in agreement with the Local Negotiating Committee). In the interim this means that, year-on-year, the numbers linked to the 'old style' CEA may only change as people retire or leave the organisation for other reasons.

As at March 2025 there also continued to be some consultants (predominantly male) in receipt of a national award for clinical excellence (a national application process that is renewable every 3-5 years but potentially generates much higher bonus payments dependent on the level of the award). This has a significant impact on the gender bonus pay gap.

As a way to address the inequality in bonus payments within the Trust, from March 2020 a new style Clinical Excellence Award was paid to all consultants who met the eligibility criteria (as at April of the preceding year) without the need to submit an application. The new style CEA was calculated and paid to all eligible consultants as an equal share of a total award budget and the payment made in full irrespective of someone's hours of work. This approach was aimed at creating greater equity for female consultants who are more likely to work part-time hours. The proportion of consultants receiving the new style CEA was directly related to the proportion of eligible consultants employed, rather than limited to a selection of those who have made an application for the award. Going forward this new style CEA has been stopped and is now incorporated into basic pay. However, as the last of these payments (for 2023) were paid in May 2024 they will have been picked up in the reference period for our 2025 bonus pay gap review. These equal shares payments are of a lower value and unlikely to have a significant impact on the pay gap. Therefore, any inequality in terms of our mean or median bonus pay gap is predominantly attributable to the old style and national CEA payments.

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Average Bonus Gender Pay Gap as a Mean Average

The mean average bonus payment is calculated as the sum of all values (bonus payments within a specified reference period) divided by the number of staff (consultants receiving bonus payments within that reference period). The bonus pay gap demonstrates the % difference in these mean average payments for men and women.

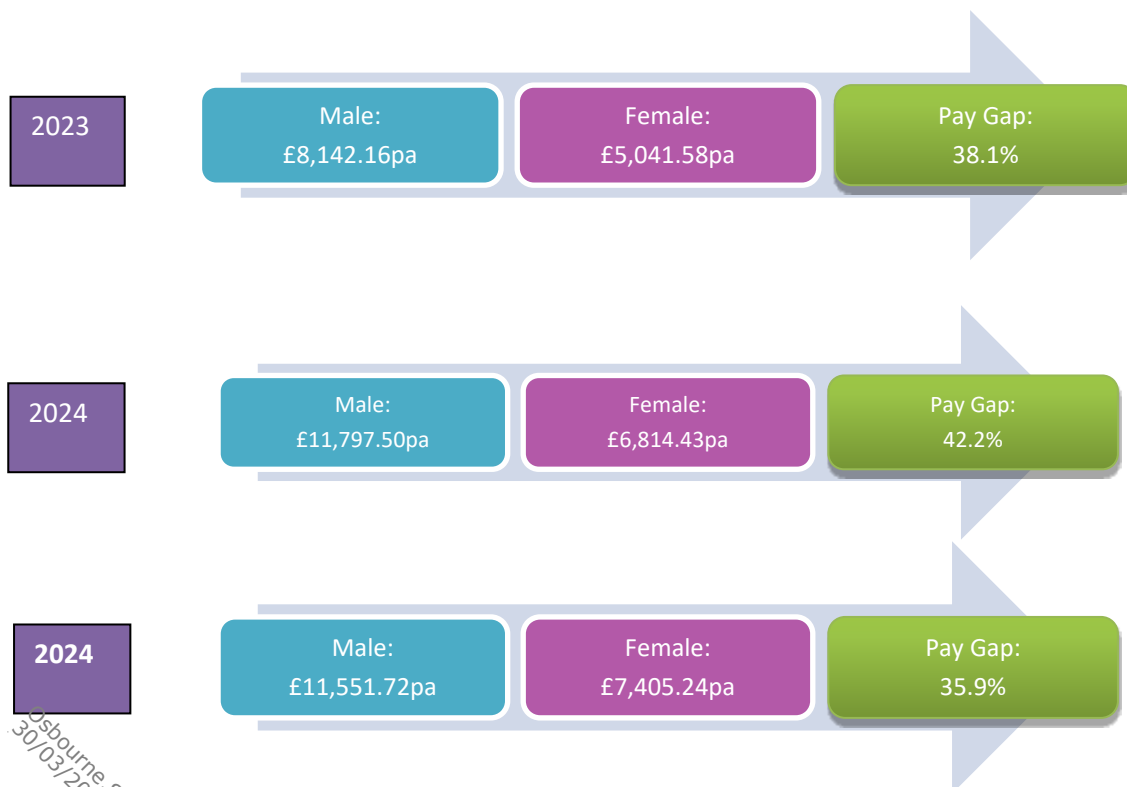
Table 3

Average Bonus Pay Per Annum	2023	2024	2025
Male	£8,142.16	£11,797.50	£11,551.72
Female	£5,041.58	£6,814.43	£7,405.24
Gap	38.1% ↑	42.2% ↑	35.9% ↓

↓ Based on this years' data calculation, men **continue to earn on average 35.9% more in bonuses than women**. However, this is a decrease of **6.3%** from last year.

The only bonus payments made in the Trust are Clinical Excellence Awards (CEA's) paid to medical & dental consultants. In recent years efforts to create greater equity in these payments has reduced our bonus pay gap slightly. However, this will not be fully eliminated until legacy (old style) local CEA payments are reduced/ eliminated through colleagues retiring or leaving the Trust and/ or through a greater proportion of female consultants applying for higher value national CEA awards – changes which are very difficult to influence.

However, it is anticipated that over the next few years we will see a gradual improvement in the mean bonus pay gap data as 'old style' CEA payments gradually diminish, and more women potentially achieve some of the higher paid national awards.



Osbourne-Sheridan
30/03/2025 10:08:30

Average Bonus Gender Pay Gap as a Median Average

Median is calculated by separating each pay list (list of bonus payment amounts) by gender and then putting each list in order from lowest to highest. The median is the middle number in each list and the median bonus pay gap is the percentage difference between that mid-point for men and women.

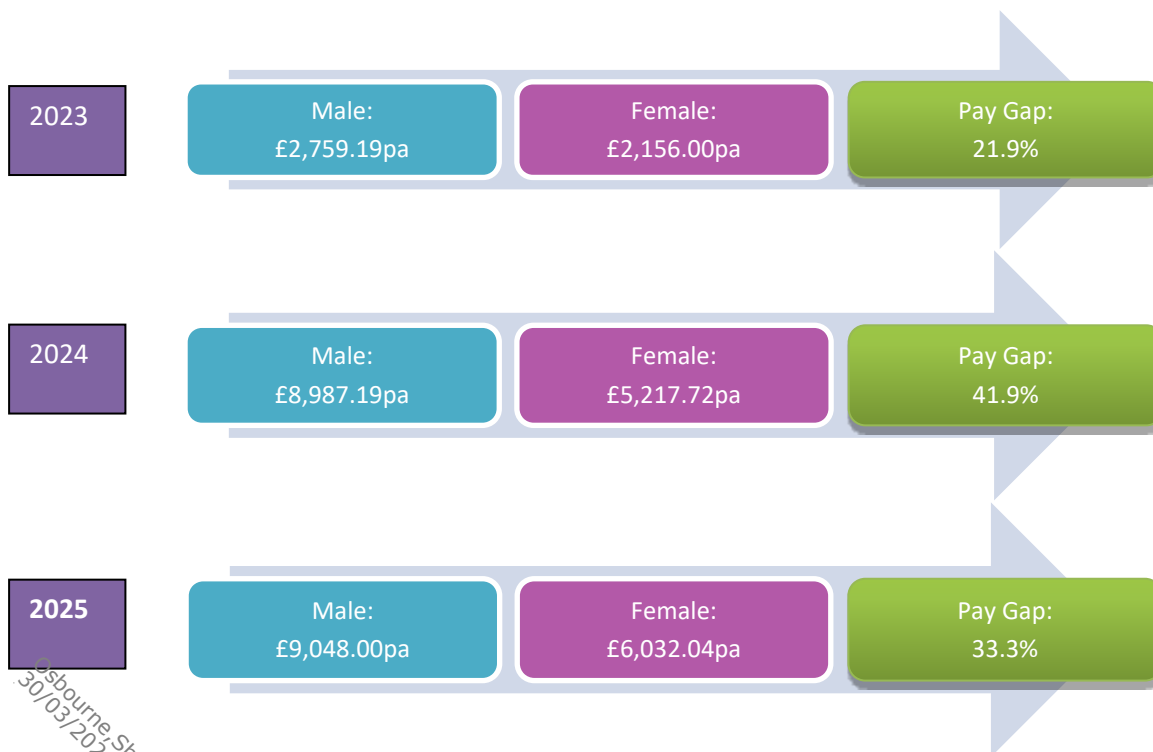
Table 4

Average Bonus Pay Per Annum	2023	2023	2024
Male	£2,759.19	£8,987.19	£9,048.00
Female	£2,156.00	£5,217.72	£6,032.04
Gap	21.9% ↓	41.9% ↑	33.3% ↓

↓ **As a median average men earned 33.3% more than women in bonuses in March 2025.**
This is a decrease of **8.6%** in the median bonus pay gap over the last 12 months.

The only bonus payments made in the Trust are Clinical Excellence Awards (CEA's) paid to medical & dental consultants. In recent years efforts to create greater equity in these payments has reduced our bonus pay gap slightly. However, this will not be fully eliminated until legacy (old style) local CEA payments are reduced/ eliminated through colleagues retiring or leaving the Trust and/ or through a greater proportion of female consultants applying for higher value national CEA awards – changes which are very difficult to influence.

However, it is anticipated that over the next few years we will see a gradual improvement in the median bonus pay gap data as 'old style' CEA payments gradually diminish, and more women potentially achieve some of the higher paid national awards.



Sbournie-Sheridan
30/03/2025 10:08:30

Meeting Title	Board of Directors		
Date	31 March 2026	Agenda item	Bo.3.26.12a

Committee Escalation and Assurance Report

Report from the: Finance and Performance Committee

Date of meeting: 17 February 2026

Key escalation and discussion points from the meetings
Alert:
<p>Financial position: The Committee discussed the latest 2025/26 year to date and forecast financial position. As the situation has moved on considerably since the February meeting it is not necessary to provide details here; suffice to say that the Committee noted that very substantial improvements would be required over the last two months of the financial year if the deficit forecast that the Board had agreed in December 2025 should be submitted to NHS England was to be achieved.</p> <p>The Committee further noted that a request for cash support had been made and that a decision was imminent.</p> <p>High Level Risks: The Committee noted one new risk relevant to its work, the risks arising from the EPR standard workflow not being used in Theatres, Anaesthetics and Critical Care. The Committee sought to understand why something that the Trust was aware of in November 2024 was only now being highlighted as a new red risk. The explanation of the new risk concerning a new awareness of alternative workarounds being used by some system users was accepted by the Committee. Prior to this the known workarounds had been mitigated by additional data quality workarounds.</p> <p>The Committee noted and agreed with the decision to increase the risk of failing to meet the revenue financial plan from 16 to 20.</p> <p>Joint Venture Governance Mechanisms: The Committee was advised that underpinning operations were working well but governance, although robust on paper, was not operating as tightly as it could. There were leadership challenges to be addressed, and the service appeared more aligned more to three separate sites than a single joint venture. A report was in preparation which the Committee would receive once it had been through due process.</p> <p>Operational Performance: The Committee received updates on the KPI performance exceptions:</p> <ul style="list-style-type: none"> DM01 6-weeks: Performance for January and December has deteriorated following the previous 15% recovery related improvement. Challenges with capacity within NOUS have worsened and its now likely recovery through insourced capacity will extend into 2026/27. Elective Activity: Q4 recovery is progressing well, although productivity gains in theatre remain a challenge. The data and productivity work-stream are progressing actions which could further improve the position.

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- Outpatient Transformation: OPPROC recording is once again being investigated. Follow up activity remains too high which negatively impacts this KPI. The data and productivity work-stream are progressing actions which could improve OPPROC and first OPA though, and Q4 targets are being met.
- Cancer 28-day FDS: Performance impacted by deterioration in histology reporting and ongoing challenges across key tumour groups. Year-end requires recovery above 80% in February in March, with forecast improvements in skin and H&N suggesting this is possible.

The Committee discussed whether an earlier financial intervention to address DM01 performance could have resulted in the target being achieved as had occurred with other KPIs. A detailed explanation was provided as to the considerations made in this regard which the Committee welcomed and accepted.

Advise:

Operational Performance: The Committee was advised of the following in month exceptions / early warnings:

- 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.
- Cancer 62-day FT: Diagnostic delays are also impacting on this standard and whilst December is above plan, January has seen some deterioration. It remains possible that March will meet the 75% target, but 62-day backlogs are being closely managed to support this.
- G&A Bed Occupancy: Total G&A bed occupancy increased in January to 94.2% delivering above plan because of the winter pressures in elderly care beds. It is expected to fall to planned levels throughout the end of February and into March. Length of Stay and Discharge metrics are also following similar trends but not with the same variance to plan.

Whilst noting the operational performance exceptions ('alerts' above) and the in-month exceptions / early warnings the Committee was assured that overall delivery against performance indicators is understood and noted the escalation of areas of underperformance and, improvement actions in place to address these.

Capital Finance Position: The Committee noted that capital expenditure was slightly behind plan but that the Executive was not significantly concerned as robust processes existed to keep schemes on track or identify mitigations if slippage was identified. The Committee was assured that whilst a capacity gap in Estates had been identified, that gap was predominantly in design and procurement which would not impinge significantly on the end of year delivery expenditure. An emerging risk concerning the renal dialysis delivery plant becoming unsupported by the supplier in 2027, however discussions were already ongoing with NHS England for support for a replacement.

Financial Recovery: The Committee received an update from the Chief Executive on progress, noting the appointment of a Recovery Director, the messaging to the organisation and the governance structure being established. As part of a detailed

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discussion the Committee raised issues concerning workforce productivity (including addressing sickness absence rates) and the interface between day-to-day budget management and delivering required expenditure savings. These issues will remain a focus for the Committee's scrutiny of delivery of the financial recovery plan.

Estates and Facilities Dashboard: Whilst noting the ongoing to work to develop an assurance map for Estates and Facilities, the Committee sought to understand why the work to improve performance against the people KPIs did not seem to be resulting in improvements. The Committee was advised that there was a detailed action plan covering sickness absence, appraisals, and manager training. The Committee welcomed an offer of a detailed report on the issues highlighted.

Assure:

Internal Audit Plan: The Committee was assured about the level of involvement in formulating the Internal Audit Plan for 2025/26 and the coverage provided. The Committee, in conjunction with the Audit Committee and other committees will be seeking increased assurances from the audit programme that it was not just processes that were being assessed, but the outcomes being delivered by those processes.

Urgent and Emergency Care Operational Improvement Plan: The Committee received a presentation from the Deputy Director of Operations, Unplanned Care which focussed on the improvement work in UEC and the impact that had had on 2025/26 operational delivery compared to the previous year. The presentation highlighted six metrics and noted improvements across all, particularly ambulance handovers and long emergency department waits.

The Committee welcomed the informative and assuring presentation, and congratulated the Deputy Director of Operations, Unplanned Care on the improved performance he and his colleagues had delivered.

Report completed by:

Bryan Machin
Committee Chair and Non-Executive Director
23 March 2026

Osbourne-Sheridan
30/03/2026 10:08:30

Meeting Title	Board of Directors		
Date	31 March 2026	Agenda item	Bo.3.26.12a

Committee Escalation and Assurance Report

Report from the: Finance and Performance Committee

Date of meeting: 25 March 2026

Key escalation and discussion points from the meetings

Alert:

Financial position

Income and Expenditure: The Committee discussed the latest 2025/26 year to date and forecast financial position. Whilst some risk remained, the most likely outcome was that the revised deficit target would be delivered. The Board will receive a detailed report at its meeting on 31 March 2026.

Cash: The Committee further noted that the request for cash support had been successful and the detailed work that had been completed in the finance team to meet all the NHS England requirements. However, the cash position remained challenging moving into 2026/27.

Capital: Whilst there is risk of slippage in the capital delivery as a result of late additional allocations, the capital position is considered 'advise' rather than 'alert'.

Financial Recovery: The Chief Executive provided an update on the steps being undertaken on financial recovery in 2025/26 and how this would be continued into 2026/27. The Committee discussed the interface between the Grip and Control action plan progress, Closing the Gap delivery and monitoring, day to day budget management and Financial Recovery. Whilst the Committee is minded to monitor Financial Recovery as a separate agenda item, the interrelationship between each of these pieces of work is significant and the Committee will work with ELT to develop streamlined, effective scrutiny.

2026/27 Planning

The Committee was advised of the latest position on the 2026/27 plans. The Board will receive updated information on or before 31 March 2026

High Level Risks

The Committee noted that updated information about the risks arising from the EPR standard workflow not being used in Theatres, Anaesthetics and Critical Care would need to be presented to the Board meeting on 31 March 2026.

Operational Performance

The Committee received updates on the KPI performance exceptions:

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- 18 Weeks Incomplete RTT: The Committee heard that it had been hoped that RTT performance would improve to meet the out-turn plan of 66.7% during Q4. Unfortunately, it had not been possible to run all the additional clinical sessions due to service specific delays in recruitment and lower than anticipated uptake of additional clinics. There has also been increased leave during February which reduced the activity run rates expected. Overall, the impact has been a gap to plan of c.2% which will need to be recovered in 2026/27 on top of 5% planned improvement.
 - The Committee discussed whether the increased leave could have been anticipated, concluding that taking known holiday periods into account would further improve planning in the future
- DM01 6-weeks: Performance for February has increased overall by 5% but there are emerging pressures within DEXA, Echocardiography and Neurophysiology.
- Elective Activity: Q4 activity through theatre has increased with the use of Bronte forward wait for Plastic Surgery procedures but overall volumes will not recover to plan before year end. Productivity gains in theatre remain an opportunity to progress at greater pace and this will be a priority within the recovery meetings with each CSU.
- Outpatient Transformation: There is a level of coding opportunity being progressed within the data and productivity workstream which may recover past month performance. Increasing the proportion of new appointments has been a Q4 priority which will continue into 2026/27 and will feature as a KPI within the new recovery structure.
- Cancer 28-day FDS: Performance impacted by deterioration in histology reporting and ongoing challenges across key tumour groups. Year-end requires recovery above 80% in March. Forecast improvements in Gynaecology, Skin and H&N suggest this may be possible but not guaranteed.
 - The Committee received a 'deep dive' presentation on the operational improvement plan for Cancer and Diagnostics which expanded on the reasons for performance and specific patient breaches against the targets. The challenges in Histopathology were noted, as was the histopathology targets in the new Cancer Plan which will require a very significant improvement in current performance over the next three years. The Committee will be revisiting this as part of a discussion next month on the Pathology Joint Venture.

Advise:

Operational Performance

The Committee was advised of the following in month exceptions / early warnings:

- Cancer 62-day Performance: Diagnostic delays are also impacting on this standard with February performance projected to remain below target
- Cancer 62-day Backlog: It remains possible that March will meet the 75% target as the 62-day backlog shows considerable improvement and remains closely managed to support this

Whilst noting the operational performance exceptions ('alerts' above) and the in month exceptions / early warnings the Committee was assured that overall delivery against performance indicators is understood and noted the escalation of areas of underperformance and improvement actions in place to address these.

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Estates and Facilities Assurance Framework and Dashboard

A draft of the assurance map for Estates and Facilities was received and welcomed by the Committee. It prompted a helpful discussion of the need for triangulation between the developing assurance ratings, the “estates” BAF risk, the risk register and estates operational performance. The Committee will use the estates assurance framework to deep dive into different areas over coming months. The People Academy will take responsibility for more detailed consideration of performance against the estates and facilities workforce KPIs

Assure:

Whilst there is no specific item here, the Committee remains assured that the Executive Team is aware of the challenges, risk and issues on matters under the remit of the Finance and Performance Committee and is taking steps to address or mitigate them. Where actions appear insufficient to deliver targets and outcomes, the Committee is grateful that Executives and their teams are open to challenge and discussion. The Committee undertook an effectiveness review at this meeting and will use this as a basis for ensuring it continues and improves its work in 2026/27.

Report completed by:

Bryan Machin
Committee Chair and Non-Executive Director
25 March 2026

Osbourne-Sheridan
30/03/2026 10:08:30

Board of Directors			
Meeting Date:	31.03.26	Agenda Reference:	Bo.3.26.12b
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 <input type="checkbox"/>	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> Information <input type="checkbox"/>
Summary of Key Issues/Highlights:	<p>The integrated Board dashboard is developed by combining the individual performance reports that are received and scrutinised by the Committees:</p> <p>(1) Finance and Performance Committee (2) People Academy (3) Quality Committee</p> <p>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.</p> <p>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.</p> <p>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.</p>		
Recommendation/s:	<p>The Board is invited to receive and review the document attached.</p> <p>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.</p>		
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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Osbourne, Sheridan
30/03/2026 10:08:30

Integrated Dashboard

Board of Directors

February 2026

Osbourne Sheridan
30/03/2026 10:08:30

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 <u>(H)igher or (L)ower</u> 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/>

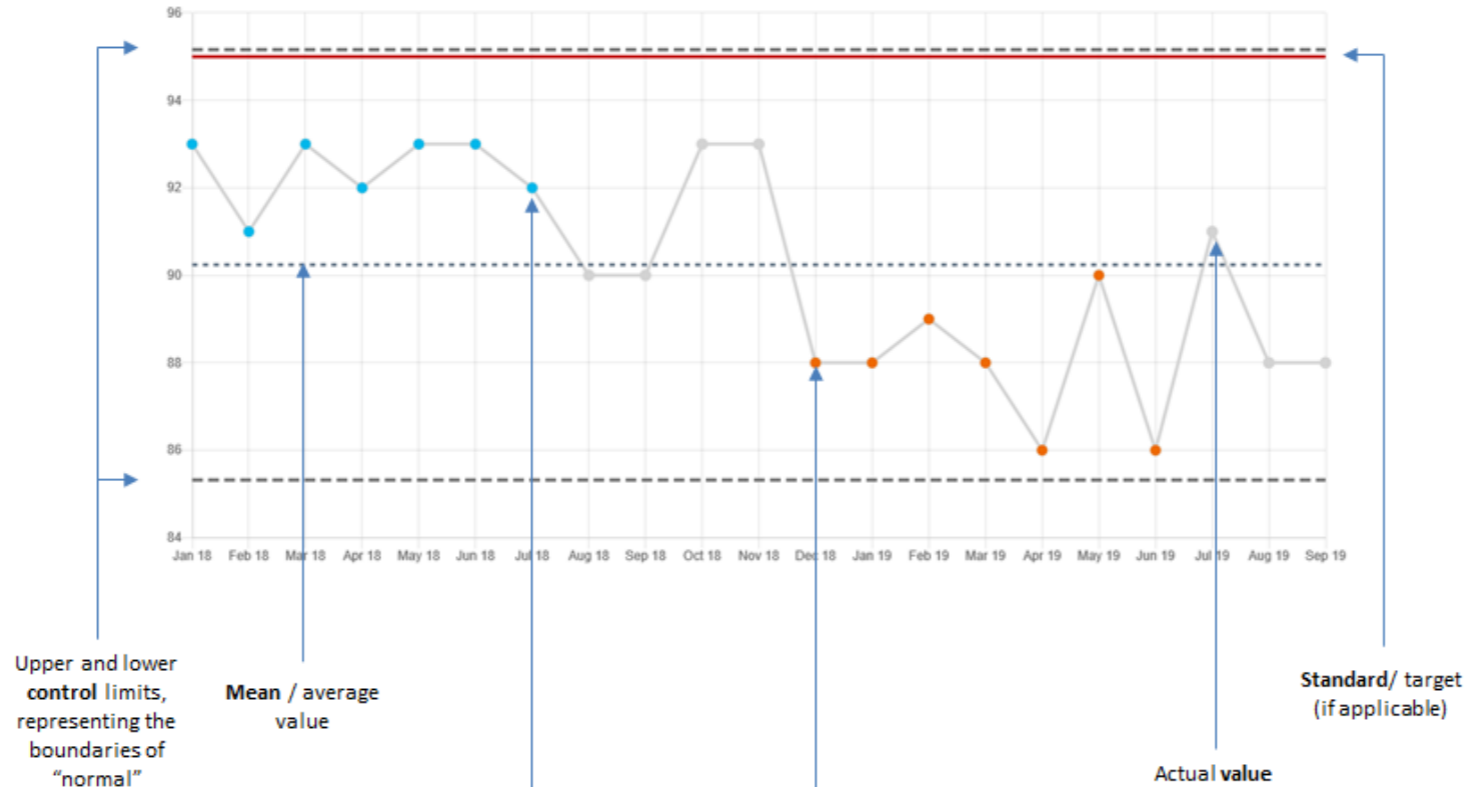
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Interpreting Statistical Process Control Charts

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



Points of special cause variation:

- Single point outside process limits
- Run of 7 points above/below the mean (**shift**)
- Run of 7 points all consecutively ascending/descending (**trend**)

● Concern ● Improvement

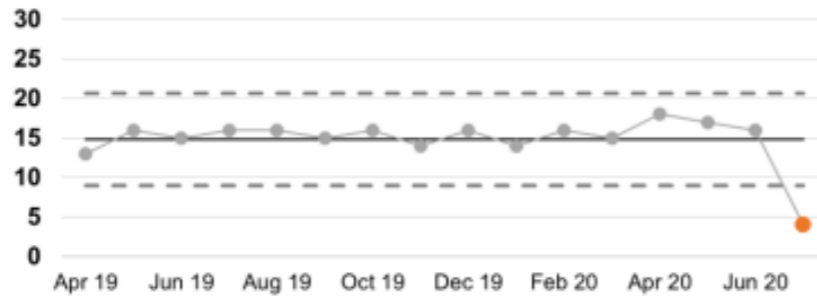
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Interpreting Statistical Process Control Charts

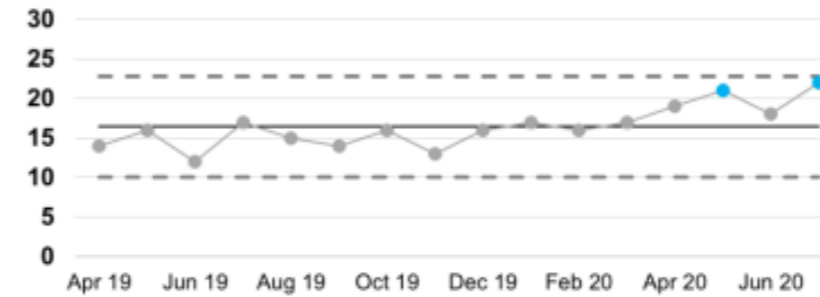
SPC rules : special cause variation



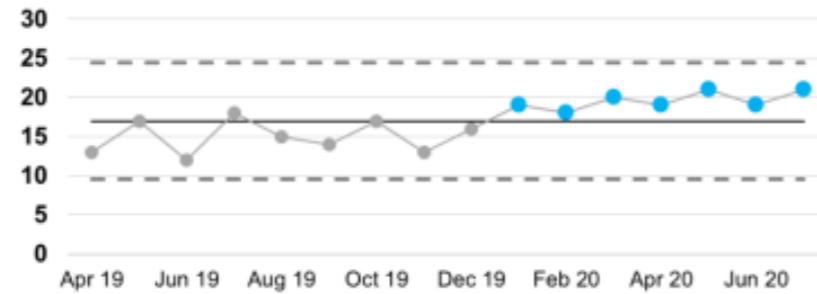
A single point outside the process limits



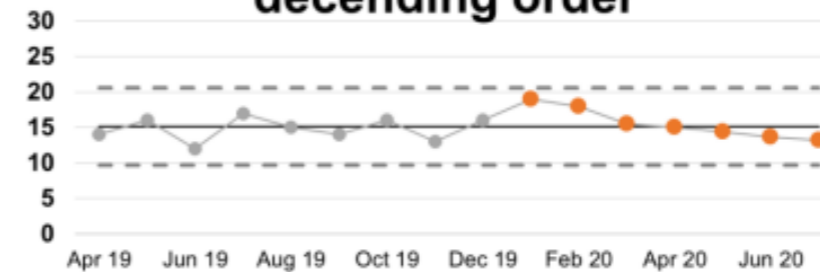
Two out of three points close to a process limit



A shift of points above / below the mean



A run of points in consecutive ascending or descending order



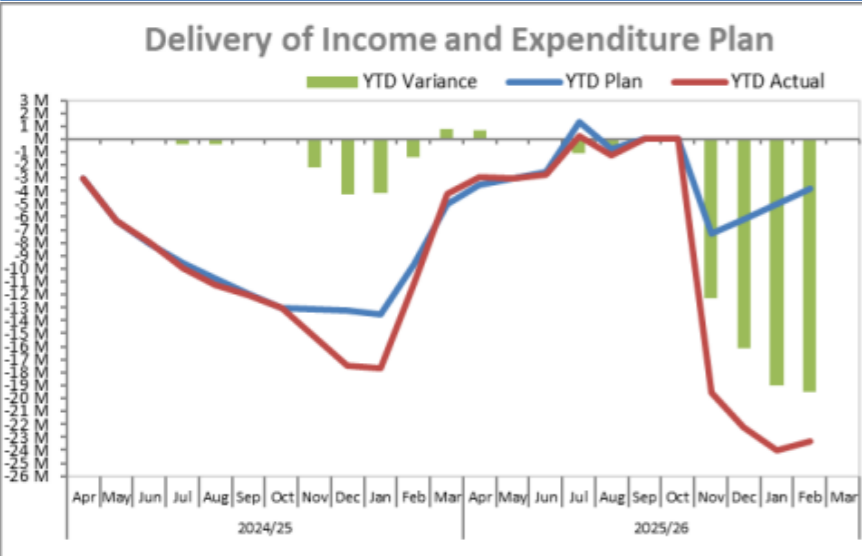
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Metric	Period	Latest Value	Target	Variation	Assurance	Mean
% Ambulance Handover <15 Mins - * All	Feb-26	52.4%				56.40%
% Ambulance Handover <30 Mins - * All	Feb-26	86.0%				85.80%
% Ambulance Handover <60 Mins - * All	Feb-26	99.2%				96.50%
Ambulance Arrivals - * All	Feb-26	3,167				3,200
Bed Occupancy - * All	Feb-26	93.06%	93%			90.70%
Cancer 2 Week Wait - * All	Jan-26	92.57%				93.80%
Cancer 28 Day Faster Diagnosis	Jan-26	74.61%				81.6%
Cancer 31 Day 1st Treatment	Jan-26	95.51%				92.6%
Cancer 62 Day Wait - * All	Jan-26	68.18%	75%			74%
Day Case Rate - * All	Feb-26	87.47%				88.90%
Diagnostic Waiting List - * All	Feb-26	7,754				10,236
Diagnostic Waiting List (% < 6 Weeks) - * All	Feb-26	81.40%	95%			72.50%
DTA to Admission > 12 Hours	Feb-26	3.3%				2.01%
DNA Rate - All	Feb-26	8.40%				8.85%
ED - Time to Initial Assessment - * All	Feb-26	18.90				24.4
ED Attendances (% < 4hr) - * All	Feb-26	72.80%	77.30%			75.60%
Elective Ordinary and Daycase Admissions	Feb-26	4,420				4,190
Elective Theatre Sessions Volume Completed	Oct-24	616				520
Length of Stay 21+ Days - * All	Feb-26	83				103.5
Not Meeting Criteria to Reside - * All	Feb-26	9.32%	14.79%			13.06%
Outpatient Attendances	Feb-26	44,405				41,567
Outpatient Attendances % New or with Procedure	Feb-26	56.80%				56%
Outpatients Discharged to PIFU	Feb-26	6.28%				2.14%
Patients Discharged on/before DRD	Feb-26	75.8%				81.90%
Patients in ED >12 Hrs - * All	Feb-26	763				680.1
RTT 18 Weeks (%) - * All	Feb-26	64.49%				68.90%
RTT 18 Weeks (Total Pathways) - * All	Feb-26	31,261	30,571			35,619
RTT 52 Week Breaches - * All	Feb-26	69				613.3
RTT 65 Week Breaches - * All	Feb-26	0				81.6
Theatre Capped Utilisation	Oct-24	85.30%				82%

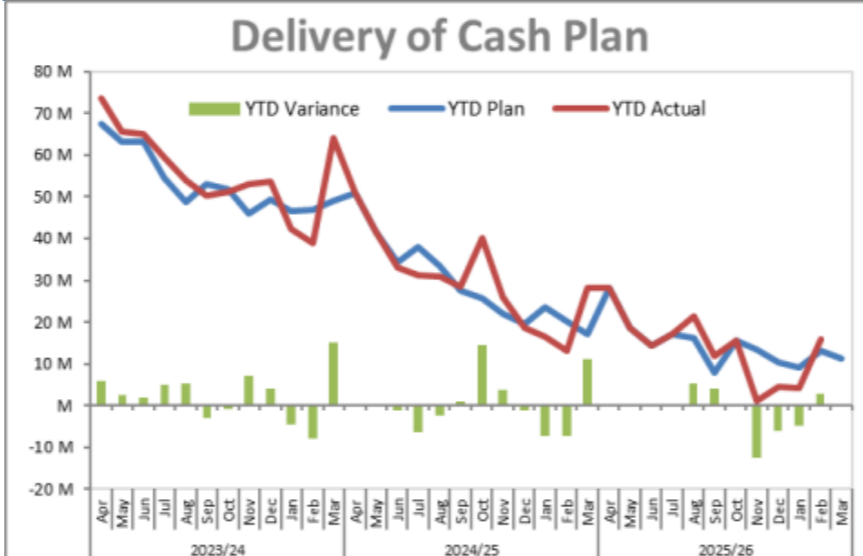
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Finance – To deliver our key performance targets and finance plan

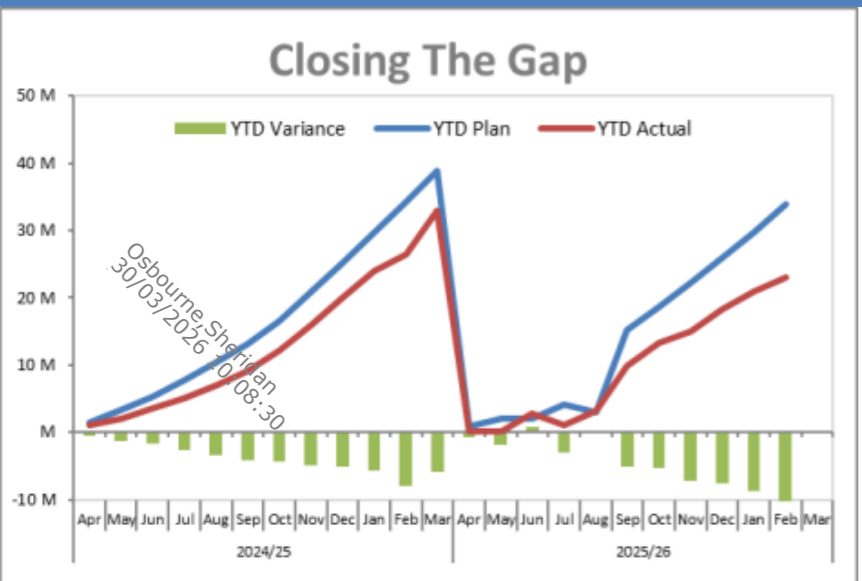
February 2026 – -£23.4



February 2026 – £15.9m



February 2026 - £23.0m



February 2026 – £32.8m



Analysis

The Trust is reporting a year to date I&E position worse than the formal plan by £19.5m at Month 11, with an actual deficit of £23.3m compared to the originally planned deficit of £3.8m. The Trust is marginally ahead of the revised off plan forecast submitted to NHSE for 2026/27. Delivering the revised forecast £17.8m year end deficit (which is £15.1m adverse to the formal planned £2.7m deficit) will be reliant on approximately £10m of run rate improvements and non-recurrent measures in Month 12. Sufficient measures have been identified to make this a feasible scenario for 2025/26, however there remains some risk to achieving this and there remains a risk that the revised £17.8m deficit ceiling may be exceeded. Clarity on some measures will not be available until the end of March 2026.

The Trust ended the period holding £2.9m more cash than planned. I&E cash was £8.3m below plan, driven mainly by the in-year deficit, which reduced the organisation’s operating cash generation to -£22.9m. This adverse position is partially offset by higher-than-planned cash balances relating to Research and Development, Health Education England, and ICB funding, which have been received in advance of the periods in which the associated expenditure will occur.

In contrast, capital cash was £11.1m above plan. This favourable variance is the result of two key factors: Capital expenditure has been lower than expected, meaning planned cash outflows for capital projects have not yet occurred; and The Trust has drawn down Public Dividend Capital earlier than required, in line with national deadlines for accessing these funds, resulting in higher cash holdings ahead of scheme completion.

Overall, the combined impact of lower I&E cash generation and higher capital cash balances explains the net position versus plan. being completed (in line with national deadlines). The Trust has received £5.4m cash support towards 2025/26 Capital Programme.

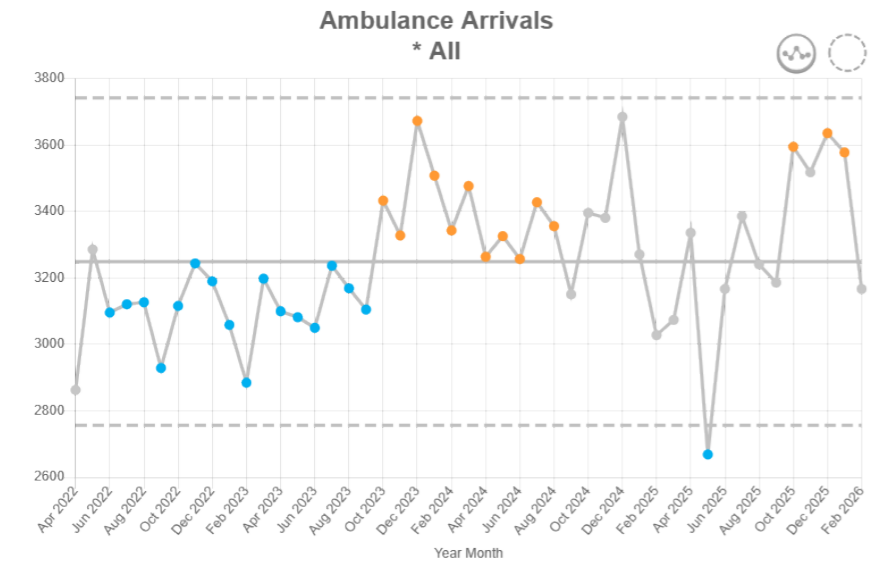
The Trust has reported delivery of £23m of efficiencies up to Month 11 via the Closing The Gap programme. This is £11m short of the £34m YTD target. The focus in Quarter 4 has been on realising the benefits targeted via the Financial Recovery Plan, many of which are not recorded as CTG efficiencies. Budget holders have been asked to focus on grip and control within their budgets and on developing plans for 2026/27. They will be supported in this by a revised Recovery Plan governance structure and Recovery Director to assure more sustainable savings delivery in the next financial year.

The Trust has reported year-to-date capital expenditure that is £2.8m behind plan. The variance is driven predominantly by two key programme areas:

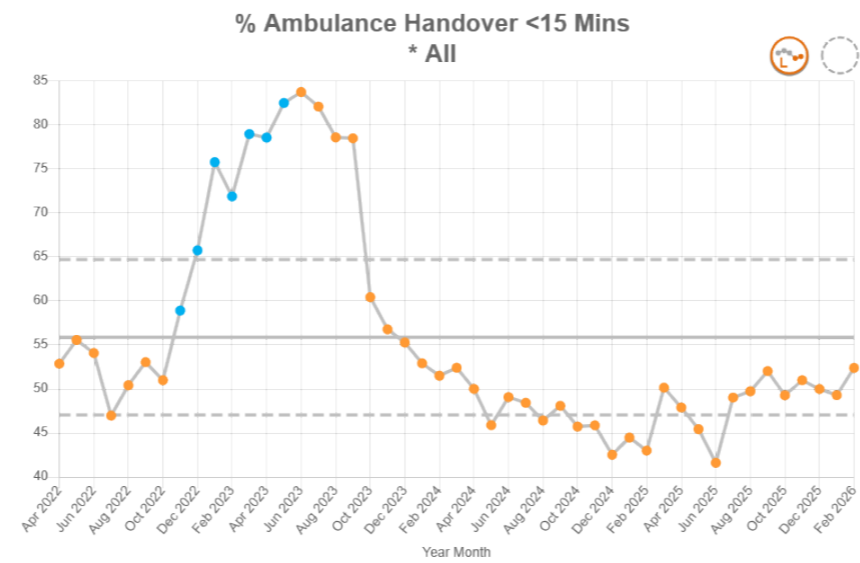
- Estates Critical Infrastructure Risk schemes, which account for £2.4m of the slippage. Progress on these projects has been slower than anticipated, reflecting delays in procurement, contractor availability, and sequencing of works to ensure operational continuity.
- MRI Scanner investment, which is also running behind schedule. This delay is linked to longer-than-expected lead times for equipment delivery and preparatory works required before installation can begin.

Performance – To deliver our key performance targets and finance plan

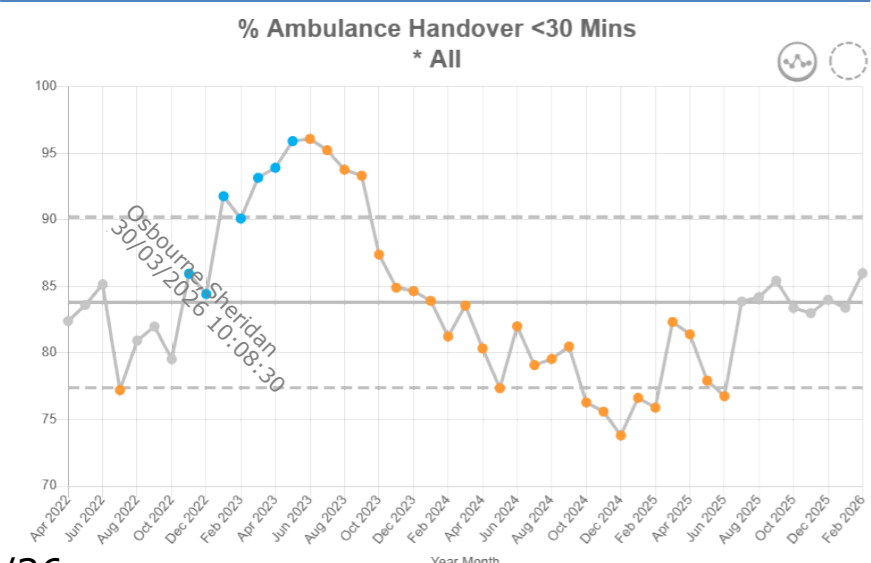
February 2026 – 3,167 Ambulance arrivals
Common cause variation



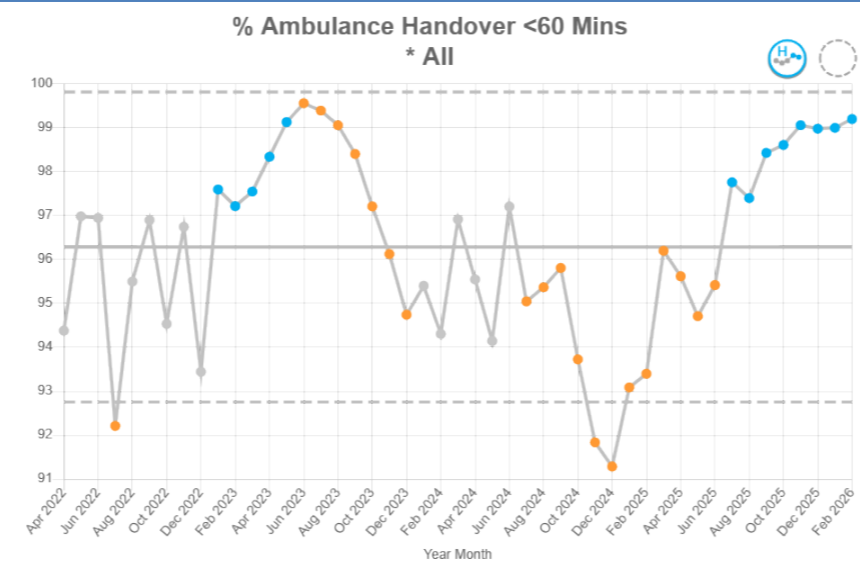
February 2026 – 52.4% ambulance arrivals
Special cause variation of a deteriorating nature



February 2026 - 86% ambulance arrivals
Common cause variation



February 2026 – 99.2% ambulance arrivals
Special cause variation of an improving nature



Analysis

15-minute handover performance improved to 52.5% in February (from 49.3% in January). Performance has improved despite sustained high conveyance volumes, with faster handovers and turnaround enabling crews to re-enter the system more quickly.

Risks, Mitigations and Assurance

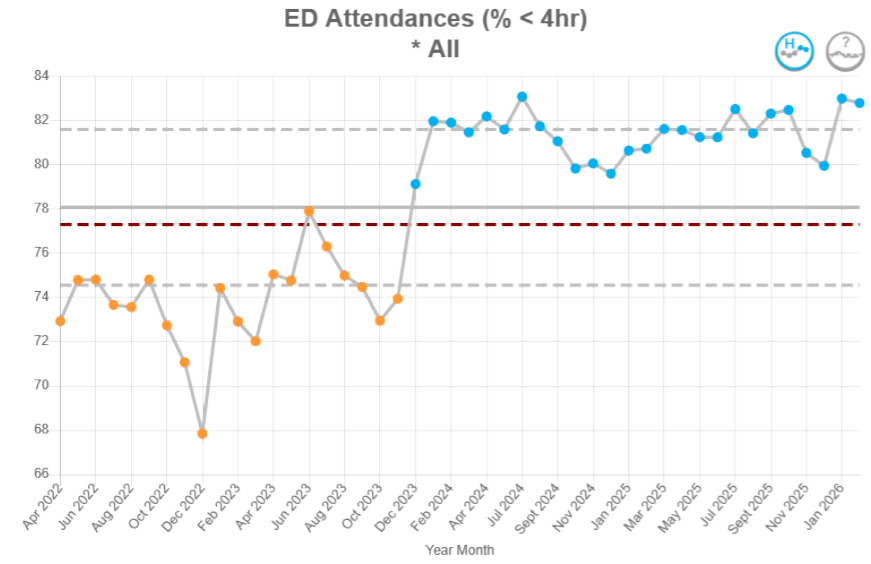
Live handover validation, introduced in January, has reduced data queries and currently operates Monday to Friday (9–5), with plans to extend to 24/7 within the next three months. The Transfer of Care (ToC) protocol ensures patients are transferred to a BTHFT trolley within 45 minutes, enabling YAS crews to return to service more quickly. Self-handovers are currently in line with peer group averages, with ongoing promotion and auditing by YAS. Crew Clear Times remain stable, supporting sustained improvement in overall ambulance turnaround performance.

Benchmarking

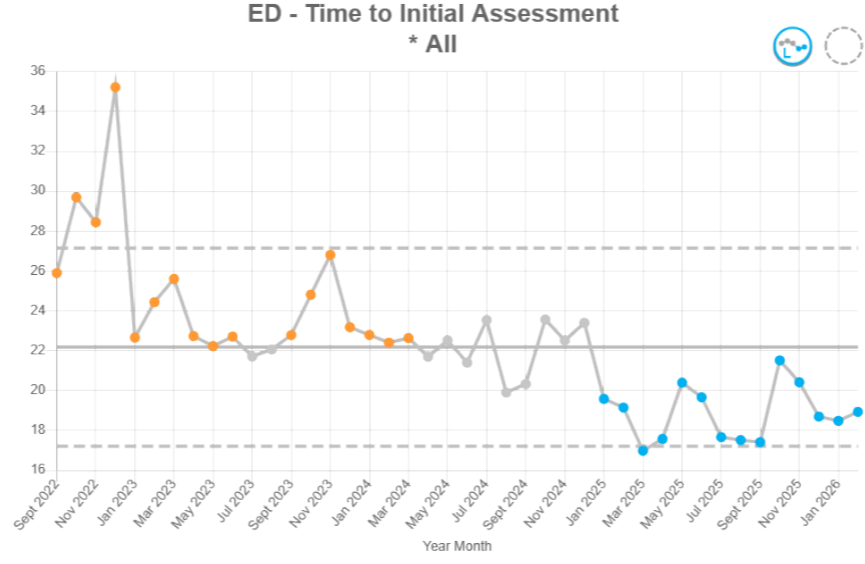
Compared to peer we have sustained a better than average position.

Performance – To deliver our key performance targets and finance plan

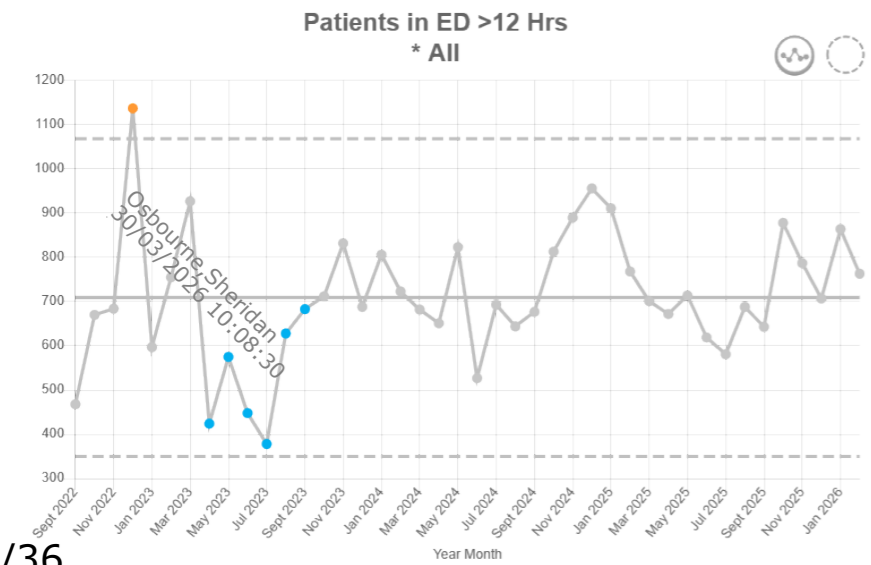
February 2026 – 72.8% - Year end target 77.3%
Common cause variation of an **improving** nature



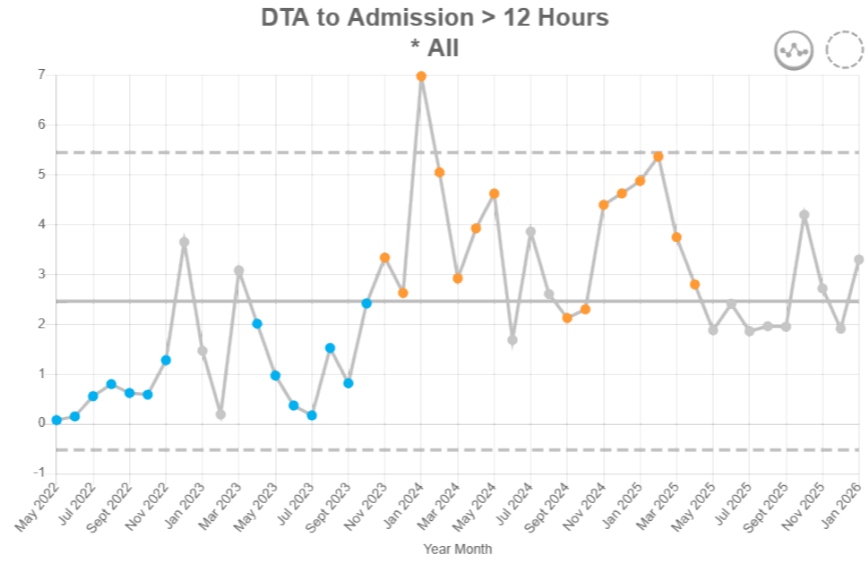
February 2026 –18.9 minutes
Common cause variation of an **improving** nature



February 2026 – 763 patients
Common cause variation



February 2026 – 3.3%
Common cause variation



Analysis

Daily ED attendances in February averaged 445, broadly in line with the 449 forecast and below November's peak of 475 following a period of higher-than-expected demand.
ECS Performance for the 4-hour target remains strong at 84.2% in January and 84.1% in February, above the 82% plan and in line with the upper decile across combined Trusts.
February saw a reduction in 12-hour DTA trolley breaches, when compared with January, driven by pressures in the elderly care pathway, particularly transfers to intermediate care.

Risks, Mitigations and Assurance

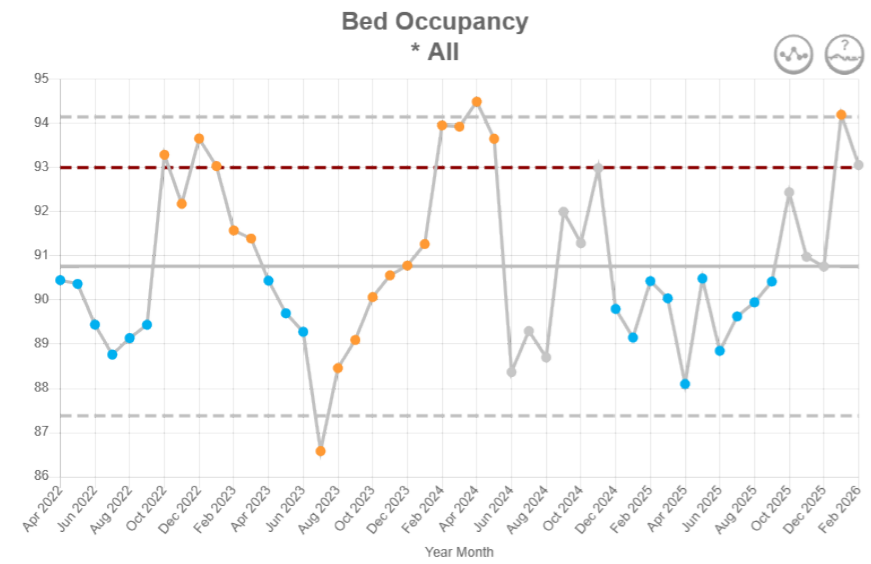
Expanded clinical streaming in Ward 8's Same Day Emergency Care and Ambulatory Emergency Care, supported by additional trolleys and discharge lounge chairs, continues to manage high-demand periods, while improved performance largely reflects more accurate recording.
The EXCEL Programme is progressing, with a focus on decompressing the ED, to improve patient and staff experience. Engagement with patient groups, system partners, and other stakeholders has demonstrated a strong appetite for change and active participation. A range of change ideas are currently being explored further. The delivery work programme is being delivered under new executive sponsorship to ensure stronger alignment between the CSU and the EXCEL programme and to support effective implementation.

Benchmarking

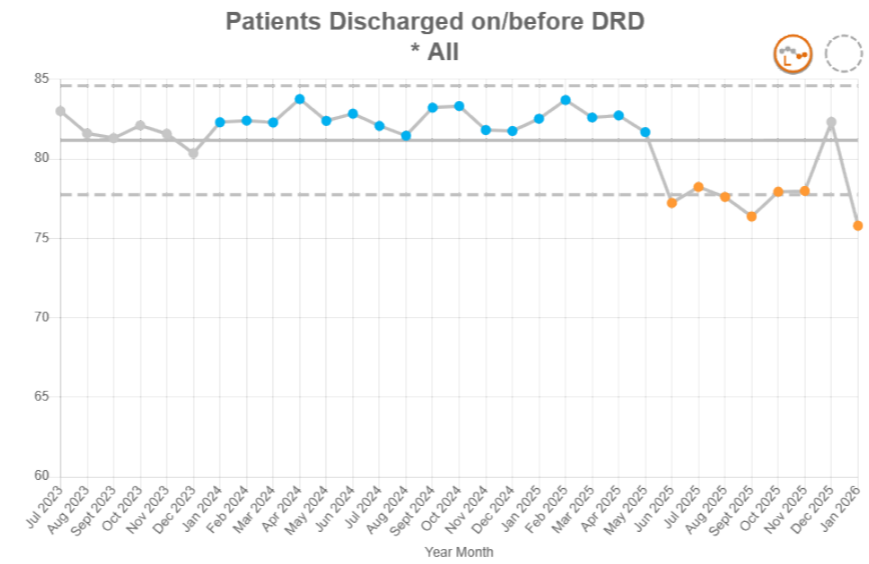
Performance is above national, peer and WY averages. For ECS the Trust performs in the upper decile of Acute Trusts in England.

Performance – To deliver our key performance targets and finance plan

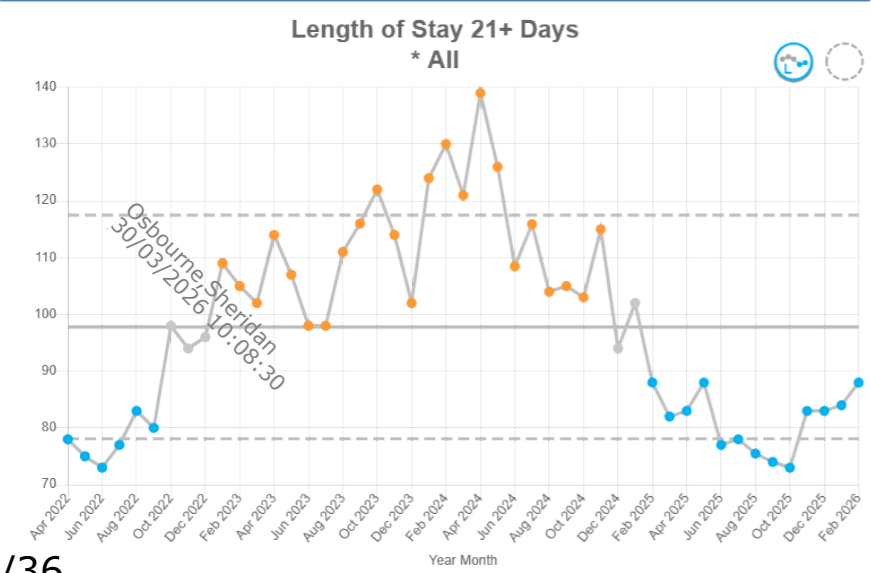
February 2026 – 93.06% occupancy – Year end target 93%
Common cause variation



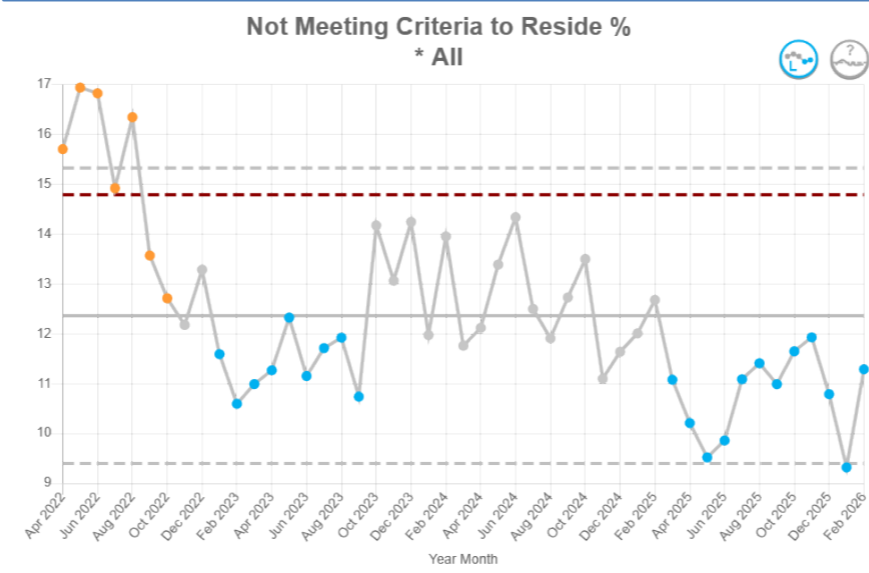
February 2026 – 75.8%
Common cause variation of a **concerning** nature



February 2026 – 83 patients
Special cause variation of an **improving** nature



January 2026 – 9.32% – Year end target 14.79%
Common cause variation of an **improving** nature



Analysis

Total G&A bed occupancy reached 93.06% in February and remained above plan. Levels are expected to return to plan during March as winter pressures decrease.

Risks, Mitigations and Assurance

Temporary staff shortages and high bed occupancy are limiting therapy support, contributing to assessment and discharge delays. Caseloads are being continuously monitored and prioritised based on discharge needs and new assessments. H-FAST capacity remains at four discharges per day and is broadly sufficient for demand; however, eligibility criteria and assessment processes can add ~1 day discharge delay, increasing reliance on the BEST pathway. Work with Adult Social Care is underway to reduce BEST delays through parallel processes with private provision, while LA bed bureau implementation and Care Act choice requirements continue to contribute to delays; a system review and improvement actions are in progress.

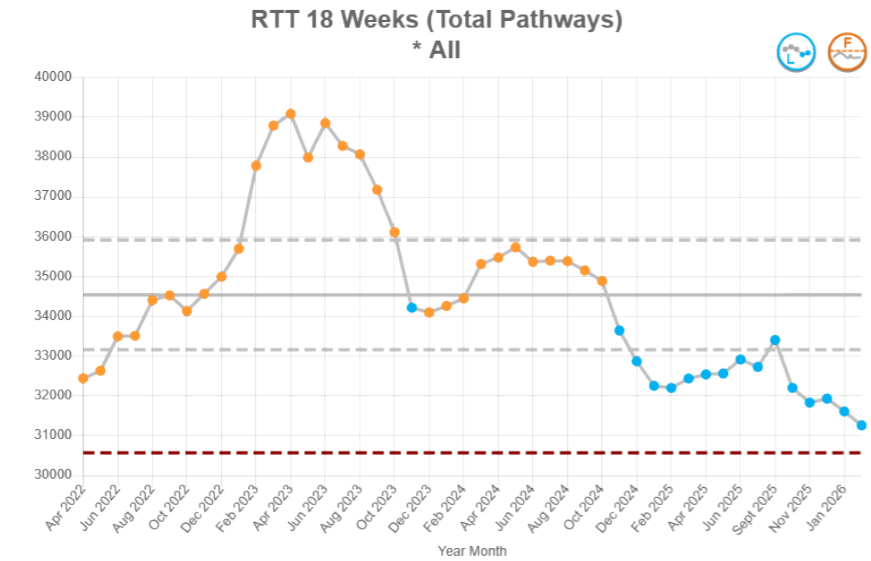
OPTICA went live mid-February 2026, improving integrated health and social care discharge coordination and real-time visibility of delays. Over 200 users have been trained, with targeted support and mandated training for senior nursing teams in place to increase ward adoption and maximise system benefits.

Benchmarking

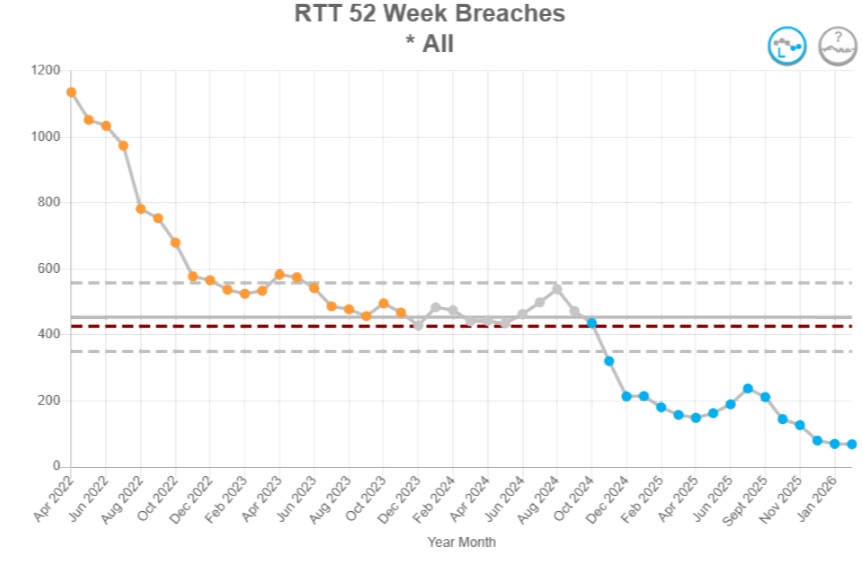
As a % of emergency spells the number of 21-day LoS for BTHFT continues to benchmark better than the national and peer averages and close to the best quartile nationally despite the increases.

Performance – To deliver our key performance targets and finance plan

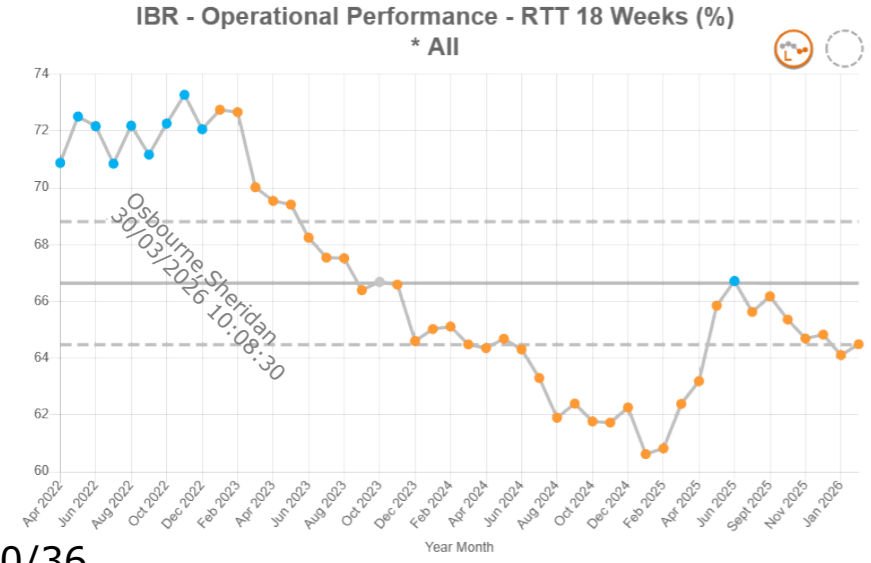
February 2026 – 31,261 pathways – Year end target 30,571
Special cause variation of an **improving** nature



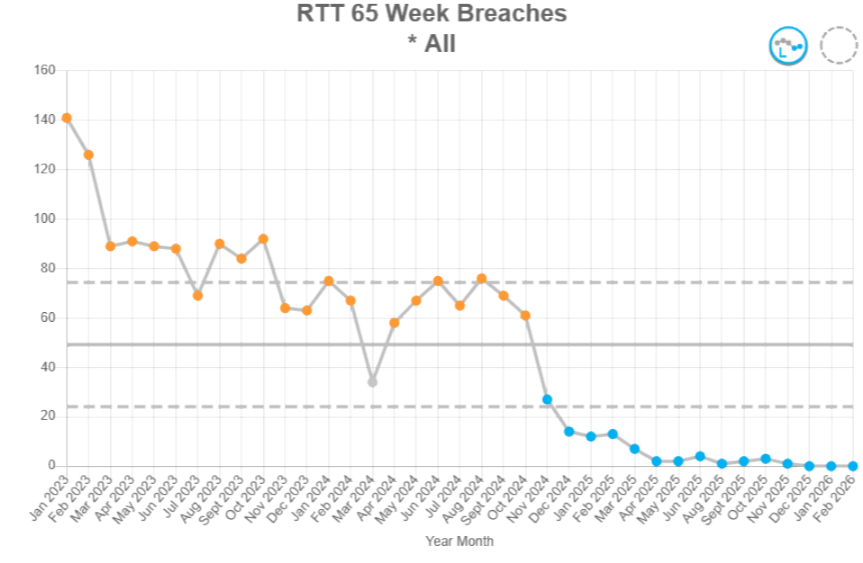
February 2026 – 69 pathways – Year end target 426
Special cause variation of an **improving** nature



February 2026 – 64.49%
Special cause variation of a **concerning** nature



February 2026 – 0 patients
Special cause variation of an **improving** nature



Analysis

It was hoped that RTT performance would improve to meet the out-turn plan of 66.7% during Q4, with waiting list management and service level productivity improvement enhanced by the outpatient activity sprint and additional operating lists via the Bronte forward wait area opening. The latter has seen improvement achieved within plastic surgery during this period, but we have not been able to run all the additional clinical sessions we had hoped, due to service specific delays in recruitment and lower than anticipated uptake of additional clinics. There has also been increased leave during February which reduced the activity run rates we expected. Overall, the impact has been a gap to plan of c.2% which will need to be recovered in 2026/27 on top of 5% planned improvement. 52-week performance has remained ahead of plan.

Risks, Mitigations and Assurance

The Q4 outpatient sprint is underway with additional new appointment slots in place and weekend clinics planned during March. Uptake against the original plan has not been fully achieved but performance is likely to have deteriorated without this specific push as run-rate activity has been impacted by annual leave above normal Q4 levels.

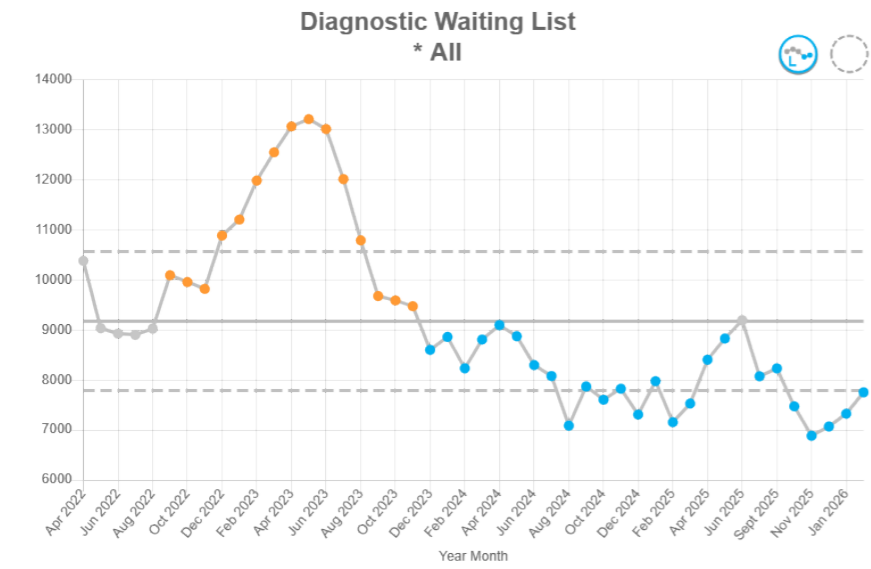
The support services improvement programme is progressing with the aim to improve understanding and compliance with the Referral to Treatment (RTT) policy across support services to strengthen their role in overall delivery. This programme is reviewing the standardisation of processes, targeted staff training, and the implementation of robust, data-driven monitoring systems.

Benchmarking

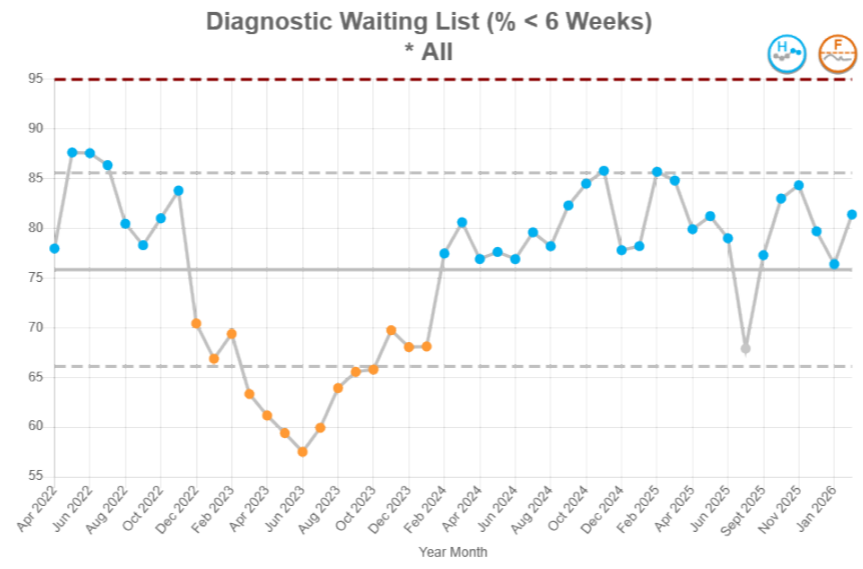
52-week performance benchmarks in the best quartile nationally whilst we are just below the best quartile for 18 weeks, although at the lower end compared to WYAAT.

Performance – To deliver our key performance targets and finance plan

February 2026 – 7,754 pathways
Special cause variation of an **improving** nature

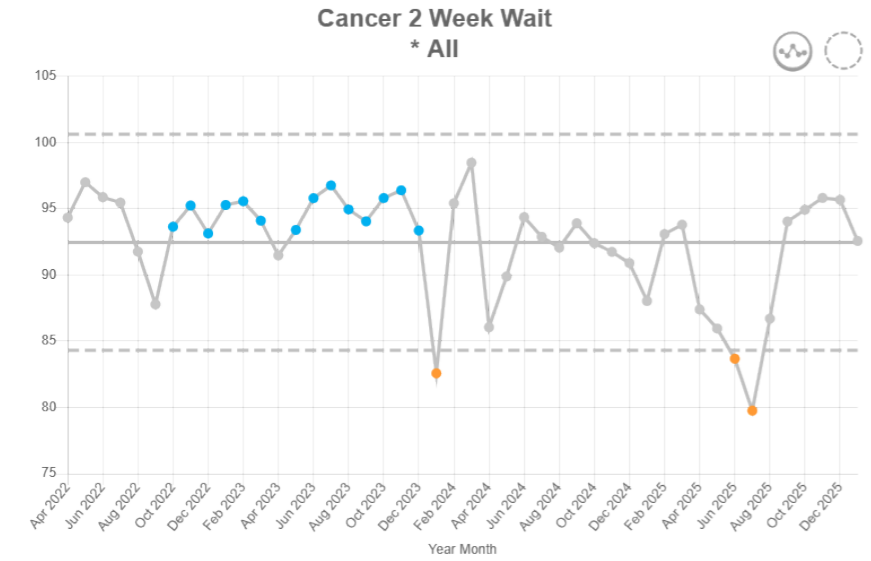


February 2026 – 81.4% <6 Wks – Year end target 95%
Special cause variation of an **improving** nature

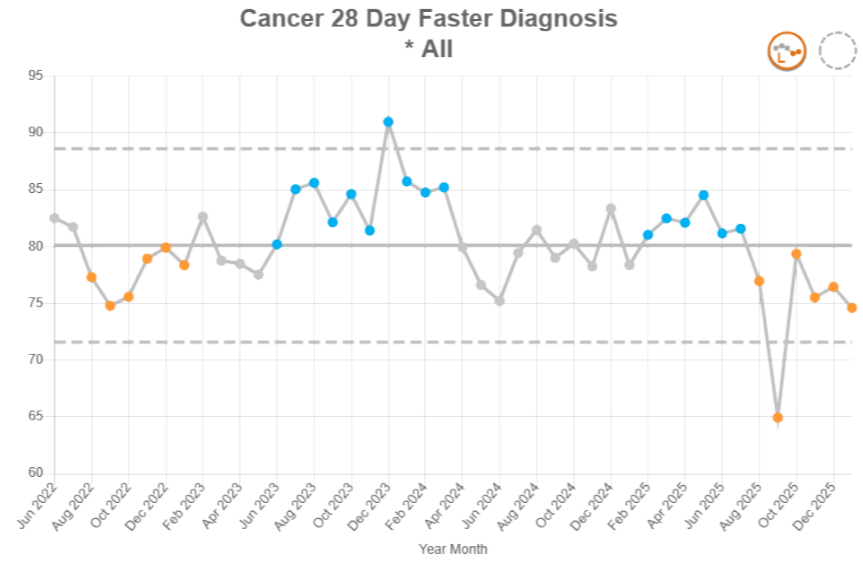


Performance – To deliver our key performance targets and finance plan

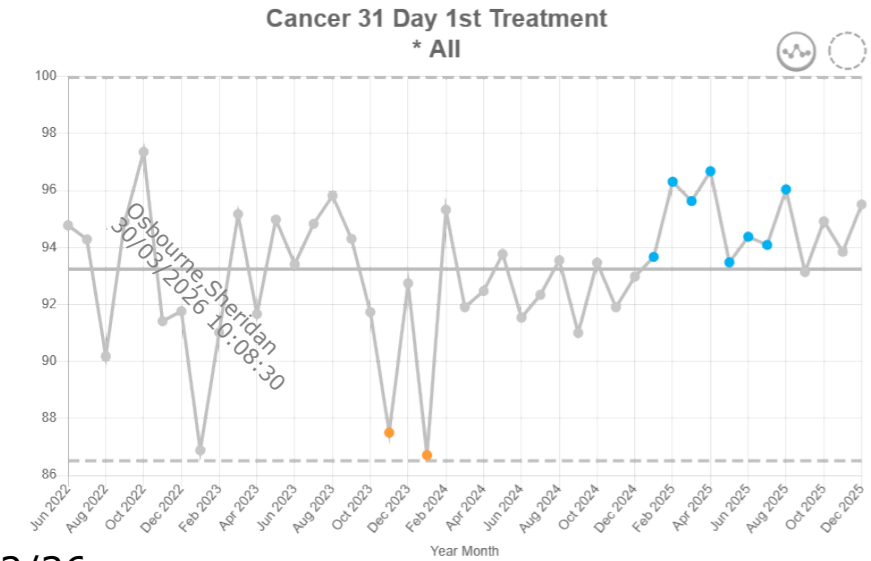
January 2026 – 92.57%
Common cause variation



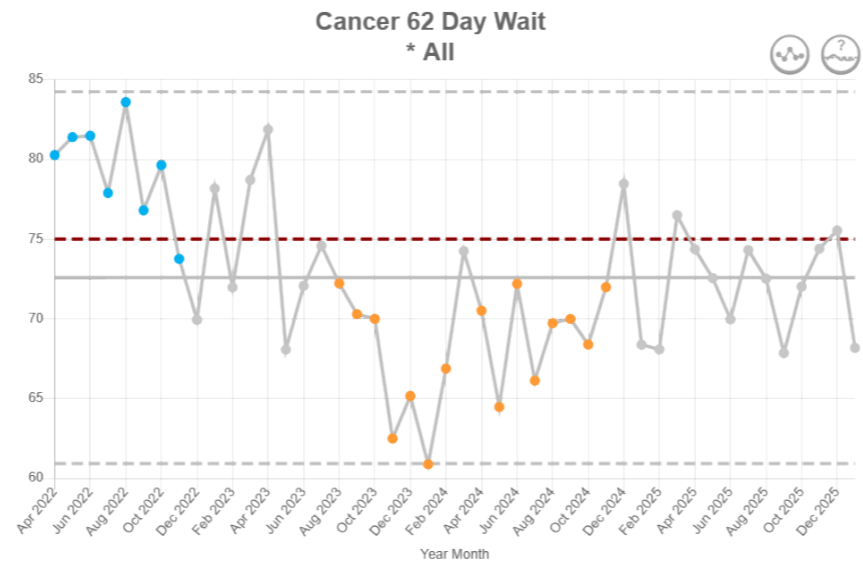
January 2026 – 74.61%
Special cause variation of a **concerning** nature



January 2026 – 95.51%
Common cause variation



January 2026 – 68.18%
Common cause variation



Analysis

Two week wait (2WW) performance remained above average but FDS and 62-day performance for January was below target and plan. FDS performance is forecast above plan for February and March; whilst 62-day backlogs have reduced meaning performance should exceed target for the year end position in March.

Risks, Mitigations and Assurance

The Skin and Gynaecology pathways continue to be impacted by histology reporting backlogs, and complex diagnostic pathways are still impacting performance. Across most pathways, administrative delays, outpatient capacity and patient compliance issues are noted as an overarching challenges.

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.

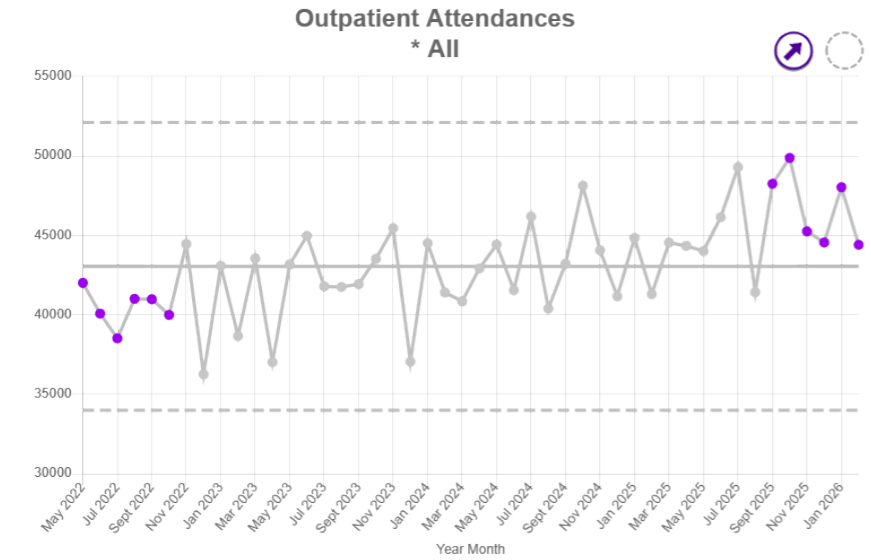
The Lung pathway is being reviewed, with an aim to align with the best practice timed pathway. As a result, patients will undertake all required diagnostic tests prior to MDT rather than additional tests being carried out at later dates, prolonging the diagnostic phase. Broader work on MDT streamlining 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

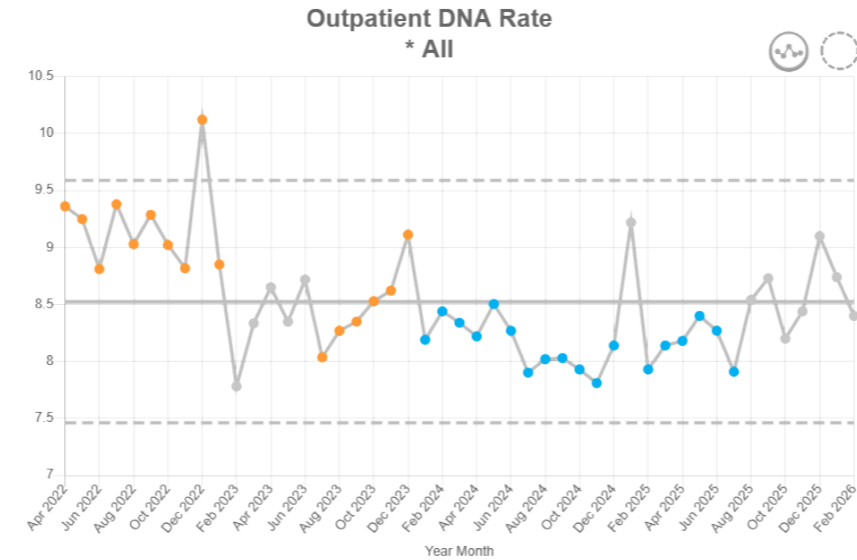
Despite challenges the Trust continues to benchmark above national and peer averages.

Performance – To deliver our key performance targets and finance plan

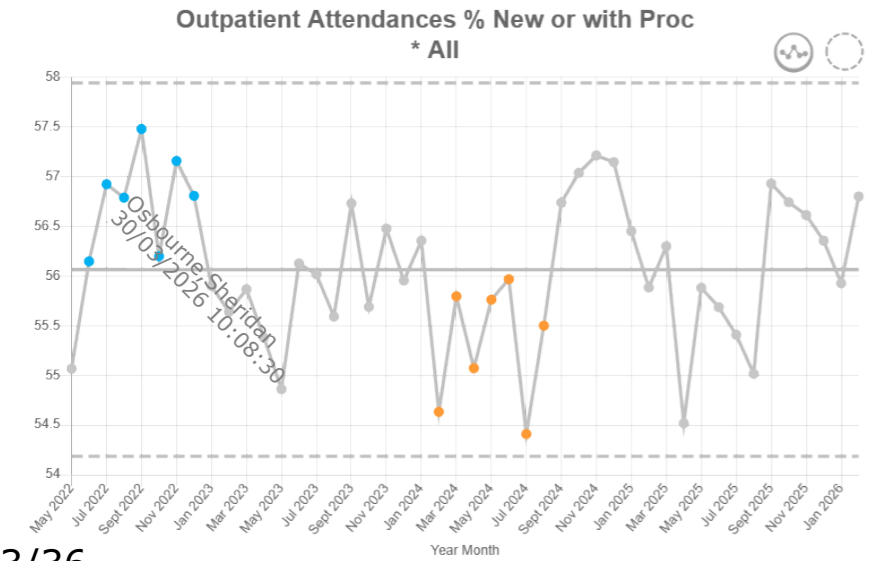
February 2026 – 44,405
Common cause variation



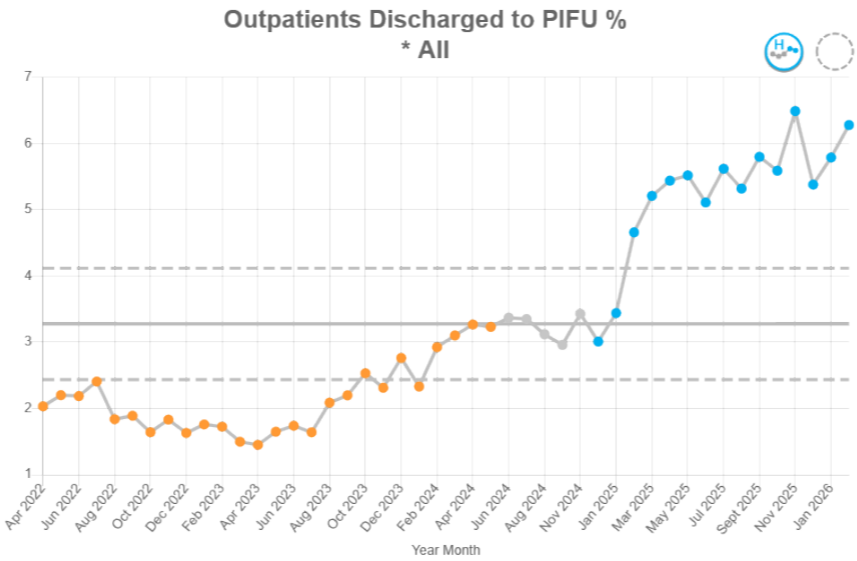
February 2026 – 8.4%
Common cause variation



February 2026 – 56.8%
Common cause variation



February 2026 – 6.28%
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

Outpatient Transformation will remain focussed on service led pathway redesign supported by digital advancement, estate modernisation, 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.

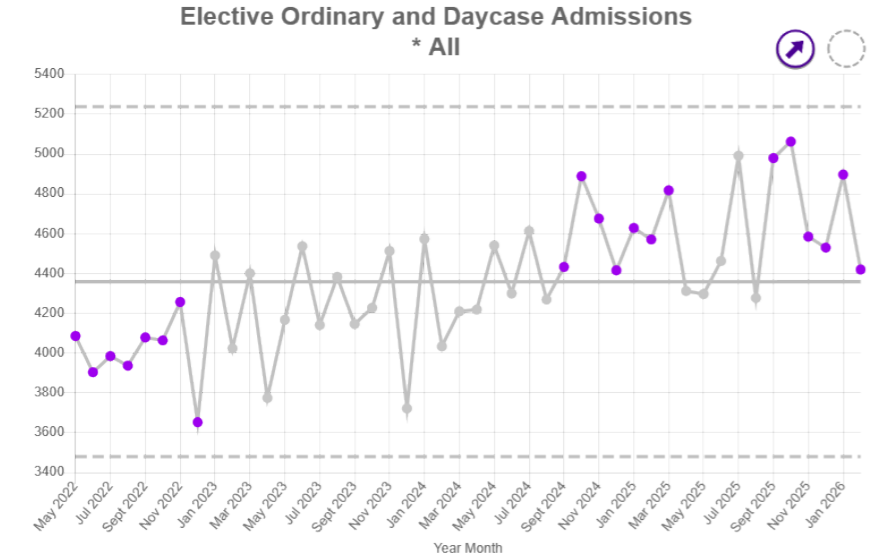
Service Improvement training and clinical engagement efforts continued, and these are integral to long term transformational objectives.

In the more immediate term, we are accelerating productivity related improvements, particularly relating to DNA rates and clinic template configuration as part of the Recovery Board structure. The related Data and Productivity workstream focusing on improving delivery of new outpatient appointment and outpatient with procedures.

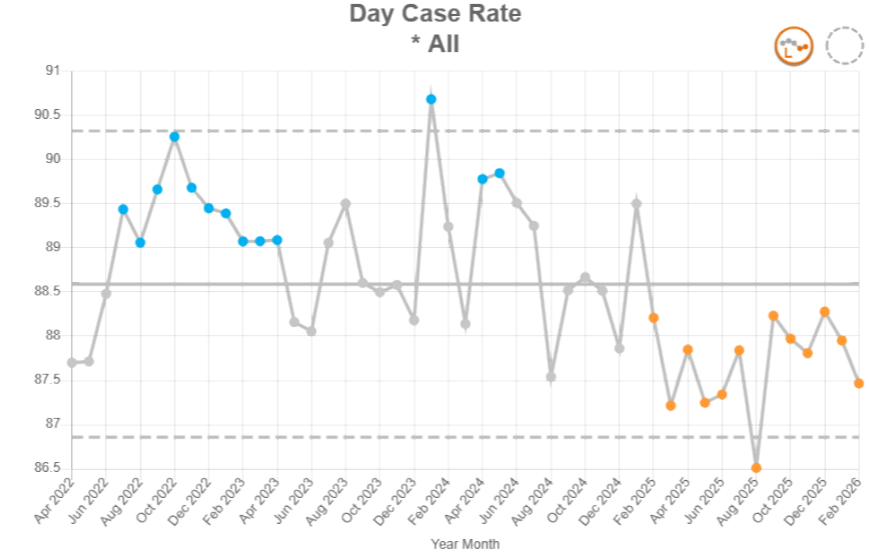
Benchmarking

Performance – To deliver our key performance targets and finance plan

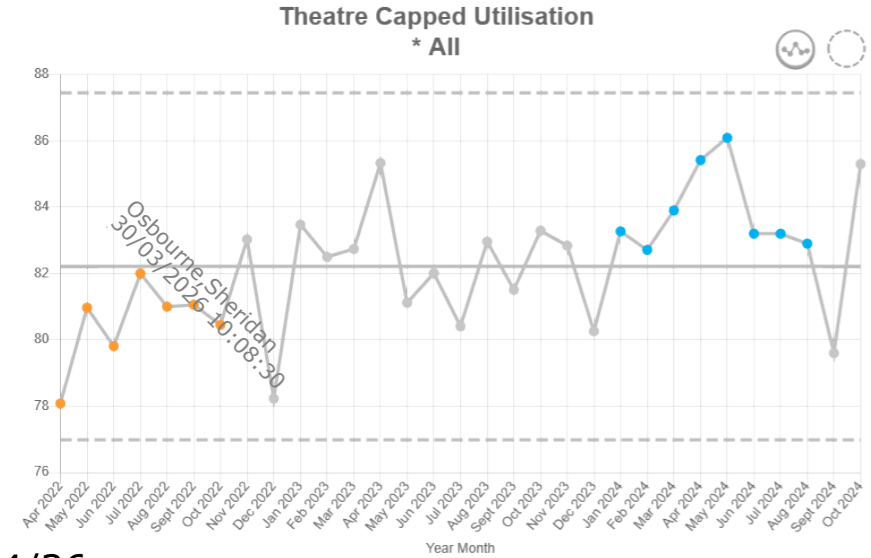
February 2026 – 4,420
Common cause variation



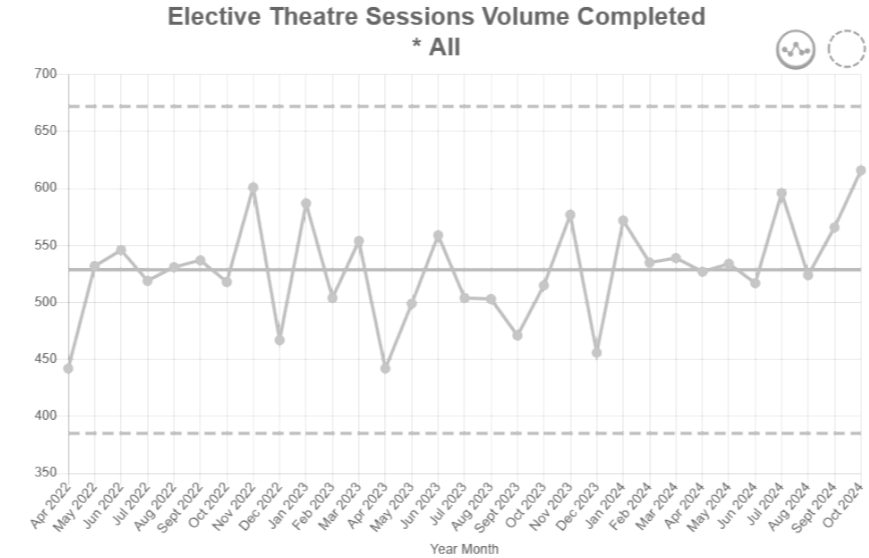
February 2026 – 87.47%
Special cause variation of a concerning nature



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 February.

Risks, Mitigations and Assurance

The T&O improvement programme is now up and running with positive results in primary care engagement to review referral criteria and the reduction of LOS. Medical cement supply shortages resulted in two weeks of reduced activity however this has now been mitigated with resource provided by another supplier. Conversation with services and theatres are taking place regarding job planning, resources and session allocation in preparation for 2026/27 to ensure plan can be delivered with focus on 642 and scheduling to guarantee theatre utilisation and PPL meet target. Fit for Surgery texting has commenced in Gynaecology following a successful trial. With a response rate of 89% the process identified 7 patients who may have been at risk of cancellation on the day due to recent flights, transport not arranged, skin/cuts and not understanding fasting instructions. The trial has now been rolled out to encompass T&O and Ophthalmology.

Benchmarking

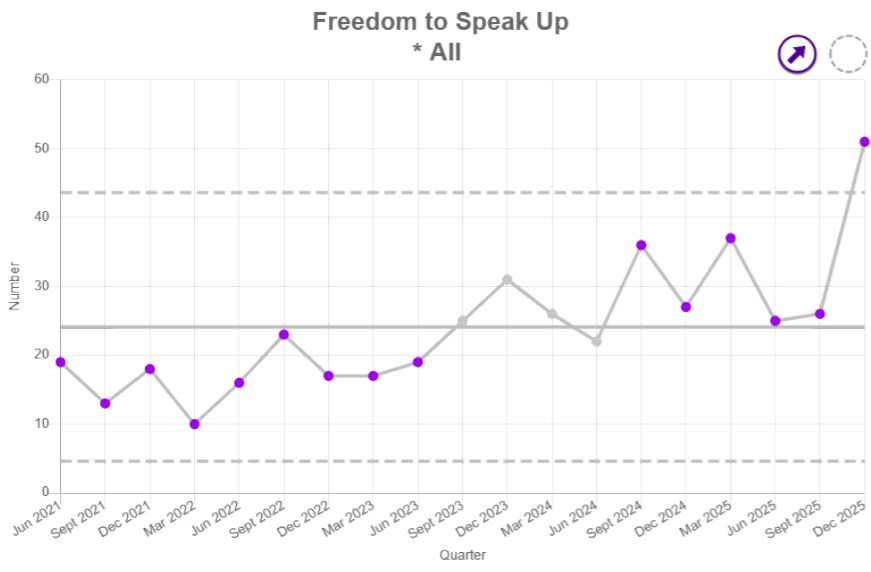
Benchmarking not available due to the issues with reporting post TACC implementation.

Metric	Period	Latest Value	Target	Variation	Assurance	Mean
Agency - %	Jan-26	0.62%				2.10%
Appraisal Rate - Non-Medical	Jan-26	80.3%				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 Manadatory Training - * All	Jan-26	92.0%				90.90%
Disability Declaration - * All	Sep-25	6.0%				3.9%
Freedom to Speak Up - * All	Oct 25 - Dec 25	51.00				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	Jan-26	33.0%				49%
Job Planning - Medics	Jan-26	60.0%				25%
Job Planning - Nurses	Jan-26	2%				60%
Nursing Agency Fill Rate - %	Jan-26	5.1%				11.8%
Nursing Bank Fill Rate - %	Jan-26	68.7%				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	Jan-26	6.46%				6.3%
Staff Stability - * All	Jan-26	93.30%				98.8%
Staff Turnover - * All	Jan-26	10.57%				11.1%

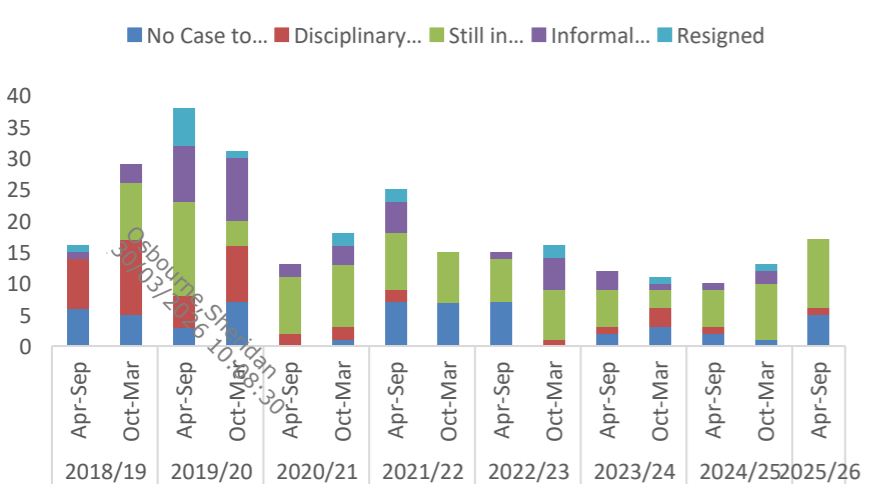
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People – Engagement – To be in the top 20% Employers

2025/26 Quarter 3 - 51



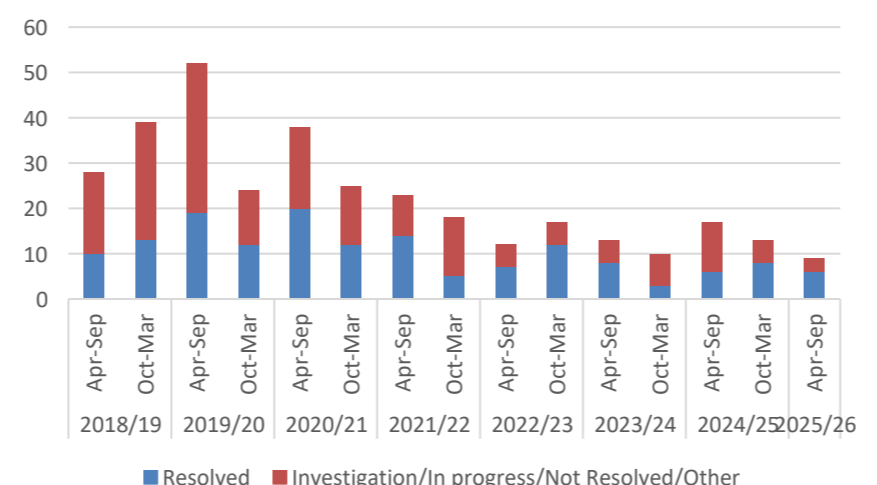
2025/26 Quarter 2 Harassment and Bullying



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%.

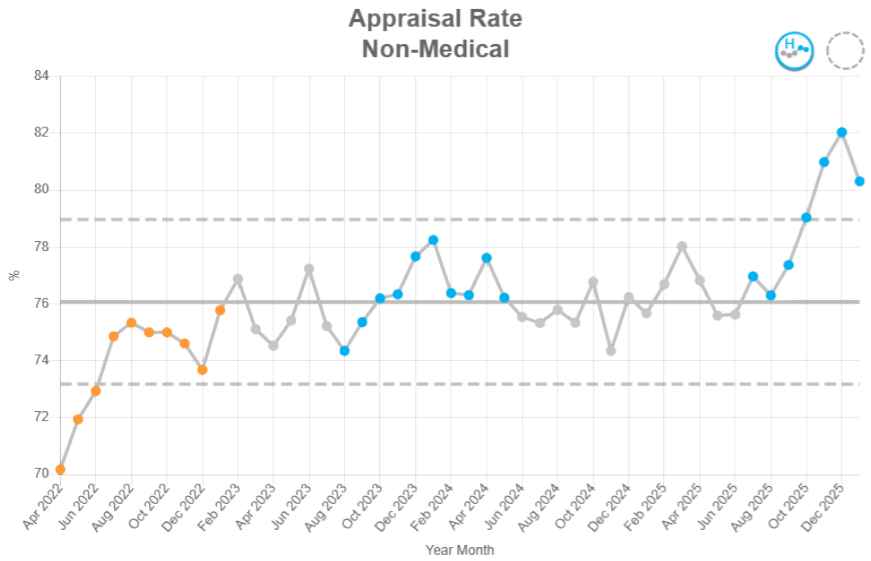
Freedom To Speak Up: There were 51 concerns raised to the FTSU team in Q3. This is the highest number of concerns raised in a quarter since the start of FTSU. The highest category of concerns (24) had an element of worker safety or wellbeing and there were 10 concerns raised that had an element of other inappropriate attitudes or behaviours. This quarter, the highest group of staff raising concerns were from Estates and Ancillary staff (12). There were 10 concerns reported anonymously in Q3 via the FTSU App

Risks, Mitigations and Assurance

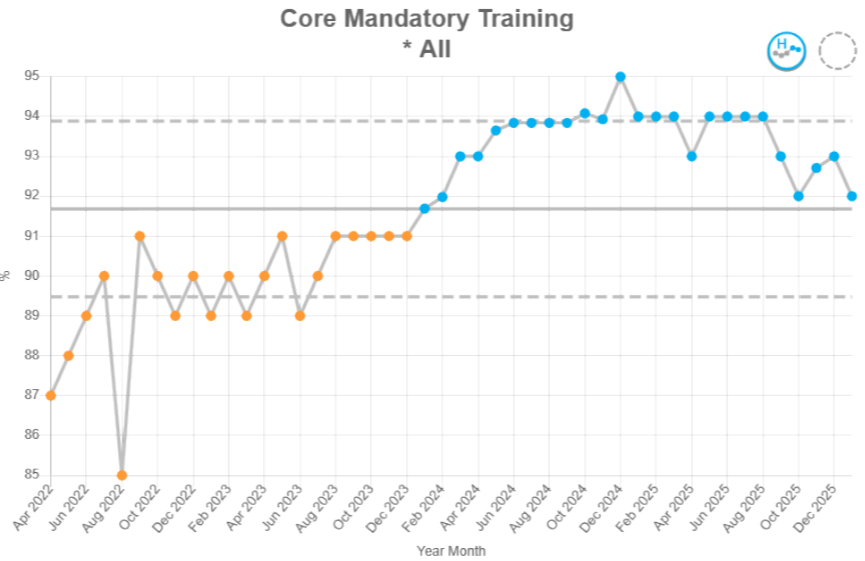
Harassment & Bullying Outcomes: Further focus and efforts are required in terms of raising awareness around informal conflict resolution. This will be a key area of focus in the next 12 months as we launch the newly developed Respect, Civility & Resolution policy. This will involve a targeted implementation 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

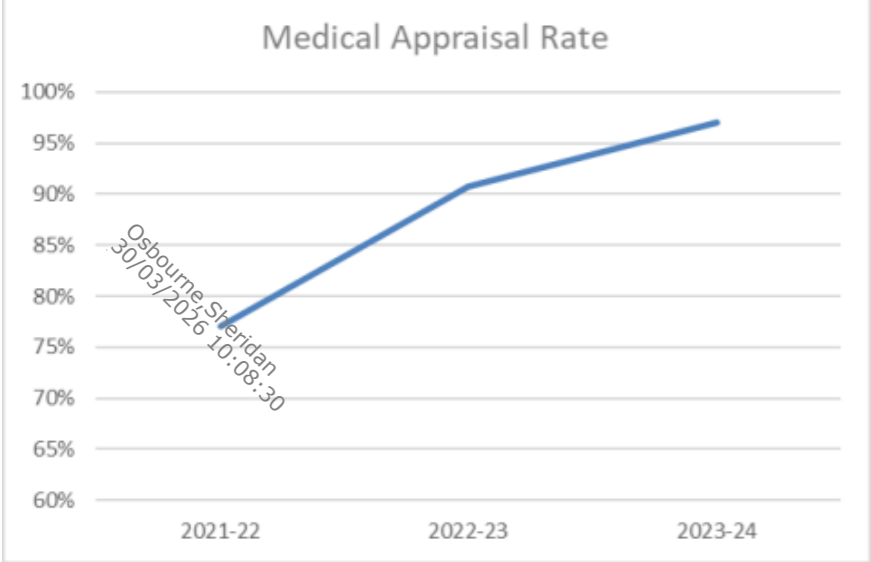
January – 80.31%
Common cause variation of an **improving** nature



January 2026 – 92%
Common cause variation of an **improving** nature



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).

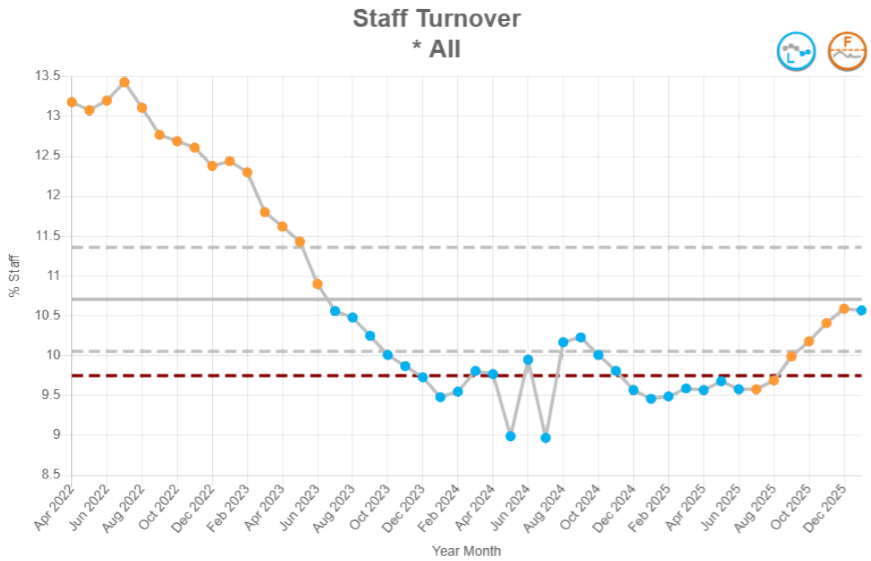
Risks, Mitigations and Assurance

Core Mandatory Training
Overall compliance for January was 92%, 1% decrease from December. The majority of subjects saw a 1% drop in compliance from last month. Safeguarding Children Level3 compliance dropped by 3% to 67%. Increased numbers of newly qualified staff have contributed to the drop over the last few months.

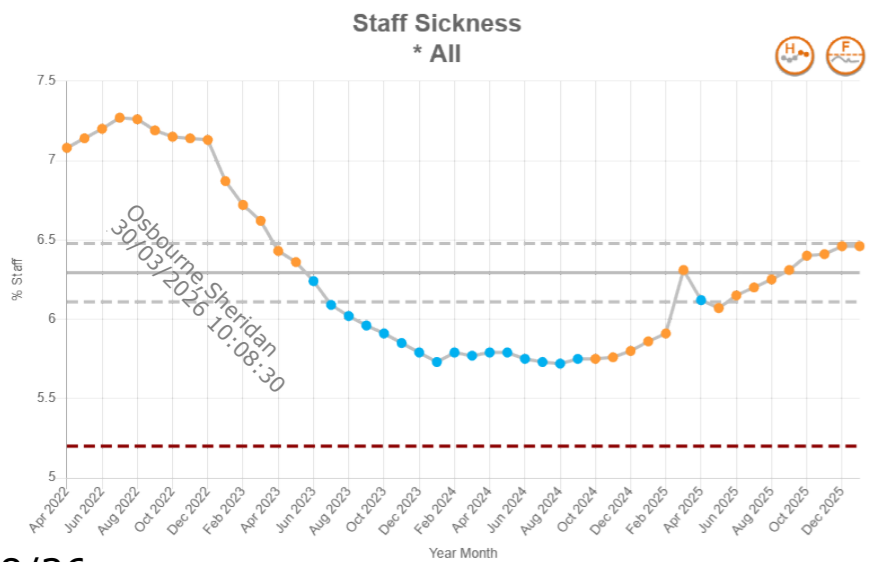
Non-Medical Appraisals
Appraisals are central to creating an environment of continuous learning and improvement; they unlock the potential of our people, developing individual performance and driving personal and professional development. Appraisals ensure everyone is working towards our Trust Strategic 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. Since mid-November, managers have been pro-actively reminded where their staff appraisals are due for renewal and non-medical appraisal completion rate continues to increase (82.04% in December 2025).

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

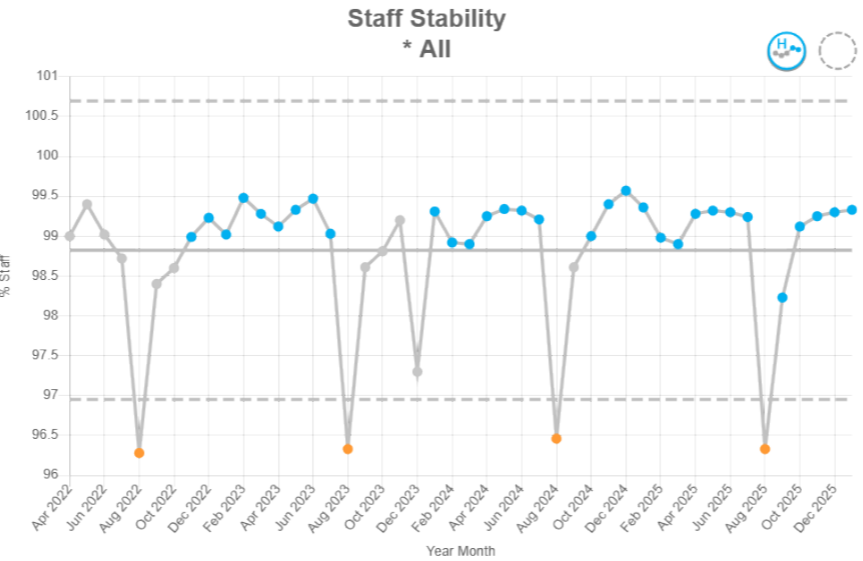
January 2026 – 10.57%
Common cause variation of an **improving** nature



January 2026 (rolling 12 months) – 6.46%
Common cause variation of a **deteriorating** nature



January 2026 – 99.3%
Common cause variation



Analysis

Sickness
Since August 2024 the Trust has seen an increase in sickness absence levels with monthly rates consistently between 6% and 7%. As at January 2026 sickness remains high across the Trust with the monthly sickness rate is at 6.52% and the year to date sickness figure is at 6.46%
The staff groups with the highest sickness rates as at January 2026 are Estates & Ancillary at 10.18%, Additional Clinical Services at 9.26%, Additional Professional Scientific and Technical' at 7.65%, Admin and Clerical at 6.71% and Nursing and Midwifery at 6.16%. The only staff groups with sickness below target in January 2026 were Healthcare Scientist at 2.85% and Medical & Dental at 2.20%.
The overall YTD sickness % has remained consistently above 5.5%. In February 2025 we saw a spike in absence figures, followed by a steady decrease in March, April and May 2025. However, since May 2025 there has been a consistent rise in absence rates across the Trust, only with a slight drop in January 2026.

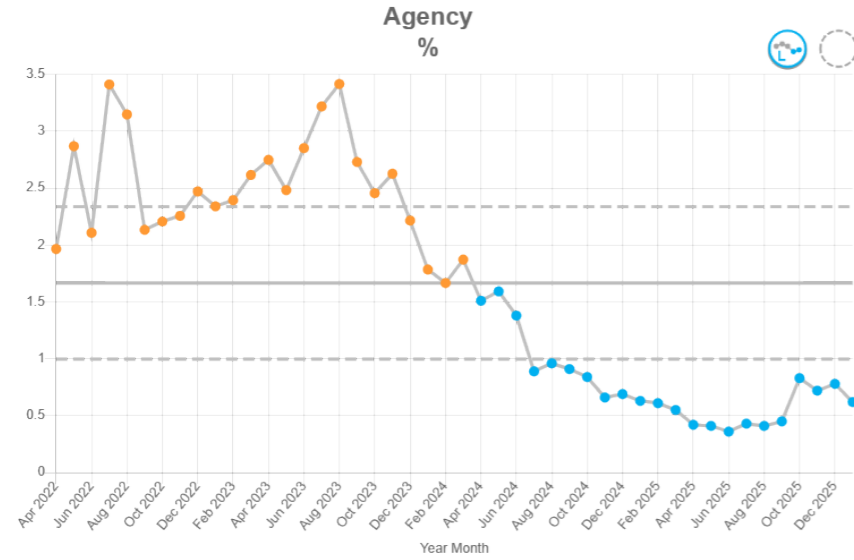
Turnover & Stability
Turnover - The monthly turnover rate in January 2026 remains around 10.5% with no material difference since November 2025.
The stability index shows the percentage of all colleagues including rotational doctors and fixed-term appointments who are still in post at the end of the month 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 November 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 January 2026, the highest turnover rate was within Estates and Facilities at 12.31%, followed by Unplanned Care Services at 11.04%, Planned Care at 10.56% and then Diagnostics and Corporate Operational Services at 10.36%.

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

January 2026 – 0.62%
Special cause variation of an **improving** nature



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Analysis

Agency

There has been an overall decrease in agency usage in January compared to December

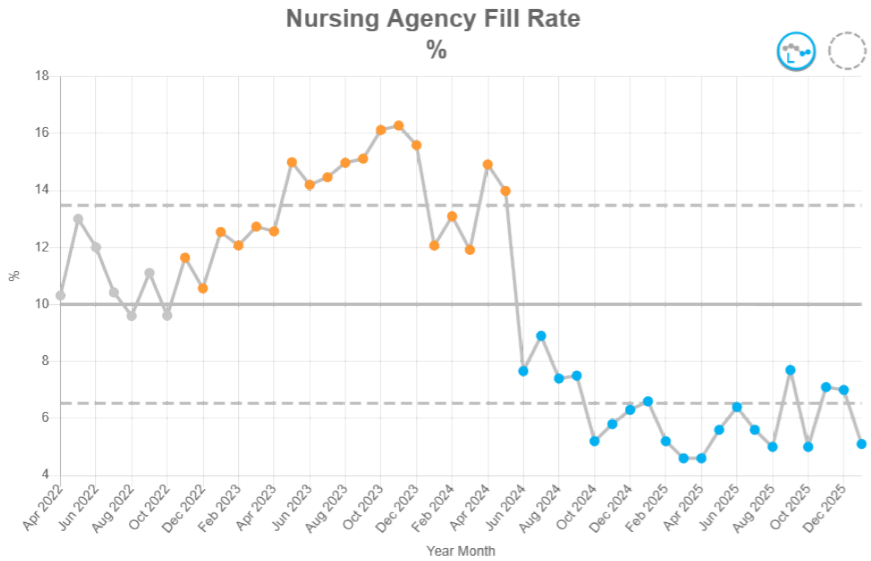
The decrease has been in the following areas
 Medical and Dental
 Nursing and Midwifery
 Professional Scientific & Technical and AHP's
 Admin and Clerical
 Estates and Facilities

Risks, Mitigations and Assurance

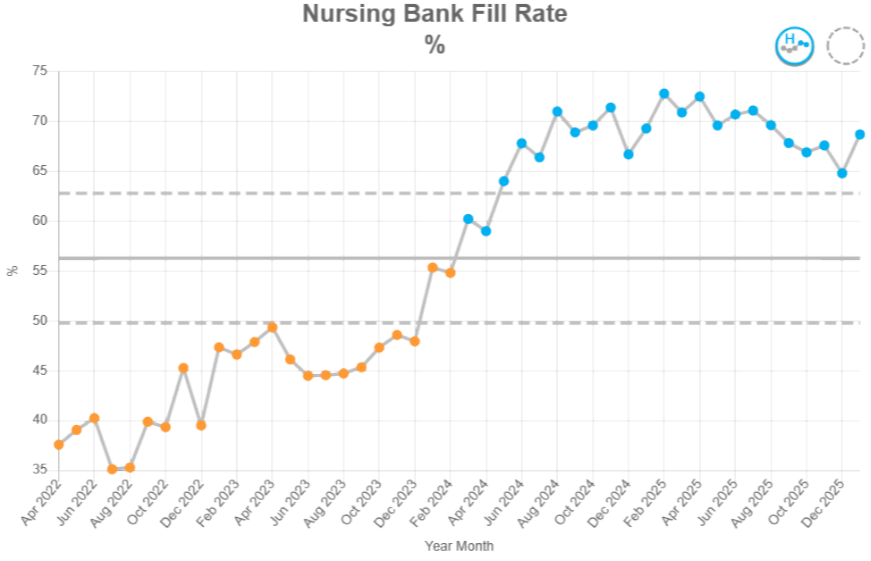
The Trust wide bank is working across the Trust to reduce the reliance on agency. CSU's are working to remove agency where it is safe to do so. No risks have been identified by the removal of agency.

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

January 2026 – 5.1%
Special cause variation of an **improving** nature



January 2026 – 68.7%
Special cause variation of an **improving** nature



Analysis

Bank Staffing Nursing

In January, the total number of requests sent to bank was 9380 compared with December requests of 9686 a decrease of 306 requests. This is split as 3768 requests for registered staff and 5612 requests for unregistered staff. Of those 3768 registered requests a total of 2589 were filled by bank staff which is 68.7% compared with 64.8% in December with a increase of 3.9%. Out of the 5612 requests for unregistered staff 3867 were filled by bank which is 68.9% compared to December which was 65% an increase of 3.9%.

Agency Nursing

Agency shifts filled for December were 191. This is split 191 registered and 0 unregistered staff. Out of the 191 filled registered shifts, 157 were filled with registered theatre staff. In January Agency fill rates decreased overall from December by 1.9% for registered staff, unregistered remains at zero usage. This is due to decreased demand from Renal and Theatre's and AED

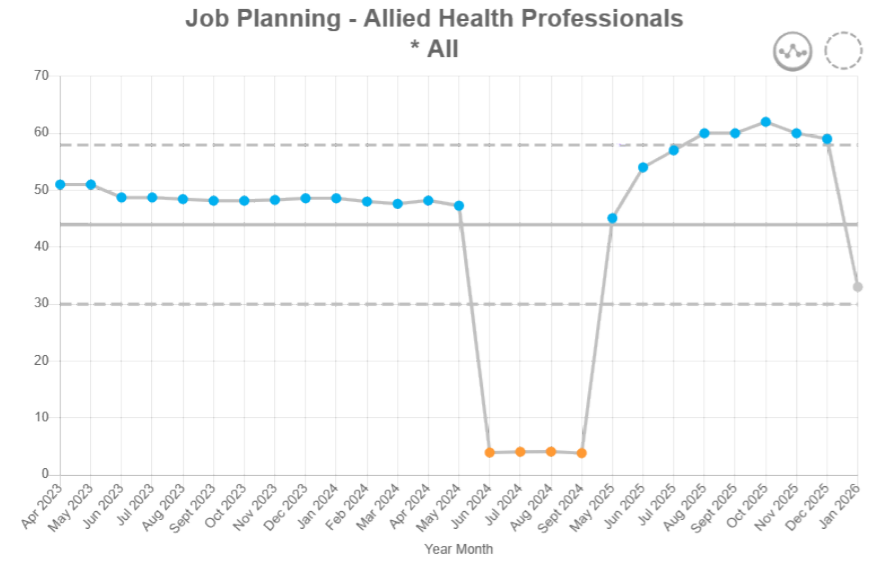
Risks, Mitigations and Assurance

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.

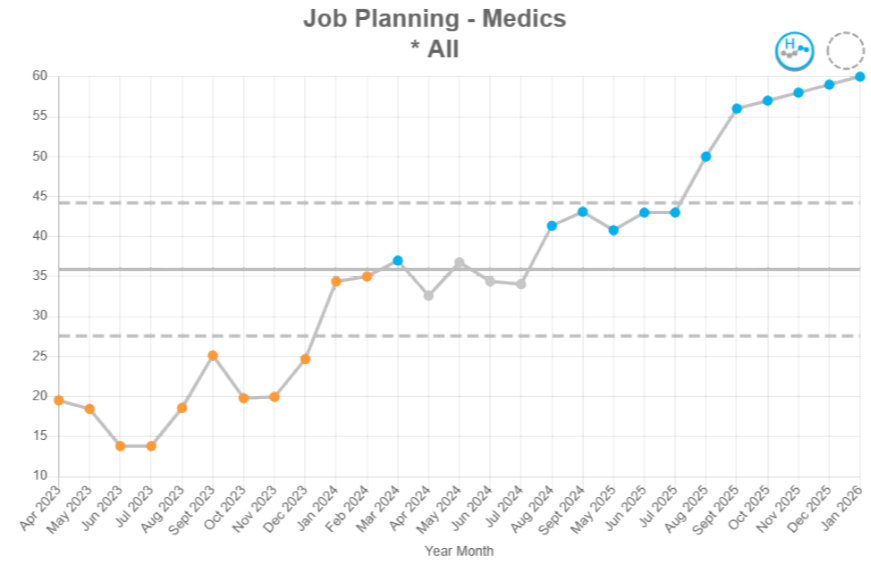
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People – Engagement – To be in the top 20% Employers

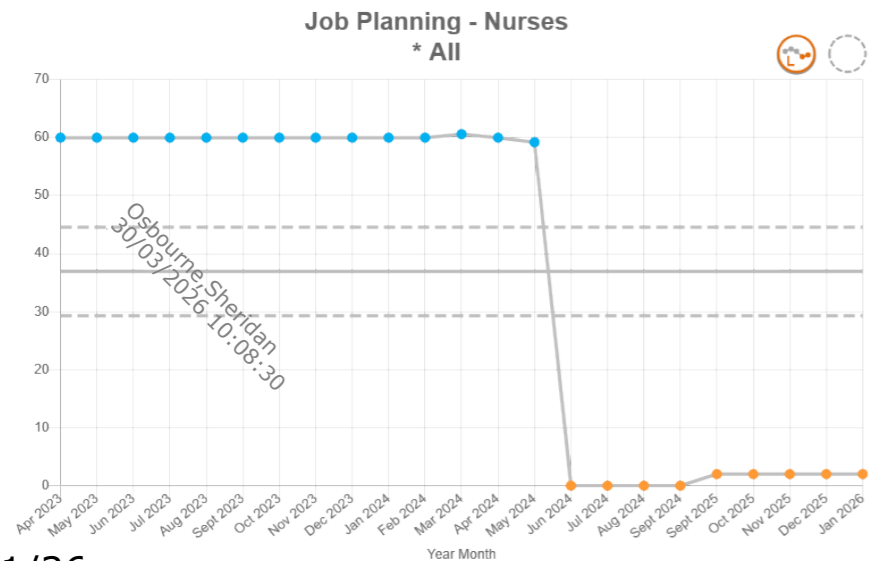
January 2026 – 33%
Common cause variation



January 2026 – 60%
Special cause variation of an improving nature



January 2026 – 2.0%
Special cause variation of a deteriorating nature



Analysis

Medics – There are currently 458 Medics registered within the system and 275 job plans signed off, which is 60%

AHP – There are currently 422 AHPs registered within the system and 141 job plans signed off, which is 33%.

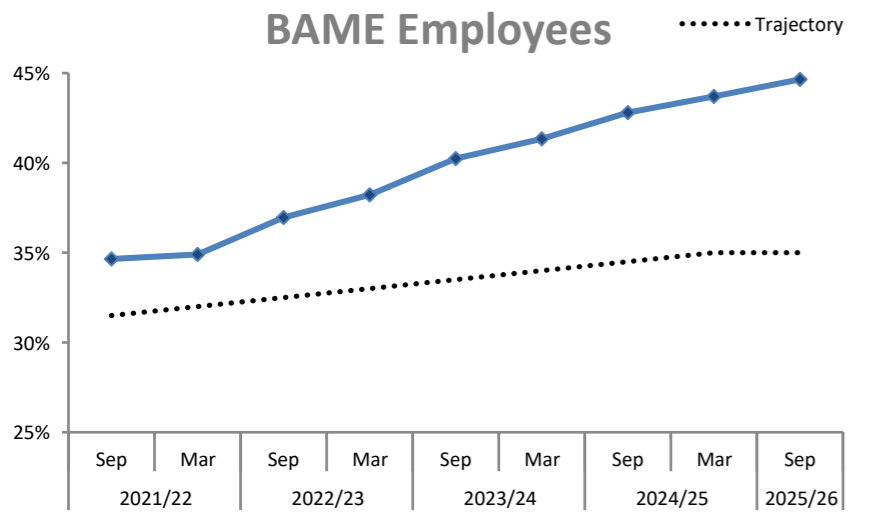
CNS – There are currently 215 CNS registered within the system and 5 job plans signed off, which is 2%.

Risks, Mitigations and Assurance

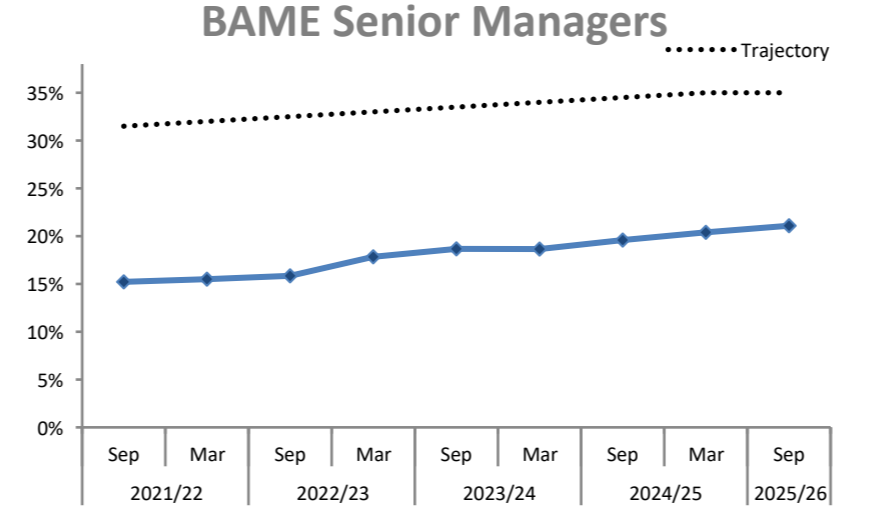
Non-medical job planning guidance will provide support with completion of CNS and AHP job plans.
Ongoing support to Medics colleagues to achieve 90% signed off job plans.

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

2025/26 Quarter 2 - 44.65%



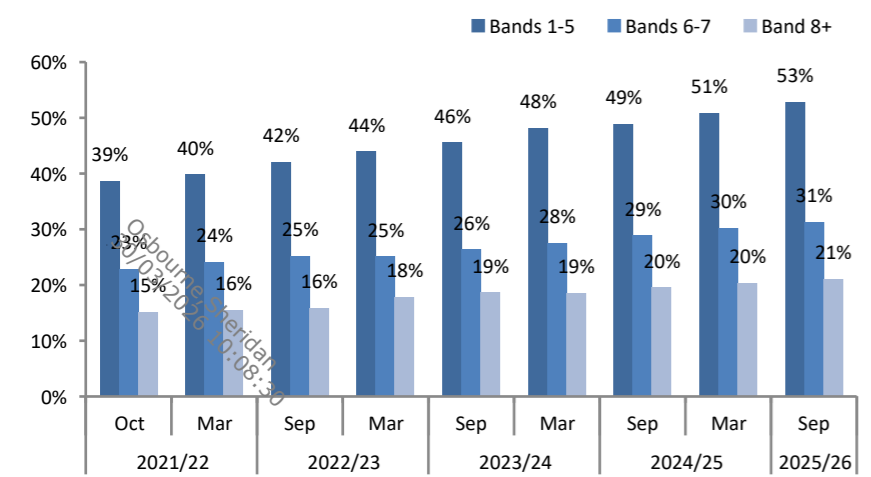
2025/26 Quarter 2 – 21.09%



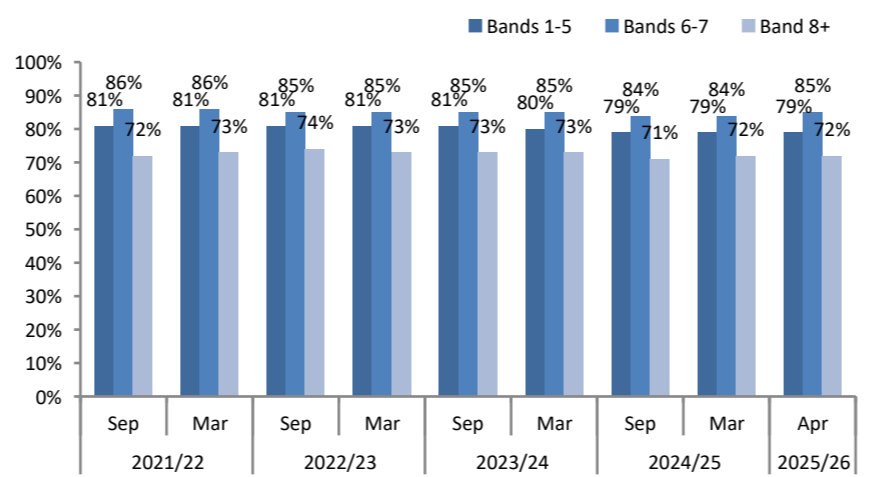
Analysis

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)

2025/26 Quarter 2 – BAME employee % by band



2025/26 Quarter 2– Female workforce by band group



Risks, Mitigations and Assurance

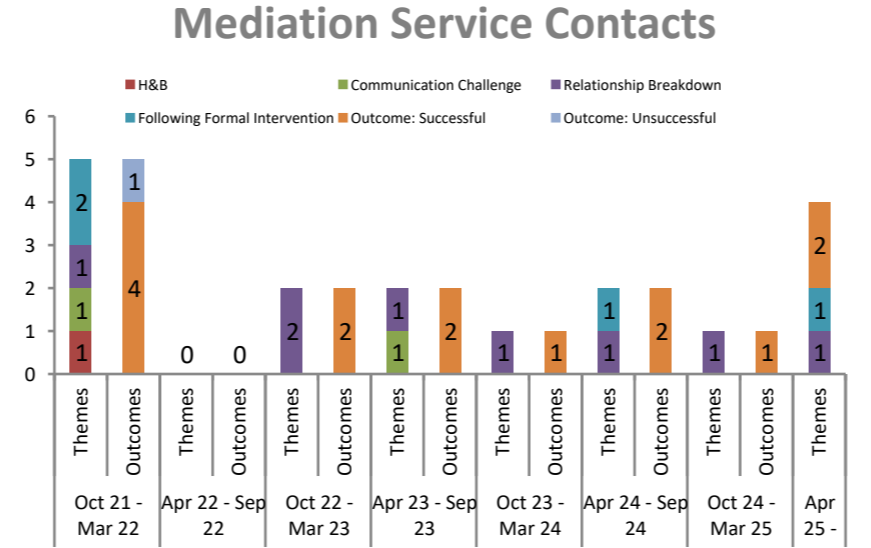
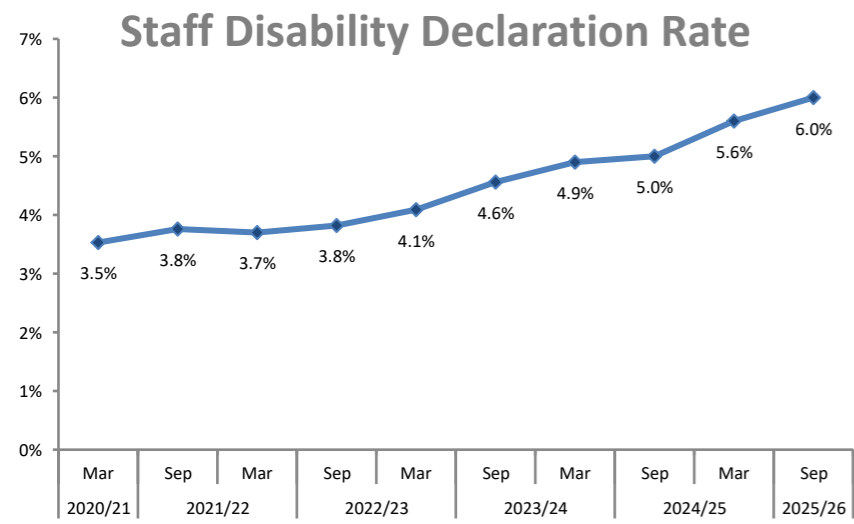
We know that achieving our ambitions around senior leadership representation continues to an area of focus. In 2025 (as part of the new People Strategy Launch) we set ourselves a refreshed target of 28% representation at Bands 8a+ by Sept 2027 and our activity over the next 12 months will be pivotal 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.

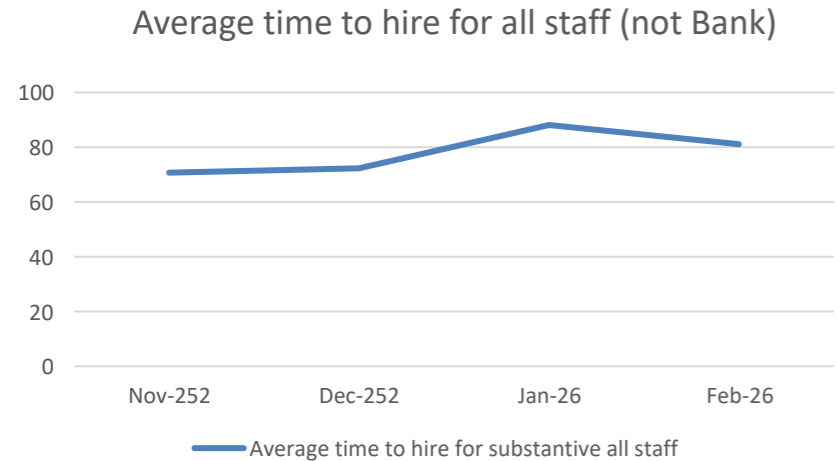
Mediation continues to provide a crucial role in supporting staff to deal with any workplace disagreements/conflict and is an important tool for 'nipping issues in the bud' and repairing relationships that may have been damaged by long standing issues or formal processes. The mediation service will become 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.

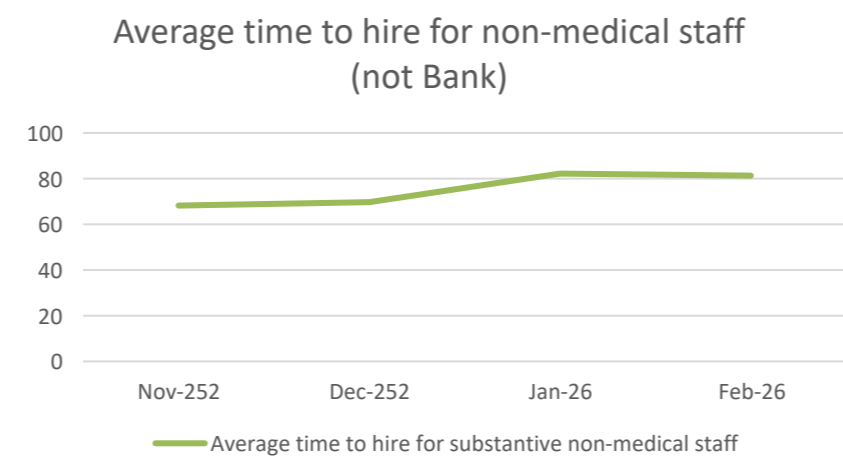
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People – Engagement – To be in the top 20% Employers

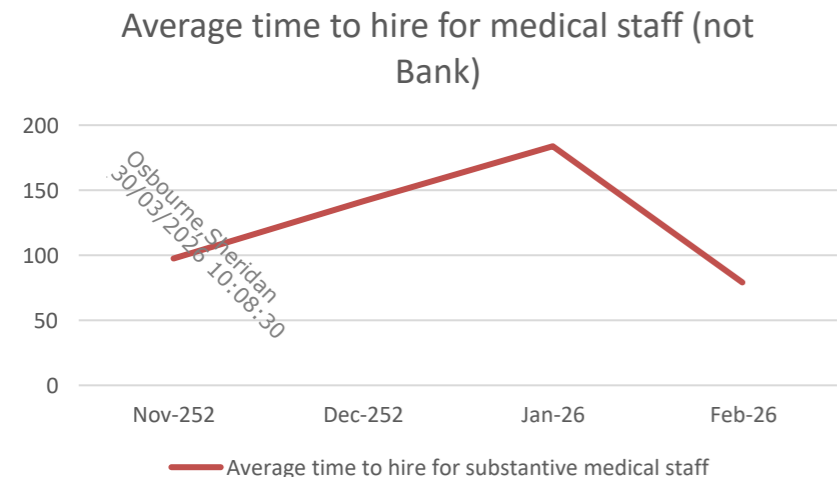
February 2026 Total substantive staffing – 81.1 working Days
Special cause variation of an **improving** nature



February 2026 Recruitment – 81.3 Working Days
Special cause variation of an **improving** nature



February 2026 Medical – 79.1 working days
Special cause variation of a **detrimental** nature



Analysis

Time to hire for February 2026 (AfC) currently stands at 81.3. This data reflects Advert Close to Candidate Start date. February saw 115 AfC candidates move through from Conditional Offer to Contract Sent with 88 starting within month and others with agreed start dates in the future. Pre-employment checks were completed for AfC staff in 33.9 days in February. This has shown a slight increase on previous months, but we have seen a significant increase in the time for Occupational Health to be cleared, and, for recruiting managers to return interview paperwork. The impact of current recruitment freeze will likely not show in the figures until around the 3–4-month mark due to still progressing pre-freeze candidates through the process.

February’s Time to Hire for Medical has significantly decreased to 79.1 days. This improvement is primarily down to the introduction of a workflow rota. The rota allows all workflows to be actioned daily, therefore ensuring that work is prioritised accordingly and bottlenecks are identified and addressed immediately. This way of working is streamlining the processes and creating more transparency within the team so as to better identify the current needs. 50% of the starters in February were internal staff and therefore require less pre-employment checks which also lends to the TTH reduction this month.

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.

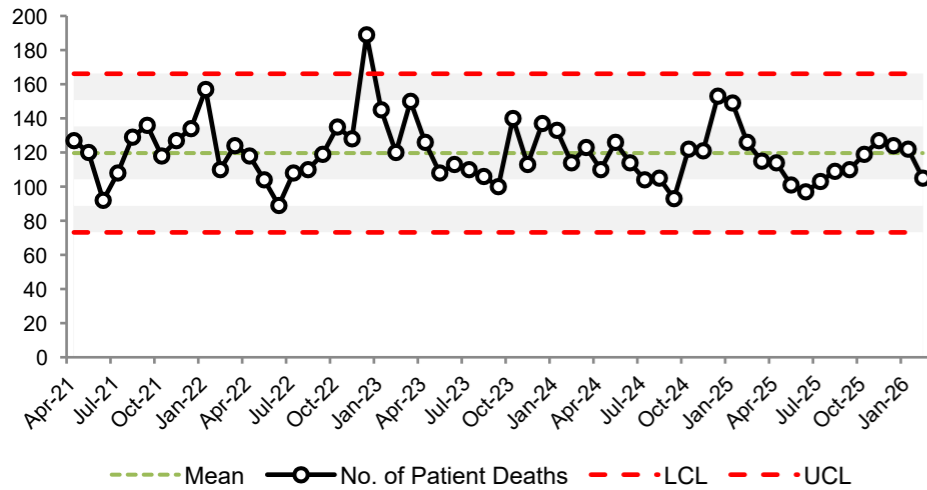
As part of this continued improvements in the Medical Recruitment team, they have introduced a rota-based system similar to that currently used in the non-medical recruitment team. The new rota system will dedicate time to each workflow daily; therefore, meaning that all activities will be actioned in 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.

Work has begun on looking at how CCT affects the time to hire figures. Those waiting GMC/CCT compared to generic medic recruitment has a longer turn around time due to static time scales. As this review is in its infancy we do not yet have the data to share but hope to in the future.

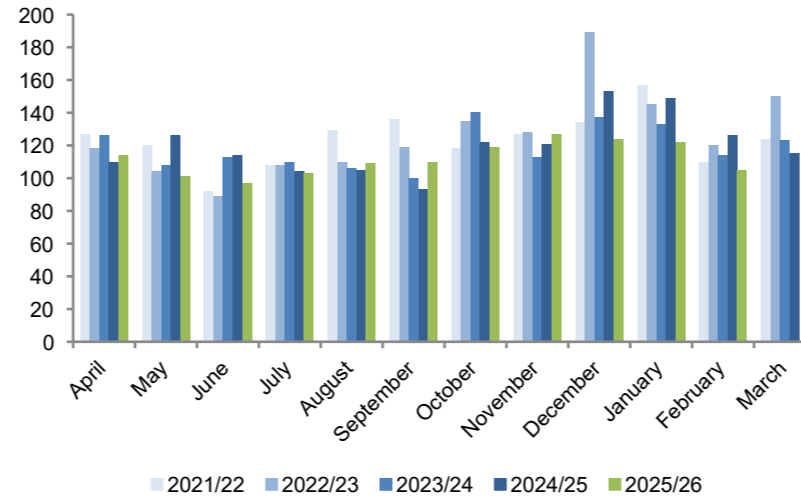
Clinical Effectiveness - To provide outstanding care for patients

February 2026 – 105 Adult Inpatient Deaths

Adult Inpatient Deaths at BTHFT (April 2021 - February 2026)

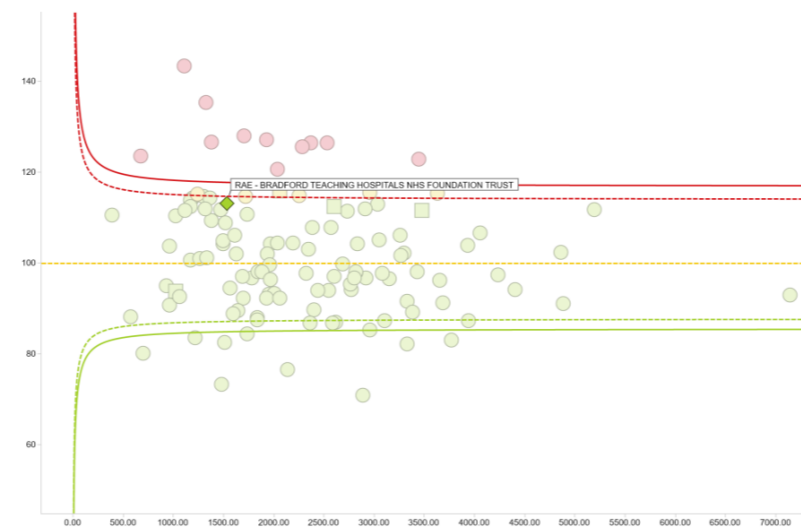
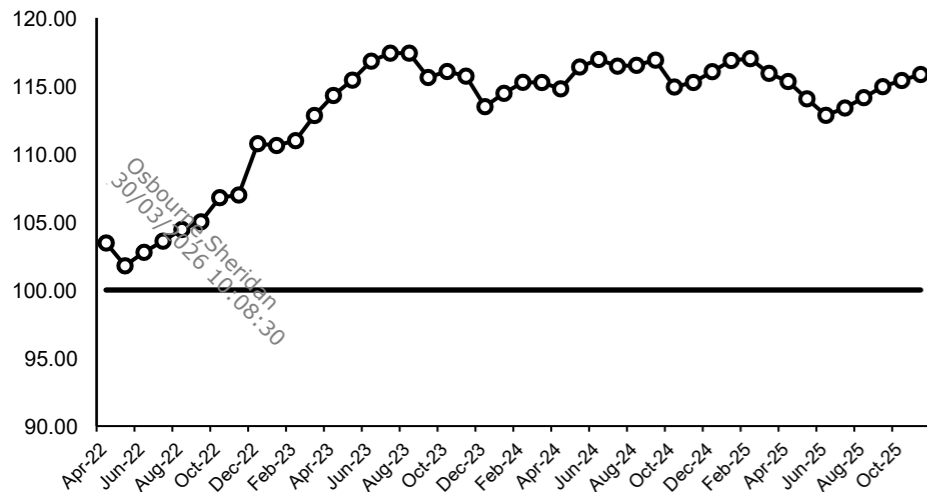


Number of Deaths by Month and Year (April 2021 - February 2026)



SHMI 12-month Rolling – 115.84 (figure covering December 2024 – November 2025: Reported February 2026)

SHMI (12-month Rolling)



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

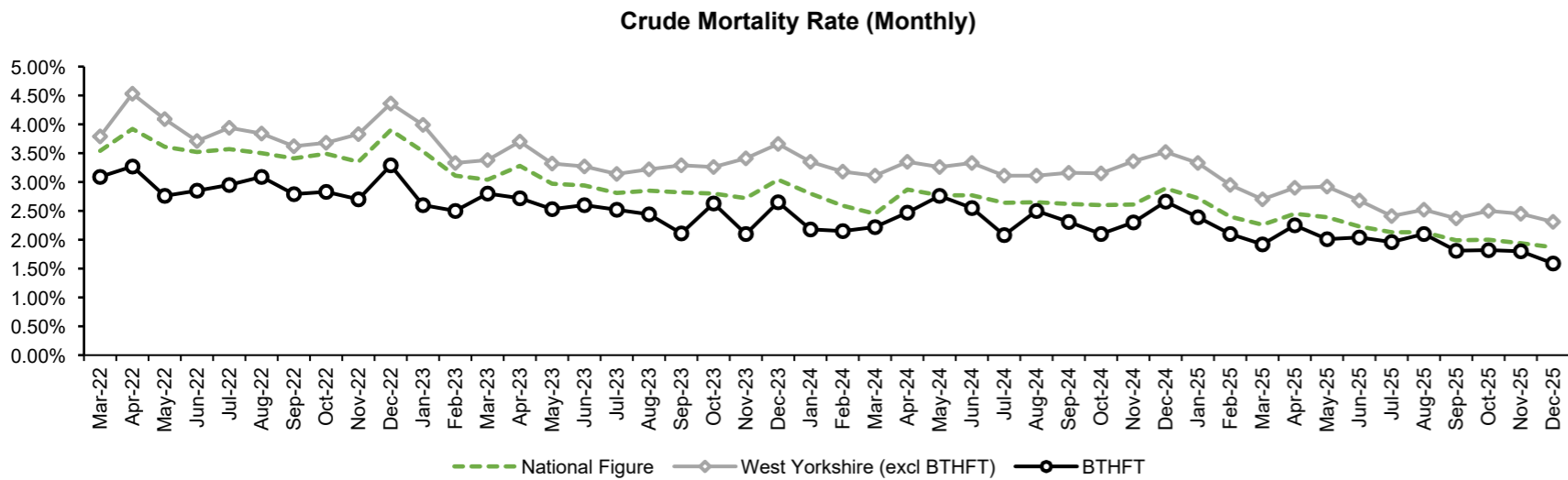
In February 2026, the Trust saw 105 adult inpatient deaths. This continues a decline in the number of deaths seen at the Trust for the last 4 months. We are also averaging at 111 patient deaths per month for the year, our lowest annual average for the last five years.

SHMI has increased slightly to 115.84 but is still within expected range.

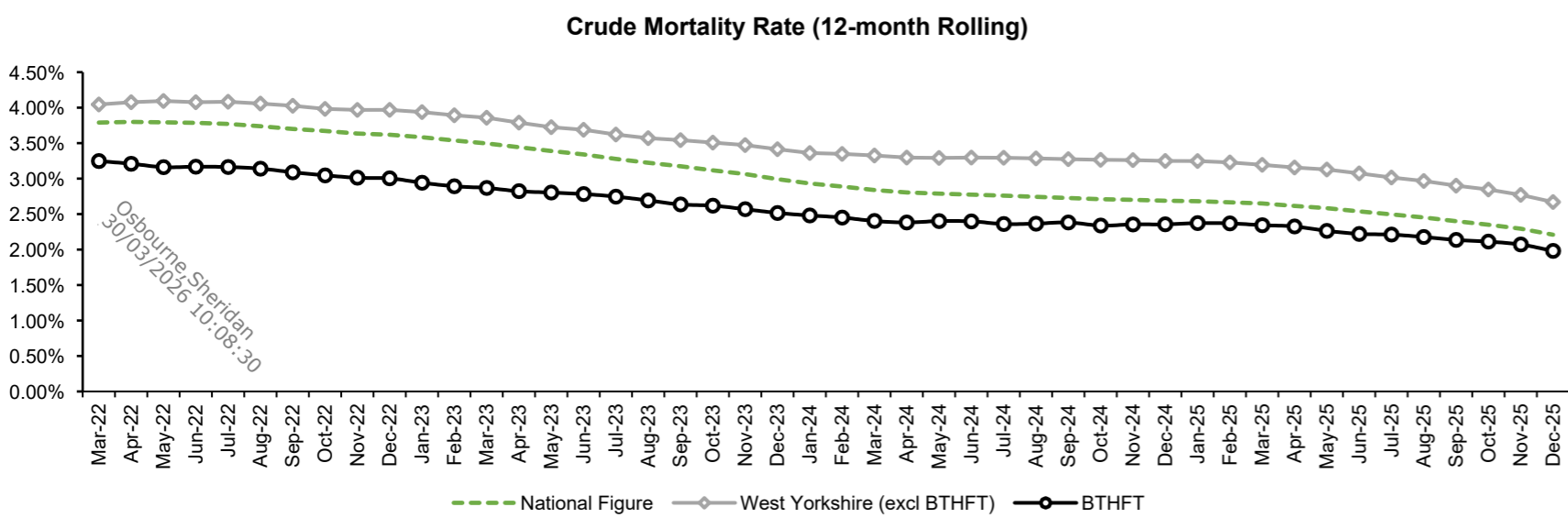
Having identified the main issue surrounding submission of historical coding data, along with continued efforts from the Coding Team to eliminate any backlog, our SHMI has been updated by NHS England to reflect these changes.

Clinical Effectiveness - To provide outstanding care for patients

Crude Mortality Rate (monthly) – 1.59% (figure for December 2025: Reported February 2026)



Crude Mortality Rate (12-month Rolling) – 1.98% (figure covering January 2025 – December 2025: Reported February 2026)



Analysis

Our crude mortality rate decreased to 1.59% for the month of December, the latest reported figure (reported in February 2026). This rate is lower than the national figure (1.87%) 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 1.98%, lower than the national average of 2.21% and well below the average for the rest of the West Yorkshire region, which has an average rate of 2.67%.

Learning, Improvement, Assurance

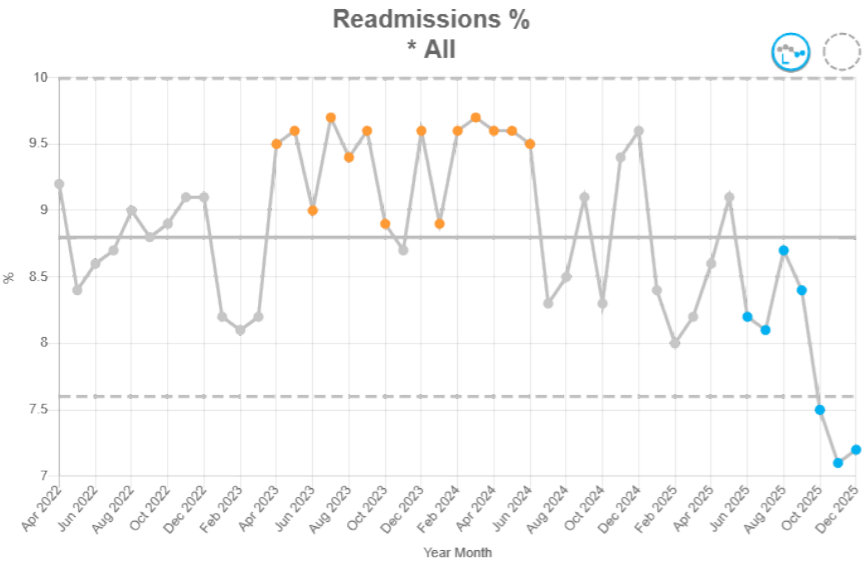
Crude mortality rate is a measure of the number of patient deaths as a proportion of overall patient activity. Crude Mortality Rate is an excellent way of looking at the rate of patient deaths as it takes into account the activity of the hospital by using the number of patient discharges as the denominator.

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

December 2025 – 7.2%
Common cause variation



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Analysis

On average re-admissions 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). Re-admission rates appear to have been sustained at between 7-7.5% since September 2025 which indicates these improved coding changes have now been embedded.

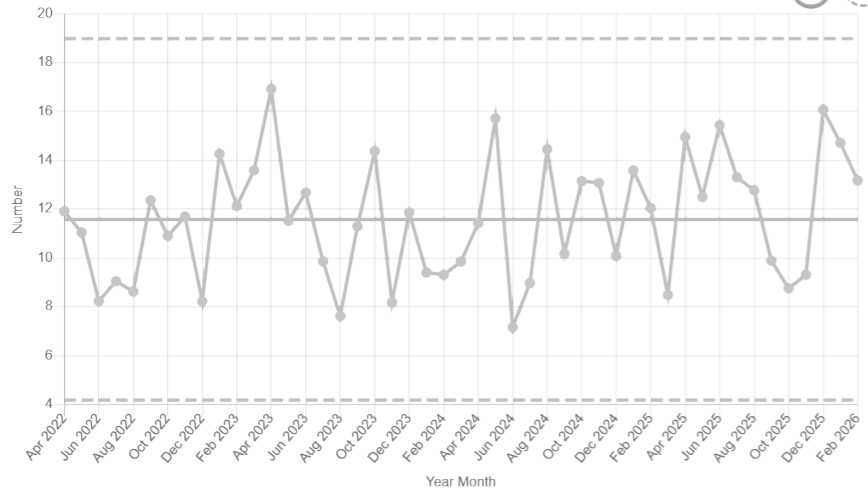
Learning, Improvement, Assurance

There is on-going work with BI, performance and CSUs to continue to improve coding for planned returners following an initial NEL spell. This improved coding into planned activity is forming part of the planning submission and could improve our financial position as part of the elective recovery program.

Clinical Effectiveness - To provide outstanding care for patients

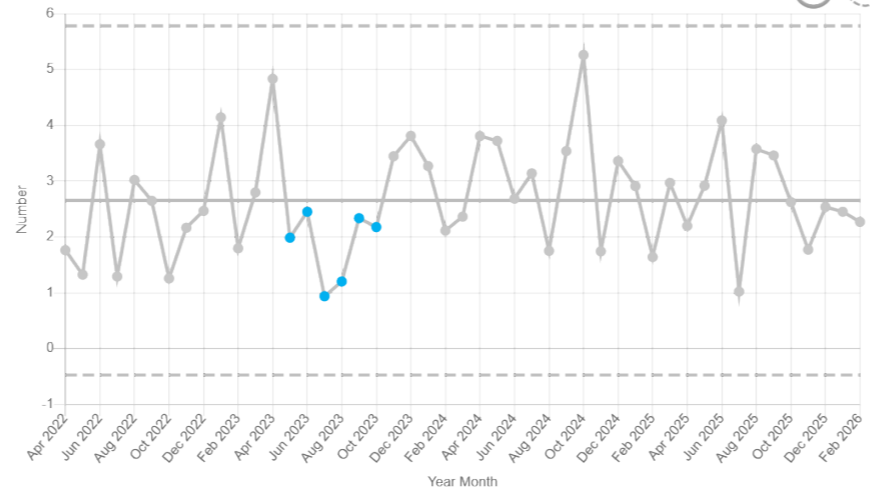
February 2026 – 13.1
Common cause variation

Pressure Ulcers
Category 2 per 10,000 bed days



February 2026 – 2.27
Common cause variation

Pressure Ulcers
Category 3+ per 10,000 bed days



Analysis

In February the number of pressure ulcers per 10,000 bed days remained above the control limit. Category 3+ incidents decreased but category 2 incidents continue to be 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:

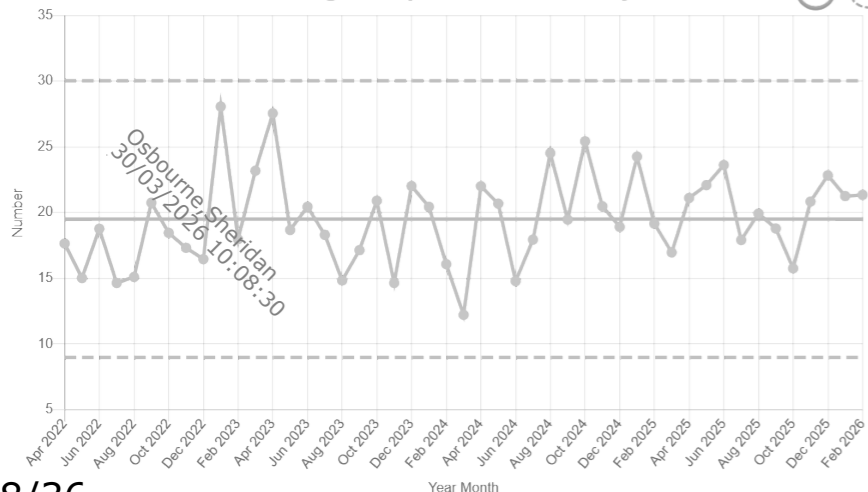
1. Planned collaboration with Calderdale and Huddersfield NHS Trust is planned regarding improving the accurate completion of the risk assessment tool on EPR (PURPOSE T).
2. Quality improvement support has been provided to wards 23, 26, ED & 17 by TVN. Planning is underway for a pressure ulcer collaborative 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.

February 2026 – 21.34
Common cause variation

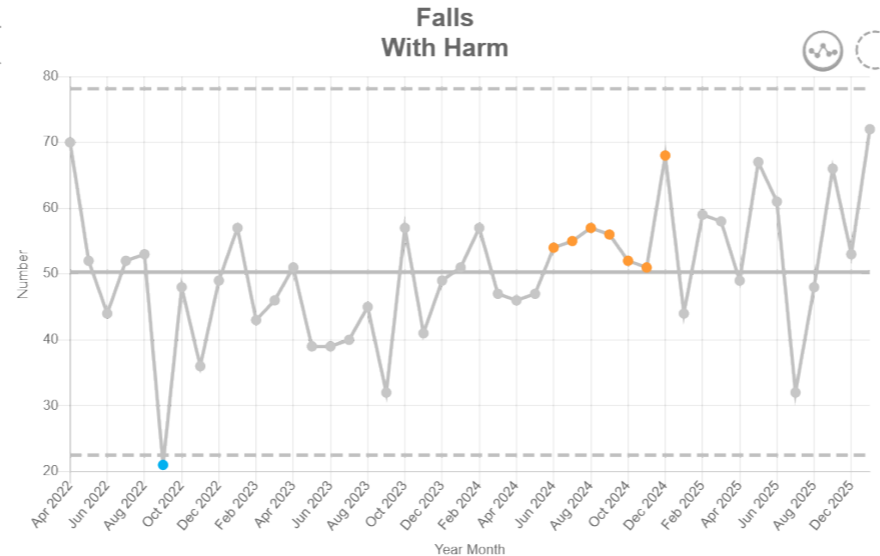
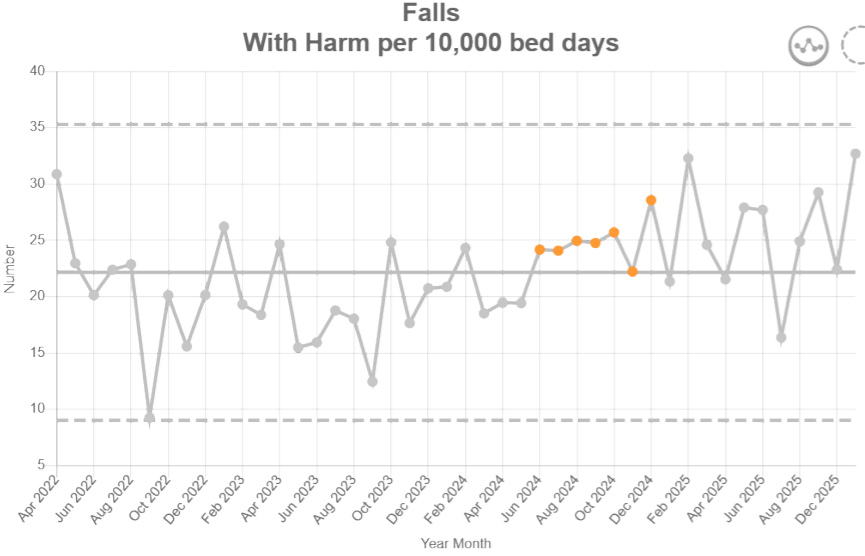
Pressure Ulcers
All Categories per 10,000 bed days



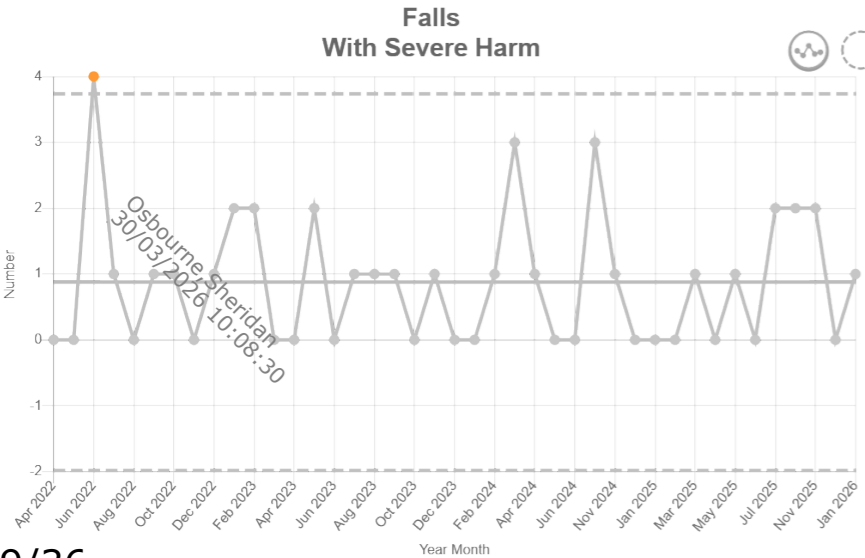
Clinical Effectiveness - To provide outstanding care for patients

January 2026 – 32.69
Common cause variation

January 2026 – 72
Common cause variation



January 2026 - 1
Common cause variation



Analysis

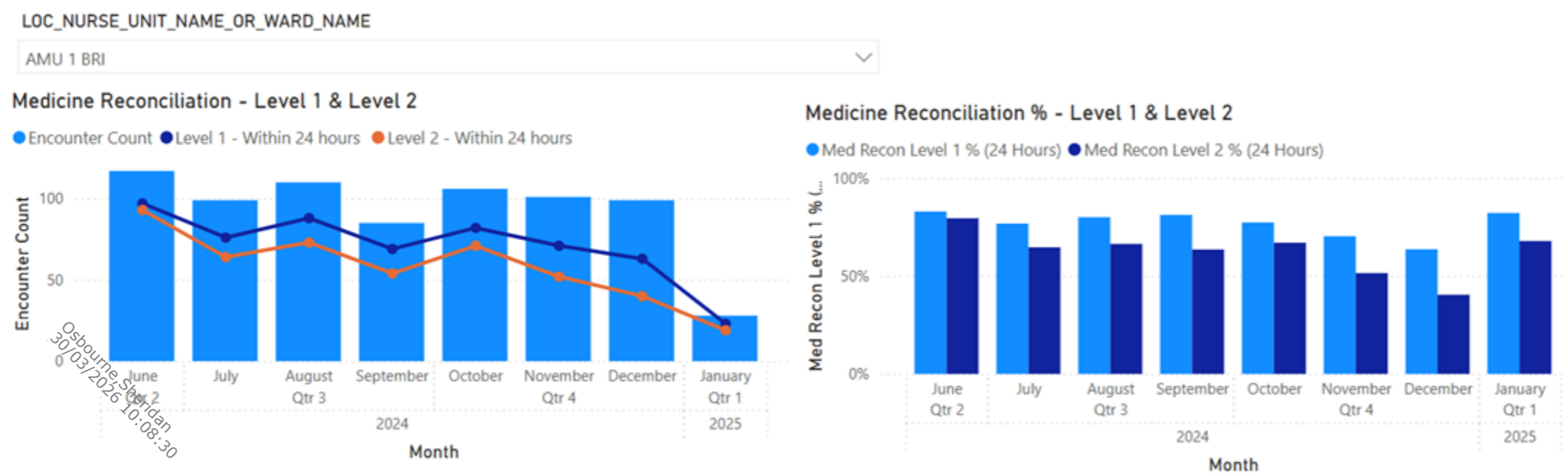
Learning, Improvement, Assurance

- 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.

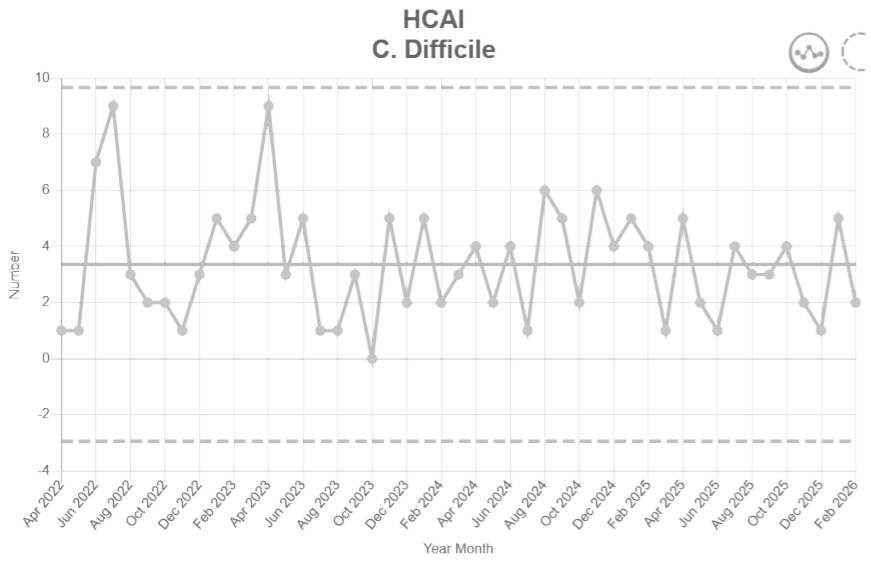
Business Intelligence have supplied an example image of how the data may be presented upon completion of the project:



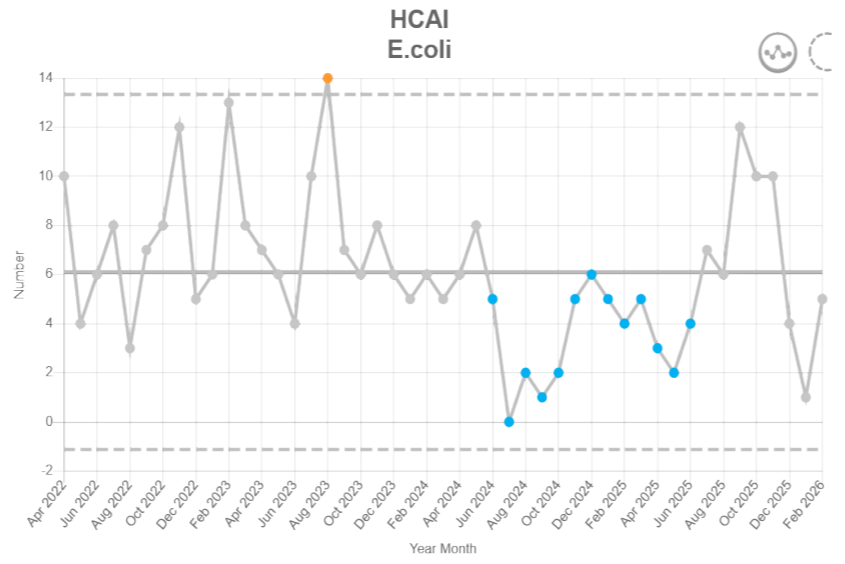
Please note that the data used for this representation is still undergoing validation and is not representative for this ward.

Clinical Effectiveness - To provide outstanding care for patients

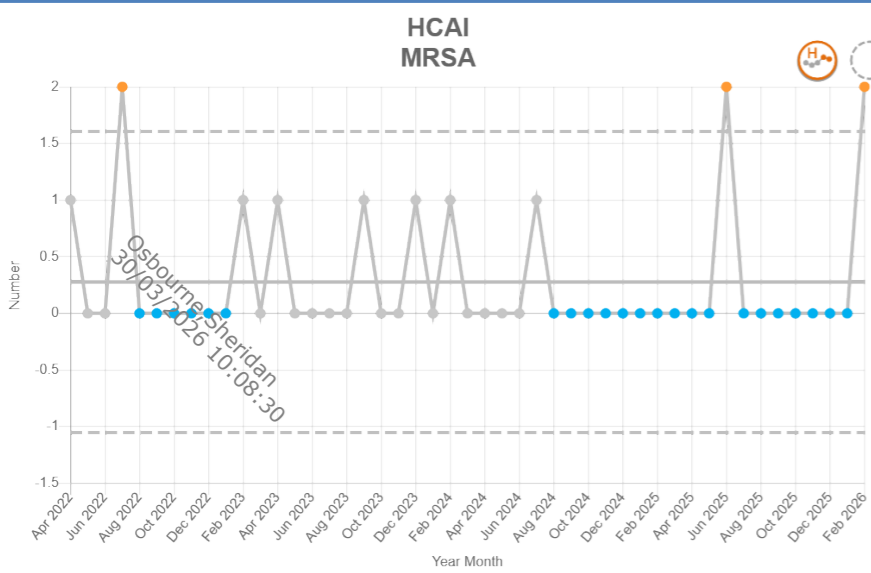
February 2026 – C. Diff Cases - 2



February 2026 – E. Coli Cases - 5



February 2026 – MRSA Cases - 2



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
Just one MRSA bacteraemia case has been observed in last eight months. Only two cases have been observed in the last 12 months.

Learning, Improvement, Assurance

Clostridioles diff Infections reduction plan.

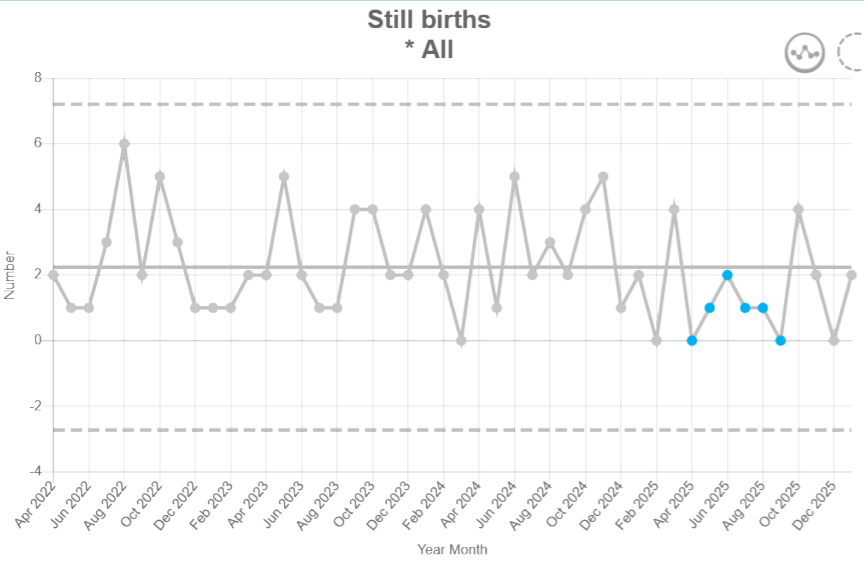
- CDI Improvement plan in place with regular updates.
- Immediate review of cases for quick learning
- Triangulation of cases using PSIRF
- Multidisciplinary team meeting in case of increase in the cases
- Adhoc and regular environmental audits
- Commode audits with IRIS on non-compliance
- Dedicated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

Bacteraemia Reduction plan

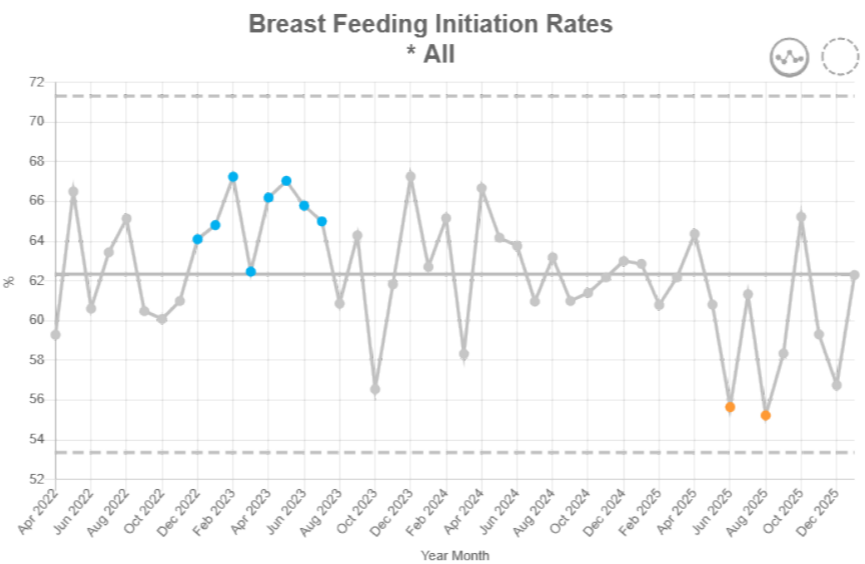
- A comprehensive improvement plan updated regularly
- Immediate review of bacteraemia cases for quick learning
- Triangulation of cases using PSIRF
- Preparing for ANTT accreditation
- Updated SOP for Central Venous Access devices (CVAD)
- Support Gloves off Campaign
- Hydration improvement project
- 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

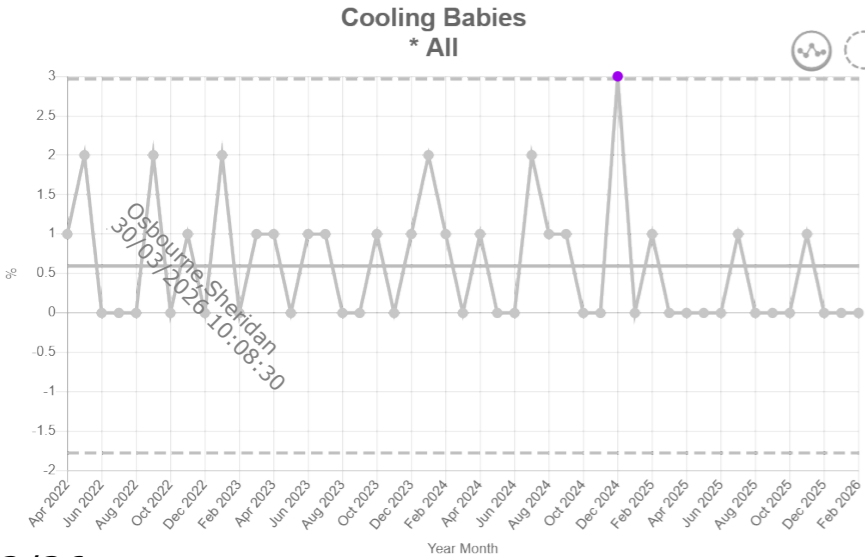
January 2026 - 2
Common cause variation



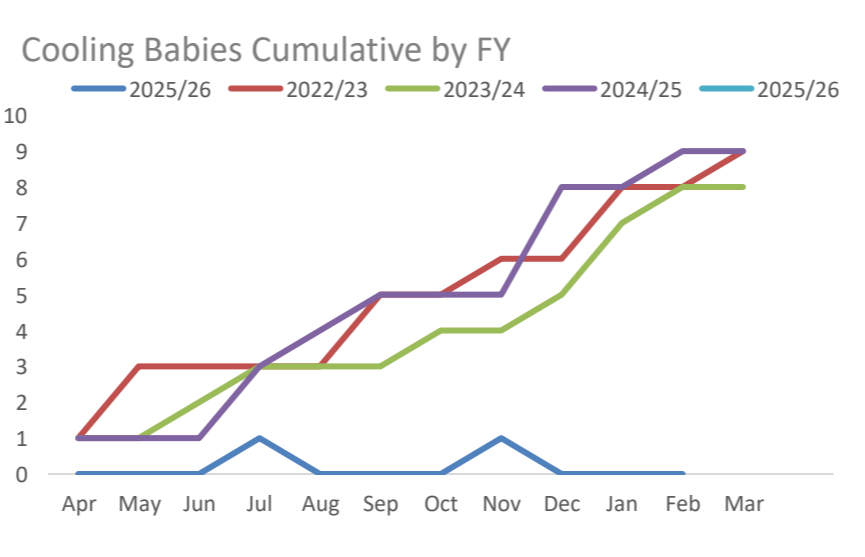
January 2026 – 62.3%
Common cause variation



February 2026 - 0
Common cause variation



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.

The annual stillbirth rate decreased significantly during 2025. Likely due to a number of factors including SBLCBV3 compliance, smoking cessation initiatives, adherence with NICE diabetes guidance. This focus and monitoring continues into 2026.

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, including around smoking cessation and management of diabetes during pregnancy.

The Specialist Midwife for infant feeding continues to prepare teams for UNICEF BFI accreditation later in the year.

Academy Dashboard Quality

Appendices

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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 <u>(H)igher or (L)ower</u> 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/>

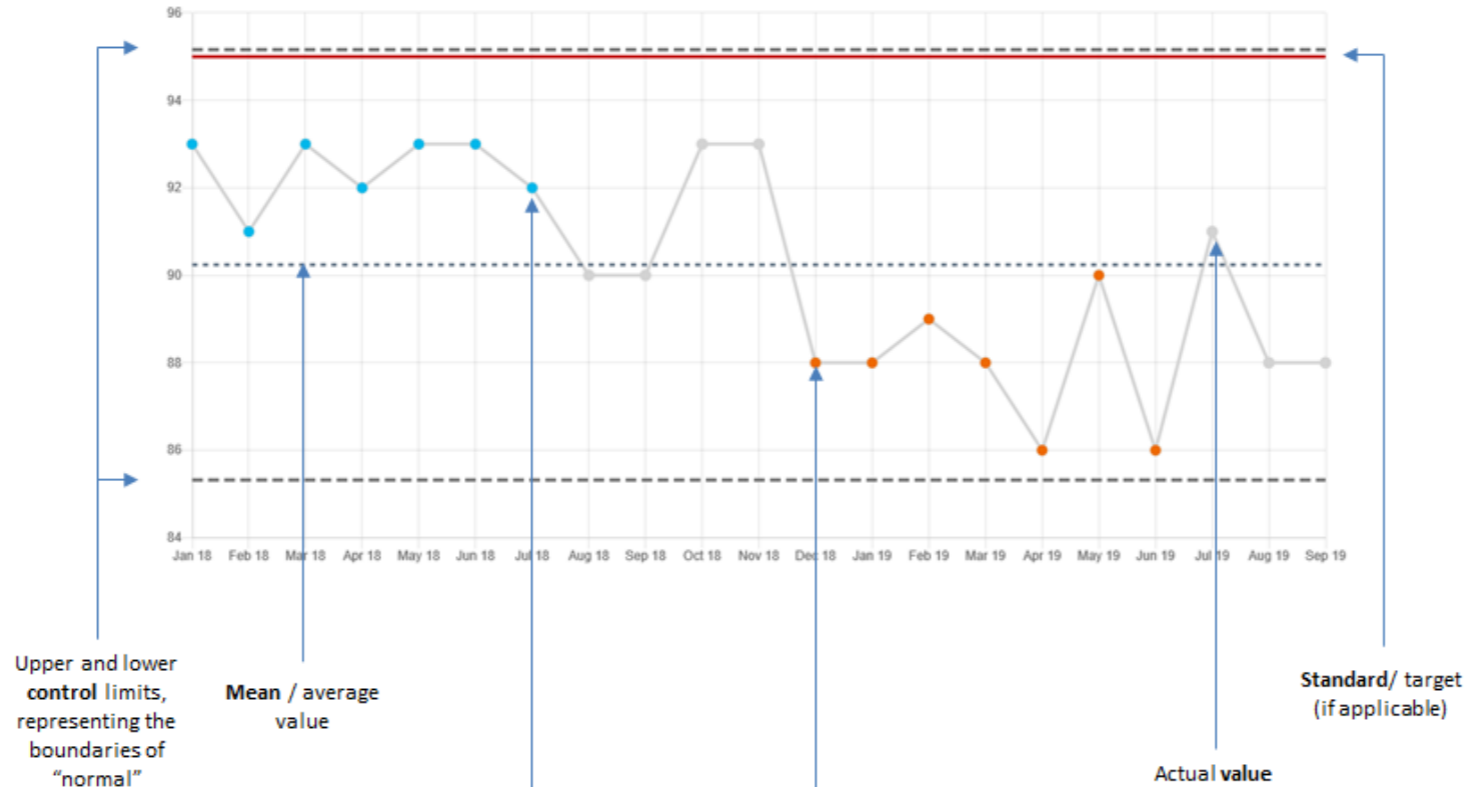
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Interpreting Statistical Process Control Charts

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



Points of special cause variation:

- Single point outside process limits
- Run of 7 points above/below the mean (**shift**)
- Run of 7 points all consecutively ascending/descending (**trend**)

● Concern ● Improvement

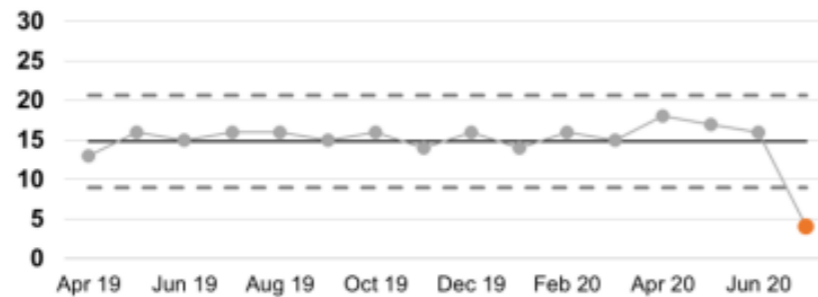
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Interpreting Statistical Process Control Charts

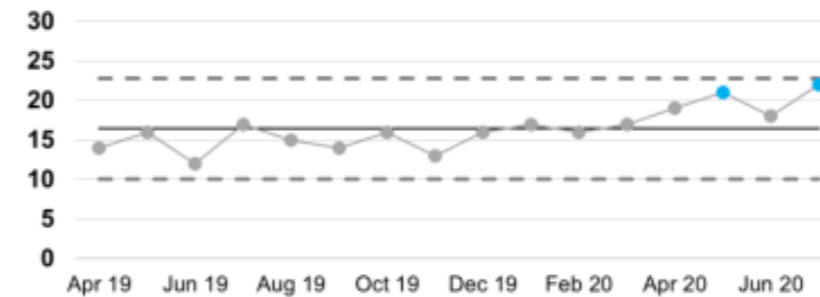
SPC rules : special cause variation



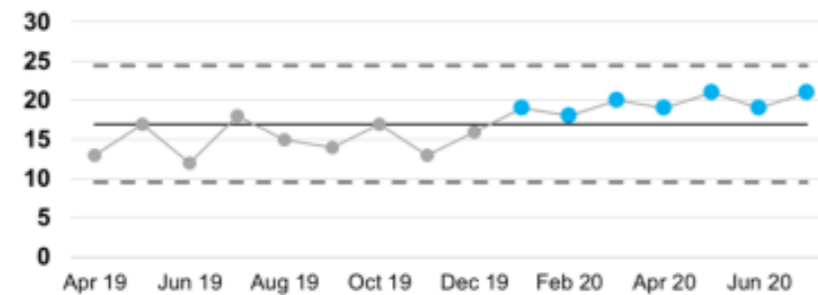
A single point outside the process limits



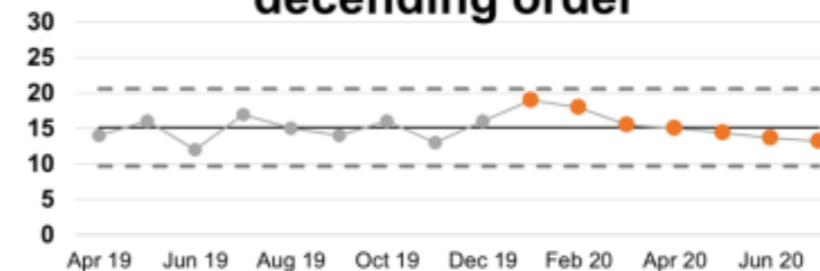
Two out of three points close to a process limit



A shift of points above / below the mean



A run of points in consecutive ascending or descending order



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Board of Directors				
Meeting Date:	31/03/2026	Agenda Reference:	Bo.3.26.12	
Report Title:	Month 11 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 <input type="checkbox"/>	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/>	Information <input type="checkbox"/>
Summary of Key Issues/Highlights:	<ul style="list-style-type: none"> As agreed by the Board of Directors in December 2025, the Trust formally submitted an off plan forecast for the financial year to NHS England at Month 9 reporting. The forecast to NHSE was 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 was dependent on the delivery of £12m of recurrent and non-recurrent mitigations in Quarter 4 via the CEO-led Financial Recovery Plan. The Trust is reporting a year to date I&E position worse than the formal plan by £19.5m at Month 11, with an actual deficit of £23.3m compared to a planned deficit of £3.8m. The February in-month position was a surplus of £0.7m which is £0.5m adverse to the original £1.2m planned surplus. The in-month position was supported by the deployment of £3.9m of recovery plan measures. The revised off plan forecast trajectory to Month 11 is a cumulative deficit of £24.4m. The reported £23.3m year to date deficit is therefore £1.1m better than the revised forecast, although it should be noted that the vast majority of the recovery measures are required to be delivered in Month 12. The capital programme is currently £2.8m behind plan, with year-to-date expenditure concentrated on the Endoscopy Programme (£14.2m), Outstanding Maternity improvements (£4.6m) and Estates Safety Standards (£5.6m). The variance is due to timing delays in planned schemes, with the year to date (YTD) underspend mainly driven by slippage in MRI Scanner (£1.2m) and Estates Critical Infrastructure projects (£2.4m). At Month 11, the Trust's closing cash balance was £15.9m, which is £2.8m ahead of the planned position. This comprises an I&E cash balance of £5.8m and a capital cash balance of £10.1m. NHSE has advised that NHS Trusts must clearly distinguish between I&E cash and capital cash when requesting cash support. As such, the Trust is required to demonstrate the position of each cash stream separately, ensuring that any support requests accurately reflect the specific area of pressure. To maintain liquidity, the Trust is scheduled to receive £9.6m of revenue cash support in March 2026. Provided the Trust delivers its revised I&E position, 			

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	<p>this level of support should enable the organisation to continue meeting supplier payment terms in full and on time.</p> <ul style="list-style-type: none"> 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 original CTG efficiency programme is £10.5m behind plan at Month 11, with £23.5m of efficiencies reported against a year-to-date target of £34m. The latest risk adjusted forecast is that £24.3m 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 £14m.
Recommendation/s: (including any decision/approval required)	<p>The Board is asked to:</p> <ol style="list-style-type: none"> 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:	<p>Provides an update relevant to Strategic Objective 2 on the Board Assurance Framework, Reference no 6.</p> <p>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.</p>
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	
Meetings where content has been discussed previously:	N/A

Board of Directors			
Meeting Date:	31 March 2026	Agenda Reference:	Bo.3.26.12d
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 <input type="checkbox"/>	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> Information <input type="checkbox"/>
Summary of Key Issues/ Highlights:	<p>Headline KPI summary page:</p> <ul style="list-style-type: none"> 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. <p>Assurance provided through the exception report and the recovery actions being progressed.</p> <p>Headline KPI exceptions:</p> <ul style="list-style-type: none"> 18 Weeks Incomplete RTT: It was hoped that RTT performance would improve to meet the out-turn plan of 66.7% during Q4, with waiting list management and service level productivity improvement enhanced by the outpatient activity sprint and additional operating lists via the Bronte forward wait area opening. The latter has seen improvement achieved within plastic surgery during this period, but we have not been able to run all the additional clinical sessions we had hoped, due to service specific delays in recruitment and lower than anticipated uptake of additional clinics. There has also been increased leave during February which reduced the activity run rates we expected. Overall, the impact has been a gap to plan of c.2% which will need to be recovered in 2026/27 on top of 5% planned improvement. DM01 6-weeks: Performance for February has increased by 5% due to improvements in NOUS, Audiology and Urodynamics. Audiology and NOUS recovery will extend into 2026/27, and there are emerging pressures within DEXA, Echocardiography and Neurophysiology. Elective Activity: Q4 activity through theatre has increased with the use of Bronte forward wait for Plastic Surgery procedures but overall volumes will not recover to plan before year end. Productivity gains in theatre remain an opportunity to progress at greater pace and this will be a priority within the recovery meetings with each CSU. Outpatient Transformation: There is a level of coding opportunity being progressed within the data and productivity workstream which may recover past month performance. Increasing the proportion of new appointments has been a Q4 priority which will continue into 2026/27 and will feature as a KPI within the new recovery structure. Cancer 28-day FDS: Performance impacted by deterioration in histology reporting and ongoing challenges across key tumour groups. Year-end requires recovery above 80% in March. Forecast improvements in Gynaecology, Skin and H&N suggest this may be possible but not guaranteed. 		

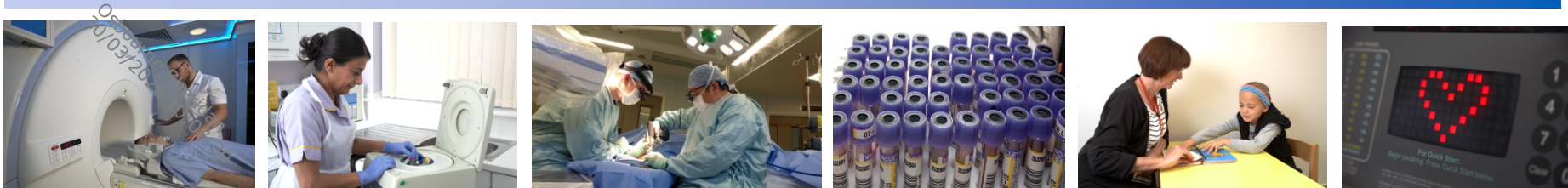
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	<p>In month exceptions/ early warning metrics:</p> <ul style="list-style-type: none"> • Cancer 62-day Performance: Diagnostic delays are also impacting on this standard with February performance projected to remain below target • Cancer 62-day Backlog: It remains possible that March will meet the 75% target as the 62-day backlog shows considerable improvement and remains closely managed to support this <p>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.</p>
Recommendation/s: (including any decision/approval required)	<p><i>The Board is asked to:</i></p> <ol style="list-style-type: none"> 1. Receive assurance that overall delivery against performance indicators is understood. 2. 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.

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Operational Performance Highlight Report

Board of Directors
February 2026 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
Average Ambulance Handover	Feb-26	23:11	17:55	↑	N/A	19:47	21:23	G
Emergency Care Standard	Feb-26	82.00%	84.12%	↑	11 of 123	83.2%	82.00%	G
12 Hour LoS in Emergency Department	Feb-26	9.00%	8.85%	↑	44 of 119	7.7%	7.99%	G
Length of Stay ≥21days	Feb-26	82	88	↑	N/A	N/A	82	G
Average Delay Post Discharge Ready Date	Feb-26	3.8	3.7	↓	N/A	3.6	3.8	G
18 Week RTT Incomplete	Feb-26	66.43%	64.49%	↓	29 of 131	N/A	66.70%	R
18 Week RTT Incomplete vs Plan	Feb-26		-1.94%		52 of 131			-
52 Week RTT Incomplete	Feb-26	0.65%	0.22%	↓	20 of 131	N/A	0.66%	G
52 Week Community Waits	Feb-26		0.00%		1 of 79	N/A		-
%age New & OPPROC of all outpatients	Feb-26	46.55%	43.96%	↓	N/A	45.09%	46.56%	A
Elective Activity vs Plan	Feb-26	100.00%	93.17%	↑	N/A	95.81%	100.00%	R
6 Week Diagnostic Standard (DM01)	Feb-26	94.13%	81.39%	↓	N/A	N/A	95.00%	R
Cancer 28 Day Faster Diagnosis Standard	Jan-26	80.02%	74.61%	↓	53 of 118	79.28%	80.00%	A
Cancer 31 Day General Treatment	Jan-26	93.00%	94.30%	↑	N/A	94.61%	93.00%	G
Cancer 62 Day General Treatment	Jan-26	74.84%	68.18%	↑	55 of 118	72.76%	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

↓ 18 Weeks Incomplete RTT:

It was hoped that RTT performance would improve to meet the out-turn plan of 66.7% during Q4, with waiting list management and service level productivity improvement enhanced by the outpatient activity sprint and additional operating lists via the Bronte forward wait area opening. The latter has seen improvement achieved within plastic surgery during this period, but we have not been able to run all the additional clinical sessions we had hoped, due to service specific delays in recruitment and lower than anticipated uptake of additional clinics. There has also been increased leave during February which reduced the activity run rates we expected. Overall, the impact has been a gap to plan of c.2% which will need to be recovered in 2026/27 on top of 5% planned improvement.

↓ DM01 6-weeks:

Performance for February has increased by 5% due to improvements in NOUS, Audiology and Urodynamics. Audiology and NOUS recovery will extend into 2026/27, and there are emerging pressures within DEXA, Echocardiography and Neurophysiology.

↔ Elective Activity:

Q4 activity through theatre has increased with the use of Bronte forward wait for Plastic Surgery procedures but overall volumes will not recover to plan before year end. Productivity gains in theatre remain an opportunity to progress at greater pace and this will be a priority within the recovery meetings with each CSU.

↔ Outpatient Transformation:

There is a level of coding opportunity being progressed within the data and productivity workstream which may recover past month performance. Increasing the proportion of new appointments has been a Q4 priority which will continue into 2026/27 and will feature as a KPI within the new recovery structure.

↓ Cancer 28-day FDS:

Performance impacted by deterioration in histology reporting and ongoing challenges across key tumour groups. Year-end requires recovery above 80% in March. Forecast improvements in Gynaecology, Skin and H&N suggest this may be possible but not guaranteed.

Headline KPI – In Month

Cancer 62-day Performance:

Diagnostic delays are also impacting on this standard with February performance projected to remain below target.

Sub-metrics / Early Warnings

Cancer 62-day Backlog:

It remains possible that March will meet the 75% target as the 62-day backlog shows considerable improvement and remains closely managed to support this.

Appendix A

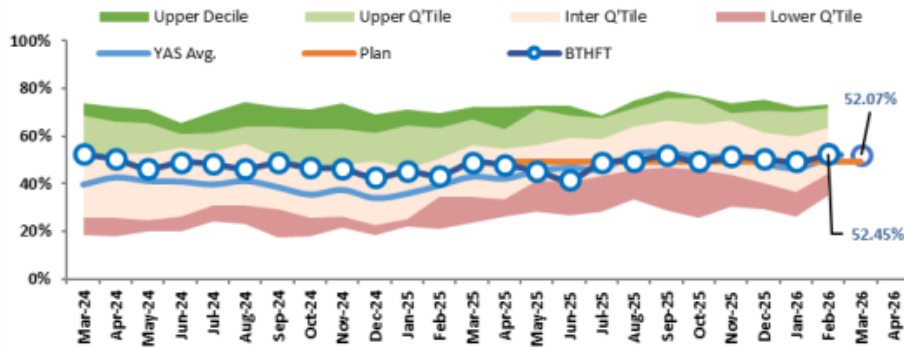
Headline KPI Highlight Reports

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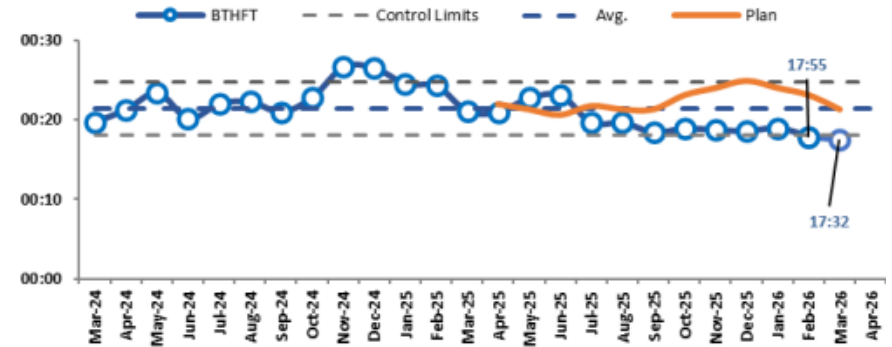
1. Ambulance Handover Performance

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Avg. Daily Arrivals	108	112	108	111	111	106	108	118	119	120	117	115
Avg. Handover Time (MM:SS)	21:05	21:01	22:48	23:06	19:39	19:40	18:25	18:56	18:45	18:36	18:59	17:55
Avg. Crew Clear Time (MM:SS)	28:03	29:20	28:24	27:30	26:28	27:02	26:50	26:36	25:22	24:43	24:50	25:08
Total Turnaroud Time (MM:SS)	49:04	50:16	51:05	50:20	45:57	46:34	45:04	45:18	43:50	43:01	43:38	42:53
% <60 mins	96.6%	95.9%	96.1%	95.8%	98.0%	97.5%	98.5%	99.2%	99.1%	99.0%	99.0%	99.1%
% Handover <45 Mins	92.3%	91.5%	90.2%	89.8%	94.4%	93.8%	95.3%	94.9%	94.1%	95.8%	95.2%	96.8%
% Turnaround <45 Mins	50.2%	45.3%	45.5%	45.4%	54.2%	52.6%	54.6%	55.1%	58.0%	60.3%	58.7%	60.6%

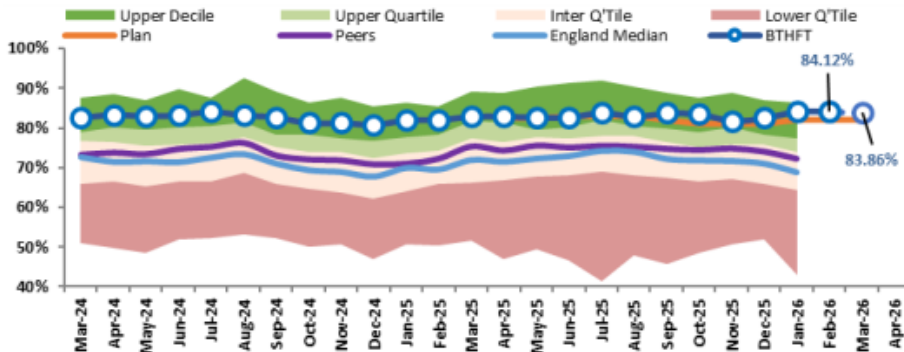
Latest position

- **YAS Handovers:** 15-minute handover performance improved to 52.5% in February (from 49.3% in January). Live handover validation, introduced in January, has reduced data queries and currently operates Monday to Friday (9–5), with plans to extend to 24/7 within the next three months.
- As of February, BTHFT have validated 69 YAS handovers reducing the volume of 45 min breaches on average by ~1%.
- The Transfer of Care (ToC) protocol ensures patients are transferred to a BTHFT trolley within 45 minutes, enabling YAS crews to return to service more quickly.
- **Ambulance Conveyances:** Performance has improved despite sustained high conveyance volumes, with faster handovers and turnaround enabling crews to re-enter the system more quickly. Self-handovers are currently in line with peer group averages, with ongoing promotion and auditing by YAS.
- **Crew Clear Times:** Crew clear times remain stable, supporting sustained improvement in overall ambulance turnaround performance.

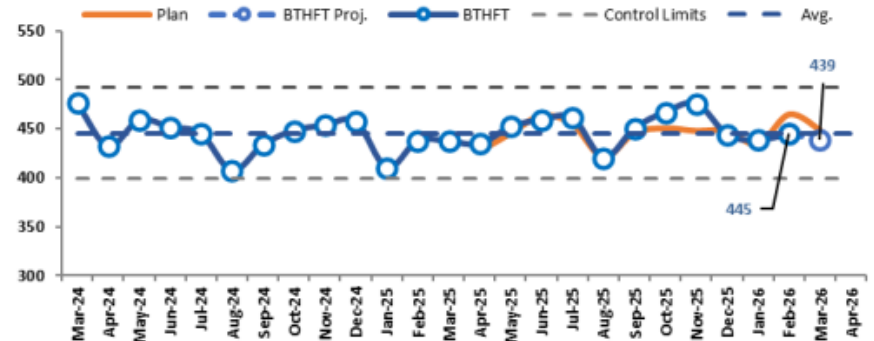
2. Emergency Care Standard (ECS)

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Type 1 Performance	75.1%	74.5%	74.3%	74.7%	76.2%	74.7%	75.9%	76.1%	74.0%	75.3%	77.0%	77.1%
Arrival to Assessment	00:16	00:17	00:20	00:19	00:17	00:17	00:17	00:21	00:20	00:18	00:18	00:18
Assessment to Treatment	02:50	02:45	02:56	03:02	03:07	03:18	02:42	03:04	03:03	02:54	03:00	02:57
Treatment Length	01:58	01:57	02:01	01:53	01:50	01:56	01:53	01:59	01:57	01:58	02:04	02:01
% Patients Streamed	46.4%	46.4%	46.5%	46.7%	47.0%	47.1%	47.0%	46.7%	44.4%	45.5%	50.8%	48.4%

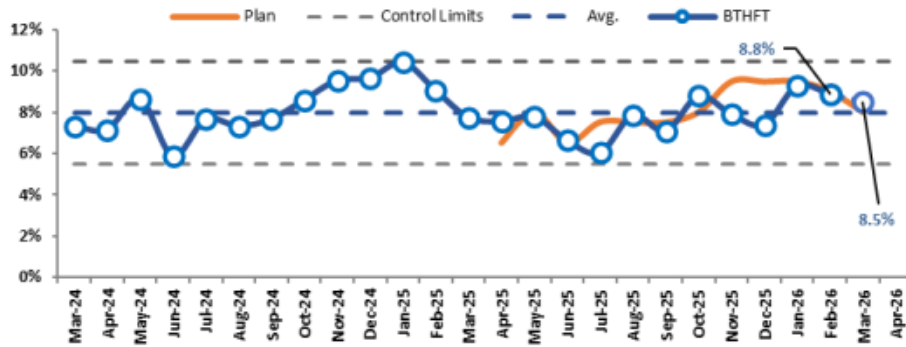
Latest position

- Daily **ED attendances** in February averaged 445, broadly in line with the 449 forecast and below November's peak of 475 following a period of higher-than-expected demand.
- **ECS Performance** for the 4-hour target remains strong at 84.2% in January and 84.1% in February, above the 82% plan and in line with the upper decile across combined Trusts. Expanded clinical streaming in Ward 8's Same Day Emergency Care and Ambulatory Emergency Care, supported by additional trolleys and discharge lounge chairs, continues to manage high-demand periods, while improved performance largely reflects more accurate recording.
- Out of hours presentations are creating early-hours pressures on **Paediatric ECS** performance. We are looking at options to mitigate this including expanding pre-booked next-day appointments for minor injuries and primary care presentations.
- Expanded consultant coverage in ED has strengthened senior decision-making across 24/7 services, supporting more timely patient flow. Commenced with March rotas; monitoring and evaluating impact.
- Implementation of **FirstNet Model Content** is now planned for post-April 2026 to enhance ED operational efficiency, with technical design issues currently being addressed.

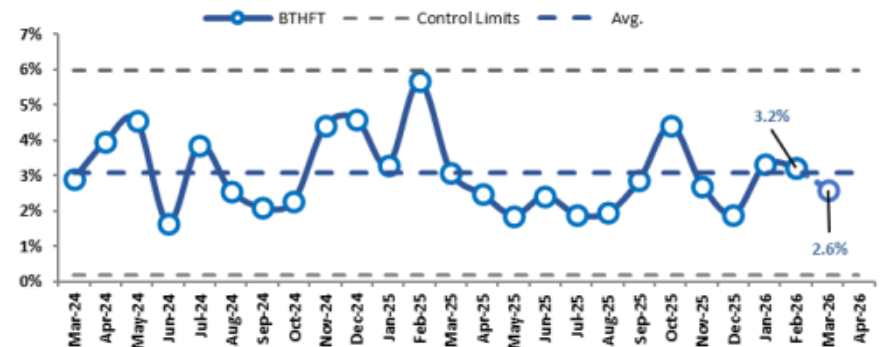
3. Emergency Department (ED) Length of Stay

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Avg. # Daily Admissions	84	84	84	87	86	81	88	87	85	84	80	84
Avg. Wait DTA to Admit	05:15	04:53	05:02	04:32	04:30	05:06	05:05	06:21	06:02	05:38	07:02	06:39
LoS (Admitted P'ts)	07:21	07:09	07:28	07:06	06:47	07:31	07:15	08:11	08:19	07:30	08:20	08:08
LoS (Discharged Pts)	03:02	03:03	03:05	03:02	02:53	02:50	02:56	03:08	03:09	03:03	03:01	02:58
LoS (Admitted & Discharged Pts)	03:56	03:53	03:58	03:52	03:40	03:49	03:51	04:09	04:09	03:57	04:04	04:01
% Patients Admitted	20.9%	20.5%	20.2%	20.5%	20.4%	21.0%	21.3%	20.0%	19.3%	20.4%	19.7%	20.4%

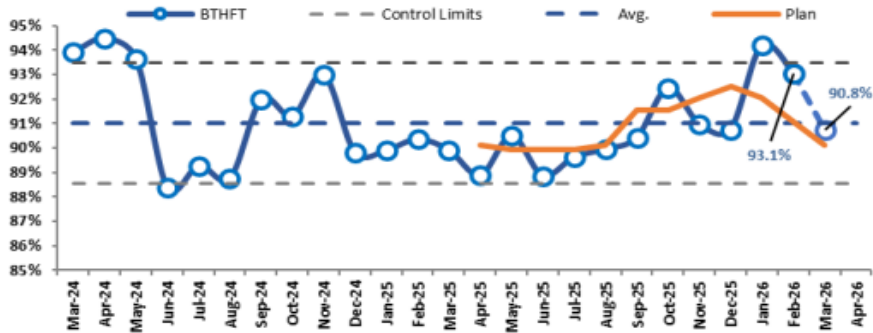
Latest position

- February saw a reduction in 12-hour **DTA trolley breaches**, when compared with January, driven by pressures in the elderly care pathway, particularly transfers to intermediate care. This increase was expected and is forecast to ease in March. There are plans for a bed reconfiguration in medicine prior to next winter to re-align capacity with demand.
- As part of the winter plan **Ward 8** was established as a multi-functional unit to reduce ED LoS, reduce crowding and to reduce the use of temporary escalation spaces (TES) in the Emergency Department (during winter, Ward 8 functions as Same Day Emergence Care (SDEC), a medical discharge lounge, and an ED observation/assess-to-discharge area for patients needing >4 hours of care). Ward 8's overnight model is due to come to an end in March.
- The **EXCEL Programme** is progressing, with a focus on decompressing the ED, to improve patient and staff experience. Engagement with patient groups, system partners, and other stakeholders has demonstrated a strong appetite for change and active participation.
- A range of change ideas are currently being explored further. The delivery work programme is being delivered under new executive sponsorship to ensure stronger alignment between the CSU and the EXCEL programme and to support effective implementation.

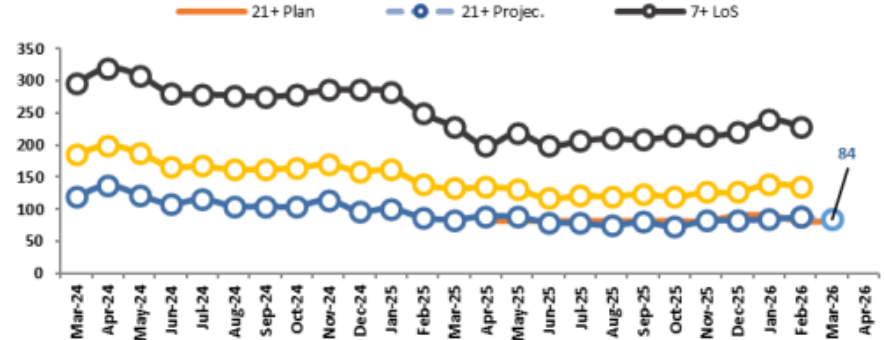
4. Inpatient Length of Stay (LoS)

Objective: Maintain Hospital capacity for daily admissions

4.1 Bed Occupancy



4.2 Patient LoS Profile (Source: EPR)



4.3 Additional Inpatient LoS Metrics

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Avg. Inpatient LoS	4.3	4.9	4.3	4.2	4.5	4.7	4.6	4.5	4.4	4.8	4.7	5.1
% Patients Discharged <4PM	42.8%	40.0%	39.6%	38.5%	39.5%	38.7%	40.7%	38.3%	36.9%	42.1%	40.2%	38.9%
# NEL Admissions	4,423	4,180	4,437	4,344	4,391	4,054	4,237	4,434	4,246	4,380	4,173	3,896
7+ LoS	229	200	219	199	207	211	208	214	214	221	241	229
14+ LoS	133	135	132	117	121	121	124	120	127	127	140	136
21+ LoS	84	90	88	79	79	75	81	73	82	82	84	88

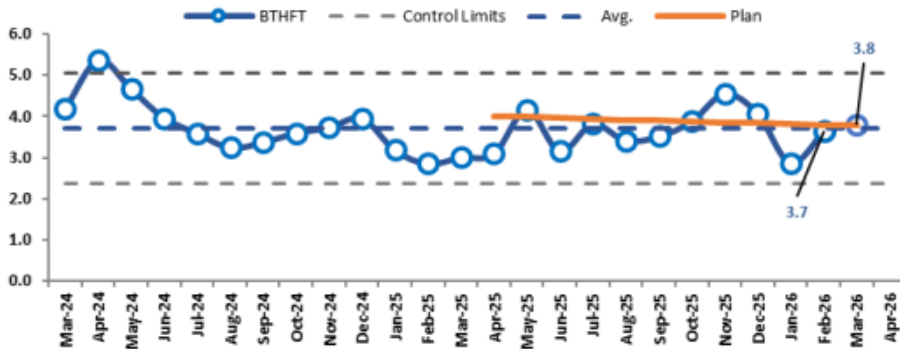
Latest position

- Total **G&A bed occupancy** reached 93.06% in February, and remained above plan, primarily due to the pressure on medical wards, predominately AMU 1. Levels are expected to return to plan during March as winter pressures decrease.
- Temporary staff shortages and high bed occupancy are limiting **therapy support**, contributing to assessment and discharge delays. Caseloads are being continuously monitored and prioritised based on discharge needs and new assessments.
- H-FAST capacity remains at four discharges per day and is broadly sufficient for demand; however, eligibility criteria and assessment processes can add ~1 day **discharge delay**, increasing reliance on the BEST pathway. Work with Adult Social Care is underway to reduce BEST delays through parallel processes with private provision, while LA bed bureau implementation and Care Act choice requirements continue to contribute to delays; a system review and improvement actions are in progress.
- A feasibility review is underway with **Virtual Royal Infirmary (VRI)** support to identify suitable patient cohorts for discharge – this will support the closure of the overnight assess to discharge beds as per winter plan.
- **OPTICA** went live mid-February 2026, improving integrated health and social care discharge coordination and real-time visibility of delays. Over 200 users have been trained, with targeted support and mandated training for senior nursing teams in place to increase ward adoption and maximise system benefits.

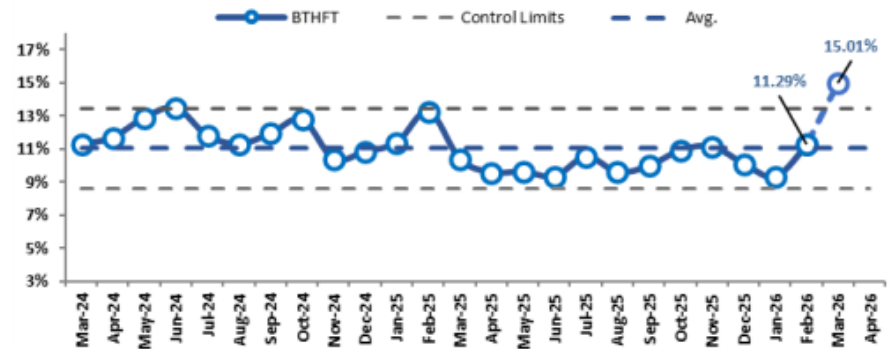
5. Discharge Processes

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
% of Pts with Discharge Ready Date	94.5%	93.0%	93.0%	93.9%	93.9%	93.6%	94.9%	95.8%	95.6%	94.9%	95.5%	94.9%
% of Pts Discharged on/before DRD	80.0%	79.8%	79.4%	79.2%	80.3%	79.8%	78.4%	79.4%	80.2%	78.5%	77.8%	78.0%

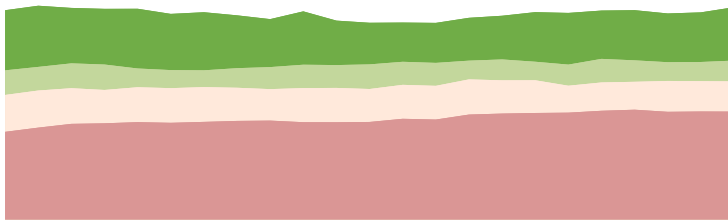
Latest position

- Whilst January showed a reduction in **No Criteria to Reside** (NCTR) patients, rising length of stay, high bed occupancy, and therapy capacity constraints has resulted in increased discharge delays in February and March. Some of the increase in NCTR can also be attributed to improved/more accurate recording post-OPTICA implementation.
- A **Therapy Capacity & Demand** review identified discharge pathway gaps. Modelling shows the team can only meet ~40% of demand (physiotherapy ~20%) even if fully staffed a case of need is being developed.
- Staffing and operational constraints within **Local Authority Enablement** services continue to impact Pathway 1 discharges, contributing to delays for medically fit patients. The Trust is working with system partners to address capacity and process issues, with system workshops underway to inform BCF planning for 2026/27.
- Recruitment to an additional **Discharge Coordinator** post has been progressed with the pilot starting week of 26 March 2026. An evaluation is expected after six months and will focus on discharge delays, NCTR/DRD recording, length of stay, and lost bed days.
- The implementation of OPTICA will hopefully improve **Discharge-Ready Date (DRD) recording** in line with expectations following audits earlier in the year. To strengthen compliance we are refreshing SOPs, monitoring the recording for all known patients, and increasing ward manager accountability. The Deputy Chief Nurse is routinely monitoring progress and review of ward processes through the EXCEL programme is underway. A re-audit of DRD reporting compliance by Internal Audit is also underway (March 2026).

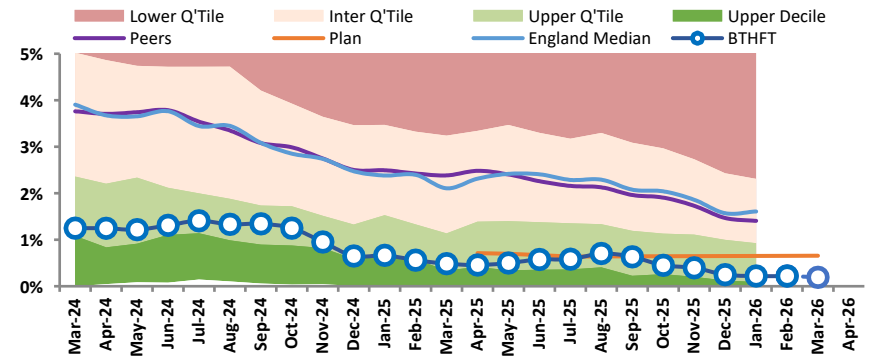
6. Referral to Treatment (RTT)

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Waiting List Size	32,438	32,541	32,563	32,915	33,149	33,728	33,405	32,204	31,832	31,932	31,610	31,261
Waiting List Change		+103	+22	+352	+234	+579	-323	-1,201	-372	+100	-322	-349
% New RTT Within 18 Weeks	65.5%	66.5%	69.2%	68.2%	68.6%	68.4%	67.5%	68.0%	67.7%	67.8%	66.2%	68.1%
Incomplete (52+)	158	149	163	190	193	238	212	145	127	80	70	69

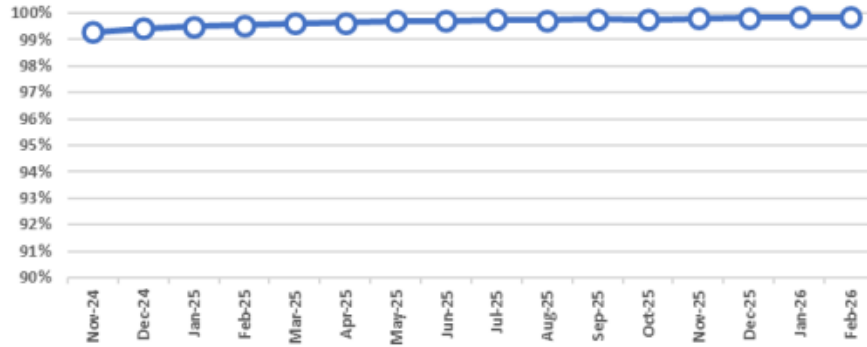
Latest position

- **RTT related activity** levels have remained below plan, with increased annual leave as we near the end of the financial year reducing the benefit from Q4 action plans to increase clock stops. As a result, performance is forecast to out-turn below plan.
- The number of **RTT over 52 weeks** waits remained stable in February. Improvements continue in the Plastic Surgery position following the opening of the theatre forward wait area, whilst challenges in Pain Management are expected to resolve in April. No patient waited over 65 weeks, with none projected over the foreseeable future.
- The **Q4 outpatient sprint** is underway with additional new appointment slots in place and weekend clinics planned during March. Uptake against the original plan has not been fully achieved but performance is likely to have deteriorated without this specific push as run-rate activity has been impacted by annual leave above normal Q4 levels.
- The **support services improvement** programme is progressing 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 programme is reviewing the standardisation of processes, targeted staff training, and the implementation of robust, data-driven monitoring systems.

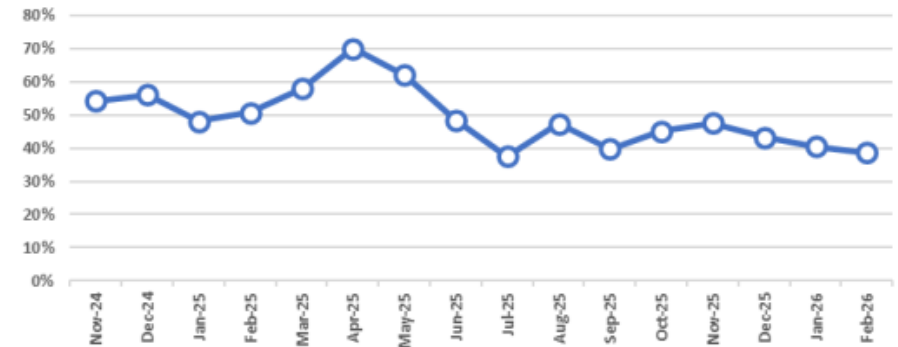
7. Waiting List Management and Validation

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
RTT LUNA DQ Metrics	888	788	689	657	590	660	567	647	503	456	425	425
Correction Rate - Non RTT	19.00%	33.92%	6.23%	7.36%	41.97%	23.36%	14.94%	15.28%	20.20%	23.09%	19.21%	10.21%
Non-RTT DQ Process Failures	30,442	28,434	27,303	25,119	23,825	21,160	20,130	19,644	18,922	18,738	19,088	19,088

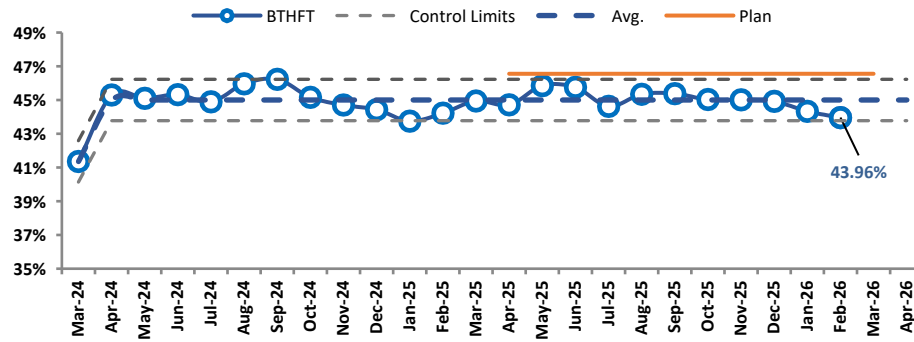
Latest position

- Confidence in the RTT waiting list, as expressed nationally via the **Luna Dashboard**, remains high at 99.81% in February 2026. The number of DQ errors on RTT PTL reported on LUNA Dashboard remain low.
- The significant reduction in the number of DQ metrics on the RTT waiting list, this is due to targeted validation of incomplete pathway.
- Validation of patients currently on **active monitoring** with no activity since being on active monitoring is being conducted.
- Corporate Access Team (CAT) has cleared the process failure backlog. The team is now only working on 1637 process failures created more than 3 months ago. There has also been significant reduction in creation of Process failures due to DQ prevention work.
- The Data Quality Intervention Specialist (DQIS) team is work on DQ prevention with admin team and clinical teams of services with high error rate including Urology, ENT and Dermatology.
- Text based validation of RTT and long waiting Non-RTT patients has been 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.

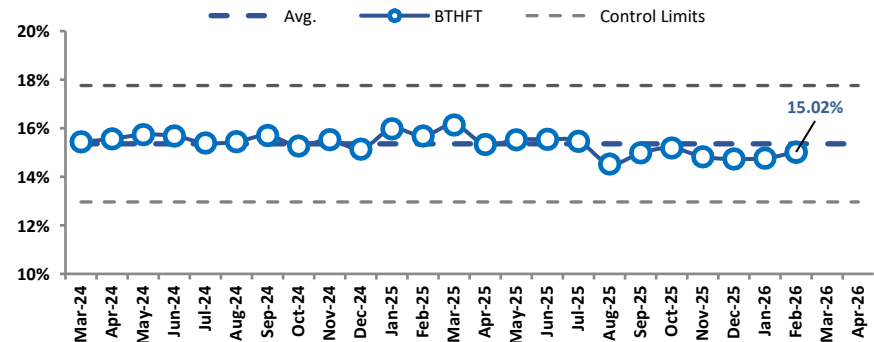
8. Outpatient Productivity

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
% New vs Plan	108%	103%	101%	107%	102%	102%	101%	98%	101%	103%	101%	98%
% Follow Up vs Plan	119%	116%	108%	113%	109%	113%	107%	106%	110%	116%	112%	109%
DNA Rate	7.51%	7.80%	7.90%	7.73%	7.64%	8.00%	8.17%	7.79%	8.32%	8.48%	8.40%	8.27%
Follow Up Orders	27,347	27,529	28,296	27,329	29,062	24,062	29,800	30,492	27,799	27,372	29,519	26,830
PIFU %	4.27%	4.50%	4.49%	4.43%	4.65%	4.37%	4.92%	4.75%	5.72%	5.35%	5.14%	5.69%
PIFU % (including Therapies)	5.24%	5.44%	5.52%	5.19%	5.67%	4.88%	5.16%	5.63%	6.50%	5.34%	5.35%	6.29%
First to Follow Up Ratio	2.6	2.8	2.7	2.6	2.7	2.8	2.7	2.7	2.7	2.8	2.8	2.8

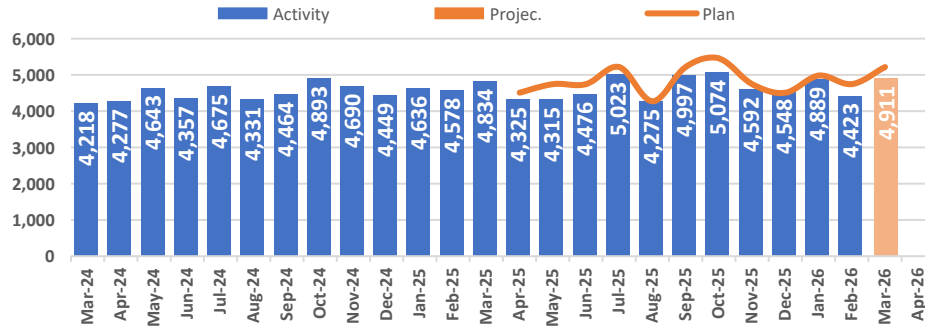
Latest position

- The percentage outpatient appointments that are new or with procedure remain behind plan. Work continues to identify areas achieving below plan and improve the position through **Robotic Process Automation (RPA)** where possible.
- PIFU usage has increased in February with weekly follow up demand reducing since January 2026 however follow up activity remains above plan. Recovery structures will focus teams on increasing new appointments with weekly oversight throughout 2026/27.
- **Outpatient Transformation** will remain focussed on service led pathway redesign supported by digital advancement, estate modernisation, 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 Recovery Board structure. The related **Data and Productivity** workstream focusing on improving delivery of new outpatient appointment and outpatient with procedures.

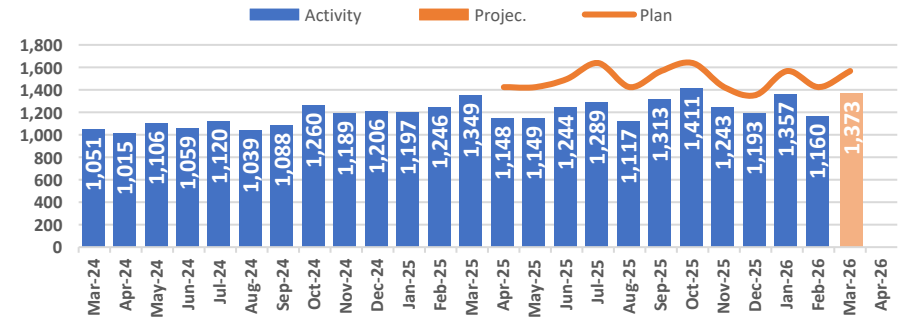
9. Inpatient Productivity

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Admitted Clock Stops	1,647	1,247	1,231	1,275	1,425	1,100	1,315	1,391	1,245	1,226	1,421	1,284
Daycase Rate	87.5%	89.7%	89.1%	88.5%	87.9%	86.9%	88.5%	88.1%	88.0%	88.5%	88.4%	87.5%
Number of Lists Run	657	599	580	632	631	564	666	714	609	596	671	600
Patients Per List	2.1	1.9	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	1.9
Reportable Cancellations	31	35	46	31	66	45	45	56	44	28	64	64
28-day Rebooking Breaches	11	9	9	8	7	13	17	7	4	8	7	8

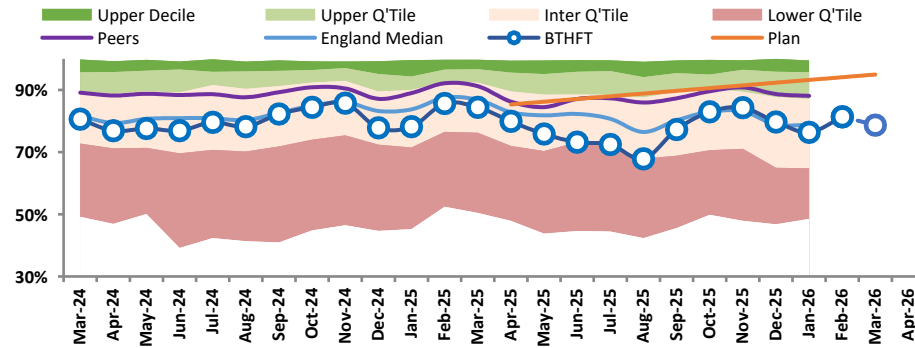
Latest position

- Activity remains slightly behind plan although above M1-9 run rates with **Bronte forward wait** providing additional theatre capacity.
- The **T&O improvement programme** is now up and running with positive results in primary care engagement to review referral criteria and the reduction of LOS. Medical cement supply shortages resulted in two weeks of reduced activity however this has now been mitigated with resource provided by another supplier.
- Conversation with services and theatres are taking place regarding job planning, resources and session allocation in preparation for 2026/27 to ensure plan can be delivered with focus on 642 and scheduling to guarantee theatre utilisation and PPL meet target.
- **Fit for Surgery** texting has commenced in Gynaecology following a successful trial. With a response rate of 89% the process identified 7 patients who may have been at risk of cancellation on the day due to recent flights, transport not arranged, skin/cuts and not understanding fasting instructions. The trial has now been rolled out to encompass T&O and Ophthalmology.
- The Trust are confident that a national submission will be made before the end of the financial year with a full reporting dashboard developed shortly after. An improvement group has been formed to identify and rectify process failures resulting in data quality concerns.
- 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.

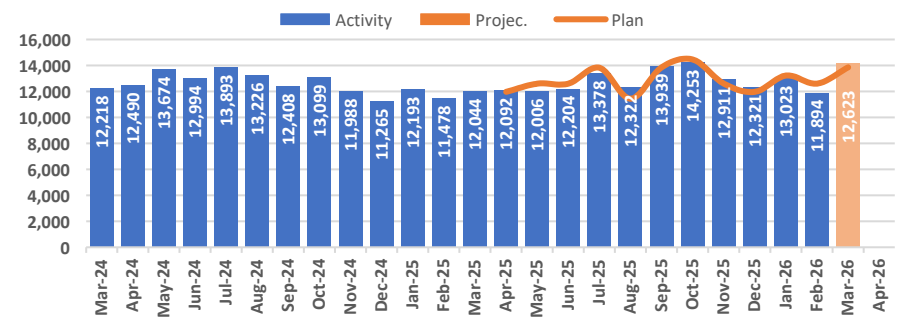
10. Diagnostic Waiting Times

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
(Phys. M'ment) Activity	1,428	1,461	1,403	1,686	1,872	1,711	1,862	2,035	1,740	1,539	1,734	1,413
(Phys. M'ment) Performance	74.9%	69.2%	62.6%	56.6%	59.1%	60.5%	70.2%	70.8%	69.1%	58.3%	55.5%	63.9%
(Imaging) Activity	9,070	9,147	9,148	9,081	9,792	9,174	10,270	10,536	9,577	9,262	9,716	9,146
(Imaging) Performance	86.9%	83.8%	81.2%	78.8%	76.3%	68.4%	77.7%	85.2%	87.7%	84.5%	80.9%	85.1%
(Endoscopy) Activity	1,546	1,484	1,455	1,437	1,714	1,437	1,807	1,682	1,594	1,520	1,573	1,335
(Endoscopy) Performance	90.7%	85.4%	83.9%	80.6%	82.7%	82.5%	92.8%	92.4%	92.6%	89.5%	86.7%	90.8%

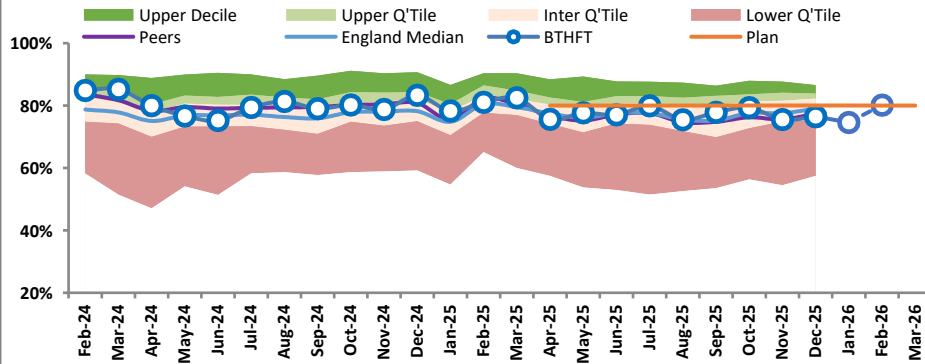
Latest position

- DM01 performance for February has increased to 81.39% due to improvements in Non-Obstetric Ultrasound, Audiology & Urodynamics.
- Staff sickness continues to impact DEXA with a business case pending for additional staff. Performance is expected to decrease by a further 10% in March.
- In Audiology, Medinet was appointed as an insourcing provider following a tender process and the service is awaiting a start date. Further overtime has been approved by the workforce control panel however there has been no uptake in March due to Ramadan.
- Neurophysiology continues to face staffing challenges however an insourcing contracted has been awarded with additional capacity expected from March.
- In Urodynamics a recovery plan is in place with support from medical physics with recovery expected for May.
- Cardiology performance has been impacted by the increase in Stress Echo referrals as per GIRFT recommendations (previously referred as Myoview) which will be a challenge until additional capacity can be applied. A business case has been submitted.
- The new Endoscopy Unit has now opened on a phased operational approach. Under this schedule, the unit is projected to utilise 6 rooms, matching 100% of the activity levels seen in the previous facility by the end of March. Recruitment is underway for 4.5 WTE nurses to fully utilise the 8 procedure rooms by the end of June supporting the repatriation of CDC activity back to BTHFT.

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)

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Trust	75.5%	77.8%	79.4%	75.5%	76.5%	74.6%	80.2%
Breast	94.1%	96.2%	97.8%	97.4%	95.6%	94.6%	97.8%
Gynaecology	74.8%	64.9%	77.8%	68.3%	68.1%	63.2%	81.3%
Haematology	46.2%	59.1%	75.0%	72.7%	50.0%	45.5%	50.0%
Head & Neck	78.7%	80.1%	80.8%	77.1%	83.6%	73.2%	75.7%
Lower GI	55.1%	61.7%	63.4%	59.6%	71.7%	63.7%	75.1%
Lung	87.5%	91.9%	86.0%	89.7%	87.8%	87.5%	85.4%
NSS	75.0%	100.0%	94.4%	94.1%	95.0%	100.0%	93.3%
Upper GI	72.0%	77.3%	77.7%	87.1%	77.9%	84.6%	88.7%
Skin	68.7%	74.6%	67.9%	62.2%	62.1%	58.3%	66.4%
Urology	65.7%	68.6%	84.6%	77.8%	72.0%	71.8%	79.5%

11.3 Additional Cancer Diagnostic Metrics

	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
# 2WW Refs	1,899	1,799	1,817	1,963	2,050	2,067	1,737	2,123	1,976	1,822	1,739	1,996
% 2WW Performance	92.5%	93.5%	85.1%	82.3%	83.7%	79.8%	83.8%	94.0%	94.9%	94.8%	95.7%	92.6%
28 Day FDS Performance	81.0%	82.5%	82.1%	84.5%	81.2%	81.6%	75.5%	77.8%	79.4%	75.5%	76.5%	74.6%
# Total Patients Seen FDS	1,598	1,782	1,703	1,727	1,917	2,106	1,982	2,080	2,020	1,872	1,742	1,879
# Undiag, unbooked >28 days	228	244	267	261	213	340	264	288	337	282	307	275

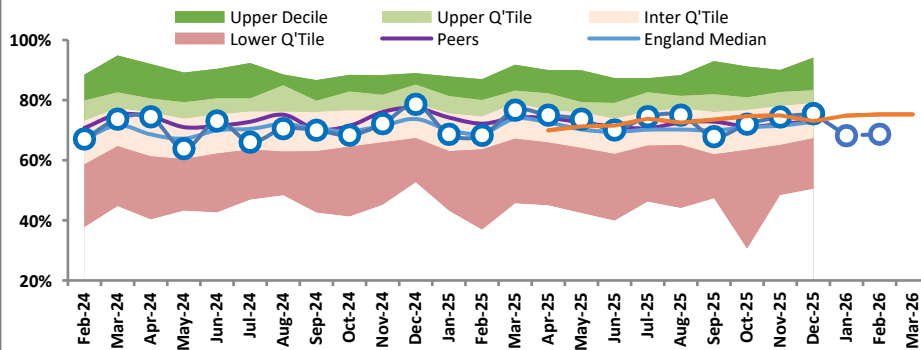
Latest position

- The estates work for the additional Radiology/Breast room is complete, but additional staffing is needed to deliver the planned capacity increase. The Breast team is recruiting a clinical fellow to provide this. A review of the breast pain pathway is also underway, as around 25% of patients currently seen in the cancer one-stop clinic could be managed in other outpatient settings, freeing up cancer capacity.
- OMFS currently have a consultant vacancy, shared between BTHFT and AGH. The service have mitigated some of the impact with standardised clinics however with hot week capacity and AGH/CGH support required, elective activity will be impacted. The FDS performance for February is forecast to be above the 80% target.
- The Skin pathway continues to be impacted by capacity backlogs however the current skin locum contract has been extended to July with Skin AI aiming to be implemented prior to the seasonal increase in demand.
- Histology reporting delays remains a concern in Skin and Gynaecology however the backlog is starting to reduce.
- The Lung pathway is being reviewed, with an aim to align with the best practice timed pathway. As a result, patients will undertake all required diagnostic tests prior to MDT rather than additional tests being carried out at later dates, prolonging the diagnostic phase.
- 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)

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Trust	75.0%	67.9%	72.0%	74.3%	75.5%	68.2%	68.7%
Breast	83.7%	85.9%	83.7%	92.6%	84.7%	77.5%	75.4%
Gynaecology	100.0%	20.0%	87.5%	77.8%	60.0%	80.0%	33.3%
Haematology	52.9%	66.7%	72.7%	73.9%	86.7%	82.1%	65.4%
Head & Neck	100.0%	39.3%	35.0%	35.9%	18.8%	61.1%	40.0%
Lower GI	40.0%	33.3%	31.0%	70.0%	42.9%	53.6%	41.2%
Lung	69.6%	10.5%	42.1%	63.6%	42.9%	30.0%	48.0%
Upper GI	87.5%	88.0%	77.8%	77.8%	77.8%	50.0%	86.7%
Skin	97.2%	84.7%	83.0%	80.5%	96.9%	76.9%	85.3%
Urology	74.6%	72.1%	74.7%	68.2%	81.5%	72.4%	75.4%

12.3 Additional Cancer Treatment Metrics

	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
# 31 Day Treatments	217	229	241	230	249	254	232	277	295	260	245	263
31 Day Performance	96.3%	95.6%	96.7%	93.5%	94.4%	94.1%	95.7%	93.1%	94.9%	93.8%	95.5%	94.3%
62 Day Performance	68.1%	76.7%	74.4%	72.6%	70.0%	74.3%	75.0%	67.9%	72.0%	74.3%	75.5%	68.2%
62 Day Backlog	86	48	60	74	53	50	89	87	63	50	70	84

Latest position

- February performance against the 62 Day standard is projected to remain below plan however following significant reduction in the backlog, March performance is projected to be over 75%.
- Complex diagnostic pathways are still impacting performance across most 62-day pathways. Provider delays are prevalent across most 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.
- Across most pathways, administrative delays, outpatient capacity and patient compliance issues are noted as an overarching challenges. 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.
- 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.

Board of Directors				
Meeting Date:	31 March 2026	Agenda Reference:	Bo.3.26.14	
Report Title:	Health Equity and Health Inequalities			
Presented by:	Mark Hindmarsh, Director of Strategy and Transformation			
Executive Lead:	Mark Hindmarsh, Director of Strategy and Transformation			
Author:	Naveed Saddique, Health Equity Lead Carl Stephenson, Associate Director of Performance James Bowler, Performance Improvement Lead Alison Smith, Head of Strategy and Partnerships			
Report Summary				
Purpose of the paper:	Decision <input type="checkbox"/> (approve/recommend/ support/ratify)	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> (review/discuss/ comment)	Information <input type="checkbox"/>
Summary of Key Issues/Highlights:	<p>Health inequalities are unfair and unavoidable differences in health across the population, and between different groups in society.</p> <p>BTHFT is committed to tackling health inequalities to support equitable access, outcomes and experience for our patients and the wider communities we serve. The Trust seeks to exceed the minimum requirements advised by NHSE and embed a comprehensive approach to improving health equity at the heart of all that we do.</p> <p>This paper provides an update on the Trust's Health Equity approach as at March 2026:</p> <ol style="list-style-type: none"> 1. The Health Equity and Health Inequalities Programme 2. Using data to improve equity of access to care <ul style="list-style-type: none"> ○ Partnerships and inequalities: strategic objective metrics ○ The impact of missed appointments for patients from more deprived areas. 3. Health Equity Work Plan progress update 4. Health Inequalities Statement 2025/26 <p>The Committee are asked to note that this paper now encompasses the 'Health Inequalities and Access to Care' update which was previously submitted to the Board of Directors separately.</p>			
Recommendation/s: (including any decision/approval required)	The Board of Directors is asked to note progress.			
Link to Strategic Objective:	Partnership - To collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals			
Link to Priority Initiatives 2025/26:	Health Equity and Health Inequalities			
Implications				
Risk:	Strategic Risk: If the Trust fails to address health inequalities, then this will contribute to a widening of the gap in health outcomes, access and experiences across Bradford District and Craven.			

Legal/Regulatory:	This report links to the Annual Report requirements concerning health inequalities. Specifically, the production of the Health Inequalities Statement and its supporting narrative is a statutory requirement under the NHS Act 2006. There are also links to the Equality Delivery System 2022. This report may also be used to inform NHS England's contractual reporting requirements relating to health inequalities.
Quality & Patient Safety:	The Health Equity Programme aims for patients to receive equitable access, outcomes and experiences.
Equality, Diversity and Inclusion and Health Equity:	Impacts on health equity as mentioned within the body of the paper.
Resources:	No further impact on resources to report – 2 WTE working on the programme.
Environmental sustainability:	Development of health equity projects may have positive effects on the Trusts' role as an anchor organisation and the delivery of the Green Plan.
Assurance Route	
Meeting/s where content has been discussed previously:	6-monthly update to Quality Committee and Board

Report content
<p>1. The Health Equity and Health Inequalities Programme</p> <p>The aim of this programme is to improve equity of access, outcomes and experience for our services and take action to reduce health inequalities across the wider population. There are a series of initiatives led by the Health Equity team (some of which are described in this paper) and each have plans for improving health equity/addressing health inequalities during 2025/26, which were set out on posters displayed across the Trust earlier in the year.</p> <p>2. Using Data to Improve Equity of Access to Care</p> <p>2.1 Partnerships and inequalities: Strategic Objective Metrics</p> <p>The Board will be receiving an update on all the strategic objective metrics in March 2026. The Partnerships objective is <i>“to collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals”</i>.</p> <p>The metrics linked to this objective focus on health inequalities, specifically improving equity of access for patients from more deprived areas. The aim is to show faster improvements in waiting times for patients from more deprived areas.</p> <p>Core 20Plus5 is a national approach to reducing healthcare inequalities. Appendix 1 provides a detailed breakdown of new outpatient waiting times, emergency department waiting times and cancer waiting times for the most deprived 20% of the national population (Core20) compared to the other 80% of the national population (non-core20).</p> <p>Over the past year there have been improvements for all patients across all measures and a larger improvement for Core20 patients compared to non-core 20, which narrows the performance gap between these two groups of patients.</p> <p>The strategic objective metric for Partnerships takes a snap shot of data each six months for these three areas (Outpatients, Emergency department and cancer waits) and shows which patient cohort has</p>

contributed most to the improved performance position. Since the baseline data was reported to Board in July 2025 the dial has shifted:

- For the cancer 62-day standard, waiting times have improved more for the patients from more deprived areas.
- For the Referral to Treatment standard, waiting times have improved more for the patients from more deprived areas.
- The Emergency Care Standard data shows better performance for the patients from more deprived areas (more Core20 patients wait less than 4 hours than non-core 20). However, between March 2026 and September 2026 the improvement for the non-core20 group has been slightly bigger than the Core20 group.

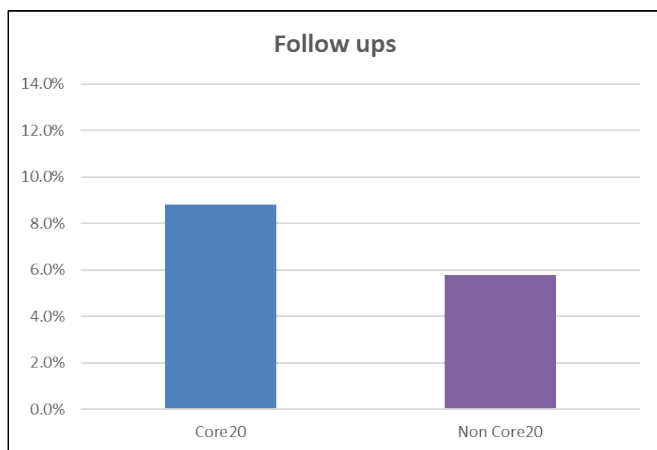
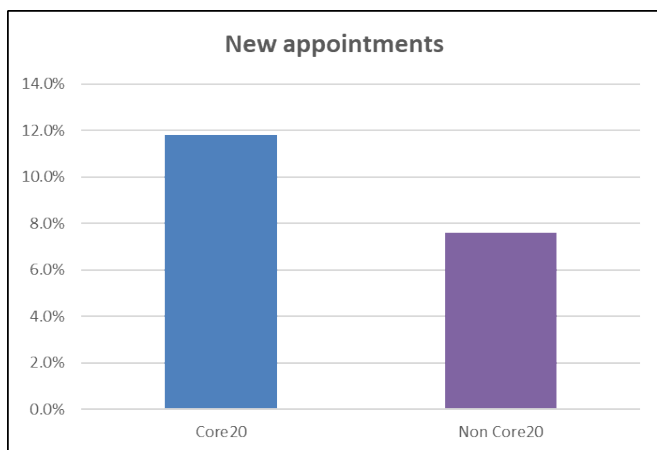
All the strategic objective metrics are being reviewed as part of the overall review of the Strategic Framework for 2026-27, and a detailed report on all of the Strategic Framework is included in a separate paper to this meeting.

2.2 The impact of missed appointments for patients from more deprived areas

One of the key reasons behind longer waiting times for patients from more deprived areas is a higher number of missed appointments. High Did Not Attend (DNA) or Was Not Brought (WNB) rates lead directly to longer waiting times and reduced access for patients who already face the greatest barriers to care.

A DNA dashboard has been developed to understand how deprivation affects non-attendance across outpatient services. CSUs have access to this dashboard, which is updated weekly, allowing them to track changes in their DNA rates on an ongoing basis and identify opportunities to improve equity while also reducing costs.

Across the Trust, Core20 patients have a DNA rate of approximately 12% for new appointments compared to around 8% for non-Core20 patients. There is a similar gap for follow-ups at around 8.5% for Core20 versus 6% for non-Core20.



Nephrology is the speciality with the largest gap between new appointment DNA rates for Core20 patients and non-Core20 patients (18.5% compared to 7.5%). Nephrology has been selected as the initial focus for focused work to reduce the number of appointments missed by patients from the Core20 demographic. The renal team are also participating in the Yorkshire and Humber Renal Equity Programme which is the first of its kind to take a regional approach to health equity in renal services and runs to March 2027. Learning from the renal project will be shared with other services across the Trust.

A project team is now in place led by clinical colleagues and supported by operational colleagues as well as the Health Equity team. Transplant clinic data is being analysed and will likely be the starting point. Patient

engagement work will draw on learning from previous work with Paediatrics, which found that the likelihood of cancellation rather than DNA increased as the level of deprivation increased. A workshop is planned for April 2026 and will explore interventions to enable more patients to attend their appointments. These will be tested and their impact measured using the [Trust's model for improvement](#) and PDSA cycles.

3. Health Equity Work Plan progress update

The Health Equity and Health Inequalities work plan was approved at the Health Equity Oversight Group (HEOG) in August 2025 and informed by the [NHS Providers health inequalities self-assessment tool](#). The work plan has five objectives:

- embedding health equity
- data analysis and utilisation
- fulfilling the Trust's role as an anchor organisation
- providing care based on population profiles
- collaborating with partners.

A revised work plan will be developed with HEOG in Summer 2026, aligned to the three shifts set out in the 10 Year Health Plan.

3.1 Embedding health equity

The Director of Strategy and Transformation holds executive lead responsibility for health inequalities and chairs the HEOG. The Health Equity and Health Inequalities Programme reports to Quality Committee, Board and the Equality and Diversity Council.

As well as overseeing the Health Equity and Health Inequalities Programme, the HEOG has an important role in sharing good practice across the Trust and learning from good practice across the District, and in other places. Since its inception in August 2026, this has included:

- Outstanding Maternity Services work to improve equity in maternity care
- Improving access to diabetes education, particularly for people whose preferred language is not English
- Living Well
- BIHR inequalities research
- Evaluation of the Bradford District & Craven Core20Plus5 programme
- Health Literacy and how it impacts health
- The Yorkshire and Humber Kidney Network's health equity programme

3.2 Data analysis and utilisation

The DNA dashboard described above has been created to provide services with data on disparities between the Core20 and non-Core20 cohorts. The next steps will be to upgrade this to a more comprehensive Health Equity dashboard using the indicators from the new Health Inequalities Statement (see below). This will be a live dashboard with automated updates. The Health Equity team is also working with Business Intelligence to add health inequalities metrics and intersectionality to the Accident and Emergency Department dashboard, broadening how inequalities are tracked in operational data and supporting local improvement initiatives.

3.3 Anchor organisation

The library team are going to provide public access to computers from the BRI library as part of our efforts to promote digital inclusion. It will enable patients and members of the community to access health records, use DrDoctor and write NHS job applications with support from HR colleagues. It is due to open in the first week of April following installation of the equipment and staff training.

We are also linking with the Yorkshire Women's Forum (based at Manningham Mills Community Centre) to combine efforts to address digital exclusion and develop ideas for a Community Connectors project that will place volunteers in the heart of the community to provide healthcare navigation and support.

3.4 Providing care based on population profiles

The Making Every Contact Count (MECC) project aims to use routine conversations (taking 30 seconds to a few minutes) to help people make positive, sustainable changes to their physical and mental health. MECC has been trialled in phlebotomy and Adult Outpatients using the Trust's improvement model and a report has been completed on the first year of trials.

84 staff have now undertaken the training. The data shows that when a MECC conversation takes place, in 49% of cases it results in a referral to Living Well (covering alcohol reduction, smoking cessation, physical activity, and mental health support), 17% result in patients accessing digital (multi-lingual) hypertension advice and we also have data showing that 4 patients were immediately referred to their GP for follow up.

The next step is to enable more MECC conversations by simplifying the way they are recorded (to include a referral destination for all conversations) and incorporating MECC into the EPR system to make it easier and quicker for staff to record the conversation. The form will also help track patients who have had a MECC conversation to potentially understand ongoing impacts on health. Our colleagues at Living Well have also designed a BTHFT-specific QR code so that we can track the referrals they receive.

3.5 Collaborating with partners

The Reducing Inequalities Alliance hosted by the West Yorkshire ICB has been a key partner for this work, providing valued expert advice to HEOG and a key source of population health data. Unfortunately, because of the ICB reorganisation it will not be continuing, and we are part of conversations to decide how to continue cross-district work on health inequalities with colleagues in Public Health.

Engagement with BIHR is developing with research represented at HEOG and initial discussions held around the Connected Bradford dataset.

The Trust has also supported Locala do develop their Health Equity work, who are now mirroring the Trust's health equity approach within their own organisation. This shows the work is having an effect beyond the Trust's own walls.

3.6 Developing health equity capability

Progress on workforce capability has been positive this year. Building knowledge and capability is key to the success of the programme. Since February 2025, over 600 new starters have been introduced to population health and health inequalities as part of their Trust induction. The session introduces them to the Bradford population, the health inequalities that exist and what we can do to reduce them. The feedback has been very positive and from June 2026, this will be extended to the nursing preceptorship scheme.

Five Health Equity Fellows have been recruited for 2025/26 and are currently completing their projects spanning subjects such as digital inclusion and language barriers in maternity care. Unfortunately, the fellowship programme will not continue after April 2026 because of structural changes within the ICB.

4. Health Inequalities Statement – update and implications on BTHFT

NHS England published an updated [Health Inequalities Statement in November 2025](#) under powers in the NHS Act 2006. The statement sets out what NHS Trusts are required to collect, analyse, publish and act on in relation to health inequalities.

The reporting requirements have increased significantly compared to the 2023 Health Inequalities Statement. It requires the Trust to systematically analyse and report performance data including waiting times,

appointment attendance and clinical outcomes, by age, sex, ethnicity and deprivation and improve data quality (e.g. ethnicity data recording).

The statement requires trusts to publish the data in the Annual Report with analysis and commentary on trends, drivers and actions taken. The data will be useful for the Health Equity and Health Inequalities programme because it will provide new insights into inequalities in access to and experience of our services to inform our work programme for 2026/27.

5. Recommendation

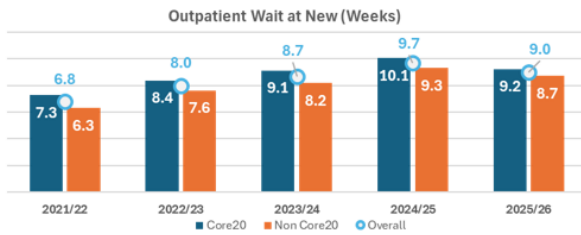
- The Board of Directors is asked to note this update on the Health Equity and Health Inequalities programme.

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Appendix 1 – Components of the Partnerships Strategic Objective

Metric: Impact of deprivation on waiting times

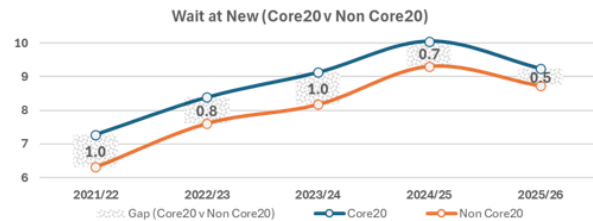
Outpatient Wait at New



Average waiting times for first outpatient appointments **increased steadily** between **2021/22** and **2024/25** across all groups. The combined average wait increased from **6.8 weeks** in **2021/22** to a peak of **9.7 weeks** in **2024/25**, with similar upward trends seen for both Core20 and Non-Core20 patients. Throughout the period, patients from the most deprived communities (Core20) consistently waited longer than those from less deprived groups.

Whilst waiting times remain higher than earlier years, this improvement suggests some recovery in system performance.

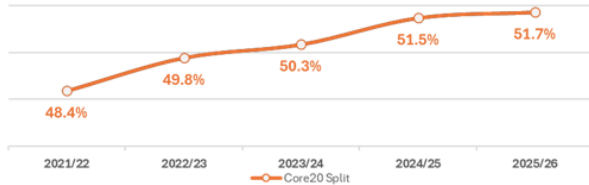
Encouragingly, the gap in waiting times between **Core20** and **Non-Core20** patients has narrowed, reducing from **1.0 week** in **2021/22** to **0.5 weeks** in **2025/26**. This indicates that reductions in wait times have been relatively more favourable for patients from the most deprived communities, contributing to progress in reducing inequalities in access to outpatient care, although a difference in waits between groups remains.



In **2025/26**, waiting times improved across all groups following the previous year's deterioration. The overall average wait reduced by **0.7 weeks**, with a slightly larger improvement for **Core20** patients (-**0.8 weeks**) compared with **Non-Core20** patients (-**0.6 weeks**).

Whilst waiting times remain higher than earlier years, this improvement suggests some recovery in system performance.

Percentage of Patients Seen from Core20 Group

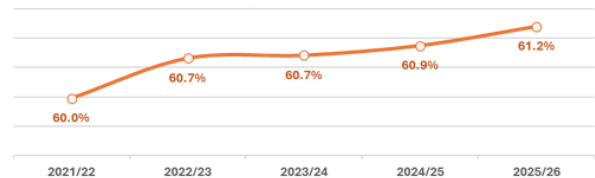


ECS 4-hour Performance

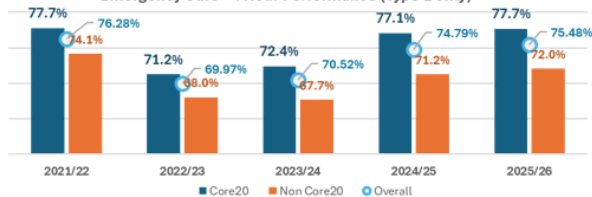
Core20 patients account for around **60–61% of ED attendances across the period**, which is higher than might be seen nationally but is indicative of Bradford's population profile - Bradford has a relatively large proportion of residents living in the most deprived national quintile, and therefore a higher share of activity from Core20 groups would be expected.

Over time, the proportion of attendances from Core20 patients has **increased slightly** (from **60.0%** in **2021/22** to **61.2%** in **2025/26**), indicating that the activity profile is **shifting further towards patients from more deprived communities**. This trend broadly reflects the underlying demographic and deprivation characteristics of the local population rather than indicating unequal access to ED services.

Percentage of Patient Attendances from Core20 Group (Type 1 only)



Emergency Care - 4 Hour Performance (Type 1 only)



Emergency Department (ED) four-hour performance for Type 1 attendances declined between **2021/22** and **2022/23**, with the combined performance falling from **76.3%** to **70.0%**, reflecting increasing demand and system pressures during this period.

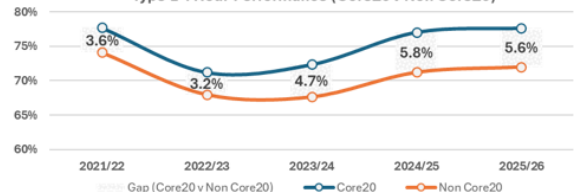
Performance stabilised slightly in **2023/24** and then improved more substantially in **2024/25**, reaching **74.8%**, with further improvement to **75.5%** in **2025/26**.

This recovery was accompanied by a reduction in total breaches, which fell from **38,184** in **2022/23** to **25,904** in **2025/26**, despite continued pressures on urgent and emergency care services.

Across the period, **Core20** patients consistently experienced **higher four-hour performance** than **NonCore20** patients. In **2025/26**, performance was **77.7%** for **Core20** patients - compared with **72.0%** for **Non-Core20** patients, meaning patients from the most deprived communities were more likely to be seen, treated, admitted or discharged within four hours.

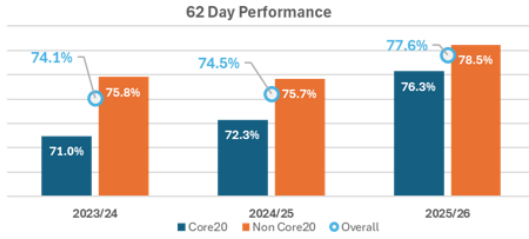
Despite the **proportional increase in Core20 attendances**, the **performance gap between the groups has widened over time** (in favour of Core20), increasing from **~4%** in **2021/22** to **~6%** in **2025/26**.

Type 1 4 Hour Performance (Core20 v Non Core20)



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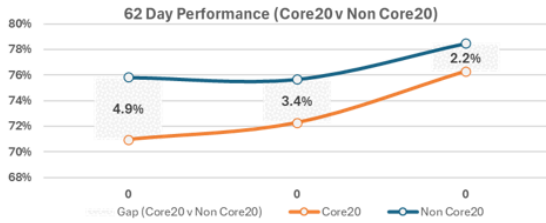
Cancer 62 Day Treatment Standard



Core20 performance on the 62-day cancer pathway has shown sustained improvement over the past three years, rising from **70.97%** in **2023/24** to **76.29%** in **2025/26**. This represents a **5.3% increase**, with the most significant year-on-year improvement occurring in the latest year (**+4.0%**).

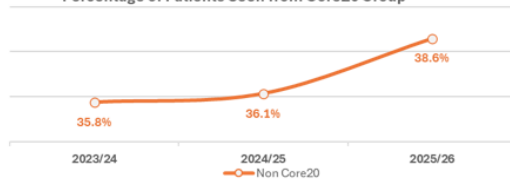
Whilst **Non-Core20** patients continue to demonstrate slightly higher performance overall, their improvement has been more modest, increasing from **75.83%** to **78.47%** across the same period.

Combined performance has also improved steadily, reaching **77.63%** in **2025/26**, up from **74.09%** in **2023/24**.



Importantly, the **performance gap between Core20 and Non-Core20 groups is narrowing**, reducing from **4.9%** in **2023/24** to **2.2%** in **2025/26**. This indicates meaningful progress in reducing inequalities in timely cancer treatment and suggests that targeted interventions for the Core20 population are having a positive impact.

Percentage of Patients Seen from Core20 Group



Patient distribution has shifted slightly, with **Core20 patients representing ~36%** of total patients seen in **2023/24**, **increasing to ~39%** in **2025/26**.

Overall, the data shows a positive trend in 62-day cancer pathway performance, with improvements in overall performance and a **reduction in the gap between Core20 and Non-Core20** groups. Core20 performance has improved over the period, while Non-Core20 performance remains comparatively strong and stable, supporting the overall improvement observed.

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Board of Directors			
Meeting Date:	31/3/26	Agenda Reference:	Bo.3.26.15
Report Title:	Strategic Framework		
Presented by:	Mark Hindmarsh, Director of Strategy & Transformation		
Executive Lead:	Mark Hindmarsh, Director of Strategy & Transformation		
Author:	Alison Smith, Head of Strategy & Partnerships		
Report Summary			
Purpose of the paper:	Decision <input type="checkbox"/> (approve/recommend/ support/ratify)	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> (review/discuss/ comment) Information <input type="checkbox"/>
Summary of Key Issues/Highlights:	<p>The Trust Board approved the Strategic Framework for 2025/6 in March 2025 (Appendix A) and approved the 'dials' designed to visualise progress towards the strategic objective metrics in September 2025.</p> <p>A commitment was made to report progress towards the strategic objective metrics to the Board every six months, and this paper provides that update.</p> <p>The latest strategic objective metric progress dials have been considered by Committees during February and March 2026:</p> <ul style="list-style-type: none"> - Progress dials for Quality and Partnerships were considered by Quality Committee on 19th February and 19th March 2026 - Progress dial for People was considered by People Committee on 11th February 2026 - Progress dial for Sustainability was considered by Finance & Performance Committee on 18th February 2026 <p>The priority programmes and metrics in the strategic framework (Appendix A) are being reviewed and evaluated, and colleagues were invited to a session on 25th February 2026 to take a strategic look at the Trust's priorities for 2026/27.</p> <p>A new strategic framework will be developed for 2026/27 to reflect the changing strategic context from the NHS 10-year plan and the 5-year Integrated Delivery Plan agreed with NHS England for 2026/27 – 2030/31.</p>		
Recommendation/s: (including any decision/approval required)	<p>The Board is asked to:</p> <ul style="list-style-type: none"> • Note the latest update of the strategic objective metric 'dials' with data from end-September 2025 • Approve plans to update the strategic framework for 2026/27. 		
Link to Strategic Objective:	All		
Link to Priority Initiatives 2025/26:	Choose an item.		
Implications			
Risk:	Relevant to the strategic risks on the BAF		
Legal/Regulatory:	The Corporate Strategy 2022-2027 and the Strategic Framework for 2025/26		

	support the Shared Direction and Culture section of CQC's Well Led Framework.
Quality & Patient Safety:	Strategic Framework includes the Quality objective 'to provide outstanding care for patients delivered with kindness'
Equality, Diversity and Inclusion and Health Equity:	Equality, Diversity and Inclusion is highlighted in the People Objective which says, "to be one of the best NHS employers prioritising the health and wellbeing of our people and embracing, equality, diversity and inclusion".
Resources:	None
Environmental sustainability:	The Green Plan is one of the 10 priority initiatives linked to the Sustainability objective "to deliver our financial plan and key performance targets"
Assurance Route	
Meeting/s where content has been discussed previously:	<p>People Academy on 12 February 2026 F&P meeting on 18 February 2026 Quality Committee meetings on 19 February and 26 March 2026</p> <p><i>Working Together in 2026/27</i> engagement event on 25 February 2026</p>

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Report content

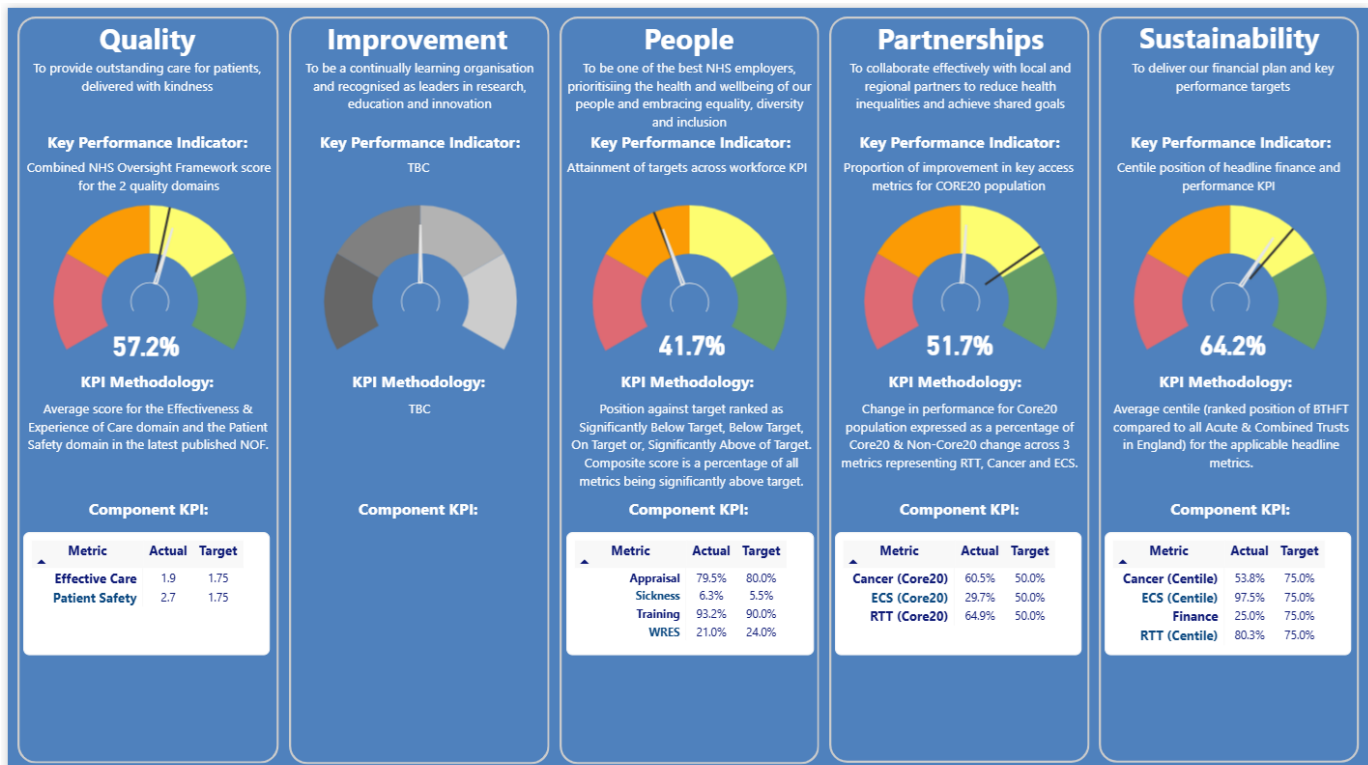
Strategic objective metrics and Progress Dials

The BTHFT Strategic Framework for 2025/26 is in Appendix A. The purpose of developing metrics linked to each of the five strategic objectives in this Strategic Framework, and visualising them on the 'progress dials', is to act as a guide to enable the Board to monitor progress and improvement over time.

Following consultation and input from all the Board Committees and colleagues across the organisation, the strategic objective metrics for Quality, People, Partnerships and Sustainability were approved by the Board in September 2025, using baseline data from March 2025. It has not yet proved possible to develop a composite metric for the improvement objective so this will be reviewed as part of the evaluation of all the metrics.

A commitment was made to update the Board every six months, and this provides that update using mid-year data from September 2025. The white bar shows the current position, and the black line is the baseline.

Figure 1: Strategic Objective Metrics (September 2025 – white arrow) compared to March 2025 Baseline (black line).



Quality: to provide outstanding care for patients delivered with kindness

There has been a small improvement in the **Quality** dial. A slight deterioration in the Patient Safety Domain score is balanced by an improvement in the Effectiveness and Experience of Care score. The measures making up the domain scores show the drop in the patient safety domain score is driven by a lower score for *C.Difficile* and MRSA infections. The score for all other measures has either stayed the same or improved.

The last time this analysis was done, the data for Q1 was provisional and has since been finalised. The table below shows both the provisional and final Q1 position and the dial uses the updated Q1 position.

	Q1 2025/26 (Provisional)	Q1 2025/26 (Updated)	Q2 2025/26
Effectiveness and experience of care	1.63	1.85	1.92
<i>Patient experience</i>		2	2
<i>Effective flow and discharge</i>		2.34	2.6
<i>Effective out of hospital care</i>		1.05	1.1
Patient Safety Domain Score	2.4	2.85	2.65
<i>NHS Staff Survey - raising concerns sub-score</i>		2.42	2.42
<i>Number of MRSA bacteraemia cases score</i>		3.01	2
<i>Proportion of C. difficile infections score</i>		3.5	2.8
<i>Proportion of E. coli bacteraemia score</i>		3.35	3.85

People: to be one of the best NHS employers, prioritising the health and wellbeing of our people and embedding equality, diversity and inclusion

There has been no overall change in the **People** dial – an increase in the sickness absence rate is balanced by improvements in the other measures relating to appraisals, training compliance and performance against the Workforce Race Equality Standard (WRES). The details are in Table 1.

Table 1: The components of the Composite Metric for the People Strategic Objective

Breakthrough metric	Baseline (March 2025)	Progress (Sept 25)	Target for 26/27
Appraisals	76.8%	79.5%	80%
Sickness	6.1%	6.3%	5.5%
Mandatory Training	93%	93.2%	90%
WRES	20.4%	21%	24%

Partnerships and Inequalities: to collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals

This dial focuses on **inequalities** and looks for a faster improvement in waiting times for patients from more deprived areas (defined as the 20% of the population living in the most deprived areas in England – Core20).

Since the baseline data was reported to Board in July 2025 the dial has shifted, with two components moving positively and one not:

- For the cancer 62-day standard, waiting times have improved **more** for the patients from more deprived areas.
- For the Referral to Treatment standard, waiting times have improved **more** for the patients from more deprived areas.
- However, even though the Emergency Care Standard data still shows better performance for patients from more deprived areas (i.e. more Core20 patients wait less than 4 hours than non-core 20) the dial has shifted down because between March and September 2025 the improvement for non-core20 has been slightly bigger than Core20.

Overall, this has given a deterioration in the partnerships dial. However, this particular progress dial has proved very sensitive to small changes in just one of the three component measures, so this will be tested as part of the evaluation.

Sustainability: *to deliver our financial plan and key performance targets*

For the sustainability objective, the aim is monitor whether the Trust is successfully delivering our patient’s needs within the resources available, and aims to achieve upper quartile performance. The metric is a designed as a balanced metric that considers financial position and performance alongside each other, and compares BTHFT’s position with the position of all Trusts in England with the aim of being in the top quartile for all four metrics:

- Deficit/surplus as a % of turnover
- Cancer waiting times (28-day faster diagnosis standard and 62-day referral to treatment standard)
- Referral to treatment within 18 weeks standard
- 4-hour Emergency Care Standard

There has been a very marginal change in the **Sustainability** dial because deterioration in some components has been balanced by improvements in others. Lower performance on cancer standards compared to all other Trusts in England is balanced by better performance for the Emergency Care Standard and Referral to Treatment. Finance is static at 25%. The details are in Table 1.

Table 1: The components of the Composite Metric for the Sustainability Strategic Objective

Breakthrough metric	Baseline (March 2025)	Progress (Sept 25)
Cancer (centile)	75	54
ECS (centile)	96	98
Finance	25	25
RTT (centile)	71	80

Strategic Framework for 2026/27

This is the first time the Trust has attempted to develop sophisticated composite metrics to assess progress against the Trust’s strategic objectives. We made a commitment to review them after a year and give colleagues and the relevant Board committees an opportunity to enhance them and use more sophisticated data sources as they become available.

This review will be part of a wider evaluation of the overall strategic framework to respond to the new strategic context in the NHS 10-year plan and the Trust’s commitments in the 5-year Integrated Delivery Plan. A session was held on 25th February 2026 looking forward to 2026/27.

An evaluation is also underway with all the teams who prepared strategy posters in May 2025 to get feedback on the process and the current list of ten priority initiatives.

The revised strategic framework for 2026/27, with priority programmes and metrics, will be shared with Committees during May 2026 and then brought to the Board for approval.

Conclusion

The Board is asked to:

- Note the latest update of the strategic objective metric ‘dials’ with data from end-September 2025
- Approve plans to update the strategic framework for 2026/27.

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30/03/2026 10:08:30

Appendix A: BTHFT Strategic Framework



BTHFT Strategic Framework 2025-2027

Our Vision

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

	Quality	Improvement	People	Partnership	Sustainability
STRATEGIC OBJECTIVES	To provide outstanding care for patients delivered with kindness	To be a continually learning organisation and recognised as leaders in research, education and innovation	To be one of the best NHS employers prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion	To collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals	To deliver our financial plan and key performance targets
STRATEGIC OBJECTIVE METRICS	CQC definitions of quality	Improvement training and recruitment to research studies	People come stay and thrive	Inequalities in access, outcomes and experience	Upper quartile performance against finance and performance standards
BREAKTHROUGH METRICS	NHS Oversight Framework domains	E.g. improvement training, research trials	Sickness, appraisals, mandatory training, EDI	Performance against constitutional standards IMD1 and 2	Balancing monthly deficit and RTT, ECS, Cancer Waiting Times
PRIORITY INITIATIVES	Martha's Rule	Digital Strategy	Thrive	Health Equity and Health Inequalities	Closing the Gap
	EXCEL Programme	Outpatient Transformation	Workforce Review	Acute Collaborations: ABCAS and WYAAT	Green Plan

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20/03/2025 10:08:30

Meeting Title	Board of Directors		
Date	31 March 2026	Agenda item	Bo.3.26.16

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Audit Committee Date of meeting: 10th February 2026

Key escalation and discussion points from the meeting

Alert:

Internal Audit – Falls. The Committee received the Internal Audit report on Falls which provided **Limited Assurance**. The audit analysis of falls incidents recorded by the Trust between April 2024 – April 2025 suggested some room for improvement as currently 12% of inpatient fall incidents had not had a multifactorial falls risk assessment (MASA) completed upon admission to the Trust.

Management had advised that they had recently introduced a live dashboard which should enable ward managers to closely monitor the completion of MASAs. The Committee was grateful for the attendance of the Chief Nursing Officer who explained further that the underlying issue was a common theme around care planning and Electronic Patient Record (EPR) optimisation. The Trust was working with informatics colleagues on a project that is looking at how we can get better oversight of information which comes in and out of EPR. Notwithstanding current constraints, the Committee was assured that management actions directly target the core causes and that meaningful progress is imminent once the data platform changes hands.

Internal Audit – Consultant Job Planning. The Committee received the Internal Audit report on Consultant Job Planning which provided **Limited Assurance**. The audit had concluded that while there are a number of positive initiatives and ongoing improvement work; significant gaps remain in ensuring that all job plans are complete, consistent, and quality checked against national guidance. Until these improvements are fully implemented and evidenced, the risk remains that consultant job plans may not accurately reflect activity, contractual requirements, or support effective workforce planning.

The completion rate of consultant job plans was 52% as of September 2025. The Committee was grateful for the attendance of the Chief Medical Officer who explained that the Trust had doubled the rate of job planning in the last eight months and anticipated that there will be increasing sign-off rates in the next six weeks as we move towards financial year-end.

Advise:

External Financial Statement Audit – Deloitte set out the results of their planning audit procedures and provided information on the materiality and risks of material misstatement which they will test as part of the annual external audit procedures.

Root Cause Analysis of emerging themes from the internal audit work had identified *oversight/accountability* and *governance/strategy* as some key themes from the audit findings thus far this year. Management assured the Committee that this information was being disseminated/discussed with the Executive and CSU colleagues and used effectively for preventative measures.

Meeting Title	Board of Directors		
Date	31 March 2026	Agenda item	Bo.3.26.16

Assure:

Internal Audit

The Committee received the following list of reports and noted the range of assurances given:

Report No	Report	Final	Draft	Opinion
BH/18/2026	Infection, Prevention and Control; Blood Culture	✓		Significant
BH/19/2026	Sustainability / Green Plan	✓		Significant
BH/20/2026	Consultant Job Planning	✓		Limited
BH/21/2026	Falls	✓		Limited
BH/22/2026	Estates Procurement	✓		Significant

The internal audit progress report and the follow up of recommendations update provided by the Associate Director of Corporate Governance detailed the number of overdue recommendations. **The Committee noted that the volume of overdue recommendations continues to gradually reduce due to the direct intervention of the Chief Finance Officer.**

The **draft 2026/27 annual audit plan** was presented and approved. In developing the plan, it had also been circulated for input from all Non-Executive Directors and will be presented at other Board sub-committee meetings for comments on the scope of planned audit activity.

The Committee received and noted the bi-annual management report regarding compliance with the Trusts **Risk Management Strategy**.

Other matters

All other matters considered by the Committee provided appropriate assurance (or approval):

- Counter Fraud Progress Update Report.
- Bradford Hospital Charity Final Annual report and accounts 2024/25 were presented for completeness following approval at Board. They had been electronically signed by the Chair, Chief Executive and Chief Financial Officer and submitted to the Charity Commission in line with the deadline of end January 2026.
- Schedules of Losses and Special Payments, and review of single source tenders.

Report completed by:

Zafir Ali, Audit Committee Chair and Non-Executive Director, 11 March 2026

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Meeting Title	Board of Directors		
Date	31 March 2026	Agenda item	Bo.3.26.17

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: CHARITABLE FUNDS COMMITTEE

Date of meeting: 3 February 2026

Key escalation and discussion points from the meeting

Alert:

Finance Report: There has been an expenditure of £270,000, excluding investments. The investment portfolio's underlying assets have appreciated in value by £157,000 in the period from 1 April 2025 which after factoring in the £200,000 drawdown in December and investment management costs, results in a net reduction in funds year to date of £113,000. Net expenditure over the year is forecast to be around £514,000 and if investments deliver as expected, to be around £360,000 net costs.

The total operational costs for the year are expected to be around £603,000 and independence costs are expected to increase.

There is a need to be mindful of operational costs increasing.

Advise:

Move to Independence. The independence process is estimated to take around 12-18 months. The team are aiming for April 2027 for the independent charity to be constituted.

How the new charity will work alongside the Trust in terms of governance, legality and existing Trust funds needs to be decided.

Assure:

Neonatal Unit. Update on key milestones.

- Sovereign Health Care has awarded a large capital grant of £250,000 following a successful pitch by the Charities team.
- The total funds received to date have increased slightly, to £878,897, with the total funds pledged standing at £1,167,293.
- Applications in the pipeline have decreased slightly, to £740,725.
- BR has signed a MoU (Memorandum of Understanding) for £130,000 (NHSE PDC). The MoU with the Sick Children's Trust is still under discussion and the £100,000 will be payable once this is signed.

Report completed by:

Ataf Sadique

Charitable Funds Committee Chair and Non-Executive Director

19/03/2026

Board of Directors Open			
Meeting Date:	31 March 2026	Agenda Reference:	Bo.3.26.18
Report Title:	Board Assurance Framework and High-Level Risks		
Presented by:	Prof Karen Dawber, Chief Nurse Laura Parsons, Associate Director of Corporate Governance/Board Secretary		
Executive Lead:	Prof Karen Dawber, Chief Nurse		
Author:	Laura Parsons, Associate Director of Corporate Governance/Board Secretary / Debbie Earnshaw, Corporate Governance Manager		
Report Summary			
Purpose of the paper:	Decision <input type="checkbox"/> (Approve/recommend/ support/ratify)	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> (Review/discuss/ comment)
Summary of Key Issues/Highlights:	<p><u>Board Assurance Framework Quarter 3 2025-26</u></p> <p>This paper provides a profile of risks, controls and assurances related to the delivery of the Trust’s strategic objectives in the form of the Board Assurance Framework (BAF) see Appendix 1.</p> <p>The BAF has been reviewed and updated by the Executive leads to reflect the position at the end of Q3 2025/26.</p> <p>There has been one change in score to report to the Board since the Q2 2025/26 report as follows –</p> <ul style="list-style-type: none"> • Following discussion by the Finance and Performance Committee, the Q3 Risk score for BAF risk 14 has been reviewed by ETM on 2 March 2026. The risk score has been reduced to 9 from 12 and the target risk score from 9 to 6. <p><u>High Level Risk Register Report – February and March 2026</u></p> <p>All operational risks scoring 15 and above (high level risks) are escalated to the Executive Team Meeting (ETM) monthly and then to the relevant Committees and the Board.</p> <p>At its meetings on 9 February 2026 and 9 March 2026 the 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.</p> <p>The Board Committees reviewed the high-level risks within their remit at their meetings held in February and March 2026 and at the time of this report there is -</p> <ul style="list-style-type: none"> • One risk beyond their target mitigation date (2612). • Three new risks (2766, 40 and 2868) with completed risk assessments. • Two risks have reduced in score (2758 and 2677). • One risk is beyond the review date (2612). <p>The high-level risk register showing all high-level risks rated 15+ for March 2026 is attached at Appendix 2.</p>		

Osbourne-Sheridan
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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 and BAF 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: 9 th February 2026 and 9 th March 2026 People Academy: 11 th February and 11 th March 2026 Finance and Performance Committee: 18 th February and 25 th March 2026 Quality Committee: 19 th February and 26 th March 2026

Report content
<p>1. Purpose</p> <p>This paper provides a profile of risks, controls and assurances related to the delivery of the Trust's strategic objectives in the form of the Board Assurance Framework (BAF) see Appendix 1 and High-Level Risk Register (HLRR) see Appendix 2.</p> <p>2. Assessment</p> <p><u>Board Assurance Framework Q3 2025-26 Review</u></p> <p>The Board of Directors has a responsibility to understand the level and type of risks being taken within the organisation. A properly functioning Board Assurance Framework (BAF) provides the organisation with an understanding of the principal risks to the achievement of its strategic objectives and should provide robust assurances over the controls in place or the action being taken to mitigate risks to an acceptable level within the Board's risk appetite.</p> <p>The BAF concerns strategic risks that could impact on the achievement of the long-term strategic objectives of the Trust. They can be affected by such areas as policy, people, partners, money, safeguarding, political, legal and regulatory changes, and reputation. They are identified at Board level (top down).</p>

(i) Q3 2025/26 Position

- The relevant sections of the BAF are attached at Appendix 1.
- The BAF has been reviewed and updated by the Executive leads to reflect the position at the end of Q3 2025/26 and the Board Committees reviewed the BAF risks within their remit at their meetings held during February and March 2026.
- Following discussion by the Finance and Performance Committee, the Q3 Risk score for BAF risk 14 has been reviewed by ETM on 2 March 2026. The risk score has been reduced to 9 from 12 and the target risk score from 9 to 6.

(ii) Future developments

- Work is in progress to develop the format of the BAF, including consideration of the recommendations identified by Audit Yorkshire, undertaking benchmarking and considering NHS Providers guidance. The updated format will aim to provide –
 - A more robust assurance reporting method to evidence that controls are in place to manage the risks aligned to the strategic objectives and that gaps in controls have been identified. To support this, the Board and Committee agendas will identify which BAF risk each agenda item is relevant to, and the work plans will be used to map the assurances received during each quarter, linked to the strategic objectives. This will allow an overall level of assurance to be presented in relation to each strategic objective.
 - Improved visuals to illustrate quarterly risk movement and changes made within the quarter.

(iii) Strategic Risks 2026/27

- Meetings have been scheduled with executive leads at the end of March to carry out the Q4 BAF reviews and to review the strategic risks for 2026/27. The draft strategic risks will be reviewed by executive leads and presented to ETM on 13 April 2026 and discussed at the Board Development Session scheduled for 29 April 2026.

High Level Risk Register (HLRR) – Operational Risk

All **operational** risks scoring 15 and above (high level risks) are escalated monthly to the Executive Team Meeting (ETM) and onwardly to the relevant Academies and the Board.

At its meetings on 9 February 2026 and 9 March 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 during February and March 2026.

The HLRR, showing all high-level risks rated 15+ in March 2026, is attached at Appendix 2.

High Level Risks Report on a Page

The document at Appendix 3 provides a visual overview of all high-level risks at BTHFT as at March 2026 and shows trends and flags areas that ETM, the Committees and 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 demonstrate over time how long risks have remained static.
- A risk that remains static over several months may indicate that further work is required to control the risk.

Target Mitigation Dates

There is one risk 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	Quality Committee

The above risks are imminently due a full risk review which will include a review of the target mitigation date.

Changes to target mitigation dates

The document at Appendix 4 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, three new risks have been accepted onto the HLRR since the last report to the Board.

Risk ID:	Current Score:	Previous Score:	Risk title:	Risk Description:	Lead Director:	Committee/ Academy:
2766	15	12	Risk related to the retention of student roster in line with national guidance	If we do not store student rosters in line with national guidance, then we will breach the expected standards. Resulting in the inability to track back for incidents, events, patient safety events, and inability to identify who was there at the time for Coroner's, breaches, duty of candour, CQC etc.	Director of HR	People Academy & Quality Committee
40	15	3	The CSU is unable to effectively demonstrate that Personalised Care Plans are in place	If we are not able to demonstrate effective implementation of Personalised Care Plans for all women, then the service will not be able to provide assurance that we are supporting service users with choice and control over the way their care is planned and received based on 'what matters' to them and their individual needs and preferences. The Trust will not be able to demonstrate compliance with the NHSE 3-year delivery plan for maternity and neonatal services recommendations resulting in limited assurance. This could result in poor patient experience, services choosing to access care at another Trust who provide a personalised care plan, thus reputational damage for the Trust. This risk is further	Chief Nurse	Quality Committee

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				complicated by the absence of a patient portal within the system, so women are unable to view their record themselves, participate in the development of their care plan and share their information if they needed to attend another maternity unit for care.		
2868	15	5	Maternal Antibody Test Tracking and Identification in Pregnancy and at Birth	Patient safety events and a clinical audit have identified concerns with identifying the presence of maternal antibodies in pregnancy. This is vital so the mother and newborn can be commenced on the appropriate surveillance pathway and receive care from the multidisciplinary (MDT). It has been highlighted there is inconsistent recording of the antibody results, plan of care and communication to the neonatal team within EPR. Newborn's that require cord blood for a Direct Antiglobulin Test (DAT) is not being consistently performed.	Chief Nurse	Quality Committee

Risks which have been removed/closed

No risks have been removed from the high-level risk register since the last report.

Risks under review

The Executive Team has requested that the score for the following two risks is reviewed. Both risks are being considered by the respective Executive Lead and risk owner, and an update will be provided as part of the next risk reporting cycle in April.

Risk ID:	Current Score:	Target Score:	Risk title:	Risk Description:	Lead Director:	Committee/ Academy:
2759	16	4	Histopathology Staffing	There are two consultant vacancies, and one consultant is currently on maternity leave with one expert practitioner BMS on long term sick leave. Therefore a 25% reduction in workforce which is impacting on turnaround times.	Chief Medical Officer	People Academy
2778	15	6	EPR TACC application not allowing corrections to be made to patient records.	If the EPR standard workflow is not used in EPR TACC then there is a risk that patient information is not available and could result in increased safety risks to patients as well as operational and reputational risks to the organisation.	Chief Digital and Information Officer	Finance & Performance Committee & Quality Committee

Risks which have changed in score

Two risks have reduced in score since the last report to the Board.

Risk ID:	Current Score:	Previous Score:	Risk Description:	Update	Lead Director:	Next Review Date:	Committee/ Academy:
2758	12	16	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.	Additional NHS CPD training planned for March/April 2026 for all grades of staff on ward 1,4 and ED and body cams being worn and footage from these being used.	Chief Nurse	30 July 2026	Quality Committee / Finance and Performance Committee
2677	10	15	There is a risk that If we do not increase respiratory	Options appraisal underway to increase respiratory HDU capacity.	Chief Medical Officer	28 May 2026	Quality Committee

		<p>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.</p>				
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Risks beyond their review date

There is one high-level risk beyond the review date.

Risk ID:	Current Score:	Target Score:	Risk Description:	Lead Director:	Review Date:	Committee/ 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	Quality Committee

3. Recommendation

The Board is asked to confirm whether it is assured 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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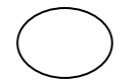
Ref	Strategic Risks	Current Score & Direction of travel	Target Score	Executive Lead	Commentary (e.g. change in risk score, completed actions, reasons for any delays in actions)
Strategic Objective 1: Quality - To provide outstanding care for our patients, delivered with kindness.		Assuring Committee: Quality / Finance & Performance		Overall Assurance Level 2025/26:	
Risk appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward				Q1 Q2 Q3 Q4	
1	If we fail to maintain and develop our care environment, then we may not be able to deliver modern, outstanding care for our patients, resulting in poor patient experience and outcomes and limited ability to deliver services	20 ↔	12	Director of Estates & Facilities	Project on new Estates Strategy commenced now new Deputy Director for Capital has commenced. NHSE announced 10-year capital budget of £110B (£26B for New Hospital Programme (NHP)), this should facilitate a strategic bid for a significant scheme. Further capital released in January 2026 and reviewing vacant space in Place with the ICB.
2	If Digital Data and Technology are not resourced accordingly, then there is a significant risk that key services and activities (including cyber resilience) will be inadequate in terms of quality, adequacy and pace of delivery, resulting in a reduced ability for the Trust to achieve its strategic ambitions.	12 ↔	9	Chief Digital & Information Officer	Risk has maintained its score for Q3 2025/26. However, this to decrease over time there is a requirement for sustained investment in the digital estate. Key roles are gradually being filled, and key leadership / specialist roles continue to be recruited to. Progress of strategic and operational recruitment shall continue to be monitored.
3	If we fail to have a robust clinical workforce model that meets increasing demand, then we will not be able to deliver elective and non-elective care in a timely manner, resulting in delays for our patients, impacting on quality, safety and widening health inequalities.	16 ↔	12	Chief Nurse and Chief Medical Officer	Risk score remains unchanged for Q3 2025/26, and scoring linked to High Level Risks on Risk Register.
4	If we fail to manage patient flow, then we will have patients staying in hospital longer than necessary, resulting in increased risk of deconditioning, hospital acquired infection and patients not being able to be seen in the emergency department and acute admission areas.	20 ↔	12	Chief Nurse and Chief Medical Officer	Risk score remains unchanged for Q3 2025/26, and scoring linked to High Level Risks on Risk Register.
Strategic Objective 2: Improvement - To be a continually learning organisation and recognised as leaders in research, education and innovation		Assuring Committee: Quality / People		Overall Assurance Level 2025/26:	
Risk appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward				Q1 Q2 Q3 Q4	
5	If it is not possible to fill rota gaps or provide experienced trainers, then we may fail to provide an appropriate learning experience for trainees, resulting in an adverse impact on our reputation and potential withdrawal of the Trust’s training accreditation status	9 ↔	6	Chief Medical Officer	No change in score since the previous update.
6	If we fail to attract research funding and researchers to the Trust, then our research capacity and capability will be negatively impacted, resulting in a negative impact on patient care and population wellbeing, and the Trust’s reputation as a leader in research	6 ↔	6	Chief Medical Officer	No change in score since the previous update. Continued success at securing research grants. Successful bid for £7m funding for NIR Commercial Research Delivery Centre, NIHR capital infrastructure and various other grants.
7	If we do not have robust processes for incident identification, escalation and learning then we may fail to learn from incidents, resulting in gaps in safe clinical care	12 ↔	8	Chief Nurse	No change in score since the previous update.
Strategic Objective 3: People – To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion		Assuring Academy: People		Overall Assurance Level 2025/26:	
Risk appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)				Q1 Q2 Q3 Q4	
8	If we are unable to maintain a healthy and engaged workforce, then we will be unable to reduce sickness absence and turnover rates, resulting in an adverse impact on patient safety and experience, and staff experience, wellbeing and morale.	9 ↔	6	Director of HR	No change to risk score since previous update. Improvement in appraisal compliance rates to 80% but still below target. Significantly reduced Occupational Health waiting times.
9	If we are unable to achieve our ambitions on ED&I, then we may have a workforce that is not representative of our community, resulting in an adverse impact on patient, staff and public safety experience.	9 ↔	6	Chief Operating Officer	Reviewed and no change to score in Q3.
Strategic Objective 4: Partnership – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals		Assuring Committee: N/A - Board		Overall Assurance Level 2025/26:	
Risk appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)				Q1 Q2 Q3 Q4	
10	If the Trust doesn’t work effectively in partnership, then there is a risk that the Trust fails to provide the best service to patients and deliver its medium-term plan, resulting in poor patient and staff experience, worse outcomes for patients and missed opportunities to address health inequalities.	12 ↔	3	Director of Strategy & Transformation	No change to risk score since previous update.
11	If the Trust fails to address health inequalities, then this will contribute to a widening of the gap in health outcomes, access and experiences across Bradford District and Craven, resulting in poor outcomes for patients and the public.	12 ↔	8	Director of Strategy & Transformation	No change to risk score since previous update.
Strategic Objective 5: Sustainability -To deliver our financial plan and key performance targets		Assuring Committee: Finance & Performance		Overall Assurance Level 2025/26:	
Risk appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward				Q1 Q2 Q3 Q4	
12	If we fail to deliver our financial plan, then we will not be financially sustainable, resulting in poor outcomes for staff, patients and the public including loss of services.	20 ↔	8	Chief Finance Officer	<ul style="list-style-type: none"> Formally forecasting off plan at Q4 in 2025/26, Financial Recovery Board established. External review actions being progressed with 35 out of 38 complete. ICB technical financial appraisal of all organisations complete. NHSE Grip and Control checklist reviewed with 137 out of 156 in place. New robust business case process introduced in 2025/26. Put in place required measures to support a potential application for external cash support in Quarter 4. First draft planning submission completed showing a return to break even in the medium term.
13	If the Trust is unable to deliver sustainable services in line with the medium-term plan, then we may need to cease services, resulting in a loss of staff, poor outcomes for patients and reputational damage.	12 ↔	8	Chief Operating Officer	Risk score remains at 12. Delay in handover of St Luke’s Day Case Unit. Medium term plan currently being developed which will include activity scheduled to be delivered in day case unit, offset by main site (BRI). Collaboration work through ABCAS continues, external support from KPMG to help develop opportunities for collaboration.
14	If the Trust fails to implement its Green Plan effectively, then the Trust may fail to meet its responsibilities in relation to climate change, resulting in an inability to deliver sustainable healthcare.	9 ↓	6	Director of Estates & Facilities	£600k LED lighting bid successful, project 60% complete. Successful bid for EV chargers. 28 Green Champions appointed. Sustainability training delivered to Board of Directors on 18 December 2025. The Q3 Risk score has been reviewed by ETM on 2/3/26 and reduced to 9 from 12 following discussion by members of the F&P Committee.

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Ref	Strategic Risks	Current Score & Direction	Target Score	Executive Lead	Commentary (e.g. change in risk score, completed actions, reasons for any delays in actions)
Risk relevant to all strategic objectives Risk appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward		Assuring Committee: N/A - Board		Overall Assurance Level 2025/26:	
				Q1	Q2
				Q3	Q4
15	If we don't have effective Board leadership or robust governance arrangements in place, then the Board won't be able to lead and direct the organisation effectively, resulting in poor decision making, a failure to manage risks, failure to achieve strategic objectives, regulatory intervention and damage to the Trust's reputation.	10 ↔	5	Chief Operating Officer	No change in risk score, board capability assessment received which is rated amber/red. New BAF template in development.

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Heat Map – Quarter 3 2025/26



= current score

LIKELIHOOD	CONSEQUENCE				
	Negligible (1)	Low (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)					
Likely (4)			2	3	1, 4, 12
Possible (3)			8, 9, 5	11, 13, 14, 7, 10	
Unlikely (2)			6		15
Extremely unlikely (1)					

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Strategic Objective 1: Quality - To provide outstanding care for our patients, delivered with kindness																				
Assurance topic – Environment – estates infrastructure																				
Ref: 1	Strategic Risk: If we fail to maintain and develop our care environment, then we may not be able to deliver modern, outstanding care for our patients, resulting in poor patient experience and outcomes and limited ability to deliver services																			
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	<p style="text-align: center;">Movement in score Q4 2024/25 – Q3 2025/26</p> <table border="1"> <caption>Score Movement Data</caption> <thead> <tr> <th>Quarter</th> <th>Current Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr> <td>Q4</td> <td>20</td> <td>8</td> </tr> <tr> <td>Q1</td> <td>20</td> <td>8</td> </tr> <tr> <td>Q2</td> <td>20</td> <td>8</td> </tr> <tr> <td>Q3</td> <td>20</td> <td>8</td> </tr> </tbody> </table>			Quarter	Current Score	Target Score	Q4	20	8	Q1	20	8	Q2	20	8	Q3	20	8	<p>Initial Score (CxL): 5x4=20 As at 30 August 2024</p> <p>Current Score (CxL): 5x4=20 As at 21 January 2026</p> <p>Target Score (CxL): 3x4=12</p>	
Quarter	Current Score	Target Score																		
Q4	20	8																		
Q1	20	8																		
Q2	20	8																		
Q3	20	8																		
Date added: 30 August 2024																				
Date of last review: 21 January 2026																				
Lead Director: Director of Estates and Facilities																				
Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance																	
<ol style="list-style-type: none"> Infection Prevention & Control policy and processes in place, oversight through Infection Prevention and Control (IPC) Committee and Quality Committee. PLACE surveys and action plans in place. Backlog maintenance annual condition surveys that prioritise available capital funding. Health and Safety governance and reporting. Policies and Procedures across Estates and Facilities – Estates Maintenance, Cleaning Services, etc. KPIs to monitor and manage the outputs from the policies. External oversight over sub-elements of Estates, i.e. Water Safety, Ventilation – (annual reports / surveys). £25m successful bid for endoscopy unit commenced on site. Due to open early 2026. Main entrance at Bradford Institute for Health Research (BIHR) – completed. Additional £1B announced in October 24 budget to address backlog maintenance in 25/26. Additional capital secured in January 2026 to address some backlog. Completed a project to review space utilisation to reduce estate and to increase the utilisation of existing estate. Arcadis produced a heat map relating to building use, to be presented to Execs. Purchased Cancer Support Yorkshire (CSY) buildings. Commenced a redevelopment design for Emergency Department. Explore collaborative working with Airedale NHS FT (ANHSFT) to align with new hospital opportunities. Health on the High Street being explored at Broadway, will release older Estate. In discussion with ICB about using vacant space within Place. 	<p>Internal Positive:</p> <ol style="list-style-type: none"> IPC Quarterly Reports Premises Assurance Model (PAM) Report to Board in November 2025. Estates Return Information Collection (ERIC) returns show an extensive knowledge base Health and Safety Committee reports to Finance and Performance Committee Patient Experience Group Monitoring E&F KPIs that impact the care environment Annual Fire Safety report <p>Negative:</p> <ol style="list-style-type: none"> A deteriorating position on backlog maintenance – physical condition from last year - £93m - £102m 	<p>Independent Positive:</p> <ol style="list-style-type: none"> Meeting National Cleaning Standards Meeting National Food Standards Annual Inpatient Survey Internal Audit reports: <ol style="list-style-type: none"> PLACE – Significant assurance (May 2025) <p>Negative: N/A</p>	<p>Gaps in control</p> <ul style="list-style-type: none"> 49% of the estate is non-clinical (model hospital target 35%) 7% void space -predominantly at SLH Majority of the estate is not functionally suitable due to age. Space utilisation is a gap in control. Clinical Services exceeding the estate physical capacity / space i.e. Skipton Renal <p>Gaps in assurance N/A</p>	<p>Action</p> <ul style="list-style-type: none"> Estates strategy in development to address site utilisation and development. Space Utilisation Group has commenced. Review of Skipton Hospital space and external options. Agreed additional demise from ANHSFT. 	<p>Timescale</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>															
Related risks on the high level risk register (operational risks)	<ul style="list-style-type: none"> 290 – Backlog maintenance and critical infrastructure risk (current score: 20) 																			

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Strategic Objective 1: Quality - To provide outstanding care for our patients, delivered with kindness																				
Assurance topic – Digital and data																				
Ref: 2	Strategic Risk: If digital data and technology are not correctly resourced (inc. talent and skills), nor adhere to professional standards, then there is a significant risk that key services and activities (including cyber resilience) will be inadequate in terms of quality, completeness and pace of delivery, resulting in a reduced ability for the Trust to achieve its strategic ambitions.																			
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	<p style="text-align: center;">Movement in score Q4 2024/25 – Q3 2025/26</p> <table border="1"> <caption>Score Movement Data</caption> <thead> <tr> <th>Quarter</th> <th>Current Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr> <td>Q4</td> <td>12</td> <td>9</td> </tr> <tr> <td>Q1</td> <td>12</td> <td>9</td> </tr> <tr> <td>Q2</td> <td>12</td> <td>9</td> </tr> <tr> <td>Q3</td> <td>12</td> <td>9</td> </tr> </tbody> </table>			Quarter	Current Score	Target Score	Q4	12	9	Q1	12	9	Q2	12	9	Q3	12	9	Initial Score (CxL): 3x5=15 As at 30 August 2024	
Quarter				Current Score	Target Score															
Q4				12	9															
Q1	12	9																		
Q2	12	9																		
Q3	12	9																		
Date added: 30 August 2024	Current Score (CxL): 3x4=12 As at 28 January 2026																			
Date of last review: 28 January 2026	Target Score (CxL): 3x3=9																			
Lead Director: Chief Digital and Information Officer																				
Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance																
<ol style="list-style-type: none"> Digital & Data Transformation Strategy sets out our key priorities and areas of focus. These objectives are now part of team and leadership objectives. Our first strategic objective in the Digital & Data Transformation Strategy (SO1-People) is the primary focus of the Informatics SLT as we continue to work to build a resilient, skilled and engaged workforce. CDIO post has been appointed to which is dedicated to BTHFT. Associate Director of Data, Analytics & AI and Technical & Data Architect are now in post. Embracing a strategic approach to talent management focusing on improving how we attract, develop, retain, and optimise our workforce. Continued professional development to ensure we are continually enhancing the skills and capabilities of our workforce to better meet the digital needs of our organisation. Our strategy includes the provision to establish a comprehensive training agenda to ensure colleagues remain engaged, and appropriately skilled and proficient to exploit new technologies and methodologies to benefit the needs of the Trust. Suite of policies in place - <ul style="list-style-type: none"> Information Governance Policy Email Policy Data Quality Policy Information Risk Policy Information Technology Security Policy 	Internal Positive: <ol style="list-style-type: none"> Informatics Performance Group (IPG) is seeing an improved position of key IT governance activities and controls. Bi-annual digital reports to Quality Committee (latest October 2025). Negative: <ol style="list-style-type: none"> Feedback from CSUs is that EPR optimisation is not progressing at the required pace. (This continues to be mitigated by internal organisational adjustments) There is an emerging deficit in automation, AI and future technologies skills and experience. Demand for digital data and technology services is increasing, as is the timeframe it is needed, and digital data and technology is in some areas struggling to maintain pace. Appraisal rates are declining. 	Independent Positive: <ol style="list-style-type: none"> Successful ISO27001 report and outcome. ISO and Data Security and Protection Toolkit (DSPT) audits are complete and have been deemed successful. Negative: <ol style="list-style-type: none"> External application assessment showing areas which require improvement. External IT service management assessment showing areas which require improvement. Staff Survey results have taken a decline. (Mitigation shall be through a focused effort to address concerns and make positive change). 	Gaps in control Whilst the Digital and Data Transformation Committee (DDTC) has been formed, it is in its infancy with the Director of Strategy & Transformation as chair. We will ensure the DDTC grows into its new role. DW/BI team requires focus to provide an efficient data model to allow timely data analysis. SO1 (People) detail not yet formalised, but remains on plan for completion and continued implementation	Action CDIO to monitor progress and formation of DDTC. Priority for incoming Associate Director Finalise SO1 (People) plan and execute.	Timescale Ongoing Ongoing Ongoing															
	Related risks on the high-level risk register (operational risks) <ul style="list-style-type: none"> 901 - Risk of Cyber Security Threats (current score: 16) 2778 – EPR TACC application (current score: 15) 			Gaps in assurance A secondary audit to assure the progress and execution of the strategy and associated business plan is expected to be undertaken in late 2025.	Adhere to audit plan and continue to progress strategy plans.	Ongoing														

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Strategic Objective 1: Quality - To provide outstanding care for our patients, delivered with kindness																				
Assurance topic – Quality of care																				
Ref: 3	Strategic Risk: if we fail to have a robust clinical workforce model that meets increasing demand, then we will not be able to deliver elective and non-elective care in a timely manner, resulting in delays for our patients, impacting on quality, safety and widening health inequalities.																			
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	<p style="text-align: center;">Movement in score Q4 2024/25 – Q3 2025/26</p> <table border="1"> <caption>Score Movement Data</caption> <thead> <tr> <th>Quarter</th> <th>Current Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr> <td>Q4</td> <td>16</td> <td>12</td> </tr> <tr> <td>Q1</td> <td>16</td> <td>12</td> </tr> <tr> <td>Q2</td> <td>16</td> <td>12</td> </tr> <tr> <td>Q3</td> <td>16</td> <td>12</td> </tr> </tbody> </table>				Quarter	Current Score	Target Score	Q4	16	12	Q1	16	12	Q2	16	12	Q3	16	12	Initial Score (CxL): 4x4 = 16 As at 9 January 2025
Quarter	Current Score	Target Score																		
Q4	16	12																		
Q1	16	12																		
Q2	16	12																		
Q3	16	12																		
Date added: 9 January 2025					Current Score (CxL): 4x4 = 16 As at 3 February 2026															
Date of last review: 3 February 2026					Target Score (CxL): 4x3 = 12															
Lead Director: Chief Nurse and Chief Medical Officer																				
Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance																	
<ol style="list-style-type: none"> Daily command and control via the Command Centre. Half hourly Operational Pressures Escalation Level (OPEL) scoring. Clearly defined escalation processes at BTHFT and West Yorkshire level. Robust incident reporting monitored daily via safety huddles with defined escalation of risk via quality governance. Daily safety huddles from Board to Ward. Monitoring of elective activity including 6-4-2 process for maximising lists. Executive-to-CSU oversight including accountability framework. Robust recruitment and selection processes. Education Strategy to enable retention and training of workforce. EXCEL programme formal launch in June 2025. Weekly Executive meetings. Weekly Quality Oversight meetings (QUOC). Nursing & Midwifery Strategy. 	<p>Internal Positive:</p> <ol style="list-style-type: none"> Monthly oversight via Committees of Board including cumulative position – Quality and People Dashboards, Quality oversight report. Annual Quality Account and quarterly updates on improvement priorities. Nursing & Midwifery Strategy updates to Quality Committee. Nursing & Midwifery staffing data publication reports to People Academy and Quality Committee. National reporting and benchmarking <p>Negative:</p> <ol style="list-style-type: none"> A number of risks highlighted by specialities in relation to increased demand against static capacity. A number of high risks in relation to overcrowding in Accident and Emergency Department (AED) resulting in poor patient and staff experience. Patient complaints increasing. 	<p>Independent Positive:</p> <ol style="list-style-type: none"> CQC Report(s) – November 2024 rated ‘Good’. NHS Oversight Framework (NOF) 3/Integrated Quality Improvement Group (IQIG). Internal Audit Reports: <ol style="list-style-type: none"> Safe staffing; international staff – Significant assurance (August 2025) Patient Experience in AED – Significant assurance (September 2025) <p>Negative:</p> <ol style="list-style-type: none"> National inpatient surveys remain below average. 	<p>Gaps in control</p> <ul style="list-style-type: none"> Increasing financial challenge vs increased demand, compounded by block contract for non-elective activity. Estate – Demand has outstripped physical capacity, and the estate remains aged and not to modern specifications. St Luke’s Hospital (SLH) – Day Case Unit opening has been delayed. 	<p>Action</p> <ul style="list-style-type: none"> Ongoing work with ICB and specialised commissioning to understand funding gaps and opportunities. Refresh of Estates Plan and Strategy. Watch and wait re: opportunities for national capital monies. Acute collaboration with Airedale General Hospital. Work with Estates and contractors to agree actions to be taken re SLH Day Case and agree revised timescales. 	<p>Timescale</p> <ul style="list-style-type: none"> Ongoing Revised to March 2026 Ongoing Ongoing Ongoing 															
					<p>Gaps in assurance</p> <ul style="list-style-type: none"> No clearly defined refreshed BDC Clinical Strategy 	<ul style="list-style-type: none"> Work across WY ICB and Bradford Place. Acute provider collaboration now in place. 	<ul style="list-style-type: none"> Ongoing 													
Related risks on the high-level risk register (operational risks)	<ul style="list-style-type: none"> 2509 – Children’s Autism pathway (current score: 16) 2549 – Workforce constraints within Non Surgical Oncology (current score: 16) 2612 - Emergency Department (ED) Consultant review of pathology and radiology results (current score: 15) 2773 – Children and young people with medical complexity (current score: 16) 2759 – Histopathology staffing (current score: 16) 95 – Emergency Department medical staff coverage – weekend and evenings (current score: 15) 																			

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Strategic Objective 1: Quality - To provide outstanding care for our patients, delivered with kindness																				
Assurance topic – Quality of care																				
Ref: 4	Strategic Risk: If we fail to manage patient flow, then we will have patients staying in hospital longer than necessary, resulting in increased risk of deconditioning, hospital acquired infection and patients not being able to be seen in the emergency department and acute admission areas.																			
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	<p style="text-align: center;">Movement in score Q4 2024/25 – Q3 2025/26</p> <table border="1"> <caption>Chart Data</caption> <thead> <tr> <th>Quarter</th> <th>Current Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr> <td>Q4</td> <td>20</td> <td>12</td> </tr> <tr> <td>Q1</td> <td>20</td> <td>12</td> </tr> <tr> <td>Q2</td> <td>20</td> <td>12</td> </tr> <tr> <td>Q3</td> <td>20</td> <td>12</td> </tr> </tbody> </table>			Quarter	Current Score	Target Score	Q4	20	12	Q1	20	12	Q2	20	12	Q3	20	12	Initial Score (CxL): 5x4 = 20 As at 9 January 2025	
Quarter				Current Score	Target Score															
Q4				20	12															
Q1	20	12																		
Q2	20	12																		
Q3	20	12																		
Date added: 9 January 2025	Current Score (CxL): 5x4 = 20 As at 3 February 2026																			
Date of last review: 3 February 2026	Target Score (CxL): 4x3 = 12																			
Lead Director: Chief Nurse and Chief Medical Officer																				
Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance																
<ol style="list-style-type: none"> Daily command and control via the Command Centre. Half hourly OPEL scoring. Clearly defined escalation processes at BTHFT and West Yorkshire level. Clearly defined escalation plans/surge plans Robust incident reporting monitored daily via safety huddles with defined escalation of risk via quality governance. Daily safety huddles from Board to Ward. Outstanding Emergency Department programme commenced (EXCEL). Monitoring of key data including clinical benchmarking. Weekly Executive meetings. Weekly Quality Oversight meetings (QUOC). Accountability framework. 	<p>Internal Positive:</p> <ol style="list-style-type: none"> Monthly oversight via Committees of Board including cumulative position – Quality and Performance Dashboards, Quality oversight report, performance report. IPC quarterly reports to Quality Committee. <p>Negative:</p> <ol style="list-style-type: none"> Increase in complaints and incidents including patient harms and staff violence and aggression (patient/visitor against staff). Higher than expected >12-hour bed waits for admission from ED. Continued reports of lack of flow and overcrowding in ED leading to negative staff and patient experience. Increase in infections (flu/Covid) over the winter months. 	<p>Independent Positive:</p> <ol style="list-style-type: none"> CQC Report(s) – November 2024 rated ‘Good’. National ranking show ED performance continually in top quartile. IQIG/NOF3 oversight. <p>Negative:</p> <ol style="list-style-type: none"> CQC Report – November 2024 highlighted some delays in discharges and lack of therapy. Although in top quartile for performance for ED nationally we are still not meeting targets. Internal Audit reports: <ol style="list-style-type: none"> Discharge Management – Limited assurance (August 2025) 	<p>Gaps in control</p> <ul style="list-style-type: none"> We cannot control demand on admission units. Poor uptake of seasonal vaccine programme. 	<p>Action</p> <ul style="list-style-type: none"> Outstanding Accident and Emergency Department Programme (EXCEL) Work with partners to promote. 	<p>Timescale</p> <ul style="list-style-type: none"> March 2026 Ongoing 															
			<p>Gaps in assurance</p> <ul style="list-style-type: none"> National comparisons can be misleading as reporting differs in organisations. Internal assurance is focused on operational performance - need to define a balanced score card. 	<ul style="list-style-type: none"> Work at regional and national level. Outstanding Accident and Emergency Department Programme (EXCEL) 	<ul style="list-style-type: none"> Ongoing Ongoing 															
Related risks on the high-level risk register (operational risks)	<ul style="list-style-type: none"> 2604 – Emergency department overcrowding (current score: 20). 2753 – Renal dialysis capacity (current score: 20) 2756 – AED long waits (current score: 20) 979 - Pandemic outbreak (current score: 16) 																			

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Strategic Objective 2: Improvement – To be a continually learning organisation and recognised as leaders in research, education and innovation																				
Assurance topic – Trainee development and progression (Nurses, AHPs and Doctors)																				
Ref: 5	Strategic Risk: If it is not possible to fill rota gaps or provide experienced trainers, then we may fail to provide an appropriate learning experience for trainees, resulting in an adverse impact on our reputation and potential withdrawal of the Trust's training accreditation status																			
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	<p style="text-align: center;">Movement in score Q4 2024/25 – Q3 2025/26</p> <table border="1"> <caption>Chart Data: Movement in score</caption> <thead> <tr> <th>Quarter</th> <th>Current Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr> <td>Q4</td> <td>9</td> <td>6</td> </tr> <tr> <td>Q1</td> <td>9</td> <td>6</td> </tr> <tr> <td>Q2</td> <td>9</td> <td>6</td> </tr> <tr> <td>Q3</td> <td>9</td> <td>6</td> </tr> </tbody> </table>			Quarter	Current Score	Target Score	Q4	9	6	Q1	9	6	Q2	9	6	Q3	9	6	Initial Score (CxL): 4x4=16 As at 1 April 2022	
Quarter				Current Score	Target Score															
Q4				9	6															
Q1	9	6																		
Q2	9	6																		
Q3	9	6																		
Date added: 1 April 2022	Current Score (CxL): 3x3=9 As at 3 February 2026																			
Date of last review: 3 February 2026	Target Score (CxL): 3x2=6																			
Lead Director: Chief Medical Officer																				
Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)		Key controls (what are we doing about the risk?)	Actions to address gaps in controls or assurance																
<ol style="list-style-type: none"> Guardian of Safe Working Hours process with quarterly and annual reports to People Academy and Local Negotiating Committee (LNC). Resident Doctor rota co-ordinator in place who works with the Flexible Workforce team to ensure gaps are covered. Resident doctor representation including on Joint Negotiating and Consultative Committee (JNCC) and Resident Doctors forum. Appointment of a number of positions to support staff from all disciplines including SAS Advocate role, Chief Registrar and Lead Physician Associate. Increased student capacity by utilising newly established services and trialling a rota-based system for students. Implementation of student led clinics in physiotherapy. Multi-professional preceptorship programme in place for Newly Qualified Nurses, Midwives and AHPs. Hospital at Night Project to support resident medical staff with routine procedures fully implemented. Enhanced support for International Medical Graduates (IMGs) – named IMG lead, bespoke NHS Orientation Day run locally, new communication skills course for IMGs. Implementing the 10 Point Plan for Improving Resident Doctor Working lives. 	<p>Internal Positive:</p> <ol style="list-style-type: none"> Guardian of Safe Working Hours – quarterly reports: latest report 11 March 2026 – People Academy. Appraisal & Revalidation Annual Report: latest report 11 June 2025 – People Academy. Appraisal Quality Assurance Group – annual review of appraisal quality. Results of appraisal feedback questionnaires. Annual Medical Appraisal Report / Board compliance statement October 2025. Education Annual Report. <p>Negative:</p> <ol style="list-style-type: none"> Guardian of Safe Working (GOSW) Exception reports re: missed educational opportunities or additional hours. GOSW hours annual report (People Academy May 2025). 	<p>Independent Positive:</p> <ol style="list-style-type: none"> Apprenticeship team recognised through the Bradford Means Business awards for their work across the district with young people and improved educational opportunities. Senior Leaders engagement event with NHSE in November 2023 – positive feedback report. National Education & Training Survey (NETS) 2024 – strong regional benchmarking (highest scoring WYAAT Trust in 11 out of 13 domains). GMC survey 2024 – significant improvement in areas identified as a concern in 2023 – Emergency Medicine FY2, Medicine FY2, Plastic Surgery. Multi-Professional Education & Training (MPET) 2025 – overall placement rating 91%, a further increase on the previous 2 years, above average score for all trusts. Internal audit reports: <ol style="list-style-type: none"> Medical Education – Significant assurance E-Rostering – Junior Doctors – Significant assurance Medical Revalidation – Significant assurance <p>Negative:</p> <ol style="list-style-type: none"> NETS 2024 – negative outlier for workload in Emergency Medicine, Surgery (both Foundation level), Obs & Gynae (GP trainees) and Ophthalmology. GMC survey 2025 – ranked 224th out of 226 acute trusts for workload. Workload is a recurrent negative outlier for FY2 trainees in Emergency Medicine (negative outlier for 4 consecutive years), Obstetrics & Gynaecology and Surgery FY1 (negative outlier for 2 consecutive years in these areas). Senior leaders' engagement event with NHSE in July 2025 – "workload pressures continue to challenge training quality. Sustained attention to workload pressures will be essential to maintaining quality and supporting future growth." 	<p>Gaps in control</p> <ul style="list-style-type: none"> Numbers of resident doctors on rotas <p>Gaps in assurance</p> <p>N/A</p>	<p>Action</p> <ul style="list-style-type: none"> Lobby Deanery to increase trainee numbers. 	<p>Timescale</p> <p>Ongoing</p>															
	Related risks on the high-level risk register (operational risks)	N/A																		

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Strategic Objective 2: Improvement – To be a continually learning organisation and recognised as leaders in research, education and innovation																			
Assurance topic – Research capacity and capability																			
Ref: 6	Strategic Risk: If we fail to attract research funding and researchers to the Trust, then our research capacity and capability will be negatively impacted, resulting in a negative impact on patient care and population wellbeing, and the Trust's reputation as a leader in research.																		
<p>Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward</p> <p>Date added: 1 April 2022</p> <p>Date of last review: 3 February 2026</p> <p>Lead Director: Chief Medical Officer</p>	<p>Movement in score Q4 2024/25 – Q3 2025/26</p> <table border="1"> <caption>Chart Data: Movement in score</caption> <thead> <tr> <th>Quarter</th> <th>Current Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr> <td>Q4</td> <td>6</td> <td>6</td> </tr> <tr> <td>Q1</td> <td>6</td> <td>6</td> </tr> <tr> <td>Q2</td> <td>6</td> <td>6</td> </tr> <tr> <td>Q3</td> <td>6</td> <td>6</td> </tr> </tbody> </table>			Quarter	Current Score	Target Score	Q4	6	6	Q1	6	6	Q2	6	6	Q3	6	6	<p>Initial Score (CxL): 3x3=9 As at 1 April 2022</p> <p>Current Score (CxL): 3x2=6 As at 3 February 2026</p> <p>Target Score (CxL): 3x2=6</p>
Quarter	Current Score	Target Score																	
Q4	6	6																	
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Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance															
<ol style="list-style-type: none"> Well-established research infrastructure – Bradford Institute for Health Research, NIHR Clinical Research Delivery Centre Bradford and West Yorkshire (previously Patient Recruitment Centre), Patient Safety Research Collaboration Yorkshire and Humber); Wolfson Centre for Applied Health Research and most recently an electric Mobile Research Vehicle to enable research delivery, engagement and promotion in our communities. The BIHR team have also recently been awarded £1.3million from the NIHR Capital Funding Scheme to fund a new modular building that will expand our current clinical research space. Research Governance and Management Structure in place. Trust Research Strategy and Trust policy on conducting research in the Trust. Trust Research Committee and regular formal reporting to Quality Committee and Trust Board. Strong research reputation particularly in the fields of applied health research teams are continually applying for grant funding. Raising awareness of research, publicity of research successes, research part of Trust induction. All research teams have research targets and performance reports sent to them and CSUs sign off capacity and capability that can conduct new research. Multiple high value successful funding bids are continually being obtained. 	<p>Internal Positive:</p> <ol style="list-style-type: none"> Bi-annual Research Activity reports to Quality Committee / Trust Board – latest September 2025. Research reports and presentation on research projects to Board. Research Performance reports for research teams sent out on quarterly basis. Internal review with each research speciality ongoing due to centralised research delivery team structure and management. Improvements to infrastructure / buildings. Research ward boards and main entrance research permanent artwork (BRI and SLH) to promote research. <p>Negative:</p> <ol style="list-style-type: none"> Unclear how the CSUs use the research performance reports to manage research activity. Some teams are not achieving targets due to lack of clinician input due to interest/ time. Lack of awareness that research is core business for the Trust. 	<p>Independent Positive:</p> <ol style="list-style-type: none"> Annual reports and reviews for projects where we are the lead organisation, e.g. NIHR programme grants, NIHR RCF annual reporting. External Performance metrics monitored monthly for NIHR Commercial Research Delivery Centre and annual report will be produced (due March 2026). Annual review meeting with Yorkshire and Humber Regional Research Delivery Network and catch up/feedback meetings to take place every two months. Various research finance audits. Participant Research Experience Survey 'PRES' – positive responses. Internal Audit on Research Governance June 2024 High Assurance. Significant, repeated successful high value grant applications. <p>Negative:</p> <ol style="list-style-type: none"> Some research areas not meeting targets in terms of Recruitment to Time and Target. 	<p>Gaps in control</p> <ul style="list-style-type: none"> Promotion of research activity and raise awareness that research is a core business for the Trust. How research is promoted and managed within CSUs as core business. <p>Gaps in assurance</p> <ul style="list-style-type: none"> Better research information to allow real time reporting and improved research activity management by CSUs and research teams. 	<p>Action</p> <ul style="list-style-type: none"> Trust Research Strategy associated action plan. Commencement of Exec-to-Exec meeting with the Research Exec and Trust Exec Team. CSUs' research activity to be part of the formal Trust Performance Framework. Production of research dashboard that can be accessed by Trust staff. Exploration of use of Power BI to enable the above. NIHR Funding application for a data specialist report. <p>Timescale</p> <p>Ongoing</p> <p>Delayed due to external IT factors with the national EDGE database which has impacted on research dashboard production.</p> <p>Anticipating hearing outcome of funding application by March 2026.</p>															
Related risks on the high level risk register (operational risks)	N/A																		

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Strategic Objective 2: Improvement – To be a continually learning organisation and recognised as leaders in research, education and innovation																					
Assurance topic – Learning organisation																					
Ref: 7	Strategic Risk: If we do not have robust processes for incident identification, escalation and learning then we may fail to learn from incidents, resulting in gaps in safe clinical care																				
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	<p style="text-align: center;">Movement in score Q4 2024/25 – Q3 2025/26</p> <table border="1"> <caption>Score Movement Data</caption> <thead> <tr> <th>Quarter</th> <th>Current Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr> <td>Q4 2024/25</td> <td>12</td> <td>8</td> </tr> <tr> <td>Q1 2025/26</td> <td>12</td> <td>8</td> </tr> <tr> <td>Q2 2025/26</td> <td>12</td> <td>8</td> </tr> <tr> <td>Q3 2025/26</td> <td>12</td> <td>8</td> </tr> </tbody> </table>				Quarter	Current Score	Target Score	Q4 2024/25	12	8	Q1 2025/26	12	8	Q2 2025/26	12	8	Q3 2025/26	12	8	Initial Score (CxL): 5x3=15 As at 1 April 2022	
Quarter					Current Score	Target Score															
Q4 2024/25					12	8															
Q1 2025/26	12	8																			
Q2 2025/26	12	8																			
Q3 2025/26	12	8																			
Date added: 1 April 2022 Date of last review: 3 February 2026	Current Score (CxL): 4x3=12 As at 3 February 2026																				
Lead Director: Chief Nurse	Target Score (CxL): 4x2=8																				
Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance																	
<ol style="list-style-type: none"> Regular Quality / Safety touchpoints including Exec led weekly Quality of Care (QuOC) Panel, daily Trust Safety Event Huddle, weekly Safety Event Group, monthly Patient Safety Group, Clinical Outcomes Group. Full implementation of PSIRF. Completed and launched Continuous Improvement Strategy in 2024, Being Open / Duty of Candour Policy updated. Participation in the West Yorkshire Association of Acute Trusts Learning Forum. Annual production of Quality Account and identification of priority learning areas. Continue to be part of the 'Learning Together' research programme. Monthly Quality and Safety meetings in all CSUs using standardised Quality Governance Framework. Exemplar work of Learning from Deaths processes recognised by CQC including role of Medical Examiner who has scrutinised 100% of deaths since October 2021, Learning from Deaths group, Mortality Review Improvement Group (MRIG) and Recognition and Response to the Deteriorating Patient Group. National lead role in 'Worry and concerns' pilot leading to implementation of Martha's Rule. Recruited Patient Safety Specialist and Patient Safety Partner. 15 Steps Assurance Programme in place with timescales on visits agreed to complement the Ward Accreditation Programme. 	Internal Positive: <ol style="list-style-type: none"> Insights report – quarterly – latest report as at Q2 2025/26. Bi-monthly Quality Assurance and Oversight report. Insights report – Q3 – Quality Committee February 2026. Learning from Deaths monthly update to Quality Committee. Deep dive review of SHMI. Annual Patient Experience Report. Medical Examiner has scrutinised 100% of deaths since October 2021. Negative: <ol style="list-style-type: none"> Departmental capacity versus demand and the impact of current work plan deliverables. 	Independent Positive: <ol style="list-style-type: none"> Internal audit reports: <ol style="list-style-type: none"> Patient Safety Incident Response Framework (PSIRF) - High Assurance (May 2025) CQC inspections September 2025 to November 2025 – Maternity Services rated as Good, Outpatient Services rated as Good, Community Hospital Services rated as Good. Commissioner review of incident investigation reports that meet the criteria under PSIRF. MNSI – full compliance. Negative: <ol style="list-style-type: none"> Emergency Department and Trust Wide Well Led CQC Inspection Reports still awaited. Internal audit reports: <ol style="list-style-type: none"> Falls – Limited Assurance (November 2025) 	Gaps in control <ul style="list-style-type: none"> Implement all actions from internal audit reports. Strong lines of governance accountability through CSU, Service group via the Quality and Patient Safety Facilitators. Being Open / Duty of Candour Policy to be reviewed with a view to re-introducing 10-day targets for initial and investigation report. Four vacancies held due to the trust financial special measures. Two Quality & Patient Safety Facilitators on Maternity Leave with no other capacity to backfill their roles leaving a gap in service. Gaps in assurance Learning clearly articulated in some but not all areas.	Action Implementation of audit recommendations. To further develop and strengthen the lines of governance through to CSUs. To review and update the policy and communicate the changes trust-wide.	Timescale Ongoing Ongoing 28 February 2026 Ongoing																
	Related risks on the high-level risk register (operational risks)	N/A			Continue to embed CSU governance model.	Ongoing															

Osbourne, Sheridan
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Strategic Objective 3: People – To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion																			
Assurance topic - Workforce																			
Ref: 8	Strategic Risk: If we are unable to maintain a healthy and engaged workforce, then we will be unable to reduce sickness absence and turnover rates, resulting in an adverse impact on patient safety and experience, staff experience, wellbeing and morale, and the Trust's ability to meet its financial and workforce plans.																		
Risk Appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	<p style="text-align: center;">Movement in score Q4 2024/25 – Q3 2025/26</p> <table border="1"> <caption>Chart Data: Movement in score Q4 2024/25 – Q3 2025/26</caption> <thead> <tr> <th>Quarter</th> <th>Current Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr> <td>Q4</td> <td>~8.5</td> <td>~6</td> </tr> <tr> <td>Q1</td> <td>~8.5</td> <td>~6</td> </tr> <tr> <td>Q2</td> <td>~8.5</td> <td>~6</td> </tr> <tr> <td>Q3</td> <td>~8.5</td> <td>~6</td> </tr> </tbody> </table>			Quarter	Current Score	Target Score	Q4	~8.5	~6	Q1	~8.5	~6	Q2	~8.5	~6	Q3	~8.5	~6	Initial Score (CxL): 3x4 = 12 As at 13 September 2024
Quarter				Current Score	Target Score														
Q4				~8.5	~6														
Q1	~8.5	~6																	
Q2	~8.5	~6																	
Q3	~8.5	~6																	
Date added: 13 September 2024 Date of last review: 23 February 2026	Current Score (CxL): 3x3 = 9 As at 23 February 2026																		
Lead Director: Director of HR	Target Score (CxL): 3x2 = 6																		
Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance																
<ol style="list-style-type: none"> HR policies and wellbeing support offers Occupational Health Service, Employee Assistance Programme (EAP) provision and psychology staff support offer Staff networks Staff survey action plan Freedom to Speak Up (FTSU) policy and processes Guardian of Safe Working processes Mediation and Staff Advocacy services Leadership pathway development Wellbeing conversations Development of outdoor spaces e.g. gardens CSU to Executive meetings in place Nursing recruitment and retention plans in place Sickness Absence Action Plan in place People Strategy 	<p>Internal Positive:</p> <ol style="list-style-type: none"> Nursing & Midwifery Staffing Review – six monthly to People Academy & Board Workforce planning submission – Trust Board February 2026. Turnover rates consistently maintained with no fluctuations. Occupational Health / Psychological support referrals (management referrals, limited data on self-referrals) FTSU Quarterly Report Q3 2025/26 – presented to People Academy 11 February 2026 Occupational Health lead times are significantly reduced <p>Negative:</p> <ol style="list-style-type: none"> Sickness absence rates remain above target. Appraisal rates remain below target. 	<p>Independent Positive:</p> <ol style="list-style-type: none"> Staff survey results for 2024 remain above national average. Internal audit reports: <ol style="list-style-type: none"> Absence Management – Significant assurance (October 2025) Occupational Health service is SEQOHS accredited. <p>Negative:</p> <ol style="list-style-type: none"> Internal audit reports: <ol style="list-style-type: none"> Non clinical appraisals (February 2025) – Limited assurance (NB compliance rate has since increased from 74% to 80%) 	<p>Gaps in control</p> <ul style="list-style-type: none"> Occupational Health Service pressures Holding vacancies as part of Closing the Gap could have detrimental impact on staff wellbeing Ballot for industrial action for doctors in training – negative impact on engagement and morale which could lead to higher levels of sickness absence <p>Gaps in assurance</p> <p>N/A</p>	<p>Action</p> <ul style="list-style-type: none"> Psychology vacancy moved to psychology service in attempt to ensure it is filled following unsuccessful attempts within OH. Workforce control panel in place to assess each vacancy request Unable to mitigate – outside of the Trust's control. 	<p>Timescale</p> <p>Complete – vacancy recruited to</p> <p>Ongoing</p>														
Related risks on the high level risk register (operational risks)	N/A																		

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Strategic Objective 3: People – To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion

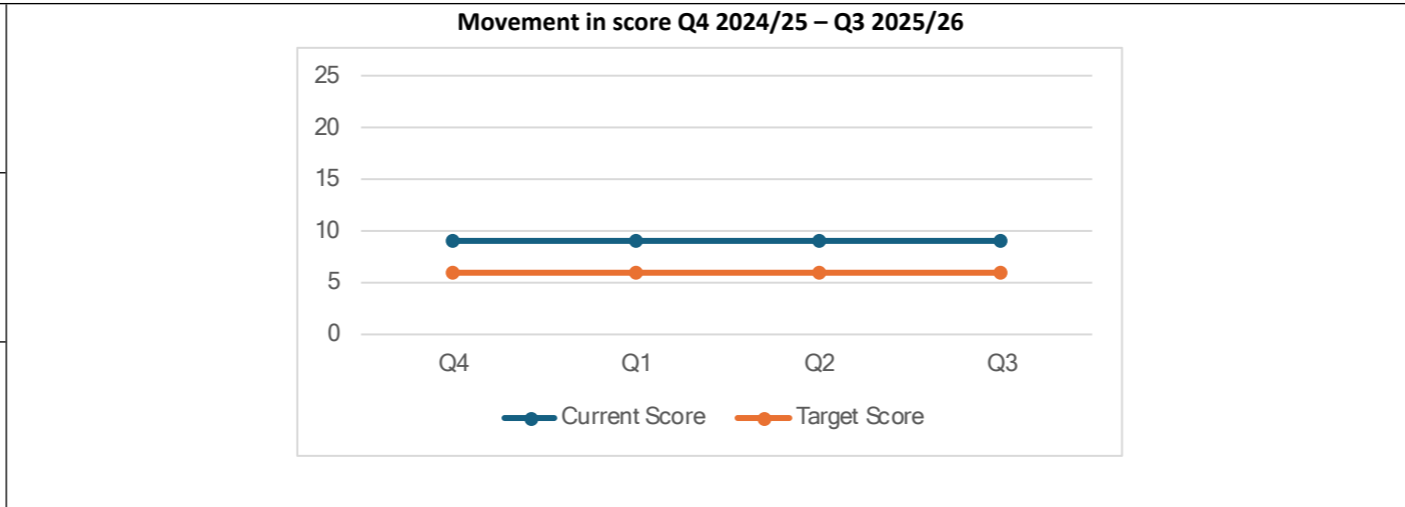
Assurance topic - EDI

Ref: 9 **Strategic Risk:** There is a risk that we are unable to achieve our ambitions on ED&I, then we may have a workforce that is not representative of our community, **resulting in** an adverse impact on patient, staff and public safety experience.

Risk Appetite:
Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)

Date added: 28 August 2024
Date of last review: 3 February 2026

Lead Director: Chief Operating Officer



Initial Score (CxL): 3x3=9
 As at 28 August 2024

Current Score (CxL): 3x3=9
 As at 3 February 2026

Target Score (CxL): 3x2=6

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance
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- Implementation of WRES / WDES / Gender Pay Gap / Race and Disability Pay Gap action plans.
- Equality & Diversity Council (with focus on both workforce and population health inequalities)
- Staff equality networks with assigned executive sponsors.
- Recruitment and selection training programme.
- Development programmes for managers including Leadership programmes.
- Head of Equality, Diversity & Inclusion and team in post.
- 3-year EDI Strategy in place with refreshed EDI objectives and implementation plan (also aligned to the WYH&CP EDI Strategy) - current strategic EDI objectives being reviewed.
- NHS Improvement plan – 6 high impact actions.
- EDI training for managers in place.
- Implementation of annual EDS2022 review (with focus on workforce, leadership and patient experience).
- Trust Equality Impact Assessment Guidance and Template in place with EIAs completed on a regular basis with support from the EDI team.
- EDI Conference with focus on Inclusion & Belonging.
- EDI Objectives agreed for all Executive Directors.
- Suite of policies -
 - Disability Equality and Disability Related Leave Policy
 - Disciplinary Policy and Procedure
 - Harassment and Bullying Policy
 - Trans Equality Policy - Staff and Patients

Internal Positive:

- EDI Strategy - Trust Board update provided November 2025.
- People Dashboard: BAME overall workforce and representation at Senior Management year on year improvements – latest as at November 2025.
- Gender Pay Gap – improving position – latest as at March 2025.
- WRES/WDES/EDI Update report - People Academy May 2025, with some notable improvements. Action plans refreshed in October 2025 (for 2025/2026).
- HEAT assessment and training for managers implemented across the Trust (Strategy & Transformation Team).
- EDS2022 review for 2024-25: scored Achieving Overall. 2025/26 review underway.
- Race and Disability Pay Gap - People Academy, January 2026.

Negative:

- Disability declaration rate.
- Representation at Senior Leadership levels for gender, disability and race.
- People Dashboard: ethnically diverse representation at senior level – latest at November 2025. Exceeded ethnically diverse representation for the Trust as a whole (44% compared to 39.9% for Bradford & Craven District) but 20% and increasing for senior management level.
- Disciplinary and Grievance data presented to People Academy in November 2025, currently under review from an EDI perspective.

Independent Positive:

- WRES/WDES benchmarking reports: some positive comparisons.
- NHS Staff survey outcomes: positive improvements in 2024 (particularly re: Harassment & Bullying)
- Gender pay gap benchmarking reports comparable with other local Trusts.

Negative:

- WRES/WDES benchmarking reports some negatives around Career Development/ Representation at Senior Management levels
- NHS Staff survey outcomes: some areas that require improvement
- Gender pay gap: some areas that require improvement (particularly at Senior Leadership level)

Gaps in control

- Good quality, comprehensive, meaningful equality impact assessments resulting in service improvements fully embedded and aligned to our decision-making processes.
- Continue to implement the 3-year EDI strategy, including the 5 key EDI objectives (which includes our ambitions to tackle wider health inequalities). Strategic EDI objectives currently under review.
- Adopting the NHS Race & Health Observatory anti-racist principles, aligned to the district wide anti racist charter. This will allow the trust to have an approach to being anti-racist.
- Breast-feeding provision within the Trust for patients and staff (a requirement under the Equality Act 2010)
- Ensuring we continue to implement the National EDI Improvement Plan with emphasis on good equality outcomes.
- Continue to review our Disciplinary and Grievance data from an equality perspective.

Gaps in assurance
 N/A

Action

- To continue to roll out the equality impact assessment guidance and proforma.
- Continue targeted engagement with CSU/ departments and developing local EDI action plans/ Continue to develop our EDI Implementation plan supporting the delivery of the EDI Objectives assigned with the EDI strategy.
- Working collaboratively with colleagues at place level.
- Continue working to meet the requirements
- Ensuring our processes and approach are free from bias.

Timescale

Ongoing

Ongoing

March 2026

Ongoing

Ongoing

Ongoing

Related risks on the high level risk register (operational risks)

N/A

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 30/10/2025 10:47:30

Strategic Objective 4: Partnership – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals																				
Assurance topic – Purposeful partnerships																				
Ref: 10	Strategic Risk: If the Trust doesn't work effectively in partnership, then there is a risk that the Trust fails to provide the best service to patients and deliver its medium-term plan, resulting in poor patient and staff experience, worse outcomes for patients and missed opportunities to address health inequalities.																			
Risk Appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	<p style="text-align: center;">Movement in score Q4 2024/25 – Q3 2025/26</p> <table border="1"> <caption>Score Movement Data</caption> <thead> <tr> <th>Quarter</th> <th>Current Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr> <td>Q4</td> <td>12</td> <td>3</td> </tr> <tr> <td>Q3</td> <td>12</td> <td>3</td> </tr> <tr> <td>Q2</td> <td>12</td> <td>3</td> </tr> <tr> <td>Q1</td> <td>12</td> <td>3</td> </tr> </tbody> </table>			Quarter	Current Score	Target Score	Q4	12	3	Q3	12	3	Q2	12	3	Q1	12	3	Initial Score (CxL): 4x3 = 12 As at 13 September 2024	
Quarter				Current Score	Target Score															
Q4				12	3															
Q3	12	3																		
Q2	12	3																		
Q1	12	3																		
Date added: 13 September 2024	Current Score (CxL): 4x3 = 12 As at 3 February 2026																			
Date of last review: 3 February 2026	Target Score (CxL): 3x1 = 3																			
Lead Director: Director of Strategy & Transformation																				
Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)		Actions to address gaps in controls or assurance															
<ol style="list-style-type: none"> Strategic Partnership Agreement (SPA) in place across the BD&C place. CEO is member of the BD&C Partnership Leadership Executive and the Committee in Common for the provider collaborative. Executive Director involvement in the three partnership programmes. Three programmes report into the Collaboration Programme Board chaired by the Place Chief Executive, which in turn reports into the Committee in Common. ABCAS Clinical Strategy has been developed. Specific examples of joint working with Airedale via ABCAS are underway e.g. for plastic surgery and Non-Surgical Oncology. NHS Planning Framework for 2026/27 requires a five year Integrated Delivery Plan from each provider organisation, these are being planned collaboratively across BDC with a common narrative about the contribution of ABCAS and Integrated Neighbourhood Health (INH). Monthly meeting with Director of Strategy counterparts from other WY trusts. Head of Strategy and Partnerships role within the Strategy and Transformation Directorate is strengthening the Trust's ability to build effective partnerships and take all opportunities to address health inequalities. Work to embed the Strategic Framework for 2025/26 and the five strategic objectives has required all CSUs and Corporate Departments to highlight their work to collaborate effectively with local and regional partners. Building and strengthening relationships with Universities (Bradford and Leeds). Plan in place to maximise BTHFT's social value impact as an Anchor Organisation. Social Value Oversight Group established. Partnership approach to developing Health on the High Street Care Models – working with health and care partners across the district. The Trust is a member of the West Yorkshire Association of Acute Trusts (WYAAT). 	Internal Positive: <ol style="list-style-type: none"> Quarterly Board paper setting out strategic view of Partnerships. ABCAS 1:1s with SRO and senior colleagues to ensure full visibility across the organisation. A new metric has been developed for partnership which focuses on health inequalities and equity of access. Anchor Institution action plan based on Joseph Rowntree Foundation self-assessment approved by the Board in November 2025. Negative: N/A	Independent Positive: <ol style="list-style-type: none"> Strong history of working in partnership across the place, evidenced by the SPA which has been in place now for over five years. WYAAT is highly respected and well embedded into organisations across the region and fosters strong partnership working. ABCAS Steering Group provides collective assurance across multiple divisions. Negative: N/A	Gaps in control Patient and public engagement e.g. ABCAS, Health on the High Street. Detailed work plan to be developed with the University of Bradford. Demands on the time, particularly of clinical and operational colleagues can make it difficult to engage fully in system-wide or partnership work.	Action Speciality level working groups for ABCAS. Stakeholder and public engagement strategy.	Timescale 2026															
	Gaps in assurance N/A																			
Related risks on the high-level risk register (operational risks)	N/A																			

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Strategic Objective 4 - Partnership – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals.

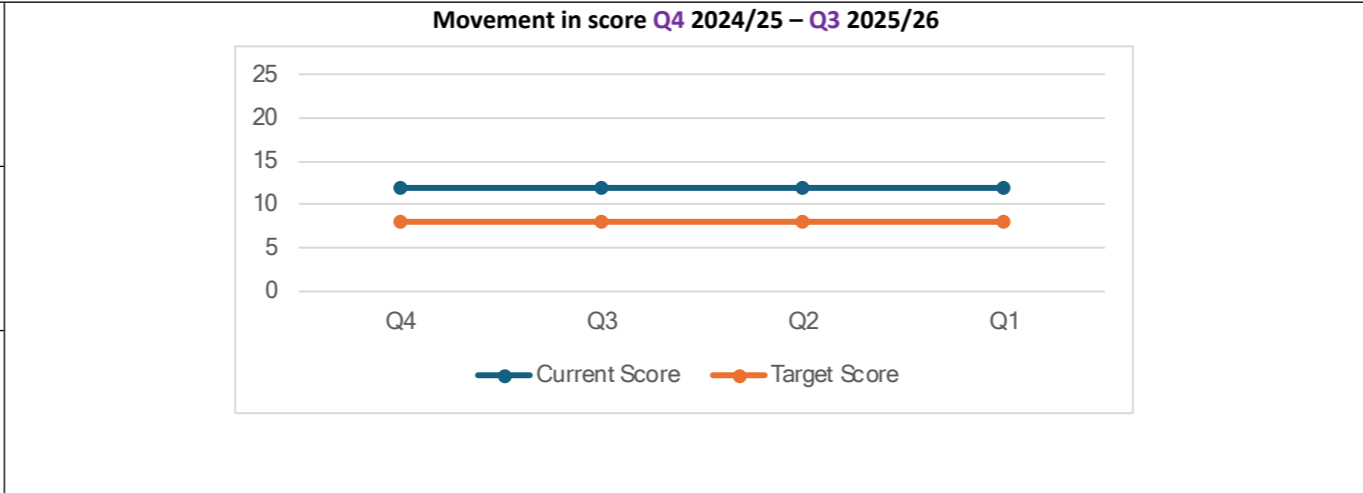
Assurance topic – Health inequalities

Ref: 11 **Strategic Risk:** If the Trust fails to address health inequalities, then this will contribute to a widening of the gap in health outcomes, access and experiences across Bradford District and Craven resulting in poor outcomes for patients and the public.

Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 6 September 2024
Date of last review: 3 February 2026

Lead Director: Director of Strategy and Transformation



Initial Score (CxL): 4 x 4 = 16
As at 6 September 2024

Current Score (CxL): 4 x 3 = 12
As at 3 February 2026

Target Score (CxL): 4 x 2 = 8

Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	Timescale
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1. EDI strategy 2023-2025 chapter 8 sets out Health Inequalities Strategy.
2. Health Equity and Health Inequalities programme is now one of the 10 priority initiatives in the Strategic Framework and is overseen by Health Equity Oversight Group.
3. The programme is implemented through the Trust-wide Health Inequalities Action Plan for 2025/26.
4. Induction training on health equity and health inequalities.
5. The Trust is collaborating with partners to strengthen our health inequalities impact, particularly working with the Reducing Inequalities Alliance at the WY ICB, BIHR, Living Well and other NHS partners.
6. Utilising data and insight to focus efforts and demonstrate improvements e.g. higher DNA rates for some populations can impact speed of access to care. New dashboard developed to show outpatient DNA rates for Core20 and nonCore20 populations by specialty and by clinic promoted during Closing the Gap week.
7. Examining pathways and service population profiles to understand opportunities to reduce points where inequalities could occur, use the Health Equity Assessment Tool to develop plans following data and pathway analysis.
8. Improvement projects using the IHI Model for Improvement (i) Making Every Contact Count (MECC) project aims to reduce health inequalities by enabling patients to access health and wellbeing support via Living Well, advice in 7 languages and referrals for blood pressure management (ii) working with the library to enable local people to get online and access health advice.
9. A further six colleagues across the trust have completed the WY ICB initiative to become Health Equity Fellows with five more this year.
10. Supporting development of Health on the High Street to ensure new model increases health equity and seeks to reduce inequalities.
11. Supporting BTHFT's role as an Anchor Institution and leading the aspects of the Joseph Rowntree Foundation Framework that focus on health equity.

Internal Positive:

1. Strategic Objective metric for the Partnerships objective will focus on health equity and be reported to Board every six months.
2. Reports to Equality and Diversity Council.
3. Reports to Quality Committee.
4. Health Equity Oversight Group chaired by the lead Executive for health inequalities, Director of Strategy and Transformation.

Negative:
N/A

Independent Positive:

1. Internal Audit reports:
 - a. Virtual programme (quality and equity of access) – Significant assurance (August 2025)

Negative:
N/A

Gaps in control
Challenge to ensure that this agenda is part of everyone's business in the Trust not just the specialist team.

Discussions ongoing to better inform the CSU to Exec meetings from a health equity perspective.

The Future of the Reducing Inequalities Alliance is uncertain because of changes at the WY ICB.

Action
Discussions ongoing.

Ongoing

Gaps in assurance
Challenges in identifying inequity in outcomes due to NHS and Trust not routinely collecting data on all protected characteristics.

Challenges automating data collection to demonstrate impact of improvement projects.

Work with colleagues in DDAT and Performance.

Work with colleagues in DDAT.

Ongoing

Related risks on the high-level risk register (operational risks)

N/A

Sheridan
03/2026 10:08:30

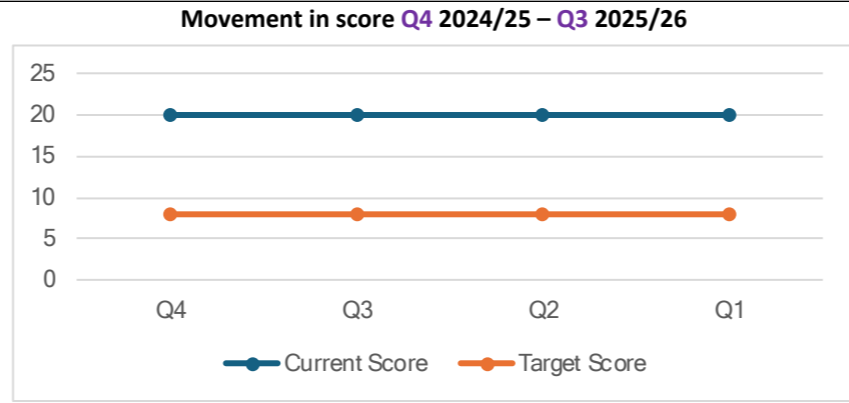
Objective 5: Sustainability - To deliver our financial plan and key performance targets
Assurance topic – Delivery of the financial plan

Ref: 12 **Strategic Risk:** If we are unable to deliver our financial plan, then we will not be financially sustainable, resulting in poor outcomes for staff, patients and the public, including loss of services.

Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 24 August 2024
Date of last review: 1 February 2026

Lead Director: Chief Finance Officer



Initial Score (CxL): 5x4=20
As at 24 August 2024

Current Score (CxL): 5x4=20
As at 1 February 2026

Target Score (CxL): 4x2=8

Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance		
<ol style="list-style-type: none"> Clinical Service Unit (CSU) financial management arrangements and framework, and accountability and performance management framework. Regular reviews between Red rated CSUs and CFO to monitor departmental recovery plans. Further development of the Closing the Gap programme and governance structure. Communications from Executive Team to highlight the importance of delivering the financial plan and increasing the priority given. Quality Impact and Financial Impact Assessment processes. Action plan to deliver recommendations of external review of financial governance arrangements and efficiency opportunities. Financial controls: Vacancy Control Process, Non-Pay Review process, Minor Work Review process and recruitment of all senior roles approved by ETM. Cash & liquidity position is managed and monitored by the Cash Committee with updates provided to the Finance & Performance Committee via the monthly Finance Report and monthly Treasury Management Report. Intensified oversight and governance of the capital programme via Capital Strategy Group and Capital Operational Group. 5 year financial and capital plan. WYAAT CEO-led efficiency workstreams. ABCAS provider collaborative workstreams. Corporate Services cost reduction plans (nationally mandated) with Exec CRO. Working Efficiency Group work plan. Review of NHSE Grip and Control checklist 129/156 interventions in place. Revised budget setting process for 2026/27. Suite of policies: <ul style="list-style-type: none"> Standing Financial Instructions Reservation of Powers to the Board and Scheme of Delegation Capital Programme Management Policy 	<p>Internal Positive:</p> <ol style="list-style-type: none"> Monthly finance report to F&P Committee. I&E run rate improvements month on month to Month 5. Weekly reporting on CTG scheme development by department. Closing the Gap report F&P Committee highlighting progress with scheme development. Capital plan approved for 2025/26 and higher levels of delivery to Month 6 than previous years. NHSE cash management process requirement to apply for external cash support are in place and reported to F&P Committee. <p>Negative:</p> <ol style="list-style-type: none"> Deficit plan with an underlying deterioration agreed for 2025/26. Underlying I&E forecast for 2025/26 exit run rate – significant deficit to address for 2026/27. Cashflow forecast report presented to F&P Committee highlighting forecast cash risks in Quarter 4 in 2025/26. CSU Monthly finance reports forecasting material overspends in many departments. CTG Plan status – 100% of plans identified but risk adjusted forecast for in year delivery below 100%. 	<p>Independent Positive:</p> <ol style="list-style-type: none"> External review providing assurance on the Closing the Gap governance and programme structure 2024/25. Internal Audit Reports: <ol style="list-style-type: none"> Financial Controls - Significant assurance (May 2025) Implementation of actions following external report (PwC) – Significant assurance (October 2025) <p>Negative: N/A</p>	<p>Gaps in control Budget holder capacity and capability to deliver a £33m cost improvement target in 2025/26.</p> <p>System partners may not deliver their financial plans, which may result in the aggregate system position being off plan, impacting adversely on BTHFT.</p> <p>Capacity and Capability to deliver the full capital programme as planned.</p> <p>27 NHSE Grip and Control recommendations not in place.</p>	<p>Action Earlier engagement in the planning process and CTG targets confirmed with clear deadlines for achievement.</p> <p>Engagement with system partners to collaborate on shared cost improvement initiatives.</p> <p>Improved resources available for the management of the capital programme, with an explicit 5-year plan to enable more effect planning of the capital programme.</p> <p>Implement the 27 Grip & Control recommendations.</p>	<p>Timescale Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Quarter 3 and 4 2025/26</p>
			<p>Gaps in assurance CSUs and corporate departments have identified the full value of their 2025/26 Closing the Gap targets, but the risk adjusted forecasts are below plan.</p> <p>BTHFT share of ICB £33m planning gap - £5.3m required over-performance 2025/26 via additional efficiencies driven by system collaboration.</p> <p>Ability to forecast delivery of the I&E plan in 2025/26</p> <p>Ability to forecast financial balance in 2025/26</p> <p>Forecast to remain liquid and not reliant on external revenue cash support is dependent on timely CTG delivery of cash releasing cost reductions but this is not yet certain.</p> <p>The assurance that major ongoing developments within the existing capital programme will not increase in cost or slip into subsequent years, resulting in reduced CDEL and cash for future capital programme.</p>	<p>CFO meetings with CSUs under the accountability framework</p> <p>Engagement with BDC system partners to deliver shared efficiency plans (Corporate Services collaboration, Acute Services collaboration). BDC system Director of Collaboration appointed to lead the Acute services collaboration work.</p> <p>Increased financial controls and CFO meetings with CSUs under the accountability framework</p> <p>Medium term financial plan to be developed and Q4 in line with NHSE guidance.</p> <p>CTG multi-year planning to be developed. Revised budget setting process for 2026/27.</p> <p>Working capital controls in line with NHSE requirements. Cash Committee to develop further strategies to maximise cash balances.</p> <p>Capital Strategy Group and Capital Operational Group oversight.</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>March 2026</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

Related risks on the high-level risk register (operational risks)

N/A

30/03/2026 10:08:30
Osburne Sheridan

Objective 5: Sustainability - To deliver our financial plan and key performance targets					
Assurance topic – Sustainable services					
Ref: 13	Strategic Risk: If the Trust is unable to deliver sustainable services, then we may not be able to deliver clinical services that are fit for the future, resulting in a loss of staff, poor outcomes for patients and reputational damage.				
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	<p style="text-align: center;">Movement in score Q4 2024/25 – Q3 2025/26</p>			Initial Score (CxL): 4x3 = 12 As at 27 August 2024	
Date added: 27 August 2024				Current Score (CxL): 4x3 = 12 As at 29 January 2026	
Date of last review: 29 January 2026				Target Score (CxL): 4x2 = 8	
Lead Director: Chief Operating Officer					
Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance		
<ol style="list-style-type: none"> Operational, Financial and Workforce Planning Submissions Operational Improvement Plan (Delivering Operational Excellence) 2025-26 approved Partnership working and transformation programme Airedale and Bradford Collaboration of Acute Services (ABCAS). Improvement programmes of work e.g. histopathology, urgent care, pharmacy Hospital Management Group, Exec-to-CSU Meetings and Accountability Framework Capital investment in infrastructure Virtual Royal Infirmary programme EPRR Policy and BCP Plans. Winter response plan Ring fenced elective wards and capacity (at BRI site) Closing the Gap programme WYAAT – case for change service review approved. 	<p>Internal Positive:</p> <ol style="list-style-type: none"> WYAAT ICS Programme Updates – latest September 2025. Delivering Operational Excellence Plan to F&P Committee: <ul style="list-style-type: none"> Cancer and Diagnostics Performance Improvement Plan to F&P Committee – latest October 2025 next report scheduled for March 2026. RTT Improvement Plan to F&P Committee – latest January 2026 Urgent & Emergency Care Improvement Plan to F&P Committee – latest February 2026 Operational, Financial and Workforce Plan – latest Board March 2025 and F&P April 2025 Winter Response Plan – F&P Committee – September 2025 and Board September 2025. Performance Report to F&P Committee – February 2026. EPRR self-assessment core standards – 56 out of the 62 were fully compliant and 8 were partially compliant – overall substantial compliant 90% – improved position. Achieved 65 week wait – 0 at end of December 2025. <p>Negative:</p> <ol style="list-style-type: none"> WYAAT reports (e.g. Non-Surgical Oncology, Haematology) Histopathology and renal performance. 	<p>Independent Positive:</p> <ol style="list-style-type: none"> GIRFT reports CQC reports - Medical Care – Good (Effective remains Requires Improvement), Neonatal Services – Outstanding, Maternity – Requires Improvement (only Well Led and Safe were assessed. Well Led remained Good and Safe improved to Good from previous inspection last year). Royal Colleges reports Benchmarking of recovery position compared to other Trusts (Performance Report, latest October 2025) Human Tissue Act assessment Internal audit reports: <ol style="list-style-type: none"> Delivering Operational Excellence – Significant Assurance (November 2025) National Oversight Framework (NOF) 40th out of 134 trusts. <p>Negative:</p> <ol style="list-style-type: none"> GIRFT Reports Joint venture – loss of UKAS accreditation Discharge Management – Internal Audit Report limited assurance in August 2025. SSNAP (Stroke Audit Programme) – new standards translated into a negative / deteriorating position due to the assimilation to the new SSNAP standards/criteria. 	<p>Gaps in control</p> <ul style="list-style-type: none"> Workforce gaps in some service areas (e.g. VIR, Histopathology, NSO) resulting in inability to maintain service provision in the longer term and shorter-term gaps Fragile services e.g. Stroke, Haematology, VIR, Histopathology, Renal Financial challenges in 25/26 resulting in less resources to develop and transform services Lack of certainty re: future funding allocation and national priorities Lack of ring fenced ultra-green elective offsite facility. JAG accreditation not achieved, lack of physical capacity Lack of funding for independent sector (IS). <p>Gaps in assurance N/A</p>	<p>Action</p> <ul style="list-style-type: none"> Work with Joint Venture to streamline pathways. Business case for histopathology expansion approved and additional consultants recruited. Currently one gap in provision. NSO business case acute oncology service approved at ETM 13 October 2025. VIR – existing consultant trained to deliver service and fill x 1 gap on rota. To continue to attract and recruit expertise. Increase in twilight shifts Capital expenditure approved to expand chair capacity at Skipton. Escalation to WYAAT and specialised commissioning Working with national and regional partners to influence and input into reviews of services Closing the Gap programme. CTG weeks with CSU colleagues. Development of short- and medium-term plan in line with national NHSE requirements – Q3/Q4 sign off. Implementation of dedicated day case theatres at St Lukes Hospital. Delayed Development of new endoscopy unit at BRI. Contractor appointed. Groundbreaking ceremony held. Work with IS and internal task and finish group to reduce reliance on IS. Plastics undertaken at Westcliffe fully repatriated to BTHFT. 	<p>Timescale</p> <ul style="list-style-type: none"> Ongoing Completed VIR Ongoing Ongoing Ongoing Ongoing Ongoing TBC following validation of water and ventilation January 2026 Ongoing
Related risks on the high-level risk register (operational risks)	<ul style="list-style-type: none"> 70 – Pharmacy Accommodation (current score: 15) 2549 – Workforce constraints in Non Surgical Oncology (current score: 16) 2604 – Emergency Department overcrowding (current score: 20). 				

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Objective 5: Sustainability - To deliver our financial plan and key performance targets																				
Assurance topic – Environmental sustainability																				
Ref: 14	Strategic Risk: If the Trust fails to implement its Green Plan effectively, then the Trust may fail to meet its responsibilities in relation to climate change, resulting in an inability to deliver sustainable healthcare.																			
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	<p style="text-align: center;">Movement in score Q4 2024/25 – Q3 2025/26</p> <table border="1"> <caption>Score Movement Data</caption> <thead> <tr> <th>Quarter</th> <th>Current Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr> <td>Q4</td> <td>12</td> <td>8</td> </tr> <tr> <td>Q1</td> <td>12</td> <td>8</td> </tr> <tr> <td>Q2</td> <td>12</td> <td>8</td> </tr> <tr> <td>Q3</td> <td>12</td> <td>8</td> </tr> </tbody> </table>			Quarter	Current Score	Target Score	Q4	12	8	Q1	12	8	Q2	12	8	Q3	12	8	Initial Score (CxL): 4 x 4 = 16 As at 4 September 2024	
Quarter	Current Score	Target Score																		
Q4	12	8																		
Q1	12	8																		
Q2	12	8																		
Q3	12	8																		
Date added: 4 September 2024				Current Score (CxL): 4 x 3 = 9 As at 21 January 2026																
Date of last review: 2 March 2026				Target Score (CxL): 4 x 2 = 6																
Lead Director: Director of Estates & Facilities																				
Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance	Actions to address gaps in controls or assurance																
<ol style="list-style-type: none"> The BTHFT Green plan outlines the action we will take to meet our obligations. Approved by the Board on 31 July 2025. Green Plan Implementation Group. The current Green Plan Implementation Group comprises of the leads for the 4 workstreams, the Exec Director of Strategy and Transformation, the Executive Director of Estates and Facilities and the Policy Manager. Successful in obtaining £1.8m bid for solar panels at St Lukes and BRI. Successful in obtaining £600k for LED lighting through National Energy Efficiency Fund (NEEF) funding, both sites will be 100% LED. Work across trust to promote good practice and share case studies and staff engagement. Joint Adaptation plan with BDCT and Airedale. This plan outlines how we as a Place based partnership will respond to risks resulting from climate change. ICB sustainability plan outlines what the ICB will do to meet its obligations on sustainability and the environment. Sustainability Manager in post. Submitted a Public Sector Decarbonisation Scheme (PSDS) 4 bid in November for St Lukes to join the Bradford heat network to significantly reduce Carbon, Bid expected to be £12m and if successful go live in 2027. Successful bids confirmed in June 25. Have received enquiries on the bid. The Carbon Energy Fund have visited BRI to be appointed to identify an energy partner to develop a strategy for decarbonisation through private funding avenues which will be repaid through future savings on energy. Rolled out recycle bins across the trust and will be throughout the trust in 2 months and improved reporting. £187k bid for electric vehicle chargers was successful. Successful bid to reduce the use of Nitrous Oxide at the trust. Board Sustainability training delivered in December 2025. 	Internal Positive: <ol style="list-style-type: none"> Annual report 2023/24 Annual Report to Board – January 2026. Negative: N/A	Independent Positive: <ol style="list-style-type: none"> WY ICB BD&C Health & Care Partnership NHSE NE&Y CQC Well Led Inspection (outcome TBC) Negative: <ol style="list-style-type: none"> Salix funding has ceased and we are unsure where future grant funding will be obtained from. 	Gaps in control Engagement on sustainability/green issues across the trust is not consistent and depends on personal interest from individual members of staff. Recycling not fully rolled out	Action Green Plan actions to be completed and driven through. Engagement plan to support the development and implementation of the plan. Network of Green Champions to be expanded, currently 28 members.	Timescale Complete To align with the launch of the new plan.															
				Gaps in assurance Routine data sets showing progress against the ten NHS E domains are not routinely available to monitor progress		Ongoing														
Related risks on the high-level risk register (operational risks)	N/A																			

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All strategic objectives																			
Assurance topic – Board leadership and governance																			
Ref: 15	Strategic Risk: If we don't have effective Board leadership or robust governance arrangements in place, then the Board won't be able to lead and direct the organisation effectively, resulting in poor decision making, a failure to manage risks, failure to achieve strategic objectives, regulatory intervention and damage to the Trust's reputation.																		
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	<p style="text-align: center;">Movement in score Q4 2024/25 – Q3 2025/26</p> <table border="1"> <caption>Movement in score Q4 2024/25 – Q3 2025/26</caption> <thead> <tr> <th>Quarter</th> <th>Current Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr> <td>Q4</td> <td>15</td> <td>10</td> </tr> <tr> <td>Q1</td> <td>15</td> <td>10</td> </tr> <tr> <td>Q2</td> <td>10</td> <td>5</td> </tr> <tr> <td>Q3</td> <td>10</td> <td>5</td> </tr> </tbody> </table>			Quarter	Current Score	Target Score	Q4	15	10	Q1	15	10	Q2	10	5	Q3	10	5	Initial Score (CxL): 5x4 = 20 As at 6 December 2023
Quarter				Current Score	Target Score														
Q4				15	10														
Q1				15	10														
Q2	10	5																	
Q3	10	5																	
Date added: 6 December 2023	Current Score (CxL): 5x2 = 10 As at 18 February 2026																		
Date of last review: 18 February 2026	Target Score (CxL): 5x1 = 5																		
Lead Director: Chief Operating Officer																			
Key controls (what are we doing about the risk?)	Assurance (+ve or -ve) (how do we know if the things we are doing are having an impact?)	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance																
<ol style="list-style-type: none"> Board and Committee/Academy structure Arrangements in place to ensure compliance with Code of Governance for NHS Provider Trusts and NHS Provider Licence Suite of governance documents in place and reviewed regularly including Constitution, Scheme of Delegation, Standing Orders Board Development programme Effectiveness reviews of Board, Committees, Academies Appraisal process for Board members Risk Management Strategy Risk Appetite Statement agreed and reviewed on an annual basis Conflicts of Interest Policy and processes Board member participation in PLACE, 15 steps and 'reach in' visits Reviews of composition of Board through NRC and Governors NRC. Fit and Proper Person checks undertaken annually Council of Governors – quarterly meetings including holding the NEDs to account for the performance of the Board New series of joint Board/Governor meetings introduced (Strategic Advisory Forum). 	<p>Internal Positive:</p> <ol style="list-style-type: none"> Annual Governance Statement Annual Report Quality Account Annual review of compliance against Code of Governance and NHS Provider Licence Annual review of NED independence BAF High Level Risk Register Academy/Committee Chair reports to the Board Annual committee effectiveness reviews and annual reports Board effectiveness survey – latest October 2025 <p>Negative:</p> <ol style="list-style-type: none"> BAF and High-Level Risk Register – risks above target score / risk appetite level. 	<p>Independent Positive:</p> <ol style="list-style-type: none"> Head of Internal Audit Opinion. Internal Audit reports: <ol style="list-style-type: none"> Fit and Proper Person Test – Significant assurance (November 2024) Quality Committee Deep Dive – Significant assurance (February 2025) Board Assurance Framework – Significant assurance (April 2025) Policy Management – Significant assurance (July 2025) Positive progress through IQIG, frequency of meetings reduced to bi-monthly. <p>Negative:</p> <ol style="list-style-type: none"> Internal Audit reports: <ol style="list-style-type: none"> Risk management strategy: CSU focus – Limited assurance (December 2024) Annual VFM assessment 24/25 – significant risk re: governance. Trust is in NOF3 with additional licence condition and agreed enforcement undertakings. Capability assessment rating amber/red. 	<p>Gaps in control</p> <ul style="list-style-type: none"> Improvements to 'technical' governance e.g. Board/Committee/Academy arrangements Improvements to Board 'dynamics' Improvements to Board Assurance Framework. Council of Governors effectiveness and development support <p>Gaps in assurance</p> <ul style="list-style-type: none"> CQC well led inspection report to be received. 	<p>Action</p> <ul style="list-style-type: none"> Work to continue to support report authors in providing succinct and clear assurance reports. Committee effectiveness reviews to be undertaken and actions implemented. Creation and delivery of Board development programme. New BAF template to be developed and deep dives to be undertaken on BAF risks. Work to continue to support Council of Governors including clarity on role and responsibilities and developing relationship with Board. 	<p>Timescale</p> <p>Complete</p> <p>Reviews to take place April 2026, implementation of actions by September 2026.</p> <p>Plan in place up to April 2026</p> <p>April 2026</p> <p>Ongoing</p>														
Related risks on the high-level risk register (operational risks)	Risk 14 and 9.																		

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All Open Operational Risks with a current scoring of 15 or over (as at 04/03/2026)

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)
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.	30 Jun 2026	25	(5) Catastrophic	(5) Will undoubtedly recur, possibly frequently	5	(5) Catastrophic	(1) Cannot believe that this will ever happen again	27/02/26 Building works have slipped and now the capacity is expected in June / July 2026. The CSU has submitted a business case for the workforce (medical and nursing) and dialysis equipment, in order to expand dialysis provision at Skipton in line with the approved capital estate work. The business case has been approved by ETM. Estates are also working up plans on Ward 15 and at St Luke's to provide additional capacity.	31 Jul 2026	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
290	01 Jul 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.	04 Apr 2026	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	15	(5) Catastrophic	(3) May recur occasionally	February 2026: The majority of projects remain on program for Q4 completion (March 2026). Two projects are complete, with one extending into Q1 and one into Q2 2026. Delivery remains focused on statutory compliance, fire safety, and infrastructure resilience.	30 Apr 2026	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
2604	04 Jul 2024	Sejjid 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.	31 Mar 2026	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 2027	(4) Major	(5) Will undoubtedly recur, possibly frequently	20

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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 Apr 2026	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 Mar 2026	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
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 Mar 2026	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	12	(4) Major	(3) May recur occasionally	05/02/26 - CSU team now embedding Excel methodology in planning around ECS improvements. Clear action plan in place which will be co-delivered to address pre / during / post pathways to reduce attendances and streamline admitted and non-admitted pathways. Medical Workforce exercise underway however delayed due to data availability - working with informatics and finance to understand capacity and demand figures. PEM ST3 overnight has improved paed's breach numbers, however this is only short-term approval. Will form part of the medical staff review. UTC has expanded the age criteria to relieve some pressure from PEM. Interprofessional standards protocol has been delivered via HMG however the department is still only seeing sporadic compliance in relation to specialty inreach and GP referrals. More work needs doing	30 Apr 2026	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
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 its 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.	31 Mar 2026	12	(4) Major	(3) May recur occasionally	12	(4) Major	(3) May recur occasionally	31/1/26 - Weekly Financial Recovery Board in place from December 25, three work streams established and meeting weekly to review expenditure, income and workforce. Vacancy freeze in place from January 26 - 31/3/26 (earliest review date). Risk being reviewed on a weekly basis Initial - Identification of further financial mitigation via the established financial recovery board, appointment of recovery director and improvement of the CTG process	31 Mar 2026	(4) Major	(5) Will undoubtedly recur, possibly frequently	20

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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	30 Mar 2026	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	12	(4) Major	(3) May recur occasionally	April to September 2026 - Recruitment of a Cyber Security Manager June 2026 - DSPT/CAF Submission / Audit March to July 2026 - Phishing Exercises & Awareness Campaigns March to June 2026 - Procurement and installation of Rubrik Backup and Resilience Tool. March 2026 - AD Audit - File Audit Add on purchased / Installed March 2026 - Incident Exercise for IT Managers / EPRR Feb 2026 - Geo-blocking enabled on Firewall for Tier 1 & 2 Feb 2026 - Incident Exercise (Table top) - Test the BTHFT Incident response plans and processes. Feb 2026 - Conditional Access - Geo Location for Azure Access	30 Sep 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	Pandemic outbreak - Linked to National RR If we experience a pandemic 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 mitigate. 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.	28 Sep 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.	06 Aug 2026	16	(4) Major	(4) Will probably recur, but is not a persistent issue	9	(3) Moderate	(3) May recur occasionally	1. BTHFT Autism Assessment Pathway Implementation Project-ongoing changes to pathway 2. Ongoing involvement in System wide Autism pathway development	05 Apr 2027	(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.	29 May 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	17/02/26 The intention is that Ward 24 which is currently Oncology will become a Palliative Care ward from June 2026, consultant recruitment is underway to support this transition. Meanwhile, the CSU are also progressing the other posts from the business case to support the new AOS pathway.	30 Jun 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16

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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
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. 3. To employ Roald Dahl nurse for children with complex medical need to commence post in April 2026	20 Apr 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16
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. ... Update 18/03/2025 Ongoing (see risk 221) for aseptic unit although preparation is ongoing	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 Mar 2026	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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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.	30 Apr 2026	15	(5) Catastrophic	(3) May recur occasionally	9	(3) Moderate	(3) May recur occasionally	27/02/26 KPMG are doing a high level demand and capacity analysis for a second lab as part of the scope of work for the New Hospital Programme and ABCAS. The outcome of this work will provide recommendations about Cath Lab capacity for BTHFT and AGH and a future service model. It is expected there will be a report by the end of March.	31 Mar 2027	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
2612	15 Jul 2024	John Bolton	Mayada ME Elsheikh	Risk Assessment	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. 23/05/2025 "Narrative has changed slightly, action plan not yet enacted. Will prioritise. Risk score unchanged." 03/10/2024 ACPs/trainees not yet able to assist in reviewing results. No admin support yet for remove results for patients already admitted to the Trust - expected date for completion revised to Nov 24 To explore whether specialty teams with patients in AECU can review all own investigations ordered through ED as part of the Outstanding programme in ED Early emerging ideas about whether a 'radiology liaison consultant' could	30 Nov 2025	(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 Mar 2026	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	3	(3) Moderate	(1) Cannot believe that this will ever happen again	06/02/2026 - Tender responses received and scoring completed moderation of tender scores planned for 11/02.	31 Oct 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
2764	30 Jul 2025	Sajid Azeb	Jen Green	Risk Assessment	Finance and Performance Committee Quality Committee	Respiratory RTT Backlog	If we are unable to source capacity to see extra respiratory new patients we will breach our RTT commitment of no patients waiting over 52 weeks for treatment. This creates a risk to patients while they are waiting to be seen, and a risk to the Trust for breaching national standards.	30 May 2026	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	17/02/26 RTT performance remains at 49%, with 3 patients over 52 weeks. The additional capacity from the approved business case won't be realised until the new consultants have started in post, recruitment process underway. Advice and Guidance has also commenced to help with demand and pre-book diagnostics ahead of the patient's first outpatient attendance to reduce the number of appointments required.	30 Sep 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15

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2766	31 Jul 2025	Faeem Lal	Faye Alexander	National Guidance	People Academy Quality Committee	Risk related to the retention of student roster in line with national guidance	If we do not store student rosters in line with national guidance then we will breach the expected standards. Resulting in the inability to track back for incidents, events, patient safety events, and inability to identify who was there at the time for Coroner's, breaches, duty of candour, CQC etc.	31-mar-26	12	(3) Moderate	(4) Will undoubtedly recur, possibly frequently	1	(1) Moderate	(1) Do not expect it to happen again but it is possible	1. Implement a Secure Electronic Rostering System 2. Ensure chosen timekeeping system complies with Data Protection & Retention Standards 3. Ensure system has secure backup & archiving procedures 4. Ensure resourcing for the process and appropriate roll out map.	31-mar-26	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
2787	23 Sep 2025	Karen Dawber	Alastair Hughes	National Guidance	Quality Committee Finance & Performance Committee	Maternity theatres	If maternity theatre staffing and perioperative practice is not delivered in line with national standards there is an increased risk of women experiencing delays in operative procedures and complications resulting in harm. With the current staffing model there is also a risk that care in the intrapartum areas could be compromised due to midwifery staffing not meeting safe staffing standards whilst undertaking theatre staffing roles.	31 Mar 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	1. Task and finish group to explore alternative workforce models 2. Write a paper to ETM to include the workforce modelling required to achieve the GPAS and AfPP standards 3. To seek funding and propose interim measure of bank recovery staff 4. Develop a business case to outline the required staffing model to achieve safe standards of care 23 September - discussed at core governance and agreement to increase the risk to 15 following discussions and risks combined, Initially placed as 12- Updated risk assessment version attached to the the risk register following updated version completed by 29 September. Next review date remains the same 19.12.25- Core governance unable to proceed due to national junior Dr Strike. All available Consultants covering clinical activity , Not Quorate.	31 Mar 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
30	30 Aug 2023	Karen Dawber	Hannah Ackroyd	Risk Assessment	Quality Committee	USS capacity	If we are unable to perform a fetal ultrasound scan within the required time frames as per guidelines there is a risk of poor fetal outcomes and an increase risk of stillbirth.	31 Mar 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	20.2.26- A request for an extension of 1 month was agreed at CSU core governance to enable the launch of the electronic availability of acceptable symphysis fundal height chart above 40 weeks, which will provide time for discussion on what challenges such as increased demands, on USS capacity.	30 Apr 2026	(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.	31 May 2026	9	(3) Moderate	(3) May recur occasionally	9	(3) Moderate	(3) May recur occasionally	27/02/26 - Clinical Fellow has just started in post and will see predominantly long waiters for latent TB. Additional clinics were undertaken by the consultants in November and December 2025 which reduced the waiting time from 65 weeks to 45 weeks on average. The additional capacity from the Clinical Fellow will further decrease this waiting time. We have 208 patients with latent TB awaiting to be seen.	30 Sep 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15

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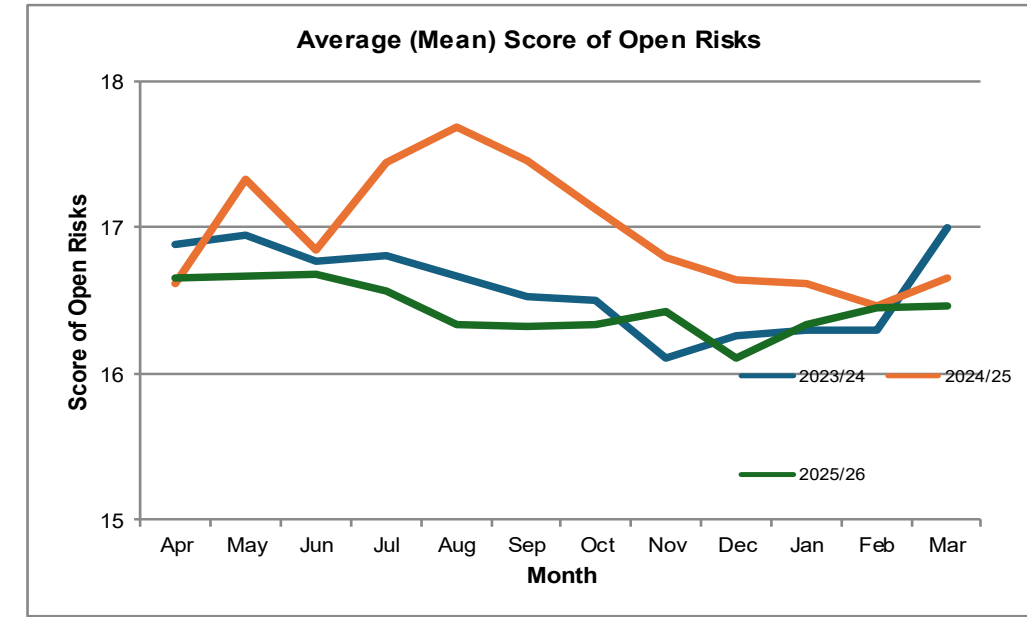
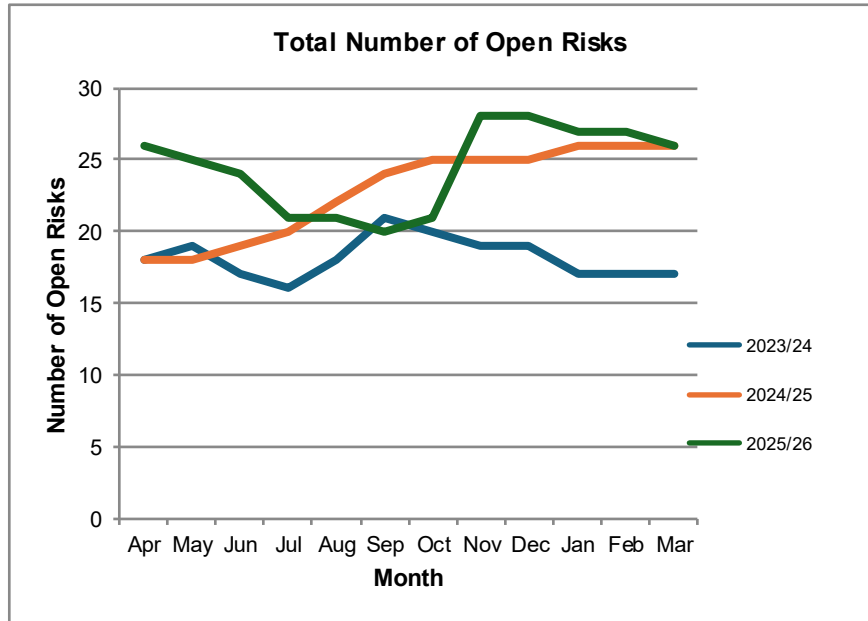
40	02-jul-23	Karen Dawber	Monica Parmar	Policy Changes	Quality Committee	The CSU is unable to effectively demonstrate that Personalised Care Plans are in place	If we are not able to demonstrate effective implementation of Personalised Care Plans for all women then the service will not be able to provide assurance that we are supporting service users with choice and control over the way their care is planned and received based on 'what matters' to them and their individual needs and preferences. The Trust will not be able to demonstrate compliance with the NHSE 3 year delivery plan for maternity and neonatal services recommendations resulting in limited assurance. This could result in poor patient experience, services choosing to access care at another Trust who provide a personalised care plan, thus reputational damage for the Trust. This risk is further complicated by the absence of a patient portal within the system so women are unable to view their record themselves, participate in the development of their care plan and share their information if they needed to attend another maternity unit for care.	29-mai-26	12	(4) Major	(3) May recur occasionally	3	(1) Negligible	(3) May recur occasionally	20/02/26 - The successful delivery of all elements of the Maternal care bundle is heavily reliant on women having access to forms and information and control over when these can be accessed and completed. Following the NHS 10 year plan publication, analogue to digital, hospital to community and prevention to treatment the lack of a Maternity portal slows down interoperability goals. As a result of the increased requirements, the score has been increased to 15	28-aug-26	(5) Catastrophic	(3) May recur occasionally	15
2868	02-mar-26	Karen Dawber	Amanda Hardaker	Incident Reporting	Quality Committee	Maternal Antibody Test Tracking and Identification in Pregnancy and at Birth	Patient safety events and a clinical audit have identified concerns with identifying the presence of maternal antibodies in pregnancy. This is vital so the mother and newborn can be commenced on the appropriate surveillance pathway and receive care from the multidisciplinary (MDT). It has been highlighted there is inconsistent recording of the antibody results, plan of care and communication to the neonatal team within EPR. Newborn's that require cord blood for a Direct Antiglobulin Test (DAT) is not being consistently performed.	31-mar-26	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	5	(3) Moderate	(1) Cannot believe that this will ever happen again	Ensure all community, MAC and ANC midwives have a current Sp ICE account and this information is recorded and can be updated for newly rotated members of staff.	31-jul-26	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15

High Level Risks Report on a Page – March 2026

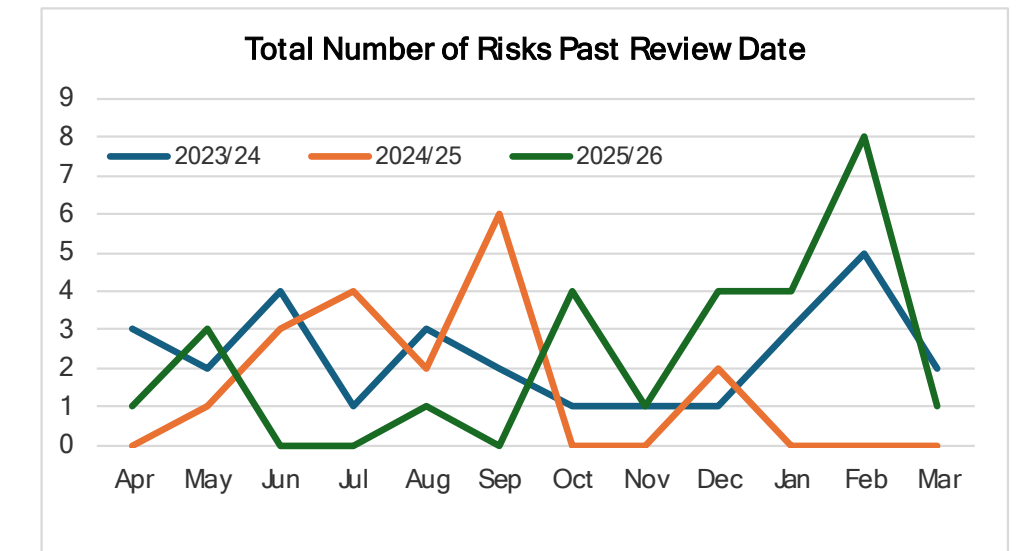
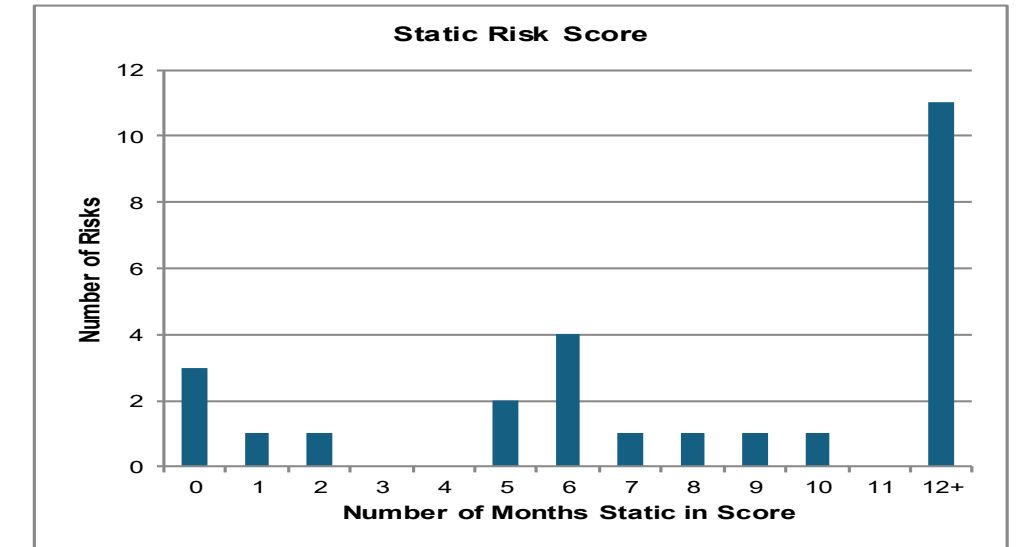
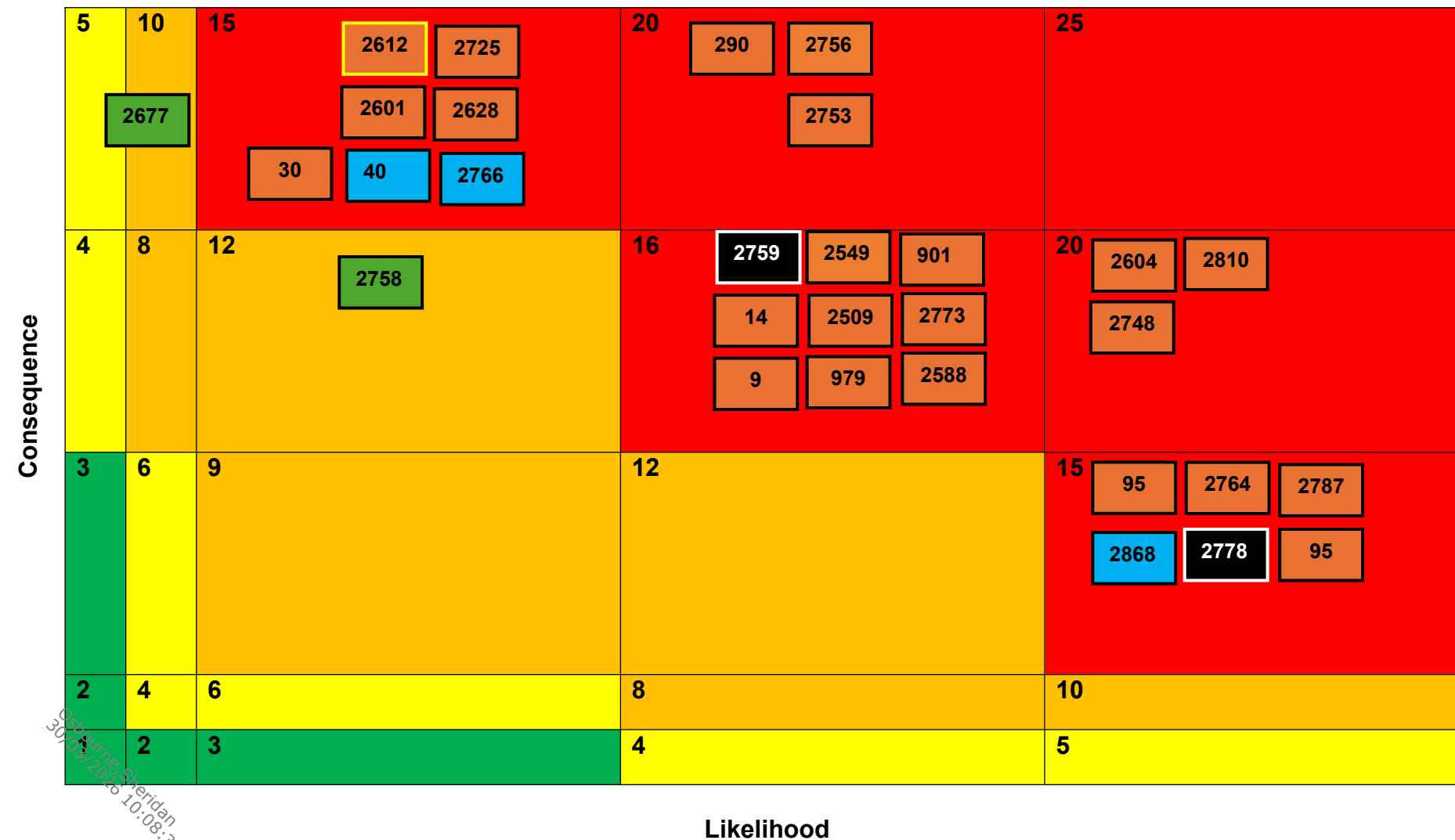
Total High-Level Risks	26*
Aligned to F&PC	9
Aligned to QC	22
Aligned to PA	6
Aligned to Board	2

Movement of Risks	
New	3
Under review	2
Marked for closure/removed	0
Risk score increased	0
Risk score static	23
Risk score decreased	2

*Note some risks are aligned to more than one Academy



Risk Overview



Key:	New	Under review	Increase	Decrease	Static	Past Review Date
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Changes to Target Mitigation Date of Current High Level Risks - March 2026

IRIS ID	Date of entry	Academy/ Committee	Current Score - March 2026	Target Score	Original	1st Change	2nd Change	3rd Change	4th Change	5th Change	6th Change	7th Change	8th Change	9th 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	30/06/2026				
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	31/03/2027					
901	07/12/2016	QC	16	9	30/04/2024	30/03/2025	30/08/2025	30/09/2025	01/04/2026	31/07/2026	30/09/2026			
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	05/04/2027						
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	30/09/2026				
2756	16/07/2025	QC, F&P	20	12	31/12/2025	30/04/2026								
2753	11/07/2025	QC, F&P	20	5	31/03/2026	31/07/2026								
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	31/03/2026								
2787	23/09/2025	QC, F&P	15	4	31/03/2026									
979	29/09/2025	PA & QC	16	16	29/01/2026	28/09/2026								
2764	30/07/2025	QC, F&P	15	6	31/03/2026	30/09/2026								
2810	04/11/2025	F&P	20	12	31/01/2026	31/03/2026								
2588	24/05/2024	QC	16	6	01/11/2024	01/04/2025	01/10/2025	30/09/2026						
2766	31/07/2025	PA & QC	15	1	31/03/2026									
40	02/07/2023	QC	15	3	28/08/2026									
2868	02/03/2026	QC	15	5	31/07/2026									

Change in target mitigation date

Due for review

Osbourne Sheridan
30/03/2026 10:08:30

Board of Directors				
Meeting Date:	31/03/2026	Agenda Reference:	Bo.3.26.19	
Report Title:	Communications Strategy			
Presented by:	Shak Rafiq, Strategic Communications and Engagement Lead			
Executive Lead:	Mel Pickup, Chief Executive			
Author:	Shak Rafiq, Strategic Communications and Engagement Lead			
Report Summary				
Purpose of the paper:	Decision <input type="checkbox"/> (approve/recommend/ support/ratify)	Assurance <input checked="" type="checkbox"/>	Action <input type="checkbox"/> (review/discuss/ comment)	Information <input type="checkbox"/>
Summary of Key Issues/Highlights:	<p>This paper, and the accompanying draft communications strategy 2026-2031, describes our evolving approach to communications and stakeholder engagement – internally and externally. The strategy is intended to drive innovation, while being realistic in ambition and timescales within the resources available to us. It was presented to the executive management team on Monday 23 February, with suggestions and amends from members reflected in the latest version that has been shared with this paper.</p> <p>This paper is designed to introduce the draft communications strategy, with more detail included in the strategy including a high level action plan that takes us to April 2028 when we will reach a natural review point. The strategy describes in detail the three pillars the Trust’s communications team will be focusing on and how the team will look to deliver against the pillars. These pillars are: organisational awareness and brand positioning; our people and our patients; and community engagement and relations.</p> <p>While the strategy is about evolving our offer, it is not seeking to bring wholesale changes, instead it focuses on natural next steps in line with communication best practice, theory and learning in practice. The strategy and this paper has intentionally been presented to exclude business as usual communications activity which will continue such as timely responses to media enquiries, responding to FOIs and video content. Instead it describes the ambition, presents a compelling and realistic case for change and demonstrates how the effectiveness of our communications will be measured.</p> <p>Some points of note:</p> <ul style="list-style-type: none"> • Support has been asked from executive team colleagues to help us source communications champions, ambassadors and content writers when we start implementing our new strategy • We are starting a refresh of our internal communications which includes a re-introduction of a team brief (cascade) and a move to a monthly round up for Mel as well as moving to a monthly Let’s Talk which will be focused on colleague stories and broader lifestyle content • This strategy supports some of the identified cost improvement plans, however some of the savings will be re-invested towards a better e-bulletin to replace the global email template allowing for better analytics and a better look and feel • Through improved opportunities to measure our activity, we will commit to developing a quarterly dashboard for comms 			

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	<ul style="list-style-type: none"> We have used insight and industry best practice to consider optimal approaches, however we will carry out colleague engagement exercises – including surveys and audits – to help us understand what’s working, what isn’t and what other channels we may need to consider such as a colleague app We are keen to adopt a test and learn process as we look to evolve, this will mean that we regularly evaluate the effectiveness of our channels, messaging approach and engagement with stakeholders rather than waiting for the April 2028 review point The strategy highlights some areas where ambiguity exists such as the impact of changes to the ICB; development of place provider partnership and associated work such as ABCAS and corporate services review; and the impact of AI on communications. These are live risks and any resource changes would impact on our ability to deliver against the timelines currently suggested in our high level plan
Recommendation/s: (including any decision/approval required)	The Board is asked to: <ol style="list-style-type: none"> Comment on the communications strategy, ensuring it links in with the wider strategic objectives and future plans for the organisation. Assure the level of ambition shown in the strategy is both achievable and demonstrates a clear drive on ongoing improvement. Approve the communications strategy for 2026-2031.
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:	Thrive
Implications	
Risk:	N/A
Legal/Regulatory:	Civil Contingencies Act (2004) – warning and informing duty.
Quality & Patient Safety:	Effective communications ensures accurate information is shared to combat misinformation and fake news. In addition communications and stakeholder engagement offers opportunities to respond to statutory and regulatory reports and investigations.
Equality, Diversity and Inclusion and Health Equity:	The principles in our communications strategy include a focus on providing and sharing information in accessible formats across our channels and working closely with our internal and external stakeholders.
Resources:	Cost savings identified through reduced activity involving external paid-for support, a relatively small re-investment will be required for an improved e-newsletter experience.
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	Executive team meeting – Monday 23 February 2026, having previously been discussed by the executive team in spring 2025 before strategic communications and engagement lead was in post

Approved by: Sheridan
23/02/2026 10:08:30

Report content

1. Purpose

This update provides assurance to Board that a forward-looking communications strategy has been developed, designed to focus on effective communications and stakeholder engagement that can support our corporate objectives. The strategy links with our ambitions both as a team and a Trust to deliver compelling stories of the work we do, involve and celebrate our colleagues and be active contributors to our local communities. The ask of Board is to provide assurance, feedback and approve the strategy incorporating suggestions and amends suggested by members. On Monday 23 February 2026 executive team members were asked to confirm that – once the strategy is amended and designed up – it is on the agenda for public board on 31 March 2026. This was agreed and the strategy shared with this paper includes the amends suggested by executive team members.

2. Background/context

There have been ongoing discussions at executive team and Board level about a refreshed communications strategy for the Trust as the previous one had run to the end of its natural course. The timing for the strategy was directly linked to the recruitment of additional roles to the communications team. With a newer team, the drafting of the strategy was subject to an onboarding process for new colleagues and an opportunity for the strategic lead to identify future opportunities, direction and vision for the team that was owned and developed by members of the team.

3. Assessment

The strategy has also been informed by discussions with senior leaders within the organisation, previous and ongoing feedback from the Board and Council of Governors, information collected through the staff survey and through an assessment of current and future communications trends and how we prepare and respond to these. With the level of ambition shown, it is clear that there will be opportunities for further learning as we adopt newer communication approaches including those that are not just new to us as a Trust but potentially new to the NHS.

4. Options analysis/Proposal

Subject to approval, the next steps are for are to finalise the strategy and publish this on our website. Work is already happening to implement some of the actions identified in the strategy to allow us to action changes from April 2026 on a rolling basis. The action plan includes activities slated for April 2026, the team is aware that we may need to factor in a short delay in introducing new activities such as the revamped Let's Talk and our e-bulletin.

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Bradford Teaching Hospitals
NHS Foundation Trust

Communications strategy

2026 – 2031

Delivering a responsive and inclusive communications service that enhances awareness of the Trust, promotes success, and helps our colleagues Thrive



Draft for consideration and approval by Bradford Teaching Hospitals NHS Foundation Trust's Board members

Command Centre

....together putting patients first



We became the first healthcare organisation in Europe to implement a Command Centre

Our Trust

Bradford Teaching Hospitals NHS Foundation Trust is responsible for providing hospital services for the people of Bradford and communities across Yorkshire. We serve a core population of around 550,000 people and provide specialist services for some 1.1 million.

We employ over 7,000 colleagues who work over several sites, including Bradford Royal Infirmary, which provides the majority of inpatient services, and St Luke's Hospital, which predominantly provides outpatient and rehabilitation services. We also provide a range of services from community sites at Westbourne Green, Westwood Park, Eccleshill, Skipton and the Bradford Macular Centre.

We are proud to have a diverse workforce that reflects the diversity of the communities we serve. We value the diversity of our people and commit to championing inclusion and compassionate workplace and continue to strive to provide inclusive and accessible services for all.

We became the first healthcare organisation in Europe to implement a Command Centre to transform patient flow in our hospitals. Our dedication to research and innovation remains strong. The Bradford Institute for Health Research (BIHR) continues to lead pioneering health studies, including Europe's first clinical trial using injections to treat asthma and a groundbreaking study into whether better blood pressure management can reduce the risk of falls in older adults. More than 60,000 Bradfordians are involved in life course studies such as Born in Bradford and Age of Wonder. Additionally, Bradford was awarded nearly £7m to set up one of 20 new Commercial Research Delivery Centres (CRDC) and will act as a regional hub for pioneering clinical trials, creating opportunities to test innovative new treatments with the latest equipment and technology.

Our Trust's vision is to "To be an outstanding provider of healthcare, research and education and a great place to work."

To deliver this vision, our current corporate strategy, has five core objectives.

- **Quality** - to provide outstanding care for patients, delivered with kindness
- **Improvement** – to be a continually learning organisation and recognised as leaders in research education and innovation
- **People** – to be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion
- **Partnership** – to collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals
- **Sustainability** – to deliver our financial plan and key performance targets

Our objectives and the way we work is underpinned by our three core values:



We Care

- We are kind and compassionate
- We take ownership and keep our word
- We are passionate, proud and committed
- We say thank you



We Value People

- We respect each other and our patients
- We embrace difference
- We support each other
- We say when we have done well and learn from mistakes



We are One Team

- We trust each other and work together
- We talk clearly and honestly
- We make every penny count
- We get better all the time

Osbourne-Sheridan
30/03/2025 10:08:30

Alongside our corporate strategy, the Trust has additional strategies to guide our work, transform the way we work and meet our objectives including corporate and social responsibility. Our other key strategies are:

- Nursing and midwifery
- People
- Patient experience and engagement
- Digital and data transformation
- Quality
- Education
- Improvement
- Safeguarding
- Equality, diversity and inclusion
- Green plan



National, regional and local context

At the time of writing this communications strategy (February 2026) there are a number of changes and challenges affecting the Trust and wider NHS, that are likely to impact on our ability to deliver all our objectives by 2029. The NHS is faced with record demand, significant financial pressures and the lowest public satisfaction recorded in national surveys. In addition, there are structural changes taking place that will see the folding of NHS England into the Department of Health and Social Care and Integrated Care Boards (including NHS West Yorkshire Integrated Care Board) being asked to reduce their headcounts by up to 50%.

The NHS 10 Year Plan for England has identified three shifts that should take place to help make the service sustainable and affordable. These are from hospital to community; from treatment to prevention and from analogue to digital. The work in response to these shifts is at an embryonic stage at both regional and local level. This includes developing integrated neighbourhood teams, a proposed health on the high street service offer and system-wide working to reduce digital exclusion.

Work is also progressing on establishing a place provider partnership, which includes delegated funding from the ICB for local commissioning, with an expectation that this will be set up no earlier than 1 April 2027. Alongside this work continues on our Airedale and Bradford Collaboration of Acute Services and our corporate services review that involves our Trust as well as Airedale NHS Foundation Trust and Bradford District Care NHS Foundation Trust. Therefore, while this is a communications strategy for our Trust we need to be ready for a greater emphasis on partnership working and sharing resources during a period of reduced capacity across our communications teams due to organisational changes and ongoing financial challenges to recruit to vacant roles.

There are wider socio-political and technological issues to consider too that impact both our Trust and our lives in general. We have the tensions caused by global conflicts, changes likely in the national and local political make up of our country, an increasingly loud, confident and influential 'anti-woke' movement and the pace of technological advances. More specifically, by 2029 we will have a clearer picture on how we can use artificial intelligence (AI) in our daily lives as well as at work. In October 2025, an NHS Communications Artificial Intelligence Operating Framework was published by NHS Confederation, and an NHS AI Ambassadors Network is guiding thinking about how technology can be used safely and ethically within the NHS and by NHS communications professionals.

This communications strategy will be reviewed in 2028, with a revised high level action plan developed as needed based on insight and some of the changes outlined above coming into effect.

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Communications are evolving and so are we

The world around us is changing, including the way people get, consume and interact with information, this means that we need to consider how our communications function reflects the changing landscape around us. Against this backdrop, effective responsive and agile communication is the lifeblood of any thriving organisation. We believe that clear, inclusive, and proactive communication can enhance our efforts to raise the profile of the Trust, promote success stories, and contribute to the overall well-being of our colleagues and patients. It should help us build a narrative about our Trust that is supported by our advocates and ambassadors, our new vision should build in the need for user-generated content as well as more traditional corporate communications and stakeholder engagement.

By integrating internal and external stakeholders, this strategy is designed to ensure that every voice is heard and that our communication practices support the Trust's vision to be an outstanding provider of healthcare, research and education, and a great place to work.

Our strategy revolves around three key pillars: organisation awareness, internal communications with a focus on our people and patients, and community (and broader stakeholder) engagement. These pillars are essential to ensuring our Trust is responsive, innovative, and trusted.

We recognise that the move towards new ways of working will not happen overnight. We need to consider our current capacity, capability and available resource to deliver on our outcome-focused ambitions. This strategy will be regularly reviewed and fine-tuned based on insights from audits and evaluations to ensure it remains effective and relevant. The review date is expected to be April 2028.

The strategic need

Research has consistently shown that the clearer staff are about an organisation's vision and objectives, the more effective they become as advocates. Active staff engagement significantly boosts communication impact and enhances positive awareness of an organisation's and the work it does. This, in turn, leads to better patient outcomes, creating a virtuous cycle of trust, performance, and satisfaction. Effective external communications, based on insight and feedback from patients and our communities, can help create open, transparent and inclusive relationships that show people that their feedback makes a difference and that information shared by us can be trusted and help them when they are seeking care.

We must address both challenges and opportunities presented by evolving communication channels, technology, and audience expectations. A key part of this refresh involves an audit of existing communication channels to identify areas of improvement, new opportunities, and the potential to build a service that proactively raises our profile and awareness of our work. At the time of writing we are not ready, for ethical and safety reasons, to embrace the opportunities presented by AI however there are other changes in the way people consume and respond to information that can influence the way we communicate with our audiences. A new organisation wide AI policy is being developed, this will help support our communications to ensure we are safe and ethical when using AI.

Positive awareness of the work of the organisation cannot be built on one-way communications, we need to use effective two-way communications with our broad audience base so that we can provide tailored information using the most appropriate channels, format and a range of messengers. This means we can build up an effective network of internal and external influencers, champions and advocates who also help challenge our thinking.

Our communications strategy will allow us to better support the Trust's mission, improve internal communications, and bolster community relations. In addition, work continues to strengthen the relationships between the Trust's corporate communications team with communication colleagues supporting the work of research teams based at Bradford Teaching Hospitals NHS Foundation Trust and those responsible for communicating about the work of Bradford Hospitals Charity. Further to this our Trust's communications team has well developed links with wider partners including the voluntary, community and social enterprise (VCSE) sector, local authority (including public health) and neighbouring NHS trusts in place and in West Yorkshire.



Active staff engagement significantly boosts communication impact and enhances positive awareness of an organisation's and the work it does.

Aims and objectives of the strategy

The overarching goals of our communications strategy are focused on reinforcing our brand, strengthening internal engagement, and optimising external partnerships. The key objectives include:

- **Organisation awareness:** Build and maintain trust among our audiences by focusing on proactive communications and promoting success stories. This includes effective stakeholder engagement and a greater focus on proactively working with key local influencers and communities.
- **Internal communication alignment:** Strengthen internal communication efforts to align with the Trust's own mission and priorities, improving staff engagement and clarity. This includes making greater use of our colleagues as our ambassadors, looking for opportunities for them to be our storytellers and brand ambassadors – internally and externally.
- **Operational efficiency:** Deliver a communication model that strikes a balance between proactive and reactive approaches, reinforcing a multi-channel framework. This means taking time to audit and reflect on the effectiveness of our current communications channels.
- **Collaborative working:** Foster collaboration with place-based and regional communications teams to reduce duplication and maximise resources. To contribute to or lead place-based communications projects and initiatives.
- **Staff engagement:** Work closely with HR and OD teams to support the People Plan, improve staff engagement, and highlight why the Trust is a great place to work.
- **Reporting and metrics:** Develop an effective reporting mechanism, including a performance dashboard with industry-standard metrics.
- **Accessibility:** Maintain a focus on accessible communications, ensuring the needs of all stakeholders are met.
- **Personal and professional development:** Ensuring we create time and space for members of the team to enhance existing skills as well as developing new ones. Become effective community anchors, role modelling this by having at least one intern every year from the University of Bradford hosted in the function.
- **Social listening:** Improve our social listening using both our social media channels as well as existing data through our patient experience and PALS teams.

These objectives will guide the transformation of our communications services into a more agile, engaged, and strategically aligned function, contributing to an enhanced awareness and profile of our Trust.

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The three pillars of the communication strategy

Pillar one: organisational awareness and brand positioning

Positive organisation awareness is shaped by the stories told by our audiences, including our staff, as well as the perceptions of patients and visitors through their accumulated experience of our hospitals, their direct contact with staff and services, and via external influences. External influences include broadcast and print media, and in a world where it is easy to self-publish and share content - social media platforms, local and regional online influencers and online communities centring around topics of interest.

Profile raising is fundamental to our success. It influences everything from patient trust to financial viability, staff retention and recruitment, crisis recovery and community standing. For patients, it influences trust in our services and reassures patients that they will receive high-quality care in a safe, supportive environment. How we measure organisational awareness and perception is important, and should form part of our strategy and future insight work. We need to understand what matters to our different audiences when thinking about the Trust, how their views are shaped and where we would need to focus our energy to shift perceptions.

We have built a strong brand position for excellence in teaching, innovation and research but recent focus has shifted to financial performance and other operational challenges. We need to shift the focus back to our key strengths, while ensuring an open and transparent approach is adopted for any reactive communications and the difficult messages that we will need to share in an ever challenging operating environment for us and the wider NHS. Under this pillar, we aim to cover:

- **Strategic communications:** Implement a communications strategy with agreed plans that balance proactive and reactive communication efforts. This includes effective forward planning, a refreshed stakeholder database and agreed metrics for reporting on success as well as areas for future focus or improvement.
- **Stakeholder engagement:** Develop a comprehensive stakeholder database and conduct mapping to understand stakeholder needs, ensuring tailored communication channels.
- **Media relations:** Continue to foster clear, consistent, and proactive media engagement on both local and national levels.
- **Closer working with Trust-based communication teams:** Build on the work we have done to actively involve and meet with colleagues supporting the communications activities for our research teams and charity. This includes joint meetings and for colleagues to share working spaces where practical to do so. This also allows us to look at shared opportunities to maximise our available resources such as training and development, skills sharing and licences for software.

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- **Digital and social media:** Expand our digital footprint by re-assessing our social media channels and growing our social media presence, representing the Trust as a modern and digitally engaged organisation. This includes a focus on a broader range of corporate story tellers, moving away from a traditional model of corporate communications that is only fronted by senior executives to one that is shared across our staff groups.
- **Brand centre:** we will develop an online brand centre to ensure we consistently apply our brand across all our communication channels. There are existing sub-brands that will be audited for effectiveness and improved as needed, with any future brand development to be limited to reduce confusion among our stakeholders. The online brand centre will include brand guidelines, pre-set templates and evidence-based guidance including the importance of meeting core accessibility standards.

This pillar ensures that the Trust is always positioned positively, and our communications reflect the values and excellence of the organisation. By taking a more strategic approach we can plan more effectively for current and future opportunities and pick up issues and challenges sooner by improving our social listening.

Stakeholder engagement – updating our approach

Refreshed stakeholder mapping will ensure we can tailor messages and provide relevant communications that resonate with the specific interests of each audience. By identifying and prioritising stakeholders, we will be able to allocate time, effort and resources more effectively, so our communications efforts can focus on the most influential or impacted groups.

Understanding who our stakeholders are, their level of interest, and their influence will help us:

- foster stronger relationships and build long-term partnerships;
- identify potential risks or address concerns raised by our audiences before they escalate;
- better manage our organisation awareness and positioning by knowing who our audience is and what their concerns or areas of focus might be.

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Pillar two: our people and our patients

The second pillar focuses on strengthening the relationship between the Trust, its employees, and its patients. We will focus our colleague communications around the four key areas of the NHS People Plan – looking after our people, belonging in the NHS, growing for the future and new ways of working and delivering care. In doing so we will highlight how our Trust is a great place to work and showcase how our service is continually improving. External communications will promote success stories and illustrate outstanding patient care and support. This pillar focuses on:

- **Internal communication:** Leverage insights from our workforce to better understand and communicate effectively with staff. This includes revitalising basic communication tools, such as organisational structure charts and contact lists.
- **Ambassadors and storytellers:** Develop a network of storytellers and ambassadors who will become the face of the Trust, representing both internal and external stakeholders.
- **Career development:** Promote training and career development opportunities to create a culture of continuous learning. To ensure communications is included in the staff induction so people know how to access information, where to go to share success stories and how they can get involved as ambassadors and storytellers.
- **Reaching non-desk based colleagues:** Our longer-term objective needs to consider how we reach colleagues who are non-desk based and those who do not have email addresses or infrequently use them. This may include considering solutions such as an app or colleague channel through social media (eg WhatsApp), any solutions would need to be insight-led and cost effective.
- **Patient success stories:** Share patient experiences and success stories to highlight the compassionate care delivered by our team. In addition we should use our storytellers and ambassadors to position ourselves as a community asset and an anchor institution that contributes significantly to our local communities.

By focusing on the needs of our people and patients, we will foster a stronger sense of belonging and shared purpose within the Trust.



A refreshed approach to internal communications

Let's Talk – re-vamped

The internal communications channel where we see highest levels of engagement is Let's Talk. Average reach is around 2,000 colleagues, nearly a third of the workforce dip in and out of it. Let's Talk is a great place to showcase our work internally and promote success stories. But we are conscious that we, as a communications team, are driving it. We want to establish more user-generated content, and an editorial group of colleagues to help us forward-plan content. The aim is to have a mix of colleague and patient stories, lifestyle pages and corporate news in a re-vamped format with shorter stories and more links to accessible intranet content.

Global emails – re-designed

While we do not want to promote and encourage an over-reliance on email, we have to acknowledge that global email is widely used. The move to Microsoft 365 has opened new opportunities and removed some restrictions on email. We are investigating new e-bulletin solutions, which will allow us to embed images and have more design features. Taking into account other measures in this plan, the overall intention is to send fewer emails but those that we do send will look and feel more engaging.



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Core Brief – re-instated

We understand that everyone is busy and that many of our colleagues do not have easy access to, or time to read some of the digital channels like the intranet and email. We therefore rely on managers to cascade important information down to their teams. However, we recognise that it can be difficult for managers to know exactly what the most important news is to share with their teams, that their time is precious and that we have not, since the COVID-19 pandemic, provided them with the support and guidance they need to be able to do so effectively.

Core Brief will be re-instated. The aim is to be rapid and relevant, to be delivered in 10 minutes or less and be done as part of an existing meeting/briefing rather than creating something new. It will provide an opportunity for leaders to encourage two-way discussion within their teams, include relevant team news and share any responses/ questions from their team.

As part of a more ambitious move, we can take our learning from core brief to roll out a weekly Team Brief live for people to hear from our Chief Executive or one of our executive team members.

The aim is to be rapid and relevant, to be delivered in 10 minutes or less.



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Testing our approach

We recognise the importance of insight while balancing this with experience, judgment and wider industry communication trends. Therefore we will use a test and learn approach initially when making these changes, accepting that we will need to review and make changes as needed. Between April and December 2026, we will also carry out periodic short surveys across employee groups and roles to understand what changes have landed well, what can be improved further and those that need to be dropped.

Pillar three: community engagement and relations

Building strong community relationships is essential to raising our profile and awareness and the success of our Trust. We recognise that relying on patient engagement alone means we do not have a deeper relationship with our communities. This is especially important during periods of challenge as people don't have an emotional bond or connection with the Trust and instead we have transactional relationships. We will do the following:

- **Community insights:** Work with our place partners - including the VCSE, local authority and university - to use existing and new opportunities to better understand our communities. These insights will help us understand what matters to people beyond their experience of care and how they currently view the Trust. This should then help us develop a messaging strategy that responds to what we hear.
- **Patient experience groups:** Work closely with patient experience groups (eg: maternity and neonatal voices partnership) to demonstrate how community feedback shapes our services. We should be using the power of these individuals and groups to tell our story in their words. It is important that we recognise and reflect any poor experiences of care and adopt a trauma-informed approach when communicating with any people or their families who have experienced any form of harm or trauma.
- **Outreach:** Rebuild connections and strengthen outreach efforts by connecting Trust colleagues with community members, promoting stories that highlight the positive impact of our services. This includes working closely with VCSE partners to build connections with local community groups such as through the Reach In, Reach Out initiative.
- **Educational partnerships:** Establish closer links with local education providers, creating internship opportunities to engage the next generation of healthcare professionals and benefit from fresh perspectives that can help shape our communications approaches, channels and messages.

This pillar ensures that the Trust remains deeply connected to the communities it serves, maintaining a strong and supportive presence.



Ambition drives us

Alongside our three pillars in our strategy we have set ourselves more ambitious targets to strive for. We have avoided a push for collecting awards as they often involve additional cost and are not always the best measurement metric for success. This does not mean we will not look for opportunities to share best practice through awards, if we feel we have strong metrics demonstrating real outcomes that reflect the core standards set out in the AMEC integrated evaluation framework.

Our broader ambitions are as below, these are designed to foster a sense of personal and team development to help us on our continuous improvement journey as a team.

- Achieving the PRCA Communications Management Standard accreditation
- Demonstrable example of sharing at least one best practice example in communications with wider regional and national peers
- Year-on-year improvement on team performance, demonstrated by industry standard metrics and internal 360 feedback

Crisis communications

Bradford Teaching Hospitals NHS Foundation Trust is a category one responder, as defined under the Civil Contingencies Act 2024. Warning and informing forms is one of our duties as a category one responder. Working with our emergency planning team, we have well-established processes in place to respond to respond quickly to an incident. This includes having media trained spokespeople, pre-written holding statements and an effective link with regional partners through the West Yorkshire Local Resilience Forum (LRF). We continually review our processes and this includes taking part in any Trust or system-wide crisis simulation exercises.



Working with our emergency planning team, we have well-established processes in place to respond to respond quickly to an incident.

Our audiences

Our Trust, and the wider NHS, has many different audiences that it needs to engage and communicate with. The stakeholder list below is not meant to be an exhaustive list instead it helps illustrate the broad range of audiences we need to communicate with and hear from. The below provides a snapshot of these stakeholders, with more detail in appendix A.

- Internal
- Patients, carers and wider public
- Local and regional partners
- Political representatives and committees
- National bodies and regulators/professional bodies
- Media



Our principles

We are committed to being open and transparent in our communications working to agreed governance processes and delivering value for money. Our five main principles that will guide our work are as below.

- We will ensure our information is as accessible as possible, considering barriers such as health literacy.
- We will use insight and be targeted and audience-led in our communications with an expected shift to a more digital-first approach.
- We will be proactive in listening, understanding and acting with a focus on two-way communications internally and externally.
- We will adopt trauma-informed communications and demonstrate cultural sensitivity to deliver inclusive messages (including apologising when we get this wrong).
- We will measure what we deliver, to ensure a cycle of continuous improvement.

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Measurement and evaluation

Effective communications should aim to get people to 'know, think, feel or do' differently as illustrated below.

Know

What does our audience know about the Trust, service or issue?

What

do we want our audience to know about the Trust, service or issue?

Think

What does our audience think about the Trust, service or issue?

What do we want our audience to think about the Trust, service or issue?

Feel

What does our audience feel about the Trust?

What do we want our audience to feel about the Trust?

Do

What are our audience doing now?

What action does the Trust want our audience to take?

Our approach to communications should be outcome focused, deliberately designed to measure our impact. These measures could include perception and sentiment, and at other times they could measure action taken. We will look to avoid any vanity metrics such as impressions and reach for social media.

In 2026-2027 we will introduce a quarterly performance dashboard that will be shared with our executive team.

The below is not an exhaustive list of evaluation measures we will use however it does cover some of the routine metrics used to assess the effectiveness of communications activity.

- Measuring behaviour change for targeted campaigns and projects
- Monitoring engagement rates on social media (note we won't include reach or impressions)
- Open rates and click through for our bulletins including unique page visits to website and intranet
- Attendance at internal and external events
- Media coverage, including sentiment analysis
- Results from any communication audits – internal and/or external stakeholders
- Feedback from communication champions/ambassadors
- National take up of our case studies and stories as well as social content
- 360 feedback of team carried out with senior leaders
- Specific team development goals such as achieving the PRCA accreditation

Risks to delivery

Our communications strategy is ambitious and achievable, however we recognise that there are risks to successful delivery. This includes a changing NHS landscape and the speed of technological change most notably AI, creating further risks around mis-disinformation.

The following is not an exhaustive list of risks, instead focusing on those that have a greater likelihood of materialising.

- Capacity and resource in the team
- Financial challenges facing the NHS further impacting on resourcing
- Moving towards a shared operating model across place-based Trusts within the current available resource at all three Trusts
- Use of AI in wider society versus time and capability to adopt within the NHS
- Impact of changes to the ICB and resourcing capacity in the ICB communications and involvement team
- Impact of setting up place provider partnerships and resource available to support
- Change in political landscape

Realising our ambition: our high level actions to deliver an evolved communications offer

It is important to note that the action plan below does not include the 'brilliant basics' business as usual work we do including proactive and reactive media, updates to our digital channels, support with TV screens and screensavers and producing videos. This high level action plan highlights the changes we are introducing to build on the work we do.

Review date: This communications strategy will be reviewed in 2028, with a revised high level action plan developed as needed based on insight and reflecting any changes to our operating environment and evolving technologies.

Pillar one: organisational awareness and brand positioning

Action	Intended outcome	Link to Trust strategic objectives	Delivered by
Develop a stakeholder database	Help identify key stakeholders, understanding who they are, their level of influence and how to reach them Use the database for proactive and reactive communications	Partnership	March 2027 Reviewed bi-annually
Review our social media channels	Limit use of X to only critical updates especially during times of crisis Increase our approach to storytelling and people-focused content on our channels Enhance our presence on TikTok alongside Instagram and Facebook for consumer content and LinkedIn for corporate content	Quality Improvement People Partnership	April 2026 Review in September 2026 Review in September 2026
Refresh our intranet site	Improved user experience and ease of use of site	Improvement People	April 2027 Any immediate improvements to be completed before this date
Set up a brand centre	Develop an online resource to support colleagues to access tools and guidance to ensure consistent use of our brand	Quality Improvement People	September 2027 Beta site to be ready for testing by June 2027

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Pillar two: our people and our patients

Action	Intended outcome	Link to Trust strategic objectives	Delivered by
Set up a new e-bulletin system for our weekly newsletter	Improved format, easier to access information and ability to evaluate open rates and click throughs	People Sustainability	April 2026 – subject to compatibility with existing IT infrastructure
Work with organisational development, equality diversity and inclusion, spiritual and pastoral care and our charity to develop a calendar of events the Trust will mark	Creating a sense of belonging for colleagues Improved awareness and support for our charity	Quality People	January 2026 template developed
Introduce a monthly news cascade	Opportunity to create two-way communications within our Trust with key corporate updates delivered once and then cascaded with an opportunity for teams to share feedback and ask questions	Quality Improvement People Partnership Sustainability	April 2026 Note this will mean that the CEO weekly video round up will become a monthly news round up Subject to feedback, we could consider a weekly 'Team Brief' live from April 2027 involving members of our exec team providing key updates including time for a Q&A
Revamp Let's Talk	To deliver a balance of corporate updates, human interest stories and wider lifestyle news.	Quality Improvement People Partnership Sustainability	Move to monthly edition from June 2026 Review feedback in January 2027

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Action	Intended outcome	Link to Trust strategic objectives	Delivered by
Set up a communications ambassadors and champions programme	Help us refine our communications approach with real time feedback. Wider colleagues to act as story tellers and internal (and external) influencers	Improvement People	April 2026 - April 2027 to do some initial testing with receptive colleagues with the aim of recruiting 25 people by this point September 2027 – review approach and sign ups
Undertake insight in engaging and reaching non-desk based colleagues	Help us consider solutions to ensure we can effectively communicate and engage with colleagues who are least likely to have access to or use email / electronic communications	Improvement People	April – June 2027, using insights shared by a similar exercise underway at Bradford District Care NHS Foundation Trust Paper, with costed options to ETM for February 2028. Implementation to begin April 2028 – March 2029 (and possibly beyond)
Carry out a communications audit to inform 2028 – 2031 high level plan	Assess effectiveness of communications channels – internally and externally, doing so after some of the refreshed approaches have been bedded in	Improvement Sustainability	April 2028 Note the quarterly dashboard for our team will be used prior to this to inform improvements and shorter insight surveys will be used periodically to test our revised internal comms approach between April and December 2026
Work with OD to assess feasibility of developing an app for colleagues	An additional channel to help support efforts to engage with wider workforce especially those that are non desk-based	Improvement People	Ongoing – subject to feasibility

Pillar three: community engagement and relations

Action	Intended outcome	Link to Trust strategic objectives	Delivered by
Share stories of service improvements from patient, carer and public feedback	Demonstrate that people's feedback is valued, makes a difference and matters to the Trust	Quality Improvement People Partnership	September 2027
Attendance at community events	Ensure Trust is represented at key community events of significance to the people we serve and our stakeholders. As a team we will use this to share opportunities to build relationships and intelligence of our communities to be culturally sensitive and inclusive in the work we do.	People Partnership	Ongoing
Provide a summer internship opportunity for a University of Bradford student	Demonstrates team commitment to social responsibility and our Trust's role as an anchor institution.	People Partnership	Every summer (6 weeks) – subject to available budget
Visit community projects	Improve relationships with the voluntary, community and social enterprise sector and link back to our Reach In, Reach Out programme	Partnership	April 2027 Allows time to diarise events and focus on some of the wider key deliverables outlined in the communications strategy
Develop a quarterly stakeholder update	Improve links with stakeholders and ensure we drive a consistent narrative using existing content and stories.	Improvement Partnership	April 2028 to coincide with delivery of stakeholder database

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Team development

Action	Intended outcome	Link to Trust strategic objectives	Delivered by
Work towards the PRCA Communications Management Standard accreditation	Shared development that reflects team achievement against industry best practice	Improvement People Sustainability	March 2029
Set up quarterly performance dashboard	Provides evidence of effectiveness of our communications with industry standard metrics as well as broader intelligence on issues management.	Improvement	September 2026
Invite a guest speaker (pro bono) to our team meeting to share top tips on topics of interest	Ensures professional development across the team and access to latest trends and thinking	Improvement People	Bi-annual from May 2026

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Appendix A: Our stakeholders

Who they are	How we will reach them
<p>Internal</p> <ul style="list-style-type: none"> • Our board and non-executive directors • Our governors • Our colleagues • Our clinical support units and non-clinical departments including general managers and heads of service 	<ul style="list-style-type: none"> • Weekly colleague e-bulletin • Monthly filmed news round up from chief executive • Monthly Let's Talk colleague magazine • Monthly team brief cascade • Global emails • Screensavers • Posters and TV screens • Intranet • Events • Staff networks
<p>Patients, carers and wider public</p> <ul style="list-style-type: none"> • Patients, carers and their families • Patient groups • Foundation trust members • Consumer champions e.g. Healthwatch Bradford and District 	<ul style="list-style-type: none"> • Media • Social media • Posters and TV screens • Website • Stakeholder updates • Foundation trust newsletter • Colleague communication ambassadors and influencers • Information shared through PALS and patient experience team

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Who they are	How we will reach them
<p>Local and regional partners</p> <ul style="list-style-type: none"> • NHS West Yorkshire Integrated Care Board (ICB) • West Yorkshire Association of Acute Trusts (WYAAT) • NHS England North East and Yorkshire (expected to change to a Department of Health and Social Care regional team in 2027-2028) • Bradford Wellbeing Board • Bradford Council • Academic partners – University of Bradford, Bradford College and Shipley College • Voluntary and community and social enterprise sector including infrastructure organisations and local/hyperlocal community groups • Faith sector • Healthwatch Bradford • Primary care, including primary care networks and community partnerships • Yorkshire Ambulance Service NHS Trust 	<ul style="list-style-type: none"> • Stakeholder update • Briefings and formal/informal meetings • Media • Social media • Website • Visits to Trust

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Who they are	How we will reach them
<p>Political representative and committees</p> <ul style="list-style-type: none"> • Members of Parliament (MPs) • Councillors • Councillors – leader and portfolio holders • Overview and scrutiny committee – chairs and members • Bradford wellbeing board • Local area committees / ward officers • Parish and town councils • Secretary of State for Health and ministers of state and parliamentary secretaries 	<ul style="list-style-type: none"> • Stakeholder update • Briefings and formal/informal meetings • Media • Social media • Website • Visits to Trust • Through formal public involvement processes when service change is proposed
<p>National bodies and regulators/ professional bodies</p> <ul style="list-style-type: none"> • NHS England (to be part of new Department of Health and Social Care in 2027 -2028) • Care Quality Commission (CQC) • UK Health Security Agency (UKHSA) • National Institute for Health and Care Excellence (NICE) • Equality and Human Rights Commission • NHS Race and Health Observatory • Health and Safety Executive • Royal colleges • Trade unions 	<ul style="list-style-type: none"> • Briefings • Visits to Trust • Formal and informal meetings
<p>Media</p> <ul style="list-style-type: none"> • Local newspapers and broadcast • Regional newspapers and broadcast • Trade journals • National media • Information websites (e.g. NHS website) • Community media / websites (e.g. BCB Radio) 	<ul style="list-style-type: none"> • Proactive media relations including press releases and feature stories • Reactive media handling • Social media • Website

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BOARD WORK PLAN 2025/26 & 2026/27

Item	Lead	May 25	Jul 25	Sep 25	Nov 25	29 Jan 26	21 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 Nov 26	28 Jan 27	30 Mar 27	Notes
STRATEGY														
Corporate Strategy / Strategic Framework	Director of Strategy & Transformation	x	x		x		x			x			x	
Mental Health Strategy	Chief Nurse		x				x			x			x	
Green Plan	Director of Estates & Facilities		x			x			x			x		
Communications - Annual Update	Chief Executive			x	x		x			x				
Digital Strategy	CDIO	x			x			x			x			
Improvement Strategy	Director of Strategy & Transformation		x			x	x		x			x		
Patient Experience & Engagement Strategy	Chief Nurse		x			x			x			x		
EDI Strategy	Chief Operating Officer			x	x			x			x			
People Strategy	Director of HR													Date TBC
Strategy - Emerging Issues	All	x	x	x	x	x	x	x	x	x	x	x	x	
QUALITY														
		May-25	Jul-25	Sep-25	Nov-25	29 Jan 26	31 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 Nov 26	28 Jan 27	30 Mar 27	
CQC Reports/Action Plan	Chief Nurse		x		x	x	x	x						Only when there is relevant information to report
Infection Prevention & Control Q4 Report (Annual Report)	Chief Nurse	x						x						
Maternity and Neonatal Services Update	Chief Nurse	x	x	x	x	x	x	x	x	x	x	x	x	
Maternity Incentive Scheme	Chief Nurse					x						x		Every January
Inpatient Survey	Chief Nurse				x						x			
Adults & Children Safeguarding Annual Reports	Chief Nurse		x						x					
Research Activity in the Trust	Chief Medical Officer			x*			x			x*			x	*Presentation from Research Team
PEOPLE														
		May-25	Jul-25	Sep-25	Nov-25	29 Jan 26	31 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 Nov 26	28 Jan 27	30 Mar 27	
Equality, Diversity & Inclusion Update (WRES, WDES)	Chief Operating Officer	x						x						Presentation
Equality & Diversity Council (quarterly reporting - update)	Chief Executive	x		x	x		x	x		x	x		x	
Staff Survey Results	Director of HR	x						x						
Freedom to Speak Up	Chief Nurse	x			x			x			x			
Nursing & Midwifery Staffing Establishment Review	Chief Nurse		x			x			x			x		
Guardian of Safe Working Hours annual report	Chief Medical Officer	x						x						
Medical Appraisal & Revalidation Annual Report & Statement of Compliance	Chief Medical Officer			x						x				
Gender Pay Gap Report	Chief Operating Officer						x						x	
Workforce Report	Director of HR	x	x		x	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						x		Item now included in CEO report
Apprenticeships	Director of HR													Presented to People Academy
Education Annual Report	Chief Medical Officer	x						x						
Education Self Assessment Report (SAR)	Chief Medical Officer			x						x				
FINANCE & PERFORMANCE														
		May-25	Jul-25	Sep-25	Nov-25	29 Jan 26	31 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 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	x	x	x	x	
Performance Report	Chief Operating Officer	x	x	x	x	x	x	x	x	x	x	x	x	
Integrated Dashboard	All	x	x	x	x	x	x	x	x	x	x	x	x	
Operational Plan Submission	Chief Operating Officer / Chief Finance Officer						x						x	Closed Board Feb 2026
Financial Plan	Chief Finance Officer						x						x	Closed Board Feb 2026
Capital Programme	Chief Finance Officer						x						x	
Budget setting process & timetable	Chief Finance Officer				x						x			
Winter Plan	Chief Operating Officer			x	x						x			
Charity ISA 260, Draft Annual Report & Accounts and draft Letter of Representation	Chief Finance Officer					x						x		

BOARD WORK PLAN 2025/26 & 2026/27

Item	Lead	May 25	Jul 25	Sep 25	Nov 25	29 Jan 26	21 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 Nov 26	28 Jan 27	30 Mar 27	Notes
PARTNERSHIPS		May-25	Jul-25	Sep-25	Nov-25	29 Jan 26	31 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 Nov 26	28 Jan 27	30 Mar 27	
Health Inequalities	Director of Strategy & Transformation			x			x			x			x	
Partnerships - strategic view	Director of Strategy & Transformation		x		x		x		x		x		x	
GOVERNANCE / ASSURANCE		May-25	Jul-25	Sep-25	Nov-25	29 Jan 26	31 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 Nov 26	28 Jan 27	30 Mar 27	
Board Assurance Framework	Chief Nurse	x	x		x	x	x	x	x		x	x		
High Level Risk Register	Chief Nurse	x	x	x	x	x	x	x	x	x	x	x	x	
Review of Standing Orders/SFIs/Scheme of Delegation	Chief Finance Officer				x						x			
Constitution - annual review	Chief Operating Officer				x	x		x			x			
Self Certification of Provider Licence	Chief Operating Officer	x						x						
NED Independence Test	Chief Operating Officer	x						x						
Compliance with NHS Code of Governance	Chief Operating Officer	x						x						
Well Led Review & Board Self Assessment	Chief Operating Officer													Date TBC
Annual Report from Academies and Committees	Committee/Academy Chairs	x						x						
Risk Appetite Review	Chief Nurse	x						x						
Annual Fire Safety Report	Director of Estates & Facilities	x						x						
Annual Health & Safety Report	Director of Estates & Facilities	x	x	x					x					
Premises Assurance Model Progress Report	Director of Estates & Facilities				x						x			
Annual Security Report	Director of Estates & Facilities	x		x						x				
Violence Prevention & Reduction Standard	Director of Estates & Facilities	x		x				x		x				Sept - part of Annual Security Report
Data Security & Protection Toolkit	CDIO	x						x						
DPO Annual Report	DPO			x						x				
Emergency Preparedness, Resilience & Response & NHSE Core Standards	Chief Operating Officer			x						x				
Use of the Trust Seal	Chief Operating Officer			x						x				
NED Champion Roles - annual review	Chair	x						x						
Fit and Proper Person Test - annual review	Chair	x						x						
Modern Slavery Statement	Chief Operating Officer				x						x			
COG Engagement Policy	Chief Operating Officer	x	x		x	x		x						
STANDING ITEMS		May-25	Jul-25	Sep-25	Nov-25	29 Jan 26	31 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 Nov 26	28 Jan 27	30 Mar 27	
Patient Story	Chief Nurse		x		x		x		x		x		x	
Getting to know the CSUs	Chief Operating Officer/Chief Medical Officer/Chief Nurse	x		x		x		x		x		x		
Chair's Report	Chair	x	x	x	x	x	x	x	x	x	x	x	x	
Chief Executive's Report	Chief Executive	x	x	x	x	x	x	x	x	x	x	x	x	
Chair's report from Committees	Committee Chairs	x	x	x	x	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

Osbourne-Sheridan
30/03/2025 10:08:30