NHS
Bradford Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC
AGENDA

Date:	Thursday 21 May 2026	**Time:**	09:30 – 13:00
Venue:	Conference Room, Field House, BRI	**Chair:**	Karen Walker, Acting Chair

Attending for specific items only:
- 09:30-10:00 – Graham Prestwich, Lauren Banner and Karen Conway – IOG update
- 10:20-10:30 – Yaseen Muhammad, Director of Infection, Prevention and Control and Alison Haigh, Lead Pharmacist Antimicrobial Therapy - Bo.5.26.9 – Antimicrobial resistance
- 11:00-11:20 - Sara Hollins, Director of Midwifery - Bo.5.26.13 - Maternity and Neonatal Services update
- 11:50-12:00 – Kez Hayat, Head of Equality, Diversity & Inclusion - Bo.5.26.16 - EDI update

Observers:
- Emma Fleary and John Waterhouse, Governors

No.	Agenda Item	Lead	Outcome	Papers attached
09:30 Section 1: Opening matters				
Bo.5.26.1	Apologies for absence	Chair	For information	Verbal
Bo.5.26.2	a. Declarations of interest b. Code of Conduct	Chair	For information	Bo.5.26.2
Bo.5.26.3	Minutes of the meeting held on 31 March 2026	Chair	For approval	Bo.5.26.3
Bo.5.26.4	Matters arising	Chair	For information	Verbal
09:35 Section 2: Business Reports				
Bo.5.26.5	Independent Oversight Group (IOG) Update	IOG Chair	For assurance	Presentation
Bo.5.26.6	Report from the Chair	Chair	For assurance	Bo.5.26.6
Bo.5.26.7	Report from the Chief Executive	Chief Executive	For assurance	Bo.5.26.7
10:15 Section 3: Patient Care				
Bo.5.26.8	Report from the Chair of the Quality Committee a. April & May 2026 b. Infection Prevention & Control Q4 report (annual report)	Chair of the Quality Committee Chief Nurse	For assurance	Bo.5.26.8a Bo.5.26.8b
Bo.5.26.9	Antimicrobial resistance	Chief Medical Officer	For assurance	Presentation
Bo.5.26.10	Baseline report - Self-assessment tool for standards for care of acutely unwell patients in their first 72 hours in hospital	Chief Medical Officer	For assurance	Bo.5.26.10
Bo.5.26.11	CQC well led action plan	Chief Nurse	For approval	Bo.5.26.11
Bo.5.26.12	CQC statement of purpose	Chief Nurse	For approval	Bo.5.26.12
Bo.5.26.13	Maternity and Neonatal services update	Chief Nurse	For assurance	Bo.5.26.13

BREAK 11:20 – 11:30

11:30 Section 4: People				
Bo.5.26.14	Report from the Chair of the People Academy a. April & May 2026 b. Freedom to Speak Up Q4 report c. Guardian of Safe Working Hours Annual Report d. Education Annual Report e. Violence Prevention & Reduction Standard	Chair of the People Academy Chief Nurse / Chief Digital & Information Officer Chief Medical Officer Chief Medical Officer Director of Estates & Facilities	For assurance	Bo.5.26.14° Bo.5.26.14b Bo.5.26.14c Bo.5.26.14d Bo.5.26.14e

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Bo.5.26.15	Equality & Diversity Council quarterly report	Chief Executive	For assurance	Bo.5.26.15
Bo.5.26.16	Equality, Diversity & Inclusion update	Chief Operating Officer	For assurance	Bo.5.26.16

12:00 Section 5: Finance and Performance				
Bo.5.26.17	Report from the Chair of the Finance and Performance Committee a. April & May 2026 b. Integrated Dashboard c. Finance Report d. Performance Report	Chair of the Finance and Performance Committee Executive Directors Chief Finance Officer Chief Operating Officer	For assurance	Bo.5.26.17a Bo.5.26.17b Bo.5.26.17c Bo.5.26.17d

12:15 Section 6: Strategy & Partnerships				
Bo.5.26.18	Strategy – emerging issues	All	For assurance	Verbal

12:20 Section 7: Audit & Assurance				
Bo.5.26.19	Report from the Chair of the Audit Committee – 12 May 2026	Chair of the Audit Committee	For assurance	Bo.5.26.19
Bo.5.26.20	Report from the Chair of the Charitable Funds Committee – 5 May 2026	Chair of the Charitable Funds Committee	For assurance	Bo.5.26.20

12:30 Section 8: Governance				
Bo.5.26.21	Risk Management Strategy (inc. risk appetite statement)	Chief Nurse	For approval	Bo.5.26.21
Bo.5.26.22	Board Assurance Framework & high-level risk register	Chief Nurse	For assurance & approval	Bo.5.26.22
Bo.5.26.23	Cyber Assessment Framework aligned Data Security & Protection Toolkit interim position 2026	Chief Digital & Information Officer	For information	Bo.5.26.23
Bo.5.26.24	Compliance with the Provider Licence (including statement in response to CoS7), Code of Governance, and NED Independence	Associate Director of Corporate Governance/Board Secretary	For assurance/ approval	Bo.5.26.24
Bo.5.26.25	Committee annual reports, terms of reference and work plans	Associate Director of Corporate Governance/Board Secretary	For approval	Bo.5.26.25

12:55 Section 9: Board Meeting Outcomes				
Bo.5.26.27	Any other business	Chair	For information	Verbal
Bo.5.26.28	Issues to refer to Committees or elsewhere	Chair	For approval	Verbal
Bo.5.26.29	Review of meeting	Chair	For information	Verbal
Bo.5.26.30	Date and time of next meeting: • 30 July 2026	Chair	For information	Verbal

Annexes for the meeting of the Board of Directors 21 May 2026

Annex 1: For Information				
Bo.5.26.31	Board of Directors work plan	Associate Director of Corporate Governance/Board Secretary	For information	Bo.5.26.31

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Employee	Role	Date Incurred	Year	Interest Type	Date Ended	Interest Description (Abbreviated)	Provider	Value £'s
Altaf Sadique	Non-Executive Director	01.12.2020	2020/21,2021/	Outside Employment		industrial member	GS1	0
Altaf Sadique	Non-Executive Director	01.06.2021	2021/22,2022/	Outside Employment		ibox healthcare is working with healthcare providers across the UK and global markets to deliver dashboards & data visualisation solutions help optimise patient flow and operational efficiency.Key customers NG	Ibox Healthcare (part of IHG Group ltd)	0
Altaf Sadique	Non-Executive Director	08.12.2021	2021/22,2022/	Loyalty Interests		Full member 6G health institute (EU)_	6G Health for Institute (EU)	0
Altaf Sadique	Non-Executive Director	01.09.2022	2022/23,2023/	Loyalty Interests		Known to myself as a personal friend of long standing	Hanif Malik	0
Altaf Sadique	Non-Executive Director	01.04.2024	2024/25	Loyalty Interests		Charity to help build better emergency healthcare in south east Asia region.My role is advisor to the board on bilateral relations with charitable hospitals in the subcontinent India & Pakistan	HALO Charity	0
Altaf Sadique	Non-Executive Director	01.05.2025	2025/26	Outside Employment		Iboxhealthcare have agreed a commercial partnership with Avanade who could be a potential supplier for BTHFT.	Ibox Healthcare Avanade Partnership	0
Benjamin Roberts	Chief Finance Officer	01.09.2006	2015/16 & befo	Loyalty Interests		Fellow of Charted Institute of Management Accountants	Charted 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 hear 2-3 disciplinary cases per year against CIPFA members. Has been voluntary until 2025; now attracts small payment.	Chartered Institute of Public Finance and Accountancy	0
David Moss	Director of Estates	01.12.2022	2022/23,2023/	Loyalty Interests		Chair of Northern and Yorkshire HEFMA	HEFMA	0
David Moss	Director of Estates	01.12.2022	2022/23,2023/	Loyalty Interests		National Chair of HEFMA	HEFMA	0
Faeem Lal	Director of Human Resources	18.12.2024	2024/25	Shareholdings and other ownership interests		£1	F&R Group limited	0
Faeem 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
Faeem 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 The Scouts Association	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**	**27.02.2026**	**2025/26**	**Hospitality**		**Lunch at the Hilltop Brasserie, Grimsargh, 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	**Medical Director**	**01.01.2023**	**2022/23,2023/**	**Loyalty Interests**		**My half-sister is a consultant orthopaedic surgeon at Sheffield.**	**Sheffield Teaching Hospitals NHSFT**	**0**
Justine Andrew	Non-Executive Director	01.10.2024	2024/25	Outside Employment		Trustee of a charitable arts organisation	York Museums Trust	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	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	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 significnat local and regional cultural organisation	Piece Hall Trust Ltd	0
Zafir Ali	Non-Executive Director	01.11.2016	2016/17,2017/	Outside Employment		Various roles including:Deputy Head of Internal Audit – Department of Health & Social CareHead of Internal audit for the NHS Counter Fraud AuthorityHead of Internal audit for the NHS Health Research Authorit	Government Internal Audit Agency	0

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Our Code of Conduct

Bradford Teaching Hospitals NHS Foundation Trust

BTHFT Inside Out Board Code of Conduct



Bradford Teaching Hospitals
NHS Foundation Trust

UNCONFIRMED - BOARD OF DIRECTORS OPEN MEETING MINUTES

Date:	Tuesday 31 March 2026	**Time:**	09:30 – 12:00
Venue:	Conference Room, Field House, BRI	**Chair:**	Karen Walker, Acting Chair
Present:	**Non-Executive Directors:** - Karen Walker (KW) - Bryan Machin (BM) - Altaf Sadique (AS) - Tim Swift (TS) **Executive Directors:** - Professor Mel Pickup, Chief Executive (MP) - Dr John Bolton, Chief Medical Officer (JB) - Professor Karen Dawber, Chief Nurse (KD) - Mark Hindmarsh, Director of Strategy and Transformation (MHi) - Ben Roberts, Chief Finance Officer (BR)		
In Attendance:	- Faeem Lal, Director of HR (FL) - Vikki Lewis, Chief Digital, and Information Officer (VL) - David Moss, Director of Estates and Facilities (DM) - James Taylor, Deputy Chief Operating Officer (JT) - Laura Parsons, Associate Director of Corporate Governance / Board Secretary (LP) - Razwana Bashir, Renal Matron (RB) *for item Bo.3.26.7 only* - Sara Hollins, Director of Midwifery (SH) *for item Bo.3.26.9 only* - Shak Rafiq, Head of Communications (SR) *for item Bo.3.26.19 only* - Tabitha Lawreniuk, Personal Business Manager as Secretariat		
Observing:	- John Waterhouse, Governor - Fiona Thompson, Governor - Emma Fleary, Governor - Rachel Pyrah, General Manager – CDIO Team - Sarah Smith, Communications Manager - Shak Rafiq, Head of Communications		

No.	Agenda Item	Action
Section 1: Opening Matters		
Bo.3.26.1	**Apologies for Absence** - Zafir Ali (ZA) - Justine Andrew (JA) - Professor Geoff Hall (GH) - Sajid Azeb, Chief Operating Officer (SA)	
Bo.3.26.2	**Declarations of Interest** No additional declarations were raised in relation to the items on the agenda.	

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	Code of Conduct The code of conduct was noted by the Board.	
Bo.3.26.3	**Minutes of the Meeting held on 29 January 2026** The minutes of the meeting held on 29 January 2026 were approved as a true and accurate record.	
Bo.3.26.4	**Matters Arising** The following actions were reviewed, outcomes noted and confirmed as closed: - Bo26001 Report from the People Academy – Workforce Report: A number of changes to be made to documentation presented at Board with clearer objectives outlined within the metrics Action closed.	
Section 2: Business Reports		
Bo.3.26.5	**Report from the Chair** KW gave a brief overview of the Chair's report which was noted by the Board.	
Bo.3.26.6	**Report from the Chief Executive** MP introduced the report which was largely taken as read, highlighting several key updates since publication: - On 26 March 2026, the British Medical Association (BMA) notified the Trust of planned industrial action over six days (the fifteenth round of strikes since 2023). Resident Doctors have received a letter with proposed negotiations in the hope of cancellation. Contingency planning remains underway and MP noted that cancellation of patient appointments will need to commence shortly to allow ample notice and this will likely include activity that may not be reinstated at short notice should negotiations be successful. - The CQC Well-Led report was published on Friday which rates the Trust as 'Good'. - With regards to the requirement to submit a three year plan to NHS England, MP confirmed that the fourth revised plan was submitted on 18 March, and the Trust awaits confirmation that this it reflects an acceptable position. - The Endoscopy Unit had received full Joint Advisory Group (JAG) accreditation following an inspection in February which was a significant achievement. The report was noted by the Board.	
Section 3: Patient Care		
Bo.3.26.7	**Patient Story** KD introduced the patient story regarding a renal dialysis patient, Anthony Harland, who has subsequently become a Trust volunteer. Anthony shared his positive experience on ward 15 at BRI, which had inspired him to return to the	

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	Trust as a volunteer from September 2025, supporting other patients during their admission. RB noted that patients respond well to Anthony and are encouraged by his story. MP highlighted the positive impact of Anthony's contribution, particularly given his ongoing health needs. MP advised that the executive team had met renal colleagues several weeks earlier to discuss the need to consider alternative dialysis models, including home dialysis. RB outlined barriers to home dialysis, including required criteria and home circumstances limiting adaptations. However, the team continued to explore the expansion of home dialysis where circumstances allow. KW thanked RB and colleagues for their work.	
Bo.3.26.8	**Report from the Chair of the Quality Committee: February and March 2026** TS gave an overview of the report from the Quality Committee meetings held in February and March 2026. The report alerted the Board to several key issues: - The histopathology service is currently operating with a 25% reduction in the consultant workforce due to vacancies, which is negatively impacting cancer turnaround times. The Quality Committee has escalated it to the People Academy for further review. - 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 Dashboard across wards, and the planned recruitment of a Falls Improvement Lead. - The Committee was advised of a red-rated assurance visit to the Paediatric wards. 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. The Committee was assured by the actions being taken. BM noted that a histopathology deep dive was received at the Finance and Performance Committee, including challenges associated with the joint venture, further detail of which was included in the Finance and Performance Committee Chairs Report. The Board noted the report and the assurance provided. **Improvement Strategy Update:** MHi gave a brief overview of the Improvement Strategy report which detailed a summary of action taken to date around implementation of the Strategy. The Board noted the update. **Mental Health Strategy Update:** KD noted that the mental health strategy is a Bradford-wide strategy and not Trust specific. It was agreed therefore that this should be removed from the Board update as a separate item and covered more widely in the annual safeguarding update.	**Bo26002 Associate Director of Corporate Governance**

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	Research Activity in the Trust: JB gave an overview of the research activity in the Trust. AS and VL noted that an update on this was provided by Michael McCooe, Deputy Director of Research at the Quality Committee who welcomed the opportunities highlighted during this meeting. MP also referenced a successful 'industry' day held on 25 March 2026 to mark the one year anniversary of the opening of the Commercial Research Delivery Centre (CRDC). The update was noted by the Board.	
Bo.3.26.9	**Maternity and Neonatal services update** SH joined the meeting to present the update which sought to assure the Board that a monthly review of maternity and neonatal quality and safety activity relating to January and February 2026, was presented to the Quality Committee. Key elements discussed included: - Regarding the national maternity and neonatal review, 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. The Trust has responded to all data requests and is yet to receive any further organisational specific feedback. - Following the publication of a Prevention of Future Deaths Report, the service was asked by the National Chief Midwifery Officer to review its home birth service provision. This was undertaken and presented to the Quality Committee in February who 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. - 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%. KD referred to the two new high level maternity risks relating to personalised care plans and maternal antibody testing. The former is linked to the lack of a digital solution after two unsuccessful procurements, and the service is considering mitigations in place to address this including the use of paper documentation that can be taken between providers. The latter is being addressed through system and process improvements, with an update due to be provided to the Executive Team Meeting on 13 April 2026. SH also updated on the red-rated assurance visit to the Paediatric wards, acknowledging that several issues were raised that were not acceptable, but there was good feedback from parents who did not identify any safety concerns. Some immediate actions were put in place and resolved such as storage of medicine, with assurance received via daily spot checks to ensure standards upheld. The service is working to a quality summit at the end of April and is reviewing underlying causes for the deterioration in standards. SH recognised that new leadership is now in place and it is hoped that this will result in significant changes made at pace. The Board was assured by the update.	

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No.	Agenda Item	Action
Bo.1.26.9	**CQC Well Led Inspection Report** KD advised that notification was received approximately two weeks earlier that the well-led factual accuracy check had been accepted and noted by CQC, resulting in a 'Good' rating with areas for continued improvement already known to the Board and being addressed. KD also noted publication of a well-led inspection report from April 2024. Significant discussion took place between the Trust and CQC, as the report had been completed under a new framework which was subsequently withdrawn. Due to the delay, a second inspection took place, resulting in two publications being issued at the same time. An action plan will be developed and aligned with the Board action plan. An overview will be presented at the May meeting to evidence progress to the CQC. As the Trust is not in regulatory breach, a formal action plan is not required. KD noted the result was positive and reflects strong achievement, while recognising further improvement is required. The Board noted the update.	
Section 4: People		
Bo.3.26.11	**Report from the Chair of the People Academy: February and March 2026** TS gave an overview of the reports from the People Academy meetings held in February and March 2026, which were largely taken as read. TS alerted the Board that Trust sickness absence remains high. 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. FL referred to activities in place to address the high levels of sickness absence, including a workshop being held on 1 April 2026. He would bring back an action plan to the next People Academy meeting in April 2026. MP referred to a deep dive around discrimination data within the staff survey which was presented at ETM on 30 March 2026. It was agreed to engage with Professor Habib Naqvi from the Race Health Observatory, with an initial proposed date for him to visit the Trust on 28 May. MP invited all Board members to attend the session if they so wished to do so. **Gender Pay Gap Review 2025/26:** FL noted the report which informs of a 22.2% mean average gender pay gap (including a very slight increase this year of just 0.1%). 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 several key areas. The Board noted the update. The Board noted the report and the assurance provided.	

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No.	Agenda Item	Action
Section 5: Finance and Performance		
Bo.3.26.12	**Report from the Chair of the Finance and Performance Committee: February and March 2026** BM gave an overview of the reports from the Finance and Performance Committee meetings held in February and March 2026. There were several issues to alert to the Board: - There were challenges around the financial position which would be covered in detail further in the agenda. - The Committee was advised that underpinning operations of the joint venture 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 - KPI performance exceptions were received and noted by the Committee. - 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. The Board was noted by the update. **Integrated Dashboard:** The Board received the report and noted the assurance provided. **Finance Report:** BR advised of a current capital risk due to over-commitment; work is underway to resolve this before year end. BR expects greater clarity next week and believes the Trust remains on track to deliver agreed financial performance. BR thanked teams for their work. The Board received the report and noted the assurance provided. **Performance Report:** The Board received the report and noted the assurance provided.	
Section 6: Strategy & Partnerships		
Bo.3.26.13	**Strategy – emerging issues** MHi informed the Board that the Trust continues to actively work with partners around the developing of Integrated Neighbourhood Health across the system. There will be a future discussion at the Board around the future of Bradford District and Craven place arrangements from April onwards, including the establishment of the Place Provider Partnership and appropriate governance arrangements. The Board noted the update provided.	
Bo.3.26.14	**Health Inequalities** MHi presented the paper which provides an update on the Trust's Health Equity approach as at March 2026 across several key areas including the Health Equity and Health Inequalities Programme, the use of data to improve equity of	

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	access to care, Health Equity Work Plan progress update, and the Health Inequalities Statement 2025/26. KD welcomed the data and advised that future reporting should include greater analysis of the drivers behind the data and its implications. JB agreed, noting the data provides insight into patient cohorts rather than solely performance. MHi would ensure additional detail would be included in future reports. The Board noted the update.	**Bo26003 Director of Strategy and Transformation**
Bo.3.26.15	**Strategic Framework** MHi presented the paper which provided the Board with an update on progress towards the strategic objective metrics as at end-September 2026, noting minimal change. The paper also updated on next steps for the framework for 2026/27, with priority programmes and metrics to be shared with Committees during May 2026 and then brought to the Board for approval. The Board noted the update.	
Section 7: Audit and Assurance		
Bo.3.26.16	**Report from the Chair of the Audit Committee – 10 February 2026** BM presented the report from the Audit Committee meeting held on 10 February 2026, noting that the Committee sought to alert the Board to the Internal Audit report on Falls which has been highlighted through several previous reports. The Committee also wished to alert the Board to 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 Board noted the report and the assurance provided.	
Bo.3.26.17	**Report from the Chair of the Charitable Funds Committee – 3 February 2026** AS presented the report from the Chair of the Charitable Funds Committee meeting held on 3 February 2026, informing the Board that total operational costs for the year are expected to be around £603,000 and independence costs are expected to increase, so there is a need to be mindful of this. AS also updated the Board on positive progress with the fundraising for the Neonatal Home from Home build. The Board noted the report and the assurance provided.	
Section 8: Governance		

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No.	Agenda Item	Action
Bo.3.26.18	**Board Assurance Framework & High-level risk register** KD introduced the paper which provided 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). In relation to the BAF, LP noted that there had been one change in score to report to the Board since the Q2 2025/26 report following discussion by the Finance and Performance Committee, and subsequent review by the Executive Team meeting. The Q3 Risk score for BAF risk 14 has been reduced to 9 from 12 and the target risk score from 9 to 6. Key changes to the high-level risk register included: - One risk beyond its review date and target mitigation date (2612), although this has subsequently been reviewed. - Three new risks (2766, 40 and 2868) with completed risk assessments. - Two risks have reduced in score (2758 and 2677). The Board confirmed assurance 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.	
Bo.3.26.19	**Communications Strategy** SR presented the updated communications strategy for 2026-2031, noting that this includes a refresh of internal communications including re-introduction of a monthly team brief led by the Executive team, and changes to the 'Let's Talk' newsletter frequency and a move to a monthly video round up. The strategy also detailed plans to engage more with stakeholders and partners. SR made reference to the development of a quarterly dashboard for communications to measure the impact of changes. BM requested a one-page summary for staff outlining key communication frequency changes; SR confirmed this exists and will be refreshed prior to publication. BM also asked how communications will reach non-computer-based staff; SR confirmed this is a priority. MP advised the Trust is exploring an app-based internal engagement solution to support this. AS noted the communications challenges associated with workforce reductions, requiring trust and transparency in messaging, and asked how the Trust will ensure the approach supports this. SR advised close working with HR and OD colleagues is required to ensure effective engagement and acceptance of key messages, including use of bottom-up communications where appropriate. KW requested that the term "responsive" be replaced with a more positive planned-approach descriptor such as "dynamic". The Board approved the Communications Strategy and associated next steps.	

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No.	Agenda Item	Action
Section 9: Board Meeting Outcomes		
Bo.3.26.20	**Any Other Business** No other business was discussed.	
Bo.3.26.21	**Issues to Refer to Board Committees/Academies or Elsewhere** There were no issues to refer elsewhere.	
Bo.3.26.22	**Review of Meeting** There were no comments in relation to review of the meeting.	
Bo.3.26.23	**Date and Time of Next Meeting** • 21 May 2026 – 9.30am	

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ACTIONS FROM BOARD OF DIRECTORS OPEN MEETING – 31 March 2026

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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	Included in the report. Action closed.
Bo26002	Bo.3.26.8	**Report from the Chair of the Quality Committee: Mental Health Strategy Update:** It was agreed that this should be removed from the work plan as a separate agenda item and instead included as part of the annual safeguarding update to the Board.	Associate Director of Corporate Governance	May 2026	Work plan updated. Action closed.
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	July 2026	The Strategic Partnering Agreement is currently being reviewed and updated in light of the Place Provider Partnership arrangements.
Bo26003	Bo.3.26.14	**Health Inequalities:** Future reporting should include greater analysis of the drivers behind the data and its implications.	Director of Strategy and Transformation	September 2026	

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Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors				
Meeting Date:	31 March 2026		**Agenda Reference:**	Bo.5.26.6
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 ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	This report provides an update to the Board on key items since the previous Chair Report provided in January 2026. The report covers: 1. Outcome of Employment Tribunal 2. Council of Governors 3. Strategic Advisory Forum: Digital and Innovation 4. 15 Steps Challenge 2026/2027 5. 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			

Osbourne Sheridan
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Report from the Acting Chair

1. Outcome of Employment Tribunal

I am providing an update on the outcome of the employment tribunal, against the Trust by our former chair, that started on Thursday 16 April. The tribunal reached a judgment on Tuesday 5 May and found in favour of the Respondent (Bradford Teaching Hospitals NHS Foundation Trust). Attached at Appendix 1 is a copy of the Summary Reasons Judgment.

2. Our Council of Governors

Key item referenced at the Council of Governors meeting in April: NHS Providers have shared a series of resources that I have drawn to the attention of our Council of Governors at their meeting on 15 April. These have been prepared in response to the government's intention to remove the requirement (from forthcoming health legislation) to have Councils of Governors. I urge all Governors to read the report published by NHS Providers, available here: Navigating uncertainty around Councils of Governors. This report focuses on how foundation trusts can sustain Councils of Governors with a focus on compliance, cost-effectiveness and sustaining morale.

Some key points from the report are included below:

- On 3 July 2025 the government published a 10-year health plan for England (10YHP). Page 81 said the following: "**We will remove the requirement for FTs to have governors**. While governors have provided helpful advice and oversight for some FTs, we expect the next generation of NHS FTs to put in place more dynamic arrangements to take account of patient, staff and stakeholder insight. This should include systematic measures of patient reported experiences and outcomes, as we detail in chapter 6."
- This unexpected announcement created understandable disquiet among governors and those who work with them. Since July, it has become clear that the legislation required to implement this proposal is being developed to a timetable that will allow it to become law by 1 April 2027.
- There has been no further information made available to Foundation Trusts (FTs) or to governors themselves following the announcement. This is in part because the change is dependent on passing legislation, which is not a certainty, and timescales cannot be guaranteed.
- If the forthcoming health Bill is passed, the statutory powers of governors will be removed, and all references to governors will be deleted from statute. The powers and functions of councils of governors will either be transferred elsewhere (most likely to DHSC / NHS regional teams) or deleted entirely.
- Councils of governors retain their legal functions and powers until the new law comes into force, and so routine activities such as elections, council meetings, inductions for new governors, essential governor training, and communications between the council and board should continue.

I have also encouraged Governors to read the following additional supporting documents, also published by NHS Providers:

Beyond Councils of Governors: rethinking public accountability (briefing)

Event insights: Beyond councils of governors - rethinking public accountability (insights, slides and recording from NHS Providers' peer learning event)

At our Board meeting in July (and our July Council of Governors meeting), we will have the opportunity to reflect on how our Trust will move forward and consider some proposals regarding how we respond to this development.

Catherine Sheridan
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I thought I would also share with you a letter (at Appendix 2) from NHS England providing clarification on the role of governors in light of the proposals set out in the 10 year Health Plan to remove the requirement for NHS Foundation Trusts to have Councils of Governors.

Key Council of Governor appointments: Mark Chambers has been reappointed as Lead Governor and Helen Rushworth, Partner Governor Healthwatch has been appointed to the Governors Nominations and Remuneration Committee.

Feedback to the Council following Board of Directors meetings: I held my second feedback session with the Council on 2 April 4pm to 5pm where I shared key items from the recent Board meeting held on 31 March 2026.

Our new Governors: I am pleased to advise that following the recent elections the pre-appointment checks for Daniel Balaz and Zulfiqar Hussain have now been completed. They will undertake their induction in June. Daniel is our new Governor representing Shipley and Zulfiqar is our new Patient Governor (out of Bradford). You will have the opportunity to meet both at our next Council of Governors meeting.

Meetings of the Council: The next meeting of the Council is scheduled for Wednesday 1 July 2026 (3.30pm to 5.30pm).

3. Strategic Advisory Forum: Digital and Innovation

Our third 'Strategic Advisory Forum' covering 'Digital and innovation' took place on Thursday 7 May. As with the two previous forums it was a resounding success. I would like to personally thank Mark Hindmarsh, Director of Strategy and Transformation for his role in pulling this together and my thanks to other Trust staff for their key roles in presenting and facilitating key conversations in this area.

- Vikki Lewis, Chief Digital and Information Officer
- Prof Tom Lawton, Consultant Anaesthetist
- Dr Michael McCooe, Deputy Director BIHR & Consultant Anaesthetist
- Faye Alexander, Head of Education
- Ben McKay, Education Manager
- Shaheen Kauser, Health Equity Project Manager
- Tracy Watson, Director of Research

The write up from the session along with the presentations will be shared shortly. The agenda for the session focussed on:

- Digital update (current priorities)
- Bradford Institute for Health Research (BIHR)
- Innovation showcase and demonstration of clinical training delivered via virtual reality Anatomage table
- An introduction to the Card Medic app
- A visit to BIHR Mobile Research Vehicle

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 February, this was an extremely engaging and interactive session. Mark is now co-ordinating our fourth forum, scheduled for Thursday 3 September. This will cover the Voluntary Sector and Communities. Further details will be published nearer the time. I would like to continue to encourage Board members to attend where their diaries permit.

Sharon Sheridan
29/04/2026 08:22:12

4. 15 Steps Challenge 2026/2027

The schedule for these visits has been circulated to all Board members and Governors. The ask is for each individual to commit to at least one visit per year in support of the programme. Thank you to those of you who have signed up to support the programme. If you have not yet done so please do provide your availability. The team is also aware that commitments will change over time and so will regularly circulate the schedule to pick up on any changes.

5. Key communications

Key communications 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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EMPLOYMENT TRIBUNALS

Claimant: **Dr M Mclean**

Respondent: **Bradford Teaching Hospitals NHS Foundation Trust**

Heard at: **Leeds**

On: **15-17, 20-24, 27-30 April, 1 May (deliberations only) and 5 May 2026**

Before: **Employment Judge Maidment**
Members: **Ms K Grace**
Mr DW Eales

Representation
Claimant: **In person**
Respondent: **Mr R Stubbs, Counsel**

JUDGMENT having been sent to the parties on 7 May 2026 (and reasons having been requested by the respondent) summary reasons are provided as set out below:

SUMMARY REASONS

1. The claimant's complaints are all of whistleblowing detriment. The first question for the tribunal is then whether the claimant made a protected qualifying disclosure.

2. The first in time, and the most significant, the claimant would accept, of those relied upon is that he told the respondent, that it had failed to investigate 3 neonatal serious incidents ("SIs) within a reasonable timescale despite a national timeframe requirement set out in the national NHS

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England SI Framework. He did this initially through his emails of 11 November and 27 November 2022 to the respondent's CEO

3. It might be thought that it is difficult for an NHS employee to raise issues of neonatal deaths and injuries to newborn babies and yet not be regarded as being a whistle-blower. Indeed, it probably is. The claimant certainly provided information critical of the handling of neonatal SIs. Did he however do so in the reasonable belief that the information disclosed, tended to show a breach of a legal obligation or health and safety?

4. As relevant to his subjective belief, the claimant had never been employed within the NHS and the tribunal has not been told of him having any medical or clinical knowledge or experience. On the other hand, he was the most senior person within the respondent, privy to reports made to the board by various academies, including the one tasked with ensuring quality and patient safety. He had the ability to obtain whatever information he wished to see, to require executives and clinicians to provide reports and to have direct access to all relevant people if he had any queries or concerns. He was tasked with the responsibility of overseeing the respondent's activities, including in terms of their contracts with commissioning bodies and their compliance with the license granted by NHSE, without which the respondent was unable to provide patient services. In a sense, when he raised concerns with his CEO, he was raising them with his subordinate, the person who reported to him. In terms of whistleblowing, he was in an unusual position.

5. Whilst the disclosure itself focused on investigation timescales, this was in the context that the claimant was asserting a wider failure to deal with neonatal SIs, the respondent failing its patients and their families.

6. The claimant was privy to numerous and extensive reports from the first occurrence of the neo-natal incidents in April 2021. The evidence, however, suggests a reluctance of the claimant to rely on what he is told or recognise a piece of information at all if it does not fit with his own narrative.

7. The claimant was notified, as chair, of the serious incidents on 28 April 2021 and, at an early stage, that, at the end of the internal investigation process, the incident reports would be submitted for an external independent review. As he had been told, by May 2021, rapid clinical reviews had taken place with early learning put in place. The quality academy had been assured of the appropriateness of the response to the incidents. The regulation and assurance committee, which the claimant himself chaired, had been taken

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through a maternity services update – an update which was provided on a monthly basis and to the board every 2 months. The claimant, as chair of the regulation and assurance committee, reported to the board that assurances had been provided and that immediate lessons had been learnt and shared. His committee was informed in July 2021 that additional staffing had been brought into the neonatal unit and that a deep dive and thematic review was being undertaken. This was produced to the quality academy in July 2021 which reported it to the board.

8. Detailed reporting continued through the academies and at board meetings. The claimant was kept updated on the progress of the investigations, receiving them in early 2022 before then receiving the external review report from Liverpool Women's Trust which commended the respondent on the standard of the reports and the learning taken from them.

9. The claimant may reasonably have been unaware as to the exact regime applying in terms of any applicable timescale. Saying that, he had been told that the investigations were being conducted in accordance with the new PSIRF methodologies. The significance of that may not have been fully obvious to him, but he raised no enquiries. He had not been specifically told that, during Covid, the 60 day timescale in the SI framework, whilst never absolute, had been suspended. However, the evidence is not that the claimant was concerned about progress against any particular timescale.

10. Clearly, he had not raised any query or concern in respect of the speed of the production of reports by 28 September 2021 as he asked Prof Dawber by email that day how they were performing in recent times with reference to timescales saying that he genuinely did not know and hadn't enquired of anyone else. He said: "I imagine sticking to timescale targets may have been tough in recent times." The tribunal does not accept that this was a straightforward general enquiry and that he had separately raised issues of concern regarding the progress of the April SI investigations.

11. When there was correspondence with the claimant about outstanding SI reports in January 2022, the claimant responded to Ms Tomlin of the quality team: "Absolutely no time pressures from me on this." Prof Pickup informed the claimant in February 2022 that she had agreed with Dr Smith that incident reports had to be produced much quicker in the future. It was clear to him then that she was aware of the need for timeliness and was proactively managing the issue. The claimant responded thanking her for the email.

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12. When the claimant was interviewed by Ms King in March 2023, he said to her that "timescale was not such an important issue". The words recorded are clear – he was not simply recognising here a balance between the need for speed and the risk of rushing an investigation.

13. After the report of Liverpool Women's Trust in June 2022, the claimant raised no issues in respect of the April 2021 SIs until his email to Prof Pickup of 11 November 2022. As relevant also to the question of whether the claimant reasonably believed the disclosure to be in the public interest, had the claimant held a belief that the delays in the conclusion of the SI investigations tended to show a breach of a legal obligation or a health and safety risk, this would have been raised by him sooner. When all the learning had, to his knowledge, been implemented, the assertion that the reports should have been completed more quickly does not sound as one where the claimant had in mind a breach of legal obligation or risk to health and safety.

14. The claimant clearly sees himself as a "hands-on" chair, diligently scrutinising the actions of the executive in order to ensure the best possible and safest service is provided to the community in Bradford. If he had concerns, he ought reasonably have taken steps to understand what had happened even by just refamiliarising himself with all the reports he had already received and effectively approved. The tribunal struggled to understand what Prof Pickup was being criticised for by the claimant and can only discern from him that he believed she ought to have managed the process more closely and held the clinicians involved and the people to whom they reported, to account for not ensuring that the process was concluded more quickly. Dr Smith said, at the meeting of the members of the board on 2 October 2022, that if anyone ought to be being criticised he, as chief medical officer and one of the executives on the quality academy, should have been more in the firing line. The timing and the way in which the concerns were first raised is not suggestive of a reasonable belief on the claimant's part that there had been or was likely to be any breach of a legal obligation or health and safety.

15. The tribunal indeed rejects further that the claimant at the time of his disclosures reasonably believed them to be made in the public interest. Without an understanding of the full context, it might appear a surprising conclusion that a chair of an NHS trust raising issues of delay in the investigation of serious incidents in neonatal did not have a public interest motivation for his disclosure. The tribunal fully appreciates that a person making a protected disclosure may have mixed motives, some of them

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highly personal, yet still be making the disclosure in the reasonable belief that it is in the public interest.

16. In this case, however, the delay in the disclosure and the lack of prior reference to his concerns to Prof Pickup or others is indicative of a lack of belief of a need to protect the public. Of course, the claimant was party to discussions of the neonatal SIs and did, at times, ask questions and seek information. The evidence is, however, of him being satisfied that the incidents had been appropriately dealt with and that there was no ongoing vulnerability within neonatal services which might be a risk to patients.

17. The claimant's raising of concerns to Prof Pickup on 11 November 2022 came out of nowhere, certainly in terms of him having any genuine public interest concerns. It is inexplicable, in its tone and timing, without the claimant having undergone some form of metamorphosis or some "lightbulb moment" or him reacting to a perceived and unwelcome challenge, as is the respondent's case. There is no evidence of the claimant having just discovered something or of some other form of "lightbulb" moment. The tribunal can only conclude that indeed the claimant raised the concerns because of an element of pushback from the respondent's senior executives when the claimant, amongst other things, was seeking a more granular level of oversight which would create a substantial amount of additional work for executives with little perceived benefit and in the context of the claimant adopting, indeed on his own perception, a more dictatorial approach. The claimant appeared to be in danger of blurring the lines between the role of a non-executive and executive officer of the respondent.

18. Up until the point of this email, the claimant was taking Prof Pickup through a routine appraisal where achievements against objectives and the setting of new objectives had been under consideration, but without any hint that the claimant was dissatisfied with her performance. Previous appraisals of Prof Pickup had been very good and there had been no discernible change in her performance up to the point of the 11 November email. The claimant himself recognises that, of all the 9 issues he ultimately raised, 2 of them, including the issue of the neonatal SIs, were most important. The inclusion of many of the issues, as will be explained, is representative of the claimant looking for things to criticise Prof Pickup for. It was very much an exercise of him "scraping the barrel".

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19. Had there been considerations of public interest in the claimant's mind, the confinement of his raising of these issues to a private internal appraisal of the CEO is surprising. If he was whistleblowing, he was whistleblowing to the person he considered was knowingly acting improperly. He did not turn

his mind to the respondent's Freedom to Speak Up Policy or the involvement of the respondent's own board or the Council of Governors or NHS England ("NHSE") as the ultimate regulator. To adopt, by way of illustration, some of the more emotive language featuring at times in this case, would a trust chair who considered that the respondent hospital was causing babies to die and that the public needed protecting, sit on that knowledge for months (or certainly, putting the claimant's case at its highest, raise issues only in passing) and then only raise the concerns as individual performance criticisms in a private appraisal process?

20. The claimant's subsequent widening of the scope of his disclosures was prompted in fact by Prof Pickup seeking to involve another, Ms Lawreniuk, as senior independent director. The claimant did not in reality see himself contemporaneously as making protected disclosures.

21. The clamant added the final 3 issues of concern only after Prof Pickup's entirely understandable and justified upset at the first 6 issues being raised in the way they had been and in circumstances where, had they been real and substantive concerns, they could and would so easily have been included from the outset.

22. The claimant did, in January 2023, escalate the concerns to NHSE, but for the purpose of procuring their intervention on his side in a personal battle he had commenced with Prof Pickup and because she had provided information which tended to demonstrate the lack of foundation of many of the concerns he raised.

23. When the issues were raised to Ms King, as part of her independent investigation, the purpose was to persuade her to find that Prof Pickup was guilty of serious misconduct. The further raising of the issues to NHSE in September 2023 represented a further escalation, and, indeed with an element of exaggeration and sensationalism, to seek to pressurise them to achieve his aim which, by then, the tribunal must conclude was the removal of Prof Pickup as chief executive.

24. The aforementioned findings are relevant to all nine issues which the claimant raised.

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25. The suggestion that Prof Pickup ignored a real and credible threat of suicide was a misrepresentation of a situation in which the claimant and Prof Pickup had been involved in May 2022. The claimant cannot have reasonably believed that he was disclosing that Prof Pickup had ignored an extant risk

of an employee suicide. The correspondence from the trade union representative cannot have reasonably been read that way. The claimant had in this matter been quickly reassured that the respondent was dealing with it and it was not something he raised with Prof Pickup at the time. Again, the raising of this concern on 11 November 2022 comes from nowhere. It is, on the evidence, likely that the claimant had just been reminded of the matter at the recent board meeting and sought to retrospectively turn it into a matter of concern which he did not have at the time. The concern was raised to construct a case of poor performance against Prof Pickup, with no consideration of public interest and no reasonable belief of a breach of legal obligation or failure to address a health and safety risk. The claimant did further seek to exaggerate the situation in his January disclosure to NHSE. The tribunal struggles to categorise this incident as anything other than a quite common HR issue which the respondent was seeking to handle appropriately.

26. Similar considerations apply to the next issue of a failure to treat an employee's complaint of discrimination with adequate care and attention. The claimant became involved in the matter because of correspondence directly to him. He discussed it with the respondent's HR director and was satisfied at the time as to how the matter had been dealt with. The claimant raised nothing with Prof Pickup about her involvement from May until 11 November 2022. There was no reasonable belief of any wrongdoing, nor that he was raising a matter in the public interest.

27. The claimant raised as a concern Prof Pickup's disruptive blocking behaviour regarding the provision of information to NEDs. The claimant has not assisted the tribunal in seeking to identify a breach of legal obligation in his mind, though it assumes that he is seeking to rely on some form of breach of governance or the respondent's constitution or the board's statutory responsibilities. The claimant accepted that Prof Pickup was entitled to reach a conclusion that a particular presentation would be too technical and not useful to non-executive directors ("NEDs"). There was a request that the COO be excused from a briefing to NEDs due to operational pressures arising out of the Covid pandemic, but the briefing did in fact take place as the claimant requested. A NED was appointed to the patient safety group, Prof Pickup acceding to the claimant's request. The claimant could not reasonably have regarded such routine matters as amounting to a breach of any legal obligation (or concealment of such breach) and, again, they were not raised in the reasonable belief that the disclosure was in the public interest.

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28. The claimant's next concern about Prof Pickup's failure to attend or arrange for an executive colleague to attend a new staff induction exposes in the claimant a level of pettiness and desperation in his desire for Prof Pickup to be found to be guilty of poor performance.

29. The raising of concerns about Prof pickup's failure to attend meetings was generalised and in circumstances where Prof Pickup had good reason for missing all the meetings which she effectively detailed herself, where she had sought permission and where it was granted – the claimant understanding the conflicting demands on her presence.

30. The concern about Prof Pickup's refusal to support or produce a health inequalities strategy was baseless, as the claimant knew. He had been satisfied in April 2022 when Prof Pickup explained the health inequalities strategy. He knew that health inequalities were part of the remit of the Equality and Diversity Council which Prof Pickup had set up. This was part of Prof Pickup's appraisal objectives which she had been found to have met in November 2021. A report had been made on health inequalities as recently as the board meeting on 10 November 2022.

31. There was no reasonable belief of any wrongdoing and no belief that this matter was being raised in the public interest.

32. The claimant then raised that the respondent was taking over a year to respond to a written instruction from NHSE to analyse waiting lists by ethnicity and deprivation. In fact, the claimant accepted before Ms King that this was not an instruction. Further, he knew that the respondent was seeking to provide a breakdown by reference to learning disabilities first. A report had then been provided in July 2022 which the claimant was clearly satisfied with at the time. The claimant has not assisted in explaining where a breach of legal obligation might arise and the tribunal must conclude that he did not have a belief that he was disclosing any wrongdoing or in the public interest.

33. The claimant's final concern was of Prof Pickup failing to inform him regarding incidents of violence against accident and emergency staff leading to the claimant only learning of this when notified by a local newspaper article.

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34. This did relate to a single incident in December 2021. The claimant in fact knew at the time he learnt of the incident that Prof Pickup herself had been unaware of the particular incident. There was no concealement. Prof

Pickup gave him information about the incident as soon she became aware of it. The claimant subsequently referred to an incident where a patient had escaped onto the hospital roof in August 2022, necessitating the calling of the emergency services. The claimant asked that he be kept appraised of such incidents and Prof Pickup confirmed that she would take steps to do so, whilst warning the claimant that incidents of this type were not infrequent.

35. The claimant had no public interest in mind in raising this issue and re-raising it through and after the process of investigation. He had no reasonable belief that this tended to show any wrongdoing.

36. On the tribunal's conclusions the claimant did not make protected disclosures and therefore cannot have suffered any detriment because of any such disclosures.

37. The tribunal has obviously, nevertheless, heard extensive evidence regarding the detriments which the claimant says he suffered. Indeed, a quick answer to this case is found on the question of causation.

38. The claimant was treated to his detriment in him being asked to resign, including in circumstances where the alternative option was the instigation of a formal process which might have led to the respondent removing him as chair. The claimant did resign. There was no decision to accept that resignation in the sense that resignation is a unilateral act and the respondent had no effective choice in the matter. Certainly, however, the respondent received the resignation as an effective resolution and as ending the claimant's relationship with the respondent.

39. There had been, by 3 October 2023, a fundamental breakdown in relationships between the claimant as chair and Prof Pickup as the respondent's CEO. This was a pivotal relationship in the functioning of the respondent and a situation had developed where the claimant and Prof Pickup were only communicating with each other in formal meetings and at set piece events. This was a situation beyond merely unhealthy - it was the conclusion of the board (with the exclusion of the claimant and Prof Pickup from any decision-making), that the situation could not be allowed to continue.

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40. The concerns raised by the claimant on 11 November 2022 were the genesis of the breakdown in relationships. They formed part of the relevant

background to the respondent's decision to ask the claimant to resign. They were not, however, the reason why he was asked to resign.

41. On the tribunal's findings, responsibility for the breakdown in relationships lay primarily with the claimant. He raised concerns about largely historic matters with which he had had no concern at the time. He misrepresented and exaggerated those concerns. He raised them in a tone and manner which was unjustified. The respondent's policy on appraisals suggests that criticisms during an appraisal process ought not to come as a surprise to the appraisee. In this case they came out of nowhere as a complete shock to Prof Pickup and reasonably so. A chief executive receiving a communication in the terms of the claimant's 11 November 2022 email would be likely to conclude that trust and confidence in them had been lost and that they were heading towards a process which would result in the termination of their employment. There is generally no way back from such a communication to someone at Prof Pickup's level.

42. From the multitude of evidence which has been presented to the tribunal, it still has not identified any misconduct or lack of personal performance on Prof Pickup's part. The claimant himself has struggled to articulate any.

43. However, the board was presented with a report where both Prof Pickup and the claimant had been found to have fallen short of the standards to be expected of them, albeit not to any serious extent which would involve, for example, a breach of the Nolan principles or which might lead to any process to remove either of them from their positions. The claimant was (and remains) blind to any findings about his own behaviour. Rather than straightforwardly accepting the report, he lobbied for action to be taken, undoubtedly hoping that Prof Pickup would be removed.

44. Whilst the claimant, during the investigation, had made some comments suggestive of a potential willingness to mediate, such comments were significantly caveated. He saw Ms King's report as a vindication of his own position that he had raised serious concerns and that Prof Pickup ought to be taken to task for them, rather than as an opportunity for peace and reconciliation.

45. Without any thought or regard to such issues, however, the board determined to accept the report and the key recommendation that the respondent should seek to resolve the issues through a mediation between the claimant and Prof Pickup. Whilst Ms King had referred to the possibility of another form of conversation if mediation was not possible, her

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recommendation was for mediation and it is difficult to conceive of her suggestion that the parties might have an opportunity to say how they felt to each other as anything other than a form of or precursor to a mediation.

46. The respondent determined to ascertain the claimant's and Prof Pickup's view on their participation in a mediation. Ms Lawreniuk approached her task of ascertaining their views fairly and in a determined effort that she treated them equally. The tribunal accepts that Prof Pickup told her verbally that she would be willing to mediate and that this was confirmed in writing on 2 October.

47. The claimant was asked for his position on mediation. He was asked that question directly and unequivocally. He replied saying that he could not in good conscience work with Prof Pickup. That was the same message he had given to Mr Barker of NHSE in an effort to persuade him to intervene. It was certainly the message he gave to the respondent, which was reasonably understood to be a refusal to mediate. Indeed, the statement could not reasonably be interpreted in any other way. It was not qualified by any suggestion by the claimant that, despite his view of the CEO, it might be possible to build bridges between them.

48. Fundamentally, Ms Lawreniuk genuinely believed the claimant to be rejecting the recommendation of mediation. She did not in any sense mislead the members of the board when she read out his and Prof Pickup's response to the request. The other board members came to their own similar understanding of the claimant's response. It was not inappropriate for her to have failed to have highlighted to the members of the board that the claimant had at times in the investigative process said that he might mediate. Indeed, that was of no relevance. Things had moved on. A report had been produced and, in the face of this report, the claimant would not mediate.

49. Nor was the claimant misled as to why he was being asked. It was obvious that his response would feed into a consideration of what decisions the board would have to take if he and the CEO could not work with each other. Ms King had previously discussed with the claimant that he might have to step down if he did not accept the recommendations of the report.

Osbourne Sheridan 19/05/2026 08:22:12

50. Ms Lawreniuk conducted the meeting of board members on 2 October 2023 in a professional and scrupulous manner to ensure everyone in attendance had an opportunity to explain their position on whether the claimant or Prof Pickup might have to leave the respondent. She ensured that the members

of the board had an opportunity to speak freely in an effective "safe space" and without any influence from herself as to her own preference. Obviously, she had her own preference formed prior to the meeting, but this was no premature pre-judgement. In any event it was not because of any of the claimant's disclosures, but because, in the context of a relationship breakdown, only one individual was willing to seek to repair that breakdown and that was the person the respondent could ill afford to lose in circumstances where a chair was eminently more replaceable than a CEO.

51. The members of the board came to a consensus along the same lines. Each individual in attendance was of the view that the claimant should be asked to resign. The closest the claimant comes to a taint in any decision-making by his disclosures is reference made by Dr Smith and Prof Dawber to their view of the concerns the claimant had raised and a questioning of his genuineness and motivation in so doing. On the tribunal's findings, those views were substantively justified. Neither, in any event, was suggesting that the claimant step down because he had raised concerns.

52. The claimant thereafter was asked to resign and communicated his own decision to resign after it was finally clear to him that NHSE would not intervene and take any form of action against Prof Pickup. The claimant was not removed from his office and there was no failure to follow due process, therefore, for the removal of a chair. Had the claimant determined not to resign, then such process would have been initiated - it was the claimant's choice not to go down such a process and effectively not to fight his corner.

53. The claimant's further detriment complaint relates to the respondent's communication strategy after his resignation. It is perhaps unjustifiably grandiose to describe the respondent as operating any form of communications strategy in the sense of a planned form of messaging. The respondent was very much in a reactive mode issuing effective press releases/responses to articles which were about to be or had already been published. It sought to ensure that its staff and partners received the same message in circumstances where otherwise their knowledge might have been limited to what they had read in the press.

54. The tribunal does conclude that the respondent's press release did not give a full account of the conclusions of Ms King's report. The release suggested that there had been no finding that Prof Pickup had fallen short of standards, not just those standards encompassed within the Nolan principles. That was inaccurate. The context was that the claimant had raised concerns. The press release was reasonably viewed by the claimant as suggestive that his

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concerns had been found to be without substance. Ms King had found them to be of some substance. He did therefore suffer a detriment.

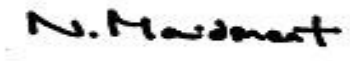
55. The context was of the claimant having sought to, at the very least, feed a campaign against Prof Pickup and the respondent which he knew amounted to a distortion of reality and a sensationalisation of his concerns. The reference to the Lucy Letby case was an obvious example and an example which the tribunal concludes came from the claimant. The potential effect of the press coverage was a loss of confidence in the respondent to take care of, in particular, pregnant women or their newly born babies. The respondent was worried that people might not receive the care they needed because of their unwillingness to engage with the respondent out of fear stoked by the distorted press coverage. The respondent was seeking to take action to try to restore the public's confidence and to provide reassurance to its staff.

56. The claimant himself suggested in these proceedings that the respondent was seeking to protect Prof Pickup and limit the damage. Indeed, the respondent was trying to rebut misleading attacks on her and its neonatal service. That was the reason for the nature of the communications. The respondent did not want to suggest that Prof Pickup had been found to have fallen short of standards as the message that would send out was damaging to the respondent in circumstances where there was no basis for concluding that Prof Pickup was anything other than an effective leader of the respondent, but where any nuances in terms of a recognition of what Ms King's findings amounted to was likely to be lost in the public arena. It wanted to concentrate on the most serious allegations, which, if upheld, might have made Prof Pickup's position untenable. That was certainly the case given the nature of the press campaign the claimant was behind. The tribunal concludes that the communications were in no sense whatsoever because of the concerns which the claimant had raised.

57. Ms Hirst's approach to the board meeting on 16 November 2023 was influenced by her desire to avoid a You Tube recording of upsetting comments being made about Prof Pickup and the potential visible effect on her. There was no motivation of a more general concealment, and the full transcript and minutes were published on the respondent's website. Again, in no sense whatsoever was her approach because of the concerns which the claimant had raised.

Osbourne Sheridan 19/05/2026 08:22:12

58. Had the tribunal concluded, therefore, that the claimant had been a whistleblower, it would have concluded that he was not treated detrimentally because of any acts of whistleblowing.



Employment Judge Maidment

Date 8 May 2026

JUDGMENT SENT TO THE PARTIES ON

13 May 2026

FOR THE TRIBUNAL OFFICE



Notes

Full written reasons will not be provided unless a written request is presented by either party within 14 days of the sending of these written summary reasons.

Public access to employment tribunal decisions

Judgments (apart from judgments under rule 51) and reasons for the judgments (other than summary reasons) are published, in full, online at www.gov.uk/employment-tribunal-decisions shortly after a copy has been sent to the claimant(s) and respondent(s) in a case.

Recording and Transcription

Please note that if a Tribunal hearing has been recorded you may request a transcript of the recording, for which a charge may be payable. If a transcript is produced it will not include any oral judgment or reasons given at the hearing. The transcript will not be checked, approved or verified by a judge. There is more information in the joint Presidential Practice Direction on the Recording and Transcription of Hearings, and accompanying Guidance, which can be found here:

https://www.judiciary.uk/guidance-and-resources/employment-rules-and-legislation-practice-directions/

Osbourne Sheridan
19/05/2026 08:22:12

To: NHS foundation trust chairs

cc. NHS foundation trust chief executives

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

6 May 2026

Dear colleague,

NHS foundation trust governors

I am writing to provide clarification on the role of governors in light of the proposals set out in the 10 Year Health Plan to remove the requirement for NHS foundation trusts to have councils of governors.

Any removal of governors – whose role is set out in law – will depend on government introducing legislation, the will of Parliament to approve it and an agreed start date. We recognise the uncertainty this brings but, until then, the role of governors is unchanged and NHS foundation trusts should continue working with them, in line with their constitutions.

If, in due course, Parliament does remove the statutory role of governors, we will expect NHS foundation trusts to continue to have mechanisms in place to engage with public and patients. We will also seek to understand organisations' plans for this as part of assessments for advanced foundation trust status.

Finally, I am aware that there may be questions about running elections as governors' 3-year terms expire. During this uncertain period, and until there is clarity on the matter, NHS foundation trusts may consider their constitutions and whether they are able to pause these elections while still ensuring a quorate council.

Should you have any further queries on this matter, please do not hesitate to contact Miranda.Carter2@nhs.net, Director of System Architecture for NHS England.

Yours sincerely,

Osbourne Sheridan 19/05/2026 08:23:12

Glen Burley
Deputy Chief Executive

Board of Directors				
Meeting Date:	21 May 2026		**Agenda Reference:**	Bo.5.26.7
Report Title:	Report from the Chief Executive Officer			
Presented by:	Professor Mel Pickup, Chief Executive			
Executive Lead:	Professor Mel Pickup, Chief Executive			
Author:	Executive Directors and Corporate Governance Manager			
Report Summary				
Purpose of the paper:	Decision ☐ (Approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (Review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	The report provides the Board with a summary position regarding our Patients, People, Place and Partners since the last report to the Board in March 2026.			
Recommendation/s: (including any decision/approval required)	The Board is asked to note the content of the report.			
Link to Strategic Objective:	N/A			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	N/A			
Legal/Regulatory:	N/A			
Quality & Patient Safety:	N/A			
Equality, Diversity and Inclusion and Health Equity:	N/A			
Resources:	N/A			
Environmental sustainability:	N/A			
Assurance Route				
Meeting/s where content has been discussed previously:	N/A			

Report content

1. Patients

During 2025/26 we delivered strongly against all the headline measures NHSE use to judge operational performance, ranking in the top quartile for Acute Trusts. Our plans for 2026/27 will look to balance further recovery against core standards whilst expanding on the transformative actions aligned to our 5-year integrated delivery plan.

Emergency attendances to the hospital increased throughout 2025/26, with some of the busiest days on record, but we were able to sustain performance against the 4-hour Emergency Care Standard and held our position in the top ten nationally for this KPI.

Osbaldeston Siobhan
19/05/2026 08:22:12

Daily attendances to the Emergency Department (ED) had recently returned to expected levels but have increased during April. Overall ECS 4-hour performance is tracking above target and remains in the best decile nationally, but 12-hour performance has deteriorated. Bed occupancy remains a challenge at levels consistently above 90%, and whilst this is an improvement on winter levels it is likely contributing to the 12-hour challenges. Discharge delays reduced over recent weeks which we hope to sustain in line with our plans for meeting demand growth without additional cost.

The Trust is also working with the Yorkshire Ambulance Service (YAS) to reduce ambulance turnaround times. Self-handover and operational control improvements have embedded further including escalation protocols which will release crews within a maximum time of 45 minutes. We are working with YAS on validation processes to improve the accuracy of reporting. The result is further improvements in average handover times and minimising handovers that exceed 45 mins.

A focus on ensuring those waiting the longest are prioritised for treatment has seen in Referral to Treatment (RTT) waits over 52 weeks, this has reduced significantly with performance ranking us 15th out of 131 Acute Trusts. Average waiting times for treatment also improved, with the out-turn position in March only 0.5% behind the stretching target set for the year. 2026/27 also includes a challenging target for reducing waiting times further but with a focus on increasing the amount of treatment through theatres and outpatient clinics we are confident we can rise to the challenge.

RTT performance was impacted by Resident Doctors industrial action which took place between 7:00am on Tuesday 7 April – 06:59am on Monday 13 April 2026. The proportion of completed pathways above 18 weeks improved following increased oversight of waiting list measures. Validation related metrics were also very strong in this period and as a result performance reached has now improved to 66.72%. We also continue to have no >65 week waits and the number of patients waiting over 52 weeks remains in line with our strong out-turn position.

Outpatient and theatre productivity programmes will pursue actions that will increase our productivity whilst also ensuring we progress our longer-term transformation plans for elective care. The focus remains on enhancing patient experience and reducing waiting times by ensuring we make best use of every contact with patients or other care professionals. Targeted work to deliver service specific transformation plans utilising the model for improvement approach has continued and work to scale up the benefits seen in smaller tests of change is underway with referral optimisation at the forefront of this.

Cancer wait times were stable against a backdrop of increased demand and delivery of foundational work to support longer term pathway optimisation that colleagues across the Trust are involved in. 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 in line with national and peer average, although has deteriorated slightly due to some diagnostic turnaround issues. Treatment time remains below the 75% requirement time for patients being treated within 62 days, although year end performance will likely meet this target.

Diagnostic performance against the 6-week standard remains below planned levels with unexpected capacity challenges delaying recovery during Q4. Additional capacity from insourcing remained in place during April, in addition some colleagues will be returning to work from sickness therefore helping improve the performance position. Work is ongoing within Audiology and Neurophysiology to increase capacity further alongside work to overcome the capacity loss.

2. People

Celebrating National Day for Staff Networks

On 13th May our four staff equality networks came together across the Trust to celebrate National Day for Staff Networks, this was an event focussed on how working together, supporting one another, and working collaboratively helps everyone across our Trust to grow and thrive.

Public Board Meeting 19/05/2026 09:30:12

This year's theme # Unity For Equity, focused on collective action bringing together staff networks and leaders to challenge inequality, amplify diverse voices and create meaningful, lasting change. The celebration reflects the Trusts commitment to equality, diversity & inclusion, and to creating a culture where everyone feels valued, heard and empowered.

I opened the celebration at BRI with the Executive Sponsor for the LGBT+ Staff Network and with other Executive Network Sponsors in attendance. Network colleagues enjoyed sharing feedback and showcasing areas of progress, where they have collaborated to influence policy, strengthen belonging and drive organisational change. Participants were able to partake in snacks and drinks as they chatted to colleagues and had the opportunity to join a network on the day.

Celebrating Vaisakhi
Vaisakhi is a major annual Sikh festival commemorating the founding of the Sikh community (Khalsa) in 1699 by Guru Gobind Singh. It also marks the beginning of the harvest season and serves as an opportunity to give thanks and celebrate.

Vaisakhi falls on 13th or 14th of April each year, and to mark the occasion another fantastic celebration took place on the BRI main concourse where colleagues could learn about the festival and about the Sikh faith with educational displays and information on show.

A free community meal (known as Langar) was provided by members of the community and the Singh Sabha Gurdwara (temple) and was offered to colleagues and visitors on the concourse as part of the event. Langar is central to the Sikh tradition with daily kitchens serving free vegetarian food to all every day, with over 700 people attending this year's event at the event, the delicious food on offer made the event a huge success. There was also a performance by local musicians playing traditional instruments such as the Indian Harmonium and Jori drums. The event was organised by colleagues from the SPaRC team in partnership with the Sikh Health and Welfare Society.

BMA Notice of Ballot
The Trust received notice from the British Medical Association of their ballot for industrial action for Consultant and SAS doctors, the ballot will start on 11 May 2026 and will close on 6 July 2026. It is expected that following the ballot the Trust will be informed of the outcome.

3. Place

Local Elections – Bradford
Local elections were held on Thursday 7 May 2026, comprising an all-out election for all 90 council seats across 30 wards in Bradford. The election in the Idle and Thackley ward has been postponed until June following the sad passing of Councillor Jeanette Sunderland. The results to date indicate that Reform has secured the largest share of seats on the council; however, it does not hold an overall majority. As of 13 May 2026, a new Council Leader has not yet been appointed, and it remains unclear whether any formal coalition arrangements will be established.

Changes to council composition will also impact the membership of the Bradford District Health and Wellbeing Board and key committees, including the Health and Social Care Overview and Scrutiny Committee. As an NHS Trust, we remain apolitical and committed to working collaboratively with all elected members to support delivery of our vision to be an outstanding provider of healthcare, research and education, and a great place to work. Further details of the election results are available on the Bradford Council website. Bradford Council's website.

Senior Leadership Update – Department of Health and Social Care
Iain MacBeath has left his role at Bradford Council to take up a national position as Senior Advisor to the Permanent Secretary at the Department of Health and Social Care and to the Chief Executive of NHS England. In his previous role as Director of Adult Social Care, Health and Housing, Iain made a significant contribution to system-wide working in Bradford, particularly through the Act as One partnership. We

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extend our thanks and best wishes to Iain in his new role and welcome the opportunity this presents to further share Bradford's experiences and insights at a national level.

National organisational change update
National work on the future DHSC structure has progressed into detailed design. Early modelling points to a significantly streamlined national footprint, with clearer separation between departmental policy, commissioning functions and regional delivery. NHSE is now assessing which national programmes and functions are likely to transfer into the new department and which may be devolved to regions or ICBs. This preparatory work is intended to ensure alignment once the Target Operating Model is released later this month.

West Yorkshire ICB
Rob Wester CBE left the ICB on 15 April after ten years of leading the Integrated Care System. It was also his last day in the NHS, after 36 years in health and care, working nationally, regionally and locally. Mark Chamberlain joined the ICB as Chair on 1 April 2026. Following an open and competitive recruitment exercise, NHS West Yorkshire ICB confirmed the appointment of three Non-Executive Member roles. Two of the three successful candidates, Jane Madeley and Majid Hussain, are currently Non-Executive Members with NHS West Yorkshire Integrated Care Board and started their second term from 1 April 2026. They are joined by Liz Towns Andrews OBE, who is currently the Regional and Business lead for the University of Huddersfield National Health Innovation Campus.

Bradford District & Craven Partnership
The **Place Provider Partnership** has now met as a shadow Joint Committee. Work is underway to confirm purpose and governance arrangements, financial due diligence and confirming the host/lead provider arrangements. Bradford District Care NHS Foundation Trust has agreed to take on this role. The initial focus of the PPP has been on ensuring the delivery of our Health, Care, and Wellbeing Strategy with a focus on neighbourhood and community services being 'in scope'. Throughout 2026/27 we will undertake 'readiness' self-assessment to provide assurance to our Boards and the ICB Place Committee.

Neighbourhood Health Centres Announcement – Westbourne Green
The Department of Health and Social Care has announced the first 27 sites designated as neighbourhood health centres as part of the Government's 10 Year Health Plan, which aims to establish 250 centres nationally. We are pleased to note that Westbourne Green has been selected as one of the initial sites. Neighbourhood health services are intended to deliver more integrated, person-centred care, providing coordinated support that addresses both clinical needs and wider determinants of health. This approach is expected to improve patient experience, reduce unnecessary hospital attendance, and support earlier intervention and prevention.

Recognition of the Bradford Sling
A World Origin Site green plaque has been unveiled at the University of Bradford, recognising the global impact of the Bradford Sling and the pioneering work of the Plastic Surgery and Burns Research Unit (PSBRU). The innovation was developed in response to the Bradford City fire in May 1985, in which 56 people tragically lost their lives, and many others sustained life-changing injuries. Colleagues from the Trust played a vital role in the emergency response. The Bradford Sling developed subsequently, is a simple yet highly effective device used to support and immobilise the arm, and has been adopted internationally, remaining in widespread use more than 40 years later. The plaque also honours the work of Professor David Sharpe OBE, who led the clinical response to the disaster and founded the PSBRU.

"Little Sparks, Big Starts" Health Visiting Resource
Bradford District Care NHS Foundation Trust has launched a new resource, *Little Sparks, Big Starts*, aimed at supporting parents, caregivers and professionals in fostering early relationships with infants. The initiative emphasises the importance of everyday interactions in building secure attachments and establishing strong foundations for lifelong mental health and wellbeing. The resource includes a free e-learning programme alongside a companion mobile application, offering accessible, evidence-based guidance to help families understand infant behaviour, strengthen bonding, and enhance confidence in

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parenting. It also supports professionals working with families to promote relational and emotional wellbeing from the earliest stages of life. Little Sparks, Big Starts

4. Partners

West Yorkshire Association of Acute Trusts (WYAAT) Programme Executive Meeting, 7th April 2026

Unfortunately, I was unable to attend the WYAAT Programme Executive meeting on 7th April 2026, however Ben Roberts deputised on my behalf.

The meeting highlighted some of the significant system-level changes and pressures. The ICB is currently undergoing organisational transition, with staff leaving through voluntary redundancy and further changes to the structure to be finalised. There is a strong focus on developing a commissioning plan by mid-May, alongside wider work on new contracting approaches, particularly moving away from block contracts. Broader system challenges were discussed at the meeting, including industrial action, variability in the maturity of the Place-based partnerships, and the complexity of managing organisational change within tight timescales.

The meeting also heard from a number of key transformation and collaboration programmes. A major focus is the "Transforming People Services" agenda, where WYAAT will look to act as a cluster to drive digital enablement, policy standardisation, with an emphasis on efficiency and shared delivery models where relevant. Updates were also provided on the WYAAT joint procurement (notably PACS/RIS), clinical programmes, alongside approvals of several closure reports. Finally, governance and planning updates confirmed ongoing work on job planning, elective performance and the annual plan, with continued attention to system risks, delivery milestones, and coordination across partner organisations.

North East Yorkshire Regional Roadshow in Newcastle, 22nd April 2026

Sajid Azeb, Deputy Chief Executive attended the above roadshow. NHSE National and the Regional team were present along with CEOs and Chairs from across the region. Jim Mackey outlined his thanks to all for the hard work over the last 12-months. There was a general confidence about the NHS and what has been achieved. The financial position was better than expected, elective performance has shown a recovery despite having had 3 rounds of industrial action as well as positive improvements in other performance metrics such as Ambulance handover times which had shown an improvement as well. The key areas of focus as we progress into this year would be on bringing Neighbourhood Health to life.

This was followed by an update from Elizabeth O'Mahony, the Director General Finance who highlighted the NHS achieved a 2.8% productivity gain against a 2.5% ask. There has been significant capital expenditure across the NHS. There is still more to do especially a focus on continuing with the productivity gains and reducing the amount of variation that exists.

Bill McCarthy was introduced as the Regional Chair from NHS North and East Yorkshire. Bill talked about his desire to ensure the working arrangements are as simple as possible especially given the changes across the ICB and NHSE. He highlighted the need for strong governance and good board and the need to be ambitious for our communities.

NHS Leadership Event in London, 28th April 2026

Sajid Azeb, Deputy Chief Executive attended the above NHSE national event that took place in London on the 28th of April 2026, and the NHS CEO reiterated the need for 'big leaps' as opposed to marginal gains and asked to build on the gains made during the last financial year. Ed Smith who has been appointed the chair of the NHS Leadership and management college talked passionately about his vision to ensure we create the right environment to support colleagues to take up leadership roles within the NHS, he will be looking to appoint a CEO in due course. In addition, Meghana Pandit gave an overview of the National Quality Strategy which they are looking to publish shortly. The strategy will be a call to action and focusses on creating the most health system in the world.

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The Deputy Chief Executive also attended the **Partnership Oversight Executive held on 29 April** and **the WYAAT Programme Executive Meeting, held in Leeds on 5th May 2026.**

West Yorkshire Leaders Forum, 5th May 2026
Unfortunately, I was unable to attend the West Yorkshire Leaders Forum held on 5th May, however Mark Hindmarsh joined on my behalf.

Following the retirement of Rob Webster in April, Jonathan Webb is currently acting as the Interim CEO and chaired the meeting which was attended by partners in the NHS, VCS and local government from across West Yorkshire. Colleagues from the ICB set out their updated purpose following the publication of the national ICB Blueprint documents and set out their mission around three core functions: Strategic Commissioning, System Convener, and to provide support to develop Place Provider Partnerships across WY. Jonathan also set out the importance of how these missions supported the development of Integrated Health Organisations (IHOs) across our places and the work around Neighbourhood Health. Colleagues also discussed how their commissioning intentions would be set out in terms of short, medium and longer term ambitions running to 2031 and would focus on life expectancy, healthy life expectancy and continued work to reduce health inequalities. There was also discussion about how changes to how funding flows between the ICB and providers will continue to be reviewed to support these aims (e.g. deconstructing block contracts and more focus on funding for outcomes not just volume). It was agreed that these forums would continue to be an important part of how we come together across West Yorkshire.

5. National Reports

Letter from Sir Jim Mackey, Chief Executive Officer, NHS England, 1st April 2026
On 1st April 2026, Sir Jim Mackey, Chief Executive Officer for NHS England wrote to ICB Chief Executives and Trust Chief Executives to recognise their work in delivering the key operational imperatives on RTT and UEC. Looking forward to 2026/27 he emphasised the need to ensure plans are refined to develop sustainable solutions to long standing problems and to maximise the opportunity of the multi-year planning process to bring the 10-year Health Plan to life.

To enhance the plans submitted, Sir Jim Mackey has requested ICBs via regional teams, to submit a single document by 15 May 2026, summarising how they plan to build on strategic commissioning narratives and describe how commissioners and providers plan to work together to ensure a strong degree of alignment and clear identification of the gaps and barriers that can be worked through and how they intend to do so.

Safeguarding children, young people and adults at risk in the NHS – Accountability and Assurance Framework (Fifth edition 2026)
On 1st April 2026 NHSE published the fifth edition of the Safeguarding Accountability and Assurance Framework (SAAF). This update reinforces the commitment to ensuring safety, protection, welfare of babies, children, young people and adults, including the prevention of harm and upholding the dignity of the deceased. Findings and recommendations from recent Public Inquiries, numerous statutory safeguarding reviews and key publications including the 10 Year Health Plan for England have been drawn upon; the publication aligns with the NHSE Operating Framework, which broadens the scope of the SAAF as a commissioning framework.

The publication can be accessed here NHS England » Safeguarding children, young people and adults at risk in the NHS

Osbourne Stanforth
19/05/2026 08:42:14

Neighbourhood health centres – guidance for regions and integrated care boards
On 16th April 2026, NHSE published guidance for neighbourhood health centre (NHC) development in the current planning period. The guidance sets out the strategic framework for how ICBs and NHS E regions, working with providers, should identify and develop NHC schemes to support neighbourhood health as

well as instructing ICBs and regions on the planning work required to develop a coherent pipeline of NHC schemes. The full publication can be found here NHS England » Neighbourhood health centre guidance for regions and integrated care boards

Osbourne,Sheridan
19/05/2026 08:22:12

Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.8a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality Committee

Date of meeting: 23rd April 2026

Key escalation and discussion points from the meeting

Alert:

- Sustained workforce and financial pressures continue to present a risk to maintaining quality and patient safety standards. Particular concern was highlighted regarding medical staffing gaps in Obstetrics and Gynaecology and ongoing Emergency Department (ED) capacity pressures. These matters are reflected within the Committee's high-level risks and will require continued Board oversight.
- The Children's Ward received a recent 'Red' Bradford Accreditation Scheme (BAS) rating. Rapid improvements have already been evidenced following a multidisciplinary summit and targeted interventions. The Committee noted the requirement for sustained Executive support in relation to workforce, estates, pharmacy, digital training infrastructure and organisational culture improvement. A further review summit will take place in three months.
- Maternity Services reported 11 stillbirths year-to-date compared to 15 across the whole of 2025. While early reviews have not identified systemic concerns and three recent cases demonstrated appropriate care in all elements, the position has triggered a thematic deep dive review to provide additional assurance and identify any emerging themes.
- Risks relating to ED demand, patient flow and medical staffing remain beyond review date:
  - ED demand exceeding designed capacity and available resources.
  - Delays in treatment/admission/discharge impacting patient experience and length of stay.
  - Availability of sufficient middle and senior grade ED doctors.

Advise:

- The Committee received updates on the refreshed EXCEL Programme, focused on decompressing the ED and improving patient and staff experience through upstream prevention, improved in-department flow, and strengthened discharge arrangements. The programme is increasingly aligned with wider neighbourhood health and system transformation work across Bradford District and Craven.
- The Committee discussed the importance of ensuring quality of care remains a "red line" despite operational and financial pressures, particularly during periods of industrial action and service pressure escalation.
- The Committee noted that the BAS accreditation process is proving valuable both as an assurance mechanism and as a catalyst for improvement. Further consideration will be given to:
  - Increasing practical peer support from high-performing wards.
  - Incorporating wider patient voice and EDI perspectives.

Osbourne, Stephen
19/05/2026 08:22:12

Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.8a

- Potential development of additional NED safety champion roles in high-risk areas such as paediatrics.

Assure:

- The Committee received assurance that despite operational pressures and recent industrial action, there were no significant quality incidents or patient harm events arising during the reporting period.
- The Trust achieved full compliance with Year 7 of the Maternity Incentive Scheme (MIS), resulting in receipt of the associated financial premium. Positive feedback was also received following the Local Maternity and Neonatal System (LMNS) assurance visit, with no formal recommendations issued.
- Significant progress has been made with implementation of Martha's Rule across all adult inpatient wards, maternity and paediatric services. All three required elements are now operational and embedded within routine practice, ensuring compliance with NHS Standard Contract requirements.
- The Committee received positive assurance regarding the Bradford Accreditation Scheme:
  - 40 adult inpatient accreditation visits completed in the last 12 months.
  - Multiple wards achieving or sustaining 'Green' ratings.
  - Improvements demonstrated in medication management standards following targeted interventions.
- The Trust received a 'Good' rating for Well Led from the CQC, with no regulatory breaches, 'must dos' or 'should dos'. The Committee recognised this as a significant achievement given the volume and pace of inspections undertaken during 2025, and noted the proposed action plan on various issues identified.

Report completed by:

Tim Swift
Academy Chair and Non-Executive Director

13th May 2026

Osbourne Sheridan
19/05/2026 08:22:12

Meeting Title	Board of Directors		
Date	21st May 2026	Agenda item	Bo.5.26.8a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality Committee
Date of meeting: 14th May 2026

Key escalation and discussion points from the meeting

Alert:

- The committee discussed concerns regarding delays in the completion of investigations into safety incidents and was assured that a review of investigation timelines and processes would be undertaken. It is important to distinguish between situations where delays are unavoidable due to external factors, and other situations. Consideration will also be given to reintroduce an early-stage review to identify immediate actions. This will be reported back to a future meeting.
- There has been a Level 1 Maternity Outcomes Signal System (MOSS) trigger due to an increase in the number of term still births. A rapid response process was completed within the required timescales and rated the service as green-amber. An in-depth review of still births is covered below.
- Workforce issues relating to obstetric staffing were highlighted, and it was agreed that further assurance will be provided through a report on obstetric staffing and associated risks to the next meeting.

Advise:

- There was a good discussion around proposed changes to the identification and management of risks, and the potential establishment of a Risk Committee. We noted that whilst the Committee receives reports on the actions taken on many of the high-level risks through other agenda items, we need a way of capturing this systematically, so we are assured that all risk action and mitigation plans are reviewed appropriately.
- The Committee received a verbal report on the deep dive that has taken place into the increased number of still births in the first three months of the year. This did not identify any consistent issues regarding the care provided by the Trust, with a range of factors involved including the possibility that the previous year's figures had been unusually low (i.e. the increase was against an unusual base level).
- The Committee continues to focus attention on ensuring that our actions are delivering quantifiable improvements, for example in areas such as the occurrence of falls or pressure ulcers, linked to the Trust's improvement strategy.

Assure:

- The Committee noted the Internal Audit report on Risk Management which provided significant assurance but is also helpful in identifying the main common themes and challenges across the whole range of risks facing the organisation.
- The Committee received a new report on Antimicrobial Resistance (AMR) driven by NHS England reporting requirements. The Chief Medical Officer has assumed the executive lead role for AMR. The Committee was made aware of national targets, including reducing antibiotic use and increasing use of narrow-spectrum antibiotics. Key priorities for the Trust included improving 48-hour antibiotic reviews, strengthening diagnostics, and reducing bloodstream infections. The governance structure will include continued reporting on AMR progress to the Quality Committee and through to Board.

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Report completed by: Tim Swift, Committee Chair and Non-Executive Director, 15/05/26

Board of Directors				
Meeting Date:	21.05.26	**Agenda Reference:**	Bo.5.26.8b	
Report Title:	Infection Prevention and Control Report for Quarter 4 2025/26			
Presented by:	Professor Karen Dawber, Chief Nurse/Executive Lead Infection Prevention and Control			
Executive Lead:	Professor Karen Dawber, Chief Nurse/Executive Lead Infection Prevention and Control			
Author:	Dr. Muhammad Yaseen, Director of Infection Prevention and Control			
Report Summary				
Purpose of the paper:	Decision ☒ (Approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (Review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	This is the quarterly (Q) infection prevention and control report which is required by the Quality Committee/Board of Directors to demonstrate progress against the annual infection prevention programme and in achieving compliance with: The Health and Social Care Act (H&SCA) 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. Regulation 12(2) (h) and 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is the Q4 report for 2025/26 and provides the final of the four reports which comprise the annual report.			
Recommendation/s: (including any decision/approval required)	*The report provides assurance to the Board of Directors by monitoring the activity of infection prevention and control annual work programme and is requested to confirm the actions arising from the recommendations identified are appropriate.* *The Board is requested to note the risks identified and approve the further actions and mitigations as detailed in the main report.*			
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness			
Link to Priority Initiatives 2025/26:	Acute Care Programme			
Implications				
Risk:	The report presents assurances for progress against the annual infection prevention work programme. The report also highlights and provides an escalation summary of key risks in systems and processes which impact on the prevention of healthcare associated infections.			
Legal/Regulatory:	The paper provides assurance for compliance with: • Corporate objectives: strategic objective 1 - To provide outstanding care for our patients. • NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. • Health and Social Care Act 2008: Code of Practice for the prevention and control of healthcare associated infections and related guidance. • NICE [QS61] Infection prevention and control.			
Quality & Patient Safety:	Yes. It has implications for Quality & Patient Safety			

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Equality, Diversity and Inclusion and Health Equity:	No implications.
Resources:	Yes, it has implications on resources.
Environmental sustainability:	No impact.
Assurance Route	
Meeting/s where content has been discussed previously:	Infection Prevention and Control Committee Quality Committee – 14.05.26

Report content

Infection Prevention and Control Report: January - March 2026 (Quarter 4, 2025/26)

1 PURPOSE/ AIM

1.1 The purpose of this report is to demonstrate progress against the annual infection prevention programme and in achieving compliance with national standards and performance indicators. The report provides assurance by monitoring the activity of infection prevention and control and identified key issues are noted. The Committee is asked to note the report in relation to:

- Corporate objectives: strategic objective 1 - To provide outstanding care for our patients.
- NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.
- Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.
- NICE [QS61] Infection prevention and control.

2 BACKGROUND/CONTEXT

2.1 Section 21 of the Health and Social Care Act (H&SCA) 2008 contains statutory guidance about compliance with the registration requirement relating to infection prevention (regulation 12(2) (h) and 21(b) (Regulated Activities) Regulations 2014. It should also be noted that Regulation 15 is also relevant.

2.2 Care Quality Commissions (CQCs) guidance about compliance with the above regulations includes a reference to the 'premises and equipment' regulation (regulation 15) as CQC considers this code to be relevant for the purposes of meeting that regulation.

2.3 The 'Code of Practice' on the prevention of infections under The Health and Social Care Act 2008 sets out the 10 criteria. Criterion 1 requires that systems to manage and monitor the prevention and control of infection and require the Director of Infection Prevention and Control (DIPC) to provide oversight and assurance on infection prevention (including cleanliness) directly to the Trust Board and produce an annual report. This report therefore provides assurance to meet the requirements set out above.

3 PROPOSAL

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3.1 This report will confirm continued assurance systems for compliance against the statutory requirements which will support assurance with corporate strategic objective 1 - To provide outstanding care for our patients.

3.2 This is the Q4 report for 2025/26 and provides the final of the four reports which comprise the annual report.

4 BENCHMARKING IMPLICATIONS

4.1 The latest information available on Healthcare Evaluation DATA (HED) in relation to infection rates is included in the section below. It shows the Trusts position for MRSA and MSSA, Klebsiella Spp, Pseudomonas aeruginosa and E. coli bacteraemia and Clostridioides difficile Infection (CDI), in relation to the national distribution for each of these infections as of March 2025. The arrows in the graph below indicate the position of BTHFT in relation to National and Regional data. Black line in the graphs represents BTHFT.

Mandatory Organism Infections



Figure 1

5 RISK ASSESSMENT

5.1 The paper provides assurance for compliance with:

- Corporate objectives: strategic objective 1 - To provide outstanding care for our patients.
- NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.
- Health and Social Care Act 2008: Code of Practice for the prevention and control of healthcare associated infections and related guidance.
- NICE [QS61] Infection prevention and control.

5.2 Gaps in compliance during April - June 2025 that have been identified are highlighted below and within the main report (Appendix 1).

6 RECOMMENDATIONS

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6.1 The report provides assurance to the Board of Directors by monitoring the activity of infection prevention and control annual work programme is requested to confirm the actions arising from the recommendations identified are appropriate.

6.2 The Board is requested to note the risks identified and approve the further actions and mitigations as detailed in the main report.

Appendix 1: Infection Prevention and Control: Main Report

1. Introduction

1.1 The following report demonstrates progress against the annual infection prevention programme and in achieving compliance with national standards and performance indicators. The report provides assurance by monitoring the activity of infection prevention and control and identified key issues are noted.

2. Strategic Context

2.1 This report summarises progress against the work plan for 2025/26 and sets out the Trust's infection control activities and performance. This is the Q4 report for 2025/26 which comprises the annual report.

2.2 The infection prevention programme of work continues to be delivered. The progress is monitored through the Infection Prevention and Control Committee (IPCC), which meets quarterly and has been chaired by the Director Infection Prevention and Control. Reports are submitted at each committee on progress against the annual plan and key performance objectives.

3. Healthcare Associated Infections

The NHS Standard Contract includes quality requirements for NHS trusts and NHS foundation trusts to minimise rates of both Clostridioides difficile (C. difficile) and of Gram-negative bloodstream infections to threshold levels set by NHS England and NHS Improvement. Trusts are required under the NHS Standard Contract to minimise rates of both Clostridioides difficile (C. difficile) and Gram-negative bloodstream Infections so that they are no higher than threshold levels set by NHS England and Improvement. The following table sets out the threshold levels for each Trust.

- The classification of healthcare acquired infection cases is split into defined groups:
    - Hospital-onset, healthcare associated (HOHA) - Date of onset is ≥3 days after admission (where day of admission is day 1).
    - Community-onset healthcare-associated (COHA) - Date of onset is ≤ 2 days after admission and the patient was admitted to the trust in the 28 days prior to the current episode days (where day 1 is date of discharge).
    - Community-onset, community associated (COCA) - Date of onset is ≤ 2 days after admission and the patient had not been admitted to the Trust in the previous 28 days prior to the current episode.

- During August 2020 the United Kingdom Health Security Agency (UKHSA) Data Capture System (DCS) started to report cases of MSSA, E. coli, Pseudomonas sp. and Klebsiella sp. bacteraemias in a similar way to CDI. The classification of cases is split into the defined groups:
    - Hospital-onset, healthcare associated (HOHA) - Date of onset is ≥3 days after admission (where day of admission is day 1).
    - Community-onset healthcare-associated (COHA) - Date of onset is ≤ 2 days after admission and the patient was admitted to the trust in the 28 days prior to the current episode days (where day 1 is date of discharge).

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- Community-onset, community associated (COCA) - Date of onset is ≤ 2 days after admission and the patient had not been admitted to the trust in the previous 28 days prior to the current episode.

- Therefore, the surveillance reporting of HCAIs for all reportable organisms has aligned with the same categories as CDI.
- Consequently, there has been transference in numbers of cases that are trust assigned, particularly as healthcare associated cases will include those with recent (last four weeks) hospitalisation. The SPC charts presented in this report reflect this change to indicate the re-assignment.
- Since January 2024, as a result of Patients Safety Incident Reporting Framework (PSIRF), the individual PIRs are not carried out as a routine, however, a quick review is carried out to identify any urgent issues.

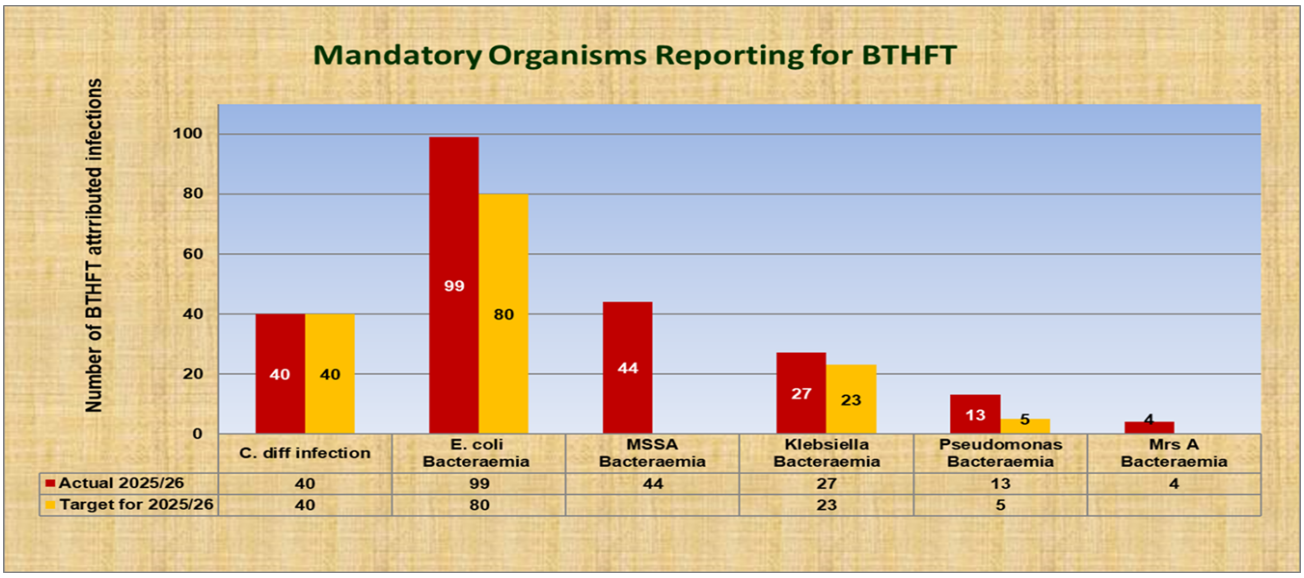


Figure 2

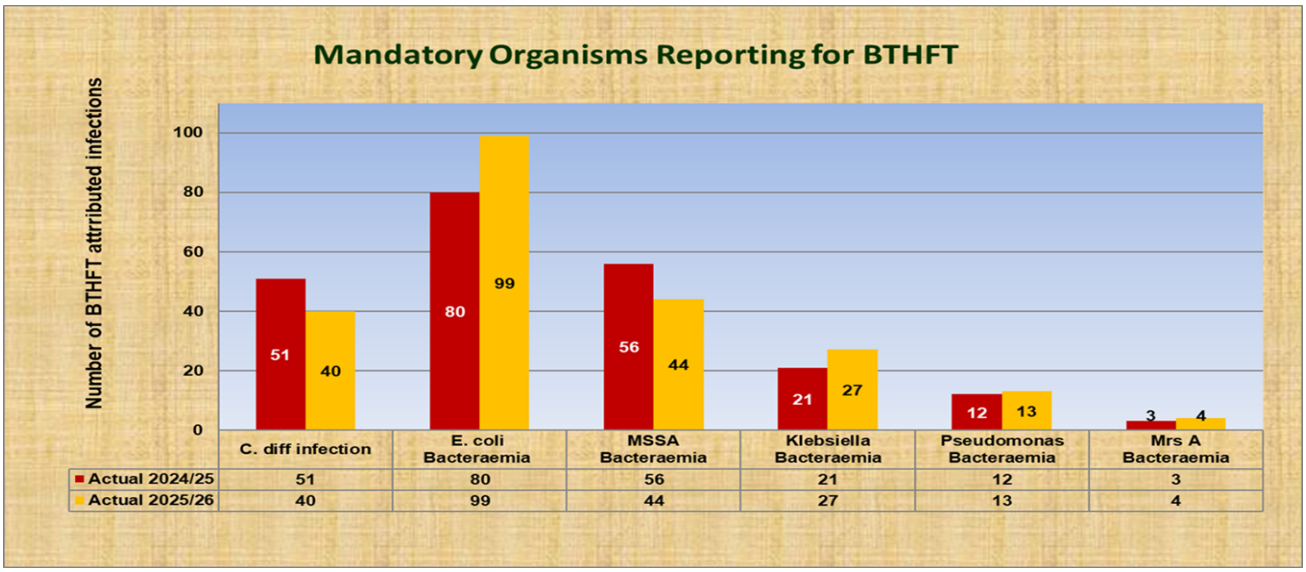


Figure 3

3.1 MRSA bacteraemia

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The Trust reported 4 cases of MRSA bacteraemia during 2025/26. Figure 4 statistical process (SPC) chart highlights the Trust allocated cases from April 2024 to March 2026.

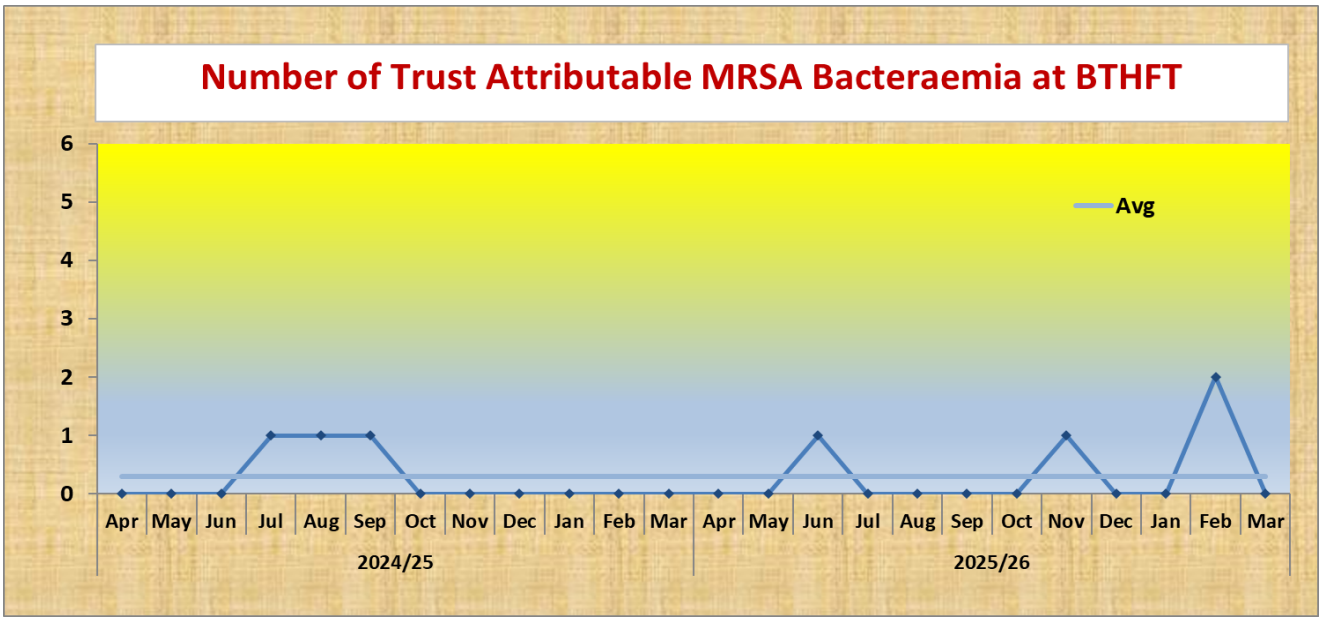


Figure 4

3.2 MSSA Bacteraemia

- The Trust reported 44 hospital attributed MSSA bloodstream infections in the year 2025/26. The trust reported 56 cases last year.
- Figure 5 statistical process (SPC) chart shows monthly number of Trust allocated cases from April 2024 to March 2026.

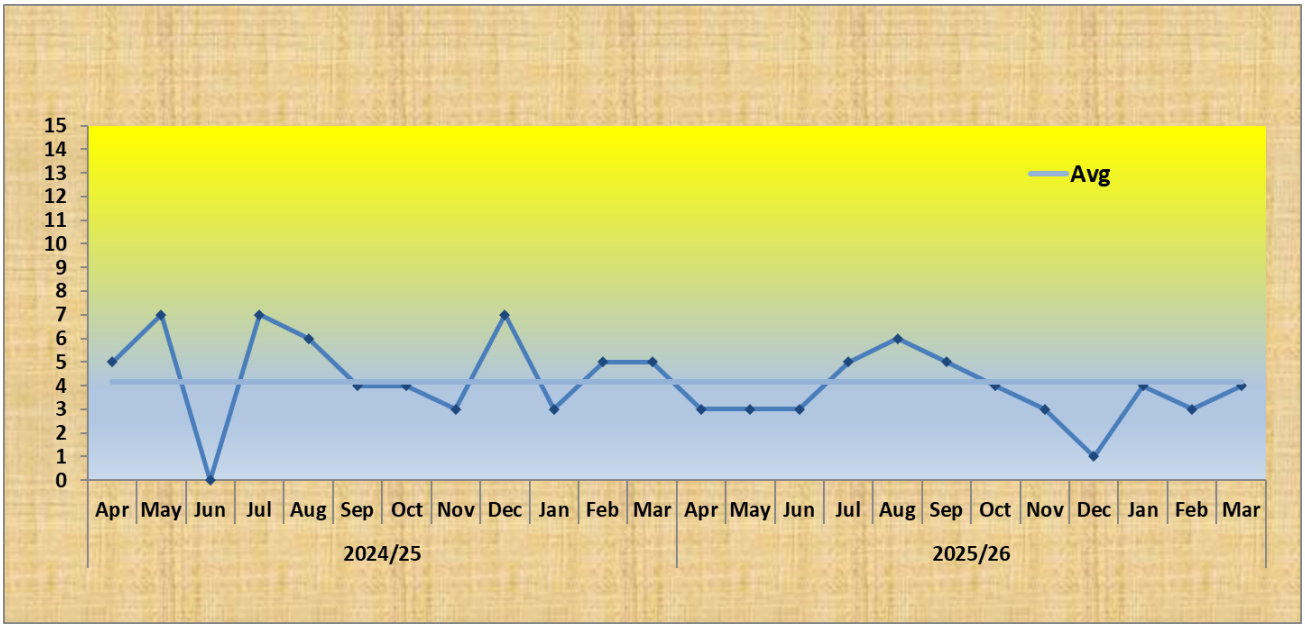


Figure 5

3.3 E. coli Bacteraemia

- The Trust reported 99 cases of *E. Coli* bacteraemias attributed to the Trust in the year 2025/26. Decrease in the number of cases has been observed in last quarter.
- Figure 6 SPC chart shows monthly number of Trust attributed cases from April 2024 to March 2026.

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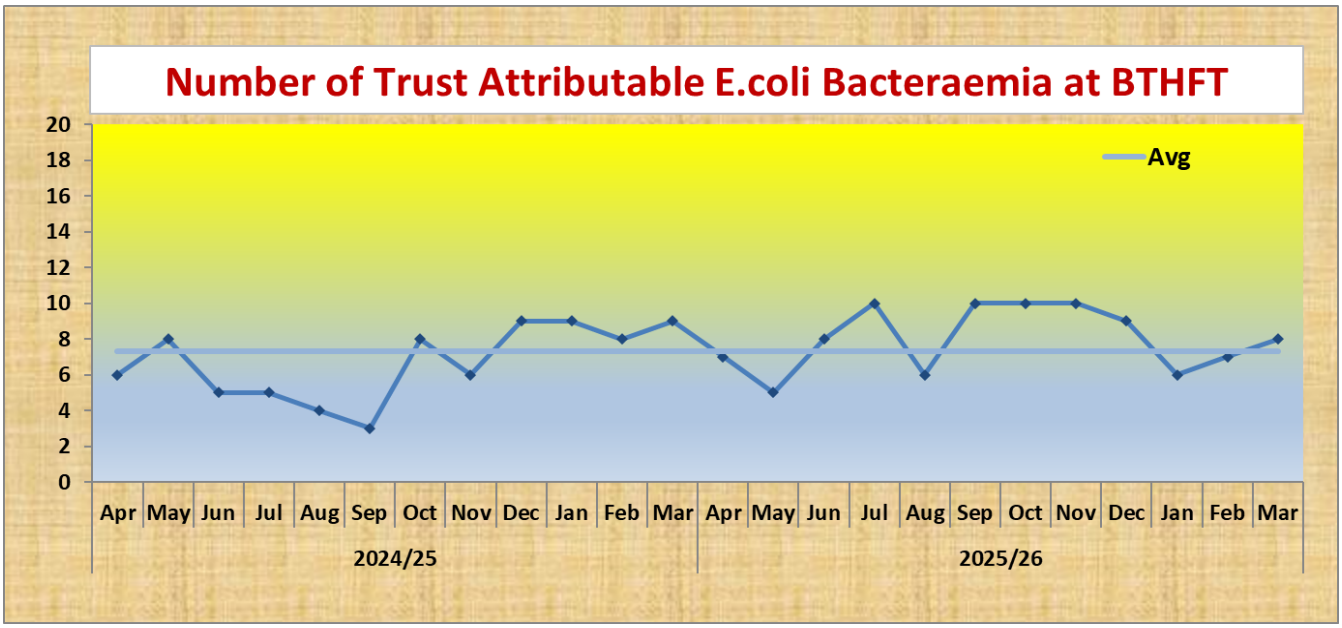


Figure 6

3.4 Klebsiella Bacteraemia

- The Trust reported 27 cases of Klebsiella Spp. bacteraemias attributed to the Trust in the year 2025/26. Decrease in the number of cases has been observed in the last quarter.
- Figure 7 SPC chart shows the Trust attributed *Klebsiella Spp. Bacteraemia cases* per month from April 2024 to March 2026.

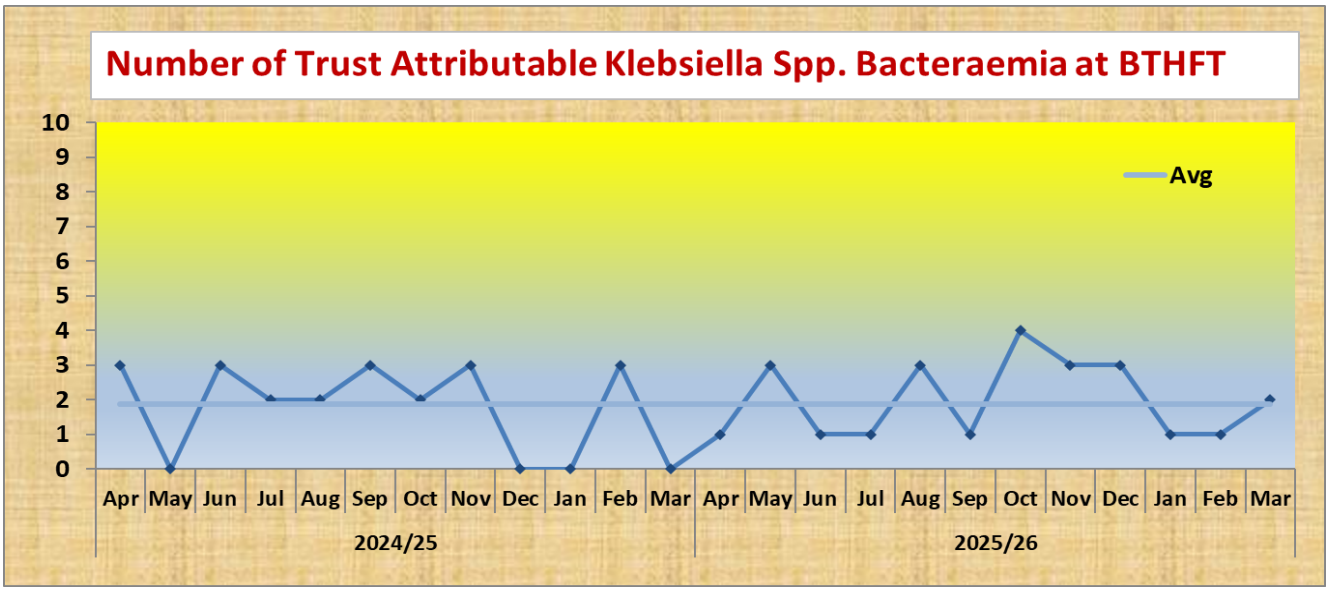


Figure 7

3.5 Pseudomonas aeruginosa Bacteraemia

- The Trust reported 13 cases of Pseudomonas aeruginosa bacteraemias in the year 2025/26.
- Figure 8 SPC chart shows the Trust attributed *Pseudomonas* aeruginosa BSI cases per month from April 2024 to March 2026.

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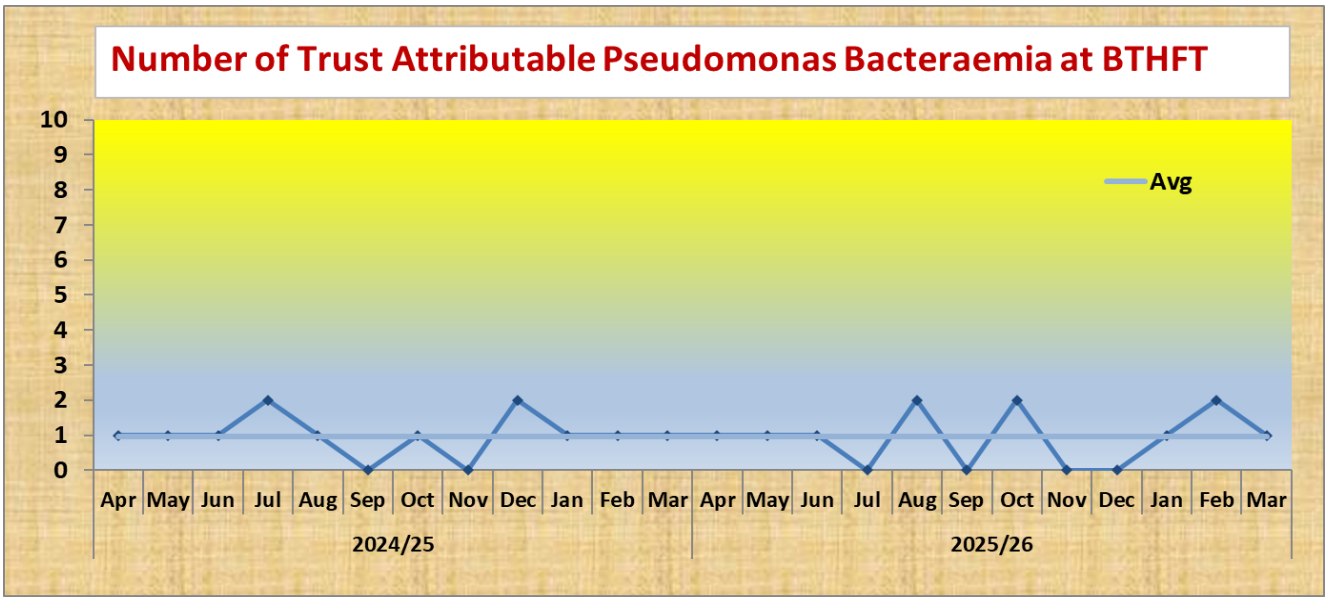


Figure 8

Bacteraemia Reduction Measures

- A comprehensive improvement plan updated regularly.
- Immediate review of bacteraemia cases for quick learning.
- Triangulation of cases using PSIRF.
- Updated SOP for Central Venous Access devices (CVAD).
- Hand hygiene improvement campaign using Semmelweis hand scanners.
- Support Gloves off Campaign.
- Audits of Octenisan compliance (IRIS on non-compliance).
- Addition of a tool to ask patients about Octenisan bath.
- ANTT training and assessment. Plan for ANTT accreditation for the Trust.
- "ASK ME" hand hygiene campaign to encourage patients to question hand hygiene by staff members.
- A wider Task and Finish group including representatives from Bradford and Airedale acute trusts as well as primary care is working on reduction in bacteraemias.

3.6 Clostridioides difficile infection (CDI)

- The objectives for reduction for CDI for 2025/26 were set as 40 cases. The Trust reported 40 hospital attributable cases during 2025/26.
- Figure 9 statistical process (SPC) chart shows Trust allocated cases.
- Each CDI case is sent to a UKHSA (previously PHE) reference laboratory for typing; Where there are any similar typing results, a search is undertaken to identify any potential risks for cross transmission (for example, the same ward either at the same time or at different times). The Ribotyping results for the cases in 2025/26 don't indicate transmission between patients. Antibiotic usage is the most common risk factor associated with Clostridioides *difficile* infection.
- The role of antibiotic stewardship is a primary preventative strategy in the prevention of Clostridioides *difficile* infection and will be a focus during 2026/27 to reduce the usage of the high-risk antibiotics.

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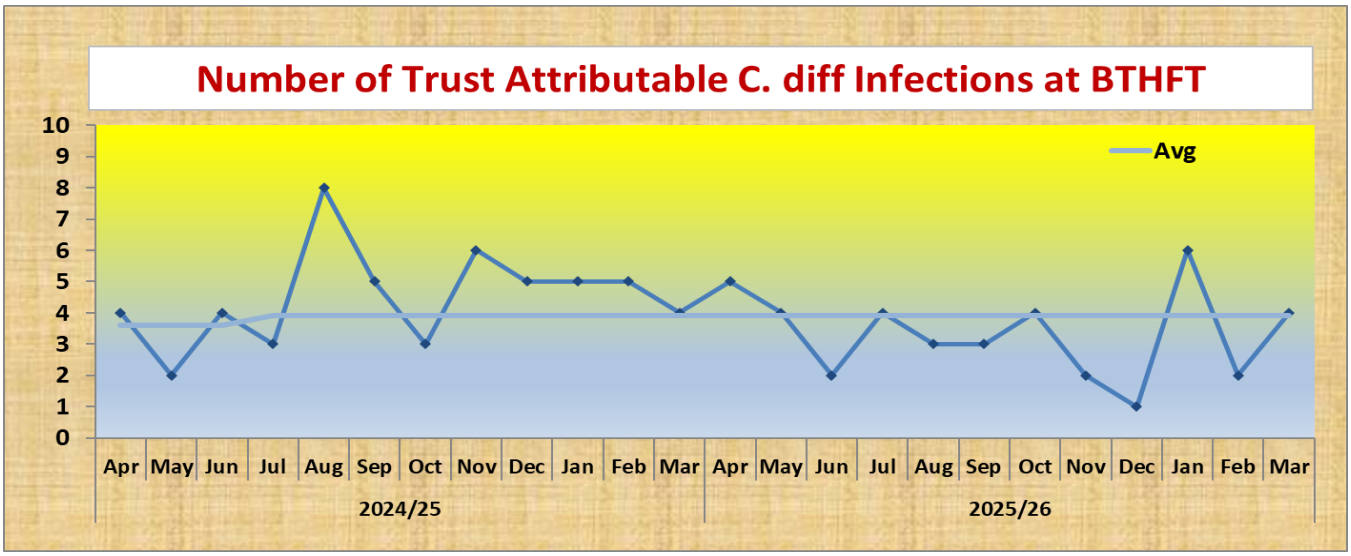


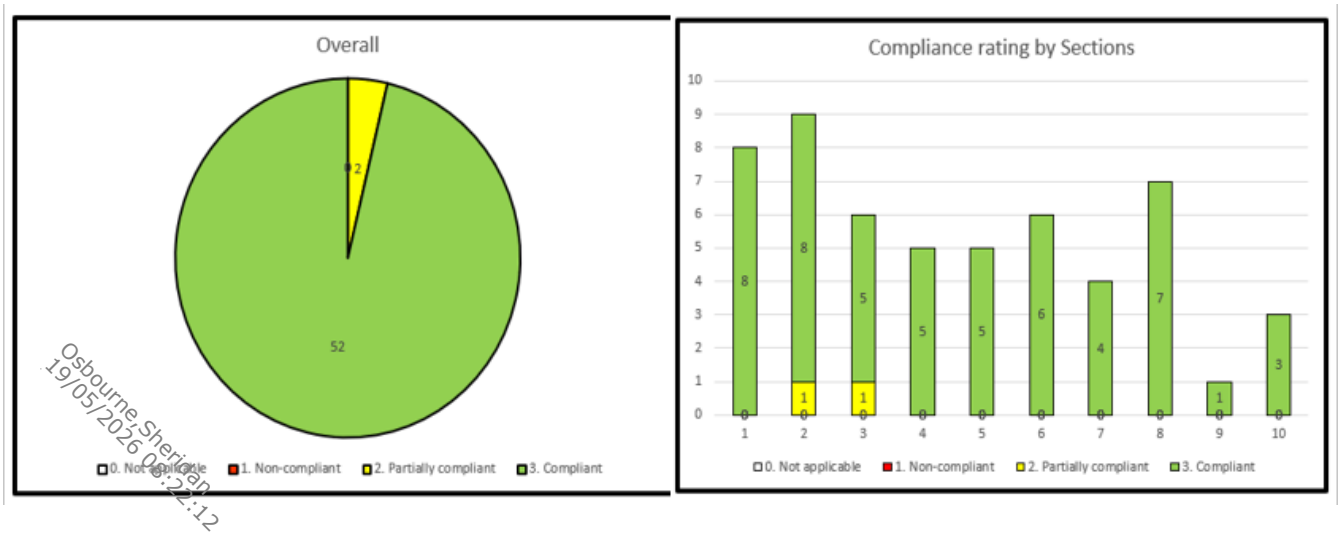
Figure 9

CDI Reduction Measures

- 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.
- Ad hoc and regular environmental audits.
- Commode audits with IRIS on non-compliance. “Golden” Commode Award.
- Dedicated antimicrobial Stewardship pharmacist.
- Data collection on compliance to Start Smart and Focus, Access, Watch and Reserve antibiotics.
- Review of Antimicrobials for all positive cases.
- “ASK ME” hand hygiene campaign to encourage patients to question hand hygiene by staff members.

4. IPC Board assurance Framework

IPC board assurance framework is a voluntary tool for trusts to monitor compliance with the Health Act 2008. The IPC BAF was updated recently, and amendments were made to the section on Antimicrobial Stewardship. The Trust compliance to the framework is summarised in Figure 8.



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Figure 8.

Gaps in assurance

- Some areas are not compliant to the HTM for ventilation.
- There's no formal Lead for Antimicrobial Stewardship with allocated hours and job description.

Mitigating Actions to assure Compliance to IPC BAF

- Risk assessment in place for HTM non-compliant.
- Additional five rooms available in Ward 1 for airborne isolation.
- Respiratory infectious patients not to be admitted in Ward 7.
- Installation of air scrubbers in Ward 23.
- There's no formal lead for Antimicrobial Stewardship but a dedicated clinical pharmacist leads the AMS activities.

5. Winter Pressures

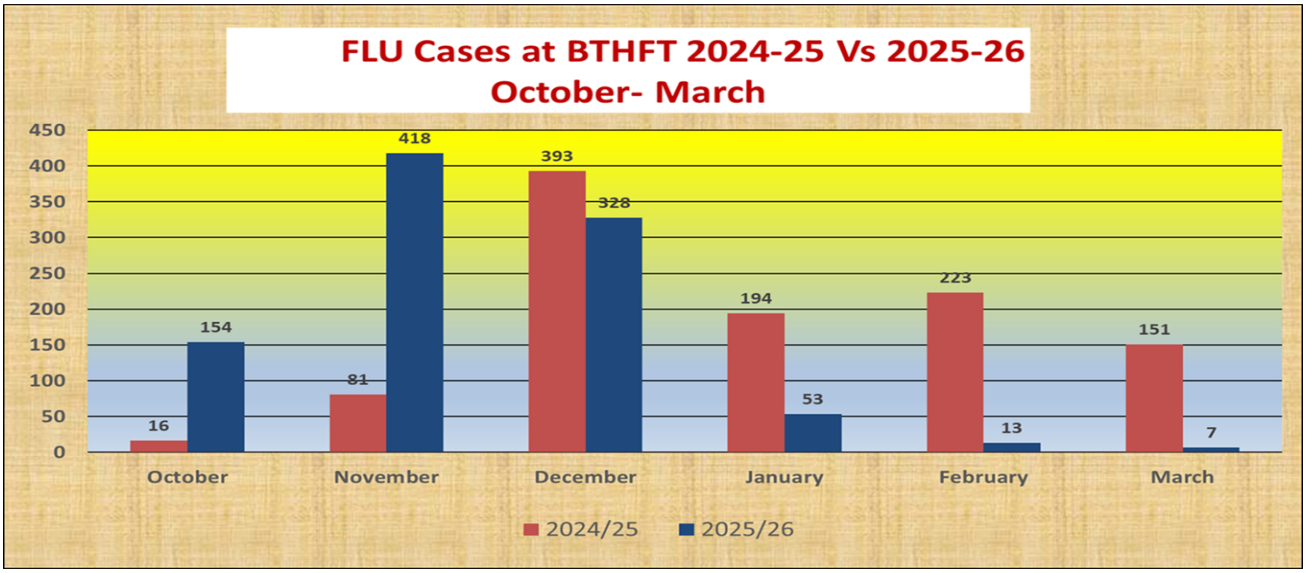
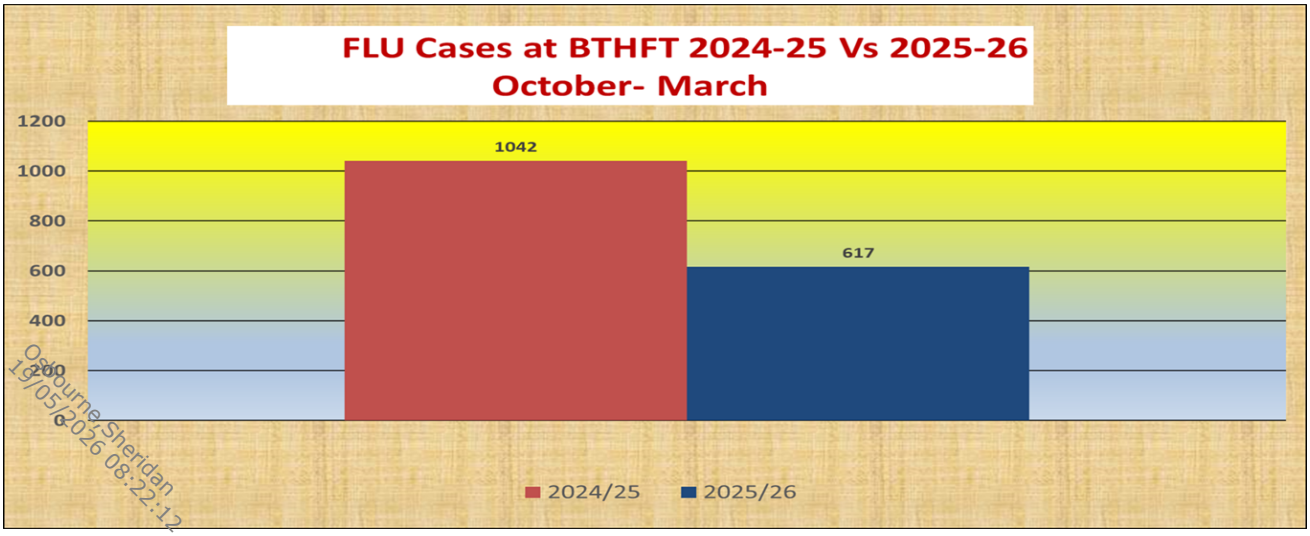


Figure 11

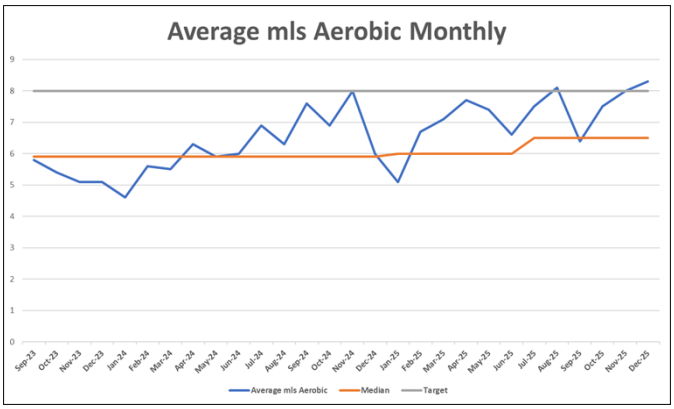


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Figure 12

6. Blood Culture Improvement

Blood culture improvement group meets monthly to discuss areas of improvement for appropriate collection, transport and processing of blood cultures. Figure 10 shows the improvement that has been made in relation of proper volume of blood.



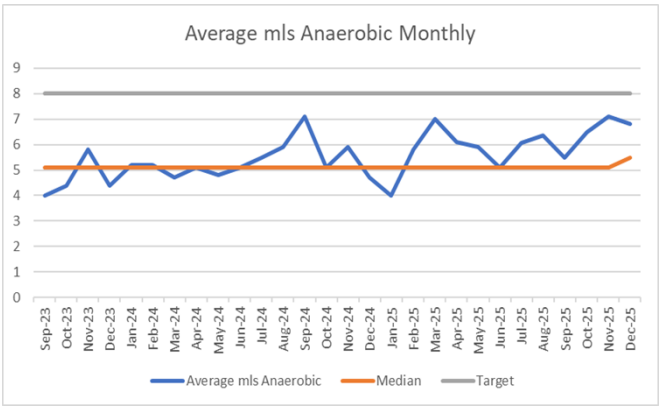


Figure 12

Failures noted in November and December due to a combination of slow transport from ward to lab at BRI and samples needing transport to AGH for loading.

Month	% loaded <4 hours
Nov 2025	71%
Dec 2025	76%
Jan 2026	89%
Feb 2026	100%

7. Antimicrobial stewardship

Good antimicrobial stewardship continues to be a priority for NHS England. A ‘Call to action’ was issued in by both UKHSA and NHSE in November 2025 challenging all NHS organisations to work towards meeting the targets in the National Action Plan for antimicrobial resistance. All our interventions around antimicrobial stewardship are intended to ensure we do all we can as an organisation to meet these targets.

Response to ‘Call to action’ letter

An initial meeting has been held with the medical director to identify our three priorities. The team is still to finalise these priorities and then define the SMART objectives and establish timelines and reporting mechanisms.

The required presentation to the board is booked, and the risk and capability assessment completed, using the national infection prevention and control board assurance framework

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CQUIN indicators

There have been no mandatory or non-mandatory AMS/AMR CQUIN indicators set for 2025/26.

Antibiotic Consumption data

Targets from National Action Plan:

- By 2029 to reduce total antimicrobial consumption by 5% compared to 2029 baseline (Baseline = 3627 DDD/1000 admissions. Target = 3445 DDD/1000 admissions)
- Aim to achieve 70% of total use of antibiotics from the Access category

Historic target but still relevant

- Reduce use of iv antibiotics (earlier IVOS). Target <20% total antibiotics given intravenously

Most recent data available (to end of March 2026 shows an unexpected increase of in consumption from 5375 DDD/1000 admissions in February to 7238 DDD/1000 admissions in March. Local trusts have also seen an increase in consumption This increase to be further investigated as the rolling 12 month watch and reserve consumption data does not show such a dramatic increase

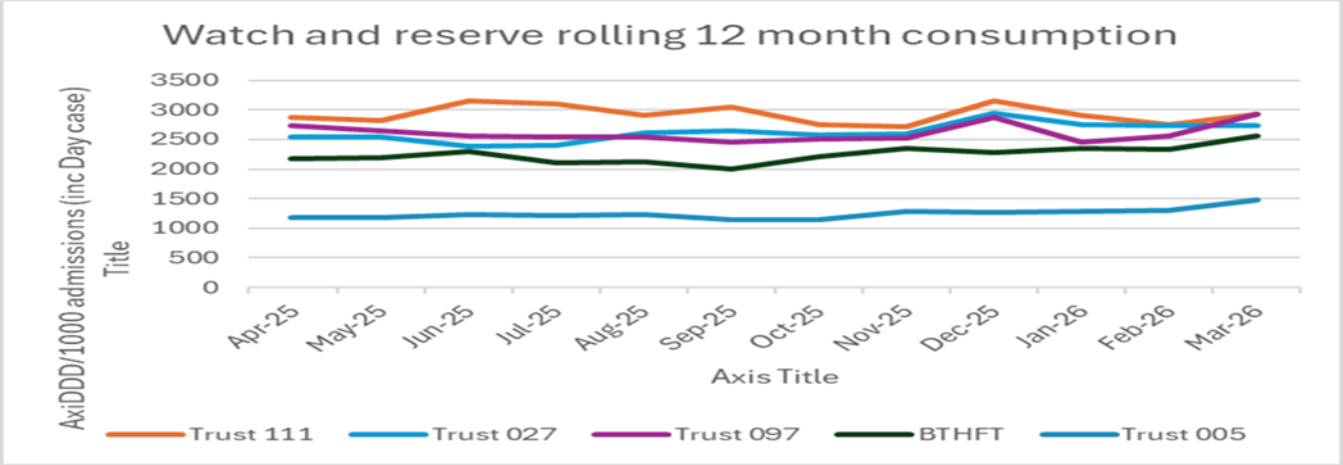


Figure 13

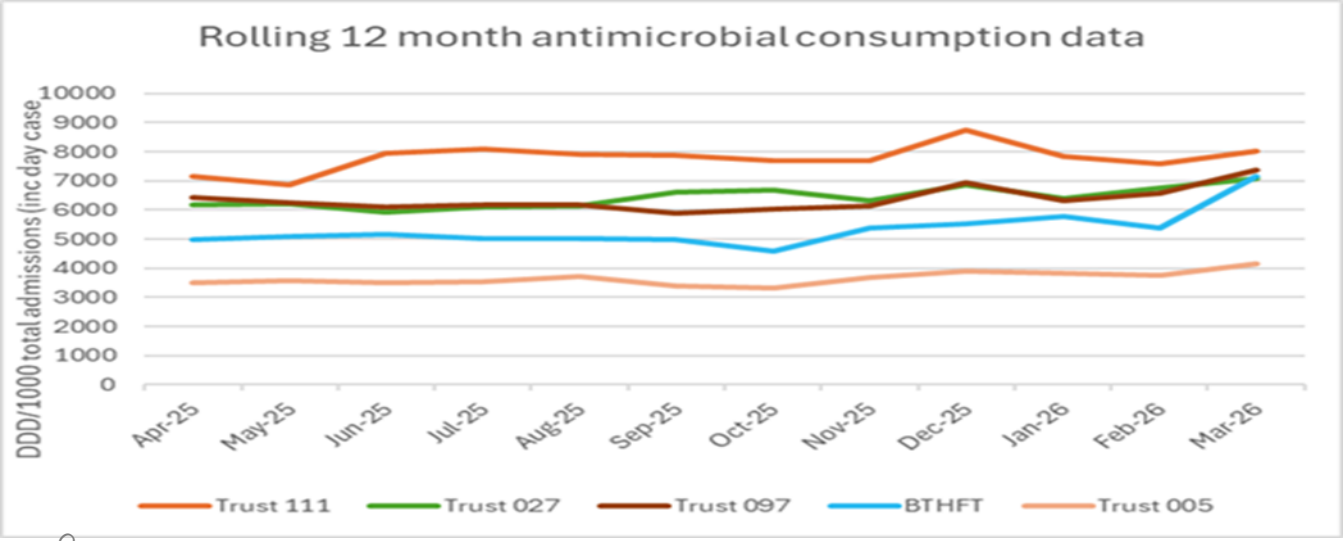


Figure 14

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Areas with the highest consumption of antibiotics are Outpatients (unable to be more specific with regard to specialty), and ED. Inpatient areas with high consumption data are ward 5, ward 18, ward 3 ward 2 and Ward 23

Watch and reserve antibiotic use

Data for the four quarters to the end of Q3 2526 suggests the trust has reduced the use of watch and reserve antibiotics compared to the 2019/20 baseline but the graph above shows there is still work to be done.

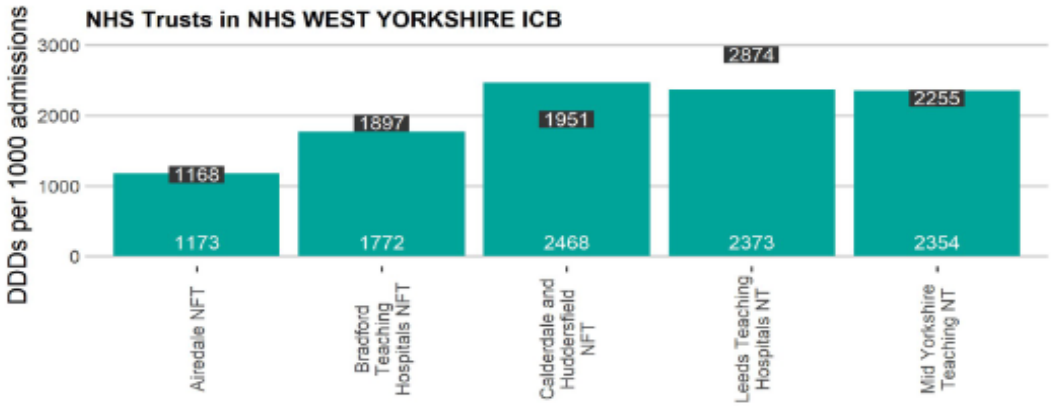


Figure 15

Co-amoxiclav is the most frequently prescribed antibiotic in this class.

Currently the proportion of antibiotics from the Access category is 56%, 42% from watch and 2%

Our use of watch and reserve antibiotics is similar to that of neighbouring trusts

The challenge in this area is that many of current antimicrobial guidelines recommend watch antibiotics as the first line option.

IV antibiotic use

Approximately 22% of all antibiotics are given as iv doses. Highest use of IV antibiotics is seen on ward 2, ward 18, ED, ward 5 and ICU

The trend of use again mirrors that of other West Yorkshire trusts

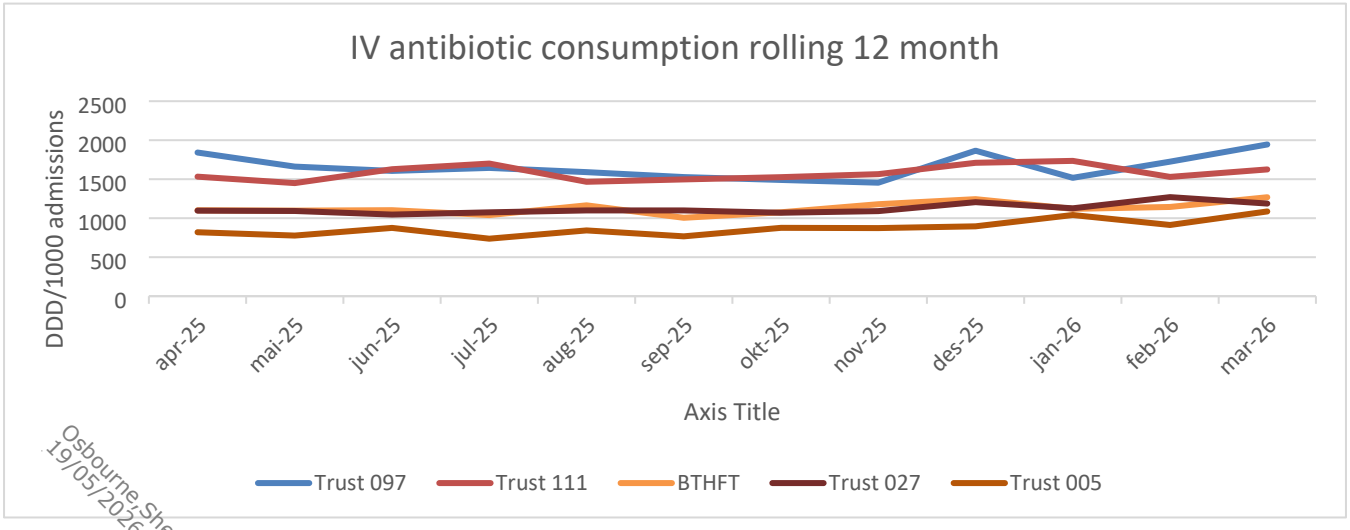


Figure 16

Appendix 2. IPC Board assurance Framework

Infection Prevention and Control board assurance framework v5.0						
	Key Lines of Enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Comments**	**Compliance rating**
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	**There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.**	**There is an Infection Prevention and Control Committee with terms of reference. The committee is chaired by the DIPC and meets quarterly. The committee reports to the Quality Committee quarterly with an annual report to the trust Board. The Infection Prevention and Control policy clearly defines the lines of accountability to the IPC team**				**3. Compliant**
1.2	**There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.**	**There is comprehensive system of data collection and reporting of mandatory organisms data on mandatory organisms. IRIS submitted for any hospital onset bacteraemia/CDI cases so that each care group can track HCAI. Immediate reviews are carried out to identify any**				**3. Compliant**

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		quick learning. Monthly triangulation is carried out to see any trends in cases.				
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Same as above				3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	the NIPCM is implemented and is uploaded into the trust intranet page and available for the staff to view.				3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	The quarterly report for hospital onset bacteraemia caused by mandatory infectious agents and CDI cases is presented in the Infection Control Committee, Patient Safety Group, Quality Committee and an annual report is presented to the trust board.				3. Compliant

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1.6	**Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.**	**Clinical audits are carried out to monitor compliance to IPC policies and protocols**				**3. Compliant**
1.7	**All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.**	**Training programme currently covers mandatory infection control and complies with National Core Skills Framework. Record of Mandatory training held centrally. The report for compliance to mandatory training is presented to the local CSU IPC meetings and the trust IPC committee**				**3. Compliant**
1.8	**There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)**	**Risk assessments completed by IPC/Risk& Governance Leads with support from Clinical MDT. Risk assessments shared for comments and approval through Silver and Gold CRG systems.**				**3. Compliant**
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						

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2.1	**There is evidence of compliance with National cleanliness standards including monitoring and mitigations (excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract these setting will have locally agreed processes in place).**	**Audit frequency is based on the functional risk category as defined in the National cleaning standards. All rectifications are undertaken within the agreed timescales and are recorded centrally Star ratings displayed and updated following audit Quarterly summary report sent to IPC Committee outlining any areas of concern Trust Cleaning Policy reflects the national cleanliness standards and has links to a suite of documents including SOP's, commitment to cleanliness charters, cleaning responsibility/frequency of cleaning framework, Cleaning Schedules etc. All functional areas have been reassessed (2023) with IPC and assigned to one of the 6 Functional Risk Categories**				**3. Compliant**
2.2	**There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.**	**PLACE inspections are undertaken annually, and all areas inspected in line with the definitions specified in PLACE guidance. Reports are produced once results reviewed and action**				**3. Compliant**

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		plans produced, which are presented to the board				
2.3	**There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.**	**The responsibilities framework identifies roles and responsibilities for cleaning in line with National Standards In addition, commitment to cleanliness charters are available for each area on the ward. These are also contained on the intranet and links are within the policy. These clearly define which items are cleaned, how often and by whom.**				**3. Compliant**

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2.4	**There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan.** **2.4.1 Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01.** **2.4.2 Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.**	**2.4.1 A schedule is kept by the authorising person (AP Vent) of all the ventilation verifications undertaken annually. The reports are also reviewed by the AE Vent (Authorising Engineer). The findings on the action plan are acted upon where feasible to do so, a program of refurbishment and upgrades is also available seeking funding.** **2.4.2 the water safety plan (WSP) is in development, the current water safety procedures are in use until the WSP is finalised, which compliments the water safety policy.**	**Not all areas are compliant to ventilation standards.**	**Risk assessment has been carried out for areas with sub-optimal ventilation. Patients with airborne isolation are prioritised in negative pressure rooms.**		**2. Partially compliant**
2.5	**There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09**	**There is a programme of PPMs which are administered via our Planet FM system and undertaken by a combination of our own trade teams and external providers where required. IPC are consulted and involved as part of the Estates Project Management Quality Manual (PMQM) on new builds or refurbishment projects.** **IPC are also consulted, when required, during maintenance**				**3. Compliant**

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		works especially when in augmented care areas.				
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen is delivered to the sites by an external contractor. This is packed to ward based standards agreed with each ward and department. Stock levels are monitored and audited to ensure suitable number of items and fit for purpose Standards are reviewed annually. Linen is delivered in cages which are covered to each ward/ department and then decanted to the areas linen cupboard. A contingency stock is kept covered in the clean linen gantry. Dirty linen is bagged and put in cages in the linen and waste				3. Compliant

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		rooms. Red alginate bags are used for infected linen				

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2.7	**The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.**	**There is a waste policy in place that reflects HTM 07:01. In addition, there is a matching set of standard operating procedures** **Bins are available at ward level, to clearly segregate all waste types in line with guidance. Colour coded bags are used, and bins are clearly labelled.** **Clinical waste is tagged with numbered tags to identify which area this has come from** **Central waste rooms are available throughout the site, and these contain waste bins separate for each waste types.** **Once full bins are moved to appropriate external storage holds prior to being removed by contractors** **Clinical waste operates a bin swap, and domestic waste are emptied on site** **There is an external chilled hold for anatomical waste, which is logged in line with HTM:07:01 and the human tissue act.** **Waste transfer notes and consignment notes are kept and logged to provide a full audit trail regarding disposal of waste.**				**3. Compliant**

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		a new e-learning package has been developed to support correct segregation of waste				

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2.8	**There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.**	**Surgical instruments processing service is provided by third party- (B Braun Sterilog). Compliance assurance audits are carried out regularly and reports provided to the trust. Endoscopes are processed in-house and processes are monitored regularly with annual review of flexible endoscope decontamination facilities.**				**3. Compliant**
2.9	**Food hygiene training is commensurate with the duties of staff as per food hygiene regulations. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.**	**The Trust has in place a food hygiene policy and a ward kitchen code of practice, which are readily available on the Trusts internet pages. The food hygiene policy has a training matrix within it and defines what training is required at each level. Both documents have clear guidance available regarding food brought in. This includes labelling, dating and storage. All fridges are monitored twice daily by Ward Hospitality assistants where they are based. and action taken if these fall outside of set temperatures. This is covered within the policy and code of practice**				**3. Compliant**

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3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	**Ensure clarity of responsibility for AMR within governance responsibilities, including how antimicrobial stewardship (AMS) aspects of Care Quality Commission (CQC) Regulation 12 to prevent individuals from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.**	**An antimicrobial stewardship strategy is now in place which outlines the arrangements for AMS in the Trust.**				**3. Compliant**
3.2	**The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.**	**The antimicrobial stewardship report that summarises performance is submitted at the IPCC meetings and subsequently is included in the IPC report presented to the QPS Committee and the Trust Board.**				**3. Compliant**

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3.3	**There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan. A formal operational lead for AMS is in post with time in their job description. Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early, accurate diagnosis and intervention upon outcomes and lengths of stay. Where there is variation with other providers which requires attention, develop plans to address unwarranted variation and to support National AMR Plan ambitions.**	**The Chief Nurse has additional responsibility as a Trust IPC Executive Lead who presents the IPC report that includes AMS activities.**	**There is no formal lead in post with allocated hours and job description.**	**A dedicated clinical pharmacist is working with the Infectious disease team for data collection on antimicrobials.**		**2. Partially compliant**

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3.4	**To optimise patient outcomes and minimise inappropriate prescribing:** **• Monitor and improve compliance with NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use'** **• Ensure adherence to the principles of Start Smart, Then Focus is implemented and monitored in secondary care.** **• Ensure AMS is included in mandatory training using national materials such as 'Start Smart, Then Focus' and 'Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET)'.**	**Antimicrobial consumption data is available via PHE fingertips. A quarterly report is circulated by the regional Antimicrobial Prescribing and Medicines Optimisation lead (APMO), which summarises antimicrobial usage and performance against the requirements of the NHS Standard Contract. The antimicrobial stewardship report (submitted at the IPCC meetings) summarises performance** **The antimicrobial strategy includes monitoring arrangements**				**3. Compliant**
3.5	**Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including:** **• total antimicrobial prescribing.** **• broad-spectrum prescribing.** **• intravenous route**	**Latest APMO report gives reassurance that BTHFT is demonstrating good practice**				**3. Compliant**

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	prescribing. • treatment course length.					
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	The data on antimicrobial usage is collected and reported regularly to the IPCC				3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	All patients/ service user information is developed taking into consideration diverse population of Bradford and is approved from with EDI and is approved from Communication and with Patients approval group (CPAG).				3. Compliant

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4.2	**Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.**	**Patient information leaflets are available on the Trust external webpage including: Reducing risk of Infection, MRSA and Clostridium difficile. Information available on the website. Easy read versions have been commissioned from Bradford Talking Media. Hands, Face, Space posters and banners in place. Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted including use of posters. Translation service is also available for diverse patient population.**				**3. Compliant**
4.3	**The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.**	**Patient information is in line with IPC and AMR policies and principles including isolation information for isolated patients.**				**3. Compliant**

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4.4	**Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include:** **• hand hygiene, respiratory hygiene, PPE (mask use if applicable)** **• Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness)** **• Explanations of infections such as incident/outbreak management and action taken to prevent recurrence.** **• Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.**	**The visiting policy includes comprehensive information on roles and responsibilities of carers and visitors.**				**3. Compliant**

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4.5	**Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.**	**Information on infectious status of patients is shared with other organisations through discharge letters, EPR and GP letters. Urinary catheter passport is used for catheterised patients.**				**3. Compliant**
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	**All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.**	**Automated electronic flagging in place on EPR for patients infected or colonised with common infectious agents including PTB, MRSA, CPE, C. diff infection etc. at previous admission. This enables effective communication by clinical teams and Command centre staff on patient transfer. Screening questions part of assessment on EPR. Admission assessment template in EPR Screening questions part of pre-op assessment and attendance at OPD**				**3. Compliant**

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5.2	**Patients' infectious status should be continuously reviewed throughout their stay/period of care. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes. The Isolation prioritisation tool is available to assist in patient placement and ongoing isolation decisions.**	**Patients' infectious status is regularly reviewed by the IPC and command centre teams based on the microbiology results. Medical input is also sought for patients needing clinical review. Additionally, side room priority boards are in place in wards to support continuous assessment in clinical areas.**				**3. Compliant**
5.3	**The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.**	**Information on infectious status of patients is shared with other organisations through transfer/discharge letters. Additionally, information can be accessed by some organisations via EPR.**				**3. Compliant**
5.4	**Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.**	**Signage in place at hospital entrances and information available on Trust website**				**3. Compliant**

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5.5	**Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.**	**All infectious cases meeting the definition criteria for outbreaks are investigated and outbreaks are reported through electronic portal. Information on all outbreaks is shared in Infection prevention and control committee (IPCC) as well as included in the quarterly reports to Patients Safety Group as well as Quality Committee.**				**3. Compliant**
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	**Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.**	**All new hirees receive IPC training on induction that includes basic IPC principles including standard and transmission-based precautions and Aseptic Non-touch technique (ANTT).**				**3. Compliant**
6.2	**The workforce is competent in IPC commensurate with roles and responsibilities.**	**IPC training level 2 is mandatory for all healthcare workers.**				**3. Compliant**
6.3	**Monitoring compliance and update IPC training programs as required.**	**Compliance to IPC training is monitored and reported regularly to the IPCC.**				**3. Compliant**

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6.4	**All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.**	**All relevant staff are trained on use of PPE including PPE for high consequence diseases**				**3. Compliant**
6.5	**That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.**	**All clinical staff are fit tested, and records are maintained in ESR.**				**3. Compliant**
6.6	**If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.**	**In addition to mandatory IPC level 2, bespoke training and competency plan is implemented by education department.**				**3. Compliant**
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						

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7.1	**Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.**	**Automated electronic flagging in place on EPR for all patients with infectious status at previous admission. This enables effective communication by clinical teams and Command centre staff on patient transfer. Screening questions part of assessment on EPR. Admission assessment template in EPR Screening questions part of pre-op assessment and attendance at OPD**				**3. Compliant**
7.2	**Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if:** **• single rooms are in short supply and if there are two or more patients with the same confirmed infection.** **• there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and**	**Source Isolation policy includes information on appropriate isolation precautions for infectious patients. The policy includes a Side room Priority System that enables command centre and clinical teams to priorities side room usage. In case unavailability of side rooms, patients with same infectious agent are cohorted. Such incidences are recorded via IRIS. Winter surge plan is created before the winter season and implemented during the season.**				**3. Compliant**

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	processes are in place to mitigate risk.					
7.3	**Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.**	**Signage is displayed with colour coding for patients requiring TBPs. PPE posters available on entry to all inpatient wards.**				**3. Compliant**
7.4	**Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.**	**Command centre staff have been instructed to avoid transfer of infectious patients to other wards/clinical areas unless clinical necessary to receive appropriate clinical care.**				**3. Compliant**

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8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	**Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.**	**All individual involved in testing for infectious illness are trained and competent. SOPs in place for training and competency management.**				**3. Compliant**
8.2	**Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.**	**All positive cultures are monitored by the IPC and clinical teams via ICNet, EPR. Sepsis pathway has been implemented for early identification and management of sepsis. All patients with respiratory symptoms are tested for identification of respiratory pathogens.**				**3. Compliant**
8.3	**Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.**	**Microbiology lab services are provided by a joint venture. Any new guidance is reviewed jointly.**				**3. Compliant**

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8.4	**Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.**	**All trust policies and protocols for testing potentials infectious patients are in line with the national guidance and updated accordingly. Information on infectious status of patients is shared with other organisations through discharge letters. Additionally, information can be accessed by some organisations via EPR.**				**3. Compliant**
8.5	**Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.**	**All trust policies and protocols for testing potentials infectious patients are in line with the national guidance and updated accordingly.**				**3. Compliant**
8.6	**There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.**	**There is agreed SOP for Laboratory action in the event of an outbreak which includes testing for high consequence diseases e.g. VHF, MERS-CoV etc.**				**3. Compliant**

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8.7	**There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.**	**The protocols are available and updated regularly. IPS_Path_MP_29 Specimen Transport IPS_Path_RAF_039 Pathology vehicle goods and sample transportation IPS_Path_RAF_016 Transport of Samples Using The Pod Airtube System. IPS_Path_QD_03 Pathology Handbook**				**3. Compliant**
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	**Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, NIPCM including the NHSE A to Z pathogens list). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider. The SICPs**	**Outbreak protocols in place. Outbreaks reported a to Quality Committee and lessons learnt shared. Outbreak reports shared at IPCC and action plans monitored through Care Group IPCC meetings.**				**3. Compliant**

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	monitoring tool can be applied to aid this process.					
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	**Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.**	**Risk assessment process in place for vulnerable groups of staff including guidance for managers and risk assessment checklist and template. Documents are regularly updated in line with national guidance. OH support available to staff/managers that have concerns about their vulnerabilities including signposting to psychological support. [local and national]**				**3. Compliant**

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10.2	**Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.**	**All staff members with evidence of exposure to an infectious agent without appropriate PPE are referred to occupational health for further follow up**				**3. Compliant**
10.3	**Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).**	**All staff undergo preemployment health checks via occupational health**				**3. Compliant**

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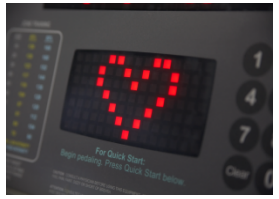
Bradford Teaching Hospitals
NHS Foundation Trust

Act now: protect our present, secure our future

Responding to the challenge of antimicrobial resistance





Together, putting patients first

Antimicrobial resistance: The National Action Plan

Key goals (by 2029)

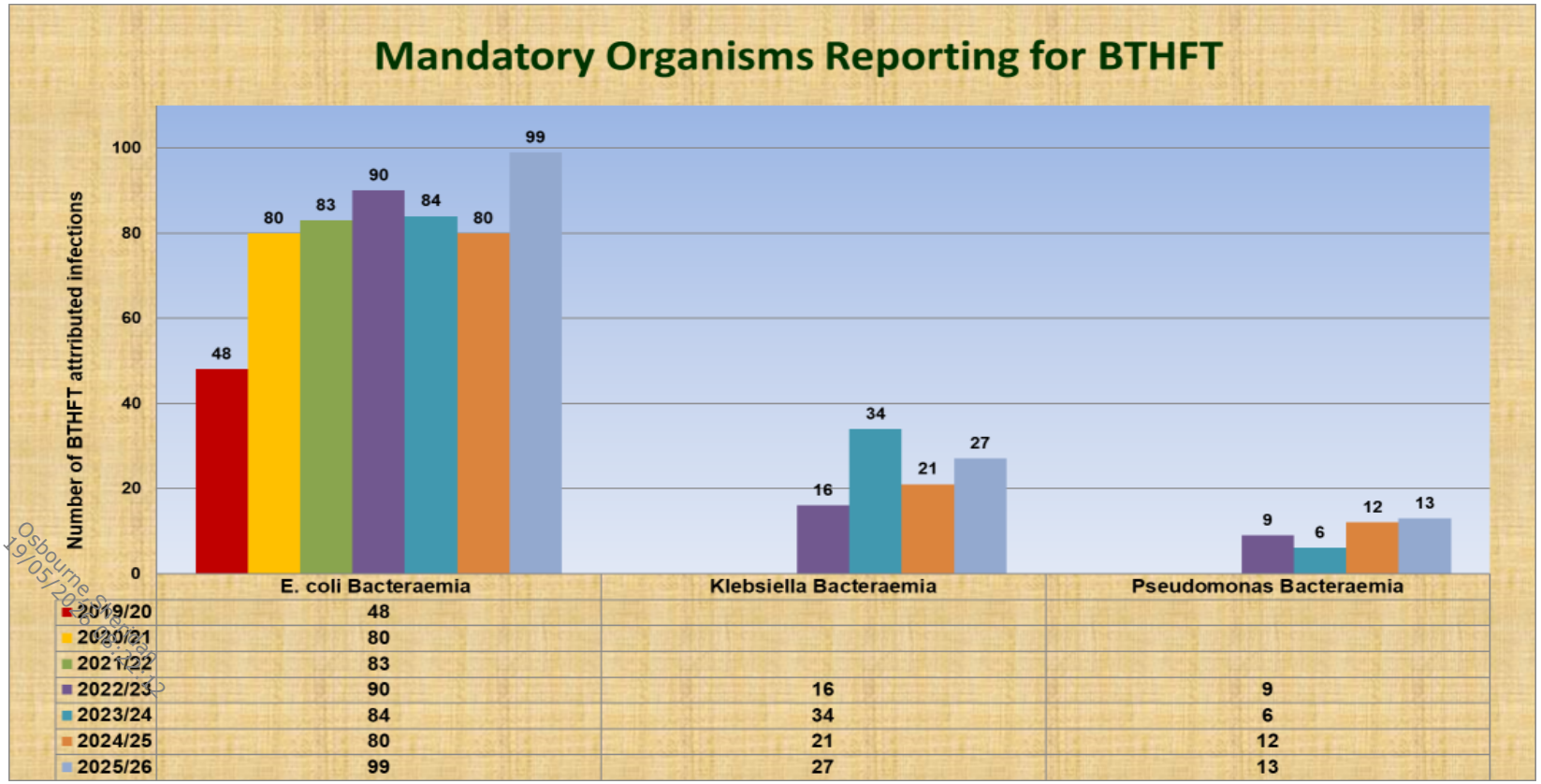
- Prevent any increase in a specified set of drug-resistant infections (from 2019-2020 financial year baseline)
- Prevent any increase in Gram-negative bloodstream infections (from 2019-2020 financial year baseline)
- Reduce total antibiotic use in human populations by 5% (from 2019-2020 financial year baseline)
- Achieve 70% of total use of antibiotics from the Access category by 2029

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How we are performing against these targets

Gram negative organism blood stream infections

- Data collection for Klebsiella and Pseudomonas started from April 2022.
- E. coli bacteraemia definition changed from 2020/21.

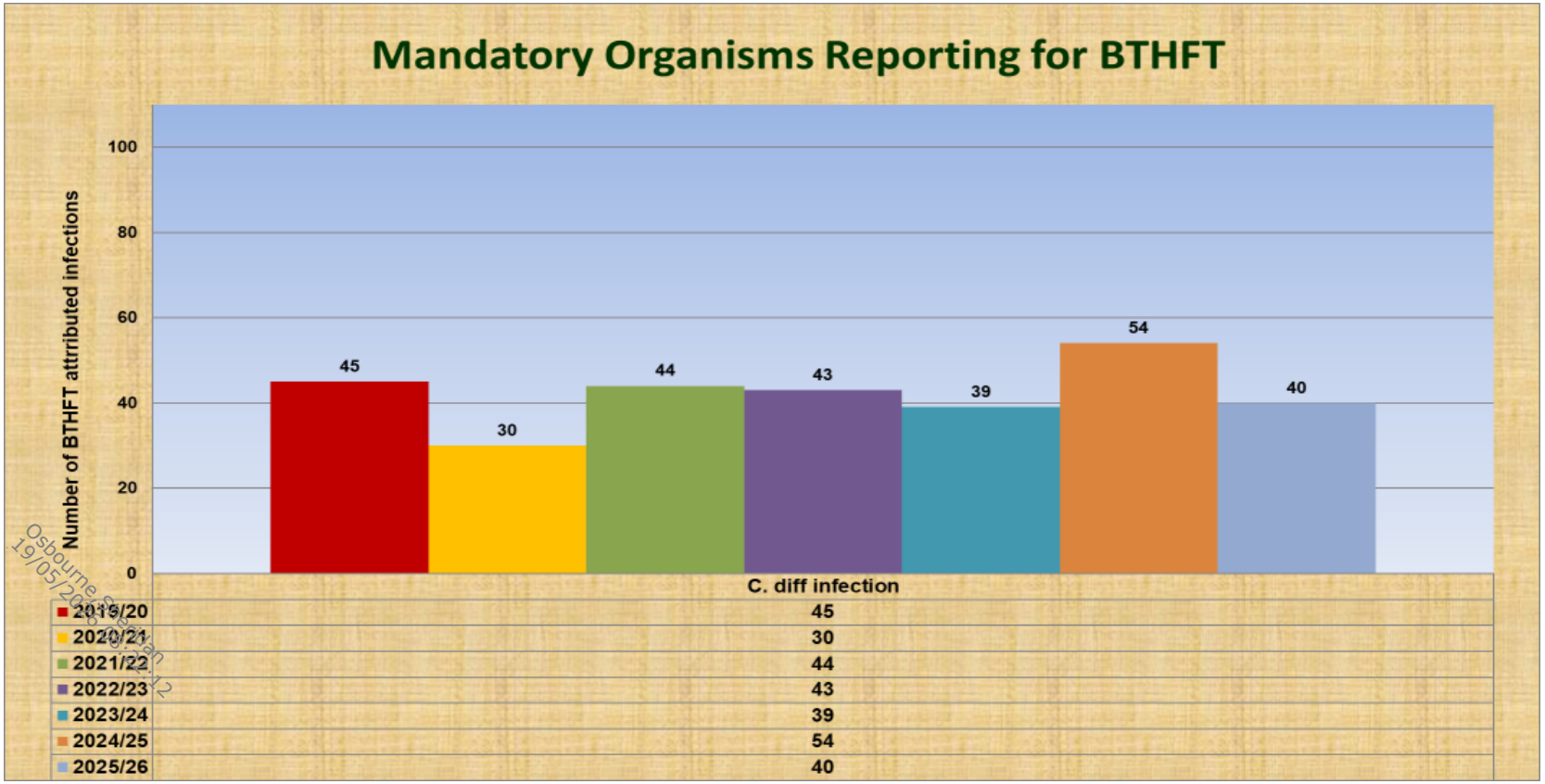


Osbourne Seminar 19/05/2022

How we are performing against these targets

Drug resistant infections

2019-20 baseline: 2026-26 outcome



Bacteraemia Reduction Measures

- A comprehensive improvement plan updated regularly.
- Immediate review of bacteraemia cases for quick learning.
- Triangulation of cases using PSIRF.
- Hand hygiene improvement campaign using Semmelweis hand scanners.
- Support Gloves off Campaign.
- ANTT training and assessment. Plan for ANTT accreditation for the Trust.
- “ASK ME” hand hygiene campaign to encourage patients to question hand hygiene by staff members.
- A wider Task and Finish group including representatives from Bradford and Airedale acute trusts as well as primary care is working on reduction in E. coli bacteraemias.

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CDI Reduction Measures

- 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.
- Ad hoc and regular environmental audits.
- Commode audits with IRIS on non-compliance. “Golden” Commode Award.
- Review of Antimicrobials for all positive CDI cases with the antimicrobial pharmacist.

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How we are performing against these targets

Antimicrobial use

Antibiotic use is measured as defined daily doses /1000 total admissions

Baseline from 2019-20: 3627
12 months 2025-26: 5377 (almost 15% increase compared to baseline)

Significant challenge is the prescribing of antibiotics in outpatient settings

BTHFT achieved the target set on the first 5 year action plan

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How we are performing against these targets

Antibiotics from the Access category

Access category antibiotics are ‘narrow spectrum’ antibiotics

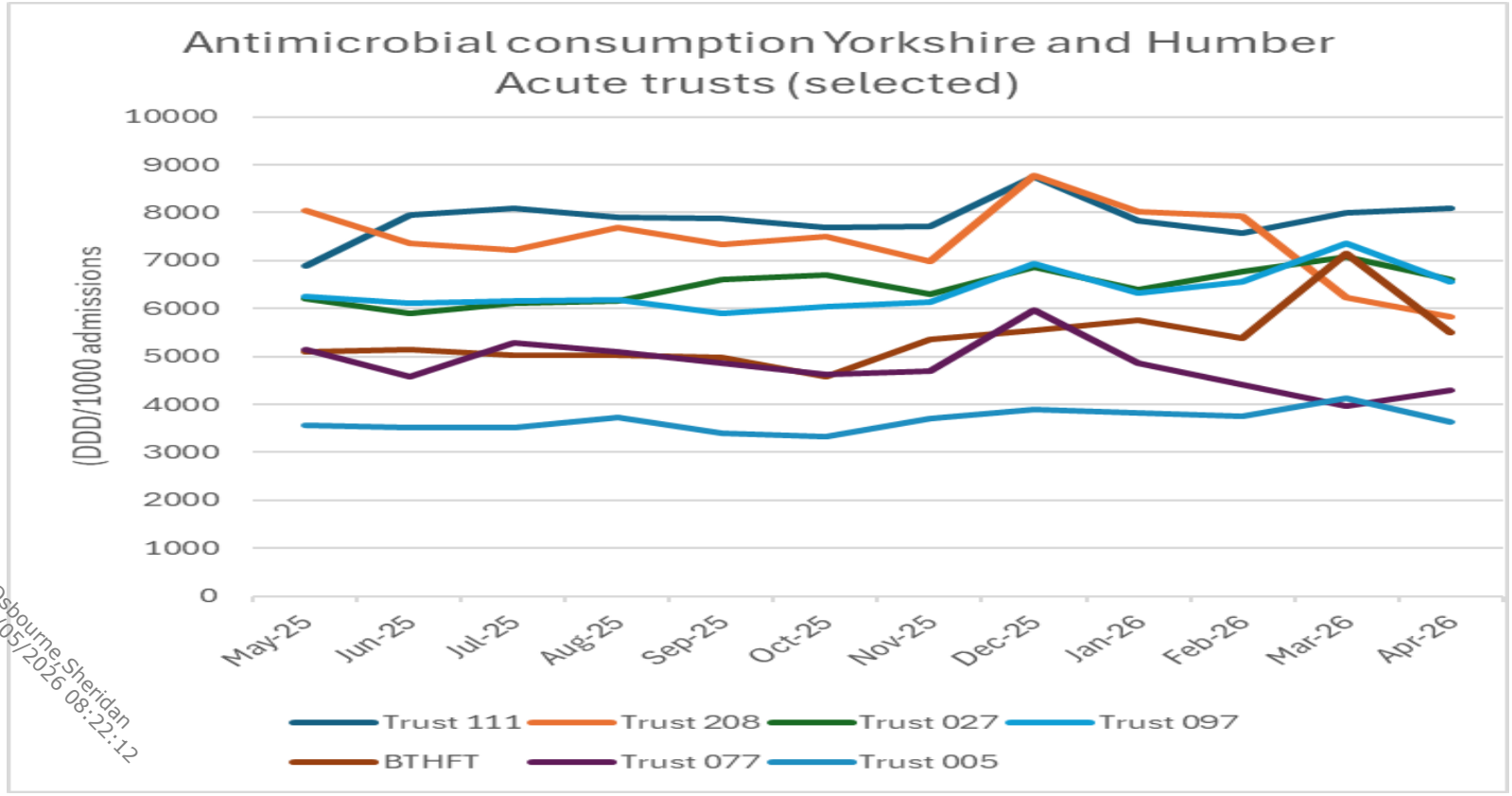
Currently the proportion in this category is 57% vs target of 70%

Key challenge is to address the prescribing of broad-spectrum antibiotics (not in the access category) in ED and outpatient settings

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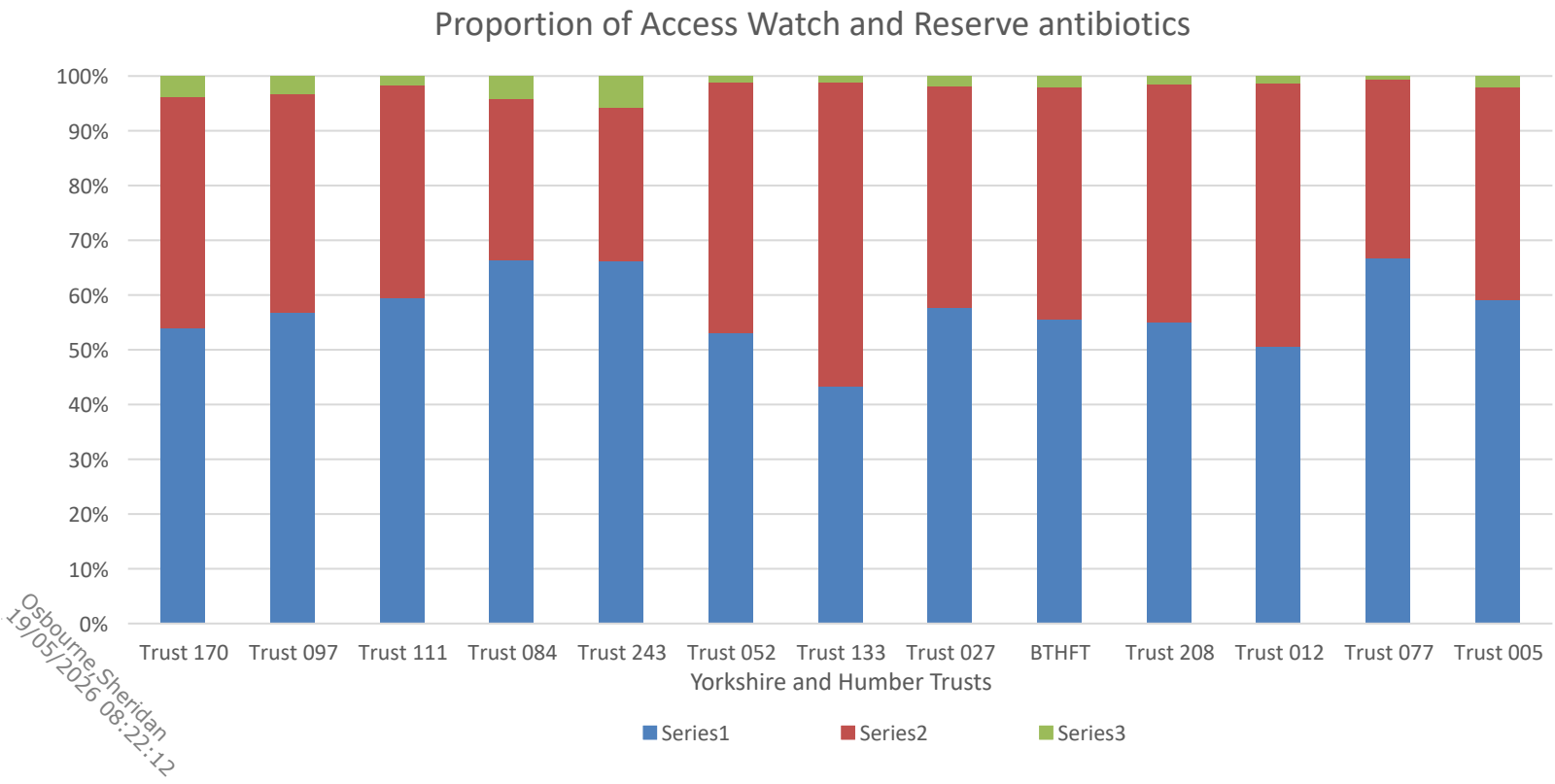
Benchmarking against local trusts and national trends

Antimicrobial use



Benchmarking against local trusts and national trends

Antibiotics from the Access category



First steps towards attaining the targets

Three priorities have been identified as the first steps in attaining these targets

- **Compliance with 48-72 hour prescribing review and timely switch to oral antibiotics.** Oral switches are often narrow spectrum agents.

- **Compliance with blood culture guidelines and timings-** adequate fill of blood culture bottles and no delay in loading onto the machine then ensures timely diagnostic certainty and allows de-escalation or discontinuation of empirical antibiotic treatment

- **Reduction in the number of blood stream infections due to Gram negative bacteria**

Osbourne,Sheridan
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Next steps

- Convene a working group to focus on these priorities
- Define measurable objectives
- Establish timelines and reporting mechanisms

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Governance and oversight

- **Appointment of a formal operational lead for antimicrobial stewardship**
- **Identifying an executive with responsibility for antimicrobial stewardship**
- **Reporting structure to be formalised**

Osbourne,Sheridan
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Board of Directors			
Meeting Date:	21 May 2026	**Agenda Reference:**	Bo.5.26.10
Report Title:	Standards for the Care of Acutely Unwell Patients in the First 72 Hours in Hospital: Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) Board Assurance Report		
Presented by:	John Bolton (Chief Medical Officer)		
Executive Lead:	John Bolton (Chief Medical Officer)		
Author:	Dr Amy Illsley (Deputy Chief Medical Officer) Caroline Varley (General Manager Chief Medical Officer Team)		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	This benchmarking report (see Appendix 1) seeks to assure the Board of the current Trust position against 15 Standards set out regarding the care of acutely unwell patients during their first 72 hours in hospital, along with highlighting gaps in provision and setting out an action plan. This exercise should be repeated every six months. Key highlights from the report can be seen in the executive summary but include: • Partial achievement of 14 of the 15 standards. • The need to focus on accuracy of data recording within EPR to allow appropriate metrics to be retrieved. • The role of local audit and departmental operational process being defined and monitored highlighted. • Ongoing work by the EXCEL team looks to improve operational processes for patients during their first 72 hours of admission which will improve compliance with multiple Standards. • Workforce review within Emergency Medicine and Acute Medicine to improve compliance with several Standards. • Gaps in therapy support, dedicated frailty services, and the requirement to significantly review consultant job planning in some areas to meet the Standards in full.			
Recommendation/s: (including any decision/approval required)	The Board is asked to: 1. Consider the appropriate frequency of Board reporting against the 15 standards – the self-assessment tool recommends six monthly Board assurance reports to be prepared and shared (this could be reduced to an annual report to Board if six monthly reports were accommodated within other Trust quality assurance processes). 2. Assess the Standards and whether appropriate to suggest joint ownership between Chief Medical Officer team, Chief Nurse team and Operations / EXCEL programme.			
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness			
Link to Priority Initiatives 2025/26:	N/A			

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Implications	
Risk:	The report contains a risk assessment – please see full document for details. The risk of not meeting the 15 Standards related to delays in patient care and flow. Improving access to clinical review, amongst other Standards, would reduce likelihood scores of risk occurring relating to delays in care including increased length of stay.
Legal/Regulatory:	Benchmarking report required by NHS with requirement to report to Board. An expectation of Trust board oversight of these standards will be included in the Insightful provider board guide when updated in 26/27.
Quality & Patient Safety:	The 15 Standards describe expectations and processes that would be expected to improve both the quality of care received and improve patient safety if fully met.
Equality, Diversity and Inclusion and Health Equity:	Compliance with the 15 Standards would not be expected to negatively impact on EDI requirements, however the self-assessment tool does not make specific reference to EDI. Standard 2 would be expected to improve provision of care for older adults and those living with long term health conditions. Trust EDI policies should be taken into account throughout work associated with the 15 Standards.
Resources:	Running a six monthly report against the 15 Standards has resource implications in a number of areas: business intelligence requests, Chief Medical Officer team capacity, departments staff undertaking audit and collating data. To meet the 15 requirements in full there may be requirements for additional staffing support or changes to job planned activity.
Environmental sustainability:	Indirectly there may be impacts on sustainability if meeting the 15 Standards was shown to reduce length of stay and / or unnecessary investigations, or delays to care.
Assurance Route	
Meeting/s where content has been discussed previously:	ETM – 18 May 2026

Report content

1. Purpose

The 'Self-assessment tool for standards for care of acutely unwell patients in their first 72 hours in hospital. Guidance for NHS Trusts' has been developed to help Trust teams assess and provide board level assurance on the safety, quality and delivery of non-elective care in the first 72 hours in hospital.

2. Background/context

The initial requirement is to undertake an initial benchmarking exercise over the Winter 25/26 period. This exercise should then be repeated every six months, with findings articulated in a formal board assurance report. The initial benchmarking exercise is described below and aims to answer the following three questions as set out in the self-assessment tool:

1. How are we doing now – to what extent are the standards are being achieved?
2. What are the gaps or areas of concern?
3. What are we doing about these gaps or concerns?

Bradford Teaching Hospitals NHS Foundation Trust
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3. Assessment

14 of the 15 standards are currently partially achieved at the Trust. To meet the Standards in full significant work will be needed focussing on data collection, EPR process, organisational processes including patient flow, and workforce utilisation. Initial priorities for the next six months will be to improve data availability and collection to allow closer monitoring of targets and assessment of interventions. Ongoing work by the EXCEL team needs mapping to the Standards to prevent duplication of work and organisation policies and pathways need establishing.

4. Options analysis/Proposal

The report contains an action plan section with a list of key activities split into 3 themes. The first is about accuracy of data recording and review, including the need for involvement by business intelligence, EPR teams, and departmental audits. The second theme is focussed on operational pathways which will require liaison between the Chief Medical Officer team, the EXCEL team and Clinical Service Units. The final theme for action relates to workforce and includes ongoing recruitment into pharmacy services to support the emergency Department, workforce review of Emergency Medicine and Acute Medicine services, and staffing gaps across therapy services.

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Standards for the care of acutely unwell patients in the first 72 hours in hospital: Bradford Teaching Hospitals NHS Foundation trust (BTHFT) Board Assurance Report
March 2026: Benchmarking Report

Background

The 'Self-assessment tool for standards for care of acutely unwell patients in their first 72 hours in hospital. Guidance for NHS Trusts' has been developed to help trust teams assess and provide board level assurance on the safety, quality and delivery of non-elective care in the first 72 hours in hospital. The initial requirement is to undertake an initial benchmarking exercise over the Winter 25/26 period. This exercise should then be repeated every six months, with findings articulated in a formal board assurance report. The initial benchmarking exercise is described below and aims to answer the following three questions as set out in the self-assessment tool:

1. How are we doing now – to what extent are the standards are being achieved?
2. What are the gaps or areas of concern?
3. What are we doing about these gaps or concerns?

Standards: Levels of Attainment

This section sets out the trust's position against each of the 15 standards and the level of attainment has been rated as achieved, partially achieved or not yet achieved.

Standard 1

All patients should have a full assessment by a **competent clinical decision-maker** within 1 hour of referral from the emergency department (ED) or of arrival on the **acute receiving area**. Any time-critical meds should be identified and prescribed with a plan for a pharmacy review within 24 hours of admission. This should complement, not duplicate, any previous assessment. EDs and acute receiving teams should work together to deliver and document a streamlined assessment that builds on a shared clinical narrative. All admitted patients should be assessed by an **expert clinical decision-maker**, normally a consultant, within a maximum of 6 hours during the day and 14 hours overnight. Acute trusts should resource and plan the expert decision-maker workforce to maximise the day's work by modelling cover for peak times.

Note: **competent clinical decision maker** = 'clinician who can perform an initial assessment and treatment of a patient'; **acute receiving area** = 'first point of entry for patients referred to hospital as an acute medical or surgical emergency by primary and community care and those requiring admission from the ED. They are inpatient facilities that are open 24 hours a day, 7 days a week'; **expert clinical decision maker** = 'clinician who can develop a comprehensive management plan, have overall responsibility for patient care and have extensive experience in managing acute patients within their specialty; usually a consultant doctor but can include specialist and SAS doctors'

Osbourne, Stephen (NHS)
19/05/2026 09:09:03 (GMT+1)

Current position: A snapshot audit of adult ED patients shows the 60-minute target for assessment by a competent clinical decision maker is met for approximately 15% of patients, and the target for review by an expert clinical decision maker is achieved for approximately 50%. Within children's services, the clinical service unit is confident that the

target for review by an expert clinical decision maker is met but feel it is unlikely that the 60-minute target is met, owing to patient numbers; manual audit will be required to confirm and monitor progress. This was also the position currently held by the general surgical team.

Pharmacy support to admissions areas operates 8am to 6pm seven days a week, focused on wards 1, 3 and 4; pharmacy provision into the ED is being expanded, with a new pharmacist due to start in May 2026 and pharmacy technician and assistant posts approved.

We do not currently have a streamlined assessment document to record patient admission and shared clinical narrative. The 'enhancing experience, reducing waiting time and shortening length of stay' (EXCEL) team workstream two is looking at reducing EPR clicks in ED and streamlining processes. The EXCEL team are also reviewing patient flow through the ED and acute medical unit.

With a view to increasing expert clinical decision maker input in ED, from 1 April 2026 the Acute Internal Medicine (AIM) team has begun in-reach into the ED from 8am, using a second 'same day emergency care' (SDEC) consultant, to improve time to expert decision-maker review. A team job-planning exercise on 15th May 2026 will examine staffing and rotas, which aims to increase access to competent clinical decision maker review. The ED department is also undergoing a workforce review.

The principal gap is standardised audit data outside acute medicine. As most non-elective admissions are to the acute medicine team, care of the elderly team, and general surgical teams the data collection going forward will initially focus on these areas, with a view to expanding to small specialty areas in due course. A manual audit tool needs to be developed and applied across all acute receiving areas every six months. SAMBA (Society for Acute Medicine Benchmarking Audit) data for SAMBA25 has not yet been released nationally and will be incorporated into future reports. Once pharmacy recruitment to support ED is complete, audit data of time to pharmacy review and prescribing of time critical medications will be requested.

Level of attainment: Partially achieved

Standard 2

Additional requirements for specific patient cohorts:

Older people with frailty:

- patients aged over 65 presenting to hospital as an emergency should be assessed by a competent clinical decision-maker within 30 minutes of arrival using the Clinical Frailty Scale (CFS) and the 4AT tool for delirium
- acute trusts should ensure that older people with frailty (CFS ≥5) have access to a **senior clinical decision-maker** with skills in managing frailty and multiple long-term conditions within 1 hour of referral during the day or before 10am the next day if overnight
- all older people with frailty (CFS ≥5) should be assessed by an expert clinical decision-maker in managing frailty, normally a consultant, within a maximum of 6 hours during the day and 14 hours overnight

Patients with long-term conditions:

- specialty and/or specialist palliative care teams should be consulted when known patients present to ED with an exacerbation of a long-term condition, where appropriate. Advice should be sought on alternatives to admission including options for accessing support in the community

Patients receiving palliative care and end-of-life care:

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- acute trusts should ensure patients who are receiving palliative care and end-of-life care or who have advance care plans can be identified to ensure their preferences and wishes are supported

- a mechanism should also be in place to identify patients who are likely to be in the last phase of life but whose needs are not yet recognised, with referral to their specialty team and/or specialist palliative care where appropriate

Note: **senior clinical decision maker** = 'clinician who can collate relevant patient information, make a diagnosis and determine a management plan that includes specific investigations and treatment, usually working at medical registrar level'

Current position: The CFS is recorded in the ED but a recent audit found it inaccurate: of 29 cases reviewed, 10 (34%) correlated with subsequent geriatrician assessment from notes; 19 (66%) did not correlate, and in all 19 non-correlating cases the ED under-scored the patient. The CFS is also being recorded for patients aged under 65, for whom it is not validated. The 4AT delirium screening tool is not in routine ED use. There is not currently a specific frailty service within the ED, however there is access to therapy, elderly virtual ward team and, often, an elderly care consultant in the mornings. Improvement will need to address scoring accuracy and the development of a frailty service to achieve this standard in full. Given the inaccuracies in CFS recording an audit of time to review by senior or expert clinical decision maker has not been undertaken.

Currently there is no agreed local definition of which long-term conditions are in scope of this standard, at the guidance document does not specify. Multiple long-term condition pathways exist within the Trust but are not consistently catalogued. The EXCEL team are working to improve the ED intranet offering, with a central up to date repository of guidelines, pathways and useful resources. The EXCEL team are also looking at alternative options to ED attendance and community services. Updates on progress by the EXCEL team will be included in future reports to map progress against areas that overlap with the first 72 hours standards.

The REACT palliative care liaison team operates 8am to 8pm, seven days a week, and identifies patients in the ED. Patients with a palliative diagnosis are not currently flagged on admission. Identification could be improved by sharing data between SystmOne and Cerner on patients with a ReSPECT form, those on the GP Gold Standards Framework register, and those known to specialist palliative care services across community, hospital and hospice. A workstream within the palliative care team is exploring how to do this.

Level of attainment: Partially achieved

Standard 3

Acute trusts must have operational policies that describe:
- how, by default, all acute admissions move from ED or directly from primary or community care to an acute receiving area as their first inpatient setting
- the exceptions to this are where there is clear patient benefit from immediate speciality intervention: for example, acute stroke and STEMI
- clear admission criteria and pathways for all commonly presenting clinical problems, as agreed with all specialties and regularly reviewed
- how care should be delivered for patients requiring shared care, ensuring that a single clinician is responsible for their overall care
- the escalation process if specialties disagree about responsibility or location of care

Osbourne Sheridan
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Current position: Policies exist in some form across most of these areas. Examples include the ED standard operating procedure for clinical readiness for transfer to a receiving ward, a paediatric flow standard operating procedure between the ED and the Children's Decisions Area, condition-specific pathways (e.g. paracetamol overdose, paediatric chest pain, syncope, palpitations), and the elderly medicine and orthopaedic admissions policy. The EXCEL programme is working on updated pathways for patient flow through their admission from ED to discharge.

Escalation of disagreement is partially covered by SOPs UEC184 (delayed outlier review) and UEC185 (management of patients on outlier wards), both currently under review to include more robust detail on escalation processes. There is no current confirmation of a Trust shared-care policy. The Trust has signposted pathways to specialist tertiary providers (for example the myocardial pathway referencing Leeds Teaching Hospitals).

There is ongoing work to improve intranet access to appropriate pathways and policies regarding patient flow and management.

The EXCEL team is working with the Emergency Department to create an intranet site bringing all operational and long-term condition pathways together, and is reviewing processes from admission to acute receiving area. A shared care policy will need creating.

Level of attainment: Partially achieved

Standard 4

Flow into and out of acute receiving areas should be clinically led to promote the right patient moving to the right specialty bed. Acute trusts should have a designated consultant in charge who is responsible for the acute take, mirroring the EPIC role in ED and working with the nurse in charge and/or allocated navigation team to prioritise and co-ordinate patient care. This includes bed allocation in acute receiving areas and maximising alternatives to admission, such as same day emergency care (SDEC) and virtual wards/hospital at home. The consultant in charge should not cover additional clinical duties such as downstream wards or outpatient care.

Current position: flow into and out of all acute receiving areas is clinically led. BTHFT does not have a dedicated consultant in charge of the whole acute take, but individual acute teams have a dedicated consultant model. This may or may not involve the consultant in charge of the take having additional duties.

Acute Medicine has a consultant on call each day who takes overall responsibility for the acute take, plus two consultants based on SDEC. Elderly Medicine has a consultant on call each day with overall responsibility for the acute take, with single point of access referrals for the elderly virtual ward who in-reach into the Emergency Department. Children's and Neonates has a dedicated resident consultant overseeing admissions to the Children's Decisions Area each day, working with a nurse coordinator. Gynaecology operates a consultant hot week model 8am to 5pm Monday to Thursday with a different consultant covering each night and weekend (Friday 8am to Monday 8am). Maternity has resident consultant cover on the labour ward 8am to 10pm seven days a week. The general surgical on-call consultant is free from elective activity on weekdays but holds additional responsibilities for downstream and elective wards on Saturdays and Sundays. Vascular surgery also operates a consultant hot week model for non-elective acute admissions.

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To fully achieve Standard 4 significant change to consultant job planning and workforce would be required, with consideration of embedding a consultant within command centre structures to have overall oversight of the acute take. To meet standard 4 on a department-

by-department basis, job planning and workforce changes would be needed in some specialties to allow the consultant covering the acute take to be relieved of all other clinical duties.

Level of attainment: Partially achieved

Standard 5

A senior clinical decision-maker or above in specialties with highest non-elective admission numbers/rates should be job planned/rostered to receive referrals and provide advice to primary and community care and hospitals 24/7. This job planning/rostering may be networked across acute trusts where appropriate or required and should not negatively impact on the general internal medicine rota. If a senior clinical decision-maker or above performs this role, they should have immediate access to an expert clinical decision-maker. A clinical record of the discussion and agreed outcome must be entered into the patient's clinical notes.

Current position: The specialties with the highest non-elective admission numbers are acute medicine, care of the elderly, paediatrics and general surgery. Children's and Neonates operate a GP advice line consultant-staffed 9am to 5pm with registrar cover out of hours and consultant on-call escalation. Acute Medicine and Elderly Medicine each have a consultant on call who will take referrals and receive advice. Surgery has a middle-grade doctor available 24/7; advice is rarely provided by telephone, with face-to-face review on SAU.

It is not yet confirmed that all advice-line discussions are routinely entered into the patient record. This is being reviewed as part of the review of internal professional standards.

Level of attainment: Partially achieved

Standard 6

Expert clinical decision-makers in acute receiving areas with accountability for individual patients should be job planned and rostered to ensure continuity of care across the first 72 hours and reduce multiple consultant episodes. This may require annualised job planning across specialties, reconfiguring other commitments and considering part-time and job share arrangements.

Current position: AIM have a consultant on call and ongoing consultant post take ward rounds. There is ongoing team job planning which will consider how best to ensure continuity of care across the first 72 hours. Elderly Medicine have several consultants whose job plan is solely based on the elderly admissions unit (ward 3) to provide continuity of care across the first 72 hours. General Surgery operates a 4/3 split consultant-of-the-week model (8am Monday to 1.30pm Friday and 1.30pm Friday to 8am Monday), with a single consultant of the week taking responsibility for all admissions across the week regardless of admission source, supported by a different on-call consultant on Wednesday night to mitigate intensity. There are no job-share arrangements in General Surgery. Vascular Surgery operates a consultant hot week model (daytime and night-time cover by different consultants Monday to Thursday, weekend cover Friday 8am to Monday 8am). In gynaecology the same consultant is on call from Friday morning to Monday morning. In maternity services the resident consultant cover is on a rotating basis with consultants

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working separate day and night shifts, to ensure availability to come in and operate overnight and have compensatory rest the following day.

Across specialties, weekday and weekend consultant cover is provided from the same pool of consultants, but weekend cover may be by a different individual; continuity over a full 72 hours therefore cannot be guaranteed.

Level of attainment: Partially achieved

Standard 7

After an initial board round, a targeted, consultant-led and multidisciplinary team (MDT)-supported ward round should take place every day for all patients on an acute receiving area, including at weekends and bank holidays. An additional action-focused MDT meeting/huddle should take place at the end of the ward round. There should be a second board round and, where clinically indicated, a consultant face-to-face review of high risk/priority patients every day: for example, in enhanced care areas or where this will confirm discharge decisions.

Current position: On Acute Medicine wards 1 and 4 a post-ward-round consultant-led huddle takes place with the lead nurse and MDT where available; an additional consultant-led board round takes place at around 4pm. In Elderly Medicine, consultant review of every patient on the elderly admission unit takes place daily, seven days a week. There is not a formal post ward round MDT. In General Surgery, consultant post-take ward rounds occur twice daily Monday to Friday on Ward 2 and daily at weekends. In Children's and Neonates, regular board rounds occur throughout the day on the Children's Decisions Area at shift starts, finishes and twilight team arrival. In Maternity, consultant-led MDT ward rounds take place after each handover (8am, 5pm, 8pm) plus an additional round at around 1pm, with discretion to delay or omit depending on labour ward acuity.

Elderly Medicine does not currently have regular access to therapy or discharge team representation on the admission unit, so no formal MDT is undertaken; outlying patients on elderly wards do receive a daily Monday to Friday MDT after the ward round. In General Surgery, board rounds occur only when time pressures allow; meeting the standard would require significant job-planning and rota change. Access to therapy support is the principal cross-Trust barrier to a useful MDT.

Level of attainment: Partially achieved

Standard 8

Clinical huddles and shift handovers must be led by an appropriate senior clinical decision-maker and take place at a designated time and place, with MDT participation from the relevant incoming and outgoing shifts. Handovers should be consistent and standardised and include the identification of high risk/priority patients and assessment of operational conditions.

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Current position: Acute Medicine has a structured handover between the night team and morning team in SDEC at 8am, with a documented supporting policy. There is also a verbal handover between the day consultant and the on-call consultant, usually between 4pm and 6pm. Elderly Medicine has handovers on Ward 3 at 8am, 4pm and 8pm, consultant- or

registrar-led. General Surgery has a daily MDT handover at 8am on Ward 5 / SAU with the overnight team, day team, on-call consultant and senior nursing team; an evening handover at 8pm between resident doctors; and a separate ward nursing handover. Children's and Neonates include Children's Decisions Area patients in the routine AM and PM handover. Maternity has structured handovers between 8.00–8.30am and 8.00–8.30pm with full multidisciplinary participation, supported by a daily 12.45pm safety huddle attended by the on-call obstetric consultant, midwife coordinator, lead midwives, MAC/ANDU, bed manager, neonatal consultant and anaesthetist.

Going forward standard operating procedures for handover practices need to be obtained or created consistently across the acute receiving areas, including for SDEC.

Level of attainment: Partially achieved

Standard 9

Where a patient requires urgent specialty opinion for acuity, clinical decision-making or discharge planning, the specialty senior clinical decision-maker should respond within a maximum of 2 hours of the request.
Patients referred to another specialty by the admitting team should be assessed by a senior clinical decision-maker (with access to an expert clinical decision-maker) within 4 hours during the extended day (as determined by demand and capacity modelling) or before 10am the next day if overnight. Face-to-face assessment is usually appropriate for patients in hospital.

Current position: A snapshot audit of Acute Medicine referrals shows the target is met in approximately 50% of cases. Neurology is the best-performing specialty for time to review. Respiratory, Neurology and Cardiology receive the highest referral volumes for patients admitted to acute medicine; almost all reviews are face-to-face. In Children's and Neonates, most children are under General Paediatrics; surgical, orthopaedic, plastics, maxillofacial, ENT and gynaecology reviews are most required and do not consistently happen within two hours of request. In General Surgery, face-to-face reviews are encouraged but ability to meet the target is limited by middle-grade doctor numbers and conflicting responsibilities (theatre, clinic).

A standardised audit tool needs to be developed to allow all teams to collect data on this standard every six months. Business Intelligence can pull referral date and time, but no reliable method currently exists for reporting the action taken in response. There is no validated list of decision-makers and senior decision-makers therefore information in the electronic patient record is not currently reliable for this purpose.

Level of attainment: Partially achieved

Standard 10

Patients requiring downstream speciality beds should be transferred within 12 hours of a bed request. If no bed is available, the specialty team should ensure daily review on the acute receiving area.
Specialty teams should know how many patients are waiting for a base ward bed at all times and work to deliver transfer within 12 hours of referral.

Patients should not move from downstream wards or ICU/ITU to acute receiving areas (reverse flow), except where areas support enhanced care or where this is locally agreed policy.

Osbourne Services
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Current position: The Trust's electronic patient record includes CapMan function which holds transfer lists. Each addition to a transfer list records the date and time of the request and remains visible. The Command Centre operates against this data. Children's and Neonates is not in scope as the children's site has a single ward.

Reporting against the 12-hour standard requires a bed-request field to be added to the data tables. This is not currently available. The Trust's Performance team will request the build from Business Intelligence; the assumed scope is transfers from AMU 1, AMU 4, Ward 3, Ward 5 (BRI) and SAU. The first reporting cycle in which this standard can be quantitatively evidenced is dependent on this build.

Level of attainment: Partially achieved

Standard 11

Any individual patient’s length of stay on an acute receiving area should not exceed 72 hours unless sanctioned by the responsible consultant and senior

Current position: In Acute Medicine, 58% of patients have a length of stay of less than 72 hours on the acute receiving area (this figure relates to all admissions including those subsequently transferred; the equivalent figure for those discharged directly from the acute medical unit is reported under Measure 2). The Children's Decisions Area does not have beds; short-stay and main ward beds are used as appropriate.

A Business Intelligence request is in place for length-of-stay data for other acute receiving areas, with Ward 3 and SAU as the priority for the next reporting cycle.

Level of attainment: Partially achieved

Standard 12

To ensure equity of provision of care and maximise discharge opportunities, all support services, including therapies, pharmacy and social services, should be available to acute receiving areas during extended-day working hours (for example, 8am to 8pm), 7 days a week. Input in other areas should be prioritised for patients with an anticipated length of stay of less than 72 hours. All areas providing acute and emergency non-elective care in the first 72 hours must have the same access to diagnostics, including imaging, in terms of availability and turnaround times, to support decision-making and prevent unnecessary admission. These services should align to demand across the 7 days. Processes should be in place to prioritise patients who are acutely unwell or for whom discharge is investigation dependent.

Current position: Occupational Therapy in the ED to prevent admission is funded for 8am to 8pm but provision has been limited by vacancies and sickness. Respiratory Physiotherapy operates a 7-day service 8am to 4pm with on-call cover 4pm to 8am. ICU/CCOR Physiotherapy operates the same model for critically ill patients. For other acutely unwell patients the service is 8am to 4pm Monday to Friday only.

Osbourne Clement
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The pharmacy service to admissions areas operates 8am to 6pm seven days a week, focused on AMU 1, AMU 3 and AMU 4. Monday to Friday staffing is three pharmacists and four to five pharmacy technicians; weekend staffing is one pharmacist and three pharmacy technicians. Expansion into the Emergency Department is underway.

The MAID team is available Monday to Thursday 8.30am to 5pm and Friday 8.30am to 4.30pm. Out-of-hours social care emergencies are covered by the Emergency Duty Team. The 'Annie' digital information service is available 24/7 by text. The BEST duty team provides cover until 10pm for pre-arranged packages of care.

No current quantified report on diagnostic turnaround times for Emergency Department patients. Time stamps within the radiology information system (CRIS) are not currently configured to allow accurate reporting of turnaround times for Emergency Department patients. A Business Intelligence request is open. A response on the wider radiology and diagnostic position is being prepared by the radiology general manager (delayed by a recent urgent PACS Enterprise Imaging issue).

Therapy prioritisation standards need updating. The MAID team is not available at weekends. Quantitative reporting of diagnostic turnaround times against locally agreed standards is dependent on the CRIS time-stamp build.

Level of attainment: Partially achieved

Standard 13

Patients' care should be accurately attributed and recorded to the team delivering it. For example, patients who are referred for care under acute medicine should have Treatment Function Code (TFC) 326 applied regardless of where they are physically located. If a patient is transferred from an acute receiving area to a specialty ward, the TFC should be changed to reflect the patient's responsible consultant. This will enable better understanding of activity, support capacity planning and improve visibility via national reporting, reducing the need to rely on local (ward-based) reporting.

Current position: TFC 326 is not formally approved for use at the Trust. It is being applied erroneously on a small number of encounters in an outpatient area. As a proxy, the Trust currently reports patients admitted to AMU 1 and AMU 4: approximately 90% of these admissions are coded under TFC 300 (General Internal Medicine Service). Measure 3 in this report uses TFC 300 on AMU 1 and AMU 4 as the proxy denominator.

Discussions are underway with the clinical coding lead on whether TFC 326 can be approved for use at the Trust. Until it is, the Trust cannot meet this standard, cannot report against the national benchmarking measure for it, and has reduced visibility within national reporting.

Level of attainment: Not yet achieved

Standard 14

All patients and carers must be: • treated with dignity, have their basic needs met – in terms of hydration, access to toilet facilities and food – and be offered adequate pain control when needed • fully involved in decisions about their care • kept regularly informed about waiting times and delays to their care • clear about what they need to achieve to get home, when they should expect to go home and who to contact when they are at home

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19/05/2026 08:22:22

Current position. Multiple sources of evidence support this standard, although none are currently synthesised against it as a single assurance set. Care plans, intentional rounding, pain documentation and discharge planning are recorded in the electronic patient record. Ward accreditation audits include these elements when assessing wards. Ward managers and matrons undertake local audits. A patient admission letter is given on admission. A discharge care plan is provided, including the telephone number of the discharging ward. The Trust has a dignity and privacy policy, available on the intranet.

A monthly discharge steering group, attended by community representatives, reviews discharge practice. The MAID team is involved in complex discharges. Friends and Family Test feedback is presented to the Board and included in annual and bi-annual reports. Patient stories are presented to the Board. Complaints are discussed weekly with each Clinical Service Unit leadership team and within the Chief Nurse team. A bi-monthly complaints steering group identifies themes and trends. A monthly patient experience group with patient representatives discusses patient experience issues and improvements.

Four CQC patient surveys (Maternity, Paediatrics, Inpatients, Emergency Department) are presented to the Quality Committee. Specific specialty sources include the Meridian nutrition and pain audits (used in HASU), Genome audits (General Surgery, monthly), the PMOS patient questionnaire, and Envoy data used as a Friends and Family equivalent in General Surgery. Reasonable adjustments include access to interpreters, learning disability nurses, and the 'See Who I Am' document.

Going forward liaison with the Chief nursing team around specific metrics for 6 monthly reporting for Standard 14 need to be identified and metrics collated for comparison.

Level of attainment: Partially achieved

Standard 15

The site-level detail of all standards should be reflected in a written internal professional standards document, developed following discussion and agreement between hospital teams and owned at executive level. Acute trusts must assure their board of compliance with the standards. This should be regularly reviewed and robust plans, owned at executive level, put in place to achieve compliance where necessary.

Current position: The Trust has an internal professional standards document for the Emergency Department. Coverage of other acute receiving areas is being established. This bi-annual report is the Board assurance mechanism. A position is needed on whether further site-level operational standards documents are required. Internal professional standards should be subject to regular audit; a process for this is not yet defined. There is planned work with the EXCEL team and BTHFT colleagues to review and revise the Internal Professional Standards Document and review of the BTHFT intranet to ensure a central repository for all relevant policies, standards and documents.

Level of attainment: Partially achieved

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Summary level of attainment for Standards 1-15

Std	Theme	Level of attainment
1	Time to clinical decision-maker	Partially achieved
2	Specific patient cohorts (frailty, LTC, EoL)	Partially achieved
3	Operational policies for admission and shared care	Partially achieved
4	Designated consultant in charge	Partially achieved
5	Senior decision-maker 24/7 in non-elective specialties	Partially achieved
6	Continuity of consultant care across 72 hours	Partially achieved
7	Consultant-led MDT-supported ward rounds	Partially achieved
8	Clinical huddles and shift handovers	Partially achieved
9	Specialty response to urgent review requests	Partially achieved
10	Transfer to downstream specialty bed within 12 hours	Partially achieved
11	Length of stay on acute receiving areas	Partially achieved
12	Seven-day support services and diagnostics	Partially achieved
13	Data attribution and TFC 326	Not yet achieved
14	Patient and carer experience	Partially achieved
15	Internal professional standards and Board assurance	Partially achieved

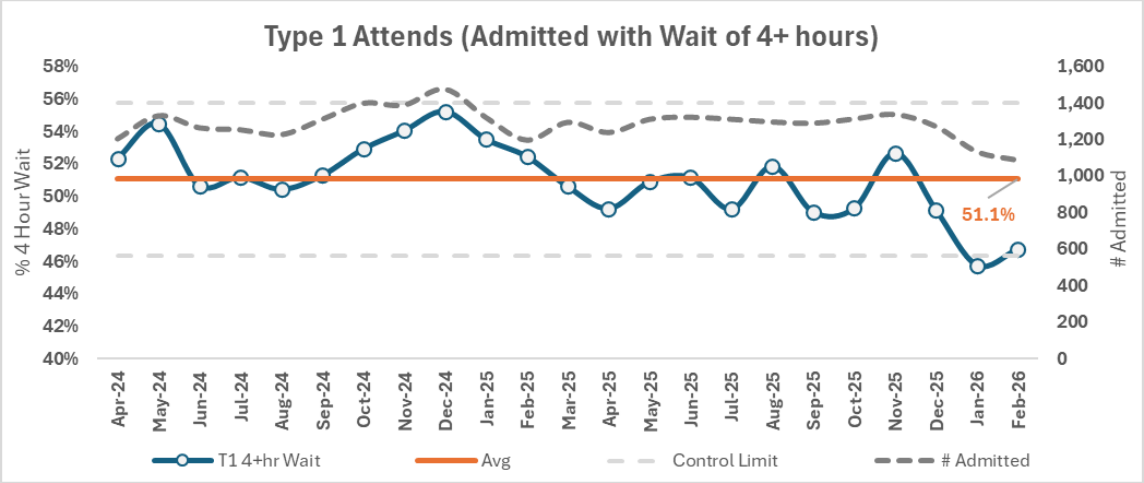
Impact: Performance Metrics

This section reports the Trust's position against the four national benchmarking measures and the wider performance metrics specified in the NHS England guidance. The 4 measures requested in the initial self-assessment tool are as follows:

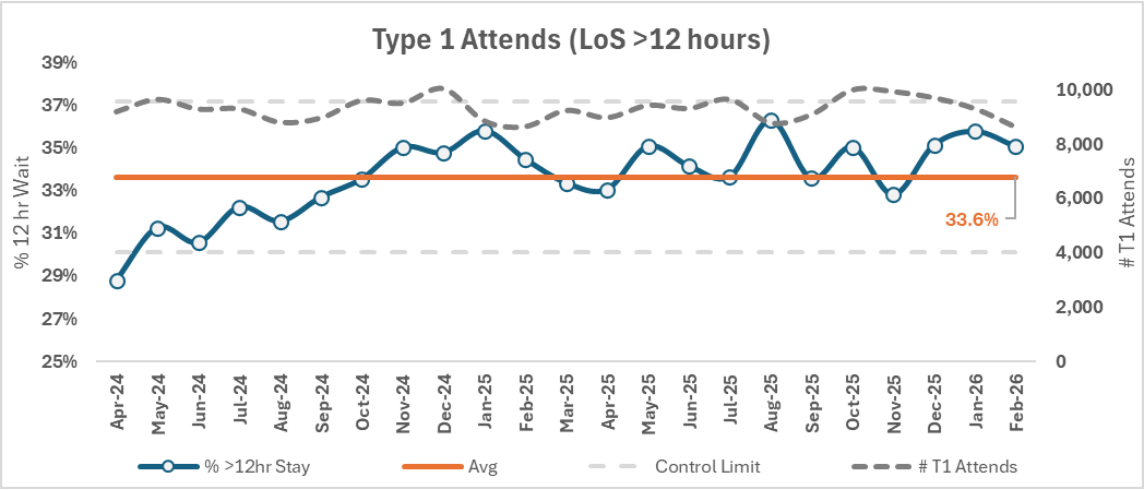
Measure 1: Emergency Department (ED) waits

The percentage of ED (type 1) patients who were admitted who waited more than 4 hours between April 2024 and February 2026

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The percentage of ED (type 1) patients who waited for over 12 hours (admitted and non-admitted) between April 2024 and February 2026

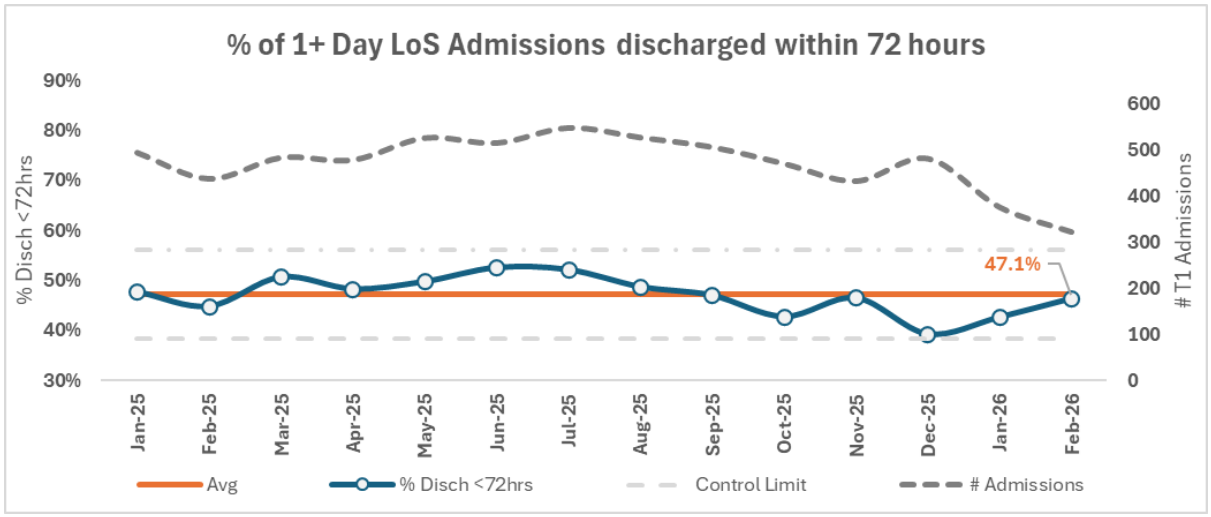


Summary: Our percentage of patients admitted to the ED who wait more than 4 hours for admission, discharge or transfer is well below the national average. The number of patients attending ED who wait more than 4 hours who are admitted is slightly above national average but within the control limits. Those waiting over 12 hours for a decision is slightly above national average but within control limits.

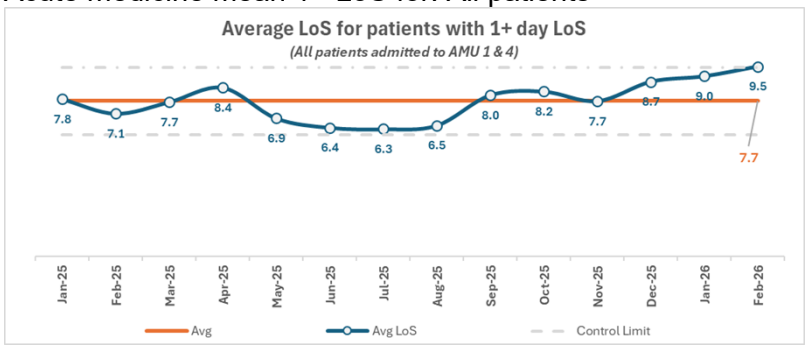
Measure 2: Length of Stay (LoS) for non-elective patients admitted to BTHFT

a) The percentage of 1+ LoS non-elective admissions discharged within the first 72 hours between January 2025 and February 2026

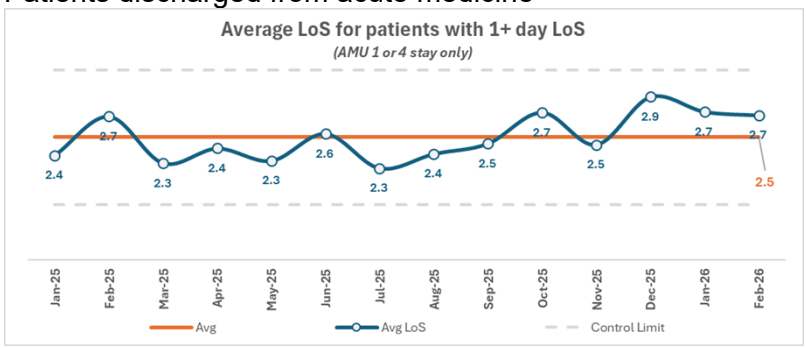
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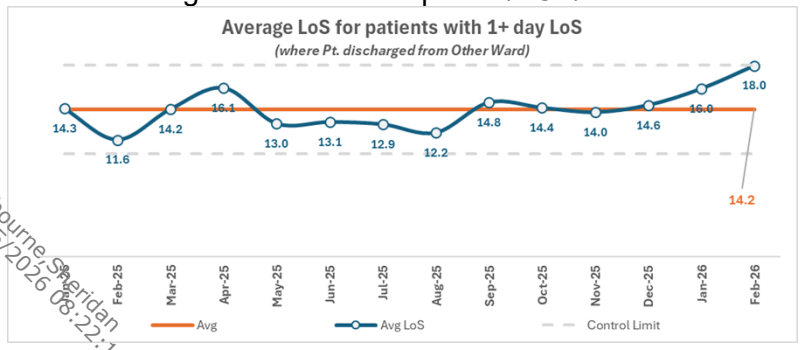
Acute medicine mean 1+ LoS for: All patients



Patients discharged from acute medicine

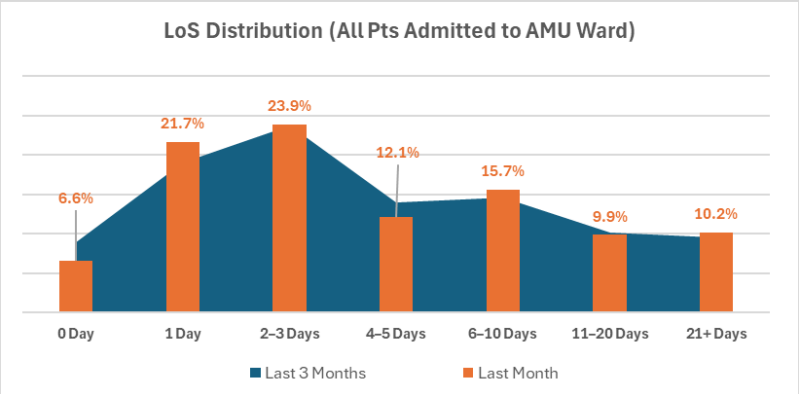


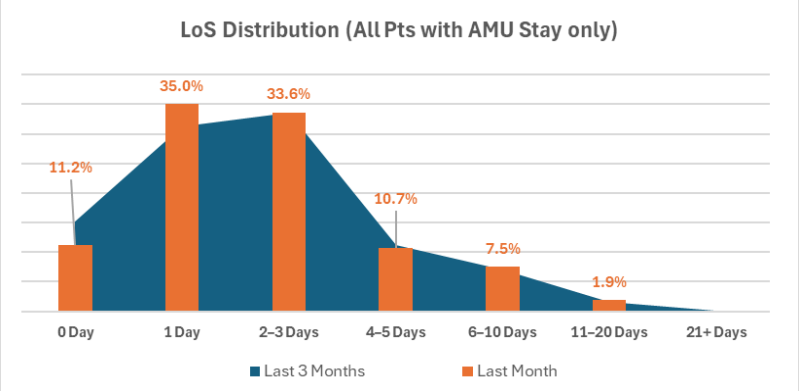
Patients who go on to another episode/FCE/ward transfer

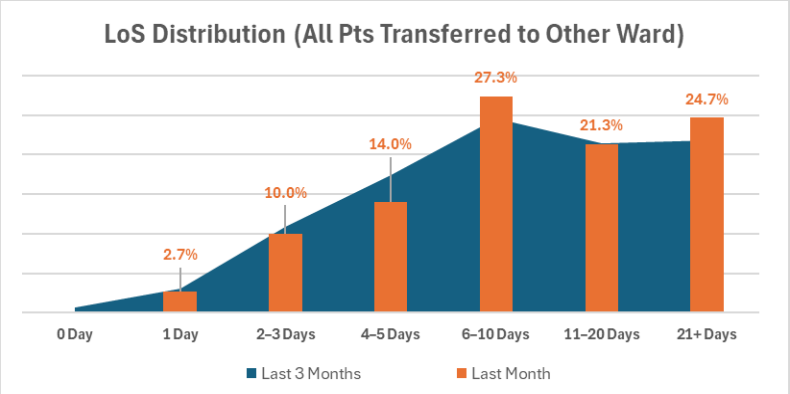


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b) The distribution of LoS in acute medicine (relevant to **Standard 11**: 'Any individual patient's length of stay on an acute receiving area should not exceed 72 hours unless sanctioned by the responsible consultant and senior nurse in charge')







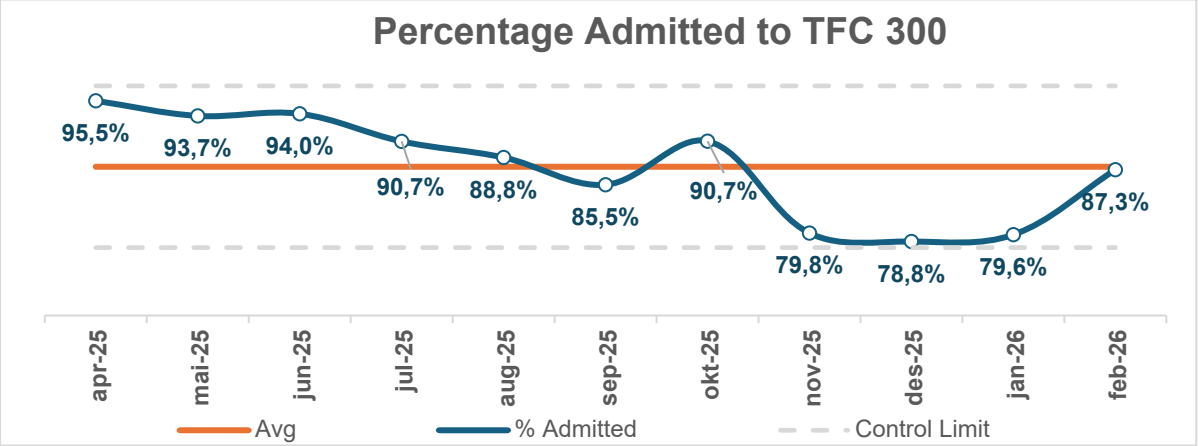
Summary: Across the Trust our average length of stay for all emergency admissions is below the national average. Within our acute medical unit the majority (80%) of patients discharged from the acute medical unit are discharged within 72hours of admission, looking at all acute medical unit admissions (including those later transferred elsewhere) 52.2% are discharged within 72 hours.

Measure 3: Data Quality

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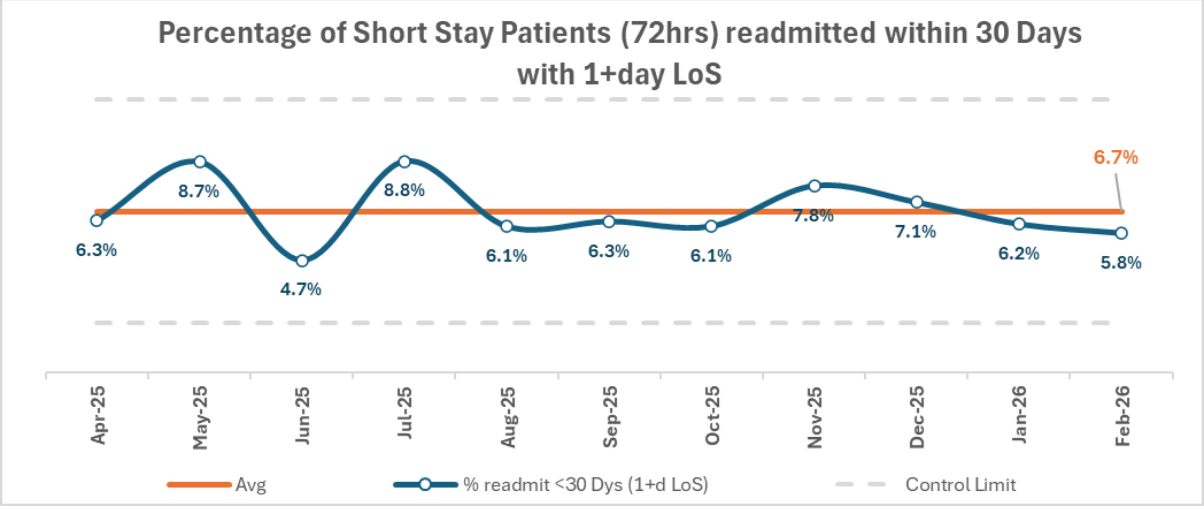
The percentage of non-elective medical patients with a Treatment Function Code (TFC) 326 for their first episode of care (relevant to **Standard 13:** patients who are referred for care under acute medicine should have Treatment Function Code (TFC) 326 applied regardless of where they are physically located).

TFC 326 = Acute Internal Medicine Service in the NHS Data Model and Dictionary. At BTHFT we do not currently use TFC 326, and some clinicians carry an incorrect TFC in EPR, therefore the proxy for TFC 326 is to look at those admitted to AMU1 & 4. In addition, most admissions to AMU 1 or 4 (~90%) occur under Treatment Function 300. Therefore we are currently presenting data for TFC 300:



Summary: 87% of patients are on TFC 300 (General Internal Medicine Service). We have used this as a proxy for TFC 326.

Measure 4: Re-admissions (balancing measure)



Summary: our readmission rate for short stay patients is below the National average.

Patient and staff experience

The self-assessment tool specifies that patient and staff experience should be articulated. As described above when referring to Standard 14, the Trust draws on the following sources for patient experience:

- Friends and Family Test: presented to the Board and included in annual and bi-annual reports.

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- Complaints, PALS contacts and patient stories: discussed weekly with Clinical Service Unit leadership; bi-monthly themes review at the complaints steering group; patient stories presented to the Board.
- CQC patient surveys (Maternity, Paediatrics, Inpatients, Emergency Department): presented to the Quality Committee.
- Local audit: ward accreditation audits, Genome audits (General Surgery), Meridian audits (HASU; nutrition and pain), the PMOS patient questionnaire, and Envoy data (used as a Friends and Family equivalent in General Surgery).

Staff experience evidence specifically against the first 72 hours pathway is not currently consolidated. The next reporting cycle will include a position drawn from the National Staff Survey; AMU, elderly and SAU local engagement; and the AIM team's job-planning exercise (May 2026).

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Risk Assessment

Step 1: Identify the hazards *(Using bullet points write down here the potential hazards)*			
• **Standard 1: delayed access to review by competent or expert clinical decision maker, pharmacy review, prescription of time critical medications.** • **Standard 2: inaccurate recording of CFS with limited access to senior clinical decision maker with frailty expertise.** • **Standard 4: currently no designated consultant in charge of the acute take and some on call consultants have additional clinical responsibilities.** • **Standard 7: targeted consultant-led and MDT supported MDT do not occur daily on all acute receiving areas.** • **Standard 9: patients not seen within recommended time frames when referred for an urgent specialty opinion.**			
Source	**Self assessment tool first 72 hours**	**Category**	**Organisational**
Step 2: Decide who might be harmed and how (*For each hazard you need to be clear about who might be harmed; it doesn't mean listing everyone by name, but rather identifying groups of people e.g. patients, nursing staff, porters, secretaries etc. and how they may be harmed)*			
• **Standard 1: potential risk of delayed investigations, diagnosis, management or time critical medication administration could affect patient outcomes and expose clinical staff to complaints.** • **Standard 2: frail patients may have poorer outcomes and longer length of stay due to reduced access to clinicians with frailty expertise.** • **Standard 4: could negatively impact on patient flow meaning longer ED waits for beds and increased risk of patients being admitted as an outlier patient.** • **Standard 7: patients could experience increased length of stay and poorer outcomes due to a lack of MDT led care on acute receiving areas due to lack of therapy and social care team support.** • **Standard 9: investigations and treatments may be delayed, poorer outcomes could be experienced, including the risks attached to a longer length of stay awaiting specialty review.**			
Step 3: Evaluate the risk and decide on the existing precautions and decide if there is a need for further precautions. *(Having spotted the hazards, you then have to decide what to do about them. Listing existing control measures here or note where the information can be found e.g. existing policies, procedures, work etc.)*			

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Existing control measures

- **Standard 1: triaging processes and escalation protocols within ED and acute receiving areas in place to identify deteriorating patients, with access to pharmacy services as well as clinicians outside of Standard specified timeframes.**
- **Standard 2: in reach into the ED by the elderly virtual ward team, and regular presence of elderly medicine consultants in ED when pressures allow.**
- **Standard 4: all acute specialties have on call consultant models with consultant responsibility for the acute take.**
- **Standard 7: some acute receiving areas do have daily MDT, the others have daily consultant ward rounds of all patients with nursing presence.**
- **Standard 9: patients do receive specialty review outside of recommended timeframes.**

Risk rating taking into account existing controls

Likelihood	5	X	Impact	3	=	Risk rating	15

Rationale

The above risks are likely to occur regularly based on audit data and current staffing processes however the impact of the above risks would be expected to result in some delays to care and treatment, but monitoring and escalation processes used to assess inpatients should prevent serious harm from clinical deterioration.

Target risk rating

Likelihood	3	X	Impact	3	=	Risk rating	9

Rationale

If all the above risks were resolved it would be expected that the likelihood of a harm occurring (in essence a delay to investigation, diagnosis, treatment or discharge) would reduce whereas the impact of a delay is likely to remain the same.

Lisa Sheridan 19/03/2026 08:22:12

Risk matrix

Table 3 – Impact / Severity							
	Catastrophic	5	5	10	15	20	25
	Major	4	4	8	12	16	20
	Moderate	3	3	6	9	12	15
	Low	2	2	4	6	8	10
	Negligible	1	1	2	3	4	5
Risk = Table 2 - Likelihood x Table 3 - Impact			1	2	3	4	5
			Extremely Unlikely	Unlikely	Possible	Likely	Almost Certain
			Table 2 – Likelihood / Probability				

Escalations

This section sets out specific asks of the Board, including estates, digital, business intelligence, and other organisational-level support requirements.

Data and business Intelligence prioritisation

Several standards cannot be quantitatively evidenced at this baseline because the underlying data infrastructure is not in place:

- Configuration of CRIS time stamps to enable reporting of radiology turnaround times for Emergency Department patients (Standard 12).
- Addition of a bed-request field to the data tables to enable reporting of transfer time from request to ward move (Standard 10).
- Extension of length-of-stay reporting in acute receiving areas to Ward 3 and SAU (Standard 11).
- A reliable methodology for tracking action taken in response to specialty referrals (Standard 9).

Digital priorities

Several actions depend on changes to EPR or work led by the EXCEL team:

- Work by the EXCEL team to streamline EPR and reduce clicks, including consideration of a continuous clerking document for admitted patients on EPR (Standard 1).
- The mechanism for clinicians to be correctly linked to TFC 326 in EPR once approval is resolved (Standard 13).
- Data sharing between SystmOne and Cerner to support identification of patients with palliative and end-of-life care needs (Standard 2).
- Improvement to the trust intranet to allow easier access to operational and clinical guidelines, policies and procedures (Standard 2, 3, and 4)
-

Workforce and operational change

Some compliance gaps cannot be closed by medical workforce action alone. The Board is asked to note that:

- Standard 2 frailty service provision (senior decision-maker review within one hour of identification) requires both an Elderly Medicine workforce conversation and operational redesign.
- Standard 4 compliance in surgery would require significant change to consultant job planning to have an overarching designated consultant in charge with no other additional clinical duties.
- Standard 6 compliance may require job planning and workforce review for some specialties to provide continuity of care.
- Standard 7 compliance is limited by lack of availability of a full MDT 7 days a week, in particular therapy and social services support.
- Standard 12 weekend and out-of-hours therapy and social services provision is constrained by resourcing decisions outside the medical workforce. Current limitations on Occupational Therapy in ED (vacancies and sickness) and the absence of weekend MAID team cover are noted.

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Audit and assurance infrastructure

Several standards require manual audit until automated reporting is in place. The Board is asked to note the resource implication of:

- Six-monthly manual audits of time-to-clinical-decision-maker across ED, AMU 1, AMU 4, Ward 3, SAU, GATU, paediatrics (Standard 1).
- Audit of pharmacy review and time critical medications (Standard 1)
- Recurring frailty score accuracy audits and use of 4AT in ED (Standard 2).
- A standardised audit tool for time-to-specialty-review (Standard 9).

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Action Plan: Next Reporting Period (March 2026 to September 2026)

The Trust's working action plan is held as a live spreadsheet. This section presents a Board-level summary of the priorities the Trust will pursue over the next six months, grouped by theme to support oversight rather than restate the spreadsheet. Going forward the action plan will be updated with evidence and any learning obtained from other NHS Trusts.
The priority for the next reporting period is establishing robust data for this work going forward.

Theme 1 — improving benchmarking data

Action	Standards	Owner	Target
Develop manual audit tools for time-to-clinical-decision-maker covering ED, AIM, Ward 3, SAU; time to speciality review and apply six-monthly	1, 9	Deputy CMO with clinical leads	Audit tool finalised by July 2026; first cycle complete by September 2026
Receive and incorporate SAMBA25 audit data when released by Society for Acute Medicine	1, 7	Acute Internal Medicine SAMBA lead	On release
Audit pharmacy input in ED and prescription of time-critical medications once the team is in place	1, 12	Chief Pharmacist	First audit by January 2027 (post recruitment)
Palliative Care team exploring how to share data between SystmOne and Cerner to improve identification of patients who are in the last phase of life on admission to hospital	2	Palliative Care Team	Update October 2026
Add a bed-request field to the data tables to enable measurement of transfer time from request to ward move	10	Business Intelligence	Specification by July 2026; build by September 2026
Extend length-of-stay reporting in acute receiving areas to Ward 3 and SAU	11	Business Intelligence	September 2026
Configure CRIS time stamps to allow accurate reporting of radiology turnaround times for ED patients	12	Business Intelligence	Specification by July 2026; build by September 2026
Review the approval position for TFC 326 within the Trust	13	Clinical coding lead with Deputy CMO team	August 2026

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Action	Standards	Owner	Target
If approved, agree and implement the operational mechanism for clinicians to be correctly linked to TFC 326 in EPR	13	Clinical coding lead with Deputy CMO team	September 2026
Commence reporting against the national benchmarking measure (proportion of non-elective medical patients with TFC 326 for first episode of care)	13, M3	Business Intelligence	October 2026
Liaise with Chief Nurse team around agreed metrics for Standard 14	14	Deputy CMO and Chief Nurse team	August 2026

Theme 2 —focus on organisational pathways and structures

Action	Standards	Owner	Target
Work with acute receiving are teams and ED to ensure SOPS / pathways available outlining consultant responsibilities, staffing, handover and huddle arrangements available	1	CMO team with relevant clinical leads, general managers and the EXCEL team	Update on progress September 2026
Audit recurrence and accuracy of the Clinical Frailty Scale and 4AT in ED – exploring AI solutions	2	Deputy CMO with ED and Elderly Medicine clinical leads	First repeat audit by September 2026
Determine and document the local list of long-term conditions in scope of Standard 2	2	Deputy CMO with relevant specialty leads	September 2026
Complete the EXCEL team review of admission processes from ED and community to acute receiving areas	3	EXCEL team	July 2027
Development of shared care policy alongside review of medical outlier policies	3	Deputy CMO and EXCEL team	September 2026
Develop SOPS / pathways for patients moving through ED, SDEC and acute receiving areas.	8	EXCEL team, ED clinical lead and AIM clinical lead	September 2027
Update therapy prioritisation standards	12	Therapies leads	January 2027
Determine whether further site-level operational standards documents are required beyond the existing ED	15	Deputy CMO with EXCEL team	September 2026

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Action	Standards	Owner	Target
document, and define an audit cycle for them			

Theme 3 — workforce

Action	Standards	Owner	Target
Complete the AIM team job-planning exercise (15 May 2026); implement agreed staffing and rota changes	1, 6	AIM General Manager and Clinical Director with support from Deputy CMO	Job-planning exercise May 2026; implementation through summer 2026
Embed the new ED pharmacist (start May 2026) and recruit to the approved pharmacy technician and pharmacy assistant posts	1, 12	Chief Pharmacist	Recruitment complete by September 2026
Liaise with elderly care team regarding provision for frail patients presenting to ED	2	Deputy CMO and Clinical Lead for elderly medicine	January 2027

Osbourne Sheridan
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Board of Directors			
Meeting Date:	21.05.26	**Agenda Reference:**	Bo.5.26.11
Report Title:	Care Quality Commission Well Led Action Plan		
Presented by:	Professor Karen Dawber, Chief Nurse		
Executive Lead:	Professor Karen Dawber, Chief Nurse		
Author:	Byron Johnson, Assistant Director of Quality Nazzar Butt, Moving to Outstanding Lead		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	The Care Quality Commission (CQC) Well Led review rated the Trust as Good, with clear improvement since the previous inspection. No regulatory breaches were identified; however further improvements were identified across four quality statements: • **Shared Direction and Culture:** absence of a clearly articulated clinical services strategy and the need to further strengthen organisational culture • **Capable, Compassionate and Inclusive Leaders**: continued focus required on Board development and leadership effectiveness • **Freedom to Speak Up:** While the CQC noted variable staff confidence in speaking up and in consistent leadership response, this feedback was drawn from a qualitative analysis of CQC feedback and the National staff survey. • **Workforce Equality, Diversity and Inclusion:** WRES data indicating workforce inequalities, discrimination, and underrepresentation at senior levels A focused and proportionate action plan has been developed, aligned to existing strategy programmes to ensure integration rather that duplication. In addition, targeted process improvements have been identified to strengthen assurance and governance grip, including: • Improving the quality, clarity, conciseness and impact of Board and Committee reporting • Reviewing best practice guidance to introduce a self-declaration process as part of DBS checks • Strengthening the completeness and reliability of workforce absence and turnover data recording • Implementing the updated 2024 Safer Nursing Care tool across the Trust (now completed) • Delivering targeted actions to improve compliance in BLS and Level 3 safeguarding requirements			
Recommendation/s: (including any decision/approval required)	*The Board of Directors is asked to:* 1. Review and approve the proposed CQC Well Led Action Plan. 2. Support the proposed approach.			

Caroline Meridan
21/05/26 08:22:12

Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness NB: Links to all strategic objectives
Link to Priority Initiatives 2025/26:	N/A NB: Links to all priority initiatives
Implications	
Risk:	Supports mitigation of potential risk, particularly those relating to patient safety and regulatory compliance. Progress against the CQC Well Led action plan directly addresses gaps previously identified by the CQC therefore strengthening assurance against the CQC Well Led framework
Legal/Regulatory:	Actions respond directly to CQC Well Led findings and support compliance with regulatory expectations
Quality & Patient Safety:	Delivery of the improvement plans is designed to improve and assure key aspects against the CQC Well Led framework
Equality, Diversity and Inclusion and Health Equity:	The enhanced EDI programme directly addresses inequalities identified in WRES and staff survey findings
Resources:	Actions will be delivered within existing programmes and resources where possible
Environmental sustainability:	Not Applicable
Assurance Route	
Meeting/s where content has been discussed previously:	CQC Well Led action planning meeting Executive Team Meeting – 20.04.26 Quality Committee - 23.04.26 - QC.4.26.10

Report content

Purpose

To present the Trust's response to the Care Quality Commission (CQC) Well Led review and seek approval of a proposed action plan to address identified areas for improvement.

Background / context

The CQC Well Led review rated the Trust as Good, with clear improvements noted since the previous inspection. This follows the outcomes of the Trust's most recent unannounced CQC inspections which resulted in 'Good' ratings for maternity services, outpatients and St Luke's Hospital and community inpatient services at Westwood Park and Westbourne Green.

The report highlights a number of strengths including:

- A clear improvement journey, supported by the appointment of new leader to the Trust Board
- A strong focus on safety and risk management
- Excellence in research, with particular recognition of the exceptional work delivered through the Bradford Institute for Health Research
- A demonstrable commitment to Equality, Diversity and Inclusion through positive initiatives
- Innovation through partnership working

Osbourne Clement
19/05/2026 07:22:12

- Recognition for significant progress in the developing and implementing robust environmental sustainability actions

However, the CQC identified areas for further improvement in relation to:

- The absence of a clearly articulated clinical services strategy
- Organisational culture, including psychological safety and staff experience
- The need to strengthening board development
- Mixed staff confidence in raising concerns and limited confidence that leaders will consistently take action
- Workforce equality, diversity and inclusion

The Trust has already recognised many of these issues and work is underway; however, further action is required to ensure consistency and satisfy CQC reporting expectations.

Assessment

A detailed review of the inspection report findings has been undertaken, and a corresponding action plan has been developed (Appendix 1). The key themes arising from this review are set out below.

Strategy

While the Trust has an established corporate strategy that describes and sets out how services will be delivered, the CQC identified the absence of a clearly articulated clinical strategy aligned to financial, workforce and activity planning. The report also highlighted a potential risk of confusion due to the number of supporting strategies and lack of alignment to an overarching clinical strategy is highlighted.

The Trust is clear that its partnerships and wider ABCAS work will support alignment of clinical services across the city. References to the absence of a clinical strategy relate specifically to the clinical blueprint currently in development, in partnership with the Integrated Care Board, Airedale NHS Foundation Trust, and Bradford District Care Trust, and aligned to the NHS 10-Year Plan.

Culture and staff experience

The Trust demonstrated a positive commitment to improving organisational culture but acknowledged that further work is required, including:

- Addressing areas where psychological safety is led well established
- Tackling pockets of poorer culture, particularly with some non-clinical areas and pharmacy services
- Improving visibility and impact of leadership

The THRIVE programme is positively described in the report as "*an internal staff wellbeing, development, and inclusion program focused on creating a positive, supportive, and equitable culture for employees to flourish, emphasise kindness, teamwork, valuing people, and continuous improvement*". The Trust will continue to harness and enhance this existing programme to address the inspection findings. In addition, work is already underway within the Pharmacy Department, under the stewardship of the Chief Pharmacist, will continue at pace to demonstrate sustained and impactful cultural improvement.

Freedom to Speak up

Osbourne Iverson
09/05/2026 08:22:13

Although robust Freedom to Speak Up arrangements are in place, the CQC reported mixed staff confidence, particularly in relation to:

- Confidence among some staff in raising concerns

- Psychological safety at senior levels

Although not indicative of a widespread issue, the Trust recognises that such concerns are significant and warrant attention, and the action plan therefore focuses on consistency of leadership response, psychological safety at senior levels, and strengthening staff confidence across all services. The Trust will undertake a series of listening exercises focusing on creating a sense of belonging by improving staff voice and influence and developing our wellbeing support. The outputs from this work will be used to inform, refresh and update the existing Staff Survey action plan.

Workforce equality, diversity and inclusion

The Trust demonstrated a strong commitment to Equality, Diversity and Inclusion (EDI) through positive initiatives such as talent management, civility programmes, and the use of health inequalities data. However, Workforce Race Equality Standards (WRES) data highlighted:

- Evidence of workforce inequalities, discrimination, and underrepresentation at senior levels

The Trust is currently reviewing and refreshing its strategic EDI objectives. A series of listening events and a survey will be undertaken with staff and diverse communities to gather feedback, with proposed priorities subsequently presented to the Equality and Diversity Council for approval.

Targeted process improvements:

Further opportunities for improvement have been identified to strengthen assurance and governance grip, including:

- Improving the quality, clarity, and conciseness of Board and Committee reporting
- Reviewing best practice guidance to introduce a self-declaration process as part of DBS checks
- Strengthening the completeness of workforce absence and turnover data
- Implementing the updated 2024 Safer Nursing Care tool across the Trust (completed)
- Delivering targeted actions to improve compliance with Basic Life Support (BLS) and Level 3 safeguarding requirements
- Perceived conflict of interest relating to senior roles of individuals holding FTSU responsibilities

Progress against the action plan will be monitored through existing governance structures, including the Quality Committee.

Proposal

A proportionate action plan has been developed to address the areas for improvement identified through the CQC Well Led review.

The Board of Directors are asked to:

1. Review and approve the proposed action plan.
2. Agree the approach to ongoing oversight through existing governance arrangements.

Appendices

Appendix 1: CQC Well Led Action Plan
Appendix 2: BTHFT Well Led Inspection report

Caroline Sheridan
2/10/2026 08:22:12

CQC Well Led Improvement Action Plan

Summary Description Action Plan

Action plan to address the areas for improvement from the CQC inspection report.
Date of inspection visit:
Date of publication:

Action plan commencement date:	April 2026

Status:	
O	Open
O	Open and compromised
C	Closed
OD	Overdue

No	Areas for Improvement –	Actions and tasks to achieve the objective or aim	Named Individual responsible	Completion Date	Progress Update	Status	Evidence of action completed	Method of assurance	Assurance Level (RAG Rating
			WELL LED						Good
1	**Shared Direction and Culture:** absence of a clearly articulated clinical services strategy and the need to further strengthen organisational culture	Develop and approve a joint Clinical and Estates Strategy with system partners	Helen Farmer Director of Collaboration Mark Hindmarsh Director of Strategy	To be confirmed		O	Approved strategy document Board approval TORs for governance arrangements	Committee in Common	
2	**Shared Direction and Culture:** absence of a clearly articulated clinical services strategy and the need to further strengthen organisational culture	Enhance the Trust's THRIVE offer and staff survey action plan, incorporating CQC findings	Catherine Shutt Head of OD	01/06/2026		O	Updated THRIVE programme Staff survey action plan; Delivery milestones	People Academy Staff survey reporting Pulse survey data	
3	**Shared Direction and Culture:** absence of a clearly articulated clinical services strategy and the need to further strengthen organisational culture	Accelerate delivery of the Pharmacy improvement journey addressing culture, medicines optimisation, strategy, workforce and to influence estates strategy for pharmacy needs	Osman Chohan Director of Pharmacy	31/07/2026 Estates strategy expected April 2027		O	Pharmacy strategy Workforce reporting Staff survey response Medicines optimisation strategy Response to Audit Yorkshire review of Aseptic KPI delivery	Quality Committee Pharmacy Q&S Meeting	

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No	Areas for Improvement –	Actions and tasks to achieve the objective or aim	Named Individual responsible	Completion Date	Progress Update	Status	Evidence of action completed	Method of assurance	Assurance Level (RAG Rating
4	**Capable, Compassionate and Inclusive Leaders**: a need to continue strengthening Board development and leadership effectiveness	Continue and strengthen leadership development programmes for Board and Council of Governors, including introduction of a Shadow Board	Catherine Shutt Head of OD	01.09.2026		O	Board development programme Board Effectiveness Survey Shadow Board established Participation records	Board oversight	
5	**Freedom to Speak Up:** mixed staff confidence in raising concerns and limited confidence in whether leaders would always take action to address concerns	Enhance the Trust's THRIVE offer through listening exercises and actions to improve belonging, reduce discrimination and enhance wellbeing	Catherine Shutt Head of OD Kez Hayat Head of EDI	30.06.2026		O	Listening exercise outputs Updated Staff Survey action plan	People Academy	
6	**Workforce Equality, Diversity and Inclusion:** WRES data demonstrates some evidence of workforce inequalities, discrimination, and underrepresentation at senior levels	Define an enhanced EDI programme focused on reducing discrimination and improving representation at senior levels	Kez Hayat Head of EDI	01/06/2026		O	Updated EDI programme and objectives with focus on measurable actions Progress of WRES Action Plan	People Academy	
7	**Process Improvements** Board Committee reporting not sufficiently focused or usable	Improve the quality, focus, usability and conciseness of Board and Committee reporting to support effective decision making through the Board Effectiveness process	Laura Parsons AD of Corporate Governance	01/06/2026		O	Committee Effectiveness Survey outputs	Board oversight	
8	**Process Improvements** Potential introduction of incorporating self-declaration checks	HR to review and provide feedback on the following opportunity for improvement: To review national guidance and best practice regarding the introduction of a self declaration process for all staff following DBS checks	Faeem Lal Director of HR	30/09/2026		O	Updated policy	People Academy Board oversight	

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No	Areas for Improvement –	Actions and tasks to achieve the objective or aim	Named Individual responsible	Completion Date	Progress Update	Status	Evidence of action completed	Method of assurance	Assurance Level (RAG Rating
9	**Process Improvements** Incomplete workforce data recording (absence and turnover)	HR to review and provide feedback on the following opportunity for improvement: • To review sickness rate recording for medical/dental staff to ensure the reason for absence is clearly documented as per the People strategy implementation plan • To review processes for recording the reasons for leaving in the electronic staff record to improve intelligence as per the People strategy implementation plan	Faeem Lal Director of HR	30/09/2026	14.04.2026 Verbal confirmation that the reason for absence recording was rectified. The option of using 'Other' in health roster live is no longer possible.	O	Report to People Academy	People Academy	
10	**Process Improvements** Safer nursing care tool (2024) not fully implemented	Implement the updated safer nursing care tool across the Trust	Laura Loveday Associate CN for Quality and Workforce	Completed		C	Tool implementation	People Academy	
11	**Process improvements** Training compliance risk (BLS and Safeguarding Level 3	Deliver targeted actions to improve compliance in BLS and Safeguarding level 3	Ben Mackay Education Manager	Review planned 01.07.26		O	Mandatory training action plans 85% >compliance overall for service	People Academy	
12	**Process improvements** Perceived conflict of interest relating to senior roles of individuals holding FTSU responsibilities	In response to the concerns raised regarding potential perceived conflicts of interest of senior leaders holding FTSU responsibilities. New arrangements are now in place to address any concerns. The new Executive Lead is the Chief Digital Information Officer.	Mel Pickup Chief Executive Officer	Completed		C	Independent oversight Alternative escalation routes e.g. external FTSU guardian Monitoring of culture No evidence of detriment	Board oversight	

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Board of Directors				
Meeting Date:	21.05.26		**Agenda Reference:**	Bo.5.26.12
Report Title:	Care Quality Committee (CQC) Statement of Purpose			
Presented by:	Professor Karen Dawber, Chief Nurse			
Executive Lead:	Professor Karen Dawber, Chief Nurse			
Author:	Byron Johnson, Associate Director of Quality Nazzar Butt, Moving to Outstanding Lead			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☒ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	The Trust's Statement of Purpose has been reviewed and refreshed to ensure continued compliance with the requirements of the Health and Social Care Act 2008 (Regulated Activities) and associated CQC guidance. The refresh aligns the document with current Trust structures, regulated activities, and governance arrangements. Updates include: • revised aims and objectives • revised service descriptions • updates to people that use the location, service types and regulated activity carried out The revised Statement of Purpose supports readiness for future CQC inspection activity, particularly under the Single Assessment Framework and Well Led domain. Providers must notify CQC of any changes to their statement of purpose and ensure it is kept under review, and notify CQC when there are any changes to the information listed in Schedule 3. Assurance is provided that the refreshed document has undergone internal review with operational, and governance leads.			
Recommendation/s: (including any decision/approval required)	*The Board is asked to:* 1. Review the refreshed Statement of Purpose. 2. Note the amendments made to ensure ongoing regulatory compliance. 3. Approve the refreshed Statement of Purpose			
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	Failure to maintain an accurate and current Statement of Purpose may result in regulatory non-compliance.			
Legal/Regulatory:	Registered providers are required to maintain an accurate and up-to-date Statement of Purpose describing regulated activities, locations, and service user groups.			
Quality & Patient Safety:	The refreshed Statement of Purpose reinforces the Trust's commitment to safe, effective and person-centred care, quality improvement and patient experience and engagement.			

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Equality, Diversity and Inclusion and Health Equity:	None identified
Resources:	No financial implications identified.
Environmental sustainability:	No environmental sustainability impacts identified.
Assurance Route	
Meeting/s where content has been discussed previously:	Quality Team SLT Chief Nurse Meeting

Report content

Purpose

The purpose of this paper is to present the refreshed CQC Statement of Purpose for review and approval.

The refresh has been undertaken to ensure that the Trust maintains compliance with regulatory requirements and that the document accurately reflects current service provision, governance structures, and regulated activities

The paper seeks assurance from the Board that the revised Statement of Purpose is appropriate, current and reflective of operational practice.

Background/context

Under Regulation 12 requirements, all registered providers are required to maintain a current Statement of Purpose describing:

- Information about the Trust including legal status
- Aims and objectives
- Locations where we provide services including regulated activities
- Details of registered manager(s)

The existing Statement of Purpose was reviewed as part of routine governance processes. The review identified the need to update:

- aims and objectives
- service descriptions
- people that use the location, service types and regulated activity carried out

The refresh reflects Trust developments and operational changes implemented since the previous version and aligns better with current CQC templates.

Assessment

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The refreshed document has been benchmarked against:

- current CQC guidance
- requirements of the Health and Social Care Act 2008

The revised document provides improved clarity regarding:

- the people who use the service there
- their service type(s)
- their regulated activity(ies)

The revised Statement of Purpose supports readiness for future CQC inspection activity.

Proposal

Note the amendments made to ensure ongoing regulatory compliance.
Approve the refreshed Statement of Purpose

Appendix1 – BTHFT Statement of Purpose

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Bradford Teaching Hospitals NHS Foundation Trust

Statement of purpose

Health and Social Care Act 2008

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Statement of purpose

Health and Social Care Act 2008, Regulation 12, schedule 3

Version	4	**Date of next review**	June 2029

Service provider	
Name	Bradford Teaching Hospitals NHS Foundation Trust
Address line 1	Bradford Royal Infirmary, Trust Headquarters
Address line 2	Duckworth Lane
Town/city	Bradford
County	West Yorkshire
Post code	BD9 6RJ
Email	mel.pickup@bthft.nhs.uk
Main telephone	01274542200
ID numbers	
CQC provider ID	RAE
Legal Status	Individual

Aims and objectives

What do you wish to achieve by providing regulated activities?
How will your service help the people who use your services?
Please use the numbered bullet points:

1. The Trust provides hospital services for the people of Bradford and communities across Yorkshire. We serve a core population in the Bradford District of 648,000 people and provide specialist services for more than 1.1million citizens. Each year at the Trust, we deliver around 6,000 babies, perform over 300,000 operations and see around 500,000 people in outpatient clinics.

   Our 7,500 staff work over several sites, including Bradford Royal Infirmary, which provides the majority of inpatient services, and St Luke's Hospital, which predominantly provides outpatient, diagnostic, rehabilitation services day case electives. We also manage local community hospitals at Westwood Park, Westbourne Green, and Eccleshill, and we have a satellite haemodialysis unit at Skipton Hospital.

2. To provide outstanding care for patients, delivered with kindness
   In line with our vision *to be an* ***outstanding provider of healthcare, research and education and a great place to work***, the Trust aims to deliver consistently safe, effective and compassionate care across all regulated activities. Guided by our values **We Care, We Value People** and **We Are One Team**, services focus on dignity, respect, safety and a positive experience at every stage of the

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patient journey. This helps people using our services feel safe, supported and confident in the care they receive.
3. To improve health outcomes and reduce health inequalities The Trust aims to make a difference for every member of our community by meeting people where they are and supporting them to live longer in good health. Through partnership working, population health intelligence and targeted prevention, services are designed to address the significant inequalities affecting our local population. This helps ensure fairer access, better outcomes and reduced variation in experience for people who use our services.
4. To deliver high quality, innovative and continuously improving services The Trust is committed to being a continually learning organisation, embedding quality improvement, research and innovation into everyday practice. By using data, audit, clinical leadership and evidence-based pathways, services are regularly reviewed and improved. This ensures patients receive care that is safe, timely, effective, equitable and centred around their individual needs.
5. To involve patients, families and carers as partners in care Reflecting our strategic focus on patient experience and kindness, the Trust aims to actively engage patients, families and carers in decisions about care. Listening, learning from feedback and responding to concerns supports more personalised, responsive services and empowers people to have a stronger voice in their care. This leads to improved trust, confidence and experience.
6. To develop and sustain a skilled, supported and inclusive workforce In line with our aim to be one of the best NHS employers, the Trust prioritises the health, wellbeing and development of our people and embraces equality, diversity and inclusion. Our value We Are One Team underpins how we work together across roles and services. A supported and engaged workforce is essential to delivering safe, compassionate and high-quality care for patients.
7. To work effectively with partners across the health and care system The Trust aims to collaborate effectively with local and regional partners, acting as one to deliver coordinated and seamless care. By working across Bradford District and Craven and West Yorkshire, services are better integrated, pathways are improved and duplication is reduced. This helps patients experience smoother transitions, timely access and more joined up care.
8. To deliver services sustainably and manage resources responsibly In line with our strategic objective to deliver our financial plan and performance targets, the Trust aims to use resources wisely and sustainably. This includes developing new models of care, embracing digital and virtual services, and ensuring estates and services are fit for the future. This helps secure the long term delivery of safe, high quality services for current and future patients.

Location(s) and

- **the people who use the service there**
- **their service type(s)**
- **their regulated activity(ies)**

Location ID	RAE01
Name	Bradford Royal Infirmary
Address line 1	Trust Headquarters
Address line 2	Smith Lane

Document Set ID: 1093202 Version: 1

Town/city	Bradford
County	West Yorkshire
Post code	BD9 6DA
Telephone	01274 364305
Description of the location	Full range of services acute hospital care, intermediate care and outpatient services

The people that will use this location ('The whole population' means everyone).

Adults aged 18-65	☐	Adults aged 65+	☐		
Mental health	☐	Sensory impairment	☐		
Physical disability	☐	People detained under the Mental Health Act	☐		
Dementia	☐	People who misuse drugs or alcohol	☐		
People with an eating disorder	☐	Learning difficulties or autistic disorder	☐		
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐
The whole population	☒	Other (please specify below)	☐		

The CQC service type(s) provided at this location

Acute services (ACS)	☒	Doctors treatment service (DTS)	☒
Prison healthcare services (PHS)	☐	Mobile doctor service (MBS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☒	Dental service (DEN)	☒
Hospice services (HPS)	☒	Diagnostic and or screening service (DSS)	☒
Rehabilitation services (RHS)	☒	Care home service without nursing (CHS)	☐
Long-term conditions services (LTC)	☒	Care home service with nursing (CHN)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐	Specialist college service (SPC)	☐
Hyperbaric chamber (HBC)	☐	Domiciliary care service (DCC)	☐
Community healthcare service (CHC)	☒	Supported living service (SLS)	☐
Community-based services for people with mental health needs (MHC)	☐	Shared Lives (SHL)	☐
Community-based services for people with a learning disability (LDC)	☐	Extra Care housing services (EXC)	☐
Community-based services for people who misuse substances (SMC)	☐	Ambulance service (AMB)	☐
Urgent care services (UCS)	☒	Remote clinical advice service (RCA)	☒
Doctors consultation service (DCS)	☒	Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location

Personal care	☐
Registered Manager(s) for this regulated activity:	
Accommodation for persons who require nursing or personal care	☐
Registered Manager(s) for this regulated activity:	

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Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Surgical procedures	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Management of supply of blood and blood derived products etc	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Termination of pregnancies	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Family planning service	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		

Location ID	RAE05
Name	St Lukes Hospital
Address line 1	Little Horton Lane
Address line 2	
Town/city	Bradford
County	West Yorkshire
Post code	BD5 0NA
Telephone	01274 734744
Description of the location	Primarily functions as a centre for outpatient and rehabilitation services. Includes a range of diagnostic, therapeutic, and long term care services.

The people that will use this location ('The whole population' means everyone).

Adults aged 18-65	☐	Adults aged 65+	☐
Mental health	☐	Sensory impairment	☐
Physical disability	☐	People detained under the Mental Health Act	☐
Dementia	☐	People who misuse drugs or alcohol	☐
People with an eating disorder	☐	Learning difficulties or autistic disorder	☐

Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐	
The whole population	☒	Other (please specify below)			☐	

The CQC service type(s) provided at this location				
Acute services (ACS)	☐	Doctors treatment service (DTS)	☒	
Prison healthcare services (PHS)	☐	Mobile doctor service (MBS)	☐	
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐	Dental service (DEN)	☒	
Hospice services (HPS)	☒	Diagnostic and or screening service (DSS)	☒	
Rehabilitation services (RHS)	☒	Care home service without nursing (CHS)	☐	
Long-term conditions services (LTC)	☒	Care home service with nursing (CHN)	☐	
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐	Specialist college service (SPC)	☐	
Hyperbaric chamber (HBC)	☐	Domiciliary care service (DCC)	☐	
Community healthcare service (CHC)	☒	Supported living service (SLS)	☐	
Community-based services for people with mental health needs (MHC)	☐	Shared Lives (SHL)	☐	
Community-based services for people with a learning disability (LDC)	☐	Extra Care housing services (EXC)	☐	
Community-based services for people who misuse substances (SMC)	☐	Ambulance service (AMB)	☐	
Urgent care services (UCS)	☐	Remote clinical advice service (RCA)	☒	
Doctors consultation service (DCS)	☒	Blood and Transplant service (BTS)	☐	

Regulated activity(ies) carried on at this location	
Personal care	☐
Registered Manager(s) for this regulated activity:	
Accommodation for persons who require nursing or personal care	☐
Registered Manager(s) for this regulated activity:	
Accommodation for persons who require treatment for substance abuse	☐
Registered Manager(s) for this regulated activity:	
Accommodation and nursing or personal care in the further education sector	☐
Registered Manager(s) for this regulated activity:	
Treatment of disease, disorder or injury	☒
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber	
Assessment or medical treatment for persons detained under the Mental Health Act	☒
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber	
Surgical procedures	☒
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber	
Diagnostic and screening procedures	☒
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber	
Management of supply of blood and blood derived products etc	☒

Disclosure Date: 26/04/2019

Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Termination of pregnancies	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Family planning service	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		

Location ID	RAE5H
Name	Westbourne Green Community Hospital
Address line 1	26 Heaton Road
Address line 2	Heaton
Town/city	Bradford
County	West Yorkshire
Post code	BD8 8RA
Telephone	01274 366803
Description of the location	Provides specialised care, including elderly care, intermediate, and rehabilitation services. Supports patients through dedicated inpatient beds and outpatient clinics, focusing on rehabilitation and recovery.

The people that will use this location ('The whole population' means everyone).

Adults aged 18-65	☒	Adults aged 65+			☒
Mental health	☐	Sensory impairment			☒
Physical disability	☒	People detained under the Mental Health Act			☒
Dementia	☒	People who misuse drugs or alcohol			☒
People with an eating disorder	☐	Learning difficulties or autistic disorder			☒
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐
The whole population	☐	Other (please specify below)			☐

The CQC service type(s) provided at this location

Acute services (ACS)	☐	Doctors treatment service (DTS)	☒
Prison healthcare services (PHS)	☐	Mobile doctor service (MBS)	☐
Hospital services for people with mental health needs, learning disabilities and problems with substance misuse (MLS)	☐	Dental service (DEN)	☐
Hospice services (HPS)	☐	Diagnostic and or screening service (DSS)	☐

Rehabilitation services (RHS)	☒	Care home service without nursing (CHS)	☐	
Long-term conditions services (LTC)	☒	Care home service with nursing (CHN)	☐	
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐	Specialist college service (SPC)	☐	
Hyperbaric chamber (HBC)	☐	Domiciliary care service (DCC)	☐	
Community healthcare service (CHC)	☒	Supported living service (SLS)	☐	
Community-based services for people with mental health needs (MHC)	☐	Shared Lives (SHL)	☐	
Community-based services for people with a learning disability (LDC)	☐	Extra Care housing services (EXC)	☐	
Community-based services for people who misuse substances (SMC)	☐	Ambulance service (AMB)	☐	
Urgent care services (UCS)	☐	Remote clinical advice service (RCA)	☐	
Doctors consultation service (DCS)	☒	Blood and Transplant service (BTS)	☐	

Regulated activity(ies) carried on at this location		
Personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Registered Manager(s) for this regulated activity:		
Surgical procedures	☐	
Registered Manager(s) for this regulated activity:		
Diagnostic and screening procedures	☐	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Management of supply of blood and blood derived products etc	☐	
Registered Manager(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☐	
Registered Manager(s) for this regulated activity:		
Termination of pregnancies	☐	

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Registered Manager(s) for this regulated activity:	
Services in slimming clinics	☐
Registered Manager(s) for this regulated activity:	
Nursing care	☒
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber	
Family planning service	☐
Registered Manager(s) for this regulated activity:	

Location ID	RAE3A
Name	Westwood Park Community Hospital & DTC
Address line 1	Cooper Lane
Address line 2	Horton Bank Top
Town/city	Bradford
County	West Yorkshire
Post code	BD6 3NL
Telephone	01274 425990
Description of the location	Provides specialised care including elderly and intermediate care, audiology, and physiotherapy services. Includes a Diagnostic and Treatment Centre (DTC) focusing on planned care

The people that will use this location ('The whole population' means everyone).

Adults aged 18-65	☒	Adults aged 65+	☒		
Mental health	☒	Sensory impairment	☒		
Physical disability	☒	People detained under the Mental Health Act	☒		
Dementia	☒	People who misuse drugs or alcohol	☒		
People with an eating disorder	☐	Learning difficulties or autistic disorder	☒		
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☒
The whole population	☐	Other (please specify below)	☐		

The CQC service type(s) provided at this location

Acute services (ACS)	☐	Doctors treatment service (DTS)	☒
Prison healthcare services (PHS)	☐	Mobile doctor service (MBS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐	Dental service (DEN)	☐
Hospice services (HPS)	☐	Diagnostic and or screening service (DSS)	☒
Rehabilitation services (RHS)	☒	Care home service without nursing (CHS)	☐
Long-term conditions services (LTC)	☒	Care home service with nursing (CHN)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐	Specialist college service (SPC)	☐
Hyperbaric chamber (HBC)	☐	Domiciliary care service (DCC)	☐

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Community healthcare service (CHC)	☒	Supported living service (SLS)	☐
Community-based services for people with mental health needs (MHC)	☐	Shared Lives (SHL)	☐
Community-based services for people with a learning disability (LDC)	☐	Extra Care housing services (EXC)	☐
Community-based services for people who misuse substances (SMC)	☐	Ambulance service (AMB)	☐
Urgent care services (UCS)	☐	Remote clinical advice service (RCA)	☐
Doctors consultation service (DCS)	☒	Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location	
Personal care	☐
Registered Manager(s) for this regulated activity:	
Accommodation for persons who require nursing or personal care	☐
Registered Manager(s) for this regulated activity:	
Accommodation for persons who require treatment for substance abuse	☐
Registered Manager(s) for this regulated activity:	
Accommodation and nursing or personal care in the further education sector	☐
Registered Manager(s) for this regulated activity:	
Treatment of disease, disorder or injury	☒
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber	
Assessment or medical treatment for persons detained under the Mental Health Act	☒
Registered Manager(s) for this regulated activity:	
Surgical procedures	☒
Registered Manager(s) for this regulated activity:	
Diagnostic and screening procedures	☒
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber	
Management of supply of blood and blood derived products etc	☐
Registered Manager(s) for this regulated activity:	
Transport services, triage and medical advice provided remotely	☐
Registered Manager(s) for this regulated activity:	
Maternity and midwifery services	☐
Registered Manager(s) for this regulated activity:	
Termination of pregnancies	☐
Registered Manager(s) for this regulated activity:	
Services in slimming clinics	☐
Registered Manager(s) for this regulated activity:	
Nursing care	☒
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber	
Family planning service	☐
Registered Manager(s) for this regulated activity:	

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Location ID	RAE4H
Name	Eccleshill Community Hospital
Address line 1	450 Harrogate Road

Address line 2	Eccleshill
Town/city	Bradford
County	West Yorkshire
Post code	BD10 0JE
Telephone	01274 323200
Description of the location	Provides outpatient clinics, and specialist diagnostic services, including a community diagnostic centre. Key services include clinical oncology, clinical haematology, audiology/ENT, trauma and orthopaedics.

The people that will use this location ('The whole population' means everyone).

Adults aged 18-65	☒	Adults aged 65+		☒	
Mental health	☒	Sensory impairment		☒	
Physical disability	☒	People detained under the Mental Health Act		☒	
Dementia	☒	People who misuse drugs or alcohol		☒	
People with an eating disorder	☐	Learning difficulties or autistic disorder		☒	
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☒
The whole population	☐	Other (please specify below)		☐	

The CQC service type(s) provided at this location

Acute services (ACS)	☐	Doctors treatment service (DTS)	☒
Prison healthcare services (PHS)	☐	Mobile doctor service (MBS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐	Dental service (DEN)	☐
Hospice services (HPS)	☐	Diagnostic and or screening service (DSS)	☒
Rehabilitation services (RHS)	☐	Care home service without nursing (CHS)	☐
Long-term conditions services (LTC)	☐	Care home service with nursing (CHN)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐	Specialist college service (SPC)	☐
Hyperbaric chamber (HBC)	☐	Domiciliary care service (DCC)	☐
Community healthcare service (CHC)	☒	Supported living service (SLS)	☐
Community-based services for people with mental health needs (MHC)	☐	Shared Lives (SHL)	☐
Community-based services for people with a learning disability (LDC)	☐	Extra Care housing services (EXC)	☐
Community-based services for people who misuse substances (SMC)	☐	Ambulance service (AMB)	☐
Urgent care services (UCS)	☐	Remote clinical advice service (RCA)	☐
Doctors consultation service (DCS)	☒	Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location

Personal care	☐

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Registered Manager(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Registered Manager(s) for this regulated activity:		
Surgical procedures	☐	
Registered Manager(s) for this regulated activity:		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Management of supply of blood and blood derived products etc	☐	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☐	
Registered Manager(s) for this regulated activity:		
Termination of pregnancies	☐	
Registered Manager(s) for this regulated activity:		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☒	
Registered Manager(s) for this regulated activity: Prof Karen Louise Dawber		
Family planning service	☐	
Registered Manager(s) for this regulated activity:		

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Registered manager details

1. Manager's full name	Prof Karen Louise Dawber
2. Manager's contact details	
Business address	Bradford Royal Infirmary Trust Headquarters
Town/city	Bradford
County	West Yorkshire
Post code	BD9 6RJ
Business telephone	01274 382407
Manager's email address	
Karen.Dawber@bthft.nhs.uk	

3. Locations managed by the registered manager at 1 above (Please see part 3 of this statement of purpose for full details of the location(s))
Name(s) of location(s) (list)
Bradford Royal Infirmary St Lukes Hospital Westbourne Green Community Hospital Westwood Park Community Hospital & DTC Eccleshill Community Hospital

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4. Regulated activity(ies) managed by this manager		
Personal care	☐	
Accommodation for persons who require nursing or personal care	☐	
Accommodation for persons who require treatment for substance abuse	☐	
Accommodation and nursing or personal care in the further education sector	☐	
Treatment of disease, disorder or injury	☒	
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Surgical procedures	☒	
Diagnostic and screening procedures	☒	
Management of supply of blood and blood derived products etc	☒	
Transport services, triage and medical advice provided remotely	☐	
Maternity and midwifery services	☒	
Termination of pregnancies	☒	
Services in slimming clinics	☐	
Nursing care	☒	
Family planning service	☒	

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Board of Directors			
Meeting Date:	21.05.26	**Agenda Reference:**	Bo.5.26.13
Report Title:	MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE, MARCH/APRIL 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 ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	The Director of Midwifery and the Chair of Quality Committee (QC) provide Trust Board with the assurance that a monthly review of maternity and neonatal quality and safety relating to March and April 2026 activity, was presented and key elements discussed including: • The number of harms occurring in March and April, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of Maternity Newborn Safety Investigations (MNSI) and Patient Safety Incident Investigation (PSII) cases were discussed. • There were no completed MNSI reports and recommendations in March or April. • No Maternity Outcomes Signal System (MOSS) triggers were received in March, and a level 1 trigger was received on 27 April. This paper also includes: • Feedback from the March Local Maternity and Neonatal System (LMNS) Assurance visit. • MOSS Critical Safety Check response completion. • Maternal Medicine Network escalation of concern regarding the low number of BTHFT referrals and actions to address. • Initial feedback of the multidisciplinary team (MDT) thematic tabletop review of stillbirths between 1 January and 30 April 2026. • Update on Maternity Incentive Scheme, Year 8, including the agreed second checkpoint date for training compliance.			
Recommendation/s: (including any decision/approval required)	The Board is asked to: 1. Confirm that they are assured that Quality Committee have reviewed and discussed the contents of the March and April 2026 Maternity and Neonatal (Perinatal) Services Update papers, as a committee of the Board with delegated authority (the papers are available in the reading room). 2. Note Appendix 5, the completed MOSS Critical Safety Checklist, and the rating of Green/Amber, with risks monitored via Women's Core Governance Group (available in the reading room). 3. Note the actions agreed with the Maternal Medicine Network regarding the receipt of information about women who are suitable to be managed at BTHFT.			

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	4. Note the initial findings and proposed actions following the thematic tabletop review of stillbirths January to April 2026. 5. Note that the second Maternity Incentive Scheme, Year 8, Training Compliance Checkpoint is agreed as 1 July 2026.
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness
Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	N/A
Legal/Regulatory:	The December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety. The requirements to strengthen and optimise Board oversight for maternity and neonatal safety includes: • That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board. • That all maternity Serious Incidents (SIs) are shared with Trust Boards and the Local Maternity and Neonatal System (LMNS), in addition to reporting as required to Maternity and Newborn Safety Investigation (MNSI) programme. • To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	Quality Committee, April and May 2026

Report content

Purpose

The December 2020 NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

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The requirements to strengthen and optimise Board oversight for maternity and neonatal safety includes:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.

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

The monthly maternity and neonatal services report presented to Quality Committee (QC) ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that QC, as a committee of the Board 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 closed Trust Board, in addition to any completed Maternity and Neonatal Safety Investigations (MNSI) and internal Patient Safety Incident Investigation (PSII) reports.

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

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

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

Background/context

The March and April updates and associated appendices were discussed at thr April and May 2026 Quality Committees respectively.

The key elements of the papers discussed included:

- The number of harms occurring in March and April, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of MNSI and PSSI cases were discussed and are available to Closed Trust Board as appendices 3 and 4.
- There were no completed MNSI reports and learning/recommendations to share in March and April.
- The April and May QC reported and recorded that they were assured by the papers, presentation, and discussion. There was nothing identified requiring escalation to Board.

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

Local Maternity and Neonatal System Assurance (LMNS) Visit:

Members of West Yorkshire and Harrogate LMNS, along with representatives from the North East and Yorkshire, Regional Maternity Team, undertook the annual Maternity and Neonatal assurance visit in March.

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High level feedback was received on the day, and a follow-up report was received in April.
Feedback was positive regarding:

- Improvements to the environment
- Staff happy and reported being supported
- Examples of personalised care and women centred care
- Continued commitment to service improvement

Even better if:

- Improved awareness of safety champions
- Review of visiting policy
- More accessible dissemination of learning, not just social media platforms
- More inclusive feedback mechanisms to reflect diversity of service users

Next steps:

- Meeting planned to consider any improvements in collaboration with our MNVP lead

Maternity Outcomes Signal System (MOSS):

- The maternity service received a level 1, MOSS signal trigger on 27 April, following an increase in the number of term stillbirths expected for a unit of Bradford's size, in the last 3 months.
- The service had 8 working days in which to complete the critical safety check, which is designed to assess the current safety of intrapartum services. To note that none of the 4 cases generating the trigger, were receiving intrapartum care on the labour ward or in the unit, at the time the death was diagnosed. The completed checklist was returned to ICB and Regional colleagues, following Executive sign off, within the agreed time frame and can be reviewed as Appendix 1.
- Members of the Perinatal Leadership team, Maternity and Neonatal Voices Partnership (MNVP) Lead, and other members of the multidisciplinary team (MDT) met to populate the safety checklist, which was then discussed with the Executive and Non-Executive Perinatal Safety Champion prior to their approval and sign off.
- The team assessment is that intrapartum services at Bradford are currently considered to be RAG rated 'Green/Amber': There is at least one known safety issue in our intrapartum service, with a plan of action already in place and progressing as planned.
- The safety issues identified relate to ongoing improvement work around documentation of SBAR handover, and Obstetric staffing gaps which do not impact on the safety of labour ward but contribute to delays in the obstetric review of women in the Maternity Assessment Centre (MAC) and inpatient areas.
- No further action is requested or required at present and monitoring progress of the risks described will continue through Women's Core Governance, with escalation to the Perinatal Safety Champions/Quality Committee/Board as required.

<u>Maternal Medicine Network (MMN) escalation of concern:</u>

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- On 14 April, the service received a formal escalation letter from the Yorkshire and Humber MMN, regarding a low number of referrals from Bradford to the Leeds tertiary centre.
- Whilst Leeds is the 'hub' provider of maternal medicine, Bradford is a recognised 'spoke' unit, with the capacity and expertise to provide care for some maternal medicine conditions in house.

However, the number of referrals from Bradford in the last 3 quarters, are considered by the MMN to be lower than expected.

- In response to the letter of concern, the MM lead obstetrician, Director of Midwifery, and Head of Midwifery, met with the MMN team on 22 April, to discuss the concerns and consider actions.
- During the meeting it became clear that some conditions managed appropriately in house, still require a referral to the MMN team for awareness and regional data collection purposes. There was an agreement that an email from the Bradford MM Consultant was acceptable, rather than completion of the full referral form.
- The number of this category of 'referral' will be monitored by the MMN and any ongoing concerns flagged.
- There was also a brief conversation regarding the MMN's recommendation that BTHFT should have a designated Specialist Maternal Medicine Midwife, which is not currently within our structure. The service does have an identified BTHFT link midwife and will consider the need for a MM specialist midwife as part of the next full Birth Rate Plus review in 2027, unless there is further indication that this role should be considered sooner.

Thematic Tabletop Review of Stillbirths January to April 2026:

- On 7 May, the service conducted a tabletop, thematic review, of the 12 stillbirths occurring between January and April, on the basis that there is an increase in the number of stillbirths at term, and an overall increase in stillbirths compared to the same period in 2025.
- The review was attended by members of the MDT, MNVP Lead to ensure service user voices and experience of care are considered, external peer reviewer and representatives from Executive and Non-Executive colleagues.
- The review team were unable to identify any major thematic clinical findings of significant concern, but noted:
    - Most of the women lived in deprivation indices 1
    - Most of the women were in their first substantive pregnancy
    - 50% of the women were of South Asian heritage
    - Most of the women experienced reduced fetal movements
- The review team concluded that the 50% reduction in stillbirths during 2025 was likely an anomaly, and the number of deaths so far this year is similar to 2024 and earlier.
- The review team discussed that the only discernible difference in clinical practice between 2025 and 2026, is an increase in the junior workforce, both medical and midwifery. However, the team were unable to find evidence that the seniority of staff was a factor in many of the cases but acknowledged that this may be impacting in other areas of the service.
- The findings/actions/next steps from the review, will be shared in the May paper to June Quality Committee, with escalation to Trust Board as appropriate, and will include:
    - Service will approach MNSI to ask if they would apply a thematic lens to the intrapartum cases referred to them during this period, in addition to the individual investigation.
    - Undertake an audit of the reduced fetal movement information given to women.
    - Approach the Calderdale team regarding focused public health messages they undertook in response to an increase in stillbirths during 2024, particularly around reduced fetal movements.
    - Progression of the JANAM app for South Asian women, which will improve the ability to share pregnancy information in a culturally appropriate manner.
    - MDT will reconvene in 3 months when all cases will have had a Perinatal Mortality Review Tool grading.

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Maternity Incentive Scheme, Year 8, Training Compliance checkpoint:

- Members of the MDT met in April to discuss the conditions of the Maternity Incentive Scheme, Year 8, conditions.
- The year 8 scheme requires Trusts to demonstrate >90% compliance of every required staff group at two points during the MIS year (April 2026-November 26).
- 30 November is the mandatory MIS checkpoint, and Trusts are to select a second checkpoint, declared in advance through the Quality Committee.
- The MDT agreed that the second date will be 1 July 2026, and the Quality Committee was asked to record this in the May meeting minutes.

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 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.

Appendices:

- Appendix 1- Maternity and Neonatal (Perinatal) Services Update, March 2026 – available in the reading room here click here
- Appendix 2 - Maternity and Neonatal (Perinatal) Services Update, April 2026 – available in the reading room here click here
- Appendix 3 - Closed Board Harms March 2026 – available in the reading room here click here
- Appendix 4 - Closed Board Harms April 2026 – available in the reading room here click here
- Appendix 5 - MOSS Critical Safety Checklist Response – available in the reading room here click here

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Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.14a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 15th April 2026

Key escalation and discussion points from the meeting
Alert:
• There were no red alert items to raise this month.
Advise:

• **Dashboard**:
  ○ The Academy welcomed the addition of targets to the dashboard and agreed to amalgamate the various actions on the dashboard and data and work alongside the Trust executive to iterate a model that included more detail on the recovery plan targets (including workforce); the NOF data and other relevant workforce related issues.
  ○ The Academy noted an upturn in **staff turnover** and agreed to continue to monitor alongside the wider workforce reduction targets.
  ○ **Medical Job planning**: remains low and the Academy will look forward to receiving more information following the work done by the external consultants later in the year.
• Following red flags across Finance and Performance and People the **Estates and Facilities team presented a deep dive into their workforce action plan**. There are some concerning flags in sickness; appraisal rates and drivers of absence, including MSK and mental health issues. The data presented was comprehensive and transparent. The action plan was welcomed but also needed a joined-up approach with OD and other areas to ensure an holistic plan. It also lacked targets in some areas and measurable impact measures. It was agreed this would be revisited, in a lighter touch way, in 3 months to review the impact of the action plan but we were broadly assured by the actions of Estates leadership in addressing the issues.
• The Academy received the **National Education and Training Survey (NETS)** feedback. Overall, results were mixed and reflected wider underlying trends in the Trust. The organisation continues to perform well in teamwork, peer support, safety culture, education and supervision. However, most scores declined compared with the previous year. Workload was a key concern, decreasing from 64 to 56, and this theme is now reflected across medical, nursing and midwifery feedback, particularly regarding supervision and the learning environment. The organisation remains a national negative outlier for bullying, undermining and discrimination, as also picked up in the Staff Survey results. Whilst the effectiveness of the action plan will be reflected in the next annual survey, this was another pointer to some of the wider issues now being tackled by the Trust and tracked via the Academy. For example, it was noted that other actions – such as the Staff Survey action plan will also have an impact.
• The Academy received a report into its **Apprenticeship Strategy**. There was lots to discuss and consider and the Academy strongly supported the development of a more strategic approach targeted on workforce gaps and aligned to a wider workforce strategy positioning apprenticeships as a core mechanism within the 10-year workforce plan and the Trust's anchor institution role.

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Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.14a

Assure:

- It is worth noting the good work going on in Education reported each month on income generation via Education and Learning and is a testament to the quality of the Trust's output.
- The Academy was assured by the **Equality Delivery System (EDS)** report. The update covered Domain 2 (Workforce Health and Wellbeing) and Domain 3 (Inclusive Leadership) (Domain 1 is reported separately to the Quality Committee). The organisation achieved an overall EDS rating of "Achieving", with elements demonstrating progress toward "Excelling". Key learning included the need to improve communication of wellbeing offers, strengthen informal conflict resolution, enhance safety in high-risk areas, further empower managers on EDI responsibilities, and sustain senior leadership focus on equality and health equity.
- The Academy had a healthy discussion on **governance** and its role as a result of the annual governance review. Key changes include:
    - Three face-to-face meetings per year, with remaining meetings held virtually.
    - Renaming the Academy as the 'People Committee', aligning with the Quality and Finance & Performance Committees.
    - Reducing standing attendance in line with Board-level best practice, with relevant officers invited for specific agenda items only.
    - Providing additional support sessions for report authors to support best practice in preparation and presentation of papers.
    - Support to improve timeliness of papers through forward visibility of the workplan to report authors

Feedback was requested and since the meeting there has been some further refinement to the membership to ensure operational voices continue to be heard. The ongoing importance of learning will also be emphasised in the revised ToR. The review also flagged a potential gap in operational 'join up' across the different departments regarding issues discussed at People Academy, and this will be explored in more detail by the executive.

Report completed by:

Justine Andrew
Academy Chair and Non-Executive Director

7th May 2026

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Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.14a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 12th May 2026

Key escalation and discussion points from the meeting
Alert:
• There were no red alert items to raise this month.
Advise:
• In the ongoing dashboard and data iteration, alongside work on the recovery dashboard and NOF going through ELT, the **revised People Committee dashboard** to include workforce targets for the 5-year plan will be presented to committee in June. • The Committee was broadly assured by a comprehensive **WRES and WDES (Workforce Race Equality and Disability Standards** respectively) report. There was a huge amount of detail in the report; a lot of Trust wide activity to be commended. There also remain areas of improvement and entrenched challenges, particularly disciplinary disparity and recruitment outcomes. Proposed activity includes leadership development, positive action in recruitment, adoption of the NHS Race Observatory anti-racist principles, deeper analysis of disciplinary data with HR and cultural interventions to improve belonging and reduce discrimination. The Committee noted that this reflects themes in the staff survey and encouraged the team to ensure the accountability was shared across the Trust. Although this is an ongoing topic and will also be picked up on the staff survey action plan, the Committee asked that a refreshed and integrated EDI action plan be brought back to the committee by July. • The **Guardian of Safe Working Hours** report was received and noted. The Committee asked for better clarity on outcome measures to assess effectiveness and asked for alignment of mitigations to risk outcomes and impact in future reporting. • Overall, there remain some concerns on **workload**; job planning and the impact this is having across the organisation, especially in light of the overall workforce reduction targets. This was also a theme in the Education Annual report and the NETS 25 survey at the last committee. Feeding into this, the workforce reduction plan will be presented to the Committee in June and a deeper dive into medical job planning in July. The Chief Nurse also gave more detail on nursing, midwifery and Allied Health Professionals (AHP) job planning as consistently showing as very low on the dashboard and a refreshed target was agreed. It is an area People, Quality and Finance and Performance will need to track closely.
Assure:
• Following feedback, the May Committee was the first with a smaller group that still incorporated operational voices from across the Trust, and we will continue to monitor to ensure the **Committee membership** and ToRs are fit for purpose. • **Sickness absence**: the Committee was presented a comprehensive **Wellbeing and attendance managements** plan by HR and OD, which was broadly welcomed. The plan demonstrated a step in change in the approach to sickness management that looked at

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Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.14a

three core domains of absence management; early intervention and wellbeing. The multi-disciplinary approach was particularly noted with colleagues from across the Trust working together to address what we know is a stubborn issue. The action plan was SMART, and we agreed to monitor progress via a specific KPI report every other month and bring a more comprehensive report back in November. This is a much a cultural shift as anything and will require strong executive leadership.

- Following a board learning session, the committee welcomes the proposed revisions to **risk management** across the Trust. This is especially true regarding the Board Assurance Framework (BAF) if it is to be used to provide assurance on key strategic risks.
- The Committee was assured by a comprehensive **FTSU (Freedom to Speak Up)** report for the 25/26 year whilst noting the ongoing need for the FTSU process to be on the agenda for 'Executive to CSU' meetings to ensure visibility and operational ownership.

Report completed by:

Justine Andrew
Academy Chair and Non-Executive Director

14th May 2026

Osbourne Sheridan
19/05/2026 08:22:12

Board of Directors				
Meeting Date:	21 May 2026		**Agenda Reference:**	Bo.5.26.14b
Report Title:	Freedom to Speak Up Annual Report (including Q4 update)			
Presented by:	Vikki Lewis, Chief Digital and Information Officer			
Executive Lead:	Vikki Lewis, Chief Digital and Information Officer			
Author:	Sue Franklin, Associate Chief Nurse, FTSU Guardian			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☐	Action ☐ (review/discuss/ comment)	Information ☒
Summary of Key Issues/Highlights:	This paper provides the 2025-26 Quarter (Q) 4 update for the Board on FTSU at Bradford Teaching Hospitals (BTHFT).			
Recommendation/s: (including any decision/approval required)	The Board is asked to: 1. Note the contents of the report and the FTSU concerns that have been raised at BTHFT during Q4 2025-26 in this annual report. 2. Note the feedback from staff who have spoken up in Q4. 3. Note the work of the FTSU Guardians and Ambassadors 4. Note themes reported through the FTSU Ambassador network 5. Note the update on the Board development action plan 6. Note the staff survey results for FTSU 7. Note the CQC well-led report for FTSU 8. Review the recommendations for the Trust from 'Temporary Workers, Permanent Voices: A Speak Up Review.			
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	There are quality implications that FTSU may impact			
Legal/Regulatory:	Linked to the quality governance framework and FTSU is part of the CQC well led inspection.			
Quality & Patient Safety:	May have an impact if FTSU concerns are raised about patient safety and quality.			
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:	People Academy.			

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Report content

1. Purpose

1.1 This paper provides assurance to the Board in relation to the conduct and outcome management of the FTSU arrangements in the Trust by:

- Noting the update from the National Guardian's Office (NGO) about the changes to FTSU
- Providing an update, using the NGO template, on FTSU and the progress in Q4 2025-26 (Appendix 1).
- Representing the number of concerns raised per quarter and year as a line graph of data plotted over time (Appendix 2).
- Noting the number of open and closed FTSU cases (Appendix 3).
- Providing feedback received in Q4 from staff who have raised concerns (Appendix 4).
- Noting the work of the FTSU Ambassadors (Appendix 5).
- Noting the FTSU Board development action plan update (Appendix 6).
- Providing the FTSU staff survey results 2025 (Appendix 7).
- Noting the CQC well led report for FTSU (Appendix 8).
- Noting the publication by the NGO of the Temporary workers, permanent voices: A speak Up review – published March 2026 (Appendix 9).

2. Background/Context

2.1 The FTSU Guardians have a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patients' safety and/or the way that the concern has been handled. The Guardian's role is to listen and empower staff to speak up and support the organisation to a healthy speaking up culture.

2.2 The FTSU Guardians are Sue Franklin, Associate Chief Nurse and Helen Fearnley, Nurse Consultant Tissue viability. Vikki Lewis is the new Executive Lead for FTSU and the Non-Executive Director lead is Justine Andrew.

2.3 There are 22 FTSU Ambassadors who have completed the training provided by the NGO. This role is an 'add on' to their current role and the staff are from a variety of roles and areas across the Trust. There is a role description, and the ambassadors complete an activity log.

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2.4 The NGO requests regular updates and currently requests quarterly reports (in a standard template) on the concerns raised from each NHS Trust. We have complied with this submission.

2.5 The three eLearning modules for FTSU (Speak up, Listen Up and Follow Up) are now on the training matrix for relevant staff to complete.

2.6 The Board completed the FTSU Board development session in October 2025 and the most recent update of the action plan is included at Appendix 6.

2.7 From 6th April 2026, Sexual harassment becomes an explicit category of protected disclosure under the Public Interest Disclosure Act (PIDA)

2.8 From 1 July 2026, following a recommendation in July 2025 by the Dash review of patient safety across health and care, NHS England will deliver some activities previously undertaken by the National Guardian's Office (NGO). Trusts, primary care organisations, integrated care boards (ICBs) and independent providers will be taking on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements. More information can be found on this link.

NHS England » The future of Freedom to Speak Up

2.9 A review carried out by the National Guardian's Office has found that temporary workers feel (60.4%) of temporary workers surveyed saying they do not have a voice in the NHS in England. In the report review it was found that the biggest barrier to speaking up for temporary workers was the fear of losing shifts. The review heard deeply moving stories from temporary workers, with many recounting experiences of unfair treatment at work, not being supported and feeling like an outsider. In addition, temporary workers reported issues such as a lack of proper staff induction, a lack of advocacy and representation, mistrust in speaking up processes and a lack of support after raising concerns (full report is in Appendix 9).

3. Assessment

3.1 Alongside the data headlines for each quarter, the NGO publish on their webpages the data submitted by all the Trusts in England. This enables each organisation to benchmark against similar types and sizes of organisations. This data is varied, but on average at BTHFT (classified as a medium sized Trust in the NGO data set) the data is consistent with other medium sized Trusts.

3.2 In addition the annual NHS staff survey on safety culture about raising concerns provides an opportunity to monitor how BTHFT is performing in relation to other organisations classified as the best, average and worst performing. At BTHFT we are just above average on all 4 questions. (Appendix 7 includes the 2025 results).

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3.3 The FTSU team are working hard to ensure staff feel safe to speak up but need the support of leaders throughout the organisation to make speaking up just what we do here at BTFHT. All leaders are responsible for setting the tone when it comes to fostering a healthy speak up, listen up, follow up culture.

3.4 The FTSU Guardian Sue Franklin and Non-Executive director, Justine Andrew were interviewed as part of the CQC Well led inspection in November 2025. The report for FTSU is included in Appendix 8 and any actions from this will be monitored through the FTSU group.

4. Proposal

4.1 To note the number of FTSU concerns that have been raised during Q4 2025-26 at BTHFT, the main themes from these concerns and the groups of staff who have reported a concern.

4.2 To support the work of the FTSU group, continue raising awareness and education for Guardians.

4.3 To continue with quarterly reports to the Board/People Academy to update on progress with FTSU at BTHFT.

4.4 To support the staff across the organisation to complete FTSU training on the eLearning platform.

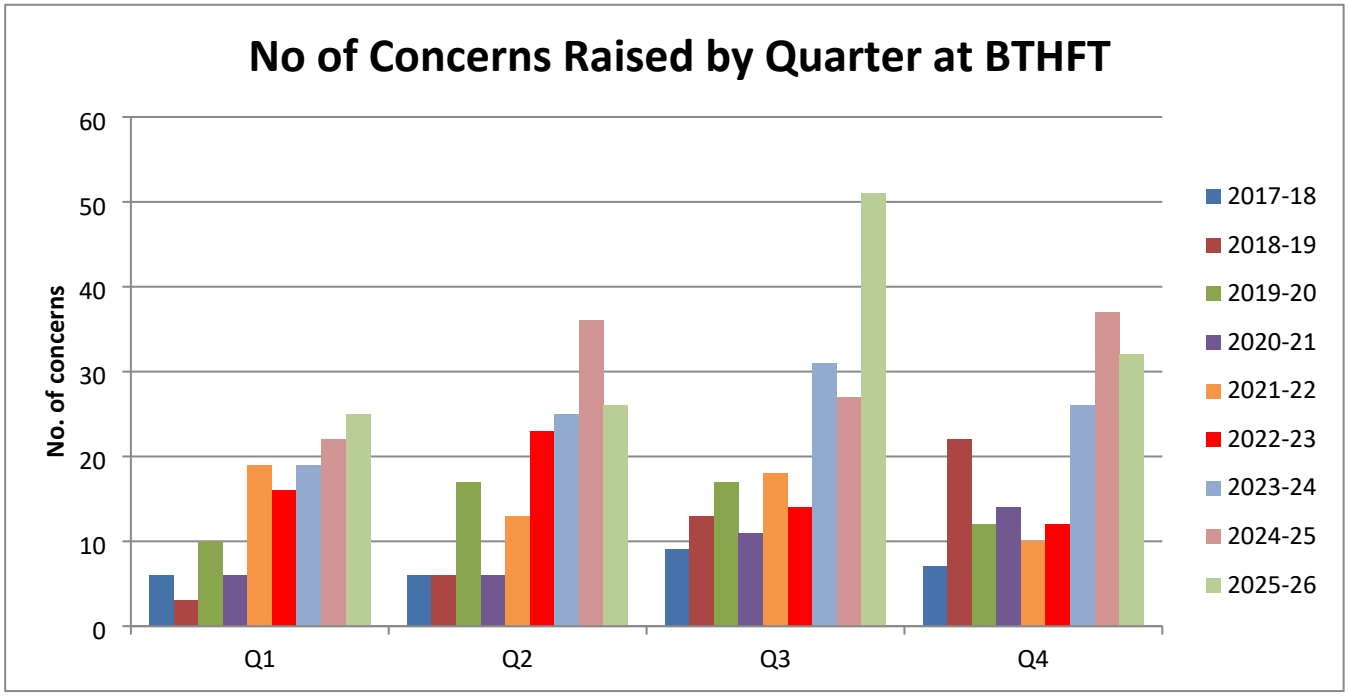
4.5 To continue supporting the FTSU team to deliver the two elements of their role. One part is the reactive – listening to workers, thanking them and supporting them so that their voices can be heard and actions taken. The other part is the proactive element – supporting the organisation to learn from the opportunities which speaking up brings.

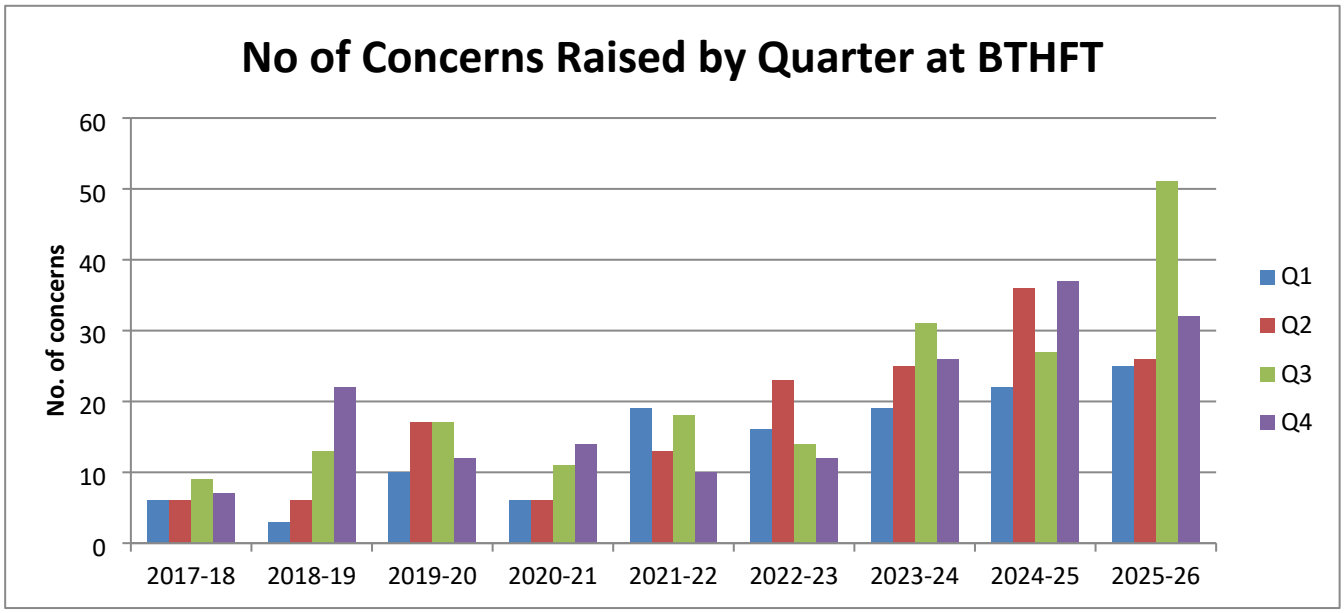
5. Appendices

Appendix 1 – FTSU Q4 data headlines and Annual data
Appendix 2 – Run charts of number of concerns
Appendix 3 – Numbers of open and closed FTSU concerns in Q4
Appendix 4 – Feedback from staff in Q4
Appendix 5 – Themes from the FTSU Ambassadors for Q4
Appendix 6 – Board Development action plan update
Appendix 7 – Staff survey results for FTSU
Appendix 8 – CQC well led report (FTSU part)
Appendix 9 – Temporary Workers, permanent voices (available in the reading room here).

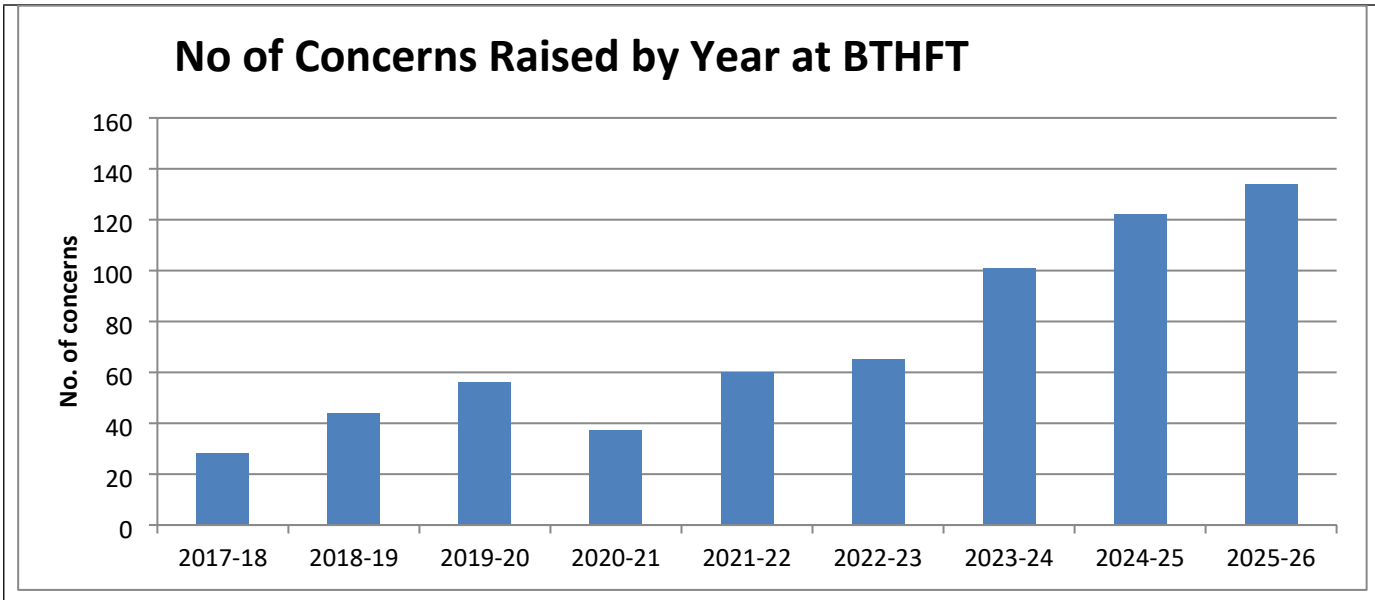
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Appendix 1 – FTSU Concerns Raised at BTHFT by Quarter and by Year.





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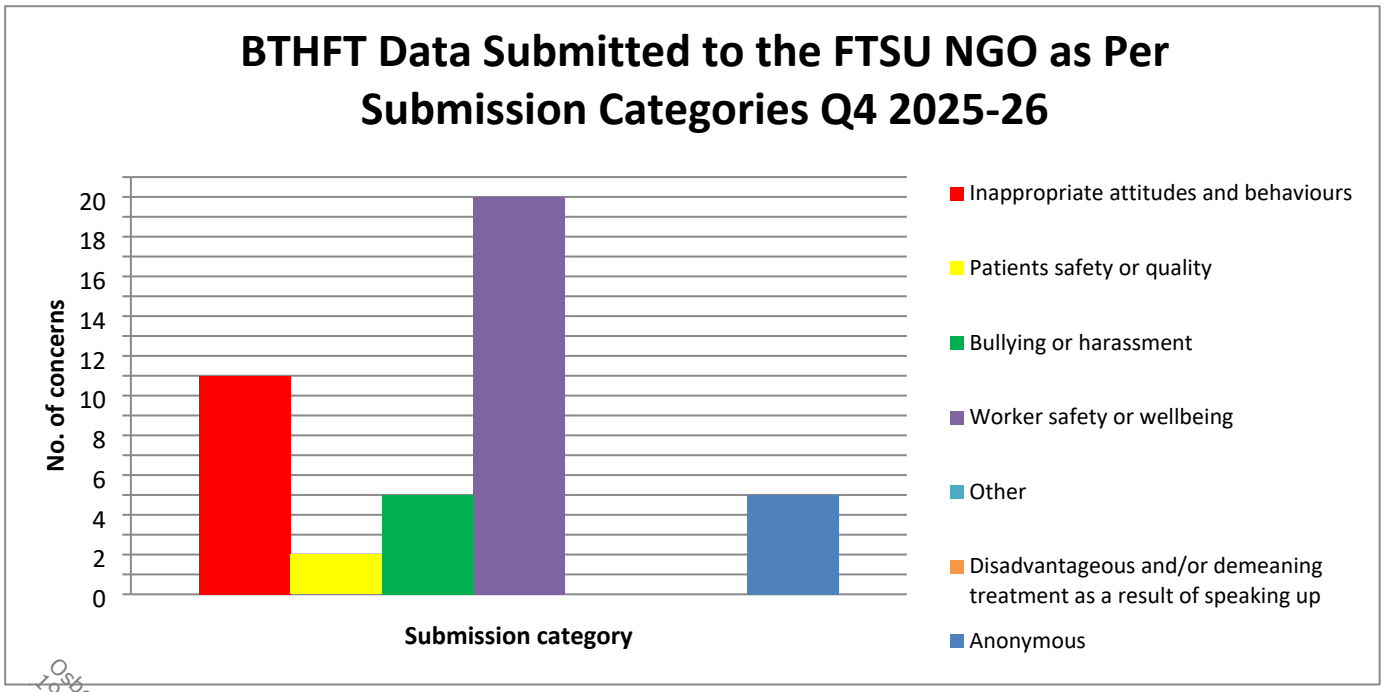
5.1 These three graphs show the number of concerns raised in Q4 at BTHFT by quarter and by full year. It is displayed alongside the previous year's data to facilitate comparison.

5.2 In Q4 there were 32 concerns raised to the FTSU team.

5.3 There were 5 concerns this quarter raised anonymously via the FTSU App. The NGO advocate that staff should be able to raise concerns anonymously if necessary.

Concerns Raised by Category (Using the NGO's submission categories)

The graph below shows the concern categories for Q4 2025-26*



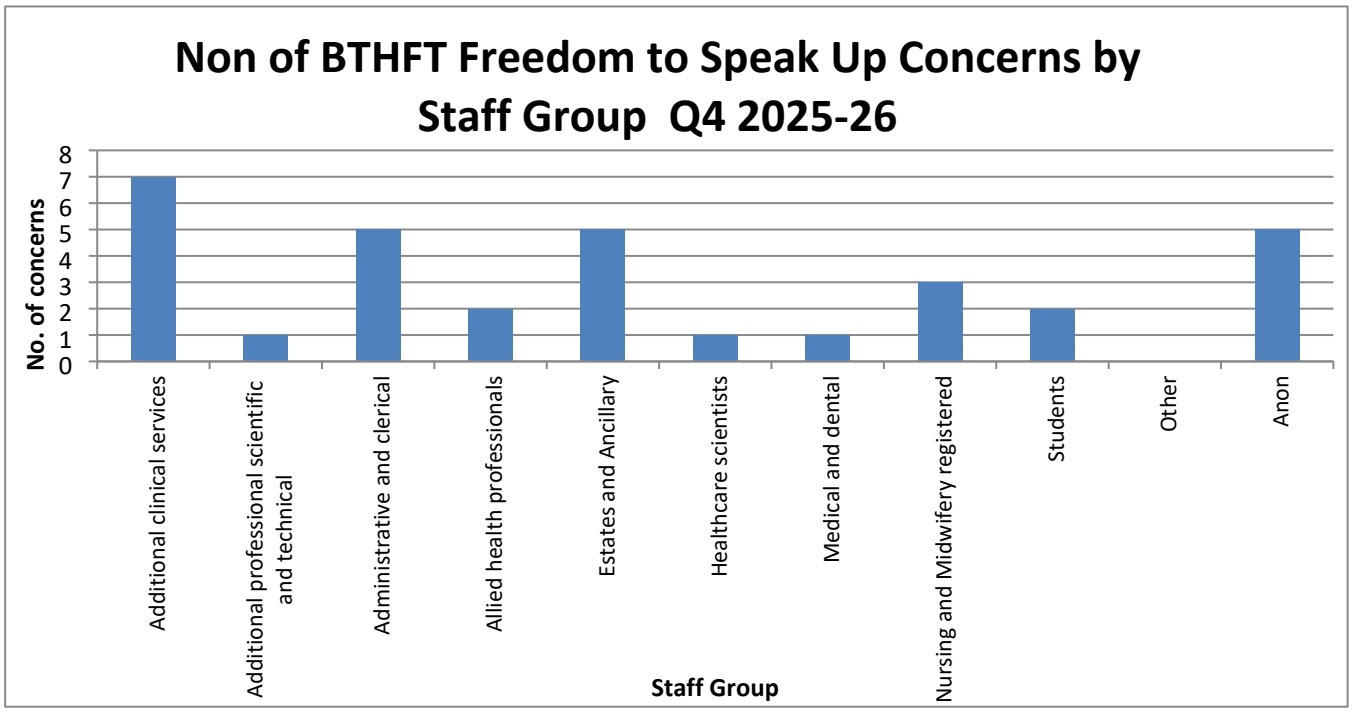
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***A FTSU concern may have more than one category.**

5.4 In Q4, of the 32 concerns raised:

- **2 had an element of patient safety/quality** - (Any case that may indicate a risk or adverse impact on patient safety or the quality of care)
- **5 had an element of bullying and/or harassment** - (This can be a current or past matter - may identify risks or be about actual events)
- **11 had an element of inappropriate attitudes and/or behaviours** - (Any case that includes an element that may indicate a risk of other inappropriate attitudes or behaviours that do not constitute Bullying or harassment).
- **20 had an element of worker safety or wellbeing –** (Any case that may indicate a risk of adverse impact on worker safety or wellbeing)
- **0 were categorised as 'other'**
- **No one** has reported that they are suffering disadvantageous and/or demeaning treatment as a result of speaking up (Detriment) this quarter.
- **5** people reported their FTSU concerns anonymously to us.

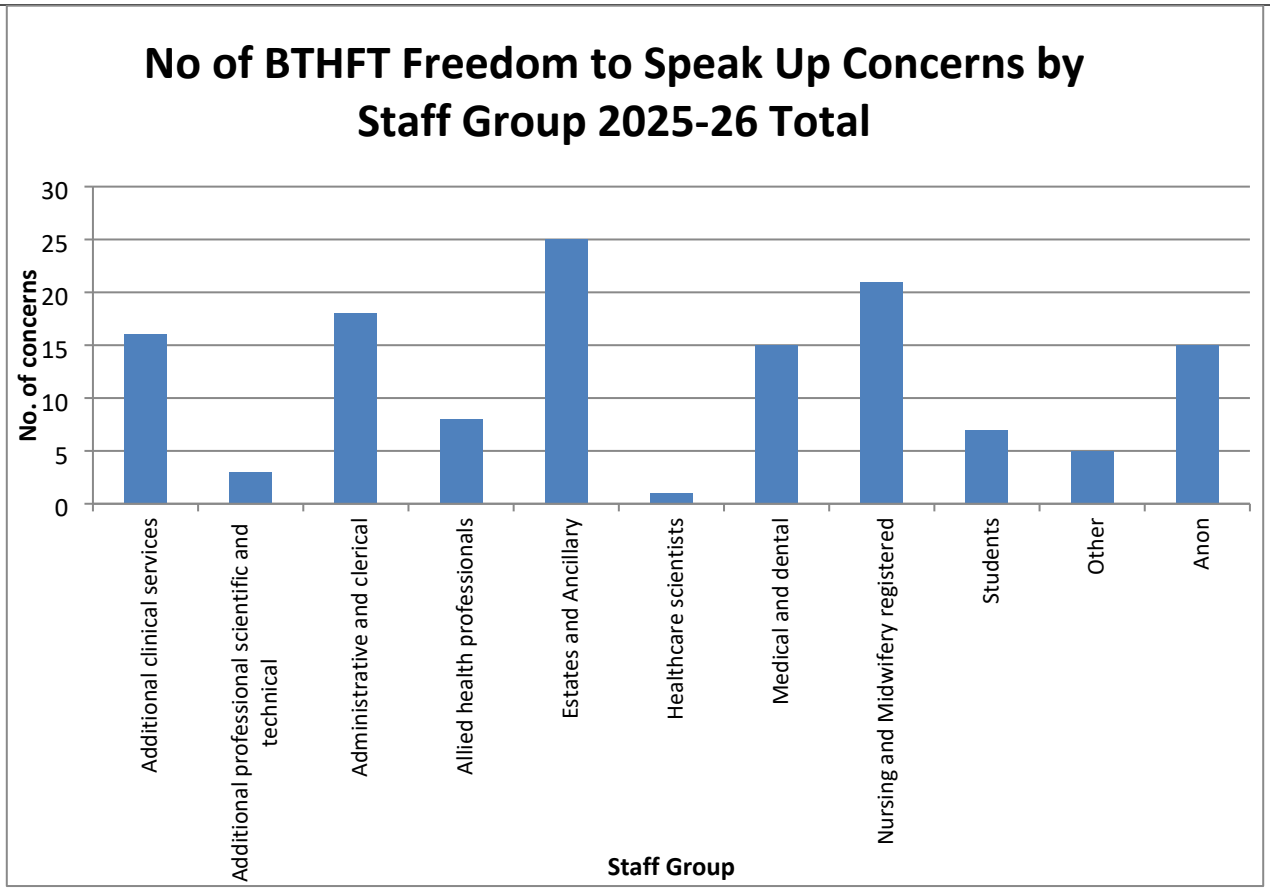
Number of Concerns by Staff Group for Q4 (Using the NGO's grouping)



5.5 The above table shows the staff groups who have raised concerns in Q4.

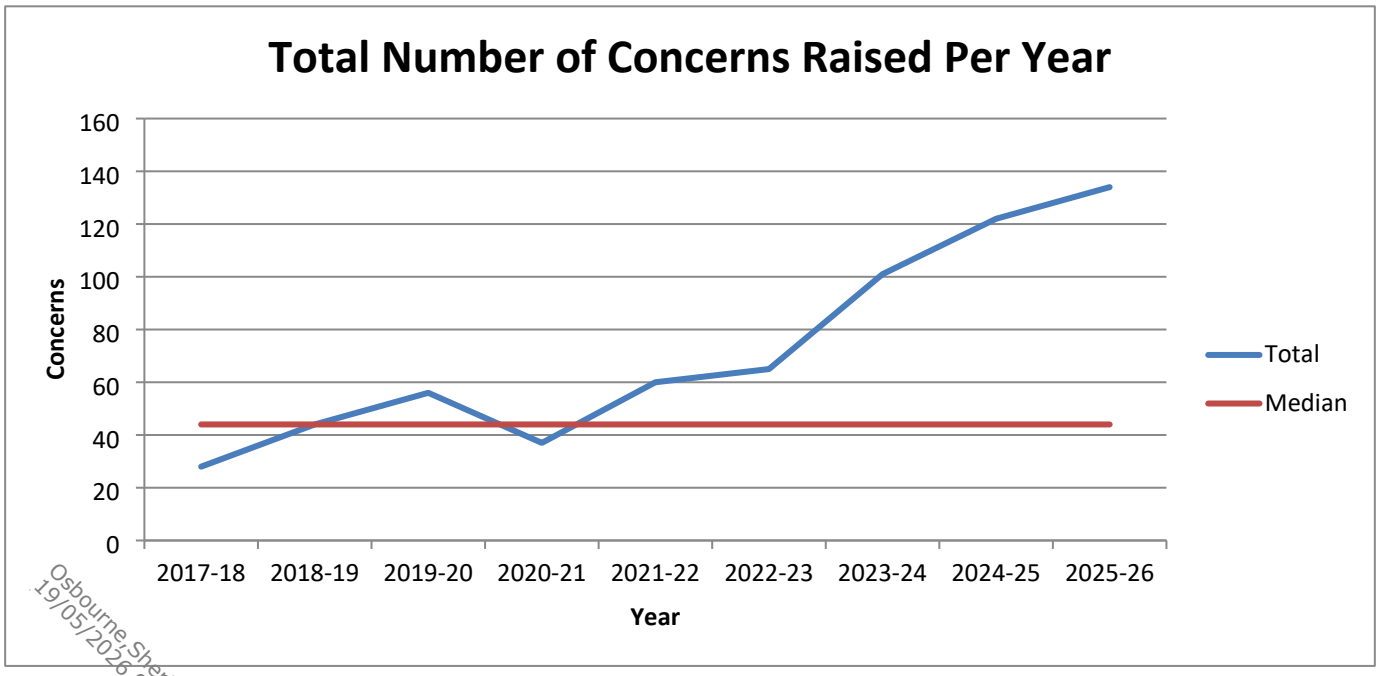
- 3 concerns were raised by either a registered nurse or midwife.
- 1 concern was raised by medical staff.
- 2 concerns were raised by AHP staff.
- 7 concern was raised by additional clinical service staff.
- 5 concern was raised from Admin and Clerical staff.
- 5 concerns were raised by staff working in Estates and Ancillary.
- 2 concern was raised by students.
- 1 concern was raised by additional and professional scientific and technical staff.
- 1 concern was raised by healthcare scientists.
- 3 of the concerns raised were unknown as they didn't stipulate or were anonymous.
- 2 of the concerns were raised by 'other' – any professional group that does not fit into any other category.

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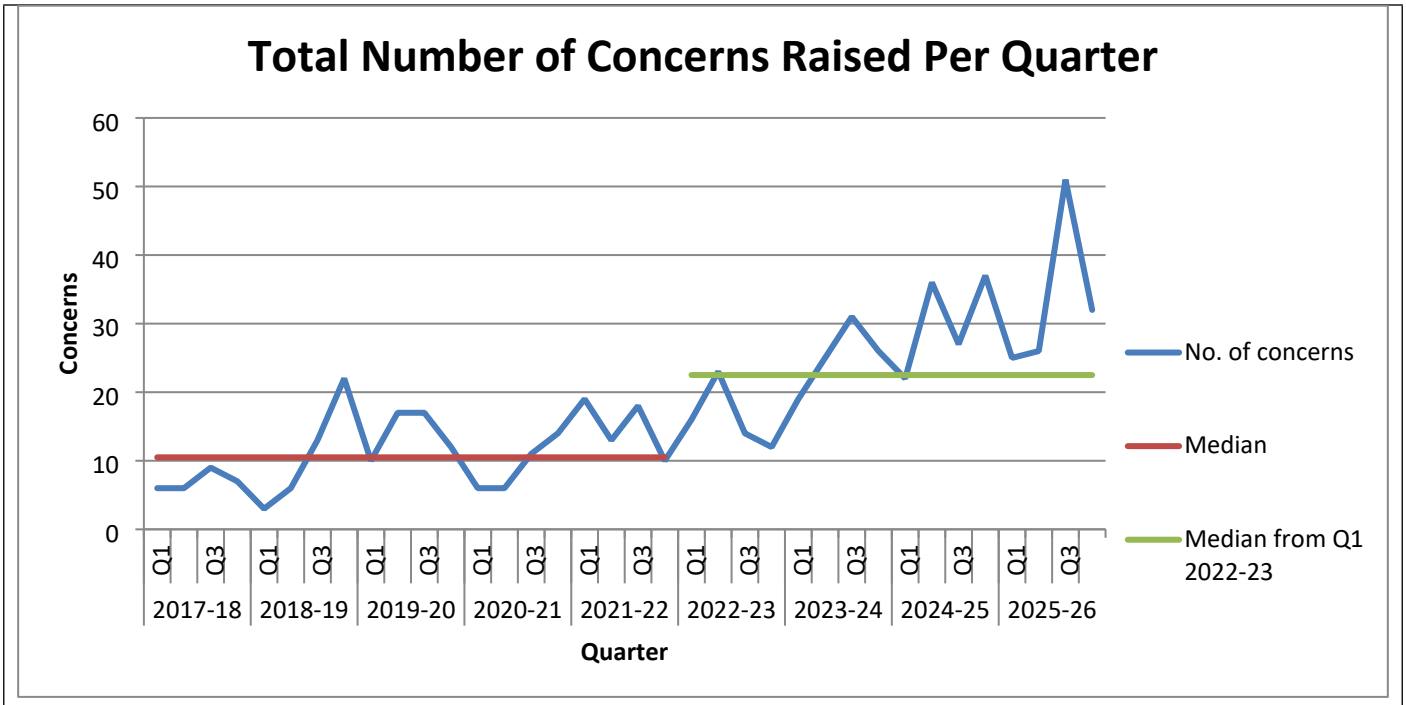


5.6 This data is utilised to identify areas where promotion/education around FTSU may be required. Estates and Ancillary staff and nursing and midwifery registered staff are the two highest staff groups who raise concerns to the FTSU team during 2025/26.

Appendix 2 – Run Charts of the Total Number of FTSU Concerns Raised by Quarter and Year



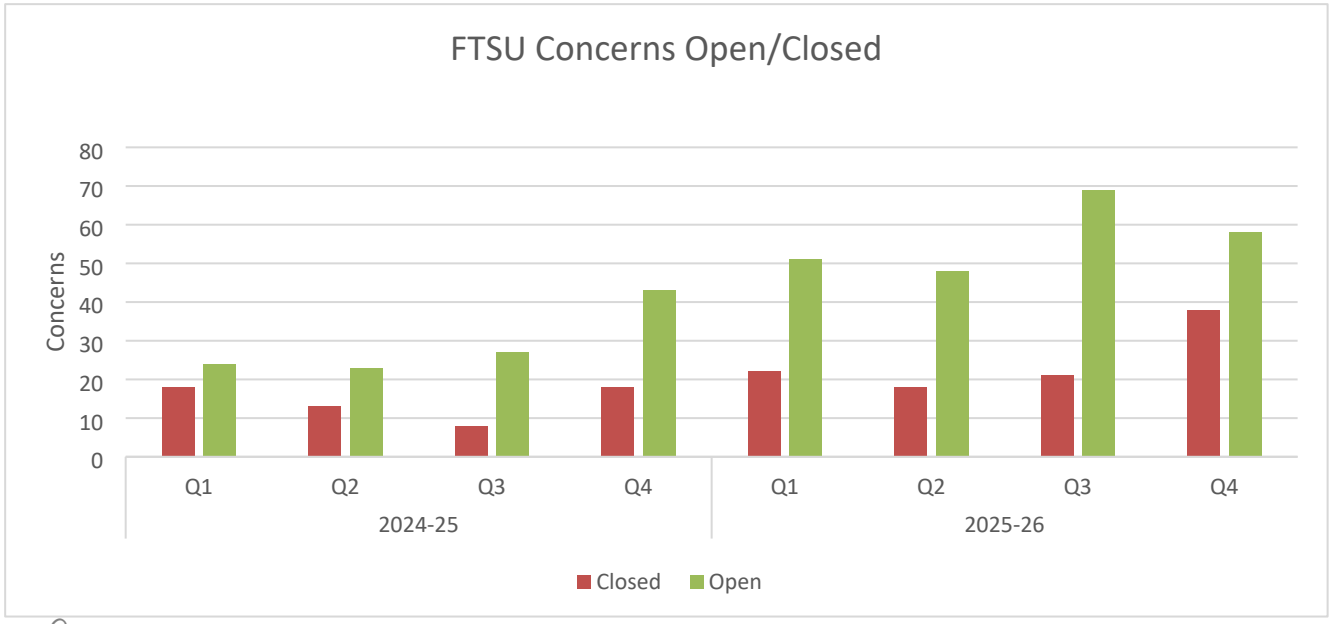
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5.7 These two charts show the number of FTSU concerns raised over time at BTHFT. In Q4 there were 32 concerns raised to the FTSU team. There were 134 concerns raised during 2025/26, an increase of **9.8%** in the total number of concerns raised.

5.8 The above graph shows an increase in the number of concerns over time and the shift in the median number from 11 – 23 over the quarters could be due to the increasing awareness of FTSU for staff and them feeling able to safely speak up.

Appendix 3 – Open Concerns up to Q4 2025-26



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Appendix 4 – Feedback from Staff in Q4 (The numbers represent the person who raised the concern to maintain confidentiality)

Person who raised the concern	Given your experience would you speak up again?	Feedback from the person raising the concern
1	Absolutely, yes	I was not getting anywhere chasing a response/outcome/closure myself but after speaking with FTSU I feel this has moved a lot a lot quicker and I now am getting to the end.
2	Yes	I just wanted to say a big thank you for your support in our recent meeting. Things are now moving forward, definitely good experience for me, thank once again for all your support.
3	Yes	Yes definitely, after years of struggles I was finally heard by going through freedom to speak and directed to the correct person who helped solve all my issues.
4	Yes	I just wanted to provide an update following my previous concerns regarding the work atmosphere within the department. Since the nurses have taken over, I have noticed a positive change in how things are being managed. The environment is starting to feel more balanced, and it appears that fairness is being applied more consistently across the team. I felt it was important to share this feedback, as I appreciate the improvements that are being made. Thank you for your support and for taking my concerns seriously.
5	Yes	Thank you for helping me navigate through this process Helen, and for steering the conversations between me, my manager and HR. I am pleased for my outcome. As I do work alongside various staff networks, I think it is something I will be raising there as not everyone may be as lucky, informed or supported as me.
6	Yes	Thank you for all the support I have received during this period
7	Yes	My purpose for approaching FTSU was met. At no point did I feel unsafe, or that my confidentiality is unprotected. FTSU is really important for Trust colleagues / employees as we are living and working in very politically divided times. There's a need to recognising differing views and perspectives, along with the need to remain equitable and respectful
8	Yes	Happy with the outcome
9	Yes, definitely	The team have been very approachable, with immediate responses taking into account care, empathy and seriousness of issues that I found distressing. The response times were quicker than I expected which helped me feel heard and listened to. My concerns were also addressed in an efficient manner with practicality and confidentiality.
10	Yes	I felt very supported throughout the whole process and have recommended the service to colleagues. If there are any more issues, we have agreed that I can contact my guardian if needed.
11	Yes	Reassuring, friendly, professional service providing valued support and navigation

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Appendix 5 - Themes from the FTSU Ambassadors for Q4

Activity Log for FTSU Ambassadors for Q4	
Date	1st Jan 2026 - 31st March 2026
No. of contacts	13 +
Themes	• Treatment from management • Car parking concerns since go live of new car parking • Working from home concerns following the global email earlier in the year • Flexible working hours, caring for a close relative. The manager not very understanding • Annual leave x 2 concerns • Constant redeployment • Inability to manage team or shifts • Infection control
Signposted to	• FTSU mailbox • HR • FTSU Guardian • Infection control
Details of proactive work	• Setting up FSTU month • Signposting staff to relevant areas • I contacted HR asked for them to contact the individual via telephone • Directed them to the Policy (Reasonable adjustments) • Following up and checking on the progress of staff's concern • Continuous awareness and information about the importance of FTSU • Availability to listen and signpost as needed
Feedback received	• Overall good as I have been signposting staff to FTSU. • They felt supported, appreciated the time I offered to allow them to discuss their concern. It was three times interaction on the phone • I sincerely appreciate your help and support, thank you so much • Thank you for listening

Appendix 6 - Board Development Action Plan

FTSU Action Plan April 2026 update fr

Appendix 7 – Staff Survey FTSU Questions

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National staff survey 2025.docx

Appendix 8 – CQC Well Led Report

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Appendix 9 - Temporary Workers Review

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FTSU Action Plan – Following on from Board Self-Assessment				Date initiated	1st December 2025
				Date of update	28th April 2026
Accountability			**Responsibility**		
Lead	**Oversight/governance structure**		**Lead**	**Work-stream/operational group**	
Chief Nurse	People Academy/Quality Committee		FTSU Guardians (FTSUG)	FTSU Operational Meeting	

Aim	**Objective**		**Expected Outcome**	**Assurance Mechanism**	**Review date**
	Ref				
To enable staff to feel safe to raise concerns within the organisation	1	To understand and analyse the FTSU data more effectively and improve triangulation	To have an updated database and business intelligence support to enable to track trends and activity	People Academy/Quality Committee	31st March 2026
	2	Leading at a higher-level training to be rolled out to all managers at all levels	All grades of managers will have completed the leadership course	People Academy/Quality	November 2026
	3	Refresh the Civility work and toolkit in line with FTSU themes and staff survey results to include detriment	Contribute to the Trust's civility work as the FTSUG	People Academy/Quality	30th June 2026

Communications plan				
What?	**Who?**	**By whom?**	**How?**	**How frequently?**
Action plan support	Sue Franklin and Helen Fearnley (FTSUG) & FTSU Ambassadors		Via FTSU Operational Group	At each meeting every 6 weeks
Action Plan Oversight	Chief Nurse – Karen		Via People Academy	At each meeting every 6

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	Dawber/Vikki Lewis		and FTSU operational group	weeks and every Quarter at the People Academy
Action Plan Management	FTSU Guardians		Via FTSU operational group	

Change team members			
Name	**Job title**	**Contact details**	**Initial**
Sue Franklin	Associate Chief nurse – FTSU Guardian	**Susan.franklin@bthft.nhs.uk**	SF
Helen Fearnley	Consultant Nurse, Tissue Viability	**Helen.fearnley@bthft.nhs.uk**	HF
Michael Rooney	Business Intelligence	**Michael.rooney@bthft.nhs.uk**	MR/BI
Faeem Lal	Interim Chief People officer	**Faeem.lal@bthft.nhs.uk**	FL
Cat Shutt	Assistant Director of HR/Head of Organisational development	**Catherine.shutt@bthft.nhs.uk**	CS

Status:	
O	Open
O	Open and compromised
C	Closed
OD	Overdue

Objective	**1**	To understand and analyse the FTSU data more effectively and improve triangulation						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1.1	Business intelligence (BI) to review the current data set	SF/ HF /BI	December 2025		**C**	16th March 2026	Meeting planned for beginning of Jan 2026	

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Objective	1	To understand and analyse the FTSU data more effectively and improve triangulation

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1.2	Develop a new FTSU data base with the capability to support data analysis	SF/ HF and BI	Jan 2026	End of Quarter 1	**O**		To develop in time for Q1 2026/27. 16.3.26 - Discussion to utilise the Intec App and see what potential there is already there	
1.3	Quarterly reporting to People academy and Quality Committee to include new data sets	SF/ HF	Jan 2026	July 2026	**O**		To be included on FTSU quarterly reports	

Objective	2	Leading at a higher-level training to be rolled out to all managers at all levels

No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
2.1	Refresh model of training to ensure sustainability and cost effectiveness	CS	Jan 2026	April 2026	**Delayed**	September 2026	Underway but delayed due to pause in Trust wide training.	
2.2	Rollout training to Bands 3,4,5, and 6	CS	Jan 2026	December 2026	**In progress**	September 2026	As above	
2.3	Ensure effective model for new and newly promoted managers in the organisation (to be delivered quarterly)	CS	Jan 2026	Ongoing	**In progress**	May 2026	Underway. Programme of 'Thrive Manager Essentials' has been designed – paper is booked on ETM 11.05. for approval and to begin roll out.	

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Objective	3	Refresh the Civility work and toolkit in line with FTSU themes and staff survey results to include detriment

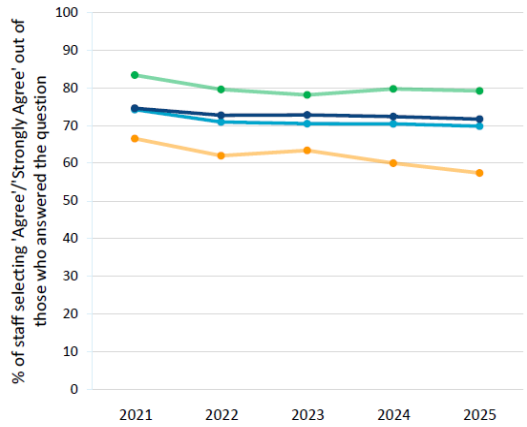
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
3.1	Civility working group to be established.	CS	Jan 2026	March 2026		**Completed**	FTSUG to be part of this work with OD (working group of HR, OD, EDI, F2SU, research, education, chief nurse. Established group	
3.2	Toolkit, training and comms campaign to be refreshed and impact measures established	CS (DJ)	Jan 26	March 2026	**Delayed**		Underway but delayed due to colleague absence.	
3.3	OD to talk to the FTSU Group about the civility toolkit	CS	Jan 26	March 31st 2026	**In progress**		Booked in	
3.4	Detriment to be considered within the civility toolkit	DJ/ SF/HF	Jan 26	March 2026	**Completed**		Completed	
3.5	OD and F2SU to host 'civility week' across the Trust	CS / SF	Jan 26	May 26	**In progress**		In line with stress awareness / mental health week (April / May 26)	

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People Promise elements and theme results – We each have a voice that counts: Raising concerns

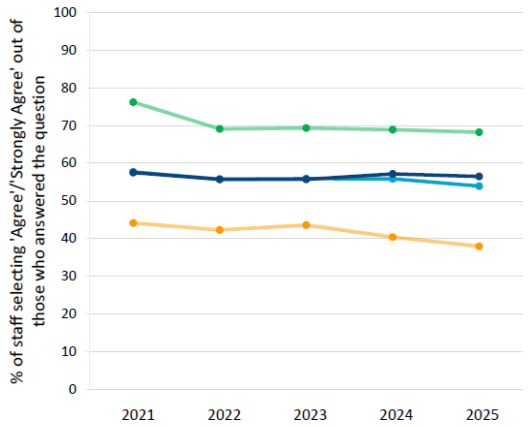
Survey Coordination Centre NHS

Q20a I would feel secure raising concerns about unsafe clinical practice.



	2021	2022	2023	2024	2025
Your org	74.58%	72.69%	72.79%	72.38%	71.69%
Best result	83.36%	79.55%	78.09%	79.72%	79.16%
Average result	74.22%	70.95%	70.47%	70.44%	69.82%
Worst result	66.54%	61.98%	63.38%	60.04%	57.41%
Responses	2944	2335	2851	3563	3188

Q20b I am confident that my organisation would address my concern.

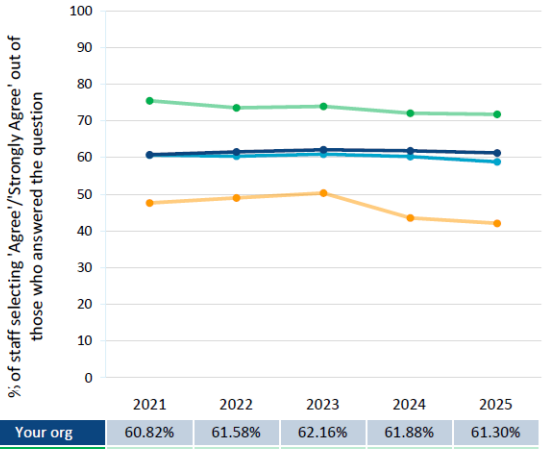


	2021	2022	2023	2024	2025
Your org	57.52%	55.73%	55.72%	57.18%	56.49%
Best result	76.20%	69.10%	69.34%	68.88%	68.23%
Average result	57.69%	55.78%	55.93%	55.88%	53.94%
Worst result	44.15%	42.28%	43.60%	40.40%	37.97%
Responses	2936	2327	2842	3554	3179

People Promise elements and theme results – We each have a voice that counts: Raising concerns

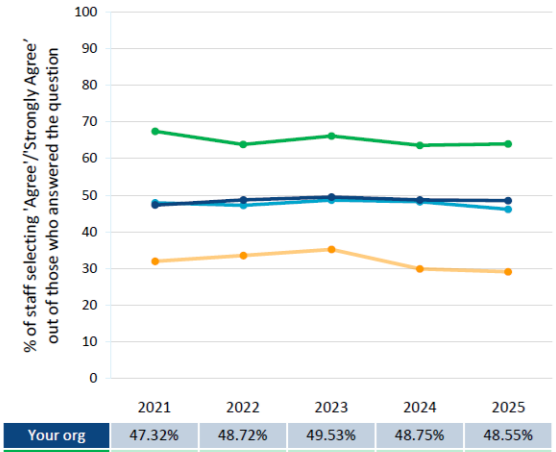
Survey Coordination Centre NHS

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2021	2022	2023	2024	2025
Your org	60.82%	61.58%	62.16%	61.88%	61.30%
Best result	75.53%	73.59%	73.99%	72.14%	71.81%
Average result	60.69%	60.38%	60.95%	60.31%	58.85%
Worst result	47.63%	49.02%	50.35%	43.57%	42.11%
Responses	2937	2333	2860	3559	3192

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023	2024	2025
Your org	47.32%	48.72%	49.53%	48.75%	48.55%
Best result	67.44%	63.83%	66.16%	63.62%	63.99%
Average result	47.96%	47.24%	48.68%	48.24%	46.18%
Worst result	32.01%	33.60%	35.23%	29.95%	29.15%
Responses	2935	2328	2863	3555	3183

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Freedom to speak up

Score: 2

Staff and leaders must act with openness, honesty and transparency. Staff and leaders should actively promote staff empowerment to drive improvement. Leaders should encourage staff to raise concerns and promote the value of doing so. All staff should feel confident that their voices will be heard. Leaders should ensure a culture of speaking up, where staff actively raise concerns and those who do (including external whistleblowers) are supported without fear of detriment. When concerns are raised, leaders should investigate sensitively and confidentially, and lessons would need to be acted upon. When something goes wrong, people should receive a sincere and timely apology and be told about any actions being taken to prevent the same from happening again.

We scored this quality statement as 2. The evidence showed some shortfalls. There were processes in place for people to speak up, in line with national requirements. The trust's freedom to speak up guardian was competent and had clear support from the non-executives. However, we received mixed feedback about the confidence levels some staff felt about speaking up and whether their voice would be heard. Feedback indicated that some staff continued to perceive biases and personal preferences amongst board members, which contributed to a lack of psychological safety.

The trust had appointed a freedom to speak up (FTSU) guardian who undertook this role 20 hours per week. The deputy freedom to speak up guardian role was being recruited to at the time of inspection. The guardian was an active member of the regional FTSU group and was also a mentor for the National Guardian's Office for new FTSU guardians.

The board had a identified a new non-executive FTSU lead and the Chief Nurse was the executive lead. The guardian was supported by 24 FTSU ambassadors. Staff had access to the guardian and a FTSU web application accessible by a QR code, downloadable on electronic devices. The app enabled people to speak up anonymously which was in line with guidance from the National Guardian's Office.

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Leaders were seeking to build a culture where all colleagues within the trust felt able to raise concerns. We heard differing opinions within the trust's leadership team how this could be further developed. This was monitored by the board through the FTSU communications plan.

Leaders referred to the recently launched Respect, Civility and Resolution policy which was being rolled out across the trust and a Managers Toolkit which included a staff and manager handbook. Leaders acknowledged further work was being undertaken to embed a robust culture allowing staff to speak up, be listened to and ensure action is taken.

The trust's current FTSU policy was issued in 2024 with a review date of February 2029.The guardian reported speak up data to the trust board and complied with the national reporting requirements. They told us they had access to speak with the Chief Nurse and Chief Executive as required.

The trust board received quarterly and an annual report focussed on freedom to speak up. These showed staff increasingly using the trust's freedom to speak processes as a way to raise concerns. Data provided by the trust showed 122 cases were raised by staff in 2024/25 which was a 20% increase from 2023/24 which is in the low to middle range compared to similarly sized local trusts. Of those cases reported, 22 were anonymous. Most cases were raised by Nursing / midwifery staff, and Estates and Ancillary staff, followed by Administration and Clerical staff, then Medical and Dental staff.

The main reasons for speaking up were 'inappropriate attitudes or behaviours' and 'bullying or harassment'. The trust provided a good level of detail regarding FTSU case numbers and categories and the board was sighted on the work underway to help reduce and remedy the causes of concern.

We reviewed NHS Staff Survey results for 2024 relating to People Promises, themes and sub scores that relate to 'We each have a voice that counts'. The trust scored slightly better than the national average for these questions and for 'I am confident that my organisation would address my concern' changed from 55.7% in 2023 to 57.2% in 2024.

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Staff survey results identified multiple ethnic background staff were not as confident about speaking up, and not as confident that it would be addressed. Additionally, staff with a long-term condition also felt less confident about the trust addressing concerns raised, or secure about raising issues concerning clinical practice. Staff from the 'Pharmacy' and 'Medical / Dental - In Training' teams were lower scorers for more themes and sub scores compared to other areas in the trust.

Board papers referred to the staff survey at a high level, the trust's action plan included a range of initiatives which intended to make the trust a better place to work.

The trust's freedom to speak up communication plan 2024/25 had ongoing actions with the last completed action dated October 2024. Progress against actions identified in the trust's refection and planning tool was not regularly monitored by the board.

Frontline staff told us that there had been investment in promoting FTSU processes and most felt empowered to speak up and that action would be taken within the clinical service units. However, some felt that if they did speak up, they would not be wholly confident matters would be addressed due to staff's previous experiences.

As part of the assessment, we analysed feedback received directly to CQC. Qualitative analysis of feedback from staff cases highlighted historical issues of culture within the trust. Concerns of bullying, harassment, racism, or incivility were described at board level of the trust as well as in various departments of Bradford Royal Infirmary. Due to reported fear of reprisal, several people were concerned about speaking out against the trust. There were also concerns about conflicting interests of those in FTSU roles due to their positions at the trust. Whilst we did not find any evidence of the historical issues continuing during this assessment, staff confidence in issues being addressed at board level remained a concern.

The trust provided training in freedom to speak up. The three FTSU training modules available for staff were Speak Up; Listen Up; Follow Up. All staff including senior executives were required to complete the Speak Up Module. The annual FTSU report for

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2024/25 reported 70% of all staff had completed this module. Band 7 (and above) module, ‘Listen Up’, compliance was 65% and ‘Follow up’ was 89%.

Partners felt the trust did have a culture where staff could feel free to raise concerns. There was mixed feedback and confidence in whether leaders would always take effective action to address concerns.

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BOARD OF DIRECTORS				
Meeting Date:	21st May 2026		**Agenda Reference:**	Bo.5.26.14c
Report Title:	Guardian of Safe Working Hours Doctors and Dentists in Training Annual Report 2025-26			
Presented by:	John Bolton, Chief Medical Officer			
Executive Lead:	John Bolton, Chief Medical Officer			
Author:	Mr Ajay Sud, Guardian of Safe Working Hours			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	The 2016 resident doctor contract (formally 2016 resident doctor contract) requires the Guardian of Safe Working Hours (GoSWH) to submit quarterly and annual reports to the board to provide assurance that doctors and dentists in training are working safe hours. Information on exception reporting, work schedule reviews, rota gaps and fines levied will be presented. This report covers the period 1st April 2025 – 31st March 2026.			
Recommendation/s: (including any decision/approval required)	The Board of Directors is asked to note the contents of this paper and derive assurance.			
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:	Workforce Review			
Implications				
Risk:	This report relates to the Board Assurance Framework (BAF) risk 11: 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.			
Legal/Regulatory:	2016 junior doctor contract requires the Guardian of Safe Working Hours to submit quarterly and annual reports to the Board to provide assurance that doctors and dentists in training are working safe hours.			
Quality & Patient Safety:	Reports of understaffing may reflect on patient safety or quality of care.			
Equality, Diversity and Inclusion and Health Equity:	N/A			
Resources:	Exception reports can lead to overtime payments and/or fines.			
Environmental sustainability:	N/A			
Assurance Route				
Meeting/s where content has been discussed previously:	N/A			

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Report content

1. Purpose

To provide a quarterly update report to give assurance that doctors and dentists in training are working safe hours.

2. Background/context

The 2016 resident doctor requires the Guardian of Safe Working Hours to submit quarterly and annual reports to the Board to provide assurance that doctors and dentists in training are working safe hours.

3. Assessment

Risks have been identified but actions have been taken and continue to be taken to mitigate against the risk.

There was a 4.93% decrease in exception reports in 2025/26 compared with 2024/25 with an associated 40.3% decrease in extra hours claimed in payment or time off in lieu (TOIL). While this is an improvement, work is ongoing to focus on workload pressures experienced by our resident doctors. This includes a business case to expand the hospital at night Clinical Support Worker provision to reduce out of hours workload, recruitment into our Chief Registrar post to support the resident doctor forum and work towards the resident doctor 10-point plan.

4. Options analysis/Proposal

Engage and empowerment of resident doctors within the safe working processes enables challenges to be identified and addressed. Continued Improvement of the resident doctors in experience ensures BTHFT remains an attractive choice. The executive, educational leads, human resources, residents and specialty leads are engaged in the improvement programs. Workforce planning, workload management and improve resident morale.

Introduction

The current resident doctor contract requires the Guardian of Safe Working Hours who will submit an annual report to the Board to provide assurance that doctors and dentists in training are working safe rotas and that working hours are compliant with terms and conditions.

Exception Reports

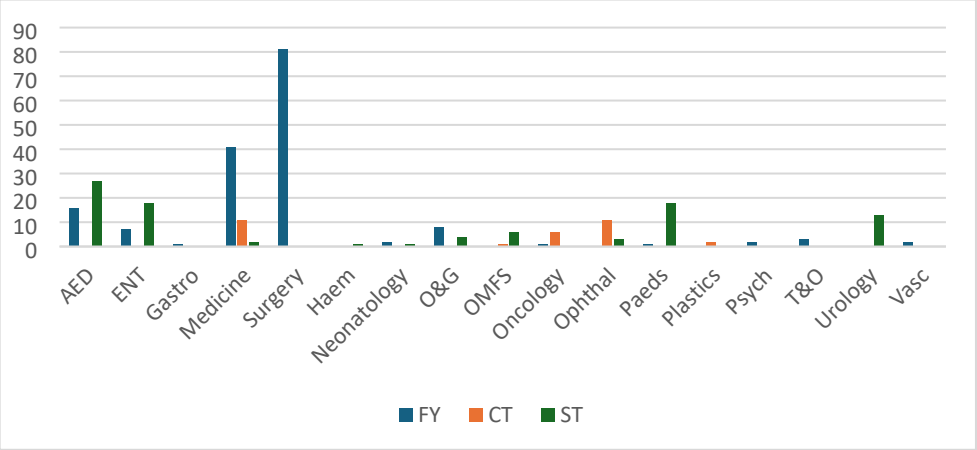
Trainees submit exception reports if working beyond contracted hours or educational opportunities are missed. Key changes to the Exception Reporting process were implemented from 4th February 2026. Going forward exception reports relating to missed educational opportunities will be managed by the Director of Education and the HR team can authorise requests for additional hours. The GoSWH retains oversight of all exception reports, including those which are withdrawn, and remains the final escalation point for any disputes. The exception reporting process is a crucial part of the junior doctors' 2016 contract as it allows contemporaneous reporting of issues, feeding into the trust and NHSE's quality processes, with potential to drive improvement.

There were 289 exception reports submitted during this year, highlighting concerns around working hours/rest and missed educational opportunities. This Is a 28% reduction on the previous year when 304 reports were submitted. Most reported exceptions came from Foundation Doctors, predominantly the General Surgery and Medicine teams, and were related to unscheduled additional hours worked/overtime and missed breaks. This sits alongside GMC survey results highlighting workload pressures as a concern for our resident doctors at BTHFT. There were low numbers of education related reports this year with a 2.4% proportion of the exception reports (4% for 2024/2025). The reports for education were around missed training opportunities resulting from having to cover ward work/referrals due to poor staffing.

In total, 172.66 additional hours were reported by resident doctors. Last year 289.25 additional hours were claimed. The two departments requesting the highest numbers of junior doctor locums were Medicine and the Emergency Department (see figure 2). This year there was a decrease in the number of requests for resident doctor locums from approximately 8,000 in the previous year to 7,398 in 2025/2026 (7.5% decrease in requests).

There was a 4.93% decrease in exception reports in 2025/26 compared with 2024/25 with an associated 40.3% decrease in extra hours claimed in payment or TOIL. While this is an improvement, work is ongoing to focus on workload pressures experienced by our resident doctors. This includes a business case to expand the hospital at night Clinical Support Worker provision to reduce out-of-hour workload, recruitment into our Chief Registrar post to support the resident doctor forum and work towards the resident doctor 10-point plan.

Fig 1: Exception Reports (Hours) by Specialty and Training Grade April 2025 – March 2026



Work Schedule Reviews

Every trainee agrees with their educational supervisor a work schedule. A work schedule review takes place when changes are needed to ensure safe working hours or to provide better training opportunities.

Foundation doctors rotating through medicine make up the second largest cohort within the resident doctors workforce. The self-reported exception data supports an improvement in the concordance to their work schedules. An expansion of the 'hospital at night' program and a proposed expansion of the resident foundation doctor grade by six additional posts aims will augment these improvements (if agreed).

There are discussions underway to review the on-call work schedules for the Oral and Maxillofacial Surgery registrars (Specialty trainees). A monitoring exercise amongst these specialties' residents has been completed and is currently under review by the Human Resources team.

Resident doctor feedback through the 2025 GMC survey report high workload in General Surgery corroborates the frequency of exception reports. There has been extensive work with Ms Coatsworth (HR manager), Ms Kidger (Urology Lead), Mr Manby (surgical foundation Lead) and Ms Kerr (College tutor), to modify the surgical foundation work schedule and on-call rota. Some of these shift pattern changes were enacted on 1st April 2026.

Resident Doctor Industrial Action

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There has been a total of 15 days of BMA resident doctor industrial action (25-30th July 2025, 14-19th November 2025, 17-22nd December 2025) which has the potential to affect resident doctors (training opportunities affected and altered workload pressures). However, this is not reflected in our annual exception reporting data.

Changing Working Patterns

As of 31st March 2025, there were 212 resident doctors that were Less than full time (LTFT) and their LTFT percentages totalled 166 WTE. Alteration in trainee work situation means more trainees are becoming LTFT. This poses challenges to the organisation in terms of increased rota gaps. Measures to address this include an application to have more Foundation Doctor posts and the introduction of self-rostering for resident doctors.

Locum Bookings

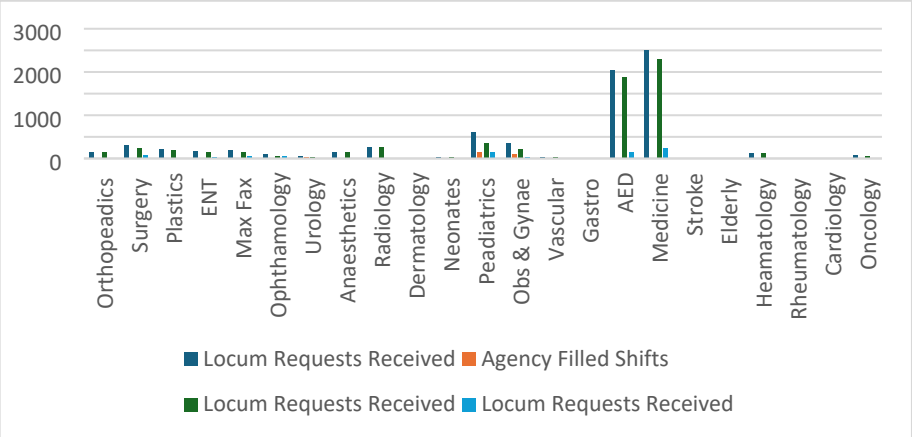
Work is ongoing around self-rostering and workforce analysis, along with an application to the Yorkshire and Humber Deanery to support an additional six Foundation Doctors from August 2026. Palliative medicine remains the only non-compliant rota (due to weekend working pattern). The trainees in post remain happy with their current pattern.

Rota gaps may be filled by bank or agency locums via the flexible workforce team. The two departments requesting the highest numbers of junior doctor locums were Medicine and the Emergency Department (see figure 2). This year there was a decrease in the number of requests for resident doctor locums from approximately 8000 in the previous year to 7398 in 2025-2026 (7.5% decrease in requests).

Of the locum shifts filled, 86.1% were filled internally and 2.4% were filled by agency locums. 8.1% of shifts remained unfilled. 61.6% of the locum requests came from AED and General Medicine, which is a marginal increase from the year before (60%).

The introduction of self-rostering for resident doctors along with a workforce review exercise by Kingsgate have been undertaken with a review to further reductions in the use of bank or agency locums in AED and General Medicine.

Fig 2: Locum Shifts by Department April 2025 – March 2026



Fines

The Guardian of Safe Working Hours can apply fines if breaches of working hours and rest periods occur. Examples of potential breaches are exceeding the 48-hour average working week, exceeding 72 hours of work in seven consecutive days, lack of 11 hours rest between shifts, or missed breaks. There have been no fines during this financial year.

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Summary/Discussion

There was a 28% reduction in the number of exception reports this year compared with the prior year. Most of the exception reports were from Foundation trainees (57% of all reports). The reports from

Foundation Doctors covered many specialities, General Surgery foundation residents, followed by General Medicine foundation residents submitted had the majority (28% and 14% of all exception reports respectively). This is different from 2024/25 where the number of general medicine and surgery specialty exception reports made up a third and a tenth of all exception reports respectively. The reason for this appears to be workload and unplanned absences leading to service gaps meaning trainees are staying past the end of their shift or miss breaks/teaching as there is often no one to cover them. It is also probable that junior trainees are more likely to submit a report as exception reporting has been around for all their training unlike the senior trainees.

Trainees must raise immediate safety concerns to patients or doctors to their duty senior immediately in person or by phone. This should be followed up by an exception report within 24 hours. Examples of immediate safety concerns include if doctors work hours exceed safe limits, if gaps between working hours are reduced to below safe limits, or if doctor staffing levels are below safe limits. The Exception Report process records this as 'patient safety' but it does not necessarily mean there has been an incident; rather that the trainee feels the poor staffing could lead to a patient safety concern if no intervention is made. A trainee ticks an 'immediate safety concern' box on their exception report but does not count as a separate report. This is distinct from the IRIS (Identification and Referral to Improve Safety) patient safety reporting process. There has been a small increase in the number of reports tagging a safety concern from 11 in 2024/25 to 19 reports in 2025/2026. These reports are largely from Foundation Doctors in General Surgery (8/19) due to unplanned absences leading to staffing issues on the ward.

There was a 7.5% decrease in locum requests this year. Despite this a high locum requirement continues in Emergency and General medicine, reflecting these high-pressure specialties with rota gaps. They account for 61.6% of the Trust locum request for resident doctors. 8.1% of locum requests were left unfilled, which is the same proportion as 2024/2025. Most of the shifts are filled internally with only 2.4% being covered by external locums.

Palliative medicine remains the only non-compliant rota (due to weekend working pattern). The trainees in post are happy with their current pattern and has been agreed to keep this under review.

Risks and Mitigations

Probable future resident doctor and potential non-resident grade (consultant and staff grade) industrial action.

- Continue to promote proactive engagement with resident doctors forums (formally junior doctor forums) and BMA representatives to continue to identify problems and solutions.
- Continue to harbour executive committee ethos of 'ethics, empathy and equity' amongst the medical workforce to improve satisfaction at work
- Ongoing work to meet targets set by the 'Getting the basics right for resident doctors: 10-point plan' include successful recruitment into the Chief Registrar role for 2025/26 who acts as peer representative.

Increased rota gaps due to unfilled Deanery posts or the impact of LTFT working:

- BTHFT has made an application to increase Foundation doctors' numbers by six for the 2026 intake of resident doctors
- Introduction of self-rostering to reduce unfilled shifts and improve resident doctor sense of wellbeing.
- Workforce review work by Kingsgate to be used to look at workforce utilisation across AED and AIM.

High-acuity team workloads (General Surgery foundation doctors)

- Work done with the team to improve 'twilight' staffing in rota compliant manner involving key stakeholders including surgical foundation lead, college tutor, urology lead, GOSW and Human Resources.
- Business case underway for expansion of Hospital at Night team to support resident doctors in terms of reducing workload out of hours.

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Acute/high-acuity area staffing and workload balance

- Continue innovative strategies (for example virtual wards) to safely and appropriately convert the demand for true emergency care to more urgent or elective care. This will help reduce inappropriate workload stress on the acute teams Accident and Emergency, General Medicine and General Surgery resident doctors.
- Increasing awareness of support and staff facilities (for example, available parking, doctors mess and onsite gymnasiums) can help improve quality of life for acute shift workers. These measures can improve stress levels and health and reduce unplanned absences.
- Work has been undertaken to improve facilities in the doctors' mess, a business case is in process to increase support from the hospital at night team to reduce workload out of hours for our resident doctors, and we have successfully recruited into the Chief Registrar post so continue joined up working between the executive and the resident doctor forum.

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BOARD OF DIRECTORS			
Meeting Date:	21st May 2026	**Agenda Reference:**	Bo.5.26.14d
Report Title:	Education Annual Report 2025/2026		
Presented by:	Faye Alexander, Head of Education		
Executive Lead:	John Bolton, Chief Medical Officer		
Author:	Faye Alexander, Head of Education		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☒
Summary of Key Issues/Highlights:	• The Education and Training service has demonstrated strong performance and continued maturity, with improved governance, clearer structures and increased impact across the organisation. • Learner experience remains positive overall, with strong performance in supervision, teamwork and safety culture, supported by improved wellbeing outcomes. • Staff survey results are above the organisational average, with particularly strong scores in compassionate and inclusive culture, leadership, team working and work-life balance. • The service has delivered against financial recovery expectations, achieving closing the gap targets and embedding more efficient, lean ways of working. • CPD funding has been well utilised, supporting workforce development and service delivery priorities. • Targeted capital investment has enhanced simulation and digital capability, including new mannikins, updated equipment and the introduction of an Anatomage table. • Education continues to demonstrate direct impact on patient care and service delivery, including innovative student-led models and improved clinical capability. However: • Workload pressures continue to impact the quality and consistency of training and learner experience, particularly in high-pressure clinical areas. • Capacity constraints (workforce, educator availability, training space and funding) remain a limiting factor. • A pause on non-essential training from January 2026, due to financial constraints, presents a potential risk to future workforce development and capability. • There is variation in experience across professional groups and specialties, requiring targeted intervention.			
Recommendation/s: (including any decision/approval required)	The Board of Directors is asked to: 1. Note the progress and impact of education and training delivery during 2025/26 2. Take assurance from the strength of governance, educational quality and workforce development activity 3. Acknowledge the key risks, particularly workforce pressure and training capacity, and support continued focus in these areas			
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

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Risk:	The report highlights ongoing risks relating to: • Workforce pressure impacting training quality and learner experience • Capacity constraints affecting delivery and access to education • Potential long-term impact of reduced non-essential training • Pipeline risks linked to wider system and education provider changes
Legal/Regulatory:	N/A
Quality & Patient Safety:	Education and training support patient safety through improved clinical competence, effective supervision and targeted training aligned to identified risk areas.
Equality, Diversity and Inclusion and Health Equity:	Education and training support equality, diversity and inclusion through widening access to careers and promoting inclusive, safe learning environments. Work is ongoing to address variation in experience, strengthen speaking up, and align approaches to sexual safety.
Resources:	Ongoing financial constraints continue to impact training capacity and delivery.
Environmental sustainability:	The service has made early progress in sustainability through the establishment of the Turning Education Green group, introduction of recycled materials and waste reduction, and exploration of carbon literacy and reduced use of single-use products.
Assurance Route	
Meeting/s where content has been discussed previously:	Education Quality Meeting & Workforce and Education Steering Group

Report content

1. Purpose

This report provides assurance on the quality, impact and sustainability of education and training provision during 2025/26, including key achievements, risks and priorities for the year ahead.

2. Background/context

2025/2026 marks the first full year following the launch of the Trust's Education Strategy 2025–2030. During this period, the Education and Training service has focused on strengthening its internal structure, improving governance and ensuring that education delivery is aligned more closely with workforce and service needs. This has taken place within a challenging environment. Workforce pressures, financial constraints and wider changes within the education system have all influenced the way education is delivered. Despite this, education remains a key enabler of safe care, staff development and organisational performance.

3. Assessment

Quality and Impact of Education

The overall quality of education and training remains strong. Learners continue to report positive experiences of supervision and teaching within a supportive learning culture

Education quality is routinely triangulated through a range of internal and external measures, including the National Education and Training Survey (NETS), General Medical Council (GMC) National Training Survey, Practice Assessment Record and Evaluation (PARE), and the Trust's annual self-assessment process. These sources are reviewed collectively through internal governance structures to identify themes, areas of strength and opportunities for improvement.

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The Trust continues to perform strongly across these measures. In the most recent NETS results, performance was strong across the majority of domains when benchmarked against peer organisations, with particular strengths in supervision, teamwork and learning culture.

GMC National Training Survey results are consistent with this position, with the Trust achieving a strong ranking for educational supervision and receiving positive feedback across a number of specialties, including anaesthetics, emergency medicine and intensive care. Targeted improvement work is underway in areas where feedback has been less positive, including surgical training environments. These findings are supported by PARE data and internal self-assessment, indicating a positive learning environment with areas for improvement linked to workforce pressure and access to learning opportunities.

Feedback from undergraduate medical students, particularly through the University of Leeds MPET placement evaluation process, continues to be a clear strength for the Trust. The latest interim report for 2025/26 shows that overall placement satisfaction is 95%, compared to an all-Trust average of 90%, positioning the Trust as a positive outlier. Performance is consistently strong across teaching, learning environment and clinical experience, with most areas scoring above 90%. Students frequently highlight the quality of teaching, supportive clinical teams and the range of practical learning opportunities available.

External assurance has also been provided through the NHS England Education Quality Review (Senior Leader Engagement visit) undertaken in July 2025. This recognised the Trust's progress in strengthening its education strategy, expanding partnerships and introducing innovative training programmes, alongside highlighting the strength of multiprofessional education and the embedding of initiatives such as the Safe Learning Environment Charter. This has been further supported by collaborative work with the University of Leeds to strengthen approaches to sexual safety, aligning processes and reinforcing expectations to ensure students feel safe and supported whilst on placement.

The review also reinforced the key challenge of workload pressure, noting its impact on training quality and the sustainability of future growth. This aligns with internal findings and remains a key focus for the Trust.

Importantly, there is increasing evidence that education is having a direct impact on clinical practice and service delivery. The Resuscitation Team has moved beyond a focus on training numbers to prioritise real-world performance, using in-situ simulation and closer collaboration with clinical teams to improve confidence and team working in emergency situations.

The Learning Needs Analysis has also provided a more detailed and evidence-based understanding of workforce capability. Rather than identifying widespread gaps, it highlights specific areas for development, including clinical assessment skills, advanced procedures and leadership capability. This supports a more targeted and proportionate approach to training.

Across services, there has been a shift towards more flexible delivery models, combining digital, face-to-face and simulation-based learning to better meet operational demands. This is further demonstrated through the development of student-led therapy services as part of the Future Leaders programme. These initiatives provide students with the opportunity to contribute to real-world service delivery while developing leadership and clinical skills. Initial feedback from students, staff and patients has been very positive, with benefits seen in both learning experience and service capacity. This work is being further developed through a Future Leaders Fellow, supported by NHS England, who is leading a review of student-led models to explore opportunities to expand capacity and embed this approach more widely.

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Workforce and Staff Experience

Staff experience within education and training is a significant strength for the organisation. Survey results show high levels of satisfaction in areas such as compassionate leadership, inclusion, teamwork and work-life balance, all of which are critical to both staff retention and learner experience. The main area for improvement is staff confidence in speaking up. This is recognised and will be addressed through ongoing leadership and cultural development work.

Workforce Pipeline and Future Talent
The Trust continues to invest in its future workforce through a range of entry routes and development opportunities. This includes the continued delivery of the Healthcare Support Worker (HCA) Bootcamp, which supports individuals new to care to enter the workforce with the foundational skills and confidence required to work safely in clinical environments. This programme supports widening access and a sustainable workforce pipeline.

Placement capacity has also been maintained and expanded across multiple professional groups, supported by strong partnerships with higher education institutions and a continued focus on learner experience and support.

However, there are increasing challenges within the wider education and workforce landscape which are beginning to impact pipeline stability. Following careful consideration of workforce position, financial constraints and regional provision, the Trust paused recruitment to Student Nursing Associate (SNA) programmes for 2026. A further planned pause for 2027 has also been agreed, reflecting ongoing uncertainty in programme availability and workforce demand.

In addition, it has not been possible to support Nursing Associate to Registered Nurse (NA–RN) top-up programmes during 2026. While there remains interest from staff in progressing through this route, the requirement for backfill and current financial constraints mean this cannot be safely supported at this time.

These decisions are influenced by wider system changes, including the planned closure of the University of Greater Manchester satellite site in Bradford and reduced regional commissioning of Nursing Associate programmes. This is likely to further impact access to local training routes and may create gaps in the workforce pipeline in future years.

Alongside this, there are emerging challenges in relation to the Physician Associate (PA) workforce pipeline. Both the University of Leeds and the University of Bradford have taken the decision to pause their PA programmes and student intake for 2026. This reflects wider national and regional challenges relating to the recruitment, deployment and role clarity of Physician Associates within the NHS.

This further limits available workforce routes and reduces the diversity of entry points into clinical roles. While alternative routes will continue to be explored, these combined changes increase pressure on workforce supply and require closer alignment between workforce planning, education provision and financial sustainability going forward.

Financial Performance and Efficiency
The service has delivered its financial targets for the year, including achieving all Closing the Gap requirements. This has been supported by a more coordinated approach to planning and a clear focus on efficiency.

There has been a shift towards working more proactively as a business, with increased emphasis on maximising value, improving visibility and generating income where appropriate. This has been supported by the development of a more structured marketing approach across education, including consistent branding, improved use of digital platforms and a coordinated education-wide calendar to promote training opportunities and reach wider audiences.

Since January 2026, in response to financial constraints and the pause on non-essential internal training, the service has expanded its external offer. This has included delivery of courses such as Oliver McGowan training, resuscitation programmes and simulation-based training to external candidates. This approach has enabled the service to generate additional income while maintaining training capacity and expertise within the organisation and supporting the Trust's wider ambition to provide education beyond its own workforce.

Demand for this external training has been driven by a combination of increased regional requirements for statutory and specialist training, alongside reduced capacity in some external providers. While this has created opportunities to grow income, further work is planned to better understand demand, explore opportunities for expansion and ensure this offer is sustainable within the current financial and workforce context.

Alongside this, there has been a continued focus on improving efficiency through:

- Greater use of digital learning to reduce reliance on face-to-face delivery
- Improved coordination and planning of training programmes
- Stronger financial oversight, including CPD funding utilisation and procurement processes

A detailed review of library subscriptions has also demonstrated that current resources provide strong value for money, with high usage and clear links to clinical practice, education and research. Further reductions would introduce disproportionate risk in terms of quality, compliance and the Trust's role as a teaching organisation.

Overall, the service has responded positively to financial pressures by becoming more agile, outward-facing and commercially aware, while continuing to support core organisational priorities. This position will need to be sustained within a continuing constrained financial environment.

Investment and Infrastructure
Targeted capital investment has enabled the service to modernise its training offer. This includes the introduction of new simulation equipment and an Anatomage table, supporting more advanced and realistic training.

Digital infrastructure has also improved, with expanded eLearning provision and increased use of online platforms.

However, there are ongoing estate challenges. While essential works such as the Field House roof repair are underway, the overall quality of some training environments requires improvement to ensure a consistent standard across the organisation.

Sustainability
Sustainability is an emerging area of focus. The establishment of the "Turning Education Green" group reflects a growing commitment to reducing environmental impact.

Initial actions include reducing paper usage, introducing recycled materials and exploring carbon literacy. Further work is planned, particularly in relation to reducing single-use products and embedding sustainable practices into education delivery.

Key Risks and Challenges
The main risks relate to workforce pressure, training capacity and the sustainability of workforce development. High service demand continues to limit the ability to release staff for training and contributes to variation in learner experience, alongside constraints in educator capacity, space and funding.

There are also emerging risks in relation to culture within some clinical areas, particularly in the context of supporting undergraduate learners. Increased promotion of escalation routes has resulted in students feeling more confident to raise concerns where their experience has not met expectations. Feedback indicates that these concerns are often linked to local team culture and, in some cases, behaviours that do not consistently support a positive learning environment.

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This is reflective of wider workforce pressures, with some areas experiencing reduced capacity to sustain high-quality learning environments alongside service demand. Ongoing staff fatigue and

burnout associated with supervision and assessment responsibilities also continue to impact learner experience. This remains an important area of focus for the Trust.

The pause on non-essential training presents a potential longer-term risk to workforce capability if not addressed.

In addition, changes within the wider education system, including provider capacity and programme availability, may impact future workforce pipelines.

4. Next Steps

Priorities for 2026/27 will focus on:

- Strengthening alignment between workforce planning and education delivery
- Reintroducing non-essential training where possible
- Addressing variation in learner experience
- Continuing to develop digital and simulation-based learning
- Embedding sustainable practices within education
- Maintaining financial sustainability while supporting workforce development

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Trust Board			
Meeting Date:	21/05/2026	**Agenda Reference:**	Bo.5.26.14e
Report Title:	Violence Prevention & Reduction Standard		
Presented by:	David Moss, Director of Estates & Facilities		
Executive Lead:	David Moss, Director of Estates & Facilities		
Author:	William Hall – Violence Prevention & Reduction Lead / Local Security Management Specialist		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	Overall VPR maturity continues to improve, with Red indicators reducing further from 10 (January 2026) to 5 (April 2026) and Green indicators increasing from 22 to 23. Leadership & Accountability, Data, and Workforce domains continue to demonstrate strong and sustained assurance, with further consolidation of Green ratings. The Interventions domain shows the most notable improvement, with Red indicators significantly reduced (from 5 to 1) and a shift toward Amber, demonstrating active development and reduced immediate risk exposure. Governance & Assurance and Evaluation domains remain partially assured, with no material deterioration; however, limited progression indicates a requirement for targeted focus to achieve full maturity. Overall, the organisation is transitioning from risk mitigation to controlled delivery, with a materially reduced risk profile and increasing confidence in sustainability of VPR arrangements. *The VPR Action plan is included in the Board reading room at Bo.5.26.14e - Appendix 1 VPR Action Plan 2026*			
Recommendation/s: (including any decision/approval required)	*The Board is asked to:* • *Note the improved VPR maturity and reduced risk profile* • *Take assurance from the progress achieved across key domains* • *Endorse continued targeted focus on Interventions and Governance & Assurance domains to achieve full maturity*			
Link to Strategic Objective:	N/A			
Link to Priority Initiatives 2025/26:	N/A			

Implications	
Risk:	• The April 2026 assessment evidence a significant reduction in overall risk exposure, with Red indicators decreasing by 50%. • The primary residual risk relates to intervention effectiveness, where consistency of delivery and robust outcome evaluation are not yet fully embedded.

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	• A secondary risk is present within Governance & Assurance, where a static position suggests limitations in the maturity and effectiveness of oversight arrangements. • Overall, risks captured within the Board Assurance Framework for staff safety and violence reduction are increasingly well controlled and showing a positive trajectory, with no evidence of systemic decline.
Legal/Regulatory:	• The April 2026 assessment evidences a significant reduction in overall risk exposure, with Red indicators decreasing by 50%. • The primary residual risk relates to intervention effectiveness, where consistency of delivery and robust outcome evaluation are not yet fully embedded. • A secondary risk is present within Governance & Assurance, where a static position suggests limitations in the maturity and effectiveness of oversight arrangements. • Overall, risks captured within the Board Assurance Framework for staff safety and violence reduction are increasingly well controlled and showing a positive trajectory, with no evidence of systemic decline.
Quality & Patient Safety:	Improved leadership, data, and workforce capability contribute positively to staff safety and the reduction of violence-related harm, supporting safer care environments.
Equality, Diversity and Inclusion and Health Equity:	Strengthened VPR arrangements support equitable protection of staff and service users, particularly those groups disproportionately affected by violence and aggression.
Resources:	No immediate additional resource implications are identified. Future intervention improvements may require reprioritisation within existing resources.
Environmental sustainability:	No direct impact identified.
Assurance Route	
Meeting/s where content has been discussed previously:	• Violence Prevention and Reduction sub-committee – (ongoing monitoring) • People Academy No formal escalation decisions have been made; this paper provides routine assurance reporting.

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Report content

- **Purpose**

To provide assurance on organisational progress against the Violence Prevention and Reduction (VPR) Standards and highlight current risk position following the April 2026 benchmark refresh.

- **Background/context**

The VPR Standards were revised in December 2024, with assessments completed for both 2025 and 2026. These assessments measure organisational maturity across seven domains using Red, Amber, and green indicators.

See updated assessment table below.

Domain	Jan 2026 (R/A/G)	April 2026 (R/A/G)	Movement	Interpretation
Leadership & Accountability	1/2/7	1/2/7	No change	Sustained strong assurance
Governance & Assurance	3/3/2	3/3/2	No change	Static – development ongoing
Collaboration	0/1/1	0/1/1	No change	Stable baseline
Data	1/1/6	0/1/7	↓ Red, ↑ Green	Now strong assurance domain
Workforce	0/1/4	0/1/4	No change	Sustained high performance
Interventions	5/2/1	1/6/1	↓ Red, ↑ Amber	Major risk reduction, active development
Evaluation	0/1/1	0/1/1	No change	Early maturity

- **Overall movement**

This position reflects active risk management and controlled progression, with risk transitioning from high exposure to managed delivery.

Metric	Jan 2026	Apr 2026	Change
Total Red	10	5	↓ 5
Total Amber	11	15	↑ 4
Total Green	22	23	↑ 1
Total Indicators	43	43	—

- **Assessment**

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The April 2026 position demonstrates continued positive trajectory and system-wide maturity improvement, building on the gains identified in January 2026.

Quantitative Improvement in VPR Standards Ratings

- Red indicators reduced from 10 to 5, representing a 50% reduction since January 2026

- Amber indicators increased from 11 to 15, reflecting transition from Red (risk mitigation in progress rather than deterioration)
- Green indicators increased from 22 to 23, indicating sustained embedding of good practice

This pattern evidence risk reduction and active progression, particularly where Red indicators have transitioned into Amber rather than directly to Green.

Domain-Level Position

Strong Assurance Domains (Sustained)

- Leadership & Accountability

Maintains strong performance (1 Red / 2 Amber / 7 Green), demonstrating embedded executive ownership and governance stability.

- Data

Further improvement with elimination of red indicators (now 0 Red / 1 Amber / 7 Green), evidencing mature intelligence capability and data-driven decision-making.

- Workforce

Remains stable and high performing (0 Red / 1 Amber / 4 Green), indicating sustained capability and resilience.

Improving Domain (Material Risk Reduction)

- Interventions

Significant improvement:

- Red reduced from 5 to 1
- Amber increased to 6
- Green stable at 1

This reflects active development and implementation, with risks now better controlled though not yet fully optimised.

The domain remains the primary residual risk, but the risk profile is materially reduced.

This represents a transition from high-risk exposure to controlled operational delivery, marking a critical inflection point in VPR maturity.

Partial Assurance Domains (Ongoing Development)

- Governance & Assurance
  Static position (3 Red / 3 Amber / 2 Green), indicating no deterioration; however, further development is required to strengthen assurance mechanisms.
- Evaluation
  Stable (0 Red / 1 Amber / 1 Green), demonstrating early maturity but not yet embedded.
- Collaboration
  Unchanged and stable (0 Red / 1 Amber / 1 Green), maintaining baseline effectiveness.

The combination of reduced high-risk indicators strengthened enabling domains, and stabilisation of delivery risk provides a clear and evidence-based basis for increasing the level of organisational assurance.

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Overall Assurance Position

Taking into account:

- The continued reduction in red indicators (now 5 of 43)

- The elimination of red risk in key enabling domains (Data, Workforce)
- The substantial improvement in Interventions (primary risk area)

The overall level of assurance is now assessed as:

Substantial Assurance (with residual risk in intervention delivery and governance maturity)

This reflects high confidence in the effectiveness of control frameworks, with remaining risks clearly understood, actively managed, and reducing.

Risk Position

- Primary residual risk: Intervention effectiveness and consistency
- Secondary risk: Governance & assurance maturity (limited progression)

However:

Risk exposure is significantly reduced compared to previous assessments.

No domains demonstrate systemic deterioration.

- **Options analysis/Proposal**

- **Short term:** Maintain targeted oversight of Interventions domain, with clear trajectories to convert Amber → Green
- **Medium term:** Strengthen Governance & Assurance frameworks to remove remaining red indicators and evidence control effectiveness
- **Long term:** Achieve sustained green ratings and transition to a continuous improvement and optimisation model

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Trust Board			
Meeting Date:	21/05/2026	**Agenda Reference:**	Bo.5.26.15
Report Title:	**Strategic Equality and Diversity Council May 2026 Update**		
Presented by:	Mel Pickup, Chief Executive Officer		
Executive Lead:	Sajid Azeb, Chief Operating Officer/ Deputy Chief Executive		
Author:	Ruth Haigh, Equality, Diversity & Inclusion Manager		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☒
Summary of Key Issues/Highlights:	The Trust's Equality and Diversity Council (EDC), chaired by CEO, has a remit for both workforce and wider health inequalities and continues to meet quarterly. This report provides an update on the key highlights from the last EDC meeting, which was held on 28th April 2026, and was chaired by Karen Dawber, Chief Nurse. The following key items were discussed at the April EDC meeting: • Health Equity Work Plan Update • Colleague Equality Network Updates • Ramadan and Community Iftar Update			
Recommendation/s: (including any decision/approval required)	*The Trust Board is asked to:* 1. Note the contents of this update report 2. Support the proposed areas of work identified in section 4			
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 we are unable to achieve our ambitions on ED&I, including tackling health inequalities due to ingrained attitudes that persist in society and across our health and care organisations. 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.
Legal/Regulatory:	There is a requirement to ensure the Trust is compliant with a whole range of NHS equality frameworks and including the Equality Act 2010 (specifically the Public Sector Equality Duty). Our progress on EDI is a key success measure under the CQC well-led framework.
Quality & Patient Safety:	Our progress on EDI and Health Equity is a key success measure for providing quality patient care.
Equality, Diversity and Inclusion and Health Equity:	EDC provides leadership and focus for advancing EDI across the Trust, including our progress on Health Equity. It also provides a platform for our four

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	staff equality networks to share their lived experience and to influence the Trust EDI agenda.
Resources:	N/A
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	N/A

Report content

1. Purpose

The purpose of this report is to update the Trust Board on the work of the Equality and Diversity Council and provide an overview of the key areas of focus since our last update in November 2025.

2. Background/context

EDC has been in place since January 2021 and continues to meet every quarter, providing strategic direction, leadership and support to the Trust EDI agenda, including the Trust's approach in tackling population health inequalities.

EDC Membership: All EDC members are encouraged to attend each meeting, and EDC is usually very well attended. Where attendance is not possible members are asked to send a representative on their behalf.

Staff Equality Networks: Chairs of each of the Trust's staff equality networks are included as members of EDC with dedicated agenda time at each meeting. This enables staff networks to have a voice where they can actively influence EDI across the Trust.

3. Assessment

EDC continues to be well attended and generates lots of useful discussion, with 15 people attending the April meeting (which was re-scheduled from the original planned date of 4th February 2026). This is the first occasion (since EDC was launched back in 2021) that Mel Pickup, Chief Exec has given apologies. However, Karen Dawber, Chief Nurse was able to chair the meeting on this occasion. Due to a number of key stakeholders unable to attend this meeting, one or two agenda items were deferred for the next meeting, where it was felt there could be more productive discussion. This section provides a summary of agenda items and actions arising from EDC since the last Trust Board update provided in November 2025.

Next EDC is due to take place on Wednesday 3rd June 2026.

4. Highlights of the EDC meeting – Wednesday 28th April 2026

Health Equity Update Workplan Update: Naveed Saddique provided an overview of progress on the Health Equity programme workplan, including "What has gone well", "Key Risks and Challenges" and "Priorities for the Next Phase", and shared a detailed update report with the meeting papers. The plan, which covered the period April 25 to March 26, was shared previously with health equity oversight group, quality committee and Trust Board, and is aligned to the Trust EDI Strategy. It includes key objectives and actions to improve:

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- Embedding Health Equity
- Data analysis and utilisation
- Fulfilling our role as an Anchor Organisation
- Providing care based on population profiles
- Collaborating with partners

Governance and assurance: Establishment of the Health Equity Oversight Group has been key to developing, progressing and monitoring progress of the workplan. The group have also developed an updated health inequality self-assessment (1 year after the initial assessment).

Workforce Awareness and capability: Health Equity is now a regular feature of the Trust Induction programme and Trust Preceptorship course (reaching over 600 staff so far), 5 equity fellows have been enrolled in the population health fellowship, and there has been training in carrying out "Making Every Contact Count" conversations for staff in Phlebotomy and Outpatients.

Visibility & Communications: The Trust Health Equity Intranet pages have now gone live (including useful reference material and case studies). The team have also developed videos to raise the profile of their work and health equity is represented on a number of groups and forums around the Trust.

Anchor Organisation contribution: The team have developed a digital inclusion led service within the Trust library, widely publicising the community support they provide, offering access to the internet and support with e.g. using the NHS app/ applying for jobs.

Priorities for the Next Phase

The team have delivered Trust Board Directives (based on last years' Board Development session), reframing health equity, developing capability and taking on small, scalable projects. Over the next few months they will be:

- Developing dashboards to help CSUs better understand how population health inequalities impact their case mix and how they can each have a positive impact on this.
- Develop a refreshed set of objectives for the 2026-2027 work plan, which will be aligned to the NHS 10-year plan, including other local and national drivers, which will include new objectives to ensure we are developing evidence-based responses to inequalities – outcome measures (rather than just descriptions of activity) and work has already started on this.
- Strengthening system and parter delivery, including community mapping, anti-poverty contribution and alignment with community organisations.

There was some useful discussion around ensuring building knowledge/ capability/ capacity across the organisation to create a "social movement" and some detailed discussion around how we can make a difference (e.g. Alison Smith agreed to pick up on suggestions to implement 12-monthly follow appointments on gestational diabetes/ raising awareness of the additional risk factors – including use of social media and to approach the Enable staff network/ Project Search students/ Neurodiversity support group to discuss how we can make services more accessible for patients with learning disabilities).

Kez Hayat and Naveed agreed to some joint working around e.g. the CSU dashboard development, to align some of this work with our EDI strategic objectives update, and to ensure CSUs can develop measurable action plans based around health equity and EDI. This will also ensure we can evidence

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a joined-up approach with CQC. Alison Smith raised the need to ensure our aligned approach to EDI and Health Equity are a key feature of the refreshed Corporate Strategy.

Colleague Equality Network Updates:

Members from each network have engaged in a series of listening events focussed on sharing their experiences and how we can improve experiences for diverse staff in response to our recent staff survey results. There is lots of focus on collaborative working between the four networks.

Gender Equality Network: Shaheen Kauser (network chair) confirmed that network membership is growing (over 70 members now) and Vikki Lewis, Chief Digital Information Officer has been appointed as Executive Sponsor. The network has been focussing on:

- Influencing policy and practice around flexible working, parental leave and workplace safety
- Rasing awareness of gender equality through campaigns, events and discussions
- Supporting leadership development (encouraging mentorship/ networking/ improving equity in gender representation at leadership levels – working closely with the Race Equality network)
- Making patient care more inclusive
- Use of gender-neutral language
- Developing career development pathways
- Strengthening our data and insight

To support some of this work, they have set up 3 work-streams focussed on data analysis,

- Development of Talent Management Opportunities for women (led by Cat Shutt, Head of OD)
- Data and Insight (led by Ruth Haigh, EDI Manager)
- Domestic Violence (led by June Thomas, Midwife/ FTSU Ambassador/ \Resin Chair Midwife and Nichola Bowles, Hospital Independent Domestic Violence Advocate)

The network held a successful International Women's Day event on 3rd March 2026 in the Sovereign Lecture Theatre. Under the theme of "Give to Gain", colleagues shared honest, moving stories of success, and navigating some of the barriers/ challenges that build the resilience to succeed. Male allies joined the discussion generating an understanding and a sense of shared experience.

LGBT+ Staff Equality Network: Saffron Blower (deputy network chair) provided an update. The last quarterly network meeting was held on 12th February, where members reviewed their work plan for 2026, which includes:

- Building network visibility and engagement
- (including development of physical media – promoting the Trust as "queer friendly", developing a poster campaign of LGBT representation across the Trust
- Promoting the network as a resource and advisory group for managers
- Supporting staff who don't feel able to be "out" at work (specific work-stream for South Asian staff and collaboration with other networks/ local partners)

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Mel Pickup has taken on the role as Exec Sponsor and is meeting monthly with Amelia Cripps (Network Chair) to go review network activity. Amelia has also delivered some training to the

audiology team on “Best practice in delivering healthcare to trans and non-binary patients” (which colleagues were keen to explore the opportunity to roll out more widely across the Trust).

On 25th February there was an event in Sovereign Lecture theatre to celebrate LGBTQ+ History Month under the theme “Science and Innovation”. This involved food, fun, a quiz (with prizes) and lots of discussion and learning, including a brief talk on “Queer History in the Media”. Plans are being developed for Pride month in June, including pulling together some LGBTQ+ merchandise (such as rainbow lanyards/ pens etc.) and discussions Pictureville Cinema and BDCT on a potential collaboration.

Network membership continues to increase, and there has been a notable increase in allyship for the network, particularly those wanting to support transgender patients/ colleagues in the context of an increasing hostility on a national and global scale.

RESIN (Race Equality Staff Inclusion Network): June Thomas (network chair) provided an update for RESIN. The network have updated their workplan following an survey for members in February this year around network priorities. The network have been developing an improved internet page, which is planned to be more informative and more accessible, and will include information on key progress and what next. Once finalised with Trust comms team, this model will be rolled out to the other three networks.

The network are keen to engage colleagues at other Trust sites (recognising they are often overlooked in favour of BRI). Joint network plans are in place for National Day for Staff Networks where colleagues will be present at both BRI and St Lukes’ to raise the profile of networks and the benefits they can provide. Colleagues are developing some merchandise (using network budgets) to make the event engaging and impactful.

The network are keen to support white allyship for the network, and to support the EDI team in implementing the NHS Race & Health Observatory 7 principles of anti-racism and to some collaborative working with the Gender Equality Network around leadership development opportunities.

Enable Colleague Equality Network: June Thomas also provided a brief update for Enable on behalf of Simon Kirk. Simon, Laura Whitakker (network administrator) and Mark Hindmarsh (Exec Sponsor) have met to plan a refreshed approach for the network and have developed their work plan with members. This will include:

- Strengthening network governance and leadership structure
- Rebuilding and broadening membership
- Assessing the current position, with focus on reasonable adjustments procedure, health passports, disability related leave policy, approach to monitoring disability declaration rates.
- Capturing staff voice and lived experience
- Developing data led actions
- Increasing visibility through communication and events
- Collaboration and partnership with other staff networks

Ramadan Community Iftar: Kez Hayat, Head of EDI shared some highlights from the recent Ramadan Community Iftar event that took place in Field House, BRI, where both Muslim and non-Muslim colleagues came together for the first time to learn a bit more about Ramadan and the significance of this to Muslims, but also to partake in the community Iftar and observe some of the prayers. Colleagues from BTHFT attended and raised over £800 for the “Home from Home” charity and local businesses (Kebab Hut and My Lahore) who provided some amazing food. Over 100

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colleagues from a diverse range of backgrounds attended and some fantastic feedback was shared about how this felt like a real demonstration of inclusion in practice. The event nicely aligned with our wider EDI ambitions and also some of the work the SPaRC team are doing to celebrate other faiths who were celebrating at the same time (e.g. the importance of Easter and Lent to the Christian faith) and some of the similarities across faiths.

Karen Dawber invited colleagues to join her for the Bradford Faith Walk, which is an inclusive event where participants of all faiths (or non-faiths) walk a mile across Bradford visiting Mosques, a Hindu and Sikh temple, finishing at the Cathedral in the city centre and learning about each faith along the way.

5. Proposal

It is recommended that the Trust Board:

1. Note the contents of this report
2. Support the proposed areas of work identified in section 4

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Bradford Teaching Hospitals
NHS Foundation Trust



We are Bradford: *we value diversity and champion inclusion*

Equality, Diversity & Inclusion Update

Progress and future direction

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Kez Hayat, Head of EDI
Trust Board – 21st May 2026

Our EDI Approach

Bradford Teaching Hospitals
NHS Foundation Trust

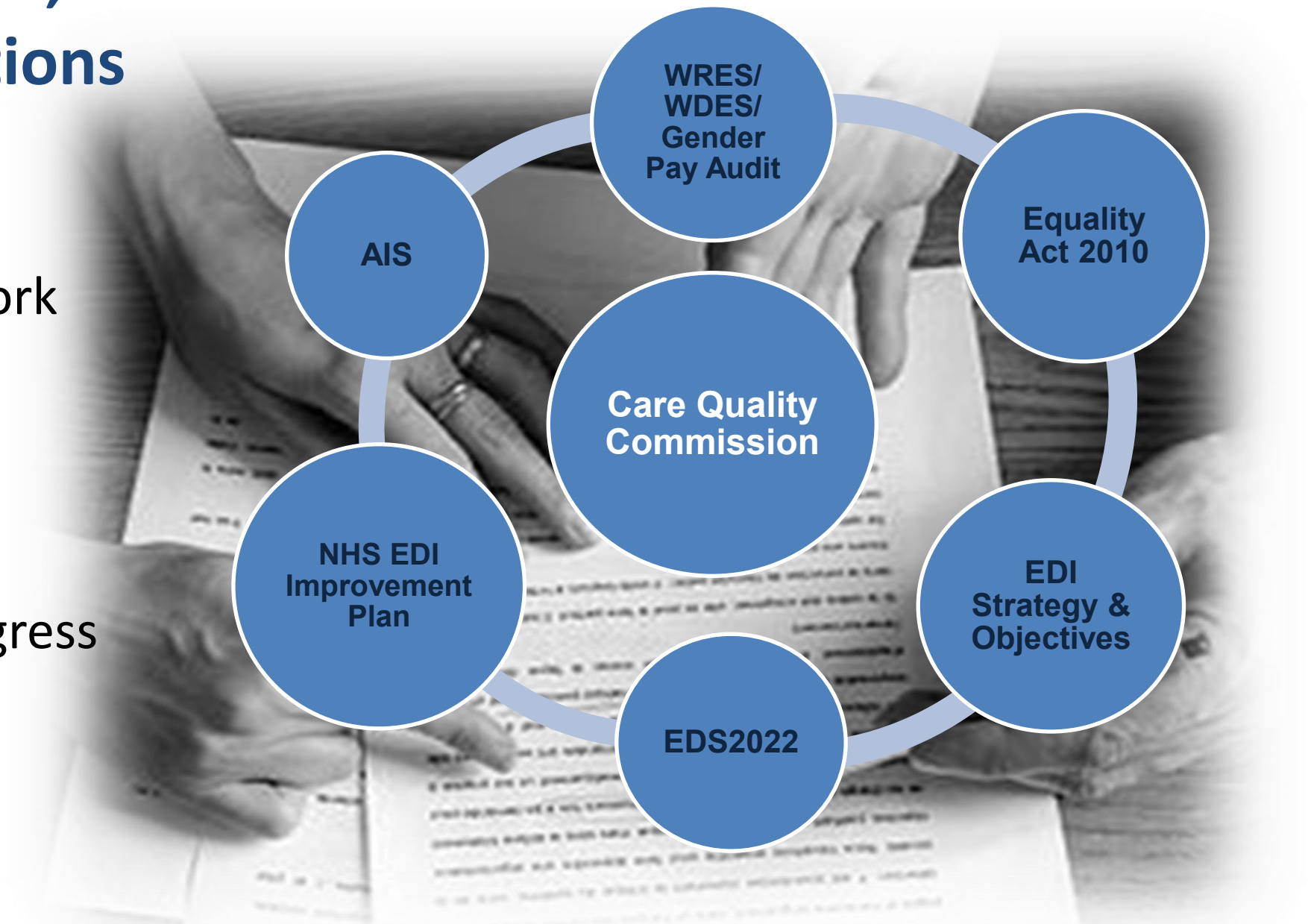


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EDI Landscape, Contractual & Legal Obligations

Key EDI framework aligned to **CQC inspections**

Focus: Evidence, approach & Progress



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Equality Act 2010
Protected Characteristics



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Our strategic approach to EDI

- From September 2025 the EDI unit is now managed by Chief Operating Officer, Saj Azeb
  - Focus on ensuring EDI is intrinsic to everyone's role and developing CSU level EDI action plans with measurable data led actions.
- Strategic Equality and Diversity Council, chaired by CEO to help us identify and align our workforce and population health inequalities priorities.
- People Committee (Workforce) with staff networks represented at each meeting
- Wider focus on Inclusion & Belonging recognising 'intersectionality'
- EDI being a key feature within our Corporate Strategy, People Strategy
- Equality Impact Assessments – Identifying positive and negative impact on the 9 protected groups

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EDI impact and achievements



Race Equality:

Continue to exceed our target of a workforce representative of the local population (currently 45%).

Set targets for senior level representation (28% by Sept 2027 and 40% by 2030) – currently 21% and rising gradually

Agreement to adopt the NHS Race & Health Observatory – 7 principles of anti-racism

Celebration of key EDI related events (i.e. Black History Month)

EDS 2025/ 2026 review:

Rated as **Achieving**

3-year EDI Strategy (5 strategic EDI objectives) – under review

Dedicated Operations EDI action plan developed

Key progress reported to ETM in September 2025

EDI Conference (Belonging & Inclusion) Oct 2025 (over 250 people attended)

Inclusive Staff Recreational area created in collaboration with our staff equality networks & EDC members

Publication of a **BTHFT Diversity Calendar**

Successful Community Iftar

Disability Equality:

Set targets for disability declaration (10% by 2027 & 15% by 2030), currently 6% and rising gradually

Disability Confident Employer (level 2). Aspiring to Disability Confident Leader (level 3)

Project SEARCH – 11 years (recently presented our approach at Project SEARCH national conference)

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LGBT Equality:

Rainbow Badge (Thrive Management Essentials)

LGBT+ History Month event (Feb 26)

Gender Equality:

Launched a Gender Equality Network

Successful IWD event (March 2026)

Improvements to gender pay gap data

Menopause Confident employer

Launch of Sexual Safety Charter

Dedicated breast/ chest feeding room

Progress on Health Equity:

The Health Equity and Health Inequalities work plan has largely been delivered, with strong governance, clear executive leadership, and increasing traction across Trust structures. Delivery to date has focused on building foundations, assurance mechanisms and workforce capability. The programme is now entering a phase where demonstrable impact and data-driven outcomes must be prioritised.

Objectives for 2026/27 are in the process of being drafted and will inform the programme's work plan which will be informed by the Health Equity Oversight Group

Current Progress: Refresh of the EDI Strategic Objectives



- **Consultation and Engagement** – staff and community
  - EDI Conference – dedicated time to seek feedback on current priorities
  - Focus groups planned and delivered to a diverse range of staff
  - Electronic feedback surveys
  - Staff Survey – a range of listening events

- **Collating the initial feedback to ensure this informs our activity over the next 3 years**

Key Themes

1. **Tackling bullying, harassment and discrimination –** staff survey data
2. **Managers role and responsibility in managing diverse teams and being clear on their roles and responsibilities in raising the profile of EDI**
3. **Promoting inclusive and compassionate behaviours, leadership styles and culture**

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What Next: CSU Action plans

- Data and evidence led plans
- CSU plans to be aligned to the strategic EDI objectives
- Alignment with WRES & WDES, EDS2 and Staff survey response
- Tackling Health Inequalities

Launch of the refreshed EDI Strategic Objectives (plan on page) - August **2026**

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What Next

Key areas of focus for the next 12 months

1. Refresh and finalise our **EDI Strategic Objectives** (July 2026)

2. Adopt and launch the **NHS Race & Health Observatory – 7 Anti-Racist Principles** (Habib Naqvi attending the Trust in July 2026)

3. **Tackling Bullying, Harassment & Discrimination** with emphasis on **Dignity & Respect in the Workplace**

4. **Empowering Managers - Thrive Management Essentials – inclusion of EDI related subjects**

5. **Development of targeted EDI Action plans for CSUs and departments**

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Thank you!

Questions, Reflections, Observations?



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Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.17

Committee Escalation and Assurance Report

Report from the: Finance and Performance Committee
Date of meeting: 22 April 2026

Key escalation and discussion points from the meetings

Alert:

Headline Operational Performance KPI exceptions

- 18 Weeks Incomplete RTT: The overall waiting list size out-turned in line with forecast, efforts to ensure long waits were prioritised, additional month end validation and additional activity delivery supported improvement in the year end performance out-turn to 66.17%, only 0.53% below plan.

  The quarterly update indicated RTT performance was trending positively through sustained grip and focus with progress on long wait clearance including 65 week and 52-week cohorts. A range of initiatives were in progress including improved clinic slot and room utilisation, a theatre cancellation root cause analysis programme focused on on-the-day cancellations, continued use of Medinet to provide additional activity whilst the SLH Day Case Unit remained closed and improved transparency by sharing waiting list information with consultants to support ownership and awareness.

  Ongoing constraints and risks included remaining 52-week breaches in orthopaedics and pain, workforce issues in oral and maxillofacial services, the continuing impact of day SLH Day Case Unit closure on activity levels, the disruptive effect of industrial action and time off in lieu as well as delays in theatre data which had affected improvement work. Outlined mitigations included locum and substantive recruitment plans, additional Medinet capacity, increased theatre sessions, recovery meetings and morale/teambuilding support where clinical engagement challenges were affecting recovery.

- DM01 6-weeks: Performance for March remained below plan in line with previous escalations. As part of 2026/27 planning targets all modalities are required to return to or sustain performance above 95%. Additional capacity for NOUS, Audiology, and Neurophysiology is in place to support this, *but current trajectories suggest extensions may be required*.

- Elective Activity: Q4 activity through theatre increased with the use of Bronte forward wait for Plastic Surgery procedures but overall volumes would 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: A coding opportunity was being progressed within the data and productivity workstream which may recover past month performance and increasing the proportion of new appointments has been a Q4 priority which will continue into 2026/27.

- Cancer 28-day FDS: Performance impacted by deterioration in histology reporting and ongoing challenges across key tumour groups. Forecast improvements in Gynaecology, Skin and H&N do not appear to be enough to bring the overall position to above plan, although will be above national and peer average

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Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.17

Pathology Joint Venture Governance Mechanisms
The Committee heard from the Managing Director of the Joint Venture, important as it had had consistent reports of the impact of delays in histology reporting on Trust performance. Technical problems precluded a full discussion, but the CFO summarised that the Trust has had long-standing concerns about how the JV operates, including governance and engagement. An independent report exists but the JV Board had not signed off releasing the full report. The Trust's focus is therefore on key themes, including inconsistent engagement, process variation between Bradford and other sites, insufficient visibility of performance data to enable effective Committee oversight and workforce/cultural issues reflected in leadership and staff survey outcomes. The Committee heard that an action plan has been developed by the Joint Venture which the Trust will use for accountability. However, an internal Trust report would be prepared highlighting unresolved issues, so that assurance is not solely reliant on JV reporting. Laboratory performance affects RTT and cancer pathways.

Looking forward the Committee heard that the Trust needs to achieve 98% of cancer histopathology reporting within 10 days within three years, but performance is currently far from that standard, reporting around 40% this month (up slightly from 38.2%). The Committee felt that this scale of improvement will need stronger grip and change; the 'arms length' nature of the Joint Venture must not dilute accountability and information flow.

It was clear from this discussion that there are issues requiring resolution and that improvement work is beginning, but stated the Committee needs to see more information if it is to discharge its assurance role. Regular updates are in the Committee's workplan.

The Committee was not assured about the performance of the Joint Venture and will monitor it closely.

Water and Ventilation (Infection Prevention)
Water and ventilation challenges mirror the wider estate position because much of the estate is old and ageing and therefore carries inherent backlog maintenance pressures. Annual backlog maintenance funding is used to improve resilience and provide assurance in relation to water and ventilation systems and that the Trust has actively engaged with NHSE to seek increased backlog maintenance allocation because the estate is older than many peer trusts. The Committee heard what is being done to strengthen assurance including moving towards digitising planned maintenance tasks so that records and reporting become more robust and continuing to rely on independent assurance from external Authorised Engineers who audit systems. A key concern is that ventilation currently has a lower level of assurance than water and this is largely due to the age of air handling units and a small number of specific units.

The Committee questioned whether the Trust was comfortable holding a residual risk score of 15 for ventilation, particularly as it appeared among the highest residual risks on the risk register and asked how the risk was being prioritised operationally. and whether the mitigations were sufficient to prevent the risk materialising. The Committee was advised that the risk cannot be reduced substantially without major estate replacement programmes.

The Committee asked whether there are areas of the Trust not meeting statutory compliance for ventilation. The Director of Estates advised that there are offices and areas without the required number of air changes and acknowledged this as non-compliance in a technical sense but highlighted the importance of distinguishing between statutory compliance and guidance, suggesting that many expectations are guidance based rather than strictly statutory requirements.

Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.17

Putting the risk in context some aspects of non-compliance arise because buildings are judged against the regulations and standards in place at the time of construction, with full alignment often only achievable during replacement or renewal. The Trust uses Standard Operating Procedures (SOPs) and operational controls to protect patients, e.g. some side rooms have ventilation constraints so the Trust mitigates by not placing respiratory patients there which can reduce winter capacity but protects patient safety. The Committee accepted that these operational controls should be recognised as mitigations alongside technical maintenance interventions but only to the extent that staff follow procedures consistently. A testing or assurance regime for SOP adherence would be useful.

The Director of Estates concluded by describing how the Trust must prioritise multiple infrastructure risks including asbestos, electrical systems, ventilation, and water. He explained that a separate group assesses which risks are highest across the building infrastructure and allocates limited funds accordingly and emphasised the structured, evidence-based approach to prioritisation.

The Committee wished to bring the residual risk, context and mitigations to the attention of the Board. The Committee also noted the high-level risk register score of 20 relates to the broader critical infrastructure risk and that the ventilation specific risk is lower.

The Committee was assured by the update recognising the need for strengthening assurance around water and ventilation, including progressing digitisation of planned maintenance records and reporting, and continuing engagement with NHSE for backlog maintenance funding.

Advise:

High Level Risks Relevant to the Committee
The Committee noted that finance risks would be reset for the beginning of the new financial year; the Board Assurance Framework (BAF) strategic risk was multi-year, whereas the High Level Risk was an in-year risk.

Business Case Post Implementation Reviews
As part of its discussion of its Terms of Reference, the Committee discussed the issue of "seeking assurance regarding post-implementation reviews of approved business cases" and concluded that the Committee would seek assurance for business cases over £0.5m and would also receive visibility of items approved at other levels via the finance pack narrative, without implying the Committee would scrutinise every single one in detail.

In month exceptions/ early warning metrics
• Cancer 62-day Performance: Diagnostic delays were impacting on this standard with February performance below target. Improvements in the 62 day backlog were expected to translate to 75.7% performance vs a 75.0% target in March 2026 for this KPI.

• Cancer 62-day Backlog: Improvements in the number of patients over 62 day on an active cancer pathway were sustained into April, although some loss of capacity during industrial action could cause an increase in the coming weeks

Bo.5.26.17 Board of Directors 21/05/2026 Page 3 of 5

On Cancer performance, the continuing impact of histology delays was noted and that this was being progressed with the Joint Venture (JV). The Chief Operating Officer (COO) indicated early signs suggested the Trust would meet the 62-day cancer standard for March but noted April would likely be challenging due to the transition out of winter capacity and the impact of industrial action. He described a focus on catching up lost time and rebalancing capacity.

Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.17

On cancer 28-day performance the COO explained that the Trust remained mid pack in quarterly ranking and emphasised the patient impact of timely diagnosis communication, noting the Trust was close to target but still marginally below.

The Committee sought assurance on whether the Trust had a credible plan to deliver very challenging targets including diagnostics and the required RTT improvement, asking where assurance would come from on the longer-term plan rather than solely in month monitoring. The Director of Planning responded that Health on the High Street would not deliver the targets in year so short-term operational changes such as capacity increases and other interventions would be needed to meet current year requirements, with larger capital driven changes likely to come later. The Committee will do a future deep dive to explore where the step change would be achieved, noting the scale of the diagnostics challenge.

Financial Recovery Update including Trust Recovery Board Terms of Reference
The Committee explored the size of financial challenge, noting that the information received in a presentation was primarily CSU focused whereas the target would require broader structural change. The Chief Financial Officer (CFO) advised that this is why Executive Directors are leading programme areas like theatres, outpatients, medicines optimisation and other longer term workstreams and a programme structure will support delivery because CSUs alone cannot deliver the full scope, particularly where corporate mechanisms and trust-wide responsibilities are necessary such as sickness improvement requiring both local action and corporate support

The CFO confirmed that if delivery falls short, cash support would be needed. He referenced a 13-week cash forecast indicating pressure around June and said the position would be managed through ongoing finance reporting.

Assure:

Urgent and Emergency Care
In a deep dive review, the COO summarised that Urgent and Emergency Care (UEC) standards were performing strongly and were presented as green rated, with the Trust also performing well regionally and nationally in several areas. He did however highlight that future expectations were increasing and that the Trust's objective remained returning to constitutional standard delivery by 2029.

Annual Emergency Preparedness, Resilience & Response (EPRR) Report
The Committee was assured that the Trust remained compliant with core standards in most areas, with continued work on a small number of standards relating to business continuity and external supplier KPIs.

Car Parking
The Committee was assured by the update recognising the progress made to date and the ongoing communication with staff.

Clinical Engineering Department Annual Report 2025
The Committee was assured by the report, noting the service's strong governance and proximity to targets, while recognising staffing and future target changes as areas to watch

Monthly Finance Report – Month 12
The Finance Report stated that the Trust's likely outturn (pre audit) met NHS England's expectations on the revenue position, was slightly below on capital, and cash was slightly better.

Bradford Teaching Hospitals NHS Foundation Trust 19/05/2026 08:47:14

Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.17

Capital Update
The Committee noted that many colleagues had delivered an additional £20m capital investment over a 2-3 month period, a significant achievement. As a result of substantial equipment replacement over the last two years, some medical equipment risks are now de-escalating because the Trust is ahead of previous risk trajectories.

Procurement Update
The Committee was assured by the report into procurement activity.

Report completed by:

Bryan Machin
Committee Chair and Non-Executive Director
14 May 2026

Osbourne Sheridan
19/05/2026 08:22:12

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors			
Meeting Date:	21 May 2026	**Agenda Reference:**	Bo.5.26.17b
Report Title:	Integrated Dashboard		
Presented by:	Mel Pickup, CEO		
Executive Lead:	Vikki Lewis, Chief Digital & Information Officer		
Author:	Vikki Lewis, Chief Digital & Information Officer		

Report Summary				
Purpose of the paper:	Decision ☐	Assurance ☒	Action ☐	Information ☐
Summary of Key Issues/Highlights:	The integrated Board dashboard is developed by combining the individual performance reports that are received and scrutinised by the Committees: (1) Finance and Performance Committee (2) People Committee (3) Quality Committee Historically, the individual metrics have been agreed with the Executive leads for these Committees and updated on a rolling basis as policy, planning and performance imperatives require. Following the recent publication of the National Oversight Framework (NOF) and other key planning documents, the organisation is working towards developing the reporting suite for inclusion in the IPR. Prior to recently published national guidance on the NOF, the organisation had confirmed its intentions to adopt the principles of the NHS England Making Data Count programme and this intention remains a guiding principle throughout this period of transition.			
Recommendation/s:	The Board is invited to receive and review the document attached. The Board is asked to note the progress to date and be assured of continued progress to create a comprehensive, detailed and informative performance dashboard going forward.			
Link to Strategic Objective:	Sustainability - To deliver our financial plan and key performance targets			
Link to Priority Initiatives 2025/26:	N/A			

Implications	
Risk:	N/A
Legal/Regulatory:	N/A
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity':	N/A
Resources:	N/A
Environmental sustainability:	N/A

Assurance Route

Joanne Sheridan
19/05/2026 05:22:12

Meeting/s where content has been discussed previously:	N/A

Osbourne,Sheridan
19/05/2026 08:22:12

Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Dashboard

Board of Directors

April 2026

Osbourne Sheridan
19/05/2026 08:22:12

Key to KPI Variation and Assurance Icons

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

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

Special Cause Improvement - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special 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

Osbourne.Sheridan
19/05/2026 08:22:12

Further Reading / other resources

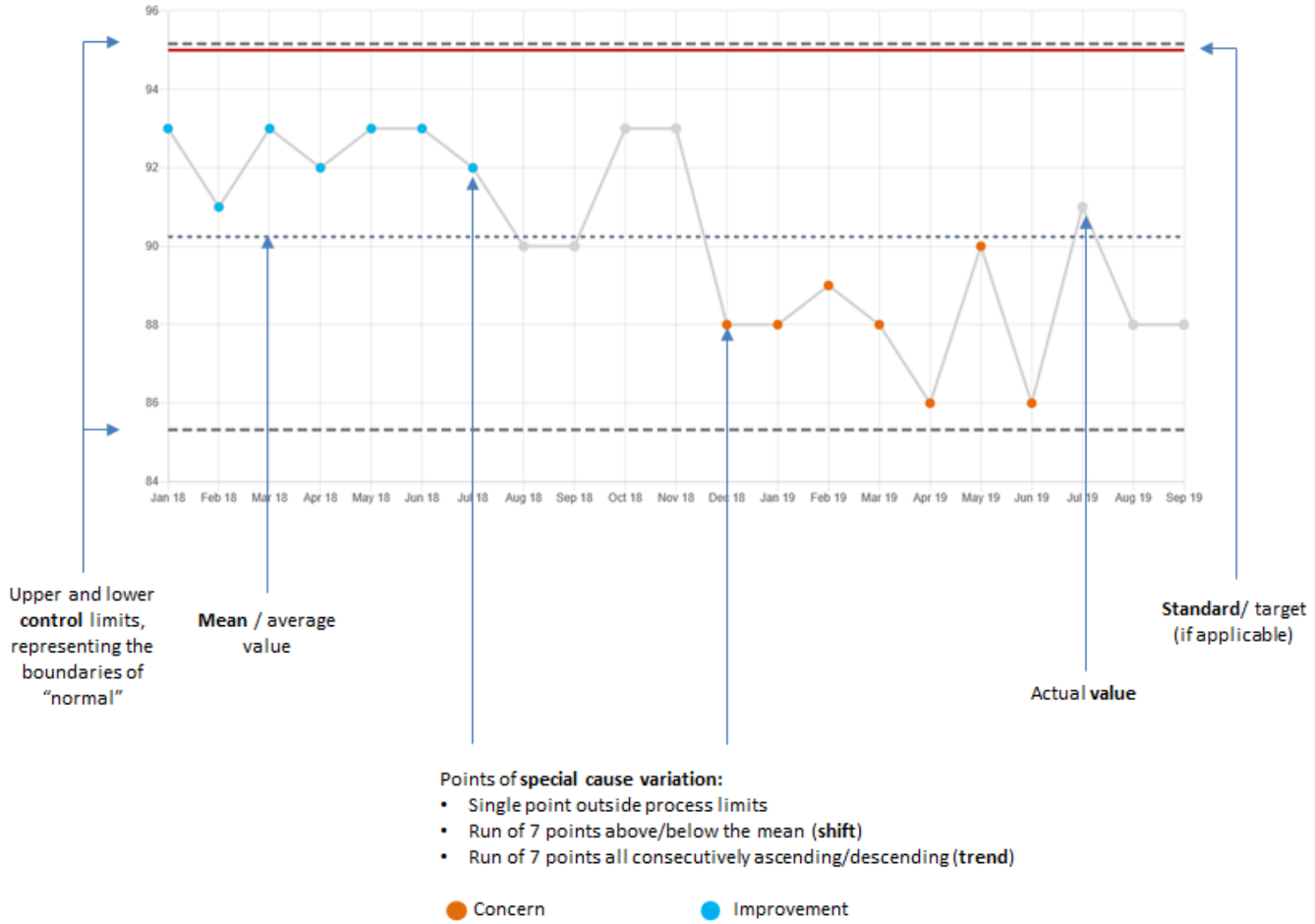
The NHS England website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://www.england.nhs.uk/publication/making-data-count/

Interpreting Statistical Process Control Charts

Guidance notes

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

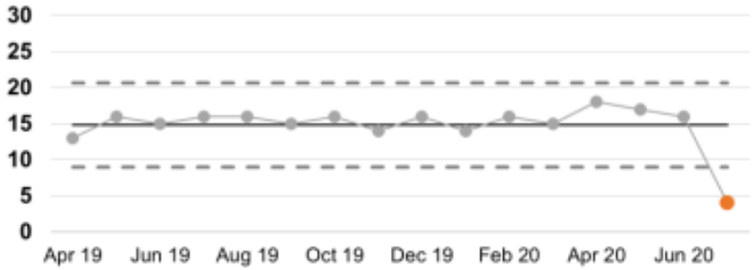
SPC charts



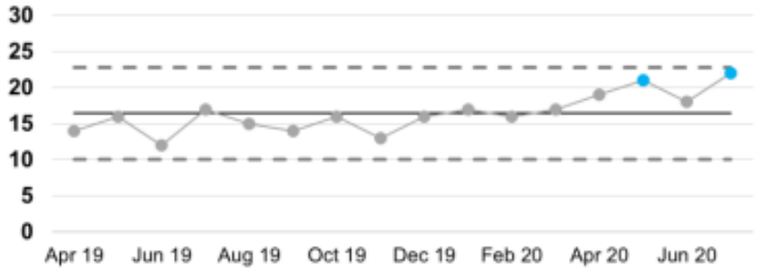
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SPC rules : special cause variation

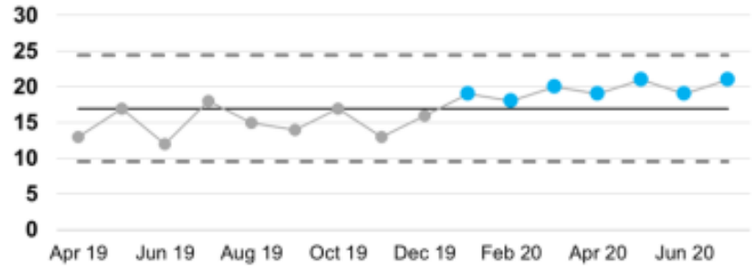
A single point outside the process limits



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 decending order



Osbourne Sheridan
19/05/2026 08:22:12

Operational Performance – Executive Director: Sajid Azeb

Bradford Teaching Hospitals NHS Foundation Trust

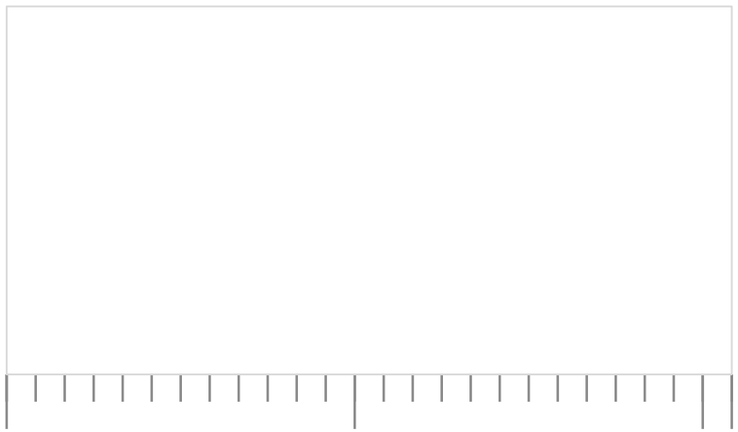
Metric	Period	Latest Value	Target	Variation	Assurance	Mean
% Ambulance Handover <15 Mins - * All	Apr-26	54.3%				56.40%
% Ambulance Handover <30 Mins - * All	Apr-26	89.0%				85.80%
% Ambulance Handover <60 Mins - * All	Apr-26	99.6%				96.50%
Ambulance Arrivals - * All	Apr-26	3,363				3,200
Bed Occupancy - * All	Mar-26	93.06%	93%			90.70%
Cancer 2 Week Wait - * All	Mar-26	84.72%				93.80%
Cancer 28 Day Faster Diagnosis	Mar-26	85.26%				81.6%
Cancer 31 Day 1st Treatment	Mar-26	98.52%				92.6%
Cancer 62 Day Wait - * All	Mar-26	78.21%	75%			74%
Day Case Rate - * All	Apr-26	88.94%				88.90%
Diagnostic Waiting List - * All	Apr-26	8,860				10,236
Diagnostic Waiting List (% < 6 Weeks) - * All	Apr-26	82.46%	95%			72.50%
DTA to Admission > 12 Hours	Apr-26	1.1%				2.01%
DNA Rate - All	Mar-26	9.04%				8.85%
ED - Time to Initial Assessment - * All	Apr-26	15.84				24.4
ED Attendances (% < 4hr) - * All	Apr-26	81.91%	77.30%			75.60%
Elective Ordinary and Daycase Admissions	Apr-26	4,778				4,190
Elective Theatre Sessions Volume Completed	Oct-24	616				520
Length of Stay 21+ Days - * All	Apr-26	84				103.5
Not Meeting Criteria to Reside - * All	Apr-26	14.08%	14.79%			13.06%
Outpatient Attendances	Mar-26	43,045				41,567
Outpatient Attendances % New or with Procedure	Mar-26	57.03%				56%
Outpatients Discharged to PIFU	Apr-26	5.85%				2.14%
Patients Discharged on/before DRD	Apr-26	77.8%				81.90%
Patients in ED >12 Hrs - * All	Apr-26	932				680.1
RTT 18 Weeks (%) - * All	Apr-26	63.63%				68.90%
RTT 18 Weeks (Total Pathways) - * All	Apr-26	31,090	30,571			35,619
RTT 52 Week Breaches - * All	Apr-26	73				613.3
RTT 65 Week Breaches - * All	Apr-26	0				81.6
Theatre Capped Utilisation	Oct-24	85.30%				82%

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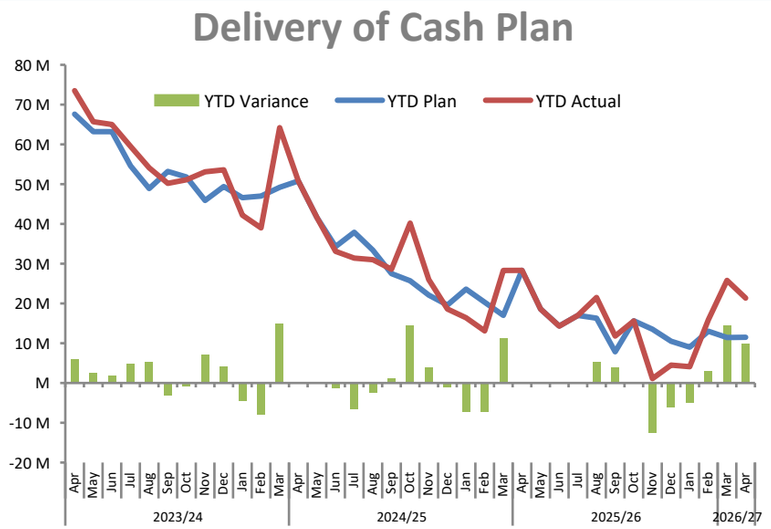
Finance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

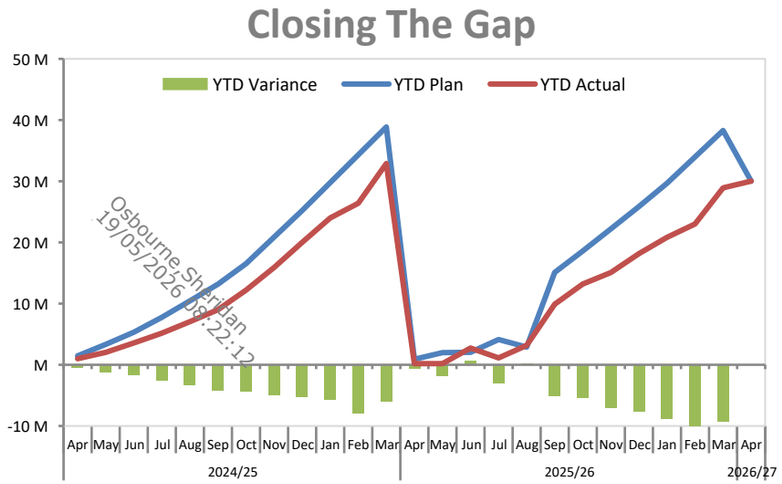
April 2026 – (£2.9m)



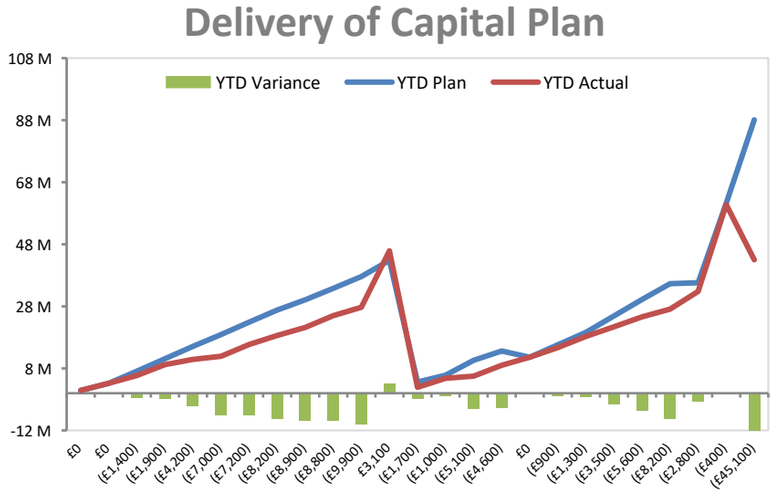
April 2026 – £11.25m



April 2026 - £3m



April - 2026 – £43k



Analysis

The Trust is reporting a Month 1 deficit of £2.9m, which is in line with plan. However, this early position does not yet evidence delivery of the required run rate improvement, which is a breakeven position.

The Trust is forecasting delivery of the breakeven plan for the financial year, but this is contingent on achieving a significant and sustained reduction in the current cost run rate over the coming months, which has yet to be demonstrated.

The main risks to the forecast are full delivery of the £58m CTG efficiency target and delivering the activity to meet the stretching Elective Recovery Fund income plan.

Revenue Cash (£11,235k) : is £5,814k ahead of the planned position of £5,269k. This favourable variance is largely attributable to higher than expected payables, particularly outstanding balances with pharmacies totalling £2,213k. While this position provides a short term benefit to cash, it is timing related rather than a recurrent improvement.

Capital Cash (£10,116k) : is £4,041k higher than the planned position of £6,075k. This favourable variance is primarily driven by a combination of programme underspend and higher than anticipated capital payables at the period end.

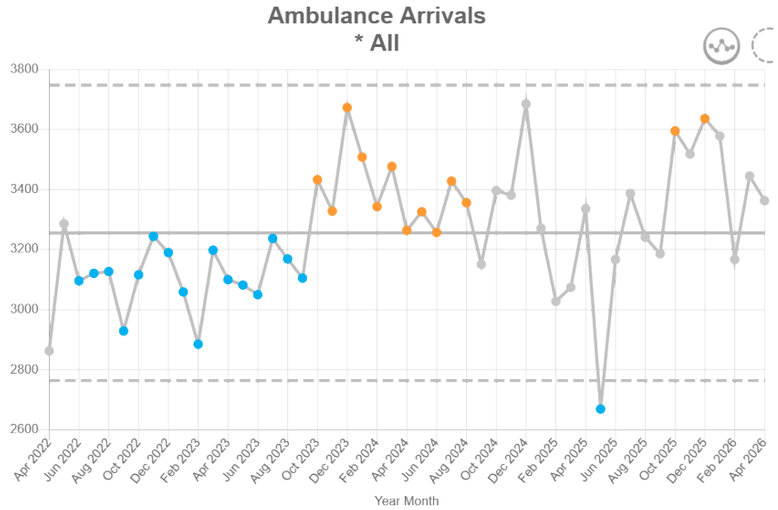
The Trust has formally reported delivery of the required £3m savings in month 1 and this is evidenced by the on plan I&E position. The reported CTG savings includes £1.8m of run rate improvements which are yet to be fully validated and categorised under the revised framework. CSUs have made good early progress in identifying schemes; however, these are subject to gateway review and will only be recognised as delivering once assurance requirements have been met. From Month 2, the CTG tracker will be used as the single source for both internal and external reporting, improving consistency and transparency.

In Month 01, the Trust incurred capital expenditure of £43k, primarily relating to medical equipment purchases. Overall, a underspend of £838k was reported for the period, reflecting lower than planned activity early in the financial year, with expenditure expected to increase in subsequent months as schemes progress.

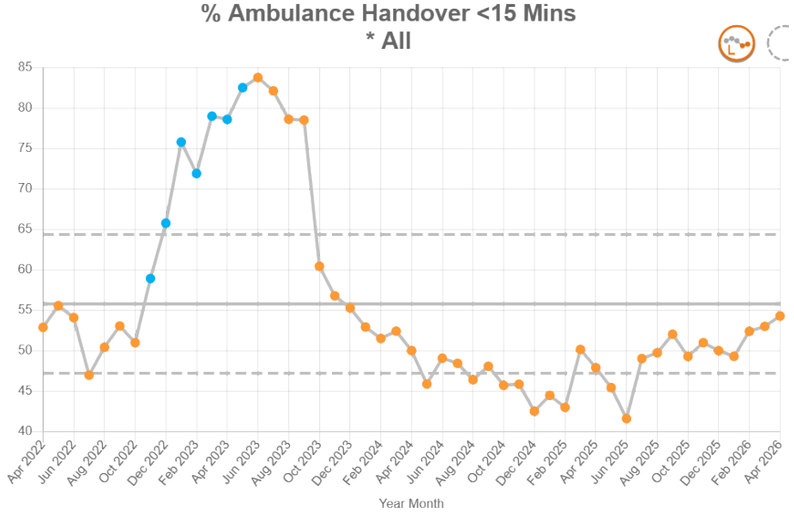
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

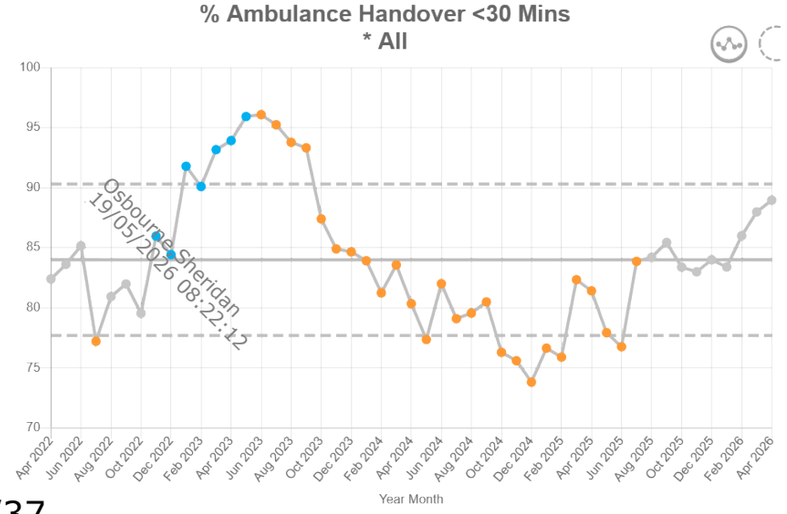
April 2026 – 3,363 Ambulance arrivals
Common cause variation



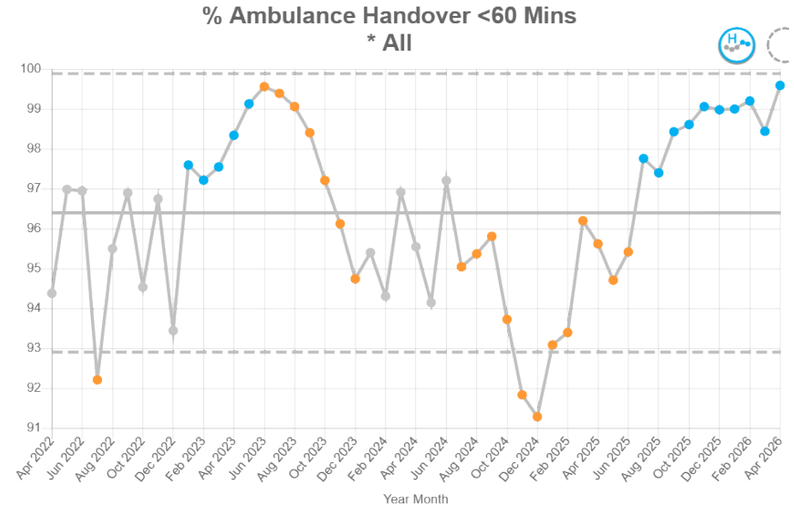
April 2026 – 54.29% ambulance arrivals
Common cause variatio



April 2026 – 88.96% ambulance arrivals
Special cause variation of a deteriorating nature



April 2026 – 99.59% ambulance arrivals
Common cause variation



Analysis

Improvements in 15-minute handover performance continued in April (54.3% compared to 53.0% in March), with average handover times continuing to perform better than plan. Overall turnaround times remained stable with a slight increase in crew clear times reducing the benefit from handover improvement.

Risks, Mitigations and Assurance

BTHFT remains within the interquartile range and continues to demonstrate a positive rate of improvement (+0.68%/month since April 2025), ranking 4th among volume-comparable peer Trusts.
Live handover validation (Mon–Fri, 09:00–17:00) continues to reduce delays and data queries, with validated handover delays remaining consistent from 24 in March to 23 in April; 45-minute breaches remain stable. A go-live for out of hours and weekend validation is still to be confirmed.
The Transfer of Care protocol continues to support timely flow, enabling transfer to BTHFT trolley within 45 minutes and faster crew release. Self-handover rates remain good and aligned with peer averages, supported by ongoing YAS promotion.

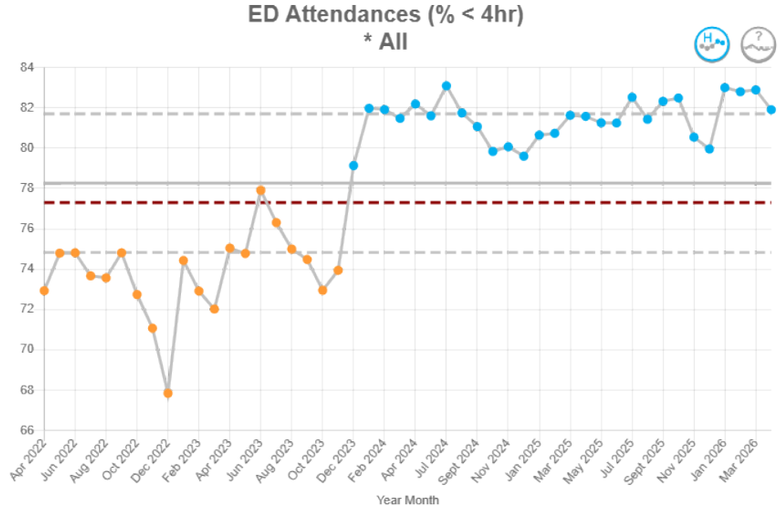
Benchmarking

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

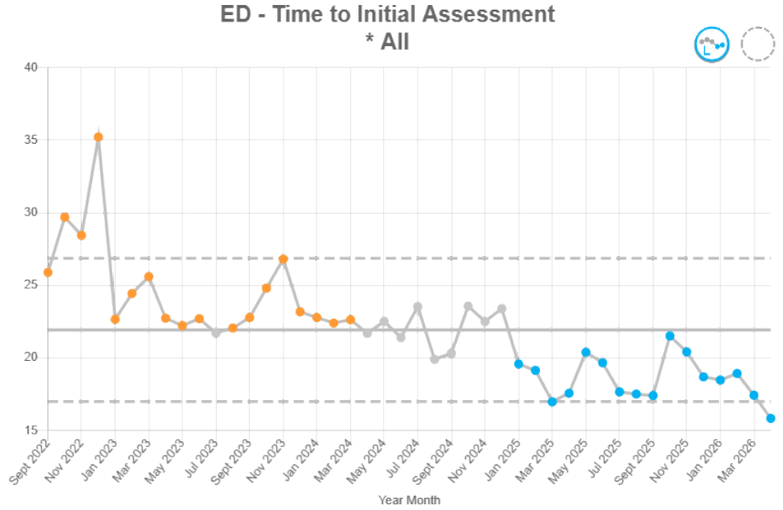
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

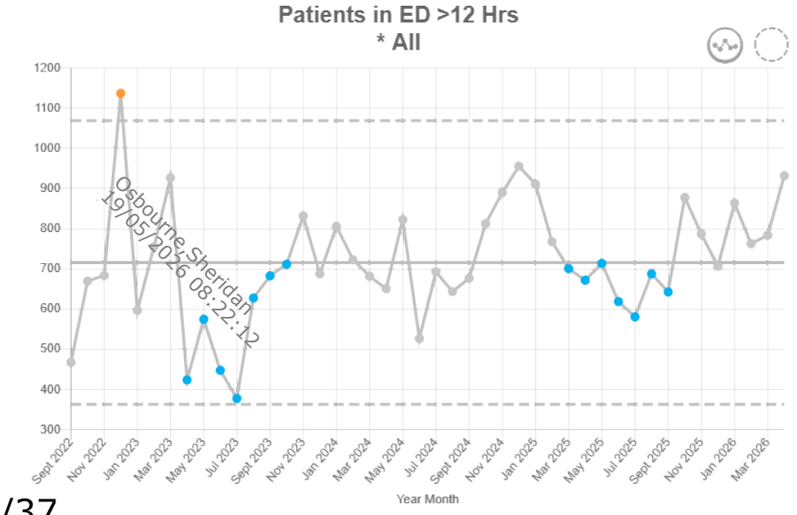
April 2026 – 81.91% - Year end target 77.3%
Common cause variation of an improving nature



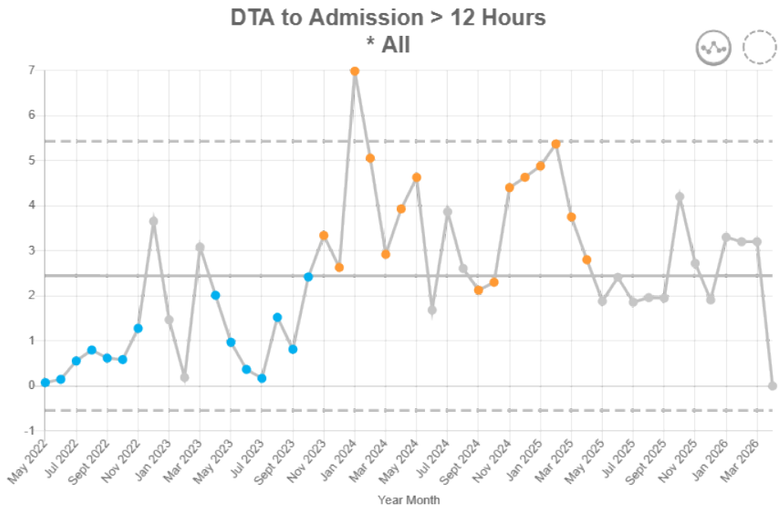
April 2026 –15.84 minutes
Special cause variation



April 2026 – 932 patients
Special cause variation



April 2026 – 1.1%
Common cause variation



Analysis

ED demand has remained higher than expected levels with increased pressures seen within Care of the Elderly and Paediatrics ECS 4-hour performance was 83.2% in April, exceeding plan and aligning with upper decile performance across combined Trusts.

Risks, Mitigations and Assurance

Expanded clinical streaming continues to support flow during high demand, alongside improved data accuracy.
FirstNet Model Content remains on track for delivery in July following delays encountered regarding outstanding technical design issues. Work is progressing to utilise AI to support the completion of discharge information in FirstNet, thereby improving the timelines of ED clock-stops and improve consistency in patient information capture.
Whilst average Decision to Admit (DTA) wait times have improved, 12-hour performance remains a challenge with several factors contributing, including the increased demand on ED. Daily oversight and a full review of each breach is in place to increase learning and improvement in response to this KPI.
The EXCEL Programme is focused on ED decompression through upstream demand management, in-department flow and discharge improvement; current focus remains ED and downstream pathways, including improved triage, acute pathway streamlining and discharge acceleration.

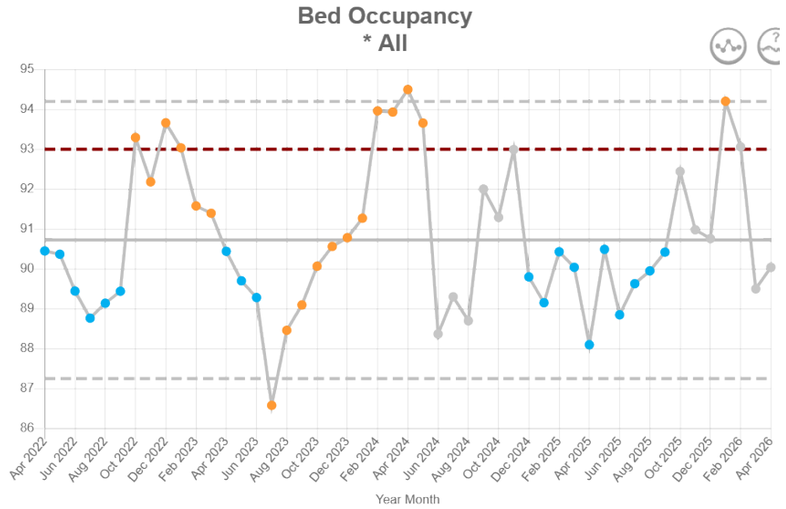
Benchmarking

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

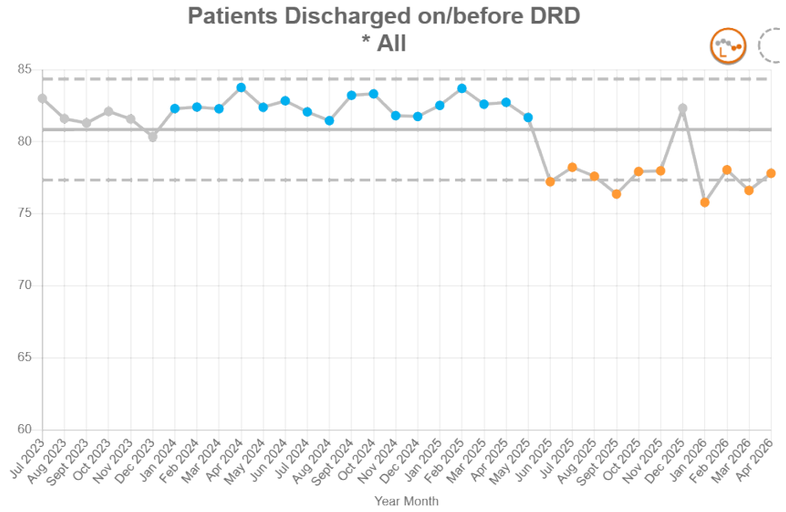
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

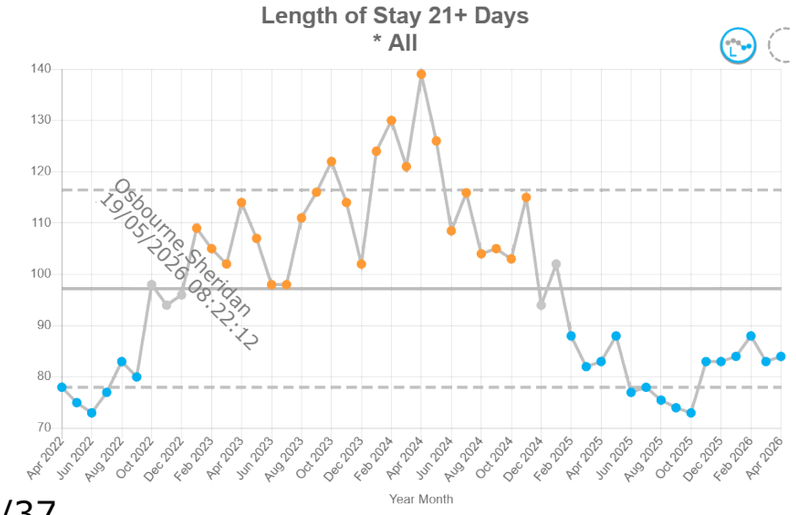
April 2026 – 90.04% occupancy – Year end target 93%
Common cause variation



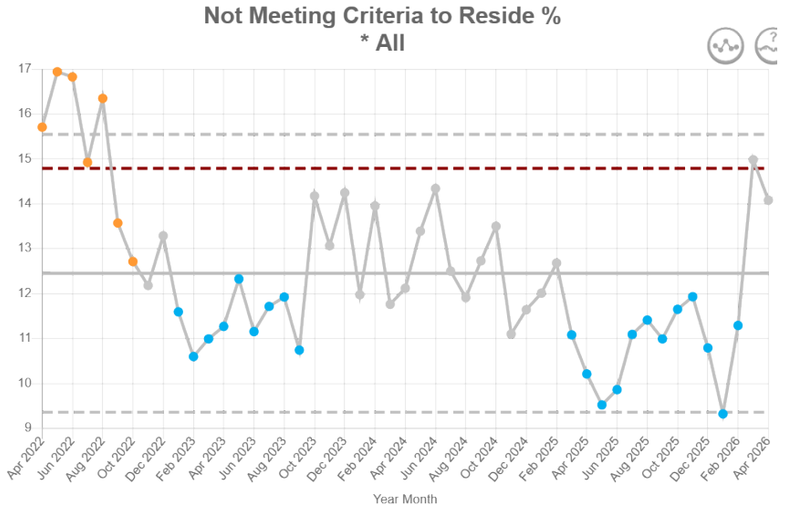
April 2026 – 77.81%
Common cause variation



April 2026 – 84 patients
Common cause variation



April 2026 – 14.78% – Year end target 14.79%
Common cause variation



Analysis

G&A bed occupancy reduced in April in line with forecast as winter pressures eased, though pressures remain across Specialist Medicine and Surgical wards.
Increases in NCtR continued into May, with an increase in the volume of patients not meeting criteria to reside, rising from an average of 54/day in January to 84/day by April. Daily NCtR averages have reduced in May (~69/day).

Risks, Mitigations and Assurance

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

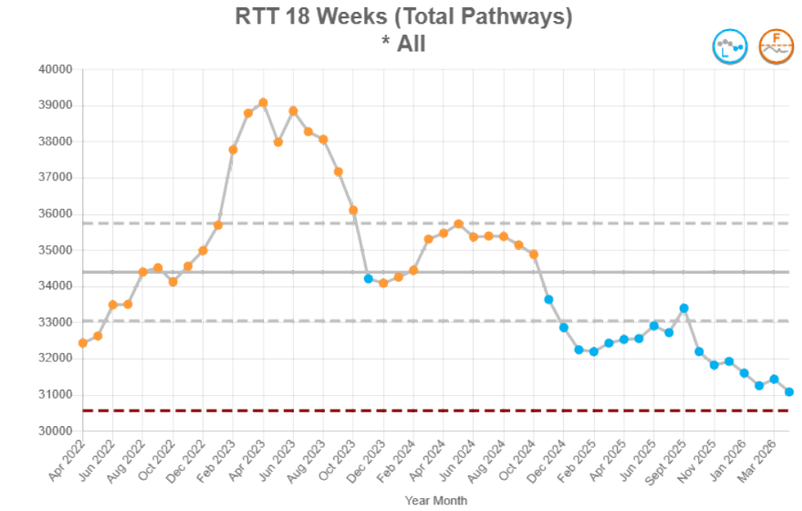
Benchmarking

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

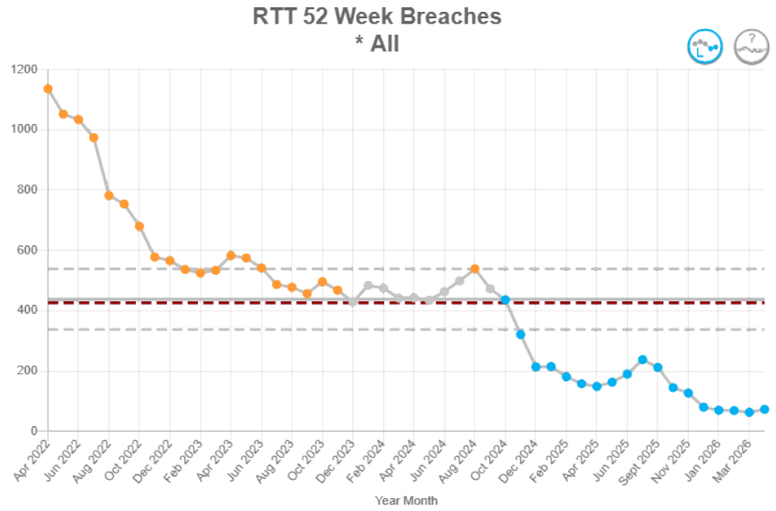
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

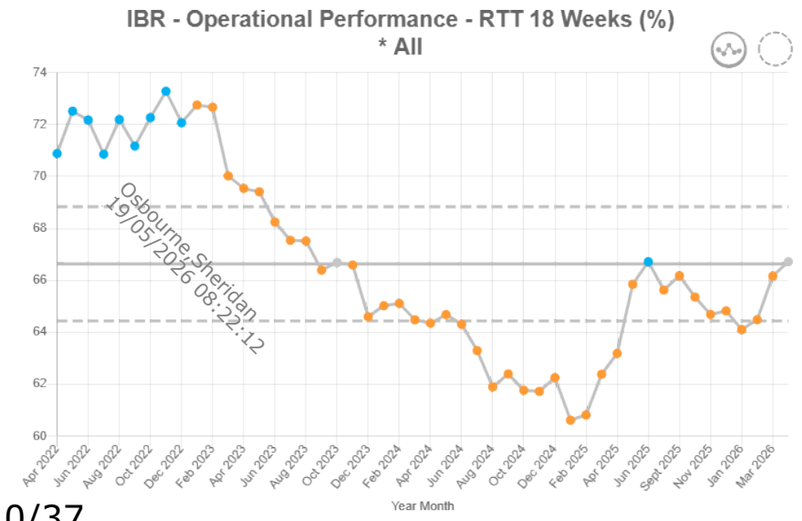
April 2026 – 31090 pathways – Year end target 30,571
Special cause variation



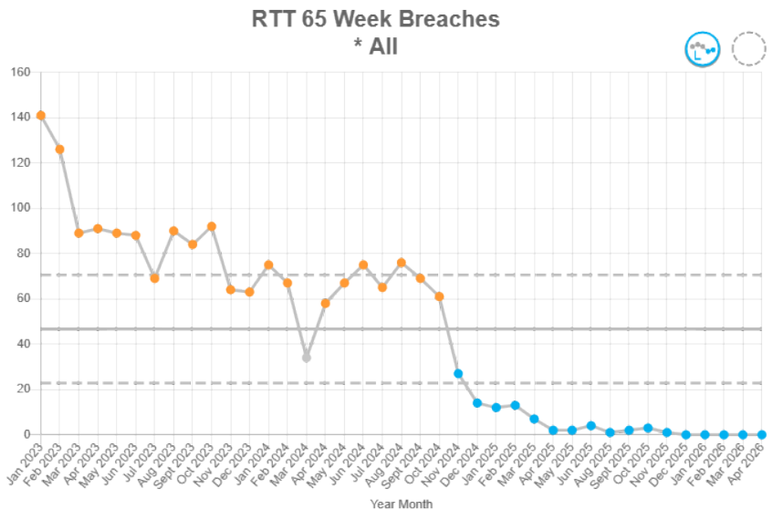
April 2026 – 73 pathways – Year end target 426
Special cause variation of an **improving** nature



April 2026 – 63.63%
Common cause variation



April 2026 – 0 patients
Special cause variation



Analysis

RTT performance improved in April despite Easter holidays and industrial action, with increased clock stops across both non admitted and admitted pathways. The number of RTT over 52 weeks waits has increased in April. Leadership teams are responding to pressures in Pain Management and Trauma & Orthopaedics, and the Plastic Surgery continued to improve. No patient waited over 65 weeks. The Trust continues to benchmark just below the upper decile for 52-week RTT.

Risks, Mitigations and Assurance

The Q4 outpatient sprint concluded with additional new appointment slots and weekend clinics during March. Uptake against the original plan was not fully achieved but performance is likely to have deteriorated without this specific push. The outpatient transformation programme reflected on this initiative and will aim to embed learning.
Activity plans for 2026/27 have been set against specific RTT improvement targets. Increasing productivity through the recovery programme and delivering waiting list management improvements through existing performance meetings will combine to deliver the stretching 7% improvement required.

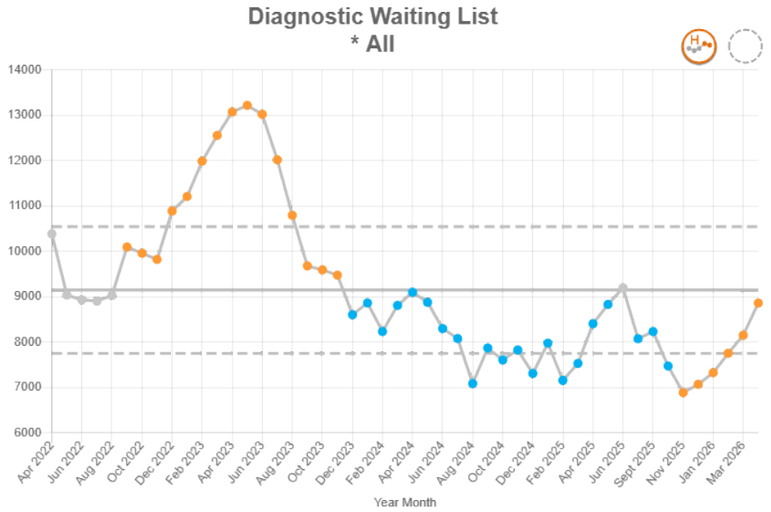
Benchmarking

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.

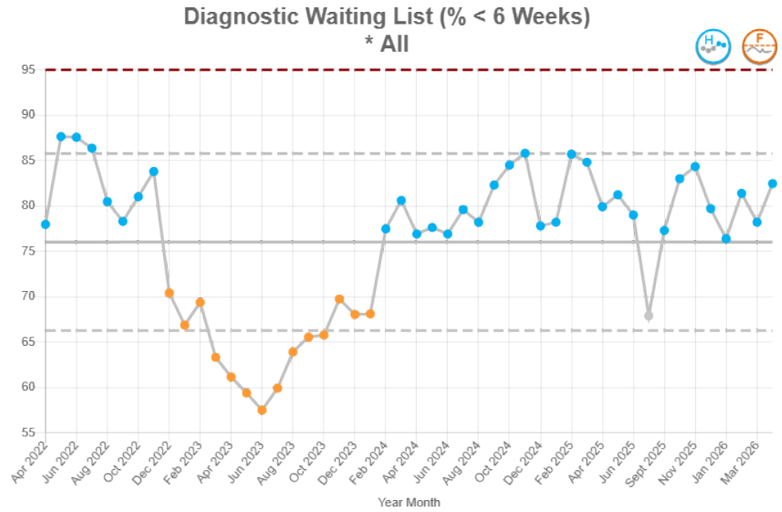
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

April 2026 – 8860 pathways
Special cause variation of a deteriorating nature



April 2026 – 82.46% <6 Wks – Year end target 95%
Common cause variation



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19/05/2026 08:22:12

Analysis

DM01 performance for April remained behind the NHSE trajectory but is in line with our internal plan based on the March out-turn and the movement of recovery plans into 2026/27.

Risks, Mitigations and Assurance

Non-obstetric ultrasound continues to be closely monitored as staffing concerns have now resolved. The waiting list continues to reduce with performance expected to recover by Q1-end with the locum contract ending in May.
In Audiology, three locums have been appointed but have provided limited availability before the end of Q2, with modelling suggesting that the waiting list will continue to grow.
Neurophysiology insourcing commenced in April with recovery projected by Q2-end. Increased delivery from substantive consultants is expected to bridge the residual gap once the contract ends.
In Urodynamics, a recovery plan with medical physics support is in place with additional capacity provided from May.
Despite increased activity in April, Cardiology is impacted by increased Stress Echo referrals (GIRFT). Performance will continue to be impacted until a long-term plan is implemented via a business case.
The new Endoscopy Unit opened on a phased approach and the service has also been awarded JAG accreditation. Both represent significant milestones in our continued provision of high-quality services.

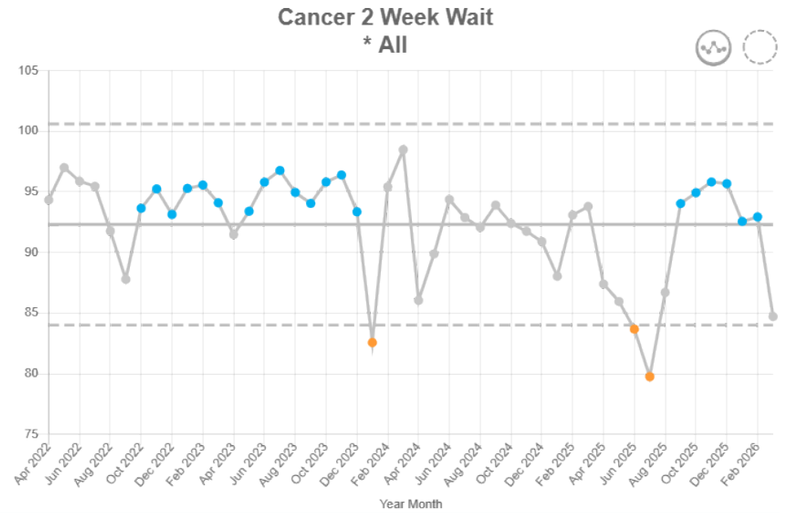
Benchmarking

Performance was improving towards national and peer average.

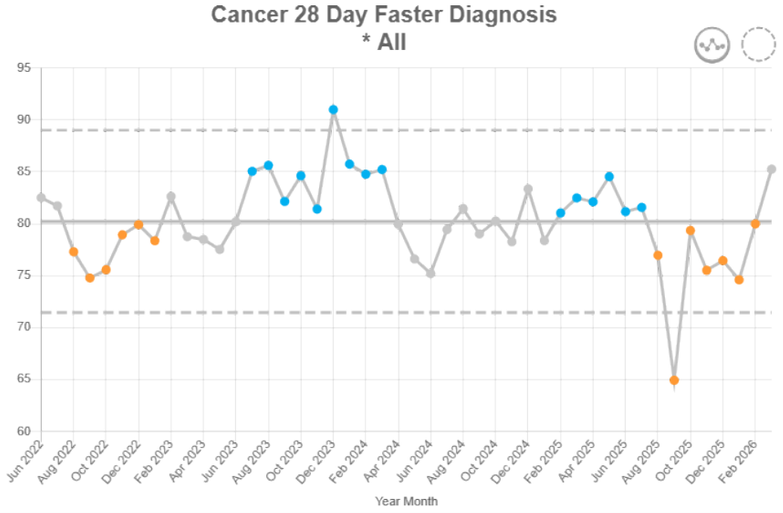
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

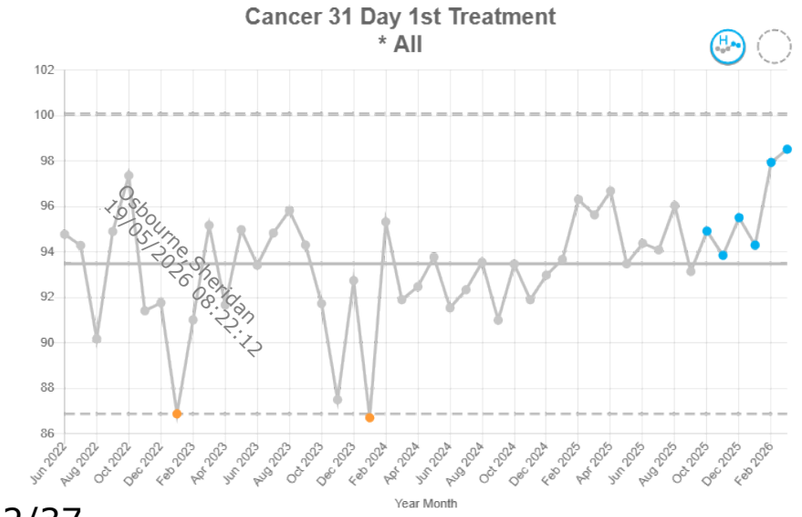
March 2026 – 84.72%
Common cause variation



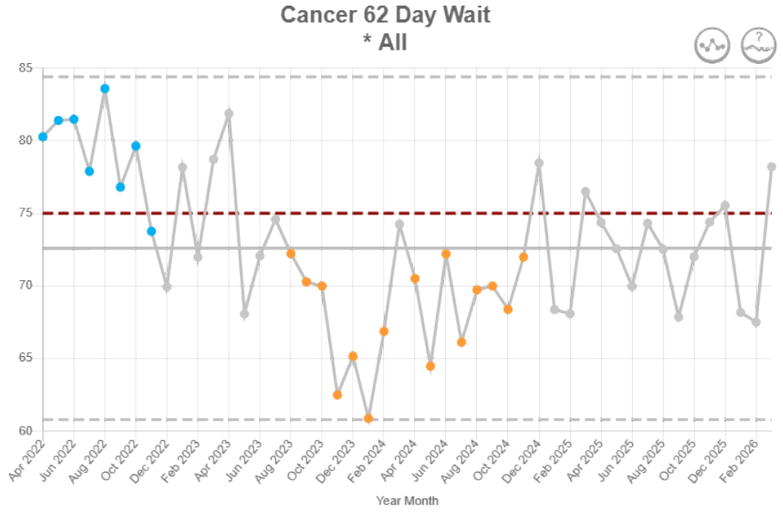
March 2025 – 85.26%
Common cause variation of a **concerning** nature



March 2026 – 98.52%
Common cause variation



March 2026 – 78.21%
Common cause variation



Analysis

March performance against the 62 Day standard exceeded plan of 75% at 78.7% following a significant reduction in the backlog in February. 28-Day performance has met target in each of the last three months.

Risks, Mitigations and Assurance

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.
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.

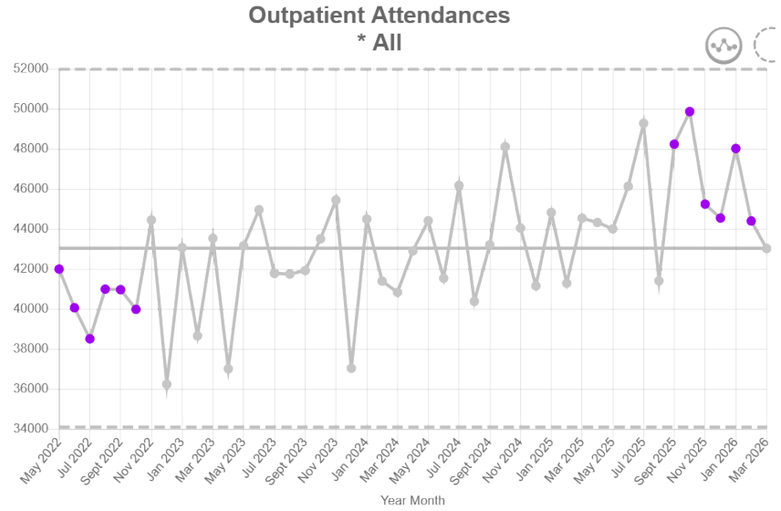
Benchmarking

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

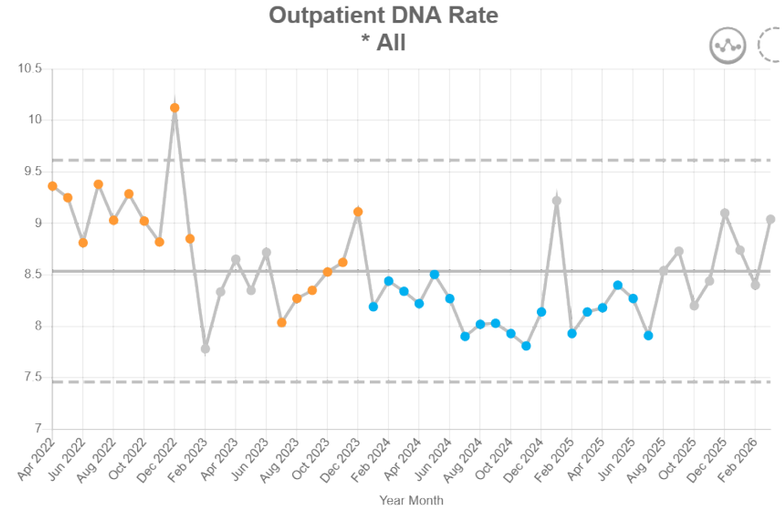
Performance – To deliver our key performance targets and finance plan

Bradford Teaching Hospitals NHS Foundation Trust

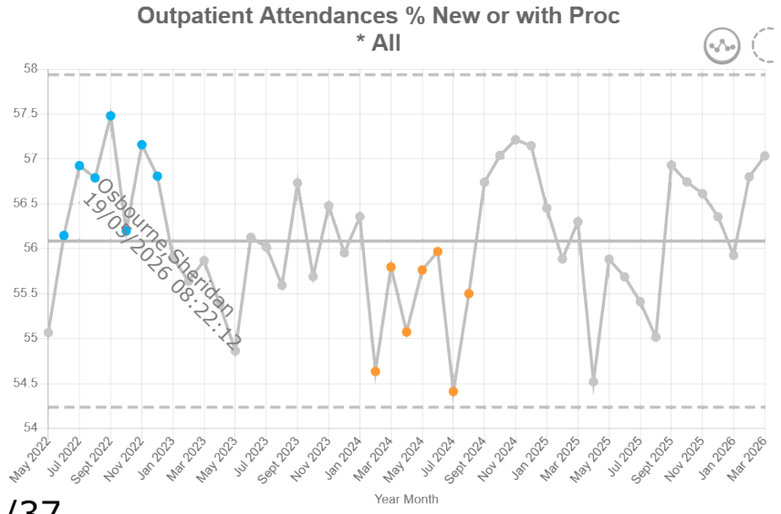
March 2026 – 43,045
Common cause variation



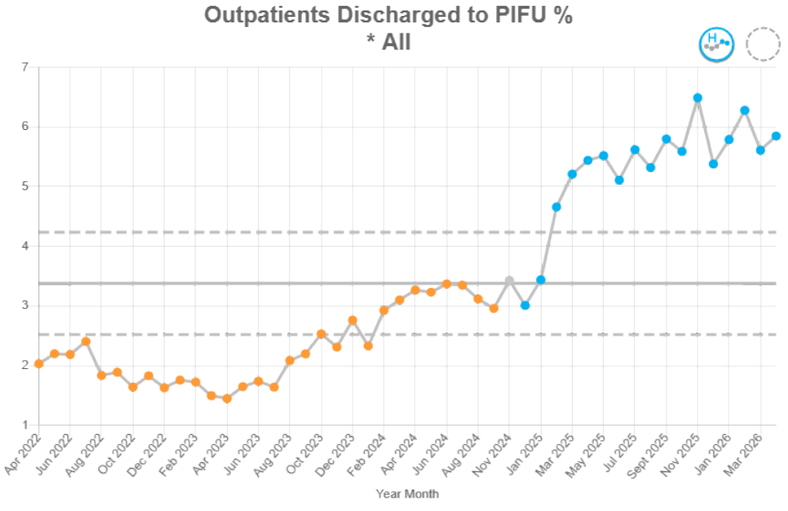
March 2026 – 9.04%
Common cause variation



March 2026 – 57.03%
Common cause variation



April 2026 – 5.85%
Special cause variation of a **deteriorating** nature



Analysis

Note: charts not up to date. New outpatient appointments (ERF) were above plan. Service level plans have been reviewed jointly by CSU and central operational teams to identify year one productivity objectives, this KPI will be tracked weekly within recovery meetings.

Risks, Mitigations and Assurance

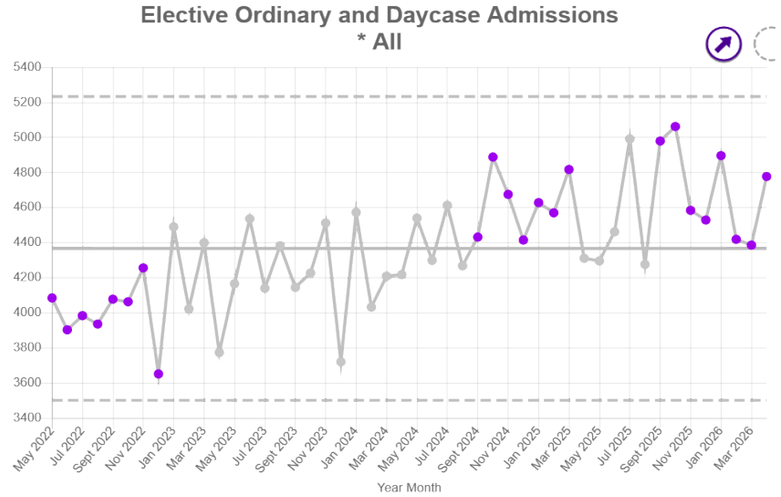
Outpatient Transformation will remain focused on service-led pathway redesign supported by digital advancement, estate modernisation, and alignment of support processes. A straight to A&G process has been rolled out in several areas already with promising reduction in referrals. Optimising referrals and organising diagnostic capacity so patients present with all available information will continue as a focus.
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. A working group focusing on Outpatient Optimisation has been set up and will first aim to improve productivity by analysing job plans and clinic templates.
The related Income and Activity workstream is working on ensuring this activity is recorded accurately and as timely as possible so that both the waiting list and income benefits are realised.

Benchmarking

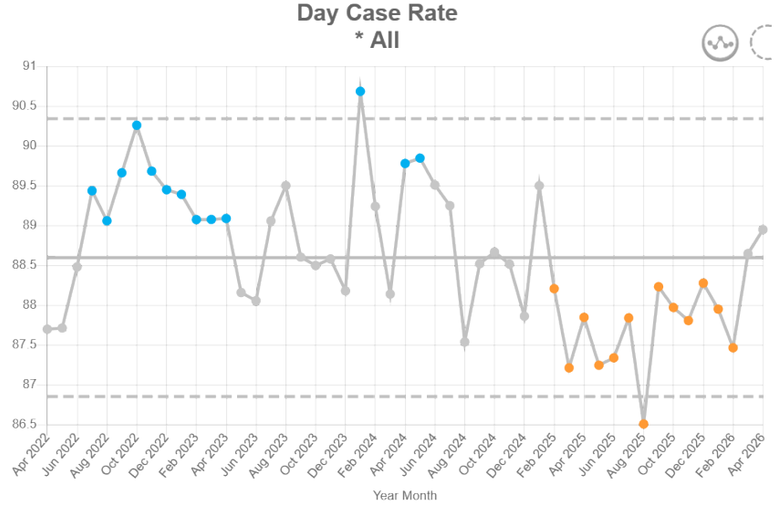
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Bradford Teaching Hospitals NHS Foundation Trust

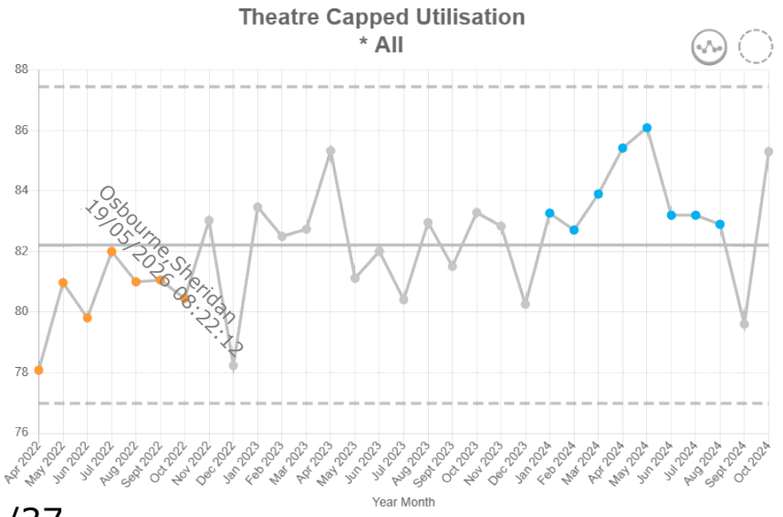
April 2026 – 4,778
Common cause variation



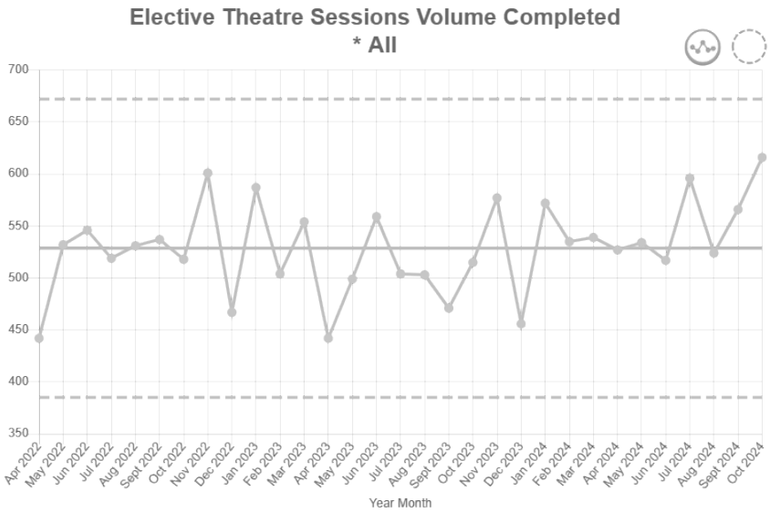
April 2026 –88.94%
Common cause variation



October 2024 – 85.3%
Common cause variation



October 2024 – 616
Common cause variation



Analysis

Activity exceeded plan in April although theatre activity was slightly below plan due to industrial action. The capacity gap from the SLH DCU delay continues to be supported using Bronte Forward Wait Theatre and Medinet weekend lists, with this metric increasing towards plan.

Risks, Mitigations and Assurance

The Theatre Improvement Programme has commenced, structured around four strategic workstreams: Workforce, Utilisation, Pre-Assessment, and SLH DCU. With staff and patient experience as the overarching framework for continuous learning and operational excellence.
Significant improvements can be seen in the number of weekly theatre sessions running however patients treated remains below plan. The Theatre Improvement Programme is the primary vehicle for driving these gains, specifically through improvements in scheduling, theatre and ward efficiency and on the day cancellations.
Endoscopy are due to move out of theatres and into the Endoscopy unit in June which will provide an additional theatre session to Trauma & Orthopaedics.
A data improvement structure is in place to help meet reporting and service user needs related to Theatres and the TACC element of our EPR, whilst addressing DQ issues through training and process redesign.

Benchmarking

Benchmarking via model hospital has identified some DQ issues that need resolving before a fair comparison is made.

People – Renee Bullock

Bradford Teaching Hospitals NHS Foundation Trust

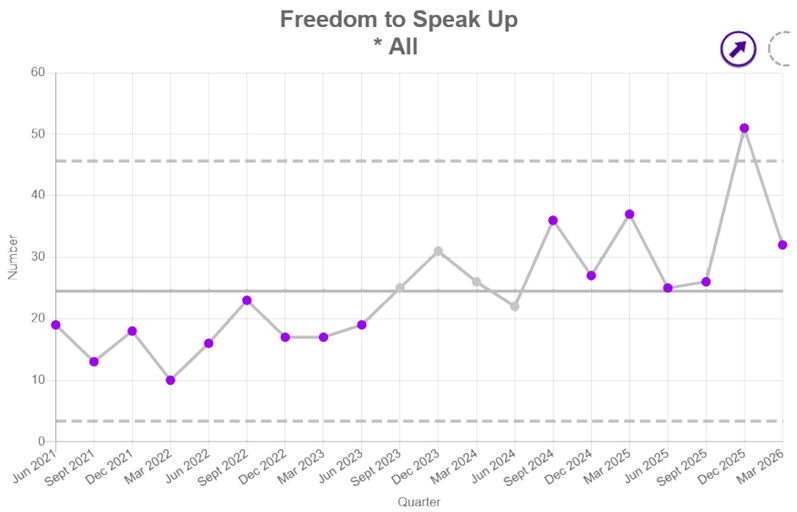
Metric	Period	Latest Value	Target	Variation	Assurance	Mean
Agency - %	Mar-26	0.61%				2.10%
Appraisal Rate - Non-Medical	Mar-26	79.9%	85%			75.36%
BAME Split - Band 8+	Mar-26	21.1%	39%			17.45
BAME Split - Bands 1-5	Mar-26	53.1%	39%			43.91
BAME Split - Bands 6-7	Mar-26	32.0%	39%			25.57
BME - * All	Mar-26	45%	39%			38.47
Core Manadatory Training - * All	Mar-26	93.0%	85%			90.90%
Disability Declaration - * All	Mar-26	6.4%				3.9%
Freedom to Speak Up - * All	Jan 26 - Mar 26	32				21.00
Harrassment and Bullying - Disciplinary Action	Oct 25 - Mar 26	3				0.67
Harrassment and Bullying - Informal Action	Oct 25 - Mar 26	0				3.00
Harrassment and Bullying - In-progress	Oct 25 - Mar 26	16				7.00
Harrassment and Bullying - No Case To Answer	Oct 25 - Mar 26	8				3.00
Harrassment and Bullying - Resigned	Oct 25 - Mar 26	2				0.67
Harrassment and Bullying - Total Investigations	Oct 25 - Mar 26	29				14.33
Job Planning - Allied Health Professionals	Mar-26	40.0%				49%
Job Planning - Medics	Mar-26	63.0%	90%			25%
Job Planning - Nurses	Mar-26	3%				60%
Nursing Agency Fill Rate - %	Mar-26	6.1%				11.8%
Nursing Bank Fill Rate - %	Mar-26	69.4%				50.6%
Staff Advocacy - Contacts	Oct 25 - Mar 26	19				14.00
Staff Advocacy - Contacts Not Resolved	Oct 25 - Mar 26	0				0.00
Staff Advocacy - Formal Complaints/Investigations	Oct 25 - Mar 26	5				0.67
Staff Advocacy - In-progress	Oct 25 - Mar 26	0				0.67
Staff Advocacy - Outcome Unknown	Oct 25 - Mar 26	3				0.33
Staff Advocacy - Resolved Informally	Oct 25 - Mar 26	9				9.00
Staff Sickness - * All	Mar-26	6.46%	5.50%			6.3%
Staff Stability - * All	Mar-26	99.40%				98.8%
Staff Turnover - * All	Mar-26	10.44%	10%			11.1%

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

Bradford Teaching Hospitals NHS Foundation Trust

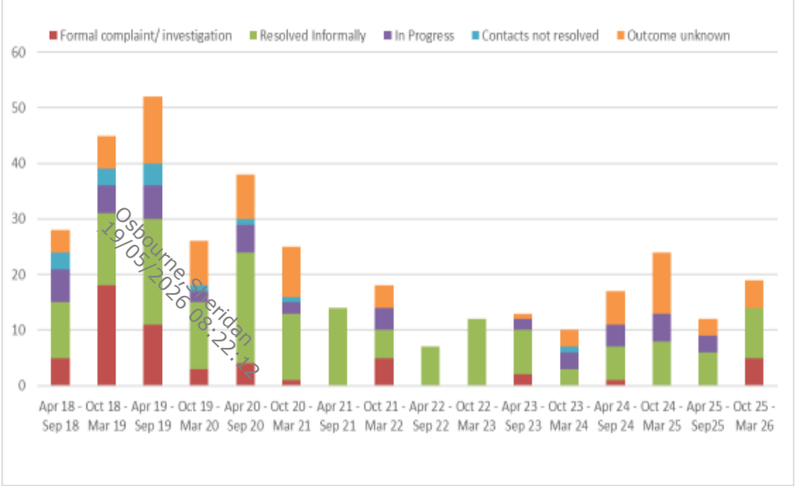
2025/26 Quarter 4 - 32



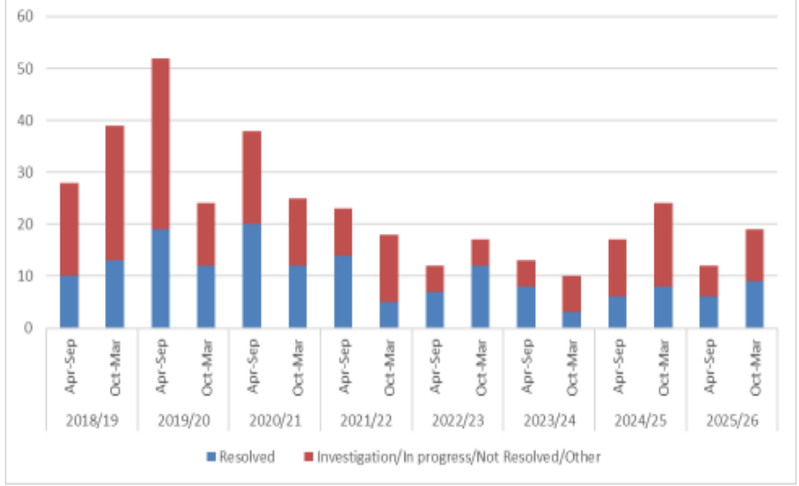
2025/26 April to March– Staff Advocacy

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 - Sep25	12	0	6	3	0	3
Oct 25 - Mar 26	19	5	9	0	0	5

2025/26 Quarter 4 Harassment and Bullying



2025/26 April to March –Staff Advocacy



Analysis

Harassment & Bullying: There has been an increase from 19 to 30 cases 'in progress' during the last 6-month period (from October 2025 to March 2026) and a number of cases have seen delays due to e.g. annual leave/ sick leave. However, there has also been an 8% increase in the number of outcomes with 3 cases resulting in disciplinary action, but also an increase from 5 to 8 cases resulting in "no case to answer" and 2 resignations. Data refreshed 6 monthly.

Contacts with staff Advocacy Service: The demand for staff advocates has increased by 58% over the last 12 months with 19 staff accessing the service since November 2025, including support for 5 formal cases. The service continues to have a positive impact with 47% of cases being resolved informally between October 2025 and March 2026.

Freedom To Speak Up: There were 32 concerns raised to the FTSU team in Q4. The highest category of concerns (20) had an element of worker safety or wellbeing and there were 11 concerns raised that had an element of other inappropriate attitudes or behaviours. This quarter, the highest group of staff raising concerns were additional clinical services which include staff directly supporting those in clinical roles, e.g Health care assistants. There were 5 concerns reported anonymously in Q4 via the FTSU App.

Risks, Mitigations and Assurance

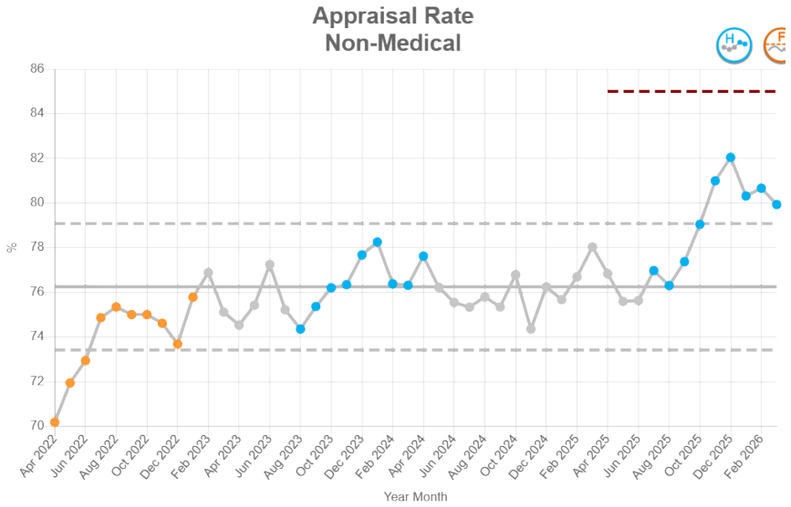
Harassment & Bullying Outcomes: Harassment & Bullying Outcomes: Colleagues are working collaboratively to develop a suite of training for managers and staff around developing cultures of Dignity & Respect in the workplace, including informal conflict resolution. Following our staff survey results, this will continue to be a key area of focus in the next 12 months as we launch the newly developed Respect, Civility & Resolution policy.

Despite a significant reduction in number of staff advocates over the last few years, they continue to have a positive impact on staff experience through the support and guidance they provide, and the service continues to receive positive feedback. We are currently recruiting/ training new advocates to increase the capacity of the service and to ensure we have staff advocates reflecting the demographics of our workforce.

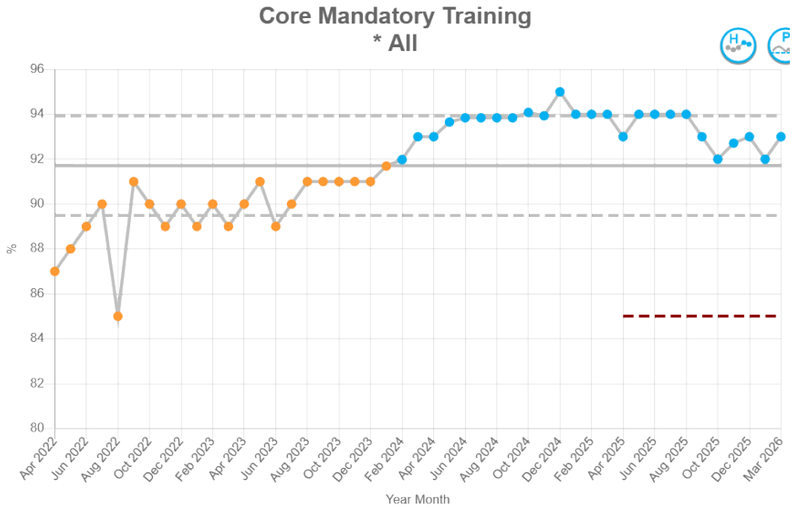
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

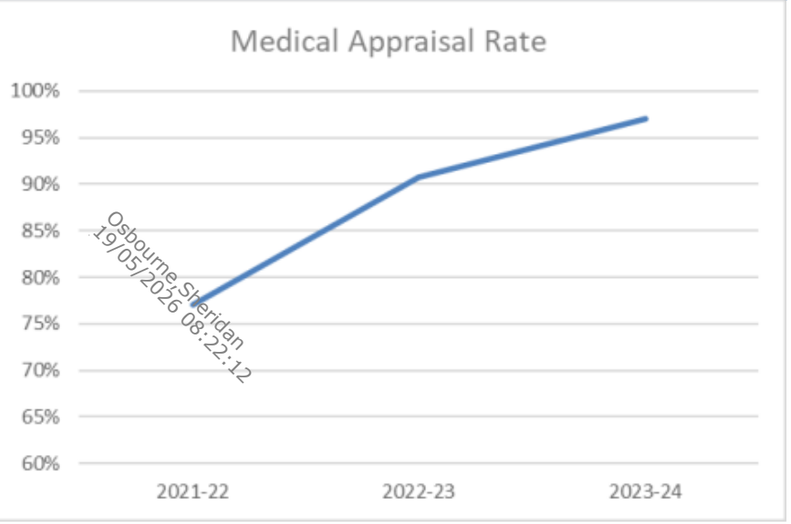
March – 79.93%
Special cause variation of an **improving** nature



March 2026 – 93%
Common cause variation



March 2024 – 97%



Analysis

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

Appraisal
Since April 2024 the target for non-medical appraisal has been set at 85%.
Appraisal compliance has increased slightly during September 2025, to 77.4%.
Medical Appraisal Rate
Medical Appraisal year from 1st April 2024 to 31st March 2025: 488 (92.9%) doctors received an Outcome Measure 1 (Completed appraisal).
37 (7.1%) doctors were allocated an Outcome Measure 2 (Approved Missed appraisal).

Risks, Mitigations and Assurance

Core Mandatory Training
Overall compliance for March was 93%, 1% increase from February. The majority of subjects maintained compliance from last month.
Basic Life Support compliance dropped by 4% to 77%. Areas with low compliance will be targeted with ad hoc insitu training provided.

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.

In April 2026, the OD team commenced an internal audit to ensure consistency and compliance with Dynamic Conversations and Dynamic Conversation Appraisals. Over 100 colleagues have been contacted to participate. Responses are being analysed, and bespoke training sessions are being offered in areas where the incorrect process is being used or there is variability in quality. In May, Audit Yorkshire will commence their audit of non-medical appraisals.

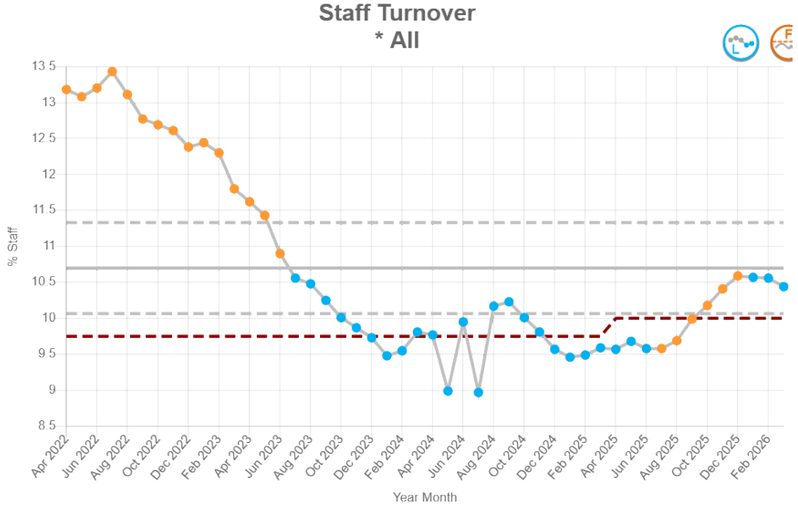
Monthly training sessions are also being held online, at BRI and at SLH – these are well attended, and feedback is positive. Going forward, this will also be delivered as a core module as part of the 'Thrive Management Essentials' programme of development for managers.

Appraisal compliance has decreased slightly this month, to 79.9% (last month: 80.7%)

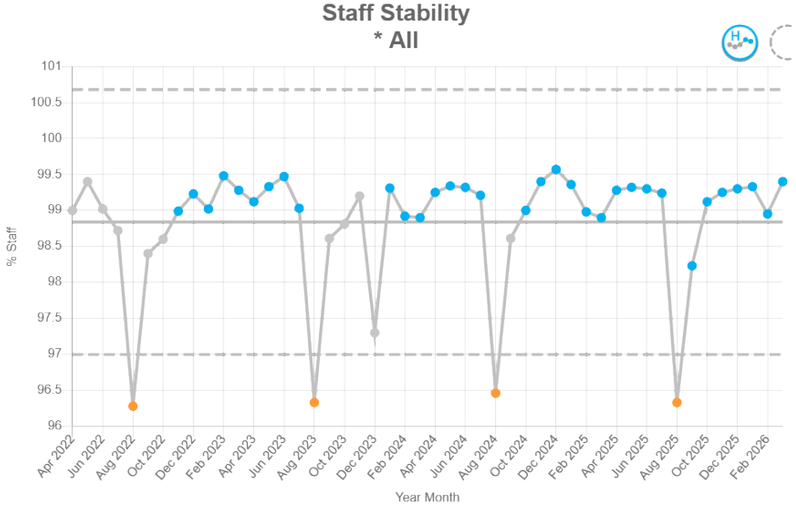
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

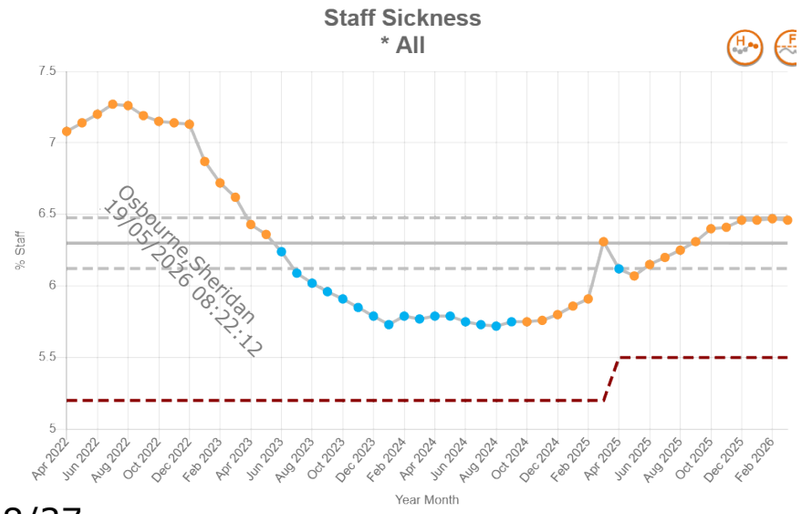
March 2026 – 10.44%
Special cause variation of an **improving** nature



March 2026 – 99.40%
Common cause variation



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



Analysis

Sickness
Since August 2024 the Trust has seen an increase in sickness absence levels with monthly rates consistently between 6% and 7%. As March 2026 sickness remains high across the Trust with the monthly sickness rate at 6.14% and the year-to-date sickness figure at 6.46%.
The staff groups with the highest sickness rates as at March 2026 are Estates & Ancillary at 9.36%, Additional Clinical Services at 9.04%, Additional Professional Scientific and Technical at 6.77%, Admin & Clerical at 6.04%, Allied Health Professionals at 5.74%, and Nursing and Midwifery at 5.55%. The only staff groups whose sickness remains below target in March 2026 were Healthcare Scientists and Medical & Dental with rates of 1.83%, 2.62% respectively.
The overall YTD sickness % has remained consistently above 5.5%. In February 2025 we saw a spike in absence figures, followed be 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.

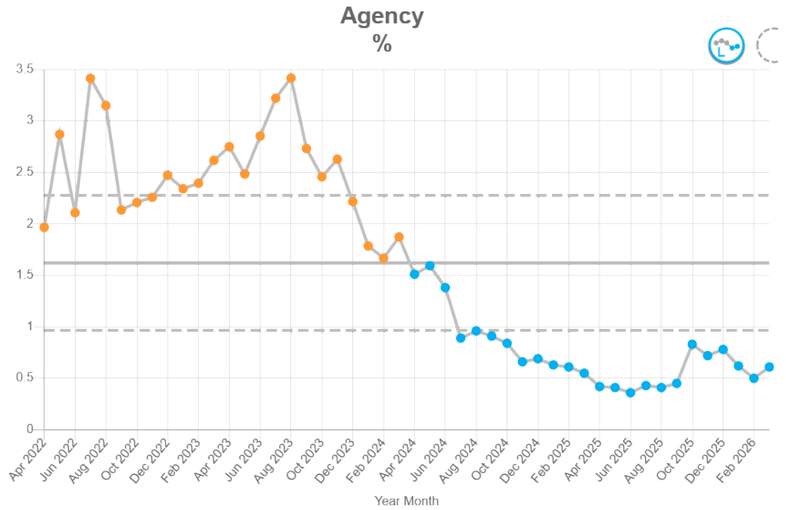
Turnover & Stability
There has been a slight reduction in turnover in March 2026 with the rate now being below 10.5% but it remains relatively static when compared to previous months. It remains below the Mean of 99.30%
The stability index shows the percentage of all colleagues including rotational doctors 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. The stability index remains at 99.5%

Risks, Mitigations and Assurance

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

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

March 2026 – 0.61%
Special cause variation of a **deteriorating** nature



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NHS Foundation Trust

Analysis

Agency
There has been an increase in agency in March compared to February

The increase is in theatres; all other areas remain stable

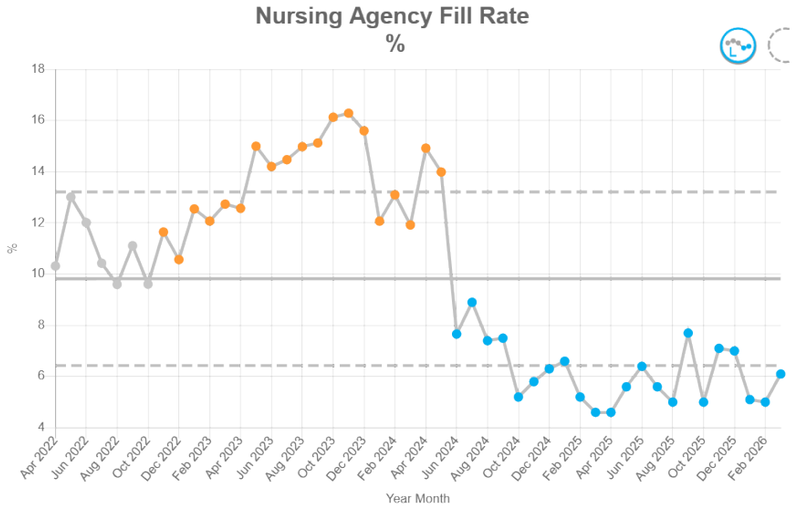
Risks, Mitigations and Assurance

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.

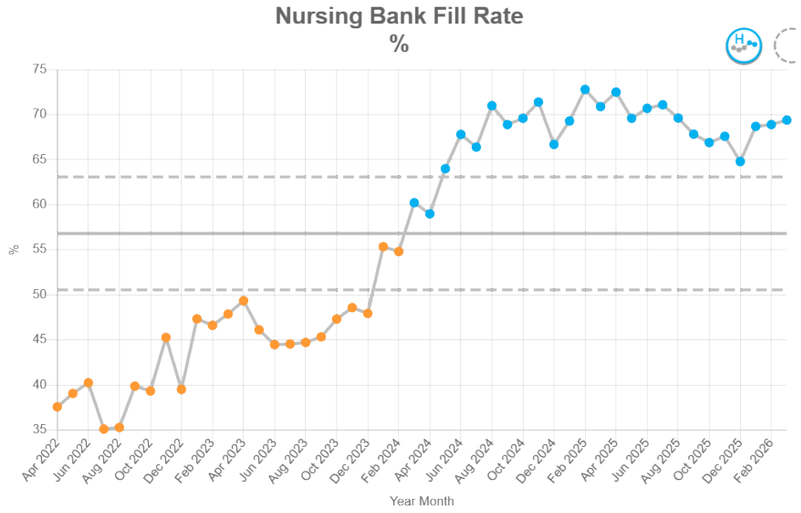
People – Engagement – To be in the top 20% Employers

Bradford Teaching Hospitals
NHS Foundation Trust

March 2026 – 6.10%
Special cause variation of an **deteriorating** nature



March 2026 – 69.40%
Special cause variation of an **deteriorating** nature



Analysis

Bank Staffing Nursing
In March, the total number of requests sent to bank was 9895 compared with February requests of 9175 an increase of 720 requests. This is split as 4148 requests for registered staff and 5747 requests for unregistered staff. Of those 4148 registered requests a total of 2879 were filled by bank staff which is 69.4% compared with 68.9% in January an increase of 0.5%. Out of the 5747 requests for unregistered staff 3470 were filled by bank which is 60.4% compared to February which was 64.9% a decrease of 4.5%.

Agency Nursing
Agency shifts filled for March were 251. This is split 251 registered and 0 unregistered staff. Out of the 251 filled registered shifts, 114 were filled with registered theatre staff. In March Agency fill rates increased overall from February by 1.1% for registered staff, unregistered remains at zero usage. This is due to increased demand in Theatre's.

Risks, Mitigations and Assurance

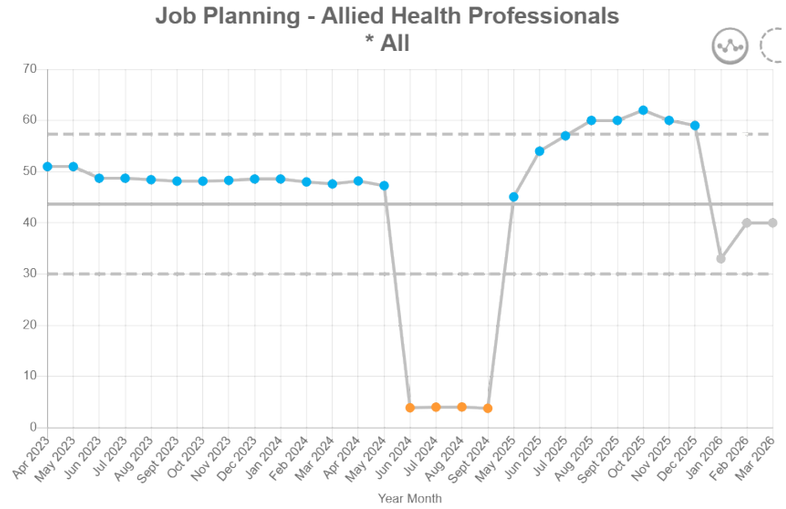
From the 20th November 2023 a new nursing agency approval process was put in place to give assurance around agency use for nursing. Reports are being shared on a monthly basis with Nursing workforce lead.

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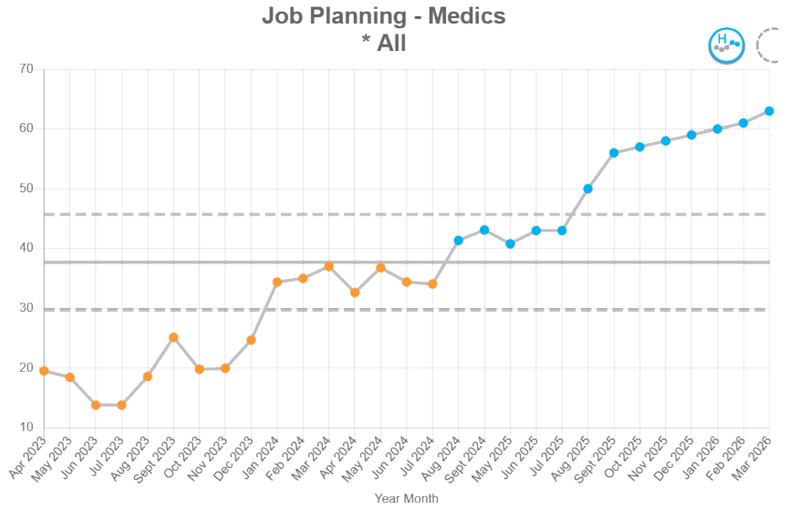
People – Engagement – To be in the top 20% Employers

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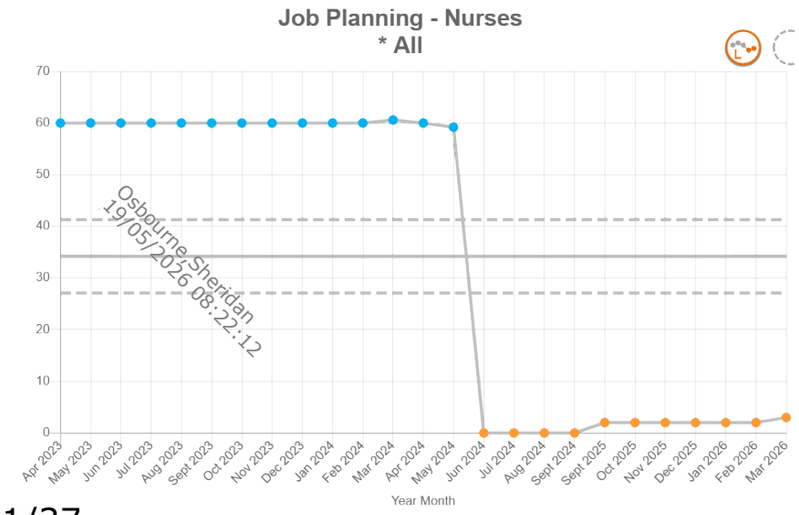
March 2026 – 40%
Special cause variation of an **improving** nature



March 2026 – 63%
Special cause variation of an **improving** nature



March 2026 – 2.0%
Special cause variation of a **improving** nature



Analysis

Medics – Medics – There are currently 462 Medics registered within the system and 291 signed off, which is 63%.

AHP – There are currently 428 AHPs registered within the system and 170 are signed off, which is 40%.

CNS – There are currently 257 CNSs registered within the system and 7 signed off, which is 3%.

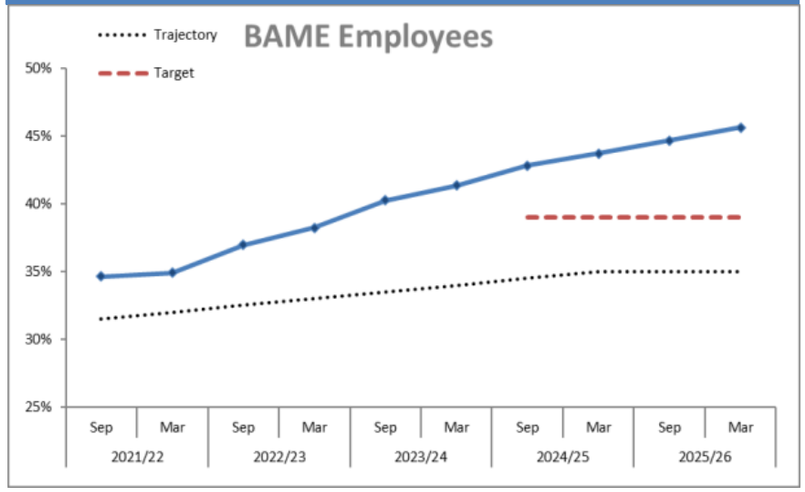
Risks, Mitigations and Assurance

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.

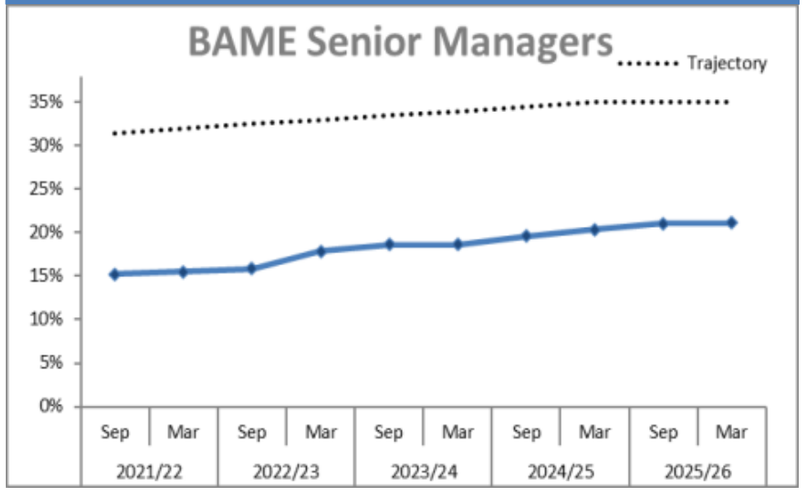
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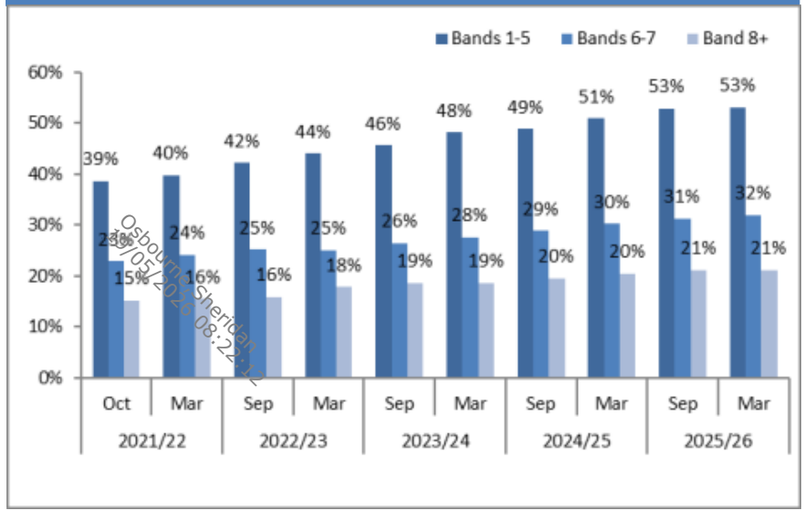
2025/26 Quarter 4 - 45.61%



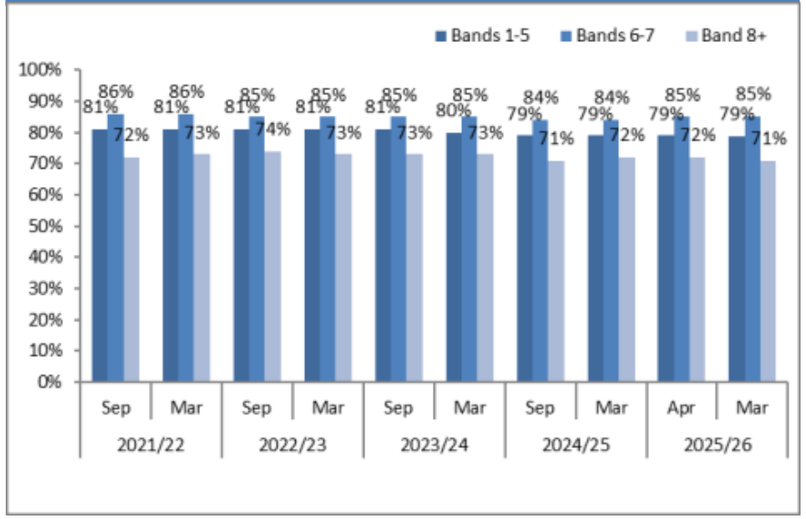
2025/26 Quarter 4 – 21.12%



2025/26 Quarter 4 – BAME employee % by band



2025/26 Quarter 2– Female workforce by band group



Analysis

The proportion of Ethnic Minority employees in the workforce continues to increase rising from 45% to 46% in the last 6-months as we continue to exceed our target of having an overall workforce reflective of the local population (39%). Representation at Senior Management level (Band 8a+) has remained fairly static at 21% (with just a 0.2% increase in the last 6-months). An increase of 1% has been seen at Bands 1-5 (to 53%), perpetuating the over-representation at lower bands, but also a 1% increase for Bands 6-7 (to 32%) which is positive.

With 77% women in the workforce as a whole; women continue to be over-represented in the lower to middle bands (with no change over the last 6-months). We have also seen a 1% decrease (from 72% to 71%) of women represented at more senior levels (Bands 8a+/ VSM).

Risks, Mitigations and Assurance

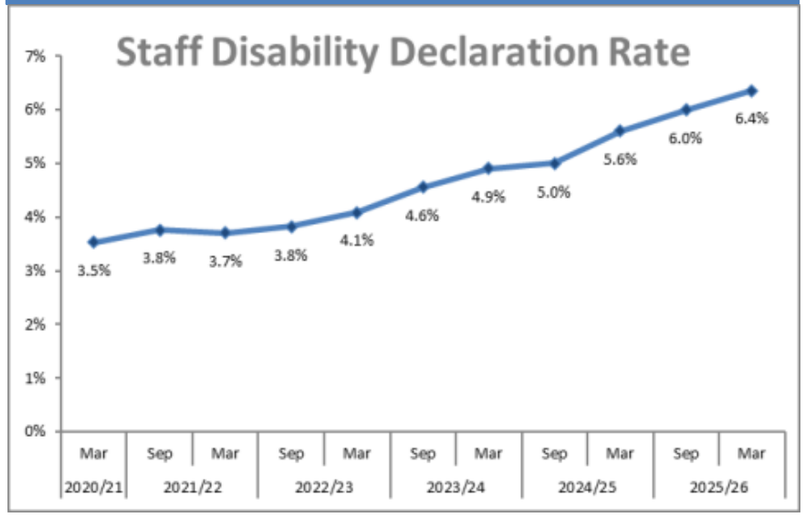
We know that achieving our ambitions around senior leadership representation continues to an area of focus. In 2025 (as part of the new People Strategy Launch) we set ourselves a refreshed target of 28% representation at Bands 8a+ by Sept 2027 and our activity over the next 12 months will be pivotal in achieving this target and a key element in our refreshed WRES action plan for 2025/2026. 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 continue to raise the profile of gender equality across the Trust and have developed a work plan to address some of the disparities for female colleagues. A series of task & finish groups have been set up to explore some of the data and insights, to better understand the impact of intersectionality and how we can most effectively address these inequalities. Another group will develop actions around career development/ talent management and addressing blockages to development.

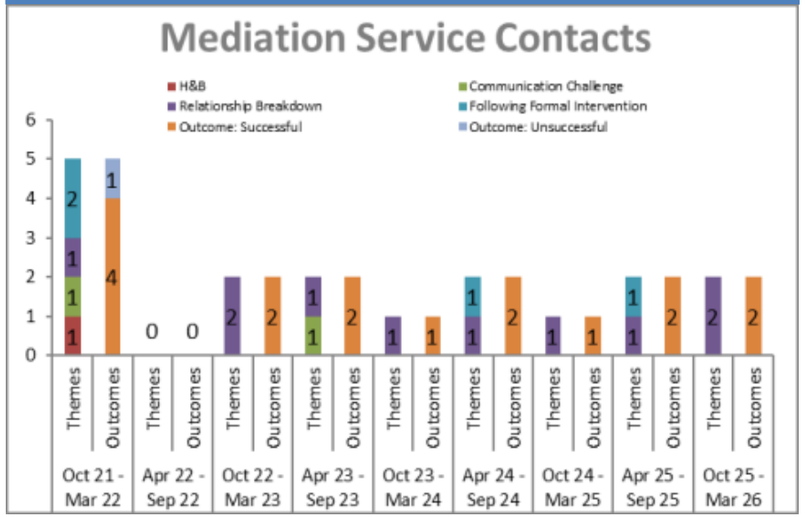
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NHS Foundation Trust

2025/26 Quarter 4 – 6.4%



2025/26 Quarter 4



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 0.53 in the last 6 months but still remains around to 6%.

2 mediations have taken place since the last update (with successful outcomes for all parties). 1 further case is still ongoing and there were 2 further cases that did not go to mediation as after initial discussions, they were resolved outside the process.

Risks, Mitigations and Assurance

Disability Declaration: Whilst the 20245staff survey results only represent 430% of our workforce, there continues to be a much higher proportion of staff survey respondents (c. 25% in 2025) 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, who have developed an ambitious work plan under the leadership of their new network chair. In addition to this, our WDES action plan provides considerable focus to improving the experience of colleagues with a disability or long-term health condition, which we hope will drive up declaration rates. We are currently reviewing and refreshing our disability equality policy and will continue to 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.

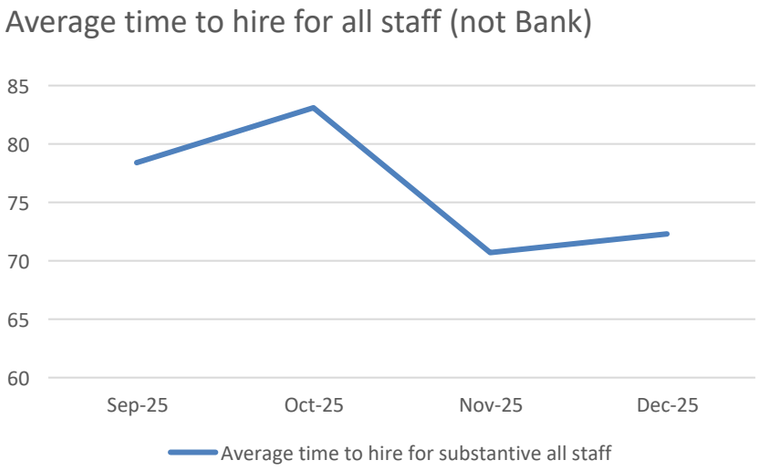
Mediation continues to provide a crucial role in supporting staff to deal with any workplace disagreements/conflict and is an important tool for 'nipping issues in the bud' and repairing relationships that may have been damaged by long standing issues or formal processes. The mediation service will become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

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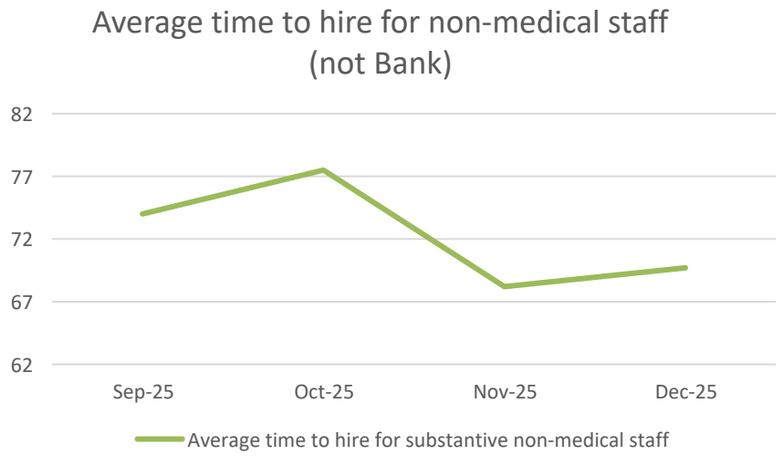
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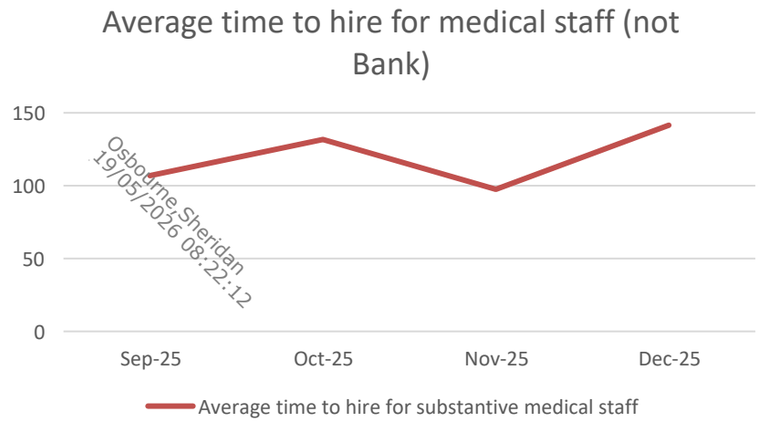
December 2025 Total substantive staffing – 72.3 working Days
Special cause variation of an **improving** nature



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



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



Analysis

Time to hire for March 26 (AfC) currently stands at 87.7 This data reflects Advert Close to Candidate Start date. February saw 90 candidates starting within month and others with agreed start dates in the future. Pre-employment checks were completed for AfC staff in 34.1 days in March. This is a slight increase on previous months, but we have seen an increase in the time for OH to be cleared, and DBS applications to be completed. Contract Sent to Start Date increased this month, but this is determined by the length of notice a candidate needs to give and is therefore out of our control. The team currently has 3 staff redeployed to other HR teams to provide support, so we are working on reduced staffing which has an also has an impact.

March's Time to Hire for Medical has seen a slight increase to 83.6 days. The increase is primarily due to the time between Starting Letter & Contract Sent. There were pay disputes and CCTs that held up this part of the process but overall, the Medical figures remain stable. The introduction of the workflow rota has continued to lend to the improved processing times. The rota allows all workflows to be actioned daily, therefore ensuring that work is prioritised accordingly and bottlenecks are identified and addressed immediately. This was of working is streamlining the processes and creating more transparency within the team to better identify the current needs.

Risks, Mitigations and Assurance

Despite showing continuous improvements in our overall TTH figure, we are still striving to further reduce figures where we have direct influence over the TTH. We are continuing to review and monitor our processes and seek improvements. The Recruitment team continues to use "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 TTH and provide a better candidate experience.

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

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

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Committee Dashboard

Quality

April 2026

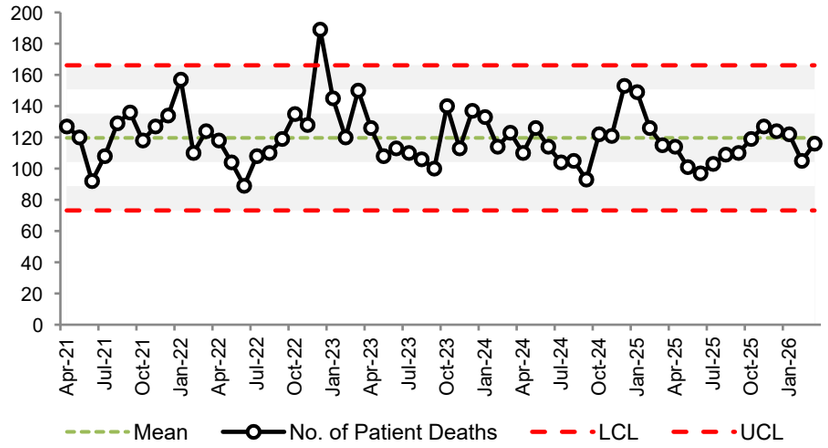
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Clinical Effectiveness - To provide outstanding care for patients

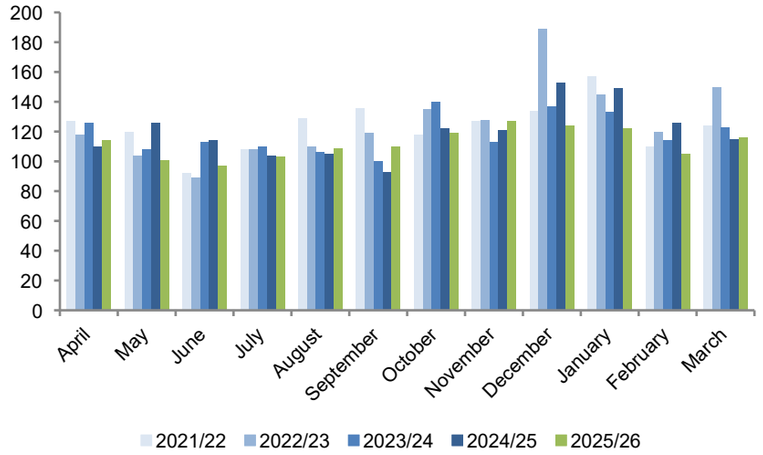
Bradford Teaching Hospitals NHS Foundation Trust

March 2026 – 116 Adult Inpatient Deaths

Adult Inpatient Deaths at BTHFT (*April 2021 - March 2026*)

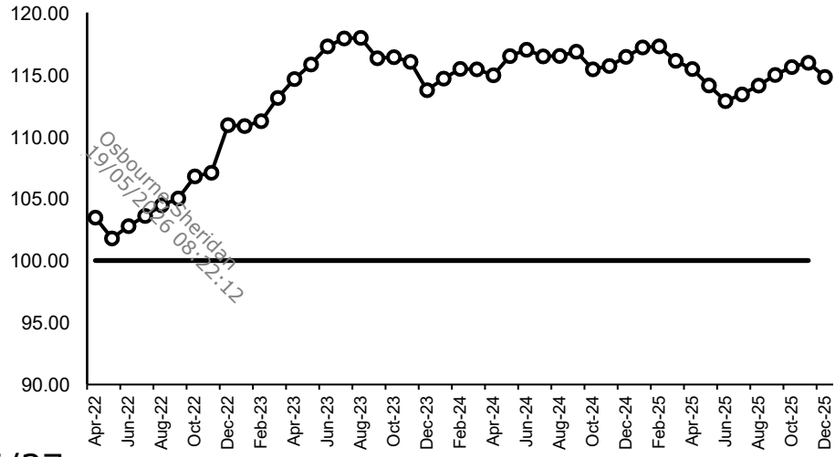


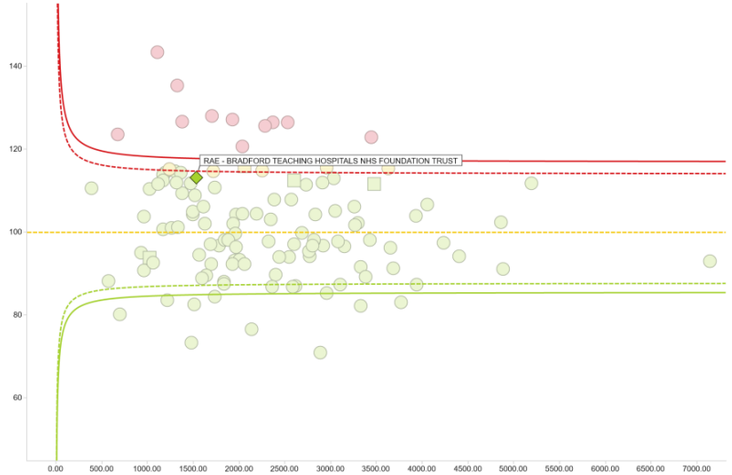
Number of Deaths by Month and Year (*April 2021 - March 2026*)



SHMI 12-month Rolling – 114.81 (*figure covering January 2025 – December 2025: Reported March 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 March 2026, the Trust saw 116 adult inpatient deaths. This is a slight increase but in line with what we observe at this time of year. We averaged 112 patient deaths per month for the year 2025/2026, our lowest annual average for the last five years.

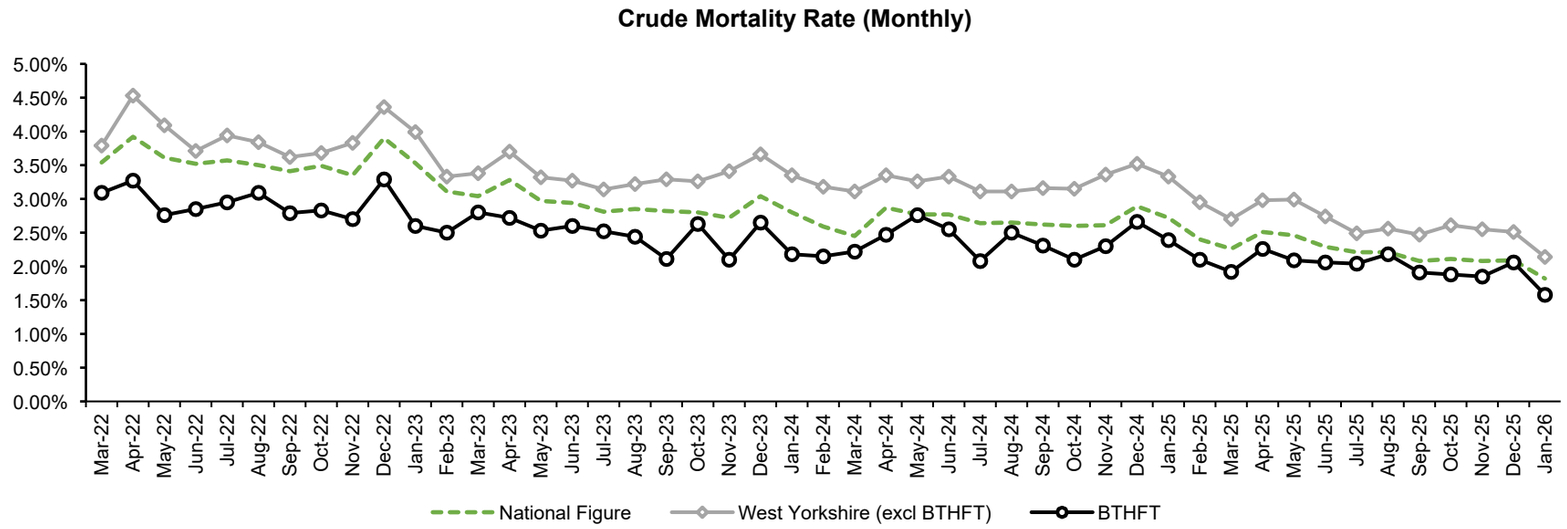
SHMI has decreased slightly to 114.81 and is within expected range.

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.

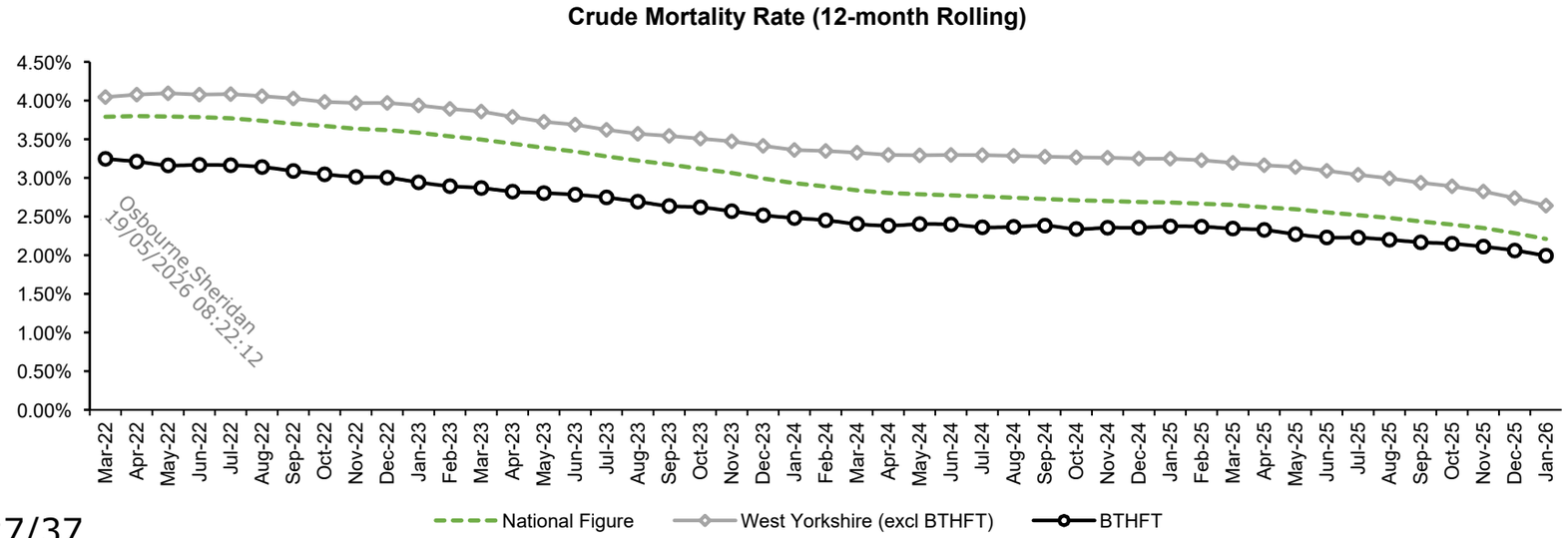
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Crude Mortality Rate (monthly) – 1.58% (*figure for January 2026: Reported March 2025*)



Crude Mortality Rate (12-month Rolling) – 1.99% (*figure covering February 2025 – January 2026: Reported March 2026*)



Analysis

Our crude mortality rate decreased to 1.58% for the month of December, the latest reported figure *(reported in March 2026)*. This rate is lower than the national figure (1.82%) 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 1.99%, 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 2.64%.

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.

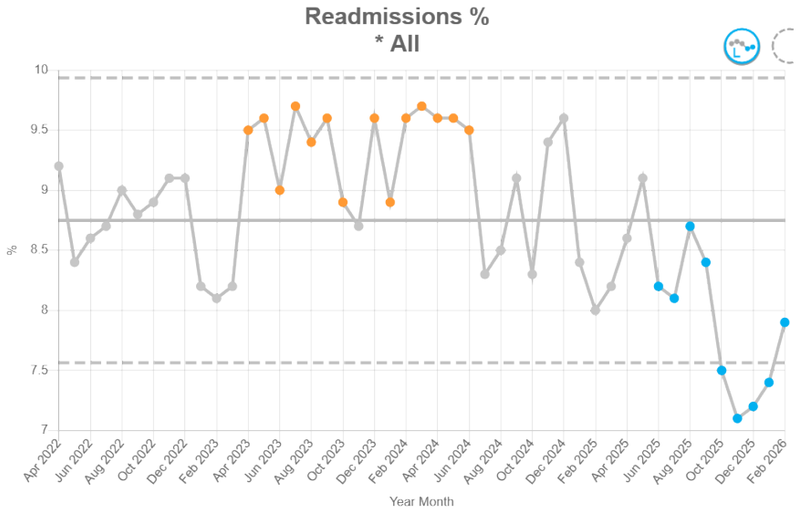
Since the discontinuation of HSMR by NHS England, the Learning from Deaths Team at BTHFT have chosen to focus on our crude mortality rates to balance against SHMI.

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

Bradford Teaching Hospitals
NHS Foundation Trust

February 2026 – 7.9%
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.

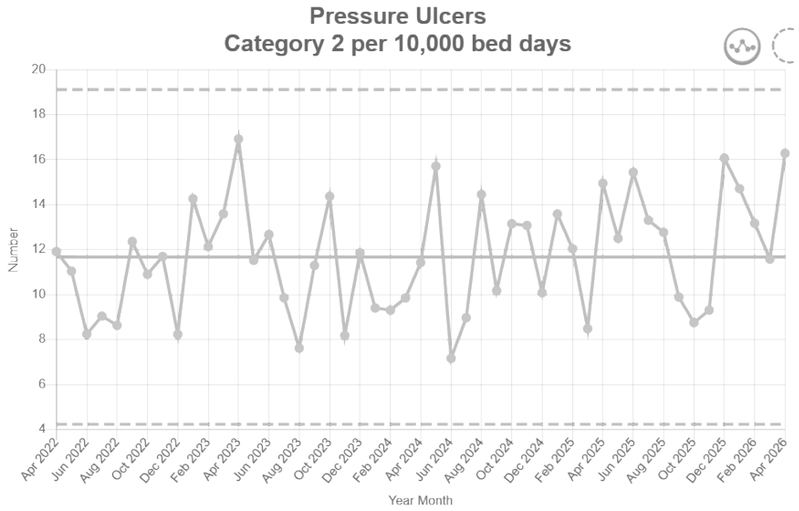
Learning, Improvement, Assurance

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.

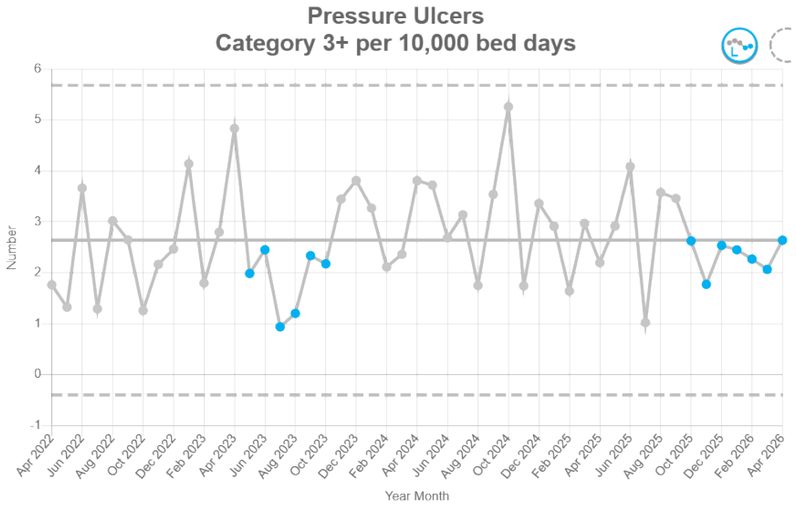
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

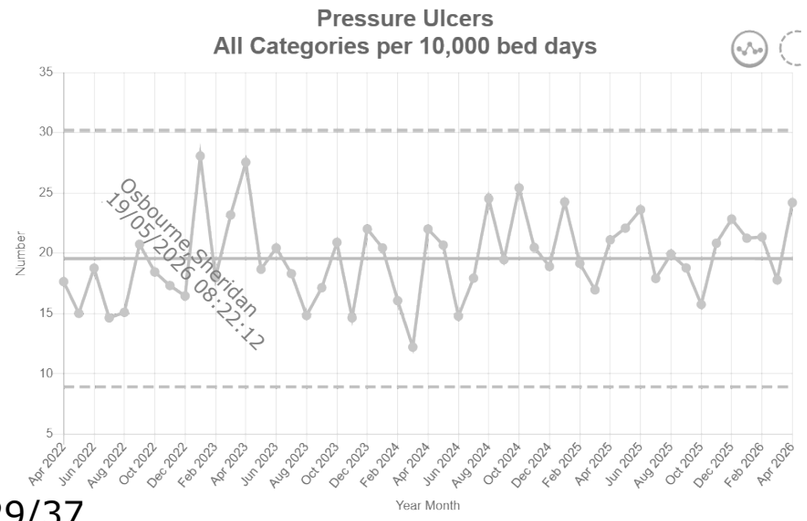
April 2026 – 16.27
Common cause variation



April 2026 – 2.64
Common cause variation



April 2026 – 24.19
Common cause variation



Analysis

In April the number of pressure ulcers per 10,000 bed days remained above the control limit. Category 2 and Category 3+ incidents have increase as well as incidents increased above the control limit.

Risks:

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

Learning, Improvement, Assurance

Mitigations:

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

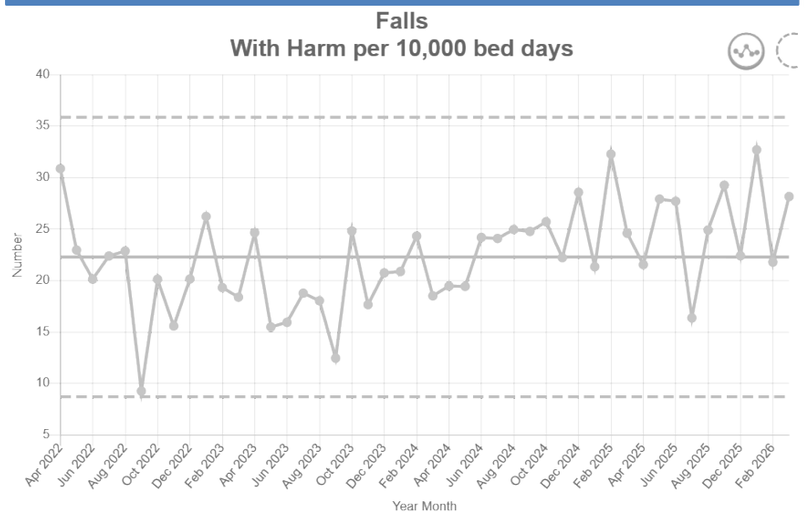
Assurance:

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

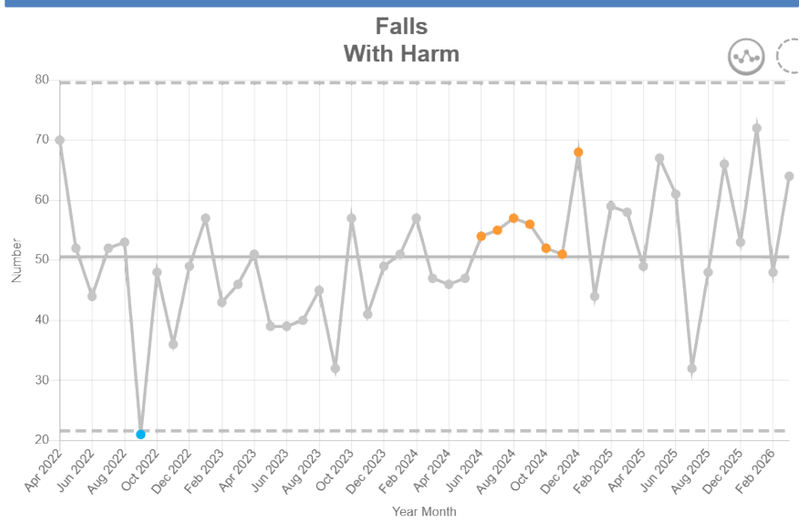
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

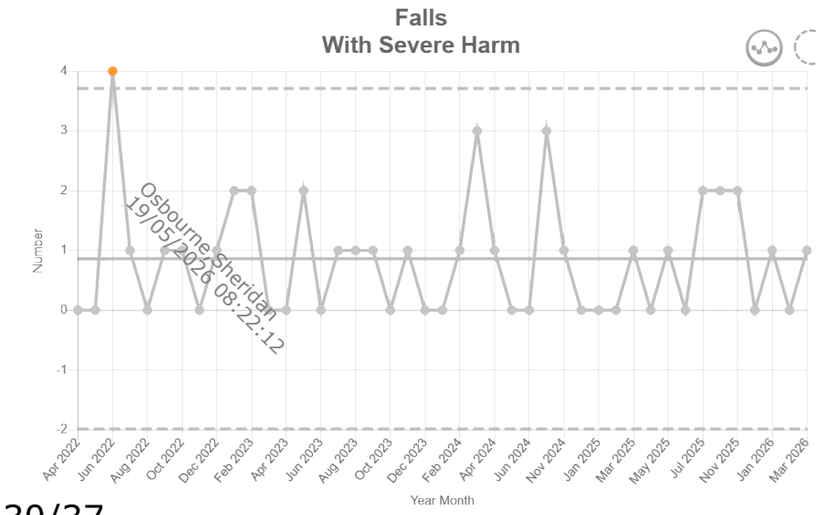
March 2026 – 28.15
Common cause variation



March 2026 – 64
Common cause variation



March 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.

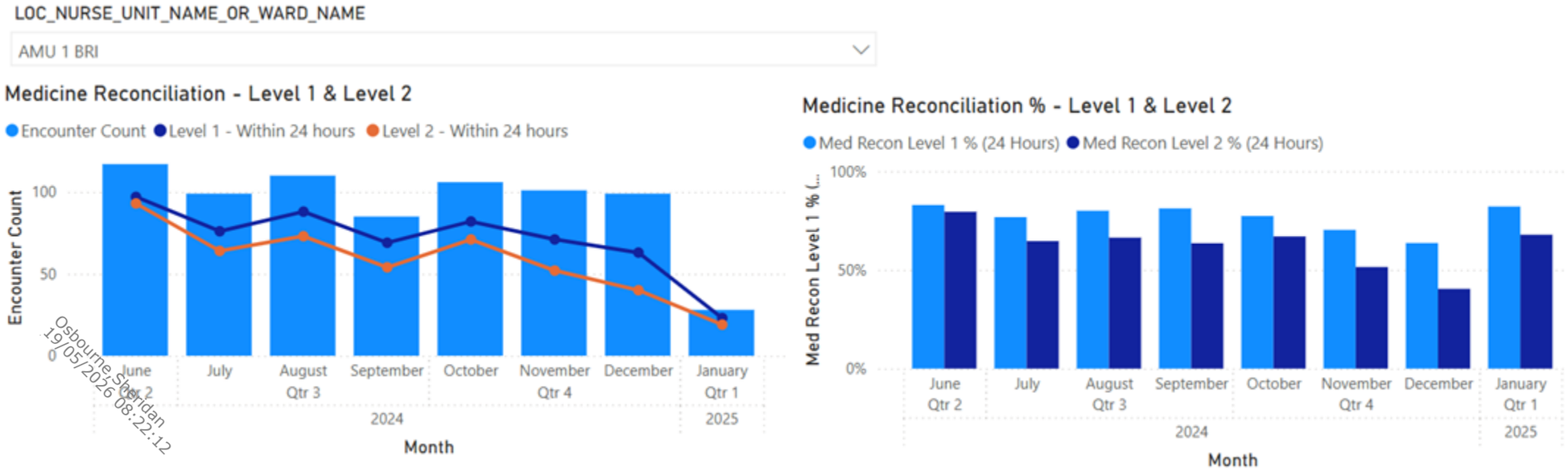
Proposed Medicines Management Metrics

Bradford Teaching Hospitals NHS Foundation 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:

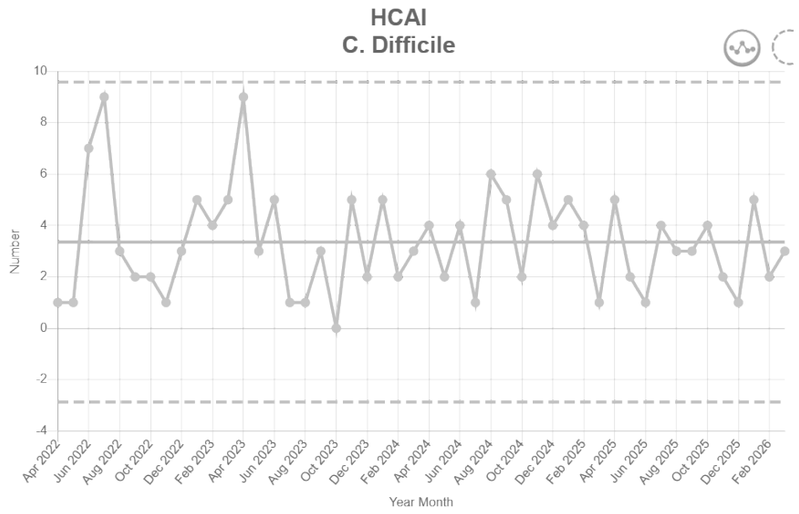


Please note that the data used for this representation is still undergoing validation and is not representative for this ward.

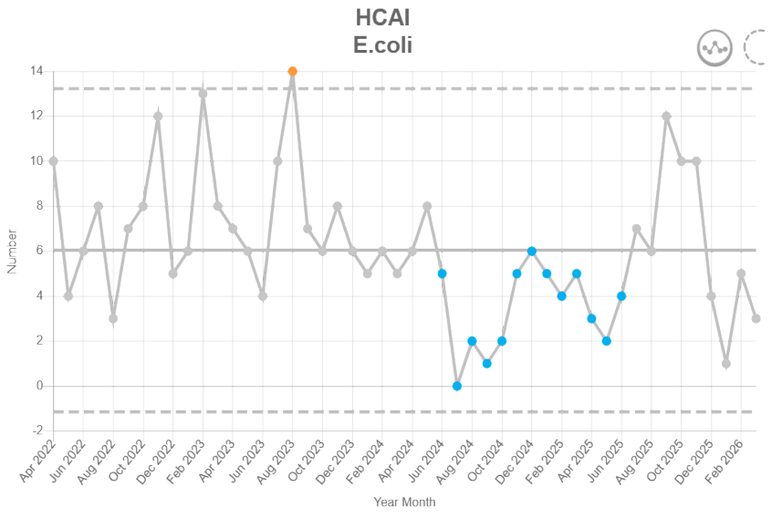
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

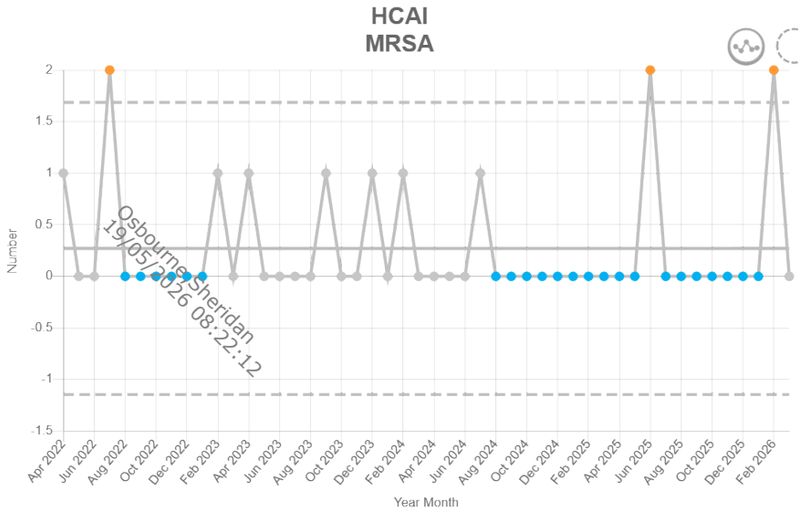
March 2026 – C. Diff Cases - 3



March 2026 – E. Coli Cases - 3



March 2026 – MRSA Cases - 0



Analysis

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

Clostridioles difficille 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 caried 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

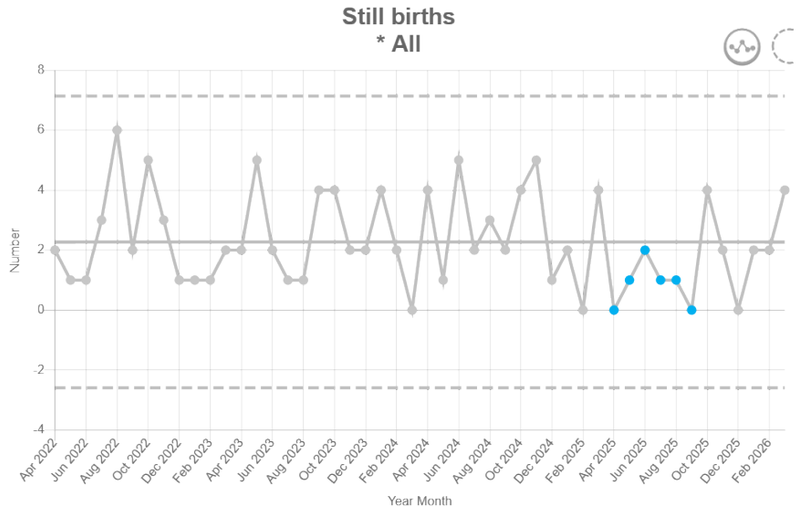
Bactearaemia Reduction plan

- 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

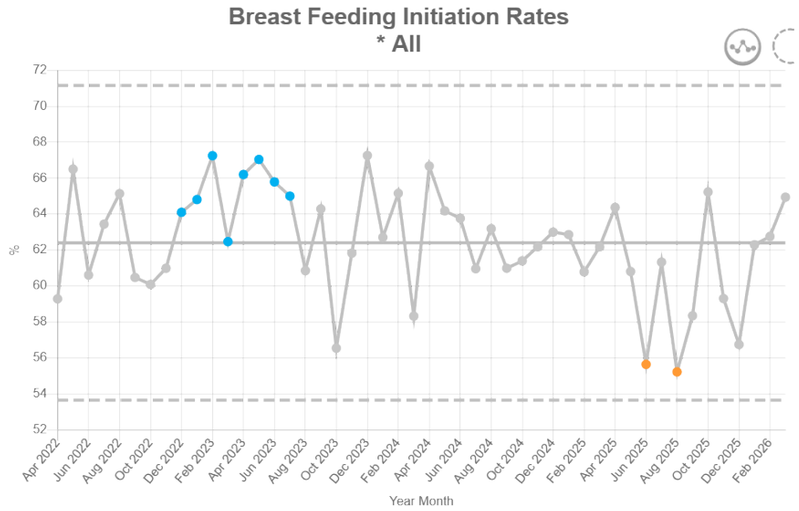
Clinical Effectiveness - To provide outstanding care for patients

Bradford Teaching Hospitals NHS Foundation Trust

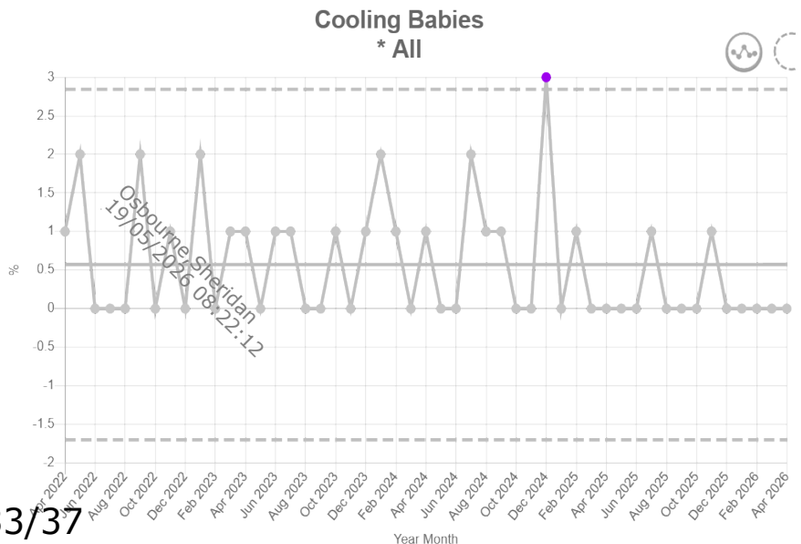
March 2026 - 4
Common cause variation

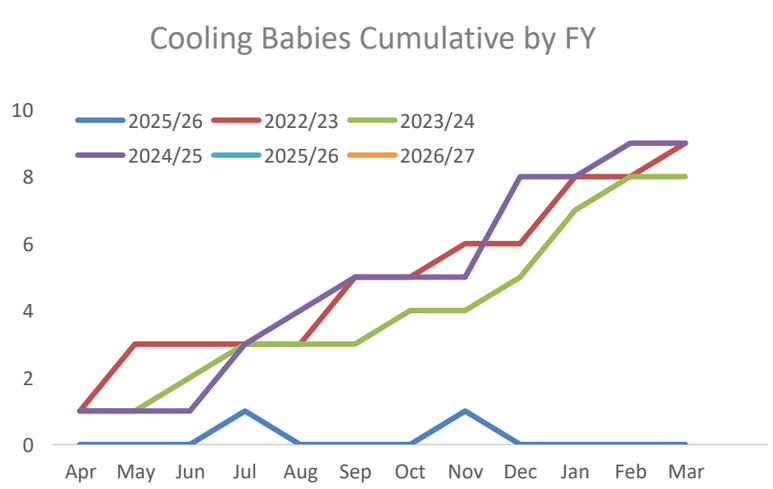


March 2026 – 64.94%
Common cause variation



April 2026 - 0
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.

Bradford Teaching Hospitals
NHS Foundation Trust

Academy Dashboard
Quality

Appendices

Osbourne Sheridan
19/05/2026 08:22:12

Key to KPI Variation and Assurance Icons

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

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

Special Cause Improvement - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special 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

Osbourne.Sheridan
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Further Reading / other resources

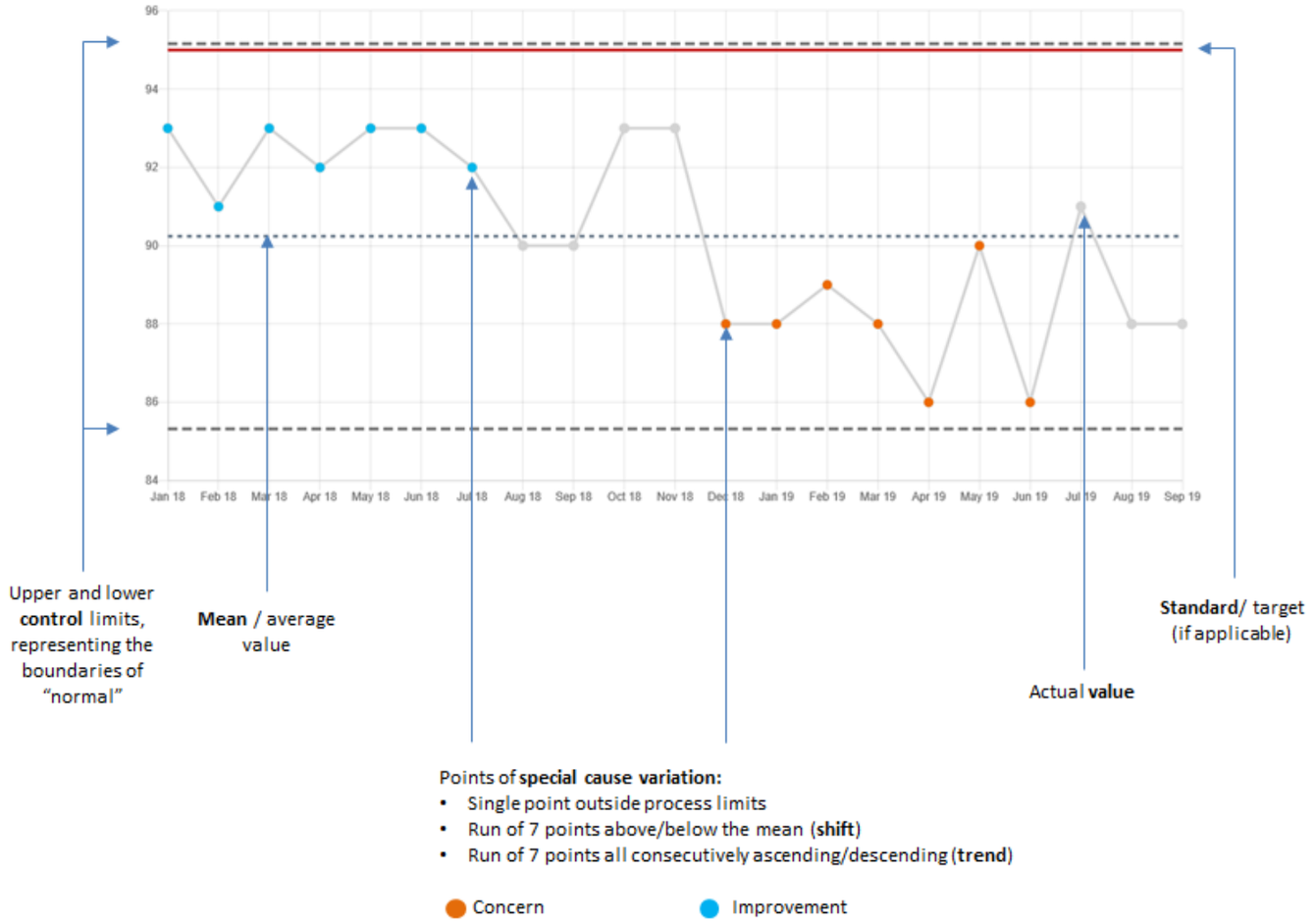
The NHS England website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://www.england.nhs.uk/publication/making-data-count/

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.

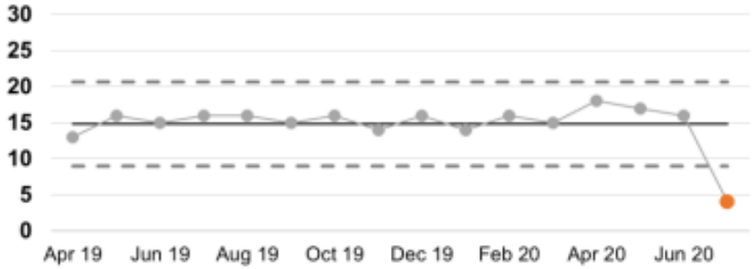
SPC charts



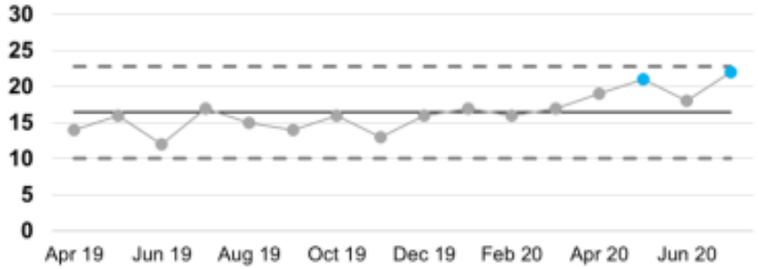
Osbourne Sheridan
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SPC rules : special cause variation

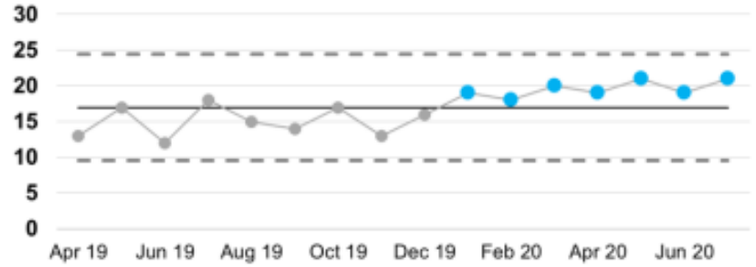
A single point outside the process limits



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 decending order



Osbourne Sheridan
19/05/2026 08:22:12

Board of Directors			
Meeting Date:	21/05/2026	**Agenda Reference:**	Bo.5.26.17c
Report Title:	Month 1 Finance Report to Finance & Performance Committee		
Presented by:	Ben Roberts, Chief Finance Officer		
Executive Lead:	Ben Roberts, Chief Finance Officer		
Author:	Michael Quinlan, Deputy Director of Finance, Chris Smith, Deputy Director of Finance		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☒

Summary of Key Issues/Highlights:

Income and Expenditure

- The Trust is reporting a Month 1 deficit of £2.9m, in line with plan; however, this early position does not yet evidence delivery of the required run rate improvement, which is a breakeven position.
- The Trust is forecasting delivery of the breakeven plan, but this is contingent on achieving a significant and sustained reduction in the current cost run rate over the coming months, which has yet to be demonstrated.
- The Closing the Gap programme is reported as delivering in full in Month 1; however, this is supported by non-recurrent measures. Delivery of recurrent savings remains dependent on the successful implementation and embedding of schemes, representing a key risk to plan.

Revenue Cash

- Year to date cash balance is £11.2m, which is £5.9m ahead of the planned position of £5.3m.
- The position reflects payment timing, with a number of 2025/26 invoices yet to be settled at the period end. These balances are expected to be cleared in May 2026 through the normal creditor payment cycle.
- The benefit to cash is therefore temporary and timing related rather than recurrent.
- Cash support requirements are front loaded in Quarters 1 and 2 due to early year deficits, with a planned shift to surplus later in the year.
- Ongoing monitoring and active cashflow management will be critical to ensure drawdowns are appropriately timed and reliance on external support is minimised.

Capital Cash

- It is not anticipated that the Trust will require capital cash support during 2026/27; however, there will be a need for careful day to day cashflow management to ensure liquidity is maintained throughout the year.

Capital Expenditure

- Capital expenditure of £43k is £838k below plan year to date due to a slower start to the year.
- Variance reflects normal phasing issues such as procurement timelines and project mobilisation.
- The Trust remains confident in full year programme delivery

Osbourne Sheridan
19/05/2026 08:22:12

Recommendation/s: (including any decision/approval required)	The Board is asked to: **1.** Note the content of this report
Link to Strategic Objective:	Sustainability - To deliver our financial plan and key performance targets
Link to Priority Initiatives 2025/26:	Closing the Gap 2025/26
Implications	
Risk:	Provides an update relevant to Strategic Objective 2 on the Board Assurance Framework, Reference no 6. **Strategic Risk: If** we and/or our Integrated Care System (ICS) partners in aggregate fail to deliver our financial plan in the short and medium term, including failure to secure an adequate capital funding allocation, **then** we may fail to maintain financial stability and sustainability, we may have insufficient internal cash and liquidity to support ongoing day to day expenditure and to support the necessary revenue and capital investments required to maintain safe and sustainable services and to support the corporate strategy, **resulting in** reduced ability to meet demand, develop services and to maintain / improve the safety and quality of care, impaired patient experience, an increased likelihood of system intervention and / or regulatory action including the potential loss of decision making autonomy and a negative impact on the Trust's reputation.
Legal/Regulatory:	Requirement from NHSE to deliver the financial plan
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/a
Assurance Route	
Meeting/s where content has been discussed previously:	N/A

Osbourne.Sheridan
19/05/2026 08:22:12

Board of Directors			
Meeting Date:	21 May 2026	**Agenda Reference:**	Bo.5.26.17d
Report Title:	Operational Performance Highlight Report		
Presented by:	Bryan Machin, Chair of F&P Committee		
Executive Lead:	Sajid Azeb, Chief Operating Officer & Deputy Chief Executive		
Author:	Carl Stephenson, Director of Planning and Performance		

Report Summary				
Purpose of the paper:	Decision ☐	Assurance ☒	Action ☐	Information ☐

Summary of Key Issues/ Highlights:

Headline KPI summary page:

- In month and YTD performance presented in the context of 2026/27 planning commitments and the latest benchmarking from the NHS Oversight Framework (NOF) where available.
- For Cancer Performance we are a month in arrears, so performance is considered in the context of 2025/26 targets.
- Year-end forecasts are derived from current performance, trends, and the measurable actions that are planned and will impact on the KPI within these timescales.

Assurance provided through the exception report and the recovery actions being progressed. During 2025/26 we delivered strongly against all the headline measures NHSE use to judge operational performance, ranking in the top quartile for Acute Trusts for the related National Oversight Framework domain. Headline KPI trends indicate relative improvement against peer average on the balance of these measures, although some early warnings can be observed and are being proactively managed.

Headline KPI trends:

- Emergency Care Standard (ECS): Performance has remained in the upper decile, and whilst 12-hour performance has deteriorated slightly our comparative position remains above peer average.
- Referral to Treatment (RTT): Performance and ranking dropped in Q3 but improvement through Q4 and into April has been ahead of national trend meaning our relative position to peer and national average will improve.
- Cancer Wait Time (CWT): Performance has trended similar to RTT with March performance likely to rank well into the best quartile, although out-turn will be slightly behind trajectory. 28-day FDS performance will sustain improved performance with initiatives such as Skin AI being implemented whilst pathway optimisation and operational productivity improvements support the 62-day standard.
- Operational Productivity: In line with the recovery priorities for 2026/27 the CSU teams and a range of Executive led programmes are focussed on increasing operational productivity. The position in April for both outpatient and inpatient activity is positive in comparison to agreed improvement trajectories.

Early warnings:

- 52 Weeks Incomplete RTT: There has been a small increase in this KPI for Pain Management and Trauma & Orthopaedic patients. Operational leadership has responded quickly to these trends and improvement forecast in May. Performance remains in the best quartile nationally.

Osbourne.Sheridan
19/05/2026 08:22:12

	• LoS >21 days: There has been a small increase in this cohort during April with length of stay on several wards and discharge metrics showing some challenges with flow, particularly when patients no longer require medical input. Compared to other Trusts this position will continue to benchmark in the best quartile, but this trend is an indicator of system pressure that operational colleagues are proactively responding to. • ED Attends: ED demand has remained higher than expected levels with increased pressures seen within Care of the Elderly and Paediatrics - operational insight suggests a large portion of attendances remain appropriate for GP management which is a focus for the EXCEL programme. • 12-hour ECS: There has also been an increase in ED spells exceeding 12-hours in this period with a range of actions to deal with high demand and improve timely hospital admission being progressed to support this, daily oversight of breach reason is in place to aid learning. Our plans for 2026/27 will look to balance further recovery against core standards whilst expanding on the transformative actions aligned to our 5-year integrated delivery plan. The majority of KPI used to track progress continue to rank above peer average and are trending upwards or exceeding planned targets. On the balance of all year-end forecasts the Trust is likely to meet the majority of its planning targets and improve its NOF ranking if current performance trends are sustained. KPI's where additional oversight is needed to aid an improved year end forecast: • DM01 6-weeks: Performance for April remained below plan. Additional capacity for NOUS, Audiology, and Neurophysiology is in place, but current trajectories suggest recovery will not be achieved without further investment. KPI kept in a red escalation whilst the case for this resource is considered. • 18 Weeks Incomplete RTT: April performance will remain behind the improvement target, but May could recover to above plan. There is a seasonal improvement from the Christmas period in the current trend and service area plans to delivery the 7% Trust target across the year are still in development, meaning we have kept the forecast as amber whilst these are tested. Additional information to aid the understanding of current and forecast positions and support the assurance provided by the exception report is included in summary analysis pages of the report.
Recommendation/s: (including any decision/approval required)	*The Board is asked to:* 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	

Lisa Kirkham-Sheridan
07/05/2026 08:22:12

Risk:	This paper demonstrates our understanding of the KPI that underpin our short-term response and shape our longer-term plans related to delivering improvement within item 7 of the BAF.
Legal/Regulatory:	The operational priorities covered by this report include those which form part of NHSE contract, annual planning, and performance assessment frameworks.
Quality & Patient Safety:	Failure to deliver improvements in the KPI covered by this report in line with our agreed plans will have a direct impact on patient experience and outcomes related to timely access to services.
Equality, Diversity and Inclusion and Health Equity:	Failure to address issues or deliver the improvements outlined for 2025/26 may have a disproportional impact on some communities and demographics where access to services correlates with poorer long-term health outcomes.
Resources:	
Environmental sustainability:	
Assurance Route	
Meeting/s where content has been discussed previously:	This report aligns to the performance and accountability framework and specifically the operational performance domain of the balanced scorecard. This report has been informed by and the content discussed at the various meetings set out in this framework for overseeing and improving performance.

Osbourne.Sheridan
19/05/2026 08:22:12

Bradford Teaching Hospitals
NHS Foundation Trust

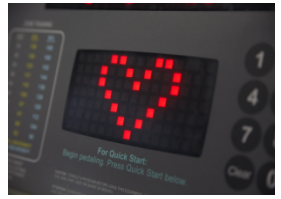
Operational Performance Highlight Report

Board of Directors

April 2026 Performance





Headline KPI Summary

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Headline KPI	Latest Month	BTHFT Plan	Perf.	3-Month Trend	Q3 NOF Rank	Year to Date	Year End Target	Year End RAG
Average Ambulance Handover	Apr-26	18:30	16:53	↓	N/A	16:53	18:30	G
Emergency Care Standard	Apr-26	83.10%	83.27%		9 of 123	83.27%	83.00%	G
12 Hour LoS in Emergency Department	Apr-26	6.35%	10.05%	↑	39 of 123	10.05%	7.30%	A
Length of Stay ≥21days	Apr-26	82	83		N/A	N/A	82	G
Average Delay Post Discharge Ready Date	Apr-26	3.7	3.3	↓	N/A	3.3	3.7	G
18 Week RTT Incomplete	Apr-26	67.19%	66.72%	↑	29 of 131	N/A	73.71%	A
18 Week RTT Incomplete vs Plan	Apr-26		-0.47%		52 of 131			-
52 Week RTT Incomplete	Apr-26	0.22%	0.23%	↑	15 of 131	N/A	0.22%	G
52 Week Community Waits	Mar-26		0.00%		28 of 77	N/A		-
New Outpatients (ERF) vs Plan	Apr-26	100.00%	103.30%	↑	N/A	103.30%	100.00%	G
Elective Activity (DC/EL) vs Plan	Apr-26	100.00%	100.94%	↑	N/A	100.94%	100.00%	G
6 Week Diagnostic Standard (DM01)	Apr-26	82.09%	82.46%	↑	N/A	N/A	95.00%	R
Cancer 28 Day Faster Diagnosis Standard	Mar-26	80.00%	85.26%	↑	63 of 118	79.21%	80.00%	A
Cancer 31 Day General Treatment	Mar-26	93.00%	98.52%	↑	N/A	95.07%	93.00%	G
Cancer 62 Day General Treatment	Mar-26	75.25%	78.65%	↑	45 of 118	72.29%	72.50%	A

Osbourne, Deridan
07/05/2026 08:22:12

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

April 2026 Highlight Report

Bradford Teaching Hospitals NHS Foundation Trust

Operational Performance Summary

During 2025/26 we delivered strongly against all the headline measures NHSE use to judge operational performance, ranking in the top quartile for Acute Trusts for the related **National Oversight Framework** domain. Headline KPI trends indicate relative improvement against peer average on the balance of these measures, although some early warnings can be observed and are being proactively managed.

Headline KPI Trends

Emergency Care Standard (ECS): Performance has remained in the upper decile, and whilst 12-hour performance has deteriorated slightly our comparative position remains above peer average.

Referral to Treatment (RTT): Performance and ranking dropped in Q3 but improvement through Q4 and into April has been ahead of national trend meaning our relative position to peer and national average will improve.

Cancer Wait Time (CWT): Performance has trended similar to RTT with March performance likely to rank well into the best quartile, although out-turn will be slightly behind trajectory. 28-day FDS performance will sustain improved performance with initiatives such as Skin AI being implemented whilst pathway optimisation and operational productivity improvements support the 62-day standard.

Operational Productivity: In line with the recovery priorities for 2026/27 the CSU teams and a range of Executive led programmes are focussed on increasing operational productivity. The position in April for both outpatient and inpatient activity is positive in comparison to agreed improvement trajectories.

Early Warnings

52 Weeks Incomplete RTT: There has been a small increase in this KPI for Pain Management and Trauma & Orthopaedic patients. Operational leadership has responded quickly to these trends and improvement forecast in May. Performance remains in the best quartile nationally.

LoS >21 days: There has been a small increase in this cohort during April with length of stay on several wards and discharge metrics showing some challenges with flow, particularly when patients no longer require medical input. Compared to other Trusts this position will continue to benchmark in the best quartile, but this trend is an indicator of system pressure that operational colleagues are proactively responding to.

ED Attends: ED demand has remained higher than expected levels with increased pressures seen within Care of the Elderly and Paediatrics - operational insight suggests a large portion of attendances remain appropriate for GP management which is a focus for the EXCEL programme.

12-hour ECS: There has also been an increase in ED spells exceeding 12-hours in this period with a range of actions to deal with high demand and improve timely hospital admission being progressed to support this, daily oversight of breach reason is in place to aid learning.

Quality Standard 01/05/2026 08:12:12

Year End Summary

Bradford Teaching Hospitals NHS Foundation Trust

Operational Performance Summary

Our plans for 2026/27 will look to balance further recovery against core standards whilst expanding on the transformative actions aligned to our 5-year integrated delivery plan. The majority of KPI used to track progress continue to rank above peer average and are trending upwards or exceeding planned targets.
The following section highlights some indicators requiring additional oversight as they are behind trajectory and recovery plans are still being finalised. On the balance of all year end forecasts the Trust is likely to meet the majority of its planning targets and improve its NOF ranking if **current performance trends** are sustained.

Headline KPI – Year End Forecast Concerns

DM01 6-weeks (26/27): Performance for April remained below plan. Additional capacity for NOUS, Audiology, and Neurophysiology is in place, but current trajectories suggest recovery will not be achieved without further investment. KPI kept in a red escalation whilst the case for this resource is considered.
18 Weeks Incomplete RTT (26/27): April performance will remain behind the improvement target, but May could recover to above plan. There is a seasonal improvement from the Christmas period in the current trend and service area plans to delivery the 7% Trust target across the year are still in development, meaning we have kept the forecast as amber whilst these are tested.

Cancer 28-day FDS (25/26): Performance impacted by deterioration in histology reporting and ongoing challenges across key tumour groups. Performance improved throughout Q4 and delivered above target in March 2026 evidencing impact of recovery actions.
Cancer 62-day Performance (25/26): Diagnostic delays are also impacting on this standard, and similar improvement into March observed. Out-turn position below plan for the total year but exceeding 75% in the final month will be viewed favourably.

Whilst it's too early to provide a definitive assessment early indications suggest 2026/27 cancer targets can be met, and the above position reflects the 2025/26 out-turn only.

Sebourne, Sheridan
19/05/2026 08:22:12

Summary Analysis by Headline KPI

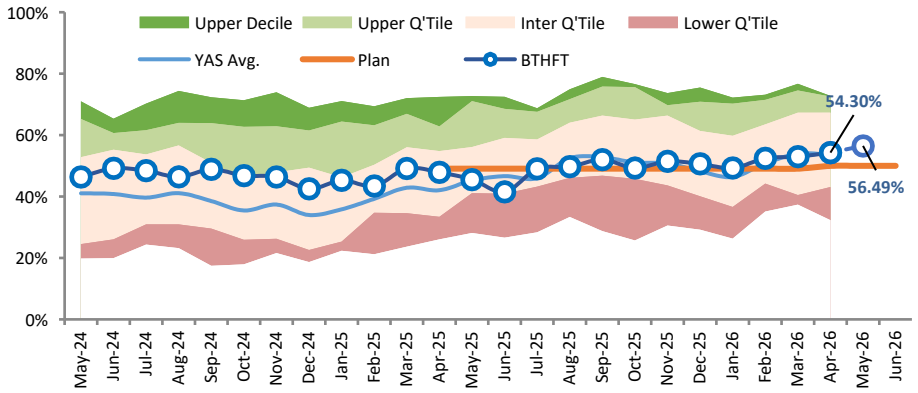
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19/05/2026 08:22:12

1. Ambulance Handover Performance

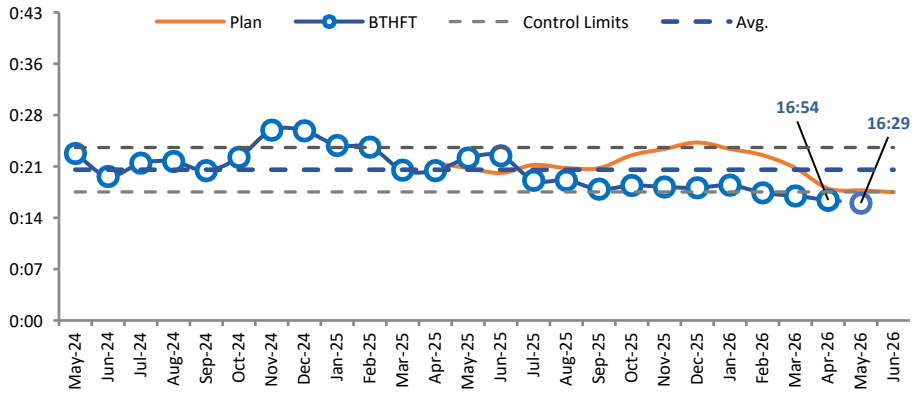
Bradford Teaching Hospitals NHS Foundation Trust

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

		May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Avg. Daily Arrivals	-	108	111	111	106	108	118	117	120	117	115	113	114
Avg. Handover Time (MM:SS)	-	22:48	23:06	19:39	19:40	18:25	18:56	18:44	18:36	18:59	17:55	17:28	16:53
Avg. Crew Clear Time (MM:SS)	-	28:24	27:30	26:28	27:02	26:50	26:36	25:23	24:43	24:50	25:08	26:25	26:42
Total Turnaroud Time (MM:SS)	-	51:05	50:20	45:57	46:34	45:04	45:18	44:07	43:01	43:38	42:53	43:43	43:21
% <60 mins	-	96.1%	95.8%	98.0%	97.5%	98.5%	99.2%	99.1%	99.0%	99.0%	99.1%	99.2%	99.6%
% Handover <45 Mins	-	90.2%	89.8%	94.4%	93.8%	95.3%	94.9%	94.0%	95.8%	95.2%	96.8%	97.0%	97.9%
% Turnaround <45 Mins	-	45.5%	45.4%	54.2%	52.6%	54.6%	55.1%	56.7%	60.3%	58.7%	60.6%	58.3%	59.4%

Latest position

- Improvements in **15-minute handover** performance continued in April (54.3% compared to 53.0% in March), with average handover times continuing to perform better than plan. Overall turnaround times remained stable with a slight increase in crew clear times reducing the benefit from handover improvement.
- BTHFT remains within the interquartile range and continues to demonstrate a positive rate of improvement (+0.68%/month since April 2025), ranking 4th among volume-comparable peer Trusts.
- Live **handover validation** (Mon–Fri, 09:00–17:00) continues to reduce delays and data queries, with validated handover delays remaining consistent from 24 in March to 23 in April; 45-minute breaches remain stable. A go-live for out of hours and weekend validation is still to be confirmed.
- The **Transfer of Care** protocol continues to support timely flow, enabling transfer to BTHFT trolley within 45 minutes and faster crew release. Self-handover rates remain good and aligned with peer averages, supported by ongoing YAS promotion.

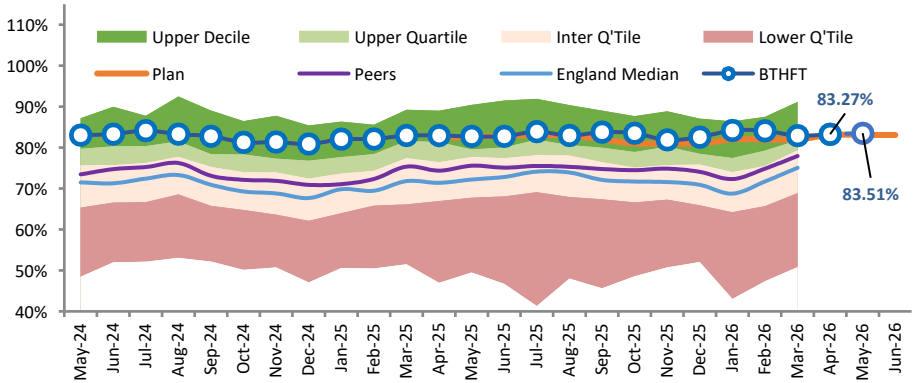
Public Session (08:25)

2. Emergency Care Standard (ECS)

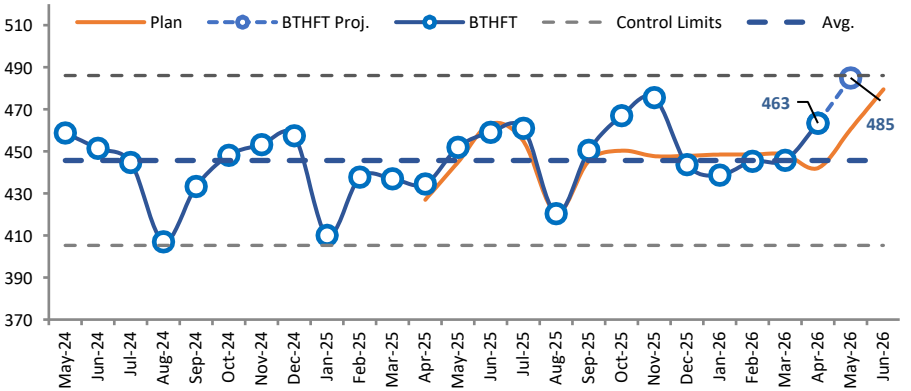
Bradford Teaching Hospitals NHS Foundation Trust

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

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Type 1 Performance -	74.3%	74.7%	76.2%	74.7%	75.9%	76.1%	74.0%	75.3%	77.0%	77.1%	75.2%	74.9%
Arrival to Assessment -	00:20	00:19	00:17	00:17	00:17	00:21	00:20	00:18	00:18	00:18	00:17	00:15
Assessment to Treatment -	02:56	03:02	03:07	03:18	02:42	03:04	03:03	02:54	03:00	02:57	03:02	02:56
Treatment Length -	02:01	01:53	01:50	01:56	01:53	01:59	01:57	01:58	02:04	02:02	01:59	02:01
% Patients Streamed -	46.5%	46.7%	47.0%	47.1%	47.0%	46.7%	44.4%	45.4%	50.8%	48.4%	46.9%	46.6%

Latest position

- ECS **4-hour performance** was 83.2% in April, exceeding plan and aligning with upper decile performance across combined Trusts.
- ED demand has remained higher than expected levels with increased pressures seen within Care of the Elderly and Paediatrics - operational insight suggests a large portion of attendances remain appropriate for GP management with increases observed in low acuity presentations (~45% of attendances carry a low acuity score at triage in April compared to 41% in March).
- Workforce resilience across all zones is being incorporated into wider job plan revisions to address what can be day to day pressure to move staff in response to sickness and annual leave.
- Increased ED pressures have resulted in the reallocation of streaming nurses, reducing the ability to stream patients on arrival; additional resource onboarding is planned to mitigate this impact.
- Expanded clinical streaming within Ward 8 (SDEC) continues to support flow during high demand, alongside improved data accuracy. **FirstNet Model Content** remains on track for delivery in July following delays encountered regarding outstanding technical design issues.
- Work is progressing to utilise AI to support the completion of discharge information in FirstNet, thereby improving the timelines of ED clock-stops and improve consistency in patient information capture.

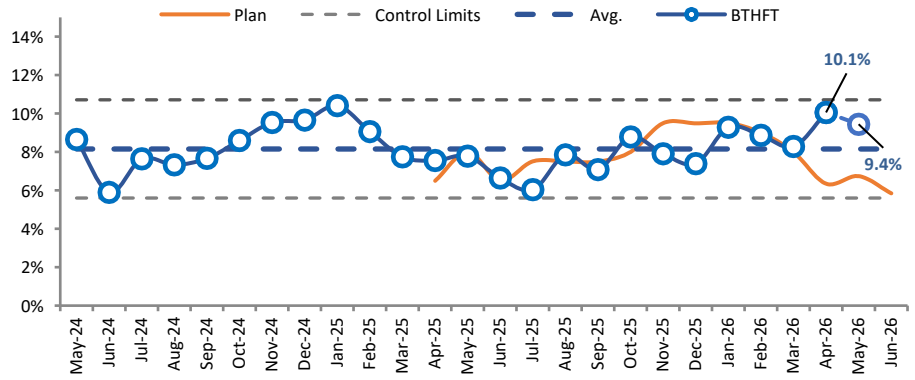
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3. Emergency Department (ED) Length of Stay

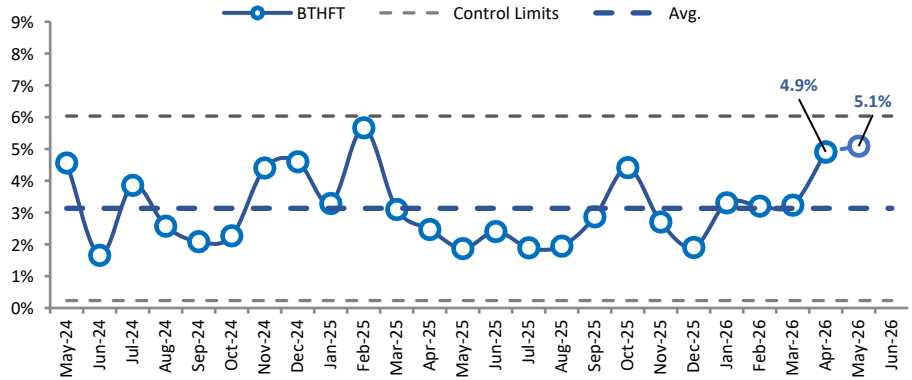
Bradford Teaching Hospitals NHS Foundation Trust

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

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Avg. # Daily Admissions -	84	87	86	81	88	87	85	84	81	84	87	85
Avg. Wait DTA to Admit -	05:02	04:32	04:30	05:06	05:05	06:21	06:02	05:38	07:03	06:40	05:57	05:46
LoS (Admitted P'ts) -	07:28	07:06	06:47	07:31	07:14	08:11	08:19	07:30	08:20	08:08	07:41	07:37
LoS (Discharged Pts) -	03:05	03:02	02:53	02:50	02:56	03:08	03:09	03:03	03:01	02:58	02:56	02:59
LoS (Admitted & Discharged Pts) -	03:58	03:52	03:40	03:49	03:51	04:09	04:09	03:57	04:04	04:02	03:56	03:54
% Patients Admitted -	20.2%	20.5%	20.4%	21.0%	21.3%	20.0%	19.3%	20.4%	19.8%	20.5%	21.1%	19.8%

Latest position

- Whilst average Decision to Admit (DTA) wait times have improved, **12-hour performance** remains a challenge with several factors contributing, including the increased demand on ED. Daily oversight and a full review of each breach is in place to increase learning and improvement in response to this KPI.
- Work is also underway to review and strengthen workforce planning, job planning processes, and interprofessional standards to support effective multidisciplinary working and service delivery.
- The **EXCEL Programme** is focused on ED decompression through upstream demand management, in-department flow and discharge improvement; current focus remains ED and downstream pathways, including improved triage, acute pathway streamlining and discharge acceleration.

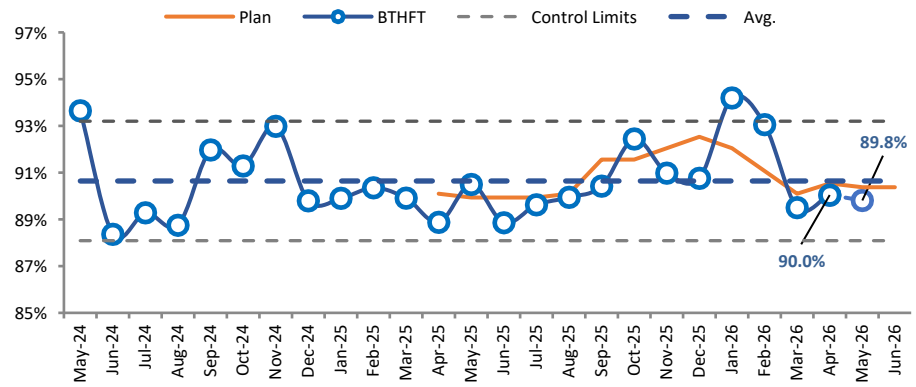
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4. Inpatient Length of Stay (LoS)

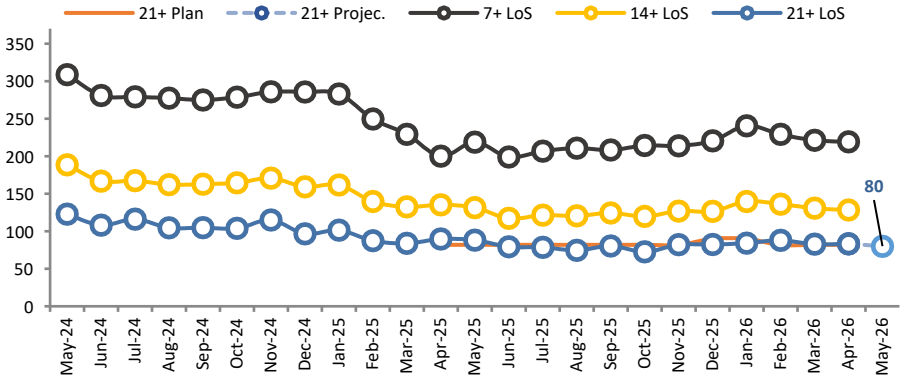
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Maintain Hospital capacity for daily admissions

4.1 Bed Occupancy



4.2 Patient LoS Profile *(Source: EPR)*



4.3 Additional Inpatient LoS Metrics

		May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Avg. Inpatient LoS	-	4.3	4.2	4.6	4.8	4.6	4.5	4.5	4.8	4.7	5.0	4.8	4.7
% Patients Discharged <4PM	-	39.7%	38.4%	39.5%	38.7%	40.7%	38.2%	36.9%	42.2%	40.1%	37.9%	40.3%	41.8%
# NEL Admissions	-	4,395	4,307	4,359	3,986	4,192	4,406	4,210	4,375	4,201	3,922	4,320	4,075
7+ LoS	-	219	199	207	211	208	214	214	221	241	229	221	219
14+ LoS	-	132	117	121	121	124	120	127	127	140	136	131	128
21+ Los	-	88	79	79	75	81	73	82	82	84	88	83	83

Latest position

- **G&A bed occupancy** reduced in April in line with forecast as winter pressures eased, though pressures remain across Specialist Medicine and Surgical wards. There has been an increase in bed closures due to Infection Prevention and Control during May so far, meaning bed occupancy is forecasted to remain in line with April whereas it might have otherwise reduced.
- **H-FAST** capacity remains at four discharges per day; eligibility and assessment processes create ~1-day delay, increasing reliance on BEST pathway. Work with Adult Social Care is underway to reduce **BEST** delays via parallel processes with independent providers.
- **Local Authority bed bureau** and Care Act choice requirements continue to contribute to delays; system-wide improvement work is ongoing.
- VRI engagement continues to increase referrals and caseload, following the closure of overnight assess-to-discharge beds on 31 March.
- **OPTICA** (live since Feb 2026) is improving discharge coordination and visibility of real-time delays. To date, 255 users (87%) have been trained, with ongoing support and mandatory senior nursing training (144 users have logged into the system). A change request is underway to record discharge pathways within EPR, improving ward visibility and supporting discharge task management, timely escalation of process delays, and coordination with social care.

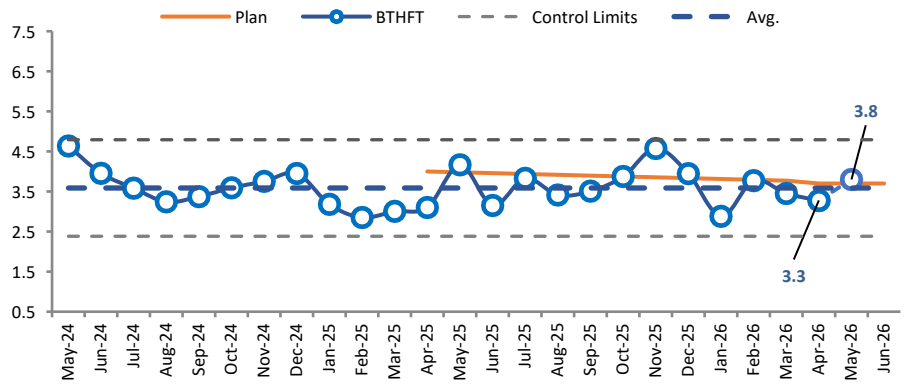
Public Board Meeting 29/05/2026 Agenda 269/523

5. Discharge Processes

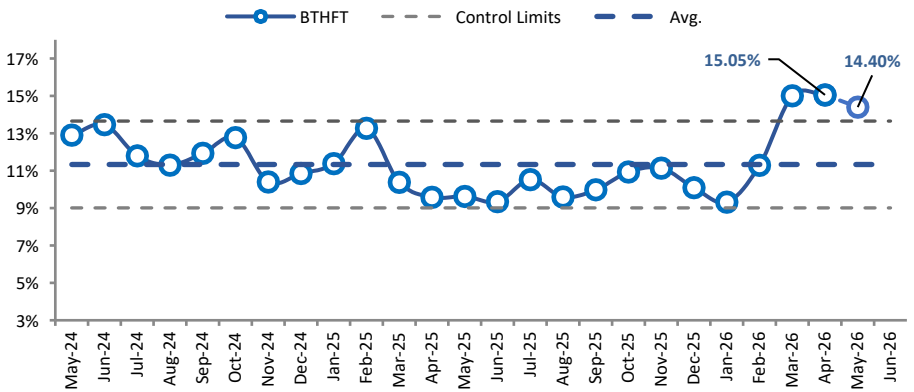
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Ensure Timely Discharge

5.1 Average Delay Past Discharge Ready Date



5.2 % Patients Not Meeting Criteria to Reside (NCtR)



5.3 Additional Discharge Metrics

		May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
% of Pts with Discharge Ready Date	-	93.0%	94.0%	93.9%	93.6%	94.9%	95.8%	95.6%	94.9%	95.5%	95.3%	95.5%	95.5%
% of Pts Discharged on/before DRD	-	79.4%	79.3%	80.4%	79.8%	78.3%	79.4%	80.4%	78.5%	78.0%	80.8%	78.3%	77.8%

Latest position

- Increases in NCtR continued into May, with an increase in the volume of patients not meeting criteria to reside, rising from an average of 54/day in January to 84/day by April. Daily NCtR averages have reduced in May (~69/day) though falling bed occupancy is offsetting this, meaning any improvement in the percentage measure forecasted is likely to be modest.
- **Therapy capacity** review identifies significant gaps; even at full establishment, capacity meets ~40% of demand (physiotherapy ~20%). A business case is in development following ETM review.
- **Local Authority** enablement constraints continue to delay Pathway 1 discharges; system workshops are underway for Better Care Fund (BCF) 2026/27 planning.
- A **Discharge Coordinator** pilot commenced in March 2026 with a 6-month evaluation focusing on LoS, NCtR, DRD and bed days lost – monitoring KPIs are currently being developed and collaboration with the Excel programme is underway.
- Discharge Ready Date compliance improvements include a SOP refresh aimed at enhancing monitoring and ward accountability; a re-audit is due to take place in May 2026. Deputy Chief Nurse oversight continues with ward process reviews being progressed through the EXCEL programme.

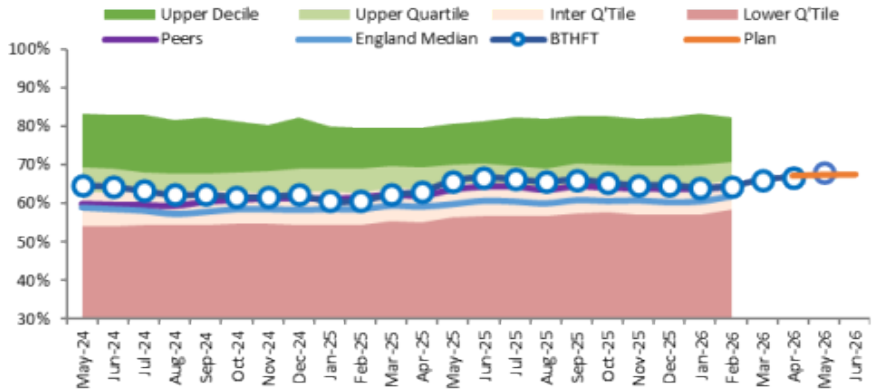
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6. Referral to Treatment (RTT)

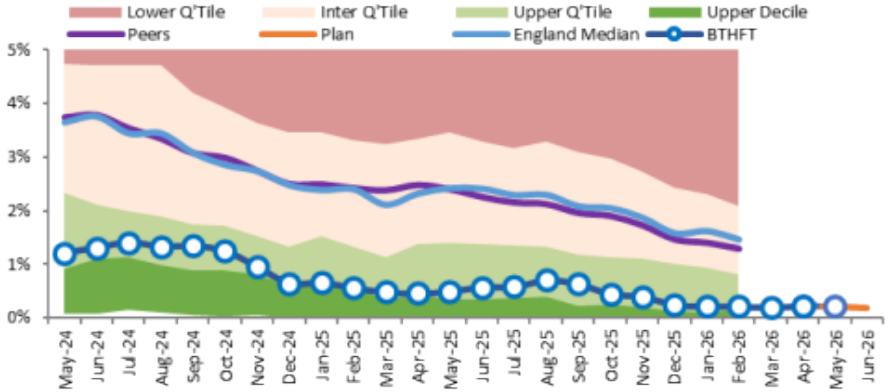
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Deliver RTT Improvements

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



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



6.3 Additional RTT Metrics

		May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Waiting List Size	-	32,563	32,915	33,149	33,728	33,405	32,204	31,832	31,932	31,610	31,261	31,444	31,090
Waiting List Change	-		+352	+234	+579	-323	-1,201	-372	+100	-322	-349	+183	-354
% New RTT Within 18 Weeks	-	69.2%	68.2%	68.6%	68.4%	67.5%	68.0%	67.7%	67.8%	66.2%	68.1%	69.6%	69.3%
Incomplete (52+)	-	163	190	193	238	212	145	127	80	70	69	63	73

Latest position

- **RTT performance improved** in April despite Easter holidays and industrial action, with increased clock stops across both non admitted and admitted pathways.
- The number of **RTT over 52 weeks** waits has increased in April. Leadership teams are responding to pressures in Pain Management and Trauma & Orthopaedics, and the Plastic Surgery continued to improve. No patient waited over 65 weeks. The Trust continues to benchmark just below the upper decile for 52-week RTT.
- The **Q4 outpatient sprint** concluded with additional new appointment slots and weekend clinics during March. Uptake against the original plan was not fully achieved but performance is likely to have deteriorated without this specific push. The outpatient transformation programme reflected on this initiative and will aim to embed learning.
- **Activity plans** for 2026/27 have been set against specific RTT improvement targets. Increasing productivity through the recovery programme and delivering waiting list management improvements through existing performance meetings will combine to deliver the stretching 7% improvement required.

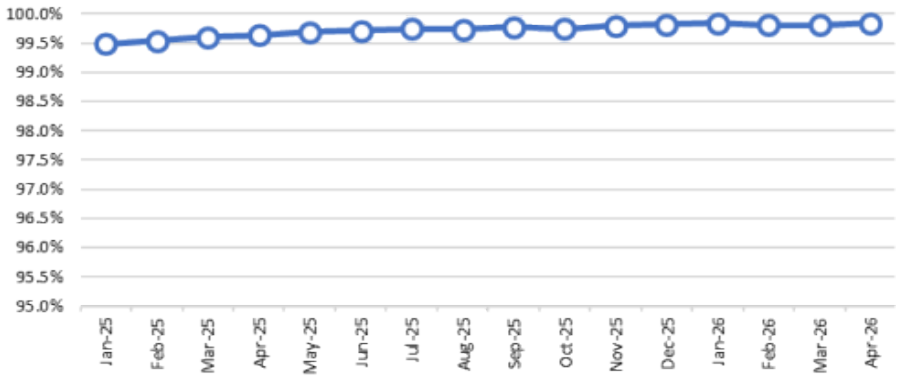
Report 18 Appendix 1 (6/8/2026 9:30 AM)

7. Waiting List Management and Validation

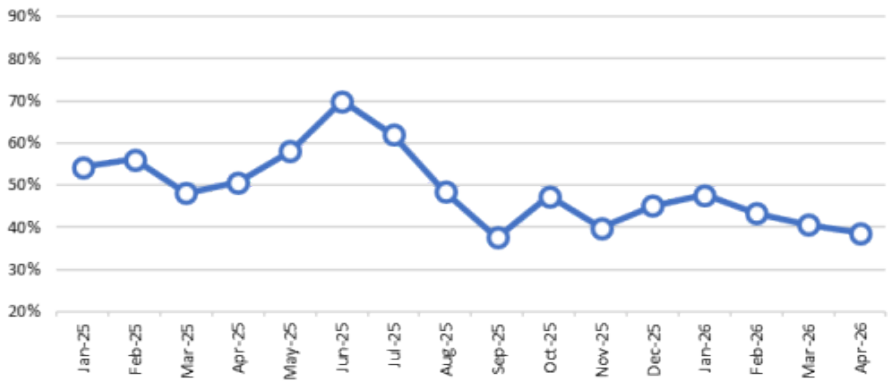
Bradford Teaching Hospitals NHS Foundation Trust

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

		May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
RTT LUNA DQ Metrics	-	689	657	590	660	567	647	503	456	425	489	468	425
Correction Rate - Non RTT	-	6.23%	7.36%	41.97%	23.36%	14.94%	15.28%	20.20%	23.09%	19.21%	14.80%	26.76%	10.21%
Non-RTT DQ Process Failures	-	27,303	25,119	23,825	21,160	20,130	19,644	18,922	18,738	19,088	19,019	19,662	19,088

Latest position

- Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, remains high at 99.79% in April 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) is working on 3,065 process failures created more than 3 months ago. This is an increase of 944 process failures to be validated since December 2025 (2,121 backlog position), this increase is due to staffing gaps in the service.
- 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, Plastics and Dermatology.
- 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.

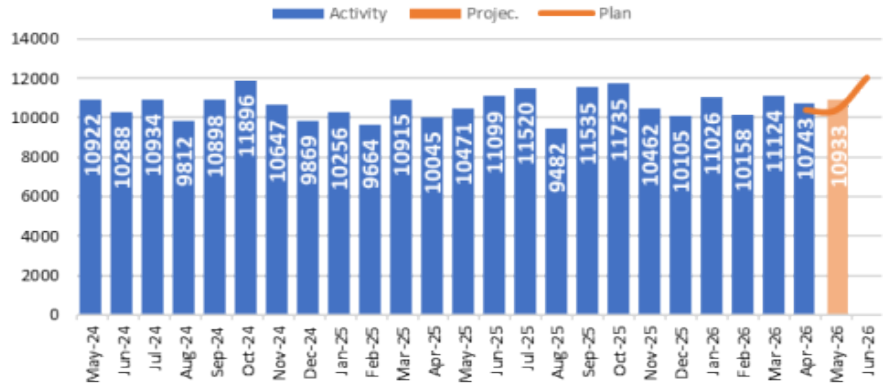
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8. Outpatient Productivity

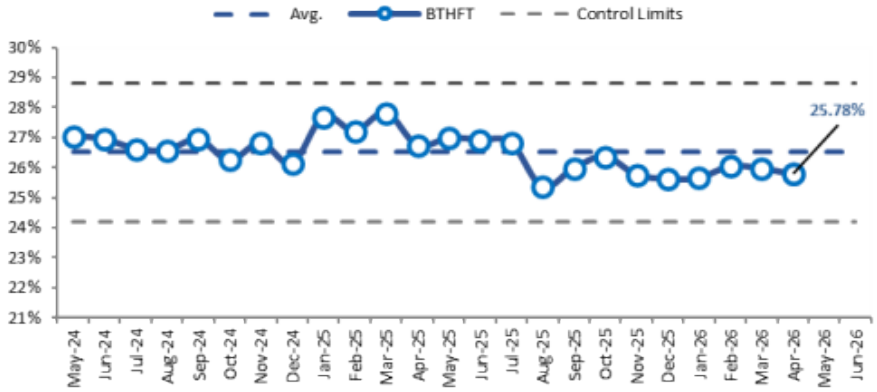
Bradford Teaching Hospitals NHS Foundation Trust

Objective: Improve Non-Admitted Productivity

8.1 New Outpatient Activity (ERF)



8.2 Clock Stops/DTAs per Outpatient Appointment



8.3 Additional Outpatient Metrics

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
DNA Rate -	7.65%	7.53%	7.46%	7.80%	7.93%	7.56%	8.13%	8.27%	8.18%	7.90%	8.07%	8.12%
Follow Up Orders -	28,299	27,328	29,062	24,073	29,817	30,505	27,812	27,375	29,527	26,835	28,289	28,558
PIFU % -	4.60%	4.60%	4.75%	4.52%	4.99%	4.88%	5.85%	4.71%	5.23%	5.78%	5.09%	4.59%
PIFU % (including Therapies) -	5.52%	5.19%	5.67%	4.88%	5.16%	5.63%	6.50%	5.34%	5.35%	6.29%	5.60%	5.08%
First to Follow Up Ratio -	2.7	2.7	2.7	2.8	2.7	2.7	2.7	2.8	2.8	2.8	2.7	2.8

Latest position

- New outpatient appointments (ERF) were above plan. Service level plans have been reviewed jointly by CSU and central operational teams to identify year one productivity objectives, this KPI will be tracked weekly within recovery meetings.
- **Outpatient Transformation** will remain focused 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. Optimising referrals and organising diagnostic capacity so patients present with all available information will continue as a focus.
- 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. A working group focusing on **Outpatient Optimisation** has been set up and will first aim to improve productivity by analysing job plans and clinic templates.
- The related **Income and Activity** workstream is working on ensuring this activity is recorded accurately and as timely as possible so that both the waiting list and income benefits are realised.

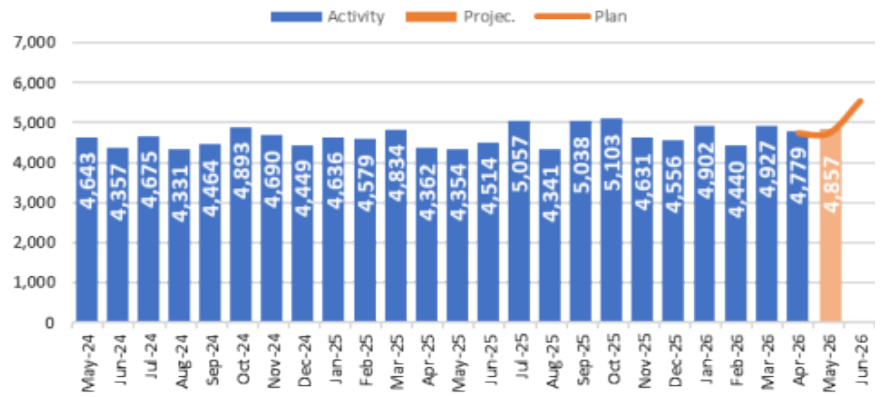
Open Board Meeting 25/26 Agenda Item 2.3.1

9. Inpatient Productivity

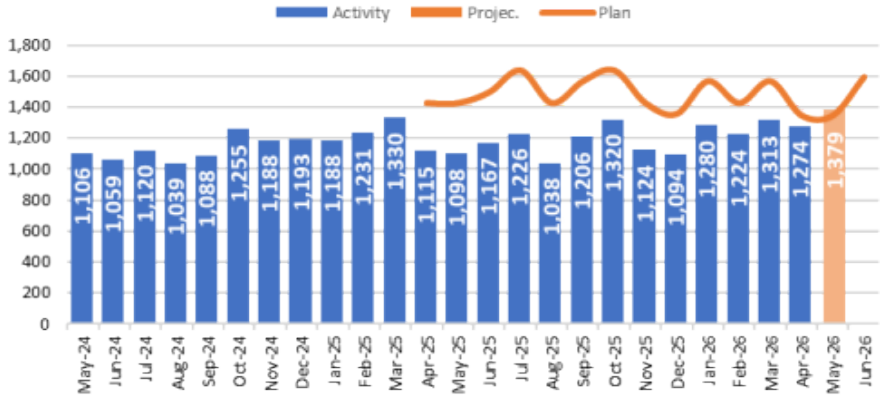
NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Objective: Increase Elective Ordinary and Day Case Volumes

9.1 Elective Activity



9.2 Elective Activity in Theatres



9.1 Elective Activity

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Admitted Clock Stops -	1,231	1,275	1,425	1,100	1,315	1,391	1,245	1,226	1,421	1,284	1,449	1,332
Daycase Rate -	88.9%	88.2%	87.6%	86.5%	88.3%	87.8%	87.8%	88.5%	88.3%	88.0%	89.2%	88.9%
Number of Lists Run -	567	615	618	549	645	695	585	573	667	621	640	615
Patients Per List -	1.9	1.9	2.0	1.9	1.9	1.9	1.9	1.9	1.9	2.0	2.1	2.1
Reportable Cancellations -	46	31	66	45	45	56	44	28	58	57	61	31
28-day Rebooking Breaches -	9	8	7	13	17	7	4	8	7	2	12	6

Latest position

- Activity exceeded plan in April although theatre activity was slightly below plan due to industrial action. The capacity gap from the SLH DCU delay continues to be supported using Bronte Forward Wait Theatre and Medinet weekend lists, with this metric increasing towards plan.
- The **Theatre Improvement Programme** has commenced, structured around four strategic workstreams: Workforce, Utilisation, Pre-Assessment, and SLH DCU. With staff and patient experience as the overarching framework for continuous learning and operational excellence.
- Significant improvements can be seen in the number of weekly theatre sessions running however patients treated remains below plan. The Theatre Improvement Programme is the primary vehicle for driving these gains, specifically through improvements in scheduling, theatre and ward efficiency and on the day cancellations.
- Endoscopy are due to move out of theatres and into the Endoscopy unit in June which will provide an additional theatre session to Trauma & Orthopaedics.
- A data improvement structure is in place to help meet reporting and service user needs related to Theatres and the TACC element of our EPR, whilst addressing DQ issues through training and process redesign.

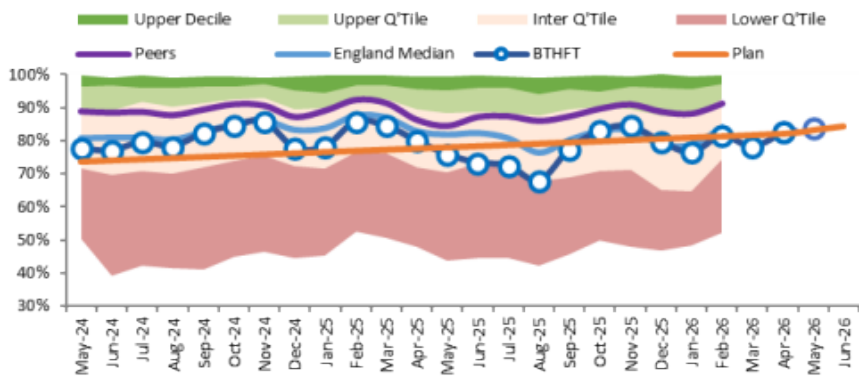
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10. Diagnostic Waiting Times

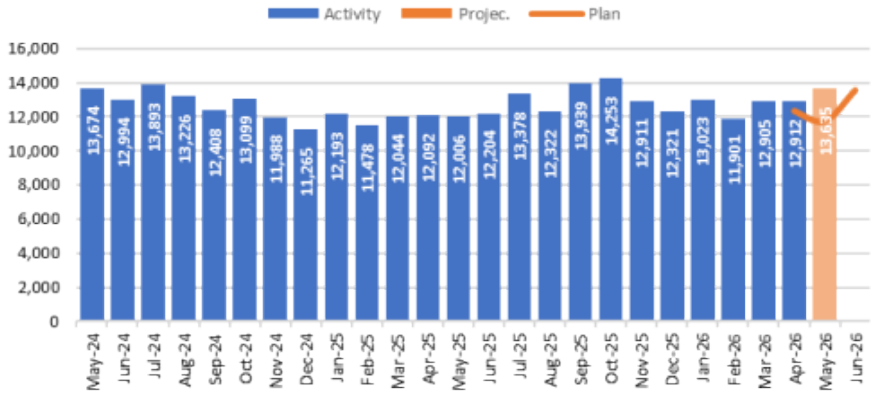
Bradford Teaching Hospitals NHS Foundation Trust

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

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
(Phys. M'ment) Activity -	1,403	1,686	1,872	1,711	1,862	2,035	1,740	1,539	1,734	1,450	1,544	1,692
(Phys. M'ment) Performance	62.6%	56.6%	59.1%	60.5%	70.2%	70.8%	69.1%	58.3%	55.5%	63.9%	63.1%	61.8%
(Imaging) Activity -	9,148	9,081	9,792	9,174	10,270	10,536	9,577	9,262	9,716	9,145	9,876	9,726
(Imaging) Performance -	81.2%	78.8%	76.3%	68.4%	77.7%	85.2%	87.7%	84.5%	80.9%	85.1%	82.1%	90.2%
(Endoscopy) Activity -	1,455	1,437	1,714	1,437	1,807	1,682	1,594	1,520	1,573	1,306	1,485	1,494
(Endoscopy) Performance -	83.9%	80.6%	82.7%	82.5%	92.8%	92.4%	92.6%	89.5%	86.7%	90.8%	88.3%	84.0%

Latest position

- DM01 performance for April remained behind plan due to delays in Non-obstetric ultrasound, Audiology and Urogynecology recovery, and the impact of increase stress-echo demand.
- Non-obstetric ultrasound continues to be closely monitored as staffing concerns have now resolved. The waiting list continues to reduce with performance expected to recover by Q1-end with the locum contract ending in May.
- In Audiology, three locums have been appointed but have provided limited availability before the end of Q2, with modelling suggesting that the waiting list will continue to grow.
- Neurophysiology insourcing commenced in April with recovery projected by Q2-end. Increased delivery from substantive consultants is expected to bridge the residual gap once the contract ends.
- In Urodynamics, a recovery plan with medical physics support is in place with additional capacity provided from May.
- Despite increased activity in April, Cardiology is impacted by increased Stress Echo referrals (GIRFT). Performance will continue to be impacted until a long-term plan is implemented via a business case.
- The new Endoscopy Unit opened on a phased approach and the service has also been awarded JAG accreditation. Both represent significant milestones in our continued provision of high-quality services.

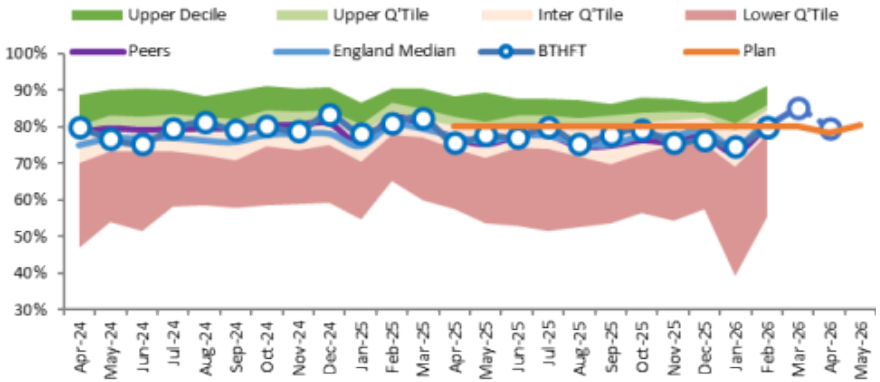
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11. Cancer Diagnostic Phase

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Deliver the Faster Diagnosis Standard (FDS)

11.1 28 Day FDS Benchmarked



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

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Trust	79.4%	75.5%	76.5%	74.6%	80.0%	85.3%	79.7%
Breast	97.8%	97.4%	95.6%	94.6%	97.5%	98.3%	96.0%
Gynaecology	77.8%	68.3%	68.1%	63.2%	81.9%	73.0%	75.2%
Haematology	75.0%	72.7%	50.0%	45.5%	50.0%	61.5%	52.9%
Head & Neck	80.8%	77.1%	83.6%	73.2%	75.3%	85.0%	85.1%
Lower GI	63.4%	59.6%	71.7%	63.7%	75.4%	78.1%	76.1%
Lung	86.0%	89.7%	87.8%	87.5%	85.7%	98.1%	92.6%
NSS	94.4%	94.1%	95.0%	100.0%	93.3%	100.0%	91.7%
Upper GI	77.7%	87.1%	77.9%	84.6%	88.9%	87.3%	80.8%
Skin	67.9%	62.2%	62.1%	58.3%	66.5%	77.4%	65.9%
Urology	84.6%	77.8%	72.0%	71.8%	79.5%	87.2%	74.2%

11.3 Additional Cancer Diagnostics

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
# 2WW Refs	1,817	1,963	2,050	2,067	1,736	2,123	1,976	1,822	1,739	2,000	1,827	2,033
% 2WW Performance	85.1%	82.3%	83.7%	79.8%	83.8%	94.0%	94.9%	94.8%	95.7%	92.6%	92.9%	84.8%
28 Day FDS Performance	82.1%	84.5%	81.2%	81.6%	75.5%	77.8%	79.4%	75.5%	76.5%	74.6%	80.0%	85.3%
# Total Patients Seen FDS	1,703	1,727	1,917	2,106	1,982	2,080	2,020	1,872	1,742	1,879	1,889	1,798
# Undiag, unbooked >28 days	267	261	213	340	264	317	358	282	307	275	172	231

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 have successfully recruited a clinical fellow to provide this. A review of the breast pain pathway has led to a trial of a **dedicated pain outpatient clinic** to free up cancer capacity which is likely to commence in May.
- OMFS currently have a consultant vacancy and sickness, shared between BTHFT and AGH. A part time consultant has been recruited, who the despite having no direct impact on cancer will free capacity for other consultants. Another substantive consultant post is currently out to advert.
- The Skin pathway continues to be impacted by capacity backlogs with a locum consultant post currently out to advert. **Skin AI** was implemented at the end of April with currently 22% of cases assessed discharged. This should have significant impact on reducing the number of biopsies which will in turn reduce the burden on histopathology and the overall Skin pathway length. Although at present histology reporting delays remain a concern in Skin and Gynaecology.
- 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.

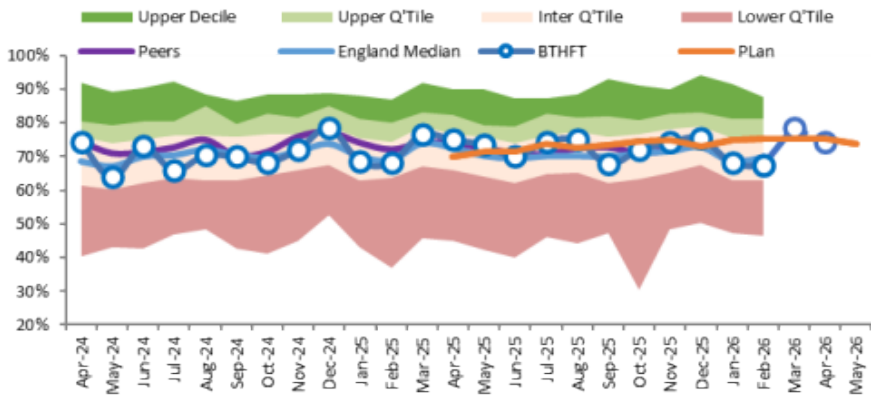
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12. Cancer Treatment

Bradford Teaching Hospitals NHS Foundation Trust

Objective: Deliver the 62 Day Treatment Standard

12.1 62 Day Treatment Benchmarked



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

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Trust	72.0%	74.4%	75.5%	68.3%	67.3%	78.7%	74.3%
Breast	83.7%	92.6%	84.7%	77.5%	72.1%	93.7%	82.3%
Gynaecology	87.5%	77.8%	60.0%	80.0%	33.3%	93.3%	72.7%
Haematology	72.7%	73.9%	86.7%	82.1%	69.0%	71.4%	92.9%
Head & Neck	35.0%	35.9%	18.8%	61.1%	42.1%	61.5%	62.1%
Lower GI	31.0%	70.0%	42.9%	53.6%	35.0%	65.2%	56.4%
Lung	42.1%	63.6%	42.9%	30.0%	44.8%	48.3%	33.3%
Upper GI	77.8%	77.8%	77.8%	50.0%	85.7%	71.4%	80.0%
Skin	83.0%	80.5%	96.9%	76.9%	84.8%	84.6%	79.8%
Urology	74.7%	68.2%	81.5%	72.4%	76.8%	74.5%	72.7%

12.3 Additional Cancer Treatment Metrics

		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
# 31 Day Treatments	-	241	230	249	254	232	277	295	260	245	263	243	270
31 Day Performance	-	96.7%	93.5%	94.4%	94.1%	95.7%	93.1%	94.9%	93.8%	95.5%	94.3%	97.9%	98.5%
62 Day Performance	-	74.4%	72.6%	70.0%	74.3%	75.0%	67.9%	72.0%	74.4%	75.5%	68.3%	67.3%	78.7%
62 Day Backlog	-	60	74	53	50	89	87	63	50	70	84	44	47

Latest position

- March performance against the 62 Day standard exceeded plan of 75% at 78.7% following a significant reduction in the backlog in February. April performance is predicted to reduce slightly below plan as the backlog increased across many specialties due to Industrial Action, timed owed form previous IA, and leave during the Easter period.
- Complex **diagnostic pathways** are still impacting performance across most 62-day pathways. Across most pathways, administrative delays, outpatient capacity and patient compliance issues are also 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.

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Meeting Title	Board of Directors		
Date		Agenda item	

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Audit Committee

Date of meeting: 12 May 2026

Key escalation and discussion points from the meeting
Alert:
Internal Audit – Closing the Gap (CTG). The Committee received the Internal Audit report which provided a **Low Assurance** because, while a CTG framework, governance structure and reporting cycle are in place with savings being delivered for the Trust, the review identified weaknesses in both the design and operation of key controls which may limit the Trust's ability to achieve the core objectives of the CTG programme as well as providing a sustainable foundation to deliver savings year on year. The Committee was grateful for the update provided by the Chief Finance Officer who explained that management had already implemented a change by introducing service area oversight via more senior colleagues as well as doing weekly management monitoring via the 'recovery director' role. The Committee noted that the Finance and Performance Committee will receive regular/ongoing assurance regarding CTG performance.
Advise:
Internal Audit – Board Assurance Framework (BAF). The Committee received the Internal Audit report which provided a **Limited Assurance**. The main conclusion was that while the BAF is well-established, clearly structured and aligned to the organisation's strategic objectives, it currently functions more effectively as a mechanism for monitoring risk than as a tool for evidencing assurance and risk reduction when assessed against strengthened expectations of effectiveness and impact. As a result, the Board's ability to consistently assess whether strategic risks are being actively reduced, rather than managed at a sustained level of exposure. The committee is aware and discussed the major work being undertaken by the Trust to amend and strengthen the BAF so that it provides the required assurance. **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.
Assure:
Internal Audit The Committee received the following list of **final** reports and noted the range of assurances given:

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Meeting Title	Board of Directors		
Date		Agenda item	

Report No	Report	Final	Draft	Opinion
BH/23/2026	Working Day One	✓		High
BH/24/2026	PSIRF: Learning Disabilities and Complex Needs	✓		Significant
BH/25/2026	Digital Strategy	✓		Significant
BH/26/2026	Board Assurance Framework	✓		Limited
BH/27/2026	Estates Capital Programme	✓		Significant
BH/28/2026	Closing the Gap	✓		Low
BH/29/2026	Utilisation of Resources - Outpatients	✓		Significant
BH/30/2026	Estates Invoicing	✓		Significant
BH/31/2026	Risk Management	✓		Significant
BH/32/2026	Data Security and Protection Toolkit	✓		Moderate / High
BH/33/2026	Benchmarking - Board Assurance Framework and Risk Management	✓		N/a
BH/34/2026	Pharmacy Aseptic Unit	✓		Significant

The internal audit progress report and the follow up of recommendations update provided by the Associate Director of Corporate Governance both detailed the number of overdue recommendations and **the Committee noted that the volume of overdue recommendations continues to reduce due to the direct intervention of the Chief Finance Officer. There were 0 overdue recommendations which was noted by the committee as a significant achievement during 25/26.**

Other matters

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

- Annual Governance Statement from the Chief Operating Officer
- BTHFT Draft Annual Report 25/26
- Verbal report from External Auditor
- Counter Fraud Progress Update Report
- Counter Fraud Annual Report 25/26
- Schedules of Losses and Special Payments, and review of single source tenders
- Audit committee governance, including annual report; annual self-assessment and review of the ToR and workplan
- Other Committee/Academy annual reports
- Charity Accounts – independent examination (approved)
- Risk Management Strategy update

Report completed by:

Zafir Ali, Audit Committee Chair and Non-Executive Director, 15 May 2026

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15/05/26 08:22:12

Meeting Title	Board of Directors		
Date	21 May 2026	Agenda item	Bo.5.26.20

Committee/Academy Escalation and Assurance Report (AAA)
Report from the: Charitable Funds Committee
Date of meeting: 8 May 2026

Key escalation and discussion points from the meeting

Alert:

- Reported net expenditure of £475k, offset by £155k investment gains, resulting in a net reduction of £320k which is £80k better than plan. However, a significant cash increase was confirmed following investment drawdown and major donations, including £250k from Sovereign Health and £100k from the Sick Children's Trust.
- There is a need for caution in future investment strategy given global volatility.
- Committee continues to be mindful of operational costs increasing.

Advise:

- **Independence Committee.** A dedicated Independence Committee is now established and functioning as a "shadow board of trustees," led by Russell Andrews with the next meeting scheduled for early June.
- **Trustee Recruitment.** Recruitment for approximately 11 trustees is scheduled to begin in September 2026, ensuring that independent trustees outnumber Trust-affiliated members as per legal advice.
- **Target Timeline.** The charity aims to achieve full operational and financial independence within the next 12 months.
- **Financial Sustainability.** here is a strategic focus on building unrestricted income—which is essential for core costs - though progress in this area has been slower than preferred.
- **External Advice**: Ongoing engagement continues with Weightmans solicitors, including a new lead adviser, to ensure legal compliance throughout the transition.

Assure:

Fundraising Performance (Home from Home Campaign)

- **Funding Progress:** The campaign has reached £2.3m in funds raised or pledged toward its £3.1m target.
- **Groundbreaking Event:** A major milestone event is scheduled for 20 May 2026, with over 130 invitees.
- **Operational Shifts:** The team is transitioning from reactive to proactive fundraising, utilizing a new financial prioritization framework to maximise return on investment.

Osbourne Stewart
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The Committee noted the exceptional contribution of ambassador Ishfaq Farooq, who had engaged over 100 businesses, secured 21 pledges for the £1,000 100 Club, and set a personal ambition of raising £100,000 towards the kitchen element of the scheme.

Report completed by: Altaf Sadique, Charitable Funds Committee Chair and Non-Executive Director, 13/05/2026

Board of Directors			
Meeting Date:	21/05/26	**Agenda Reference:**	Bo.5.26.21
Report Title:	Risk Management Strategy and Policy		
Presented by:	Professor Karen Dawber, Chief Nurse		
Executive Lead:	Professor Karen Dawber, Chief Nurse		
Author:	Byron Johnson, Assistant Director of Quality Nazzar Butt, Moving to Outstanding Lead		

Report Summary				
Purpose of the paper:	Decision ☒ (approve)	Assurance ☒	Action ☐	Information ☐
Summary of Key Issues/Highlights:	This paper presents the updated Risk Management Strategy and Policy (v3) for Board approval. The strategy sets out a comprehensive, integrated framework for identifying, assessing, managing and monitoring risk across the Trust, aligned to national guidance and best practice. It strengthens: • Governance and accountability structures • Risk appetite and tolerance clarity • Escalation and oversight arrangements • Integration of risk intelligence and organisational learning The strategy supports delivery of the Trust's strategic objectives by embedding proactive, transparent and learning-based risk management across all levels of the organisation. Clear Governance and Accountability Framework • Defined roles from Board to frontline staff • Establishment of Risk Committee and Risk Review Panel to enhance scrutiny of high-risk areas • Integration with Board Assurance Framework (BAF) and High-Level Risk Register (HLRR) Risk Appetite and Tolerance – Mature and Operationalised • Clear articulation of risk appetite levels (Avoid > Seek) • Defined tolerance thresholds and escalation triggers • Explicit linkage to decision-making and strategic planning Integrated and Triangulated Assurance Model Strong Strategic Context and Forward Look Recognises: • Global (cyber, climate, geopolitical) • National (pandemic, infrastructure, system risk) • Regional (ICS priorities) risk drivers			

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	Emphasis on Culture and Capability • Promotes openness, escalation and learning culture • Structured training (including Risk Masterclass and Board development) Note that following the recent Board Development programme included a dedicated session to inform further refinement of the draft Risk Strategy, Risk Appetite Statement and Board Assurance Framework (BAF). Structured stakeholder feedback indicated that the overall the strategy was viewed as: • Is generally clear and well received • Provides a strong foundation for Board oversight • Is useful in supporting decision-making The following points were noted for further consideration: • Better reflection of real and emerging risks e.g. global, national, regional and local risk profiles • Strengthen non-clinical risk coverage • Reduce length and increase clarity • Describe how we gain assurance on risk mitigations • Consider approaches to measure risk culture • Enhance use of data and triangulation to support assurance • Clarify approach to annual reviews • Role of the Audit Committee for risk oversight and assurance TBC • Provide a clearer distinction between strategy and policy • Reference to system risks and how oversight and alignment of risk will function and inform decision making • More detail on the management of aged or long-standing risks • Improvements to the design of the current BAF framework to inform the Board and support decision making
Recommendation/s: (approval required)	*The Board is asked to note and approve:* *Approve the strategy previously discussed in the Board Development Session in April 2026.*
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness NB: Links to all strategic objectives
Link to Priority Initiatives 2025/26:	N/A NB: Links to all priority initiatives
Implications	
Risk:	Strengthening the risk strategy will improve risk management and oversight
Legal/Regulatory:	A clear and embedded risk management approach supports compliance with governance standards and regulatory expectations
Quality & Patient Safety:	Improved clarity will support earlier identification and escalation of risks impacting care
Equality, Diversity and Inclusion and Health Equity:	Improved risk structuring will support better identification and management of risks relating to EDI and health inequalities

Catherine Shearer 14/05/2026 08:58:13

Resources:	No immediate resource implications
Environmental sustainability:	Enables stronger alignment with the Trust's Green Plan and sustainability objectives
Assurance Route	
Meeting/s where content has been discussed previously:	N/A

Report content

Purpose

To provide assurance on the ongoing development of the Trust's Risk Management Strategy, Risk Appetite Statement and Board Assurance Framework (BAF), and to seek final Board approval. with a focus on:

- Strengthening Board oversight and assurance on risk
- Ensuring alignment with emerging local, regional, and national risk profiles
- Enhancing clarity between risk strategy, policy, and operational processes
- Improving how risk appetite informs decision-making
- Developing a more effective and informative Board Assurance Framework (BAF)
- Strengthening approaches to risk culture, assurance, and triangulation of data

Background / context

The Trust has an established approach to risk management, supported by a Risk Strategy, Board Assurance Framework (BAF), and a Risk Appetite Statement. Various internal audits conducted by Audit Yorkshire have resulted in evolving changes to the Trusts risk management approach. While comprehensive, the framework is not yet formally approved and has not been fully embedded in Board level discussions or decision making.

A recent Board Development session was undertaken to support this work and gather structured feedback on the draft Risk Strategy and Risk Appetite Statement.

Assessment

The final Risk Strategy updates included:

- A widened scope of key principles and aims
- Changes to roles and responsibilities including the Audit Committee
- More detail on risk appetite and risk tolerance including setting minimum tolerance thresholds
- Changes to the risk escalation framework
- Guidance on risk assessment, management and monitoring
- Changes to training and how the strategy will be monitored

Feedback from the Board Development session highlighted has now been incorporated into the final version to address the areas that required further refinements:

- Is generally clear and well received
- Provides a strong foundation for Board oversight
- Is useful in supporting decision-making -

Areas enhanced following Quality and Audit Committee and Board Development Feedback.

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- Better reflection of real and emerging risks e.g. global, national, regional and local risk profiles
- Strengthen non-clinical risk coverage
- Reduce length and increase clarity
- Describe how we gain assurance on risk mitigations
- Consider approaches to measure risk culture
- Enhance use of data and triangulation to support assurance
- Clarify approach to annual reviews
- Role of the Audit Committee for risk oversight and assurance TBC
- Provide a clearer distinction between strategy and policy
- Inclusion of system risks (Committee in Common) and how oversight and alignment of risk will function and inform decision making
- More detail on the management of aged or long-standing risks
- Improvements to the design of the current BAF framework to inform the Board and support decision making

Proposal

To approve the Risk Management Strategy and Policy and to further consider the Risk Appetite Statement following ratification at Board in July 2026.

Appendices
Appendix 1: Draft Risk Appetite Statement
Appendix 2: Risk Assessment Form
Appendix 3: Risk Management Handbook
Appendix 4 Terms of Reference

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Risk Management Strategy and Policy

Author:	Associate Director of Quality, Byron Johnson Moving to Outstanding Lead, Nazzar Butt
Version:	3
Approved by:	Board of Directors
Date:	
Review date:	

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Foreword



Healthcare delivery is inherently complex and carries unavoidable levels of risk. Every day, our staff make decisions in challenging and dynamic environments while striving to deliver safe, compassionate and effective care for our patients and communities. Effective risk management is therefore fundamental to how we operate as a Trust and is everyone's responsibility, from ward to Board.

This Risk Management Strategy and Policy sets out the Trust's commitment to developing and sustaining a proactive, transparent and learning culture in which risks are identified early, openly discussed, appropriately escalated and effectively managed. Our aim is not to eliminate all risks, which would neither be possible nor desirable in a modern healthcare environment, but to ensure that risks are understood, proportionately controlled and balanced against the delivery of high-quality patient care, innovation and improvement.

The Trust recognises that effective risk management is central to patient safety, quality improvement, workforce wellbeing, operational resilience and financial sustainability. We are committed to reducing avoidable harm, learning from incidents and near misses, and strengthening the systems and controls that support safe care. This includes ensuring that risk management is embedded within decision-making processes at every level of the organisation.

Risk management is not simply a governance exercise or administrative requirement. It is a continuous and systematic process that enables the Trust to identify, assess, treat, monitor and review risks in a structured and evidence-based way. This includes the triangulation of information from incidents, complaints, claims, audits, performance metrics, staff feedback and external reviews to provide assurance that our controls are effective, and our learning is translated into improvement.

The Board is committed to ensuring that robust governance systems are in place to support the management of operational, corporate, strategic and system risks. Through the Board Assurance Framework, High-Level Risk Register and governance structures, the Trust will maintain oversight of the risks to achieving our strategic objectives and ensure that mitigating actions are progressing effectively.

We will continue to strengthen our culture of openness, accountability and continuous learning, ensuring that staff feel empowered to identify and escalate concerns and that lessons learned lead to meaningful and sustainable improvement.

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19/05/2026 08:22:12

Karen Dawber
Chief Nurse

Part A – Risk Management Policy

Introduction

This document outlines Bradford Teaching Hospitals NHS Foundation Trust's (BTHFT) Risk Management Policy and Risk Management Strategy. This Policy sets out the mandatory governance arrangements, responsibilities and procedural requirements for the management of risk across the Trust.

The document reflects current best practice, considering a range of governance standards including those set out in:

- UK Government's Orange Book: Management of Risk – Principles and Concepts
- NHS England Risk Management Framework
- NHS providers – Guide to Good Governance
- The NHS England Board Assurance Framework Guidance

Purpose of the Policy

The purpose of this Policy is to:

- Define the Trust's governance framework for risk management
- Clarify responsibilities and accountability for managing risk
- Ensure a consistent approach to identifying, assessing, escalating and managing risk
- Support informed decision-making and prioritisation
- Provide assurance to the Board regarding the effectiveness of controls and mitigations
- Ensure compliance with statutory, regulatory and NHS governance requirements

Principles of Risk Management

The Trust is committed to embedding a proactive and integrated approach to risk management across all organisational activities. The following principles underpin the Trust's approach

- Risk management processes will support delivery of the Trust's strategic objectives, operational priorities and statutory responsibilities.
- The Trust will maintain a minimal appetite for risks that may compromise patient safety, care quality or regulatory compliance.
- The Trust will promote a culture of openness, transparency and continuous learning in which staff feel empowered to identify, escalate and discuss risks.
- Risk management processes will support informed decision-making through the use of reliable intelligence, triangulated assurance and proportional controls.
- Risk management will be embedded within quality governance, operational management, financial planning, workforce planning and transformation programmes.

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- The Board will receive assurance regarding the effectiveness of controls through audit, review, performance reporting and governance oversight.
- The Trust will review risk management arrangements regularly to ensure alignment with emerging risks, system pressures and national guidance.

Scope

This Policy applies to all applies to all staff, teams, services, and activities undertaken within the Trust. It applies equally to clinical and non-clinical services, corporate functions, partnerships, programmes, transformation activity and system working arrangements.

The requirements set out within this Policy apply to all levels of the organisation and should be embedded within operational, managerial and strategic decision-making processes.

Definitions

Risk	The effect of uncertainty on the achievement of objectives. The chance of something happening that will have an impact on objectives. An uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives**.**
Issue	A relevant event that has happened or is certain to happen, was not planned, and requires specific management action. The distinction between an issue and a risk is that an issue is an event that has happened or will happen, and a risk is an event that may happen. Unlike a risk, an issue does not involve uncertainty.
Risk Assessment	A systematic process for identifying, analysing and evaluating risks in order to inform decision making and prioritise actions
Consequence	The outcome or impact of a risk should it materialise, expressed in terms of its effect on the Trust's objectives
Likelihood	A measure of how probable it is that a risk event or set of events will occur.
Risk Score	The severity assigned to a risk following assessment. This is determined by multiplying the consequence of the risk by the likelihood of occurrence.
Risk Management	The coordinated culture, framework and set of processes through which an organisation identifies, assesses, manages and monitors risks in order to support the achievement of objectives
Risk Register	A dynamic record of identified risks that may affect the Trust's objectives. It documents risk descriptions, scores, controls, actions, accountabilities and review dates, enabling prioritisation and effective oversight.
Controls	The systems or processes we currently have in place to prevent a risk from occurring, or to reduce the potential consequences and likelihood. Examples include policies, governance structures, training, monitoring processes, and feedback mechanisms.
Assurance	Confidence, based on reliable evidence, that controls are in place, operating effectively, and supporting the achievement of objectives

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Board Assurance Framework	The Board's primary document for identifying, monitoring and obtaining assurance on the control of principal risks that may affect the delivery of strategic objectives
Principal Risks	The most significant risks that, if realised, could seriously impair the Trust's ability to deliver its strategic objectives, financial sustainability, or organisational performance.
Risk Appetite	The level and type of risk the Trust is willing to accept or pursue in achieving its strategic objectives, as determined by the Board.
Risk Tolerance	The acceptable boundaries of variation in performance or risk exposure that the Trust is willing to permit. These thresholds indicate when further action or escalation is required
Operational Risks	Risks affecting day to day service delivery or operational activities. These risks are generally managed locally through service or departmental governance structures.
High Level Risks	Risks affecting the Trust's ability to operate effectively or meet statutory and regulatory responsibilities. These may include risks relating to workforce, estates, digital infrastructure, finance, information governance or organisational resilience. These risks have a current score of 15 or above and are managed through the High-Level Risk Register
Strategic Risks	Risks affecting delivery of strategic objectives, long-term sustainability or responding effectively to external pressures and system changes. Strategic risks are managed through the Board Assurance Framework.

Roles and Responsibilities

Board of Directors

The Board is responsible for setting and overseeing the strategic direction of BTHFT and for ensuring that the Trust delivers its agreed objectives. The Board determines the Trust's risk appetite, identifies the principal risks associated with delivering the strategic plan, and ensures that robust systems are in place for managing those risks

In fulfilling these responsibilities, the Board will:

- Formally approve the Trust's Risk Management Strategy and Policy and ensure that it reflects recognised good practice standards for governance, including clarity of roles, processes, and assurance mechanisms.
- Review and approve enhancements to risk management systems, methodologies, or reporting arrangements where required to strengthen internal control, meet regulatory expectations, or respond to emerging risks.
- Consider and approve the allocation of financial, technological, and workforce resources necessary to implement risk management initiatives.
- The Board will obtain regular assurance from the Executive Team and relevant committees that:
    - Risks on the High-Level Risk Register (HLRR) and the Board Assurance Framework (BAF) are current, evidence-based, and appropriately described.
    - Controls are in place and operating effectively, and that action plans are progressing as required where gaps in control or assurance have been identified.
    - Review cycles are adhered to, monitored and challenged.

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- Where risks are not adequately controlled within the defined risk appetite or tolerance, the Board will seek assurance that corrective action is being taken within appropriate timescales.

Chief Executive
Overall responsibility for ensuring that the Trust has in place the required systems and processes that support risk management across the organisation and that these systems and processes are approved and monitored by the Board of Directors

Executive Directors
Each Executive Director will ensure that all risks on the High-Level Risk Register and BAF for which they are identified as executive lead, are appropriately described, scored, mitigated, monitored and reviewed.

Associate Director of Corporate Governance
Is responsible for organising the Board of Director's work plan making provision for the discussion of all new risks entered on to the High-Level Risk Register and for ensuring that the BAF is maintained and reported to the Executive Team, Committees and Board.

Associate Director of Quality
Is responsible for ensuring that incident and risk management reporting processes are embedded within the organisation and that CSU and corporate department risk registers are subject to regular review and updated to reflect key risks.

Risk Committee
The Trust will establish a dedicated Risk Committee to provide oversight of risk management arrangements across the Trust. The Committee will act as the primary forum for reviewing the effectiveness of risk management systems, oversight of risks and the adequacy of assurance arrangements.
The Committee will:

- Review the effectiveness of the Risk Management Strategy and Policy
- Provide oversight of the Board Assurance Framework and High-Level Risk Register
- Receive assurance regarding the effectiveness of mitigating controls and action plans
- Review thematic risk intelligence, trend analysis and learning
- Oversee risk management performance metrics
- Receive escalation reports from the Risk Review Panel
- See Terms of Reference for further information

Risk Review Panel
A multidisciplinary Risk Review Panel will operate as a formal sub-group supporting the Risk Committee. The Panel will undertake regular detailed review of all risks scored as Extreme (15–25), including challenge regarding scoring rationale, adequacy of controls, trajectory, timescales and escalation requirements.
The Panel will:

- Review all Extreme risks on an ongoing basis

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- Challenge whether risks should be accepted onto the High-Level Risk Register
- Assess the quality of controls and assurances
- Identify thematic trends and interconnected risks
- Escalate concerns to the Risk Committee where controls or assurances are insufficient

Role of Committees of the Board

The committees are recipients of assurance regarding risks relevant to their remit and are responsible for reviewing, scrutinising and challenging the adequacy of controls, assurances and mitigating actions associated with those risks.

Committees will:

- Receive and review relevant risk reports and escalation summaries
- Provide scrutiny and challenge regarding risk trajectory and mitigation progress
- Identify gaps in assurance or control effectiveness
- To provide assurance to the Board of Directors in relation to risk relevant to their remit

CSU Triumvirate Leadership Teams/Directors of Corporate Departments will ensure through their line management structures that:

- Active implementation of the Trust's risk management processes within their teams.
- Clinical and non-clinical risk assessments are undertaken and local risk registers maintained.
- Effective implementation of policies and procedures.
- Attendance of staff at appropriate risk management training.
- Raising awareness of risk management issues within their areas.
- Seek advice from Quality and Patient Safety Facilitators as required.
- Timely escalation of risks approaching or exceeding tolerance thresholds and in accordance with the risk escalation framework.

Quality & Patient Safety Facilitators

- Provide facilitated support to CSU Triumvirate Leadership teams to ensure that risks are identified, accurately recorded, managed, reviewed and escalated appropriately.

All Managers are responsible for:

- Familiarising themselves with the Risk Management Strategy and associated procedures and guidance, and for raising awareness and understanding of risk management within their work area.
- Reviewing their areas of work to identify risks, agree appropriate actions and escalate risks as necessary.
- Creating supportive environments that encourage open reporting of risks.
- Investigating risks reported within their teams.
- Ensuring staff undertake relevant training.
- Maintaining risk management as a standard agenda item in governance meetings.

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All staff are responsible for**:**

- Co-operating with arrangements for minimising risk
- Notifying line managers of any identified risks.
- Complying with the Trust's incident reporting procedure.
- Participating in required risk management training.
- Contributing to a culture of openness, continuous learning and shared accountability.

Risk Appetite and Risk Tolerance

Risk appetite describes the amount and type of risk the Trust is willing to pursue, retain, or accept in order to achieve its strategic objectives. It reflects the balance between:

- the opportunity presented by innovation, improvement and transformation, and
- the threats that arise from uncertainty and organisational change.

Risk appetite supports informed and transparent decision making. It ensures that the Trust's ambitions are delivered responsibly, safely and in a manner aligned to statutory, and regulatory obligations.

Risk tolerance refers to the acceptable boundaries of variation in risk exposure or performance that the Trust is willing to permit. In practice, risk tolerance defines the target level of residual risk (i.e. the level of risk remaining after controls are applied) that the Trust considers acceptable. Tolerance thresholds define the point at which corrective action, additional control measures, or escalation is required.

Together, risk appetite and risk tolerance guide decision making at all levels, ensuring risks are managed consistently and proportionately across the Trust

Staff undertaking risk assessments and making operational or strategic decisions should understand the level of risk the Board considers acceptable. This understanding supports proportionate decisions on whether to:

- **Transfer** the risk
- **Treat** the risk
- **Terminate** the activity giving rise to the risk
- **Tolerate** the risk, where justified and within appetite

Decision makers must be able to demonstrate that:

- Risks have been assessed against the approved risk appetite statement,
- Controls are appropriate and effective, and
- Residual risk has been reduced to a level consistent with the Board's tolerance thresholds.

In all cases, both current risk (the level of risk at the present time) and residual risk (the anticipated level after controls) must be clearly recorded and understood. Current risk informs the urgency of response and escalation, while residual risk informs whether the risk is acceptable within tolerance.

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The Board is responsible for risk appetite and has developed a Risk Appetite Statement which forms part of the risk strategy and will guide staff in their actions and ability to accept and manage risks.

The table shows risk appetite levels, adapted from the Good Governance Institute. This forms the background to the Board's discussion and decision when defining the Trust's risk appetite. Using this model as guidance the Trust Board has agreed a risk appetite statement that aligns to the Trust's strategic aims (Appendix 2).

The risk appetite statement:

- sets the appetite levels against each strategic objective,
- defines the Trust's attitude towards different domains of risk,
- identifies the associated tolerance thresholds,
- provides guidance for decision makers across the Trust

Appetite Level	Description	Typical Behaviour
Avoid	There is a requirement to avoid risk and uncertainty to deliver an agreed organisational objective	Activity only proceeds if risk can be almost eliminated
Minimal	There is a preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.	Conservative decision making
Cautious	There is a preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for reward.	Risk must be actively managed and monitored
Open	There is a willingness to consider all potential delivery options and choose those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement and/or value for money.	Balanced approach between opportunity and control
Seek	There is a preference to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk and there is evidence that the organisation is mature: There is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.	Innovation and transformation encouraged

Table 1: Risk appetite levels and descriptions

This statement should be considered when assessing risk tolerances in the Board Assurance Framework, High Level, CSU and Local Risk Registers. The Risk Appetite Statement will be reviewed annually, or sooner if required due to changes in the operating environment, regulatory expectations, or Trust context. The Board expects risks across the Trust to be managed within the defined appetite levels. Where these levels are exceeded, action must be taken to reduce exposure and, where necessary, escalate to the appropriate group.

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Risk appetite should be explicitly considered:

- when identifying and scoring risks,

- when determining residual risk ratings,
- when evaluating risk treatment plans,
- when escalating risks through governance structures, and
- when making strategic or operational decisions that may alter risk exposure.

Minimal Risk Tolerance Thresholds

The Trust applies risk tolerance thresholds to both current risk scores (escalation) and residual risk scores (reflecting risk after controls).
Regardless of the broader risk appetite set for each strategic objective, the Trust has a minimal risk tolerance (score 1–8) for risks that may impact:

- Patient safety
- Staff safety and wellbeing
- Regulatory compliance

For these domains:

- Any residual risk score 9+ is outside tolerance and must be escalated
- Any current risk score 9+ must be escalated immediately due to the level of exposure

Risk Appetite and Tolerance Ranges

Risk appetite and risk tolerance are both expressed in terms of residual risk scores, reflecting the level of risk remaining after controls and mitigations have been applied.

- Risk appetite defines the target residual risk level the Trust aims to achieve
- Risk tolerance defines the range of residual risk that may be accepted in the short to medium term

In addition, current risk scores are used to assess risk exposure and determine escalation requirements

Risk Appetite	Target Residual risk (Appetite)	Acceptable Residual risk (Tolerance)
Avoid	1-3	4-6
Minimal	1-5	6-10
Cautious	1-8	9-15
Open	1-10	12-20
Seek	1-15	16-25

Table 2: Risk appetite and tolerance ranges

Risk appetite is not uniform across all domains. The Board has set specific appetite levels for each strategic objective (as detailed in Appendix 2), recognising that:

- some objectives (e.g., innovation, workforce transformation) require a more open or seeking appetite for risk,
- whereas patient safety, staff safety, and regulatory compliance require an inherently minimal appetite.

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This structured approach ensures the Trust can pursue ambitious strategic goals while maintaining rigorous protections for patients, staff, and the Trust's integrity. The Board recognises that risk cannot be entirely eliminated and that a balanced approach is required to support innovation, transformation and improvement while maintaining safe, effective and sustainable services.

Risk appetite will be explicitly considered in:

- Service redesign and transformation programmes
- Investment and capital decisions
- Workforce redesign initiatives
- Digital transformation programmes
- Estates and infrastructure prioritisation
- Operational recovery
- Equality and Quality Impact Assessments (EQIA)

Operational Risk Escalation Framework

The Trust manages risk through a structured escalation process to ensure risks are reviewed at the most appropriate level and that significant risks receive timely oversight and intervention. Risks must be escalated or de-escalated based on:

- Current risk score
- Nature and impact of the risk, particularly where strategic objectives may be affected
- Potential impact on patient safety, staff safety, or regulatory compliance
- Whether existing controls are effective or require strengthening
- Whether the residual risk remains exceeds tolerance

The operational risk escalation structure is set out below:

Level	Current Risk Score	When to Escalate	Responsibililities/Actions
Local Management (Ward, Specialty, Corporate Teams)	**1-8**	• Any risk with a current risk score 9+ should be esclated • Any residual risk in a minimal tolerance domain 9+ should be escalated	• Risks scoring 1–8 are managed locally. • Monitoring takes place via local governance meetings. • Implement and track controls • Review risk scores regularly
CSU Governance	**9+**	• Current risk scores exceeding thresholds 12+ and 15+ • Any residual risk in a minimal tolerance domain 9+ should be escalated	• Validate risk scoring • Review and strengthen controls • Decide if escalation to Executive Team is required • Monitor progress monthly
Risk Management Commmittee	**12+**	• Current risk score is 12+, regardless of domain • Risk has potential for escalation to the High Level Risk Register • Risk requires Trust wide oversight or cross CSU action	• Review and challenge scoring • Assess effectiveness of controls • Agree further mitigation actions • Consider escalation to High Level Risk Register

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		• Current risk score is 15+, regardless of domain • Risks that may threaten delivery of strategic objectives	• Acceptance of risk to High Level Risk Register • Assign Committee oversight • Monitor controls, and actions monthly • Assess whether residual risk is tolerable or requires further intervention or BAF acceptance
Board / Committees	**15+**	The Board and its Committees receive: • All High-Level Risks (current score 15+) • Any BAF risks • Any 9+ minimal tolerance domain risks that may threaten strategic objectives	• Committees review assigned high-level risks 10 times per year. • The Board reviews the full HLRR 6 times per year

Table 3: Risk escalation framework

Board Assurance Framework

The purpose of the Board Assurance Framework (BAF) is to assure the Board that the Trust is mitigating the strategic risks to the delivery of its strategic objectives. The BAF identifies, records and monitors:

- Strategic objectives
- Risk appetite in relation to the objectives
- Risks to achieving those objectives (strategic risks)
- Initial risk score
- Current risk score
- Target risk score (consistent with risk appetite)
- Movement in risk score
- Controls and assurances
- Gaps in controls and assurances
- Actions to address gaps
- Lead director
- Related risks on risk register

The BAF provides a high level overview of the Trust's position against the risks to achieving the Trust's strategic objectives. The BAF acts as the principal document through which the Board obtains assurance that risk management, control and governance arrangements are effective.

Executive Directors initially identify strategic risks for inclusion on the BAF. These risks are reviewed annually and agreed by the Board. The Board may also identify additional strategic risks as circumstances change.

The BAF is reviewed, challenged and assessed:

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- By the Executive Team on a bi-monthly basis (six times per year)
- By the Board at each formal meeting of the Board (six times per year)
- By relevant Committees within their remit, to provide assurance on the effectiveness of controls and actions

Committee reviews must include scrutiny of:

- the adequacy of controls,
- assurance evidence supporting those controls,
- progress against action plans,
- gaps in assurance,
- risk trajectory and whether the risk remains aligned to target risk level.

Each Committee then provides formal upward assurance to the Board, ensuring that all strategic risks have been reviewed with appropriate depth and challenge.

On an annual basis, the Board will undertake a comprehensive review of the BAF to:

- confirm the ongoing relevance of strategic risks,
- agree amendments to risk descriptions,
- close risks where objectives have been met or where exposure has stabilised, and
- identify any new or emerging strategic risks.

The annual review also ensures ongoing alignment between the BAF, the Risk Appetite Statement, the Corporate Strategy and other key planning documents.

High Level Risk Register

Any risks with a current score of 15 or above are reported to the Risk Management Committee for discussion. If the Executive Team agree that the risk is scored at 15 or above, it is included on the High Level Risk Register (HLRR). This ensures that the Trust maintains oversight of the most significant operational risks that may affect safety, service delivery, performance, financial sustainability or regulatory compliance.

The HLRR is a dynamic document that changes continually as actions are taken to mitigate high risk issues, and as new risks are identified. It provides a Trust-wide view of the most critical operational risks, enabling timely escalation, monitoring and assurance.

The HLRR is reviewed in full every month at the Risk Management Committee. The review includes:

- A summary of key changes to the Register
- Progress made against mitigating actions
- Emerging themes or interconnected risks
- Areas where controls require strengthening
- Consideration of whether risks remain within, or exceed, the Trust's risk appetite and tolerance levels

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High Level Risks are then assigned to one or more of the relevant Committees or the Board (as appropriate), each of which has governance responsibility for oversight of mitigating actions and risk trajectory. At each meeting (10 times per year), Committees must:

- Review and challenge high-level risks within their remit
- Assess whether mitigations are effective and on track
- Confirm whether risks should remain high-level or be de-escalated
- Ensure any gaps in control or assurance are addressed

The Board reviews the full HLRR at each Board meeting (6 times per year). The Board also receives:

- Executive Team discussions via a risk report
- Committee insights and assurance via Chairs' reports

This enables the Board to gain a triangulated view of the most significant risks affecting the Trust.

Local Risk Registers

Local Risk Registers are held at ward, speciality, CSU or corporate service level and form the core mechanism through which risks are identified, assessed, recorded, managed and monitored across the Trust. These registers provide the foundation of the Trust's bottom-up risk management system and ensure that emerging risks are identified early and escalated appropriately.

Each ward, speciality, CSU or corporate service must maintain a local risk register which at a minimum capture:

- risk descriptions (aligned to the Cause–Event–Effect format),
- initial, current and residual risk scores,
- existing controls and their effectiveness,
- planned mitigation actions and timescales,
- risk owner
- review dates,
- escalation decisions and rationale.

Risk registers must be routinely reviewed and monitored through the established CSU governance structure. Each CSU is assigned a Quality and Patient Safety Facilitator who supports the CSU leadership teams in fulfilling their responsibilities. This includes helping teams to identify risks, ensure quality of risk descriptions, advise on mitigation plans and support timely review cycles.

Patient safety incidents, thematic learning, complaints, performance data or other relevant intelligence must be considered alongside the CSU risk registers to ensure that emerging risks are identified and appropriately captured. Risk registers are reviewed at the CSU Quality and Safety Meetings using a standardised agenda and supported by monthly quality reports.

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Corporate team risk registers must also be routinely reviewed and monitored by Executive Directors and their teams. Corporate risks must be managed with the same level of discipline and oversight as clinical risks, recognising their potential impact on strategic delivery, resilience, finance, workforce or regulatory compliance.

Local Risk Registers must not become static repositories, they should be dynamic tools that support active decision making, prioritisation and escalation of risks

Where risks cannot be effectively controlled locally or exceed agreed tolerance thresholds, they must be escalated through the Risk Escalation Framework

Distinguishing Risks from Issues

A risk is:

- The effect of uncertainty on objectives.
- An uncertain event or set of events that may impact the achievement of objectives

An issue is an event, problem or situation that has already occurred, is currently occurring, or is certain to occur and therefore requires immediate management action. Unlike a risk, an issue no longer contains uncertainty.

The Trust expects staff and governance groups to apply the following principles when determining whether a matter should be managed as a risk, an issue, or both:

Scenario	Risk	Issue
Something may happen in the future	Yes	No
Something has already happened	No	Yes
There remains uncertainty	Yes	No
Immediate operational action is required	Possibly	Yes

Issues may generate new risks or increase existing risks. Similarly, unmanaged risks may materialise into issues. Governance discussions should therefore ensure that issues inform risk assessment activity and that recurring issues are reviewed thematically to identify underlying systemic risks.

Risk Assessment, Management and Monitoring

The formal proactive method of identifying operational risks within the Trust is through the use of structured risk assessments (Appendix 3). A risk assessment is the process of identifying potential risks, evaluating their impact, and implementing controls to reduce or eliminate them.

To support consistency and quality, the Trust has developed a Risk Management Handbook (Appendix 4) which guides staff through the following core components:

- How to identify a risk

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- How to write a clear risk description using the Cause-Event-Effect Method
- What to consider when assessing the potential for harm
- Identifying existing control measures, and the need to consider whether controls are adequate
- How to determine and select the right additional controls required
- How to score a risk correctly
- How to determine the residual risk score
- Understanding requirements when adding a risk to the risk register

Risk assessment must be undertaken in a structured, evidence-based and consistent manner across all departments, ensuring that risks are captured accurately and managed effectively.

Reviewing Risks

Risks should be managed and reviewed within specialties, CSUs and corporate departments at the appropriate governance meeting, for example, the CSU Quality and Safety Meeting or a locally established alternative.

A named risk lead will be responsible for coordinating reviews of the risk register, ensuring timely updates, closure of risks, and compliance with this strategy.

All risks should be reviewed in accordance with the Trust risk review frequency framework as shown below:

Risk Score	Minimum Review Frequency
Extreme Risk 15-25	Monthly
High Risk 8-12	Quarterly
Moderate Risk 4-6	Six Monthly
Low risk 1-3	Annually

Table 4: Risk review frequency framework

When reviewing a risk, the following elements must be assessed:

- Changes in the risk score (increase, decrease or unchanged)
- Effectiveness of current controls and whether additional actions are required
- Whether newly identified information changes the risk score
- Whether the risk remains valid and relevant, or is suitable for closure
- Whether implementation dates for controls or actions remain realistic

Where actions are delayed or ineffective, managers must take prompt steps to address barriers and re-prioritise mitigation activity.

All updates must be documented in the IRIS Risk Management System, including:

- revised controls,
- updated risk scores,
- progress on mitigation plans,

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- expected timescales for achieving target scores.

Risks with high or escalating risk scores must be discussed in detail at local governance meetings and flagged for potential escalation through the escalation framework. Leadership teams must ensure that all risks are reviewed as per the agreed date.

Management of Long Standing Risks

The Trust recognises that risks which remain open for prolonged periods may indicate insufficient mitigation, resource constraints, ineffective controls or risks that require strategic intervention.

All risks open for more than two years will be subject to formal review to ensure that:

- The risk description remains accurate and relevant
- Risk scores remain appropriate and evidence based
- Mitigating actions are progressing effectively
- The risk remains aligned to organisational priorities
- Alternative or additional controls have been considered
- Escalation arrangements remain appropriate
- Risks assessments have been reevaluated and completed

Outcomes of these reviews will be documented and reported through governance structures. Where risks remain static or unresolved over extended periods, risk leads will be required to provide clear recovery or reduction plans

Training

Contributing to risk management is the responsibility of all members of staff, and the Trust recognises the importance of providing risk education and awareness training for all grades of clinical and non-clinical staff.

Risk management training is part of the mandatory training for all clinical staff.

The following training and education will be provided to support the implementation of the governance and risk management strategy.

Board of Directors

The commitment and engagement of the Board of Directors within the Trust is paramount in creating a foundation for the implementation of this strategy and embedding the key principles throughout the Trust. To support this priority, updates and awareness training programmes will be provided at least annually from both internal and external experts. For executive and non-executive directors, this will form part of the on-going Board development programme.

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All Staff

Risk management awareness and the incident reporting procedure is a structured part of the Trust's induction programme for new staff. In addition, staff will have access to:

- Weekly risk management drop-in sessions delivered by the Quality Governance Department via Microsoft Teams.
- Targeted in-person training for clinical teams, delivered by Quality and Patient Safety Facilitators as required, focusing on risk identification, escalation and management of CSU-level risks.
- Training on use of the IRIS risk management system, including access to certified supplier-provided e-learning modules and user guides.

The Trust will provide risk management training, including a Risk Management Masterclass that will be delivered on an annual basis. This will:

- Develop staff knowledge and practical skills in identifying, assessing and escalating risks.
- Support effective development of mitigation plans and evaluation of control effectiveness.
- Strengthen competence in applying the Risk Appetite Statement and escalation thresholds.
- Enable staff to practice risk scoring using realistic scenarios, enhancing consistency and accuracy across the Trust.
- Ensure confidence in using the IRIS system to document and review risks

Assurance and Monitoring

Compliance with the Risk Management policy will be monitored through a bi-annual report to the Audit Committee.

The report will be prepared jointly by the Associate Directors of Quality and Corporate Governance, it will monitor as a minimum:

- The key individuals for risk management are discharging their responsibilities in line with the Strategy through attendance at key risk management meetings and there is evidence of activity through the minutes of those meetings.
- The Executive Team, Committees, and Board have discharged their responsibilities in line with the relevant Terms of Reference.
- How risk is managed locally through a review of compliance with the Trust-wide risk management process. A standard set of metrics will be applied consistently across CSUs, including:
    - Whether all specialties/teams are represented for the respective CSU/corporate teams
    - Age of risks and presence of legacy risks
    - Current, and residual risk (target) scores including comparison with the Trust stated risk tolerances

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- Categories of risks
- Review and target date for implementation compliance
- Evidence of mitigation progress and control documentation
- Use of Cause, Event, Effect risk descriptions
- Increasing/decreasing trend including static risks
- Distribution of risk scores
- Risks on the strategic risk register

Where deficiencies are identified, an action plan will be developed and monitored through the Executive Team.

Part B – Risk Management Strategy

Introduction

The Strategy describes how the Trust will strengthen, embed and continuously improve its approach to risk management over the next three years.

The Trust is committed to maintaining a comprehensive and integrated approach to risk management that supports the achievement of strategic objectives, protects patients, staff and visitors from avoidable harm, and supports effective use of public resources.

This strategy will directly inform, shape, and support the following activities across the Trust:

- The development, maintenance, and continual review of risk registers ensuring demonstrable and effective risk management.
- The implementation and consistent application of a structured risk escalation framework.
- The development, operation, and ongoing review of the Board Assurance Framework to provide clear oversight of strategic risks and associated controls.
- The provision of training and support for managers to ensure they are equipped to identify, assess, and manage risks as part of routine operational responsibilities.
- The effective utilisation of the Trust's quality governance systems and structures to support decision making, assurance, and accountability
- Implementation of systems and processes to ensure that risk assessments are undertaken systematically in all clinical and corporate departments, and the effectiveness of controls is monitored.
- The use of intelligence derived from risk assessments, incidents, complaints, audits, claims, external recommendations, and other relevant sources to enhance safety, inform improvement, and promote learning.
- Use of internal and external audit findings and assessments to provide assurance on the effectiveness of controls to minimise risk.
- The achievement of high standards of risk management to support external validation requirements, including compliance with the Care Quality Commission's (CQC) standards.

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Strategic Context

Global Risk Profile

The Trust recognises that healthcare organisations are increasingly affected by a rapidly changing global risk environment. The World Economic Forum Global Risks Report 2025 identifies escalating geopolitical instability, misinformation, climate-related events, cyber threats and societal polarisation as major short-term global risks. These external pressures have direct and indirect implications for NHS organisations, including operational resilience, workforce sustainability, digital security and supply chain reliability.

National Risk Profile

The UK Government National Risk Register 2025 identifies a number of acute and chronic risks relevant to NHS Trust's and local resilience planning. These include:

- Cyber attacks affecting health and care infrastructure
- Pandemic and infectious disease threats
- Terrorism and major incidents
- Environmental and climate-related emergencies
- Utility and infrastructure failure
- Industrial action and societal disruption
- Supply chain disruption and economic instability

These risks inform the Trust's Emergency Preparedness, Resilience and Response (EPRR) planning, Board Assurance Framework and strategic resilience programmes.

Sector and Organisational Risk Themes

The ECIIA Risk in Focus 2025 report identifies key emerging organisational risks including artificial intelligence and digital disruption, cyber security, workforce sustainability, talent management, macroeconomic uncertainty and climate change. These themes are reflected within the Trust's strategic and operational risk management processes**.**

Regional Risk Profile

The West Yorkshire Integrated Care Board Five Year Plan sets out a system-wide ambition to improve population health outcomes, reduce inequalities, strengthen community-based care, improve access and quality, and deliver sustainable health and care services across the region.

The Plan identifies several cross-cutting themes relevant to the Trust's risk profile, including:

- Reducing health inequalities
- Improving urgent and emergency care flow
- Developing a sustainable workforce
- Strengthening digital transformation and data sharing
- Delivering financial sustainability
- Enhancing prevention and population health approaches
- Supporting collaborative system working

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The Trust's strategic and system risk management arrangements will align to these priorities and support collaborative mitigation of risks affecting patient outcomes and service sustainability across the region.

Trust Strategic Risk Profile

The Trust's strategic risk profile reflects the principal threats and uncertainties that may impact delivery of the Corporate Strategy. Key themes currently include:

- Patient safety and quality of care
- Workforce recruitment, retention and wellbeing
- Operational performance and care flow
- Financial sustainability and productivity
- Digital resilience and cyber security
- Estates infrastructure and statutory compliance
- Partnership and system dependency risks
- Climate resilience and environmental sustainability

Operationalising Risk Management

Risk management must support practical operational and strategic decision-making across the organisation. The Trust will therefore ensure that risk assessment and risk appetite considerations are integrated into:

- Business case development
- Service redesign and transformation programmes
- Workforce planning
- Capital investment prioritisation
- Financial planning
- Quality impact assessments
- Digital transformation programmes
- Estates and infrastructure planning

Decision-making will balance the priorities of quality, finance, workforce and operational performance. The Trust recognises that risks across these domains are interdependent and require coordinated oversight and mitigation.

Three year ambition (2026-2029)

By 2028, we will:

1. **Strengthen risk maturity and consistency**
   - Achieve a high level of consistency in risk identification, scoring and description across all CSUs and corporate services
   - Ensure all risks are written in a clear Cause–Event–Effect format, with well-defined controls and actions

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- Reduce the number of long-standing or static risks, with clear trajectories for reduction or resolution
- Embed risk management as a routine and valued part of operational practice.

2. Embed risk appetite in decision-making

Ensure that risk appetite and tolerance are consistently applied in all key decisions

Integrate risk considerations into:

- business cases
- service redesign
- workforce planning
- financial and capital decisions
- Enable leaders at all levels to make confident, informed and proportionate decisions, aligned to Board expectations

3. Improve the quality of assurance

Establish a fully triangulated approach to assurance, combining:

- risk register data
- incident reporting
- complaints and patient feedback
- audit findings
- performance metrics

Provide the Board with clear, evidence-based assurance on:

- effectiveness of controls
- progress in reducing risk
- emerging themes and system dependencies

Strengthen the distinction between controls and assurances, improving the reliability of governance reporting

4. Enhance risk visibility and escalation

Ensure risks are consistently escalated at the right time and to the right level, in line with the escalation framework

Improve the quality and timeliness of risk reviews, particularly for high and extreme risks

Strengthen oversight of:

- High-Level Risk Register
- Board Assurance Framework

Enhance senior leadership visibility of:

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- cross-cutting and system risks
- interdependencies between services

5. Strengthen learning and improvement

Ensure that learning from the following is systematically translated into risk management activity:

- incidents
- complaints
- claims
- inquests
- external reviews

Establish routine thematic reviews to identify systemic risks and improvement opportunities

Demonstrate clear links between risk identification, learning and service improvement

6. Improve capability and confidence

Deliver a structured programme of:

- risk management training
- leadership development
- practical support for teams

Ensure managers and leaders are equipped to:

- identify and articulate risks clearly
- assess and manage risk effectively
- apply risk appetite in decision-making

Support continuous development through:

- targeted training
- risk masterclasses
- ongoing facilitation

Learning, Thematic Review and Intelligence

The Trust will strengthen the integration of risk, incident, complaints, audit and learning systems to support earlier identification of themes, emerging risks and systemic weaknesses.

Thematic reviews will be undertaken where patterns or recurring concerns are identified through:

- Patient safety incidents (QuOC, SEG and safety huddles)
- Complaints and patient feedback

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- Claims and litigation trends
- Clinical audit findings
- Coroners' inquests
- External reviews and inspections
- Freedom to Speak Up themes
- Staff survey findings

Learning identified through these sources will be triangulated with risk register information and quality metrics to determine whether additional controls, escalation or strategic intervention are required.

The Board and Committees will receive thematic assurance reports summarising key learning, trend analysis and progress against improvement actions.

Training and Risk Culture

The Trust is committed to developing a positive and mature risk culture in which staff are empowered to identify, escalate and discuss risks openly.

The effectiveness of the Trust's risk culture will be monitored through:

- Staff survey results
- Freedom to Speak Up themes
- Incident reporting trends
- Training compliance rates
- Audit findings
- Board and leadership engagement activity

Risk management training will be aligned to role and responsibility and will include practical application of risk assessment, escalation and assurance principles

Assurance and Monitoring

The Trust uses a triangulated approach to assurance to determine whether controls are operating effectively and whether risks are reducing as intended. Assurance will not rely solely on self-assessment or risk register reporting.

Sources of assurance will include:

- Internal audit findings
- Clinical audit programmes
- Quality dashboards and performance metrics
- Patient safety incident trends
- Complaints and PALS themes
- Claims and litigation analysis
- Workforce metrics
- External reviews and inspections (e.g. CQC)

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- Maternity Incentive Scheme and HSIB
- Peer review and benchmarking data
- Learning from inquests and Prevention of Future Death reports

Committees and the Board will receive triangulated reports that combine these intelligence sources to provide a more comprehensive assessment of risk exposure, control effectiveness and emerging themes.

The Board will seek assurance not only that controls exist, but that they are demonstrably effective and resulting in measurable improvement.

Progress against the three year ambition will be monitored through:

- improvements in the quality of risk register entries
- reduction in aging and static risks
- increased confidence in Board assurance processes
- positive trends in incident reporting and learning
- maintaining national average or above in staff survey responses relating to safety culture and engagement

Conclusion

This Risk Management Strategy and Policy establishes the Trust's framework for managing risk in a structured, transparent and accountable manner. Through effective governance, strong leadership, system partnership working and a learning culture, the Trust aims to strengthen patient safety, improve resilience and support the successful delivery of its strategic objectives.

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NHS Foundation Trust's Board of Director's Risk Appetite Statement

The Board of Directors recognises that the Trust's long term stability and continued development of effective relationships with our patients, their families and carers, our staff, our community, and our strategic partners is dependent upon the delivery of our strategic objectives. It also recognises that the "Good" rating applied to the Trust by the CQC in 2026 has an influence on the risk appetite of the organisation.

The Board of Directors believes that our risk appetite appropriately reflects the progress that the Trust has made in implementing and assuring its Corporate Strategy 2022-2027 and its associated strategies and plans and is fully aligned to our ambition. A balanced approach has been taken to reviewing the specific areas of risk associated with each strategic objective by the Board of Directors, and without exception, there is a minimal appetite in relation to any risks to patient safety, staff safety or regulatory compliance.

SO1: Quality - To provide outstanding care for our patients, delivered with kindness

Our mission is to provide high quality care to our patients at all times and we will not accept risks that could affect our ability to do this. Our mission is our key organisational driver that directly supports our strategic objective to provide outstanding care for patients, delivered with kindness, improving outcomes for our patients and their carers by providing safe, effective, personal and responsive care. We will hold patient safety in the highest regard and are averse to any risk, clinical, operational, workforce or related to strategic partnerships that may jeopardise it. But we have insight, we manage risk, we engage and involve, we improve and innovate and we assure, which enables us to have an open risk appetite in relation to our strategic objective to provide outstanding care for our patients, we are willing to consider all potential delivery options and choose, while also providing an acceptable level of reward.

SO1 Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Associated Strategic Risks: SR01, SR02

Risk Appetite Summary

Risk appetite	Avoid	Minimal	Cautious	Open	Seek
SO1: Quality		Regulatory compliance Quality and Patient safety		Operational Delivery and Performance	

SO2: Improvement – To be a continually learning organisation and recognised as leaders in research, education and innovation

The Trust recognises that to be a continually learning organisation it must have a broadly open approach that aligns the different areas of risk. These areas of risk include those associated with education and training, research translation, new technology, engagement and the learning management system. We are committed to identifying, developing, deploying and embedding learning at every level of the organisation to improve the quality of care for patients

SO2 Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Associated Strategic Risks: SR03, SR04

Risk Appetite Summary

Risk appetite	Avoid	Minimal	Cautious	Open	Seek
SO2: Improvement		Regulatory compliance Quality and Patient safety		Workforce and culture Transformation and innovation	

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SO3: People – To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing quality, diversity and inclusion

The Trust is clear that we will not accept risk where it involves potential exposure to significant harm for employees. Examples include:

- *Bullying or harassment of employees by their managers or colleagues*
- *Discrimination of employees by their managers or colleagues*
- *Exposing employees to faulty machines or equipment*
- *Exposing employees to machines or equipment where this may result in a detrimental known impact on the health of the employee.*

However in relation to all other elements of achieving our strategic objective to be one of the best NHS employers the Trust will pursue workforce innovation and be pro-active around developing and trialling new ways of working and new job role/career pathway opportunities. By doing this we will seek to both increase workforce supply and improve the skills and capabilities of our people, ensuring we provide high quality care to our patients at all times.

SO3 Risk Appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)
Associated Strategic Risks: SR05, SR06

Risk Appetite Summary

Risk appetite	Avoid	Minimal	Cautious	Open	Seek
SO3: People		Regulatory compliance Quality and Patient safety Staff safety and EDI			Workforce and culture

SO4: Partnership – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals

We will actively collaborate to increase our influence. We will actively explore opportunities for value added innovation.

SO4 Risk Appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)
Associated Strategic Risks: SR07

Risk Appetite Summary

Risk appetite	Avoid	Minimal	Cautious	Open	Seek
SO4: Partnerships		Regulatory compliance Quality and Patient safety Staff safety			Partnerships and system working

SO5a: Sustainability – To deliver our financial plan

We will not tolerate risk to patient safety in order to deliver the Financial Plan, however we will accept a degree of compromise on optimum levels of care, but actively avoiding any safety concerns. We will strive to meet regulatory requirements but will not set unrealistic challenges that compromise the delivery of clinical strategic ambitions. We will provide realistic forecasts to regulators under 'no surprises' expectation. We will maintain an open and honest relationship with our Integrated Care Board colleagues and jointly recognise the financial challenges we face. The Trust will ensure that cash balances will be maintained at a level that protects the Trust's ongoing trading liabilities. Subject to sufficient reserves the Trust will invest to transform, but only when the realisable benefits are fully tested and assured and adequate liquidity is preserved.

SO5a Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Associated Strategic Risks: SR08, SR09

Risk Appetite Summary					
Risk appetite	**Avoid**	**Minimal**	**Cautious**	**Open**	**Seek**
SO5a: Sustainability		Regulatory compliance Quality and Patient safety Staff safety	Finance and Value Operational Delivery and Performance		

SO5b: Sustainability – To deliver our key performance targets
Patient safety is our highest priority in all aspects of performance management and operational delivery. Where we have the ability to increase activity in order to achieve our performance targets. We will do this as long as it does not create other areas of unacceptable risk in relation to quality, patient safety, workforce and finance. We will work with other acute providers, other health and social care agencies including the independent sector and voluntary services to deliver activity, day to day operations to safely achieve our performance targets.
SO5b Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward **Associated Strategic Risks**: SR08, SR09

Risk Appetite Summary					
Risk appetite	**Avoid**	**Minimal**	**Cautious**	**Open**	**Seek**
SO5b: Sustainability		Regulatory compliance Quality and Patient safety Staff safety	Finance and value Operational Delivery and Performance		

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Appendix 2 – Risk Assessment Template

Risk title:				
Summarise from the description below:				
Risk description:	CAUSE	EVENT	EFFECT	**Risk location:**
Include any relevant background information to provide context of why the risk is being assessed:	***IF……..****we are unable to release clinical staff for mandatory training due to staffing levels*	***THEN……..****staff will not receive compulsory training in relation to resuscitation or blood safety*	***RESULTING IN……..****an increased safety risk to patients*	

Assessment:				
Identify the hazards - Think about what may cause harm (these are called hazards).	**Assess the potential for harm -** Who might be harmed and how?	**Existing control measures -** Indicate what is currently in place to control the hazard.	**Gaps in control measures -** Why are the existing control measures inadequate?	**Further controls required -** What further action could you take to control the hazards/ potential cause of harm?
Example: *We are unable to release clinical staff for mandatory training due to staffing levels*	*Patients may be put at risk of harm if staff are not up to date with mandatory training resulting in avoidable harm*	*Managers informed on a weekly basis of non-compliant staff to prioritise their release to complete the training*	*Staff may not be able to be released at the time of the scheduled training sessions*	*Devise alternative ways to deliver the training; for example, by video or in the ward/department by clinical leads*
Identify the hazards	**Assess the potential for harm**	**Existing control measures**	**Gaps in control measures**	**Further controls required**
1.				
2.				
3.				

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Current/Initial Risk Score

(Current/initial risk score assessed at the time the risk assessment is undertaken)

Consequence		Likelihood		Total score
	X		=	

Rationale – include narrative

Consequence	Likelihood				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Actions Required: add more lines as required

Action – develop actions to address the further controls required.	**Responsible Lead** – who needs to carry out the action	**Expected date for completion**
1.		
2.		
3.		

Residual Risk Score (This is the risk score once all mitigation has been actioned and adequate control measures are in place)

Consequence		Likelihood		Total score
	X		=	

Rationale – include narrative

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Consequence	Likelihood				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Assessment Owners	
Risk Assessment Lead: For example, Ward manager/Matron/CSU lead/Speciality Lead.	
Risk Assessment created by:	
Date:	

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Risk Management Handbook

Quality Team | Risk Management | 2025

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Our Values

We care

We value people

We are one team

Bradford Teaching Hospitals
NHS Foundation Trust

Introduction to Risk Management

Bradford Teaching Hospitals
NHS Foundation Trust

Risk management is a structured approach to identifying, assessing, and mitigating risks that could impact patient safety, staff well-being, service delivery, or regulatory compliance. Effective risk management helps reduce harm, improve decision-making, and promote a culture of safety.

What is a Risk Assessment?

A risk assessment is the process of identifying potential risks, evaluating their impact, and implementing controls to reduce or eliminate them. A risk assessment is not about creating huge amounts of paperwork, but rather about identifying sensible measures to control the risks you have identified. It applies to various areas, including:

- Clinical risks (e.g., patient deterioration, medication errors)
- Operational risks (e.g., staffing shortages, equipment failures)
- Financial risks (e.g., budget constraints, funding issues)
- Reputational risks (e.g., complaints, adverse media coverage)
- Health & Safety risks (e.g., slips, trips, falls, manual handling)

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Step 1: Identify the Risk

- What could go wrong?
- Who or what might be affected?
- Where and when is the risk most likely to occur?
- What are the potential causes of the risk?
- What is the potential for harm if the risk occurs? (Consider consequence and likelihood of harm to patients, staff, and the organisation)

Writing a Clear Risk Description: Cause-Event-Effect Method

When documenting a risk, use the cause-event-effect structure to ensure clarity: If (cause: what is leading to the risk), then (event: what happens), resulting in (effect: the outcome/consequences).

Examples:

- **If** staffing falls below safe levels due to sickness absence, **then** patient care will be delayed, **resulting** in an increased risk of patient harm and complaints.
- **If** we are unable to release clinical staff for mandatory training due to staffing levels, **then** staff will not receive compulsory training in relation to resuscitation or blood safety, resulting in an increased safety risk to patients
- **If** there is no robust system for double-checking high-risk medications, **then** staff may accidentally administer the incorrect dose to patients **resulting in** patient harm, increased length of stay, and potential litigation
- **If** the Trust is reliant on agency staff due to ongoing recruitment issues, **then** expenditure on temporary staff will exceed budgeted allocations **resulting in** financial deficits, service sustainability issues, and external audit scrutiny

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Date: 06.22.12

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Step 2: Assess the potential for harm

When assessing a risk, consider:

- Who or what could be harmed? (patients, staff, the reputation etc)
- How severe could the harm be? (minor, moderate, major, catastrophic)
- How likely is the harm to occur? (rare, unlikely, possible, likely, almost certain)

Step 3: Identify Existing Controls

Control measures are the actions or safeguards already in place to prevent or reduce the impact of the risk. These can include:

- Policies and procedures
- Training and staff competency checks
- Equipment maintenance and safety checks
- IT systems and alerts
- Emergency plans and contingency measures

For example, if the risk concerned medication errors, your existing controls could be:

- Electronic prescribing system to reduce human error
- Mandatory medicines safety training for clinical staff
- Double-checking process for high-risk medications
- Incident reporting system to track and learn from errors

If the risk concerned staff shortages which was impacting on patient care, your existing controls could be:

- Relying on agency staff
- Workforce planning and recruitment strategy in place
- Escalation process to reallocate staff in urgent situations
- Well-being initiatives to reduce staff turnover

When assessing a risk, always consider whether these controls are adequate or need improvement i.e. are there any gaps in your existing control measures?

Step 4: Determine Additional Controls Required

Once a risk has been assessed and existing controls have been identified, the next step is to determine whether additional controls are needed to further reduce the likelihood or impact of the risk.

Key Questions to Ask:

- What more can be done to reduce the risk?
- Are the existing controls sufficient to manage the risk effectively?
- Have similar incidents occurred, suggesting that current controls are not working?
- Who is responsible for implementing these actions?
- What is the timescale for implementation?

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How to Select the Right Additional Controls

When deciding which additional controls to implement, consider the following:

- **Effectiveness** – Will this control significantly reduce the risk?
- **Feasibility** – Can this control be realistically implemented within available resources?
- **Cost vs. Benefit** – Is the investment in this control justified by the level of risk reduction?

How to Score a Risk Correctly

Risks are scored by combining estimates of consequence (also described as severity or outcome)
and likelihood (frequency or probability) in the context of existing control measures. In general, the magnitude or rating of a given risk is established using a grid or matrix, with consequence as one axis and likelihood as the other.

Risk score calculation

Multiply Likelihood x Consequence to obtain the risk score

	Likelihood				
Likelihood score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 – 3 low risk

4 – 6 Moderate risk

8 – 12 High risk

15 – 25 Extreme risk

How to Use Risk Descriptors to Score Risks Accurately

One of the biggest challenges in risk management is **scoring risks accurately and consistently.**

Over-scoring can lead to unnecessary escalations and wasted resources, while under-scoring may result in serious risks being overlooked.

To ensure accurate scoring, staff must **use the defined descriptors for likelihood and consequence** rather than relying on personal judgment alone. This structured approach improves consistency and ensures that risks are assessed fairly across the Trust.

Consequence Scoring (What is the consequence?)

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	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minorintervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to longterm incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

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Consequence Scoring (What is the consequence?)

Bradford Teaching Hospitals NHS Foundation Trust

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breech of guidance/statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/slippage Loss of contract /payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

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The **consequence score** reflects the severity of harm if the risk materialises. This could be related to patient safety, operational disruptions, financial losses, or reputational damage.

Common Mistake: Staff sometimes overestimate the impact based on worst-case scenarios rather than likely outcomes.

Likelihood Scoring (How likely is it to happen?)

Likelihood score	1	2	3	4	5
Frequency	Rare	Unlikely	Possible	Likely	Almost certain
broad descriptor	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
time-framed descriptor	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
probability Will it happen or not?	<0.1 per cent	0.1–1 per cent	1.1–10 per cent	11–50 per cent	>50 per cent

The likelihood score represents how often the risk is expected to occur based on available evidence, past incidents, and existing controls.

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Common Mistake: Many staff tend to overestimate likelihood because they focus on what could happen rather than what is likely to happen. If a serious event has never occurred in years, it is unlikely or rare rather than possible.

Common Errors in Risk Scoring & How to Avoid Them

- Overscoring Likelihood: Use data/evidence to justify likelihood. The likelihood score is a reflection of how likely it is that the adverse consequence described will occur
- Overscoring Consequence: Consider actual consequences rather than worst-case scenarios unless evidence suggests otherwise.
- Ignoring Existing Controls: Always account for existing mitigations when scoring.

Residual Risk Score: What It Is and Why It Matters

The residual risk score is the risk level after control measures have been implemented.

- If the risk remains high despite controls, further action is required.
- If controls reduce likelihood or consequence, the risk score should decrease.
- When reviewing a risk, always recalculate the risk score to reflect any improvements made.

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Adding a Risk to the Risk Register

- Risks should be recorded in the Trust IRIS System.
- An approved risk assessment should be completed prior to recording a risk on the Trust IRIS system.
- The risk description must be clear, outlining the cause, event, and potential impact.
- Any existing controls measures in place should be documented
- A risk score must be assigned using the Trust's risk matrix (likelihood x consequence).
- Risk ownership should be allocated to an appropriate individual within the Trust.
- The risk should be categorised appropriately
- Any immediate mitigating actions should be documented.
- The CSU Triumvirate should review and approve new risks before they are formally entered into the register.

Reviewing Risks

All risks should be reviewed monthly usually during the CSU Quality and Governance meetings.
The review should assess:

- Changes in risk score (increase, decrease, or remains the same)
- Effectiveness of current controls and any additional required actions
- •Whether the risk remains relevant or needs closure
- Implementation dates for all open risks should be revisited to ensure they are realistic, including mitigation schedules with interim dates/risk scores based on mitigation progress.
- Updates should be documented in the IRIS Risk Management System, noting any changes and additional actions.
- Risks with high scores should be discussed in detail and flagged for potential escalation.
- CSU leadership teams must ensure that all risks are reviewed as per the agreed date.
- High and extreme risks should be escalated to the Trust Executives via the agreed governance route. Any risks with a current score of 15 or above are reported to the Trust Executive Team for discussion. Risks scoring 12 and above are reported as part of the CSU to Executive meetings, to provide the Executive team with an overview of risks which have the potential to become high level risks

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Our Values

We care | We value people | We are one team

Produced by: Nazzar Butt | M2O Lead

Bradford Teaching Hospitals
NHS Foundation Trust

Risk Committee

Terms of Reference

<table>
<tr><td>Responsible to</td><td>The Executive Team</td></tr>
<tr><td>Duties</td><td>The Risk Committee will provide oversight of risk management arrangements across the Trust. The Committee will act as the primary forum for reviewing the effectiveness of risk management systems, oversight of risks and the adequacy of assurance arrangements.

The Committee will:
Review of the effectiveness of the Risk Management Strategy and Policy
Provide oversight of the Board Assurance Framework and High-Level Risk Register
Receive assurance regarding the effectiveness of mitigating controls and action plans
Review thematic risk intelligence, trend analysis and learning
Oversee risk management performance metrics
Review of risks on the High-Level Risk Register, to ensure that risks are appropriately described, scored, and mitigated.
Accept new risks onto the High-Level Risk Register and approve the de-escalation of risks, where appropriate.
Review of risks scoring 12 and above at Executive to CSU meetings.
Review the BAF to ensure that risks are appropriately described, scored, and mitigated, and that gaps in controls and/or assurances are being appropriately addressed.
Ensure timely escalation of risks scoring 9+ in minimal tolerance domains, in line with the Risk Appetite Statement.
Receive escalation reports from the Risk Review Panel</td></tr>
<tr><td>Sub-Groups</td><td>Risk Review Panel</td></tr>
<tr><td>Membership</td><td>
<table>
<tr><th>Title</th><th>Role</th></tr>
<tr><td>Chief Executive Officer</td><td>Chair</td></tr>
<tr><td>Chief Operating Officer/Deputy CEO</td><td>Deputy Chair</td></tr>
<tr><td>Director of Strategy &</td><td>Member</td></tr>
</table>
</td></tr>
</table>

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	Transformation	
	Chief Finance Officer	Member
	Director of HR	Member
	Chief Digital & Information Officer	Member
	Chief Nurse	Member
	Chief Medical Officer	Member
	Director of Estates & Facilities	Member
	Associate Director of Corporate Governance	Member
	Corporate Governance Manager	Member
	Associate Director of Quality	Member
	Moving to Outstanding Lead	Member
	Clinical Service Areas (Planned, Unplanned and Diagnostics) – attending in rotation – each service area will attend quarterly.	In attendance

The Chair has the overall responsibility for the content, conduct and performance of the meeting and also has the final decision on actions required in order to comply with the Terms of Reference.

Where the relevant Member is unable to attend a nominated deputy can attend on their behalf.

In attendance	The Chair may request attendance by any other colleagues at the meeting. In the normal course of business it is anticipated that representatives from Clinical Service Units and departments may attend, to support/explain business cases and other discussion items.
Secretary	The Meeting will be supported by the CEO's Personal Business Manager who will be responsible for compiling the agenda (under the direction of the CEO) and commissioning any required papers/presentations.

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Quorum	The meeting is quorate with attendance by the Chair (or nominated deputy) and three Executive Directors or their nominated deputies. If quoracy is not achieved then the meeting may still go ahead, with the agreement of the Chair (for example to consider matters which urgently require a decision to maintain continuity of Trust business). In this event, any decisions must be ratified at a subsequent Executive Team Meeting. Deputies attending on behalf of an Executive Director will have full decision making rights. At the request of the Chair, meetings may be held by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to the functioning of such a meeting. These meetings will be deemed as standard meetings of the Executive Team and shall be documented accordingly.
Frequency of meetings	Monthly, at least 10 meetings per year
Circulation of papers	The agenda and papers for meetings will be distributed electronically two working days in advance of the meeting. Executive Directors will liaise with the Business Manager regarding items they wish to include on the agenda or papers/presentations they intend to submit. Presentations, handouts and oral presentations may instead be tabled on the day, if agreed in advance through the Business Manager and with the agreement of the Chair of the Meeting. The Business Manager will record the outcome of the meeting in a note, including key points discussed and decisions made. Any actions agreed which will be shown in an action log. The note will be checked for accuracy at the next meeting, and the action log will be reviewed.
Date approved by ETM:	TBC Once Strategy approved at Board
Review date:	Annually with Risk management Strategy

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Board of Directors Open			
Meeting Date:	21 May 2026	**Agenda Reference:**	Bo.5.26.22
Report Title:	Board Assurance Framework and High-Level Risks		
Presented by:	Laura Parsons, Associate Director of Corporate Governance/Board Secretary		
Executive Lead:	Prof Karen Dawber, Chief Nurse		
Author:	Debbie Earnshaw, Corporate Governance Manager		

Report Summary				
Purpose of the paper:	Decision ☒ (Approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (Review/discuss/ comment)	Information ☐

Summary of Key Issues/Highlights:

Board Assurance Framework Quarter 4 2025-26

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.

The BAF has been reviewed and updated by the Executive leads to reflect the position at the end of Q4 2025/26.

There has been no change in risk score since the last report.

High Level Risk Register Report – April and May 2026

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.

At its meetings on 13th April 2026 and 11th May 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.

The Board Committees reviewed the high-level risks within their remit at their meetings held in April and May 2026 and at the time of this report there is -

- No risks beyond the target mitigation date.
- One new risk 2879 with a completed risk assessment.
- Three risks have been closed – risks 2588, 2748 and 2810.
- Four risks have reduced in score – risks 2766, 2612, 14 and 9.
- Two risks are beyond their review date – risks 901 and 2601.

The high-level risk register showing high-level risks rated 15+ for May 2026 is attached at appendix 2.

The BAF template has been revised to reflect recommendations from internal audit and best practice. It was presented to the Board as part of the Board Development session on 29 April 2026, alongside the proposed strategic risks for 2026/27. The new template and proposed strategic risks are at appendices 5 and 6 respectively.

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Recommendation/s: (including any decision/approval required)	The Board is asked to: • Gain assurance that the BAF (appendix 1) and the risks on the High-Level Risk Register (appendix 2) are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • Note the updated 2026/27 BAF reporting template (appendix 5) discussed at the Board Development Session held on 29 April 2026. • Approve the Strategic Risks for 2026/27 (appendix 6) as presented to the Board Development Session on 29 April 2026.
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:** 13th April 2026 and 11th May 2026 **People Committee:** 15th April 2026 and 12 May 2026 **Finance and Performance Committee:** 22nd April 2026 and 20th May 2026 **Quality Committee:** 23rd April 2026 and 14th May 2026

Report content

1. Purpose

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.

2. Background/context

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.

Claudia Sheridan 27/04/2026 09:25:12

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).

3. Assessment

Board Assurance Framework Q4 2025-26 Review

(i) Q4 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 Q4 2025/26 and the Board Committees reviewed the BAF risks within their remit at their meetings held during April and May 2026.
- Risk scores remain unchanged from the BAF Q3 2025/26 report.

(ii) Strategic Risks 2026/27 and BAF reporting

- The updated BAF reporting template for 2026/27 (appendix 5) and refreshed strategic risks (appendix 6) are attached, as discussed Board Development Session held on 29 April 2026.
- The strategic risks have been refreshed to more accurately articulate the risk associated to each of the organisation's strategic objectives.
- Engagement with executive leads has informed the development of the strategic risks which will be incorporated into the updated BAF reporting template.
- The draft BAF reporting template adopts a forward-looking approach ensuring that the strategic risks are viewed not only in terms of current exposure but also in relation to longer-term organisational resilience. The revised document reflects the recommendations identified by Audit Yorkshire in their annual audit of the BAF, conducted in March 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 Committees and the Board.

At its meetings on 13th April and 11th May 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.

The Committees reviewed the high-level risks within their remit at their meetings during April and May 2026.

The HLRR, showing all high-level risks rated 15+ as at May 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 May 2026 and shows trends and flags areas that ETM, the Committees and Board may wish to consider.

The following information is included:

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- 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 are no risks beyond their 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)

There is one new risk since the last report presented to the Board in March 2026.

Risk ID:	Current Score:	Target Score:	Risk title:	Risk Description:	Lead Director:	Committee/ Academy:
2879	16	8	Middle grade medical staffing gaps in Obstetrics and Gynaecology	**Previously: Risk 2588** If the Women's CSU are not able to recruit suitable middle grade doctors then the service will not be able to move to being able to work with resident doctors and educational supervisors to develop rotas that have an appropriate balance between the needs of the patient safety and clinical service and the Learner's legitimate expectations for teaching, training, feedback and rest and recreation. This will result in not being able to move out of the HEE special measures for Category 1 - Minor Concerns, against their Quality Standard of Learning Environment and Culture.	Chief Medical Officer	Quality Committee

Risks which have closed

Three risks have been closed since the last report.

Risk ID:	Current Score:	Target Score:	Risk Description:	Lead Director:	Reason for closure	Committee:
2810	20	4	If the 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	Chief Finance Officer	The risk is related to the trust's financial position in 2025/26. The trust has agreed a break-even lan for 2026/27 and achieved its revised plan for 2025/26.	Finance & Performance Committee

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			liquidity to meet its financial obligations.			
2748	**20**	**4**	Loss of NM service – as of September 2025, redesigned Tc99m generator no longer fits.	Chief Operating Officer	Normal service was resumed on 7 April 2026. No further outsourcing required.	Quality Committee / F&P Committee
2588	**16**	**6**	Currently unable to consistently staff MAC and ANDU with middle grade obstetric doctors.	The risk has been revised and re-written as there are gaps in middle grade staffing across the service. **A new risk – Risk ID 2879 created scored 16**.	Chief Medical Officer	Quality Committee

Risks which have changed in score

The below two risks have reduced in score since the last report to the Board and two risks 9 and 14 have been reduced and reported to the closed board meeting.

Risk ID:	Current Score:	Previous Score:	Risk Description:	Update	Lead Director:	Next Review Date:	Committee/ Academy:
2766	**8**	**15**	Risk related to the retention of student roster in line with national guidance.	E roster policy to be updated to state that ward managers must retain a paper copy of any student off duty for up to period of 7 years on the ward. Medical student rosters will be stored by the education department.	Director of HR	29 May 2026	People Academy & Quality Committee
2612	**10**	**15**	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	Plans put in place to manage this risk are proving effective. Likelihood risk decreased to 2, overall risk decreased to 10.	Chief Medical Officer	30 November 2026	Quality Committee

Risks beyond their review date

There are two risks beyond their review date.

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Risk ID:	Current Score:	Target Score:	Risk Description:	Lead Director:	Review Date:	Committee:
901	**20**	**12**	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	Chief Digital & Information Officer	30 April 2026	Quality Committee

			vulnerabilities in legacy clinical systems, critical third-party integrations, and growing regulatory obligations significantly increases the likelihood of service disruption at BTHFT.			
2601	**15**	**9**	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.	Chief Medical Officer	30 April 2026	Quality Committee

4. Options analysis/Proposal

As outlined in the Risk Management Strategy, the Board's role is as follows:

Seek assurance from the Executive Team, Committees and People Academy 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.

5. Recommendation

The Board is asked to:

- Gain assurance that the BAF (appendix 1) and the risks on the High-Level Risk Register (appendix 2) are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.
- Note the updated 2026/27 BAF reporting template (appendix 5) discussed at the Board Development Session held on 29 April 2026.
- Approve the Strategic Risks for 2026/27 (appendix 6) as presented to the Board Development Session on 29 April 2026.

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Board Assurance Framework – Summary

Bradford Teaching Hospitals NHS Foundation Trust

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. **Risk appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward**				**Assuring Committee: Quality / Finance & Performance**	**Overall Assurance Level 2025/26:** **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	The risk score for Q4 remains static as the estate continues to age and will be 100 years old in 20230 (BRI). The majority of backlog maintenance work that is addressed is replaced by new backlog works, due to the age and infrastructure. **The risk is unlikely to reduce** until the hospital can secure major investment to replace a significant proportion of the hospital. Bradford has one of the oldest estates within the region and has not had the same level of investment as other WYAAT sites.
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	No change in score for Q4 2025/26.
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 Q4 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 Q4 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 **Risk appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward**				**Assuring Committee: Quality / People**	**Overall Assurance Level 2025/26:** **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. **Recommend closure of the risk moving into 2026/27.**
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 **Risk appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)**				**Assuring Academy: People**	**Overall Assurance Level 2025/26:** **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. Sickness remains high during Q4. 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 Q4.
Strategic Objective 4: Partnership – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals **Risk appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)**				**Assuring Committee: N/A - Board**	**Overall Assurance Level 2025/26:** **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 **Risk appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward**				**Assuring Committee: Finance & Performance**	**Overall Assurance Level 2025/26:** **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	Formally forecasting off plan at Q4 with the financial board established. The external review actions are being progressed with 35 out of 38 complete. ICB technical financial appraisal of all organisations is also complete. NHSE Grip and Control checklist reviewed with 137 out of 156 in place. New robust business case process introduced in 2025/26 and we have put in place the required measures to support potential application for external cash support in Q4. First draft planning submission completed, showing a return to break even in the medium term. Q4 progress has included recovery actions from teams which have assisted with progress to achieving the target position. Recovery structure in place to achieve the revised forecast up to 148/156 completed. For the risk score to reduce, additional funding from NHSE or other would have to be received, to enable the trust to bridge a £17.7m gap. Q1 2026/27 will focus on delivery of bank and agency, managing the deficit and closing the gap reductions. Closing the Gap, Cash Income reconciliation and ICB change are key risks to be considered heading into 2026/27.

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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)
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. Updated commentary and assurances for Q4.
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	The Q4 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. It will be recommended that this risk is closed and incorporated into SR01 moving into 2026/27.
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 4 2025/26 = current score

LIKELIHOOD	CONSEQUENCE				
	Negligible (1)	Low (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)					
Likely (4)			2	3	1, 12, 4
Possible (3)			8, 9, 5, 14	11, 13, 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

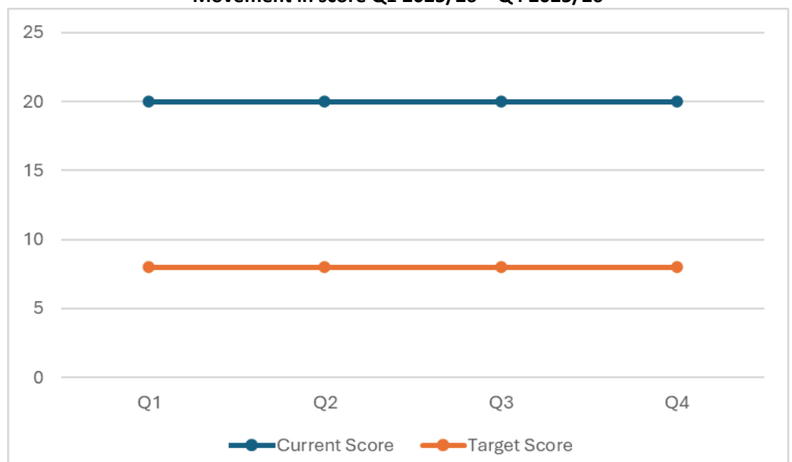
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 30 August 2024

Date of last review: March 2026

Lead Director: Director of Estates and Facilities

Movement in score Q1 2025/26 – Q4 2025/26



Initial Score (CxL): 5x4=20
As at 30 August 2024

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

Target Score (CxL): 3x4=12

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	
1. Infection Prevention & Control policy and processes in place, oversight through Infection Prevention and Control (IPC) Committee and Quality Committee. 2. PLACE surveys and action plans in place. 3. Backlog maintenance annual condition surveys that prioritise available capital funding. 4. Health and Safety governance and reporting. 5. Policies and Procedures across Estates and Facilities – Estates Maintenance, Cleaning Services, etc. 6. KPIs to monitor and manage the outputs from the policies. 7. External oversight over sub-elements of Estates, i.e. Water Safety, Ventilation – (annual reports / surveys). 8. £25m successful bid for endoscopy unit commenced on site. Opened March 2026. 9. Main entrance at Bradford Institute for Health Research (BIHR) – completed. 10. Additional £1B announced in October 24 budget to address backlog maintenance in 25/26. Additional capital secured in January 2026 to address some backlog. 11. 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. 12. Purchased Cancer Support Yorkshire (CSY) buildings. 13. Commenced a redevelopment design for Emergency Department. 14. Explore collaborative working with Airedale NHS FT (ANHSFT) to align with new hospital opportunities.	**Internal** **Positive:** 1. IPC Quarterly Reports 2. Premises Assurance Model (PAM) Report to Board in November 2025. 3. Estates Return Information Collection (ERIC) returns show an extensive knowledge base 4. Health and Safety Committee reports to Finance and Performance Committee 5. Patient Experience Group Monitoring E&F KPIs that impact the care environment 6. Annual Fire Safety report **Negative:** 1. A deteriorating position on backlog maintenance – physical condition from last year - £93m - £102m	**Independent** **Positive:** 1. Meeting National Cleaning Standards 2. Meeting National Food Standards 3. Annual Inpatient Survey 4. Internal Audit reports: a. PLACE – Significant assurance (May 2025) **Negative:** N/A	**Gaps in control** • 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 **Gaps in assurance** N/A	**Action** • 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.	**Timescale** April 2027 December 2026 July 2026

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

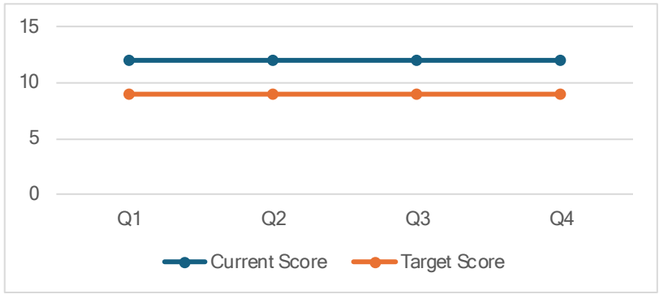
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 30 August 2024

Date of last review: 13 April 2026

Lead Director: Chief Digital and Information Officer

Movement in score Q1 2025/26 – Q4 2025/26



Initial Score (CxL): 3x5=15
As at 30 August 2024

Current Score (CxL): 3x4=12
As at 13 April 2026

Target Score (CxL): 3x3=9

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**	
1. Digital & Data Transformation Strategy sets out our key priorities and areas of focus. These objectives are now part of team and leadership objectives. 2. 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. 3. CDIO post has been appointed to which is dedicated to BTHFT. 4. Associate Director of Data, Analytics & AI and Technical & Data Architect are now in post. 5. Embracing a strategic approach to talent management focusing on improving how we attract, develop, retain, and optimise our workforce. 6. 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. 7. 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. 8. Suite of policies in place - • Information Governance Policy • Email Policy • Data Quality Policy • Information Risk Policy • Information Technology Security Policy	**Internal** **Positive:** 1. Informatics Performance Group (IPG) is seeing an improved position of key IT governance activities and controls. 2. Bi-annual digital reports to Quality Committee (latest October 2025). 3. Audit Yorkshire report has given a significant assurance rating based on the delivery of the digital strategy and the underpinning work programmes. 4. The Digital teams are engaged in the work of the organisational cross cutting transformation programmes such as Excel and Outpatients and play a pivotal part in the recovery work programme 5. Appraisal rates for staff in the CSU now at 91% and there was an increased participation rate in the NHS staff survey. 6. EPR training offer is being updated and rollout targeting specific needs related to data quality issues and clinical coding opportunities. Automation services contract in place to support RPA requirements. The Trust has invested in AI capabilities to support research asks. 7. Establishment of Technical Design Authority and digital change advisory board will support the prioritisation of asks and sequencing of work to ensure stability and manage demand. **Negative:** 1. Feedback from CSUs is that EPR optimisation is not progressing at the required pace. (This continues to be mitigated by internal organisational adjustments) 2. There is an emerging deficit in automation, AI and future technologies skills and experience. 3. Demand for digital data and technology	**Independent** **Positive:** 1. Successful ISO27001 report and outcome. 2. ISO and Data Security and Protection Toolkit (DSPT) audits are complete and have been deemed successful. 3. Recently published results from the NHSE Digital Maturity assessment process show a high level of digital maturity. **Negative:** 1. External application assessment showing areas which require improvement. 2. External IT service management assessment showing areas which require improvement. 3. External application assessment showing areas which require improvement. 4. External IT service management assessment showing areas which require improvement.	**Gaps in control** The digital strategy group has been formed, and is chaired by the CCIO it has a regular meeting cadence and will report to the quality committee DW/BI team requires focus to provide an efficient data model to allow timely data analysis. **Gaps in assurance** N/A	**Action** Digital Strategy Group is now established CCIO to chair Incoming Associate Director has identified skills and process shortfalls, and these are being addressed.	**Timescale** Ongoing Ongoing

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	services is increasing, as is the timeframe it is needed, and digital data and technology is in some areas struggling to maintain pace. 4. Skills shortfall in the data aspects of delivery compounded by long term sickness absence issues.				
Related risks on the high-level risk register (operational risks)	• **901** - Risk of Cyber Security Threats (current score: 16)				

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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.

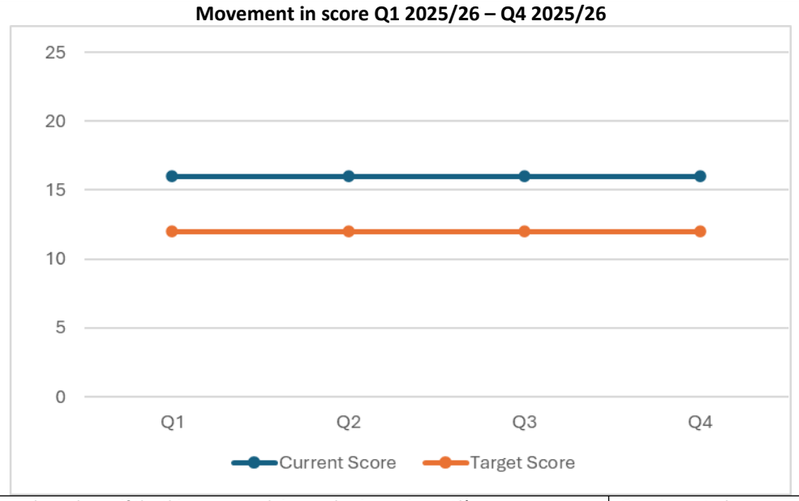
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 9 January 2025

Date of last review: 14 April 2026

Lead Director: Chief Nurse and Chief Medical Officer

Movement in score Q1 2025/26 – Q4 2025/26



Initial Score (CxL): 4x4 = 16
As at 9 January 2025

Current Score (CxL): 4x4 = 16
As at **14 April 2026**

Target Score (CxL): 4x3 = 12

Key controls (what are we doing about the risk?)

1. Daily command and control via the Command Centre. Half hourly Operational Pressures Escalation Level (OPEL) scoring.
2. Clearly defined escalation processes at BTHFT and West Yorkshire level.
3. Robust incident reporting monitored daily via safety huddles with defined escalation of risk via quality governance.
4. Daily safety huddles from Board to Ward.
5. Monitoring of elective activity including 6-4-2 process for maximising lists.
6. Executive-to-CSU oversight including accountability framework.
7. Robust recruitment and selection processes.
8. Education Strategy to enable retention and training of workforce.
9. EXCEL programme formal launch in June 2025.
10. Weekly Executive meetings.
11. Weekly Quality Oversight meetings (QUOC).
12. Nursing & Midwifery Strategy.
13. ABCAS project – Airedale and Bradford Collaboration of Acute Services.
14. Workforce Control Panel established to risk assess vacancies.

Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)

Internal

Positive:

1. Monthly oversight via Committees of Board including cumulative position – Quality and People Dashboards, Quality oversight report.
2. Annual Quality Account and quarterly updates on improvement priorities.
3. Nursing & Midwifery Strategy updates to Quality Committee.
4. Nursing & Midwifery staffing data publication reports to People Academy and Quality Committee.
5. National reporting and benchmarking

Negative:

1. A number of risks highlighted by specialities in relation to increased demand against static capacity.
2. A number of high risks in relation to overcrowding in Accident and Emergency Department (AED) resulting in poor patient and staff experience.
3. Patient complaints increasing.

Independent

Positive:

1. CQC Report(s) – November 2024 rated 'Good'.
2. NHS Oversight Framework (NOF) 3/Integrated Quality Improvement Group (IQIG).
3. Internal Audit Reports:
   a. Safe staffing; international staff – Significant assurance (August 2025)
   b. Patient Experience in AED – Significant assurance (September 2025)

Negative:

1. National inpatient surveys remain below average.

Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)

Gaps in control

- 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.

Gaps in assurance

- No clearly defined refreshed BDC Clinical Strategy

Actions to address gaps in controls or assurance

Action	Timescale
• Ongoing work with ICB and specialised commissioning to understand funding gaps and opportunities.	Ongoing
• Refresh of Estates Plan and Strategy.	March 2026
• Watch and wait re: opportunities for national capital monies.	Ongoing
• Acute collaboration with Airedale General Hospital.	Ongoing
• Work with Estates and contractors to agree actions to be taken re SLH Day Case and agree revised timescales.	Ongoing
• Work across WY ICB and Bradford Place. • Acute provider collaboration now in place.	Ongoing

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

- **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.

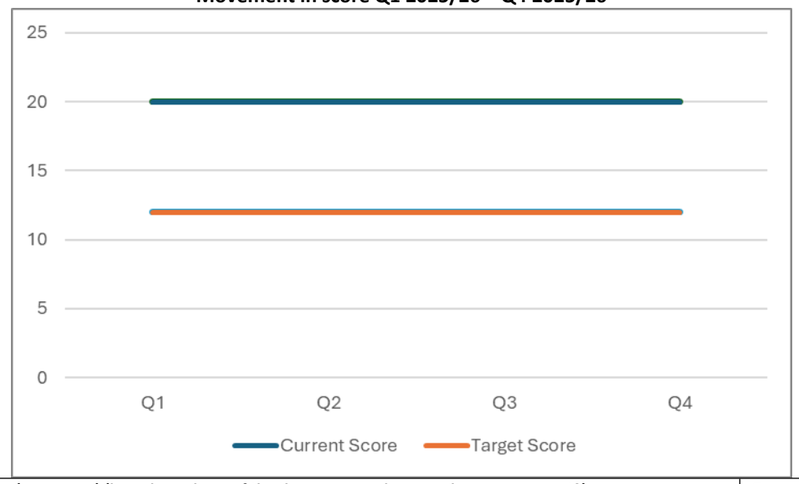
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 9 January 2025

Date of last review: 20 April 2026

Lead Director: Chief Nurse and Chief Medical Officer

Movement in score Q1 2025/26 – Q4 2025/26



Initial Score (CxL): 5x4 = 20
As at 9 January 2025

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

Target Score (CxL): 4x3 = 12

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**	
1. Daily command and control via the Command Centre. Half hourly OPEL scoring. 2. Clearly defined escalation processes at BTHFT and West Yorkshire level. 3. Clearly defined escalation plans/surge plans 4. Robust incident reporting monitored daily via safety huddles with defined escalation of risk via quality governance. 5. Daily safety huddles from Board to Ward. 6. Outstanding Emergency Department programme commenced (EXCEL). 7. Monitoring of key data including clinical benchmarking. 8. Weekly Executive meetings. 9. Weekly Quality Oversight meetings (QUOC). 10. Accountability framework. 11. OPTICA rollout completed. 12. Fit to sit (Ward discharge project) completed over winter 2025/26 13. Temporary Escalation Space (TES) working group formed. 14. Patient flow related training led by Lead for Patient Flow continues.	**Internal** **Positive:** 1. Monthly oversight via Committees of Board including cumulative position – Quality and Performance Dashboards, Quality oversight report, performance report. 2. IPC quarterly reports to Quality Committee. **Negative:** 1. Increase in complaints and incidents including patient harms and staff violence and aggression (patient/visitor against staff). 2. Higher than expected >12-hour bed waits for admission from ED. 3. Continued reports of lack of flow and overcrowding in ED leading to negative staff and patient experience. 4. Increase in infections (flu/Covid) over the winter months.	**Independent** **Positive:** 1. CQC Report(s) – November 2024 rated 'Good'. 2. National ranking show ED performance continually in top quartile. 3. IQIG/NOF3 oversight. **Negative:** 1. CQC Report – November 2024 highlighted some delays in discharges and lack of therapy. 2. Although in top quartile for performance for ED nationally we are still not meeting targets. 3. Internal Audit reports: a. Discharge Management – Limited assurance (August 2025)	**Gaps in control** • We cannot control demand on admission units. • Poor uptake of seasonal vaccine programme. **Gaps in assurance** • National comparisons can be misleading as reporting differs in organisations. • Internal assurance is focused on operational performance - need to define a balanced score card.	**Action** • Outstanding Accident and Emergency Department Programme (EXCEL) • Work with partners to promote. • Work at regional and national level. • Outstanding Accident and Emergency Department Programme (EXCEL)	**Timescale** March 2026 Ongoing Ongoing Ongoing

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

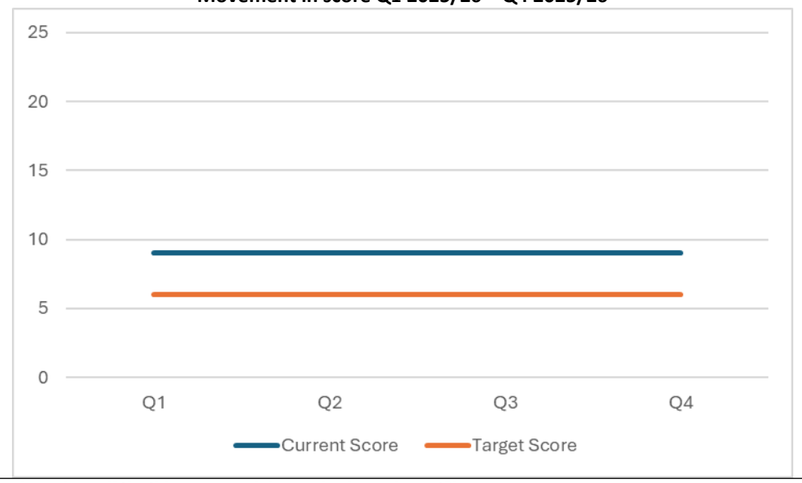
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 14 April 2026

Lead Director: Chief Medical Officer

Movement in score Q1 2025/26 – Q4 2025/26



Initial Score (CxL): 4x4=16
As at 1 April 2022

Current Score (CxL): 3x3=9
As at 14 April 2026

Target Score (CxL): 3x2=6

Key controls (what are we doing about the risk?)

1. Guardian of Safe Working Hours process with quarterly and annual reports to People Academy and Local Negotiating Committee (LNC).
2. Resident Doctor rota co-ordinator in place who works with the Flexible Workforce team to ensure gaps are covered.
3. Resident doctor representation including on Joint Negotiating and Consultative Committee (JNCC) and Resident Doctors forum.
4. Appointment of a number of positions to support staff from all disciplines including SAS Advocate role, Chief Registrar and Lead Physician Associate.
5. Increased student capacity by utilising newly established services and trialling a rota-based system for students.
6. Implementation of student led clinics in physiotherapy.
7. Multi-professional preceptorship programme in place for Newly Qualified Nurses, Midwives and AHPs.
8. Hospital at Night Project to support resident medical staff with routine procedures fully implemented.
9. Enhanced support for International Medical Graduates (IMGs) – named IMG lead, bespoke NHS Orientation Day run locally, new communication skills course for IMGs.
10. Implementing the 10 Point Plan for Improving Resident Doctor Working lives.

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Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)

Internal
Positive:
1. Guardian of Safe Working Hours – quarterly reports: latest report 11 March 2026 – People Academy.
2. Appraisal & Revalidation Annual Report: latest report 11 June 2025 – People Academy.
3. Appraisal Quality Assurance Group – annual review of appraisal quality.
4. Results of appraisal feedback questionnaires.
5. Annual Medical Appraisal Report / Board compliance statement October 2025.
6. Education Annual Report.

Negative:
1. Guardian of Safe Working (GOSW) Exception reports re: missed educational opportunities or additional hours.
2. GOSW hours annual report (People Academy May 2025).

Independent
Positive:
1. Apprenticeship team recognised through the Bradford Means Business awards for their work across the district with young people and improved educational opportunities.
2. Senior Leaders engagement event with NHSE in November 2023 – positive feedback report.
3. National Education & Training Survey (NETS) 2024 – strong regional benchmarking (highest scoring WYAAT Trust in 11 out of 13 domains).
4. GMC survey 2024 – significant improvement in areas identified as a concern in 2023 – Emergency Medicine FY2, Medicine FY2, Plastic Surgery.
5. Multi-Professional Education & Training (MPET) 2025 – overall placement rating 91%, a further increase on the previous 2 years, above average score for all trusts.
6. Internal audit reports:
   a. Medical Education – Significant assurance
   b. E-Rostering – Junior Doctors – Significant assurance
   c. Medical Revalidation – Significant assurance

Negative:
1. NETS 2024 – negative outlier for workload in Emergency Medicine, Surgery (both Foundation level), Obs & Gynae (GP trainees) and Ophthalmology.
2. 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).
3. 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.

Key controls (what are we doing about the risk?)

Gaps in control

- Numbers of resident doctors on rotas

Gaps in assurance

N/A

Actions to address gaps in controls or assurance

Action	**Timescale**
• Lobby Deanery to increase trainee numbers.	Ongoing

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

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.

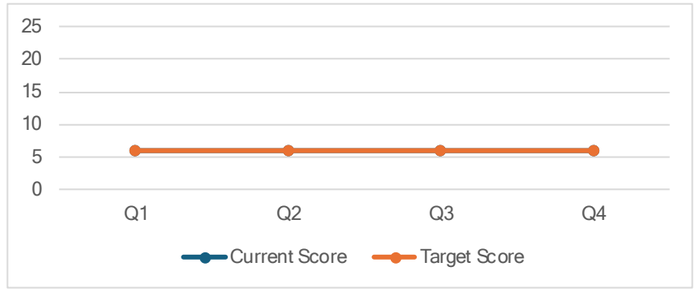
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 14 April 2026

Lead Director: Chief Medical Officer

Movement in score Q1 2025/26 – Q4 2025/26



Initial Score (CxL): 3x3=9
As at 1 April 2022

Current Score (CxL): 3x2=6
As at 14 April 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**	
1. 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. 2. Research Governance and Management Structure in place. 3. Trust Research Strategy and Trust policy on conducting research in the Trust. 4. Trust Research Committee and regular formal reporting to Quality Committee and Trust Board. 5. Strong research reputation particularly in the fields of applied health research teams are continually applying for grant funding. 6. Raising awareness of research, publicity of research successes, research part of Trust induction. 7. All research teams have research targets and performance reports sent to them and CSUs sign off capacity and capability that can conduct new research. 8. Multiple high value successful funding bids are continually being obtained.	**Internal** **Positive:** 1. Bi-annual Research Activity reports to Quality Committee / Trust Board – latest March 2026. 2. Research reports and presentation on research projects to Board. 3. Research Performance reports for research teams sent out on quarterly basis. 4. Internal review with each research speciality ongoing due to centralised research delivery team structure and management. 5. Improvements to infrastructure / buildings. 6. Research ward boards and main entrance research permanent artwork (BRI and SLH) to promote research. **Negative:** 1. Unclear how the CSUs manage research activity. 2. Some teams are not achieving targets due to lack of clinician input due to interest/ time. 3. Lack of awareness that research is core business for the Trust.	**Independent** **Positive:** 1. Annual reports and reviews for projects where we are the lead organisation, e.g. NIHR programme grants, NIHR RCF annual reporting. 2. External Performance metrics monitored monthly for NIHR Commercial Research Delivery Centre and annual report will be produced (due July 2026). 3. Annual review meeting with Yorkshire and Humber Regional Research Delivery Network and catch up/feedback meetings to take place every two months. 4. Various research finance audits. 5. Participant Research Experience Survey 'PRES' – positive responses. 6. Internal Audit on Research Governance June 2024 High Assurance. 7. Significant, repeated successful high value grant applications. **Negative:** 1. Some research areas not meeting targets in terms of Recruitment to Time and Target etc. 2. Need to continually meet the new NIHR 150 day target.	**Gaps in control** • 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. • Monitoring of 150-day metric **Gaps in assurance** • Better research information to allow real time reporting and improved research activity management by CSUs and research teams.	**Action** • 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. • Target squad set-up to ensure metrics are being monitored and achieved. • 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.	**Timescale** Ongoing Delayed due to external IT factors with the national EDGE database which has impacted on research dashboard production. Providing feedback (April 2026) on a positive application – currently awaiting final outcome.
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

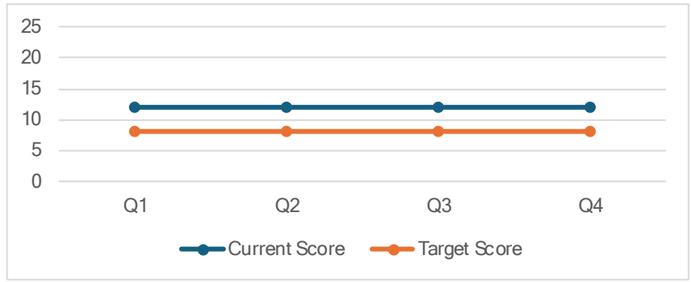
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 22 April 2026

Lead Director: Chief Nurse

Movement in score Q1 2025/26 – Q4 2025/26



Initial Score (CxL): 5x3=15
As at 1 April 2022

Current Score (CxL): 4x3=12
As at 22 April 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	
1. Established Quality and Safety governance structure 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. 2. Full implementation of PSIRF supporting a systems approach to learning 3. Delivery of Improvement Strategy in 2024, in addition to updated Being Open / Duty of Candour Policy 4. Active participation in the West Yorkshire Association of Acute Trusts Learning Forum to share best practice and learning 5. Annual production of Quality Account including priority areas for improvement and learning.. 6. Continued involvement in the 'Learning Together' research programme to strengthen learning culture 7. Monthly Quality and Safety meetings in all CSUs aligned to a standardised Quality Governance Framework. 8. Exemplar work of Learning from Deaths processes recognised by CQC including role of Medical Examiner who has scrutinised 100% of deaths since October 2021, supported by the Learning from Deaths group, Mortality Review Improvement Group (MRIG) and Recognition and Response to the Deteriorating Patient Group. 9. National lead role in 'Worry and concerns' pilot leading to implementation of Martha's Rule. 10. Recruited Patient Safety Specialist and Patient Safety Partner. 11. Implementation of the 15 Steps Assurance Programme in place with timescales on visits agreed to complement the Ward Accreditation Programme.	**Internal** **Positive:** 1. Insights report – quarterly. Demonstrating themes, trends and learning 2. Bi-monthly Quality Assurance and Oversight report. 3. Insights report Quality Committee 4. Monthly Learning from Deaths update to Quality Committee. 5. Targeted deep dives review (e.g. SHMI) to identify improvement opportunities 6. Annual Patient Experience Report. 7. Medical Examiner has scrutinised 100% of deaths since October 2021. **Negative:** 1. Departmental capacity versus demand and the impact of current work plan deliverables.	**Independent** **Positive:** 1. Internal audit reports: a. Patient Safety Incident Response Framework (PSIRF) - High Assurance (May 2025) 2. Recent CQC inspections Maternity Services r Outpatient Services Community Hospital Services, and Trust Well Led rated as **Good**. 3. Commissioner review of incident investigation reports that meet the criteria under PSIRF. 4. MNSI – full compliance. **Negative:** 1. Emergency Department and Trust Wide Well Led CQC Inspection Reports still awaited. 2. Internal audit reports: (a) Falls – Limited Assurance (November 2025)	**Gaps in control** • Pending implementation of all actions from internal audit reports. • Variability in governance maturity across CSUs • Being Open / Duty of Candour Policy to be reviewed with a view to re-introducing 10-day targets for initial and investigation report. Audit currently in progress to assess compliance. • Workforce constraints due to maternity leave and vacancies held due to the trust financial special measures impacting delivery capacity • Variability in the quality of patient safety incident investigation reports, impacting the reliability of learning and the effectiveness of subsequent actions.	**Action** Implementation of audit recommendations with strengthened oversight To further develop and strengthen the lines of governance through to CSUs. To review and update the policy and communicate the changes trust-wide post audit Work ongoing. Deliver a Patient Safety Incident Investigation Masterclass in partnership with the Improvement Academy to strengthen staff capability	**Timescale** Ongoing Ongoing 31 May 2026 Ongoing May 2026
			Gaps in assurance Learning clearly articulated in some but not all areas.	Continue to embed CSU governance model.	Ongoing
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 - 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.

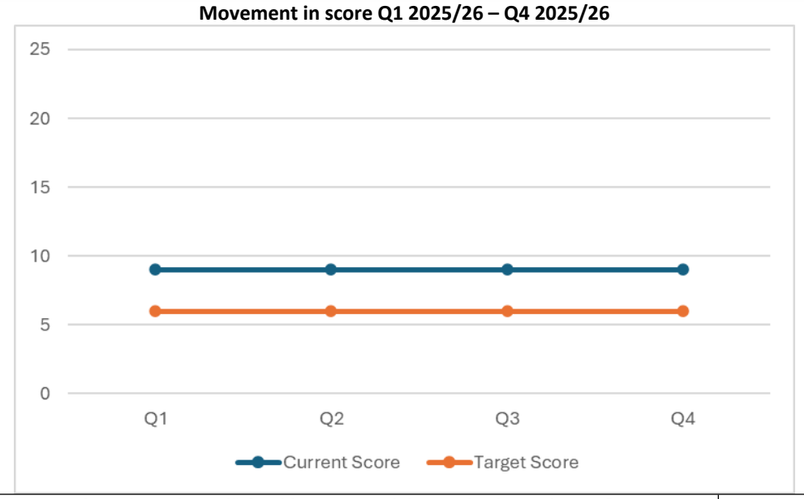
Risk Appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)

Date added: 13 September 2024

Date of last review: 14 April 2026

Lead Director: Director of HR

Movement in score Q1 2025/26 – Q4 2025/26



Initial Score (CxL): 3x4 = 12
As at 13 September 2024

Current Score (CxL): 3x3 = 9
As at 14 April 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	
1. HR policies and wellbeing support offers 2. Occupational Health Service, Employee Assistance Programme (EAP) provision and psychology staff support offer 3. Staff networks 4. Staff survey action plan 5. Freedom to Speak Up (FTSU) policy and processes 6. Guardian of Safe Working processes 7. Mediation and Staff Advocacy services 8. Leadership pathway development 9. Wellbeing conversations 10. Development of outdoor spaces e.g. gardens 11. CSU to Executive meetings in place 12. Nursing recruitment and retention plans in place 13. Sickness Absence Action Plan in place 14. People Strategy 15. Workforce Control Panel	**Internal** **Positive:** 1. Nursing & Midwifery Staffing Review – six monthly to People Academy & Board 2. Workforce planning submission – Trust Board February 2026. 3. Turnover rates consistently maintained with no fluctuations. 4. Occupational Health / Psychological support referrals (management referrals, limited data on self-referrals) 5. FTSU Quarterly Report Q3 2025/26 – presented to People Academy 11 February 2026 6. Occupational Health lead times are significantly reduced **Negative:** 1. Sickness absence rates remain above target. 2. Appraisal rates remain below target.	**Independent** **Positive:** 1. Staff survey results for 2024 remain above national average. 2. Internal audit reports: a. Absence Management – Significant assurance (October 2025) 3. Occupational Health service is SEQOHS accredited. **Negative:** 1. Internal audit reports: a. Non-clinical appraisals (February 2025) – Limited assurance (NB compliance rate has since increased from 74% to 80%)	**Gaps in control** • 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 **Gaps in assurance** N/A	**Action** • Workforce control panel in place to assess each vacancy request • Refresh of sickness action plan. • To make Sickness Policy changes	**Timescale** Ongoing May 2026 June 2026
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.

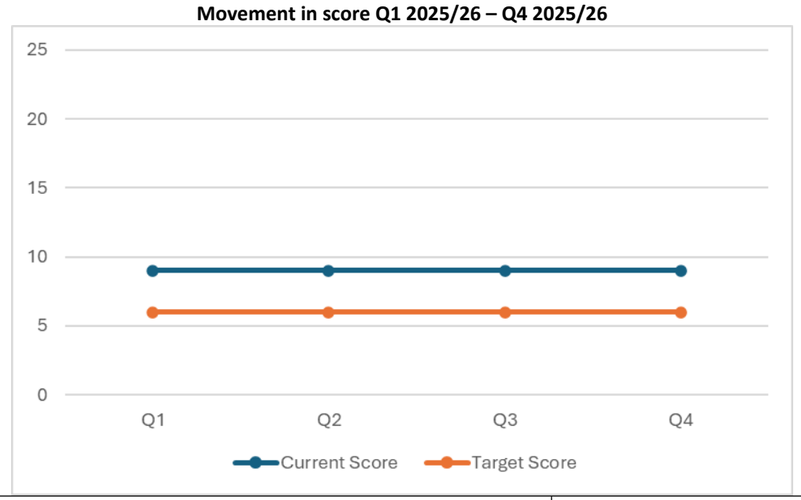
Risk Appetite:
Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)

Date added: 28 August 2024

Date of last review: 15 April 2026

Lead Director: Chief Operating Officer

Movement in score Q1 2025/26 – Q4 2025/26



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

Current Score (CxL): 3x3=9
As at 15 April 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	
1. Implementation of WRES / WDES / Gender Pay Gap / Race and Disability Pay Gap action plans. 2. Equality & Diversity Council (with focus on both workforce and population health inequalities) 3. Staff equality networks with assigned executive sponsors. 4. Recruitment and selection training programme. 5. Development programmes for managers including Leadership programmes. 6. Head of Equality, Diversity & Inclusion and team in post. 7. 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. 8. NHS Improvement plan – 6 high impact actions. 9. EDI training for managers in place. 10. Implementation of annual EDS2022 review (with focus on workforce, leadership and patient experience). 11. Trust Equality Impact Assessment Guidance and Template in place with EIAs completed on a regular basis with support from the EDI team. 12. EDI Conference with focus on Inclusion & Belonging. 13. EDI Objectives agreed for all Executive Directors. 14. 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:** 1. EDI Strategy - Trust Board update provided November 2025. 2. People Dashboard: BAME overall workforce and representation at Senior Management year on year improvements – latest as at November 2025. 3. Gender Pay Gap – improving position – latest as at March 2025. 4. WRES/WDES/EDI Update report - People Academy May 2025, with some notable improvements. Action plans refreshed in October 2025 (for 2025/2026). 5. HEAT assessment and training for managers implemented across the Trust (Strategy & Transformation Team). ~~6.~~ EDS2022 review for 2024-25: scored Achieving Overall. 7. Race and Disability Pay Gap - People Academy, January 2026. **Negative:** 1. Disability declaration rate. 2. Representation at Senior Leadership levels for gender, disability and race. 3. 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. 4. Disciplinary and Grievance data presented to People Academy in November 2025, currently	**Independent** **Positive:** 1. WRES/WDES benchmarking reports: some positive comparisons. 2. Gender pay gap benchmarking reports comparable with other local trusts. **Negative:** 1. WRES/WDES benchmarking reports some negatives around Career Development/ Representation at Senior Management levels 2. Gender pay gap: some areas that require improvement (particularly at Senior Leadership level) 3. NHS Staff survey outcomes 2025: improvement required around wellbeing, discrimination and staff voice (particularly regarding reporting of harassment and bullying). Listening events ongoing.	**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 developing local EDI action plans backed by CSU/department level data/ 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. **Action**	**Timescale** Ongoing Ongoing March 2026 Ongoing Ongoing **Timescale**

Opportune Template 09/05/2025 v1.2

	under review from an EDI perspective.				
Related risks on the high level risk register (operational risks)	N/A				

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.

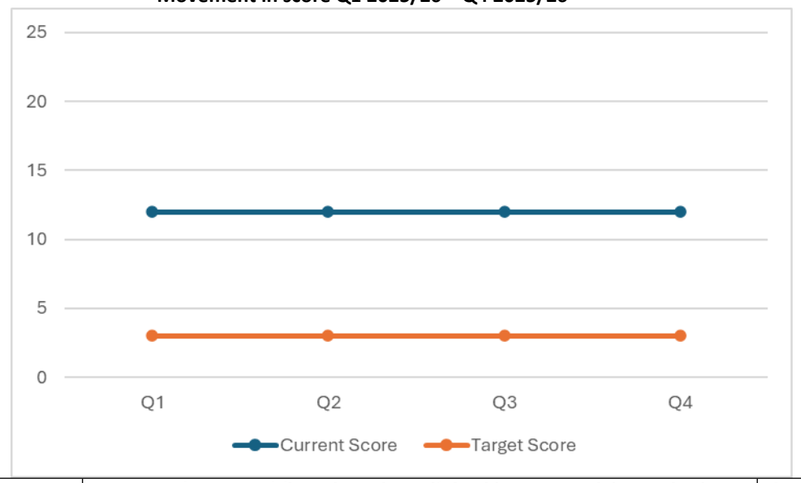
Risk Appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)

Date added: 13 September 2024

Date of last review: 22nd April 2026

Lead Director: Director of Strategy & Transformation

Movement in score Q1 2025/26 – Q4 2025/26



Initial Score (CxL): 4x3 = 12
As at 13 September 2024

Current Score (CxL): 4x3 = 12
As at 3 February 2026

Target Score (CxL): 3x1 = 3

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**	
1. Strategic Partnership Agreement (SPA) in place across the BD&C place. 2. CEO is member of the BD&C Partnership Oversight Executive and the Committee in Common for the provider collaborative. 3. Executive Director involvement in the four partnership programmes (strategic delivery groups) – ABCAS, integrated health and care, corporate services and children & young people. 4. Four programmes report into the Collaboration Programme Board chaired by the Place Chief Executive, which in turn reports into the Committee in Common 5. ABCAS Clinical Strategy has been developed. 6. Number of areas of joint working now being progressed with Airedale via ABCAS including cardiology, ophthalmology, plastic surgery, and Non-Surgical Oncology. 7. Five-year Integrated Delivery Plan for 2026/27-2030/31 agreed with NHS England. BTFHT, Airedale NHS Foundation Trust and Bradford District Care Trust included a common chapter on collaboration and partnership working in ABCAS and Integrated Neighbourhood Health. 8. Monthly meeting with Director of Strategy counterparts from other WY trusts. 9. 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. 10. Work to embed the Strategic Framework for 2025/26 and the five strategic objectives required all CSUs and Corporate Departments to highlight their work to collaborate effectively with local and regional partners. 11. Building and strengthening relationships with Universities (Bradford and Leeds). 12. Plan in place to maximise BTHFT's social value impact as an Anchor Organisation. Social Value Oversight Group established chaired by Director of Strategy & Transformation. 13. Strategic Advisory Forum on BTHFT's role as an anchor institution with a specific focus on education held jointly with the University on 4 February 2026 for Board and Council of Governors. 14. Partnership approach to developing Health on the High Street Care Models – working with health and care partners across the district. 15. The Trust is a member of the West Yorkshire Association of Acute Trusts (WYAAT). 16. Board has considered a paper on the emerging role of the Place Provider Partnership	**Internal** **Positive:** 1. Quarterly Board paper setting out strategic view of Partnerships. 2. ABCAS 1:1s with SRO and senior colleagues to ensure full visibility across the organisation. 3. Anchor Institution action plan based on Joseph Rowntree Foundation self-assessment approved by the Board in November 2025. 4. Developing a set of metrics to measure our performance as an anchor institution **Negative:** N/A	**Independent** **Positive:** 1. Strong history of working in partnership across the place, evidenced by the SPA which has been in place now for over five years. 2. WYAAT is highly respected and well embedded into organisations across the region and fosters strong partnership working. 3. ABCAS Steering Group and specialty working groups provide collective input and assurance across multiple divisions. 4. Establishment of the Clinical Executive Group across Place to lead the clinical strategy 5. Establishment of an ABCAS Clinical Reference Group to provide independent senior clinical input into the proposals. **Negative:** 1. Role of Place Provider Partnership is evolving and	**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. The ICB restructure has vastly reduced ICB capacity to engage in partnership work. **Gaps in assurance** N/A	**Action** Stakeholder and public engagement strategies. Strategic Advisory Forum write up and action plan	**Timescale** 2026 Spring 2026

Oct 2025 Board 13 of 20 Appendix 1

		not yet agreed.			
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.

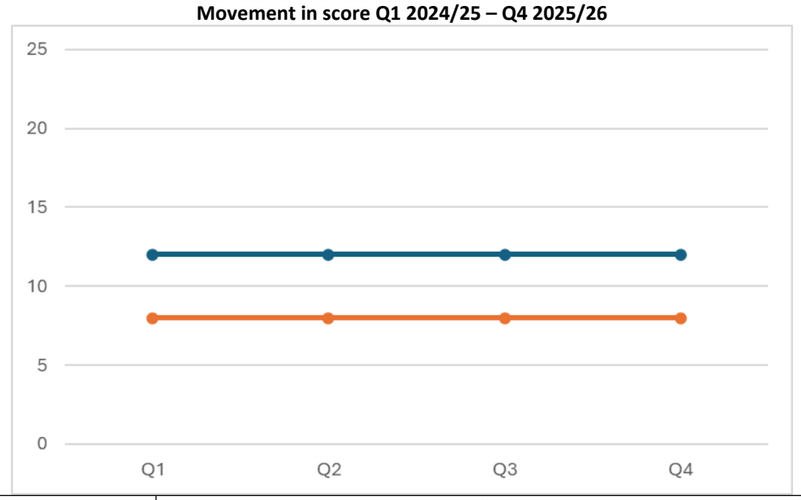
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 6 September 2024

Date of last review: 22 April 2026

Lead Director: Director of Strategy and Transformation

Movement in score Q1 2024/25 – Q4 2025/26



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

Current Score (CxL): 4 x 3 =12
As at 22 April 2026

Target Score (CxL): 4 x 2 = 8

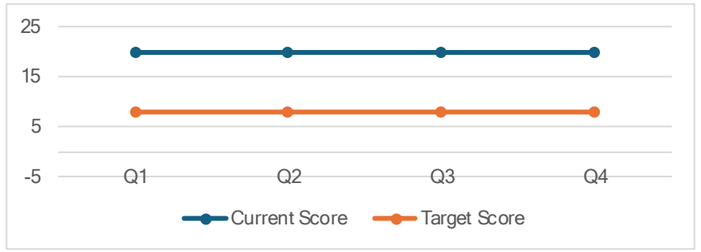
Key controls (what are we doing about the risk?)	**Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)**		**Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)**	**Actions to address gaps in controls or assurance**	
1. EDI strategy 2023-2025 chapter 8 sets out Health Inequalities Strategy. Objectives require revision as the EDI strategy has now expired – this will be done with the involvement of the Health Equity Oversight Group. 2. Health Equity and Health Inequalities programme is one of the 10 priority initiatives in the Strategic Framework for 2025/26 and will be prioritised in the 2026/27 strategic framework too. 3. The programme is implemented through the Trust-wide Health Inequalities Action Plan for 2025/26 and overseen by the Health Equity Oversight Group - a plan for 2026/27 is in the process of being developed. 4. Induction training on health equity and health inequalities continues with preceptorship training to start in June 2026. 5. The Trust is collaborating with partners to strengthen our health inequalities impact, particularly working with the 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. Dashboard developed to show outpatient DNA rates for Core20 and nonCore20 populations by specialty and by clinic 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 (iii) reduce DNA rates for core20 patients in renal services as part of a region wide health equity programme 9. Supporting development of Health on the High Street to ensure new model increases health equity and seeks to reduce inequalities. 10. Supporting BTHFT's role as an Anchor Institution and leading the aspects of the Joseph Rowntree Foundation Framework that focus on health equity. 11. Revised health inequalities statement produced for 2025/26 Annual Report based on the range of indicators and key lines of enquiry required by NHSE in their November 2025 revision to the statement. Will incorporate into a dashboard to enable focused action and monitoring throughout the year.	**Internal** **Positive:** 1. 25/26 Strategic Objective metric for the Partnerships objective focuses on health equity is 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:** Key colleagues from the Reducing Inequalities Alliance have left during the ICB re-structure leaving a gap in expertise and resource. The Health Equity Fellowship programme has also been put on hold due to the restructuring at the ICB so no new fellows will be recruited for 26/27.	**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. **Gaps in assurance** Challenges in identifying inequity in outcomes due to NHS and Trust not routinely collecting data on all protected characteristics.	**Action** Discussions ongoing. Linking directly with Public Health Work with colleagues in DDAT, Research and Performance.	Timescale Ongoing Ongoing

Related risks on the high-level risk register (operational risks)	**N/A**

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

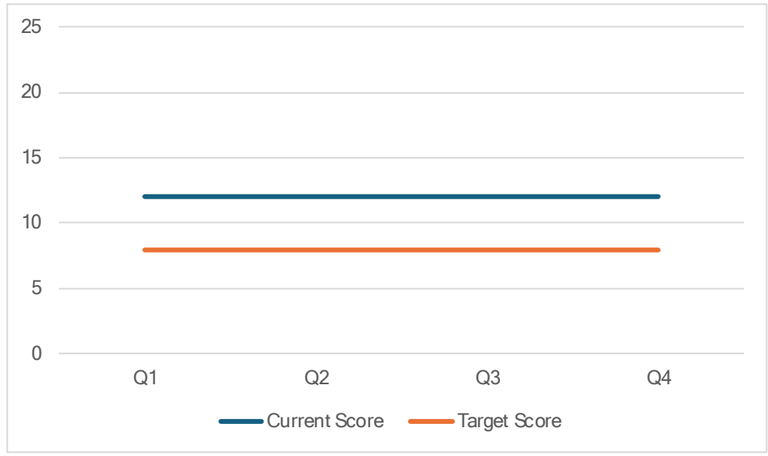
Ref: 12	**Strategic Risk: If** we are unable to deliver our financial plan, **then** we will not be financially sustainable, **resulting in** poor outcomes for staff, patients and the public, including loss of services.

Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	**Movement in score Q1 2025/26 – Q4 2025/26** 	**Initial Score (CxL): 5x4=20** As at 24 August 2024
Date added: 24 August 2024 **Date of last review:** 31 March 2026		**Current Score (CxL): 5x4=20** As at 31 March 2026
Lead Director: Chief Finance Officer		**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	
1. Clinical Service Unit (CSU) financial management arrangements and framework, and accountability and performance management framework. 2. Regular reviews between Red rated CSUs and CFO to monitor departmental recovery plans. 3. Further development of the Closing the Gap programme and governance structure. 4. Communications from Executive Team to highlight the importance of delivering the financial plan and increasing the priority given. 5. Quality Impact and Financial Impact Assessment processes. 6. Action plan to deliver recommendations of external review of financial governance arrangements and efficiency opportunities. 7. Financial controls: Vacancy Control Process, Non-Pay Review process, Minor Work Review process and recruitment of all senior roles approved by ETM. 8. 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. 9. Intensified oversight and governance of the capital programme via Capital Strategy Group and Capital Operational Group. 10. 5 year financial and capital plan. 11. WYAAT CEO-led efficiency workstreams. 12. ABCAS provider collaborative workstreams. 13. Corporate Services cost reduction plans (nationally mandated) with Exec CRO. 14. Working Efficiency Group work plan. 15. Review of NHSE Grip and Control checklist 129/156 interventions in place. 16. Revised budget setting process for 2026/27. 17. Suite of policies: • Standing Financial Instructions • Reservation of Powers to the Board and Scheme of Delegation • Capital Programme Management Policy	**Internal** **Positive:** 1. Monthly finance report to F&P Committee. 2. I&E run rate improvements month on month to Month 5. 3. Weekly reporting on CTG scheme development by department. 4. Closing the Gap report F&P Committee highlighting progress with scheme development. 5. Capital plan approved for 2025/26 and higher levels of delivery to Month 6 than previous years. 6. NHSE cash management process requirement to apply for external cash support are in place and reported to F&P Committee. **Negative:** 1. Deficit plan with an underlying deterioration agreed for 2025/26. 2. Underlying I&E forecast for 2025/26 exit run rate – significant deficit to address for 2026/27. 3. Cashflow forecast report presented to F&P Committee highlighting forecast cash risks in Quarter 4 in 2025/26. 4. CSU Monthly finance reports forecasting material overspends in many departments. 5. CTG Plan status – 100% of plans identified but risk adjusted forecast for in year delivery below 100%.	**Independent** **Positive:** 1. External review providing assurance on the Closing the Gap governance and programme structure 2024/25. 2. Internal Audit Reports: a. Financial Controls - Significant assurance (May 2025) b. Implementation of actions following external report (PwC) – Significant assurance (October 2025) **Negative:** N/A	**Gaps in control** Budget holder capacity and capability to deliver a £33m cost improvement target in 2025/26. System partners may not deliver their financial plans, which may result in the aggregate system position being off plan, impacting adversely on BTHFT. Capacity and Capability to deliver the full capital programme as planned. 27 NHSE Grip and Control recommendations not in place. **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. BTHFT share of ICB £33m planning gap - £5.3m required over-performance 2025/26 via additional efficiencies driven by system collaboration. Ability to forecast delivery of the I&E plan in 2025/26 Ability to forecast financial balance in 2025/26 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. 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.	**Action** Earlier engagement in the planning process and CTG targets confirmed with clear deadlines for achievement. Engagement with system partners to collaborate on shared cost improvement initiatives. 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. Implement the 27 Grip & Control recommendations. CFO meetings with CSUs under the accountability framework 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. Increased financial controls and CFO meetings with CSUs under the accountability framework Medium term financial plan to be developed and Q4 in line with NHSE guidance. CTG multi-year planning to be developed. Revised budget setting process for 2026/27. Working capital controls in line with NHSE requirements. Cash Committee to develop further strategies to maximise cash balances. Capital Strategy Group and Capital Operational Group oversight.	**Timescale** Ongoing Ongoing Ongoing Quarter 3 and 4 2025/26 Ongoing Ongoing Ongoing March 2026 Ongoing Ongoing Ongoing
Related risks on the high-level risk register (operational risks)	**2810 – Revenue Financial Position**				

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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	**Movement in score Q1 2025/26 – Q4 2025/26** 	**Initial Score (CxL): 4x3 = 12** As at 27 August 2024
Date added: 27 August 2024 **Date of last review:** 24 March 2026		**Current Score (CxL): 4x3 = 12** As at 24 March 2026
Lead Director: Chief Operating Officer		**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	
1. Operational, Financial and Workforce Planning Submissions 2. Operational Improvement Plan (Delivering Operational Excellence) 2025-26 approved 3. Partnership working and transformation programme 4. Airedale and Bradford Collaboration of Acute Services (ABCAS). 5. Improvement programmes of work e.g. histopathology, urgent care, pharmacy 6. Hospital Management Group, Exec-to-CSU Meetings and Accountability Framework 7. Capital investment in infrastructure 8. Virtual Royal Infirmary programme 9. EPRR Policy and BCP Plans. 10. Winter response plan 11. Ring fenced elective wards and capacity (at BRI site) 12. Closing the Gap programme 13. WYAAT – case for change service review approved.	**Internal** **Positive:** 1. WYAAT ICS Programme Updates – latest September 2025. 2. Delivering Operational Excellence Plan to F&P Committee: - 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 3. Operational, Financial and Workforce Plan – latest Board March 2025 and F&P April 2025 4. Winter Response Plan – F&P Committee – September 2025 and Board September 2025. 5. Performance Report to F&P Committee – February 2026. 6. EPRR self-assessment core standards – 56 out of the 62 were fully compliant and 8 were partially compliant – overall substantial compliant 90% – improved position. 7. Achieved 65 week wait – 0 at end of December 2025. **Negative:** 1. WYAAT reports (e.g. Non-Surgical Oncology, Haematology) 2. Histopathology and renal performance.	**Independent** **Positive:** 1. GIRFT reports 2. Latest CQC reports - Well Led - Good. 3. Royal Colleges reports 4. Benchmarking of recovery position compared to other Trusts (Performance Report, latest October 2025) 5. Human Tissue Act assessment 6. Internal audit reports: a. Delivering Operational Excellence – Significant Assurance (November 2025) 7. National Oversight Framework (NOF) 58th out of 134 trusts. **Negative:** a. GIRFT Reports b. Joint venture – loss of UKAS accreditation c. Discharge Management – Internal Audit Report limited assurance in August 2025. d. SSNAP (Stroke Audit Programme) – new standards translated into a negative / deteriorating position due to the assimilation to the new SSNAP standards/criteria.	**Gaps in control** • Workforce gaps in some service areas (e.g. Histopathology, NSO) resulting in inability to maintain service provision in the longer term and shorter-term gaps • Fragile services e.g. Stroke, Haematology, 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). **Gaps in assurance** N/A	**Action** • Work with Joint Venture to streamline pathways. • Business case for histopathology expansion approved and additional consultants recruited. Currently one gap in provision. • 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 • 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.	**Timescale** Ongoing Completed VIR Ongoing Ongoing Ongoing TBC following validation of water and ventilation Completed. Ongoing
Related risks on the high-level risk register	• **70** – Pharmacy Accommodation (current score: 15) **2549** – Workforce constraints in Non Surgical Oncology (current score: 16) **2604** – Emergency Department overcrowding (current score: 20).				

Objective 5: Sustainability - To deliver our financial plan and key performance targets
Assurance topic – Environmental sustainability

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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. **The Q4 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. It will be recommended that this risk is closed and incorporated into SR01 moving into 2026/27.**

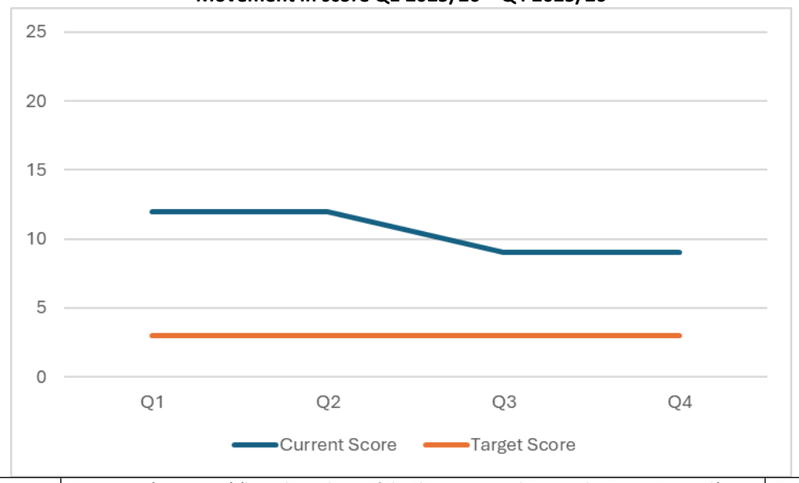
Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 4 September 2024

Date of last review: 30 March 2026

Lead Director: Director of Estates & Facilities

Movement in score Q1 2025/26 – Q4 2025/26



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

Current Score (CxL): 4 x 3 = 9
As at 30 March 2026

Target Score (CxL): 4 x 2 = 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	Actions to address gaps in controls or assurance	
1. The BTHFT Green plan outlines the action we will take to meet our obligations. Approved by the Board on 31 July 2025. 2. 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. 3. Successful in obtaining £1.8m bid for solar panels at St Lukes and BRI. 4. Successful in obtaining £600k for LED lighting through National Energy Efficiency Fund (NEEF) funding, both sites will be 100% LED. 5. Work across trust to promote good practice and share case studies and staff engagement. 6. 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. 7. ICB sustainability plan outlines what the ICB will do to meet its obligations on sustainability and the environment. 8. Sustainability Manager in post. 9. 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. 10. 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. 11. Rolled out recycle bins across the trust and will be throughout the trust in 2 months and improved reporting. 12. £187k bid for electric vehicle chargers was successful. 13. Successful bid to reduce the use of Nitrous Oxide at the trust. 14. Board Sustainability training delivered in December 2025.	**Internal** **Positive:** 1. Annual report 2023/24 2. Annual Report to Board – January 2026. **Negative:** N/A	**Independent** **Positive:** 1. WY ICB 2. BD&C Health & Care Partnership 3. NHSE NE&Y 4. CQC Well Led Inspection (outcome TBC) **Negative:** 1. 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 **Gaps in assurance** Routine data sets showing progress against the ten NHS E domains are not routinely available to monitor progress	**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. 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.

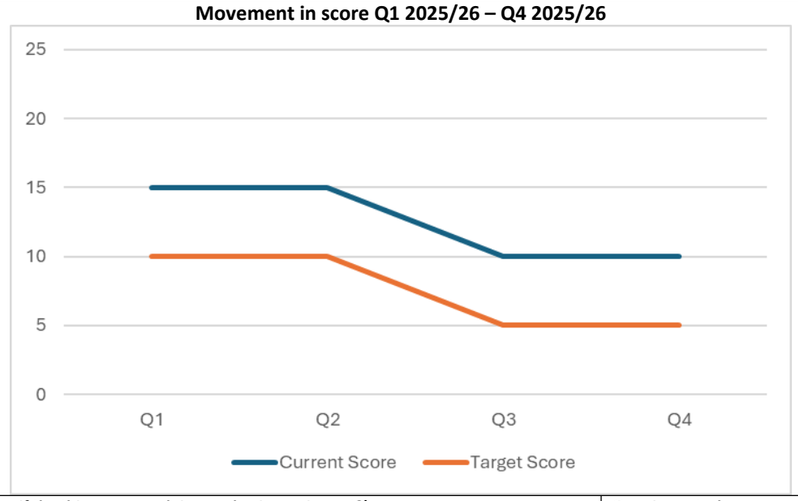
Risk Appetite:
Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 6 December 2023

Date of last review: 14 April 2026

Lead Director: Chief Operating Officer

Movement in score Q1 2025/26 – Q4 2025/26



Initial Score (CxL): 5x4 = 20
As at 6 December 2023

Current Score (CxL): 5x2 = 10
As at 14 April 2026

Target Score (CxL): 5x1 = 5

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	
1. Board and Committee/Academy structure 2. Arrangements in place to ensure compliance with Code of Governance for NHS Provider Trusts and NHS Provider Licence 3. Suite of governance documents in place and reviewed regularly including Constitution, Scheme of Delegation, Standing Orders 4. Board Development programme 5. Effectiveness reviews of Board, Committees, Academies 6. Appraisal process for Board members 7. Risk Management Strategy 8. Risk Appetite Statement agreed and reviewed on an annual basis 9. Conflicts of Interest Policy and processes 10. Board member participation in PLACE, 15 steps and 'reach in' visits 11. Reviews of composition of Board through NRC and Governors NRC. 12. Fit and Proper Person checks undertaken annually 13. Council of Governors – quarterly meetings including holding the NEDs to account for the performance of the Board 14. New series of joint Board/Governor meetings introduced (Strategic Advisory Forum).	**Internal** **Positive:** 1. Annual Governance Statement 2. Annual Report 3. Quality Account 4. Annual review of compliance against Code of Governance and NHS Provider Licence 5. Annual review of NED independence 6. BAF 7. High Level Risk Register 8. Academy/Committee Chair reports to the Board 9. Annual committee effectiveness reviews and annual reports 10. Board effectiveness survey – latest October 2025 **Negative:** 1. BAF and High-Level Risk Register – risks above target score / risk appetite level.	**Independent** **Positive:** 1. Head of Internal Audit Opinion. 2. Internal Audit reports: a. Quality Committee Deep Dive – Significant assurance (February 2025) b. Risk Management – Significant assurance (April 2026) c. Policy Management – Significant assurance (July 2025) 3. Positive progress through IQIG, frequency of meetings reduced to bi-monthly. 4. CQC Well Led Inspection report – Good rating. **Negative:** 1. Internal Audit reports: a. Board Assurance Framework - Limited Assurance (April 2026) 2. Annual VFM assessment 24/25 – significant risk re: governance. 3. Trust is in NOF3 with additional licence condition and agreed enforcement undertakings. 4. Capability assessment rating amber/red.	**Gaps in control** • 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 **Gaps in assurance** • N/A	**Action** • 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. Clarity of arrangements in light of proposals to abolish Council of Governors.	**Timescale** Complete Reviews to take place April 2026, implementation of actions by September 2026. Plan in place up to August 2026 April 2026 April 2027 – Report to CoG in July 2026 re future arrangements.
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 05/05/2026)

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	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.	fredag 5. juni 2026	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	15	(5) Catastrophic	(3) May recur occasionally	March 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.	31 Mar 2028	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
2604	04 Jul 2024	Sajid Azeb	Mayada Elsheikh	Risk Assessment	Quality Committee Finance and Performance	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-jul-26	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	12	(4) Major	(3) May recur occasionally	1. Immediate actioning of Trust-wide comms and social media campaign to inform parents of one carer policy once surge commences and SOP triggered 2. Develop an OPEL scoring system for escalation to alert the Executive team when we are under significant pressure. (Adults and Paeds) 3. Agreement from speciality teams to accept direct referrals and for ED teams to be able to send these patients directly to specialty receiving areas on their arrival to ED, including tertiary referrals and semi-elective admissions. 4. Develop business case for 24/7 consultant cover. 5. AED Pharmacist/Tech must ensure adequate stock, assist with complex prescriptions, and suggest alternatives to reduce the burden on nursing and medical staff for medication checks, issuing of TTOs, prescription reviews, and bed waits. 6. Long term Excel project launched	31 Mar 2027	(4) Major	(5) Will undoubtedly recur, possibly frequently	20

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2756	16 Jul 2025	Sajid Azeb	Mayada ME Elsheikh	Risk Assessment	Quality Committee Finance and Performance Committee	AED Long Waits	If we are unable to see, treat, and admit or discharge patients within 4 hours then patients will increasingly experience a long length of stay in the A&E department. Consequently, they are more likely to experience increased mortality and morbidity	31-jul-26	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 paeds 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	31-jul-27	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
901	07 Dec 2016	Vikki Lewis	Daniel Kay	Business Continuity	Quality Committee	Cyber Exploitation and Incidents	Cause: The rising frequency and sophistication of cyber-attacks across different sectors such as retail, banking and the health sector including the NHS, combined with known vulnerabilities in legacy clinical systems, critical third-party integrations, and growing regulatory obligations significantly increases the likelihood of service disruption at BTHFT. This evolving threat environment heightens the Trust's exposure to operational instability, loss of digital continuity, and potential failure to meet statutory and contractual obligations under the NHS England guidance and UK GDPR/Data Protection Act 2018. Event: A successful cyber-attack (such as ransomware, data breach/exfiltration, or denial-of-service) compromises critical BTHFT digital infrastructure, resulting in the disruption of clinical and administrative systems, such as patient records, appointment scheduling, internal communications, and community services. This operational breakdown impairs care continuity, reduces organisational resilience, and exposes the Trust to increased scrutiny from regulatory and commissioning bodies due to unmet service obligations. Effect: Inadequate implementation of controls may result in delayed access to critical clinical systems or patient records, directly affecting care continuity and placing patient safety	30 Apr 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	01 Apr 2027	(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 mitagate.	28 Sep 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16

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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	Feb-26 reviewed and updated by Dr Thopte Feb, no change in terms of BDCT pathway. CSU continues to clear backlog with Standard pathway/Effective Triage and plan to redesign Referral form to ensure families are being supported whilst waiting for their first new patient appointment.	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
2879	27 Mar 2026	John Bolton	Hannah Ackroyd	Risk Assessment	Quality Committee	Middle grade medical staffing gaps in Obstetrics and Gynaecology	If the Women's CSU are not able to recruit suitable middle grade doctors (Equivalent to ST5 and above) to the service then this will result in the continuation of significant gaps on the 2 tier middle grade rota. This will result in times where there is only one registrar at nights, and where this doctor is not enstrustable this might result in the on-call consultant having to step down and be resident for the whole night, resulting in the risk of stress and burnout to the consultant body who are themselves below establishment (see risk 3816). If the Women's CSU are not able to recruit suitable middle grade doctors (Equivalent to ST5 and above) to the service then this will result in the continuation of significant gaps on the 2 tier middle grade rota. This will result in times where there is only one registrar at nights, and where this doctor is not enstrustable this might result in the on-call consultant having to step down and be resident for the whole night, resulting in the risk of stress and burnout to the consultant body who are themselves below establishment (see risk 3816). If the Women's CSU are not able to recruit suitable middle grade doctors the service will not be able to move to a full 24/7 2 tier rota to all for sufficient senior medical staff factored into the rota to have consistent cover for MAC and ANDU resulting in this becoming the responsibility of the acute team who are also required to cover the Labour	30 Jun 2026	16	(4) Major	(4) Will probably recur, but is not a persistent issue	8	(2) Minor	(4) Will probably recur, but is not a persistent issue	1-The recruitment of specialty doctors and clinical fellows to fill the gaps of both the Trust grade doctors that are required for our establishment, as well as clinical fellows and MTIs to fill the gaps created by the deanery short fall. 2-To follow the Royal College Obstetricians Gynaecologists (RCOG) workforce guidance as to how to future proof the speciality for individual Trusts; promote, recruit and retain locally employed doctors and to consider recruitment through the RCOG MTI scheme. A full summary of this is available from: O&G Workforce Report 2022 | RCOG 3-The service has escalated their safety position to both the deanery and the RCOG. There are plans to support the unit with 2 MTI's which should be in post in 2026. There has also been a formal complaint to the Deanery due to the inequity of the rotation (this skill mix and shortfall is	30 Sep 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16

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2773	20 Aug 2025	Karen Dawber	Kay Rushforth	Risk Assessment	People Academy Quality Committee	Children and Young People with Medical Complexity	IF staffing resource is not commissioned to deliver higher level care to children with medical complexity when they require this THEN care for CMC remains at a nurse to patient ratio of 1:4 and untimely medical supervision RESULTING IN substandard care, for all children irrespective of care level needs, reduced flow and possible closure of beds.	20-jun-26	12	(4) Major	(3) May recur occasionally	12	(4) Major	(3) May recur occasionally	1. Aim to provide 1:1 where child in cubicle or 1:2 care. Immediate care on arrival to ED and CCDA to aim for continuity of care. 2. Increased nurse to patient ratios and recognition of HDC level 2 status. Increased medical staff hours with expertise to provide care. Non recurrent money (winter surge November 2024 - 25 for 6 months) provided to keep some complex needs children out of hospital. Pilot study only. Study a success but must continue. 2. As above. Greater discussion required nationally and regionally. Children should be cared for closer to home with the expertise necessary 3. Focus group for parents/CMC to share ideas thoughts needs	20-jun-26	(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.	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	fredag 31. juli 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)	fredag 30. april 2027	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
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

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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.	30 May 2026	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	3	(3) Moderate	(1) Cannot believe that this will ever happen again	20/03/2026 - Tender complete and tender report prepared. Will require sign of at board due to the value of the contract.	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
2868	02 Mar 2026	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.	29-mai-26	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	5	(1) Negligible	(5) Will undoubtedly recur, possibly frequently	1. 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. 2. Assurance that current caseloads in community have test tracked group and antibody screens and actioned all clinically significant antibodies. 3. Explore with Transfusion and Pathology Team the reason for transfusion reports not being accessible through ICE. If no solution is possible maternity to increase the numbers of staff who have administration rights to support team members to access Sp_ICE. 4. Explore and develop a failsafe test tracking process for community teams. 5. Maternity to agree and liaise with Transfusion the communication pathway for clinically significant antibodies. 6. Obtain staff feedback in relation	31 Jul 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15

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40	02 Jul 2023	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 May 2026	12	(4) Major	(3) May recur occasionally	3	(1) Negligible	(3) May recur occasionally	20/02/2026 The Procurement process was completed however no tender was awarded. There is currently no further update with regards to next steps. The CSU still is unable to meet the Ockenden requirements, the 3 year plan and the Maternal care bundle. The CSU are unable to audit effectively key elements of PCP such as shared decision making, active participation and equitable access. The Maternal care bundle (February 2026) further highlights the requirement for women to participate in their care plans and be invited to self-administer the whooley questions (element 4) outside of their scheduled appointments. Self-completion may enhance comfort, autonomy and disclosure. Risk to compliance is there is no patient portal for this to be sent to the women that will then feed back into EPR. Element 1 VTE - Woman to have opportunity to	28 Aug 2026	(5) Catastrophic	(3) May recur occasionally	15
2787	23 Sep 2025	Karen Dawber	Jessica Hodgins	National Guidance	Finance and Performance Committee Quality 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.	30 Jun 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	March 2026. 5/3/26 Additional Hazard identified and added - Maternity Theatre Scrub Cover & Emergency Capacity. Band 6 scrub resilience reduced resulting in increased use of Band 7 to mitigate theatre risk and main site theatre staffing increasing risk further due to reduced reliance to safely open a second theatre. Recovery plan continues. New Matron for obsteric theatres, Jess Hodgins now leading the risk assessment actions. Risk score remains 15	30 Jun 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.	30 Jun 2026	10	(5) Catastrophic	(2) Do not expect it to happen again but it is possible	5	(5) Catastrophic	(1) Cannot believe that this will ever happen again	19/03/26 - no further updates on the launch of the SFH chart therefore risk assessed with the normal urgent ultrasound demand. The score has remained the same in March 2026 to reflect that the next working day target was achieved in only 85.1% in the previous 3 month period and the 72 hour KPI was achieved in only 80% in the previous 3 month period. In view of this, the risk score is to remain as a 15	30 Sep 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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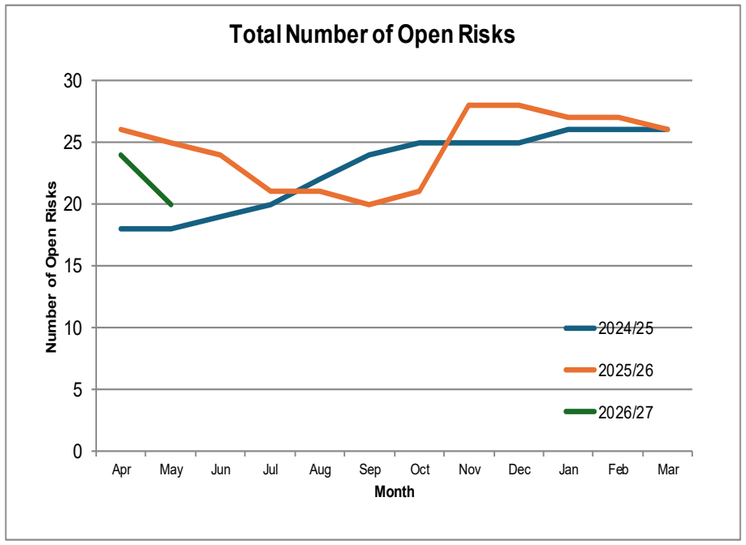
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Bradford Teaching Hospitals
NHS Foundation Trust

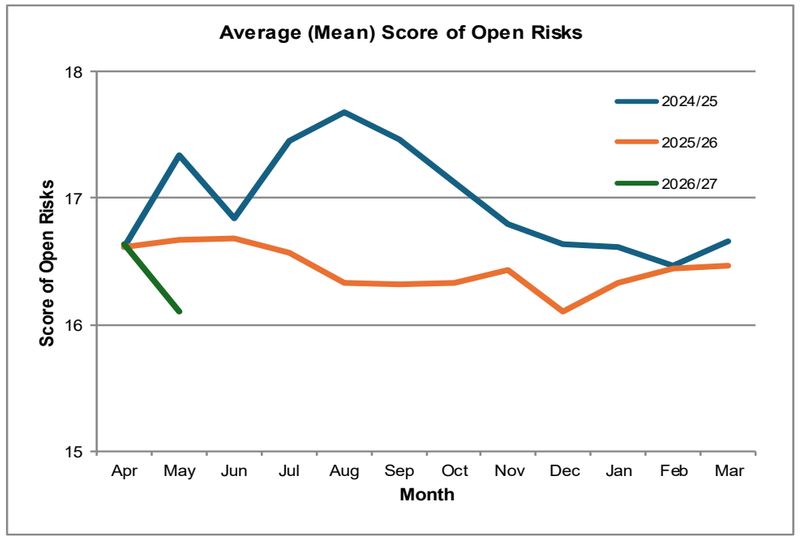
High Level Risks Report on a Page at May 2026

Total High-Level Risks	20*
Aligned to F&PC	7
Aligned to QC	19
Aligned to PA	5
Aligned to Board	2

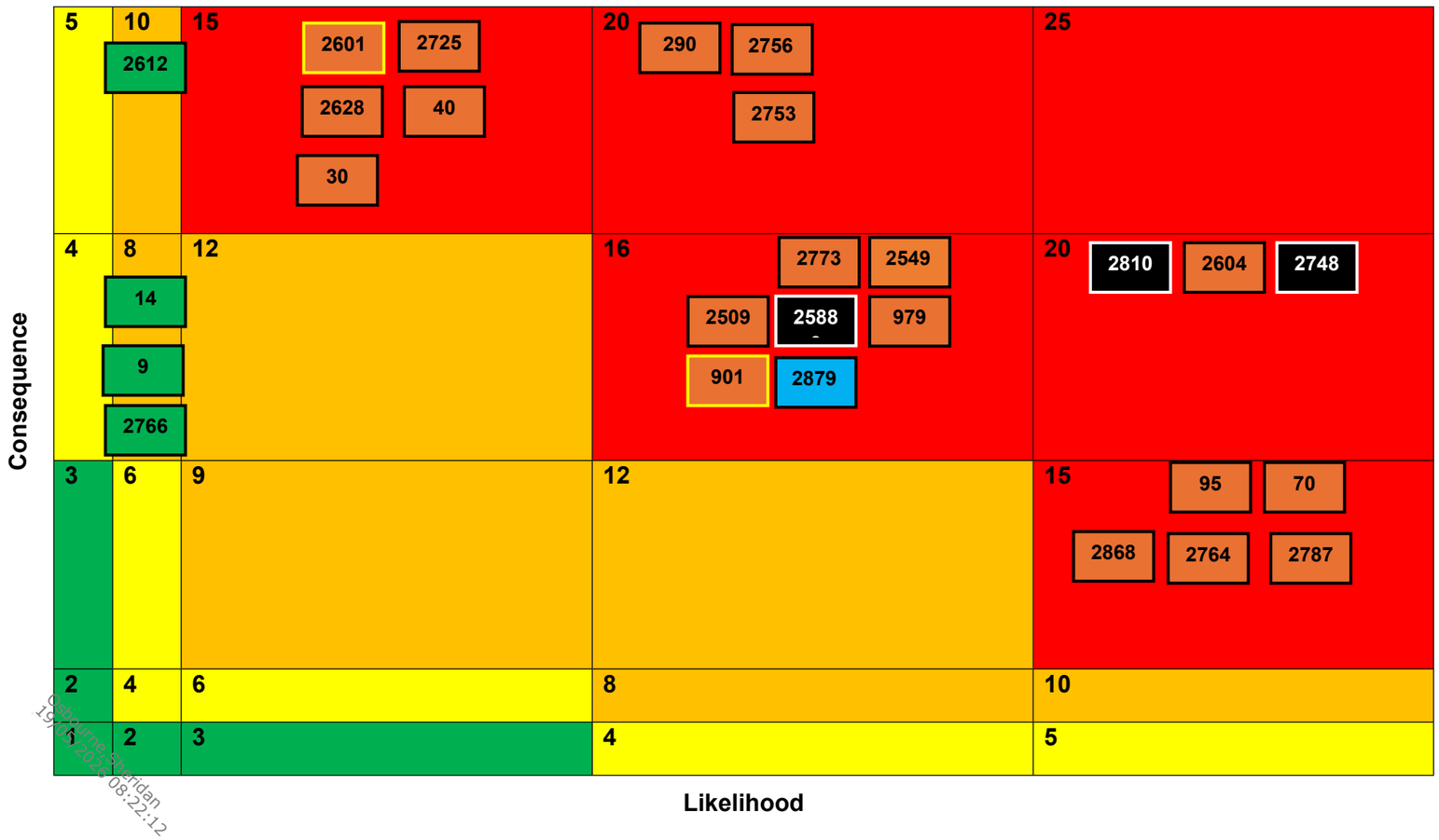
Movement of Risks	
New	1
Marked for closure	3
Risk score increased	0
Risk score static	19
Risk score decreased	4

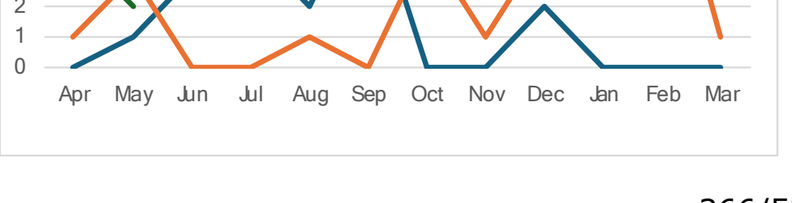
*Note some risks are aligned to more than one Academy/Committee

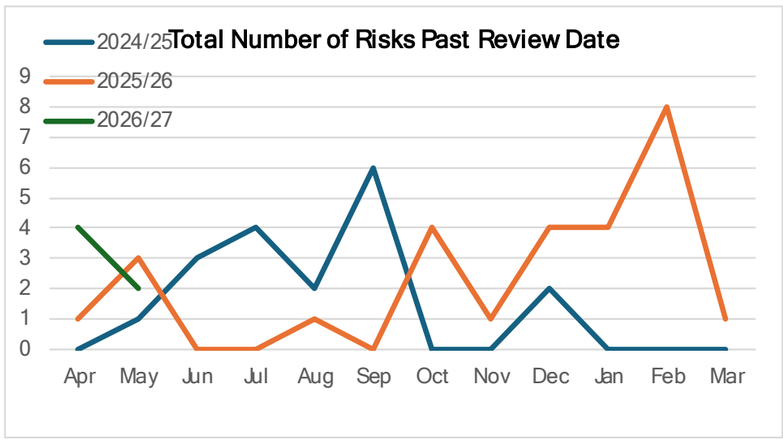




Risk Overview







Key:	New	Closed/Removed	Increase	Decrease	Static	Past Review Date

Changes to Target Mitigation Date of Current High Level Risks - May 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	10th Change
290	10/02/2021	QC, F&P	20	10	30/04/2021	31/05/2021	31/03/2023	31/03/2025	30/04/2026	31/03/2028					
2549	05/04/2024	PC & 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	PC & QC	15	6	28/02/2024	31/08/2024	31/10/2024	31/03/2025	31/03/2026	30/04/2027					
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	01/04/2027			
70	29/03/2023	F&P & PC	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	31/07/2027								
2753	11/07/2025	QC, F&P	20	5	31/03/2026	31/07/2026									
2773	30/08/2025	PC & QC	16	16	20/04/2026	20/06/2026									
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	30/09/2026				
2787	23/09/2025	QC, F&P	15	4	31/03/2026	30/06/2026									
979	29/09/2025	PC & QC	16	16	29/01/2026	28/09/2026									
2764	30/07/2025	QC, F&P	15	6	31/03/2026	30/09/2026									
2879	27/03/2026	QC	16	8	30/09/2026										
40	02/07/2023	QC	15	3	28/08/2026										
2868	02/03/2026	QC	15	5	31/07/2026										

Overdue

Change in Target Mitigaton Date

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BOARD ASSURANCE FRAMEWORK 2026/27

Proposed Q1 Position 2026/27

Example

Q1 2026/27 Position Reporting Timescales:

Executive Team Meeting:	xxxx
People Academy:	xxxx
Finance & Performance Committee:	xxxx
Quality Committee:	xxxx
Board of Directors:	xxxx

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Appendix 1: Board Assurance Framework Key

Risk Rating Matrix (Likelihood x Consequence)

Consequence	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5	5 Low	10 Moderate	15 High	20 High	25 High
Major 4	4 Low	8 Moderate	12 Moderate	16 High	20 High
Moderate 3	3 Low	6 Moderate	9 Moderate	12 Moderate	15 High
Minor 2	2 Low	4 Low	6 Moderate	8 Moderate	10 Moderate
Negligible 1	1 Low	2 Low	3 Low	4 Low	5 Low

Risk Definitions:	
Current Score	The level of the risk at the present time
Residual Score	The level of anticipated risk after controls.

Board Assurance Framework Legend					
Strategic Risk	The title of the strategic risk that threatens the achievement of the aligned strategic objective				
Rationale for Current Risk Score	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk				
Risk Appetite	The total amount of risk an organisation is prepared to accept in pursuit of its strategic objectives **(see pages 3 and 4)**				
Controls	The measures in place to reduce the risk likelihood or risk consequence.				
Assurances	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk - RAG rated.				
Levels of Assurance	The platform that reports on the assurance (**First line**: Operational **Second line**: Management Oversight **Third line**: Independent and Objective Assurance)				
Gaps in Controls	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk				
Gaps in Assurance	Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk				
Required Action	Actions required to close the gap in control(s)/ assurance(s)				
Action Lead	The person responsible for completing the required action				
Target Completion	Deadline for completing the required action				
Monitoring	The forum that will monitor completion of the required action				
Quarterly Oversight of Risk Score	The executive lead's quarterly prediction of the risk score with supporting rationale.				
Action Progress	A RAG rated assessment of how much progress has been made on the completion of the required action	Overdue	In Progress	Completed	Not started

BOARD ASSURANCE FRAMEWORK DASHBOARD 2026/27

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Strategic Risk	Assurance Committee	Exec Lead	Q1	Q2	Q3	Q4	2026/27 Residual Risk Score	Risk Appetite & Tolerance Score
Strategic Objective 1: Quality To provide outstanding care for our patients, delivered with kindness.								
SR01: If we are unable to obtain sufficient investment to develop our estate infrastructure, **then** we may be unable to deliver high quality responsive services in a safe, compliant and sustainable environment, **resulting in** the inability to achieve national standards and a negative impact on the quality of care.	**Finance & Performance Committee**	**DoEF**	**20 5x4 CxL**					**TBC**
SR02: If we do not consistently maintain evidence based, safe and effective care, **then** we may see an increased incidence of avoidable harm, poor patient experience, and inadequate patient outcomes, **resulting in** a reduction in the quality of care and failure to deliver our statutory and regulatory obligations.	**Quality Committee**	**CDIO**						
Strategic Objective 2: Improvement To be a continually learning organization and recognized as leaders in research, education and innovation								
SR03: **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.	**Quality Committee**	**CMO**						**TBC**
SR04: **If** we are unable to attract the resources, skills and experience needed **then** we will be unable to deliver our research, education and innovation priorities, **resulting in** an inability to retain our research and teaching status, and a negative impact on patient care.	**Quality Committee**	**CMO**						
Strategic Objective 3: People To be one of the best NHS employers, prioritizing the health and wellbeing of our people, embracing quality, diversity and inclusion.								
SR05: If we are unable to maintain a healthy and engaged workforce, **then** we will be unable to retain and attract staff, **resulting in** an adverse impact on service provision.	**People Committee**	**DoHR**						**TBC**

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SR06: If we are unable to achieve our ambitions on EDI **then** we will fail to have a workforce that is representative of our communities, **resulting in** an adverse impact on patient, staff and public experience.	**People Committee**	**COO**						**TBC**
Strategic Objective 4: Partnership To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals.								
SR07: If the trust fails to collaborate effectively with its partners, **then** there will be a fragmented approach to healthcare across Bradford District & Craven and West Yorkshire, **resulting in** missed opportunities to address health inequalities and improve patient and staff experience and outcomes.	**Quality Committee**	**DoST**						**TBC**
Strategic Objective 5: Sustainability To deliver our financial plan and key performance targets.								
SR08: If we fail to deliver our financial and capital plan, **then** we will not be financially sustainable, **resulting in** poor outcomes for staff, patients and the public including loss of service**.**	**Finance & Performance Committee**	**CFO**						**TBC**
SR09: If the trust is unable to deliver sustainable services in line with the 5-year medium term plan, **then** we may need to cease services, **resulting in** a loss of staff, poor outcomes for patients and reputational damage.	**Finance & Performance Committee**	**COO**						
A Well Led Organisation – Governance and Risk								
SR10: If we don't have robust governance and risk management 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, regulatory intervention and damage to the trust's reputation.	**Board of Directors**	**COO/CN**						**TBC**

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BOARD ASSURANCE FRAMEWORK 2026/27

STRATEGIC RISK SR01: If we are unable to obtain sufficient investment to develop our estate infrastructure, **then** we may be unable to deliver high quality responsive services in a safe, compliant and sustainable environment, **resulting in** the inability to achieve national standards and a negative impact on the quality of care.						**Executive Director Lead:**	Director of Estates and Facilities		
						Strategic Objective 1:	**Quality:** To provide outstanding care for our patients, delivered with kindness.		
						Committee:	Finance and Performance Committee		
BAF RISK SCORE JOURNEY:						**Risk Type:**	TBC		
01.04.26	**Q1**	**Q2**	**Q3**	**Q4**	**2026/27 Residual**	**Risk Appetite:**	TBC	**Risk Tolerance:**	TBC
20	20				10	**Risk Appetite Narrative:** TBC			
5x4	5x4				5x2				
Quarterly Oversight (risk score): Deteriorating / Static / Improving					**Q1:** Static	**Q2:**	**Q3:**	**Q4:**	**Rationale below:**
Residual Score Rationale:	10	To achieve the target score of 10, the hospital must secure major investment to replace a significant proportion of the hospital.							

Quarterly position:
The risk score for Q1 remains static as the estate continues to age and will be 100 years old in 20230 (BRI). The majority of backlog maintenance work that is addressed is replaced by new backlog works, due to the age and infrastructure. **The risk is unlikely to reduce** until the hospital can secure major investment to replace a significant proportion of the hospital. Bradford has one of the oldest estates within the region and has not had the same level of investment as other WYAAT sites.

Controls, Processes and Compliance	Assurance	Q1 Assurances						Overall Rating
		First Line		Second Line		Third Line		
Infection Prevention & Control	IPC Quarterly reporting	Compliance Risk and Assurance Group	G	Quality Committee	G	-	-	G
PLACE	Premises Assurance Model	E&F Management Board	G	F&P Committee	G	Board of Directors	X	G
Backlog Maintenance	Estates Return Information Collection (ERIC)	E&F Management Board	G	F&P Committee	G	-	-	G
Health & Safety	Health & Safety Committee Reports	Compliance Risk & Assurance Group		F&P Committee	G	NHSE reporting	X	G
Space Utilisation	Space Utilisation Project & Heat map	E&F Management Board	G	F&P Committee	G	-	-	G

Gap in Controls and Assurance	Action identified	Lead	Target completion	Progress

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Estates Strategy	To complete review of Estates Strategy	Deputy Director of Estates	April 2027	In progress
Space Utilisation	To improve use of space, using Space Modelling Technology	Deputy Director of Estates	December 2026	In progress
Estate Options	To identify options for the Estate, in line with NHS Property Services	Director of E&F	September 2026	In progress
Health on the High Street	To identify space through modern retail space opportunities	Director of E&F	June 2028	In progress

Q1 High level Risks Scored 15+ Aligned to BAF Risk: SR01							
Risk ID	**Exec Lead**	**Risk Description**	**Committee**	**Initial Score**	**Current Score**	**Trend Analysis**	**Residual Score**
290	**Director of Estates & Facilities**	There is a risk of Estates Critical Infrastructure Failure due to backlog maintenance resulting in a potential loss of premises, harm and reputation damage.	Quality Committee F&P Committee	**25 High**	**20 High**	↓	**5 Moderate**

Example
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Strategic Objectives and Risks 2026/27

Risk	Risk Description	Executive Lead	Oversight Committee
SO, 1: Quality – To provide outstanding care for patients, delivered with kindness			
SR01	**If** we are unable to obtain sufficient investment to develop our estate infrastructure, **then** we may be unable to deliver high quality responsive services in a safe, compliant and sustainable environment, **resulting in** the inability to achieve national standards and a negative impact on the quality of care.	**Director of Estates and Facilities**	**Finance & Performance Committee**
SR02	**If** we do not consistently maintain evidence based, safe and effective care, **then** we may see an increased incidence of avoidable harm, poor patient experience, and inadequate patient outcomes, **resulting in** a reduction in the quality of care and failure to deliver our statutory and regulatory obligations.	**Chief Nurse & Chief Medical Officer**	**Quality Committee**
SO, 2: Improvement – To be a continually learning organisation and recognised as leaders in research, education and innovation			
SR03	**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.	**Chief Digital & Information Officer**	**Quality Committee**
SR04	**If** we are unable to attract the resources, skills and experience needed **then** we will be unable to deliver our research, education and innovation priorities, **resulting in** an inability to retain our research and teaching status, and a negative impact on patient care.	**Chief Medical Officer**	**Quality Committee**
SO, 3: People – To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing quality, diversity and inclusion			
SR05	**If** we are unable to maintain a healthy and engaged workforce, **then** we will be unable to retain and attract staff, **resulting in** an adverse impact on service provision.	**Director of HR**	**People Committee**
SR06	**If** we are unable to achieve our EDI workforce ambitions **then** we will fail to have a workforce at a senior level that is representative of our communities, **resulting in** an adverse impact on patient, staff and public experience.	**Chief Operating Officer**	**People Committee**

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SO, 4: Partnership – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals			
SR07	**If** the trust fails to collaborate effectively with its partners, **then** there will be a fragmented approach to healthcare across Bradford District & Craven and West Yorkshire, **resulting in** missed opportunities to address health inequalities and improve patient and staff experience and outcomes.	**Director of Strategy and Transformation**	**Quality Committee**
SO, 5: Sustainability – To deliver our financial plan and key performance targets			
SR08	**If** we fail to deliver our financial and capital plan, **then** we will not be financially sustainable, **resulting in** poor outcomes for staff, patients and the public including loss of service.	**Chief Finance Officer**	**Finance & Performance Committee**
SR09	**If** the trust is unable to deliver sustainable services in line with the 5-year medium term plan, **then** we may need to cease services, **resulting in** a loss of staff, poor outcomes for patients and reputational damage.	**Chief Operating Officer**	**Finance & Performance Committee**
Well Led Organisation – Governance and Risk			
SR10	**If** we don't have robust governance and risk management 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, regulatory intervention and damage to the trust's reputation.	**Chief Operating Officer /Chief Nurse**	**Board of Directors**

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Board of Directors			
Meeting Date:	21 May 2026	**Agenda Reference:**	Bo.5.26.23
Report Title:	Cyber Assessment Framework Aligned Data Security and Protection Toolkit Interim Position 2026		
Presented by:	Vikki Lewis, Chief Digital & Information Officer (CDIO) and Senior Information Risk Owner (SIRO)		
Executive Lead:	Vikki Lewis, Chief Digital & Information Officer (CDIO) and Senior Information Risk Owner (SIRO)		
Author:	Jenny Pope, Head of Information Governance and Data Protection Officer Graeme Holmes, Information Governance Manager		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☐	Action ☐ (review/discuss/ comment)	Information ☒
Summary of Key Issues/Highlights:	The NHS Data Security and Protection Toolkit (DSPT) transitioned in 2024/25 from using the NDG's 10 data security standards to the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its underpinning assessment mechanism. The Trust's 2025/26 assessment submission takes place on the 30th of June 2026. The CAF aligned DSPT contains five Objective areas with a total of 47 Outcomes that sit below. Each has a nationally set expectation (that is the level that the Trust is expected to meet) which is Achieved, Partially Achieved or Not Achieved. The assessment confirms how the Trust is performing against each. If it meets (or exceeds) the expectation for each mandated Outcome, then the final position would be compliant, which is equivalent to 'Standards Met' in previous years DSPT models. Most Outcomes sit with IT/cyber. The Cyber Security Manager (CSM) has been the point of contact for all cyber and IT outcomes. The CSM liaises with Head of IT and other colleagues to manage the collation/requirements. Regular meetings between the IG Manager and business Owners, principally with the CSM, have taken place to provide assurance that the evidence complies with the expected outcomes. The Information Governance team has received updates from the CSM and other Owners and their assurances on the evidence they have provided. Progress has been good. A review of all the available evidence to date is complete at the time of this report. Some will require further final review, for example where statements confirm compliance but additional or the required supporting evidence is yet to be included in full or reviewed, or where some clarification is needed. The remaining incomplete items are being progressed at pace and will be reviewed once they are complete. Audit Yorkshire has undertaken its annual review of the agreed Objective Outcomes. This review began on 23 March and is now complete. The Final report providing an audit opinion based on evidence available at this stage of the assessment has been issued and a formal management response agreed with the SIRO.			

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	This paper provides the Board with the interim position for our 2025/26 assessment. It provides assurance of the activities that have taken place to date and the steps prior to our final submission on 30 June 2026. At this stage, although the assessment is not yet fully complete, we are anticipating compliance with all mandated Objectives and underlying Outcomes, equating to Standards Met. This is with the caveat that reviews of all the remaining evidence are found satisfactory, approval at the IG Group and with consideration to the Internal Audit opinion and recommendations.
Recommendation/s: (including any decision/approval required)	The Board and SIRO are asked to note the current position and progress/activities to date and planned. A final report will be approved at the IG Group and is scheduled to be received at the Quality Committee, as the agreed Board delegated sub-committee. The Board is asked to delegate final 'sign off' to the Quality Committee on the 18 June 2026.
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness
Link to Priority Initiatives 2025/26:	Digital Strategy
Implications	
Risk:	
Legal/Regulatory:	
Quality & Patient Safety:	
Equality, Diversity and Inclusion and Health Equity:	
Resources:	
Environmental sustainability:	
Assurance Route	
Meeting/s where content has been discussed previously:	Information Governance Group May 2026.

Report content

Context

Historically, the comprehensive framework for assessing the Trust's overall competence and capability with respect to the National Data Guardian's 10 data security standards was the Data Security and Protection Toolkit (DSPT). This online self-assessment tool provided assurance that the organisation was practising good data security and that personal information was handled correctly. Reflecting the increased significance of cyber threats, the DSPT has been superseded by the Cyber Assessment Framework, a more comprehensive and exacting measure of data security.
Recognising the higher challenge and more exacting standards imposed by the CAF aligned DSPT in 2024/25 when these changes took place NHS England suggested that it would be beneficial for executive teams and boards to be appraised and assured that undertaking a comprehensive, honest and accurate

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gap analysis / assessment is in the overall interest of the board, enabling helpful discussions about the actions required to build on the existing foundations in the years ahead. Board committee was briefed for the 2024/25 submission.

The move to a CAF-aligned DSPT was a significant change and challenge for many. Organisations that are unable to meet the required achievement levels for each Outcome are required to submit an improvement plan setting out how they plan to meet them following submission. In this scenario the plan would be subject to ongoing central monitoring, with the expectation of successful timely execution and the assessment status would be 'Approaching Standards' until the plan was complete.

Trust Progress to Date

There has been good progress to date with the assessment and submission is not until the 30 June, so work is still taking place to fine-tune and complete/add supporting evidence for some Objectives. Once this is completed the Objectives Outcomes are declared as 'Met' subject to final review. Until then their status is 'Draft'. See summary table for interim position.

September – December 2025

On publication of the new model, guidance was reviewed, owners of objectives identified and contacted. Details of webinars were also shared to encourage engagement for 2025/26. Briefings for the owners of the objectives was provided and meetings between the team and owners commenced.

January – April 2026

The IG team continue to work with the owners to encourage progress, review statements and any evidence is reviewed with the IG Manager and Head of IG as items are completed. Feedback is given regarding any gaps and queries are fed back. The date of the audit is confirmed as 23rd March 2026.

Internal audit review concluded 6 April. The audit is a measure of good practice and seeks to address risks in relation to the 8 prescribed mandatory outcomes and a further 3 locally selected items (approved by the SIRO, Head of IG and at ETM), which are highlighted in the summary table.

The Audit Yorkshire Final audit report has been received.

Overall Risk Assurance Rating

Overall risk determined for the 12 outcomes included in our testing sample across all five CAF objectives This is a measurement of how many outcomes have been assessed as not meeting the minimum standard as prescribed by NHS England. Basis – Number of outcomes rated as not meeting minimum achievement levels for each rating Very high = More than 4 High = Between 2 and 4 outcomes Moderate = No more than 1 Low = All met Very low = All met and at least 1 exceeded	**Moderate**
Overall confidence level of Independent Assessment This is a measurement of whether the evidence provided by the Trust meets their own self-assessment of outcome achievement levels. Level of deviation between self and independent assessment High level of deviation = Low confidence Medium level of deviation = Medium Low level or no deviation = High	**High**

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Final Planned Actions

The review and completion of the objectives/outcomes will continue to ensure any last evidence is in place through to the 30 June. This will include updates at the IG Group /to the SIRO with assurance from the Owners re evidence. One action recommended from the Internal Audit review will be completed.

This interim report will be followed by a final report for 'sign off' by the appropriate Board delegated committee as previously. This will be prior to submission on the 30th of June 2026.

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Health and Care CAF element		Expected*			Assessed as	Interim Position 06/05/2026				Separate responses log provides details	
Principle	Outcome	NA	PA	A		Incomplete	Draft Status	Review status	Audit	Audit request(s)?	Response sent?
Objective A - Managing risk											
	A1.a Board direction			A	Achieved		Met	Subject to final review	Yes	Yes	Yes
	A1.b Roles and responsibilities			A	Achieved		Met	Subject to final review			
Governance	A1.c Decision-making			A	Achieved		Met	Subject to final review			
	A2.a Risk management process		PA		Partially Achieved		Met	Subject to final review			
Risk management	A2.b Assurance			A	Achieved	Yes	Not Met	Subject to final review			
Asset management	A3.a Asset management			A	Achieved		Met	Subject to final review			
Supply chain	A4.a Supply chain		PA		Partially Achieved		Met	Subject to final review	Yes	Yes	Yes
Objective B - Protecting against cyber attack and data breaches											
	B1.a Policy, process and procedure development		PA		Partially Achieved	Yes	Not Met	Subject to final review - no IA issues raised	Yes	Yes	Yes
Policies, processes and procedures	B1.b Policy, process and procedure implementation		PA		Partially Achieved		Met	Subject to final review			
	B2.a Identity verification, authentication and authorisation		PA		Partially Achieved		Met	Subject to final review			
	B2.b Device management	NA			Not Achieved		Met	Subject to final review			
	B2.c Privileged user management	NA			Not Achieved		Met	Subject to final review			
Identity and access control	B2.d Identity and access management (IdAM)		PA		Partially Achieved		Met	Subject to final review			
	B3.a Understanding data		PA		Partially Achieved	Yes	Not Met	Subject to final review			

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Health and Care CAF element		Expected*			Assessed as	Interim Position 06/05/2026				Separate responses log provides details	
Principle	Outcome	NA	PA	A		Incomplete	Draft Status	Review status	Audit	Audit request(s)?	Response sent?
Data security	B3.b Data in transit		PA		Partially Achieved		Met	Subject to final review			
	B3.c Stored data		PA		Partially Achieved		Met	Meets expectation			
	B3.d Mobile data		PA		Partially Achieved		Met	Subject to final review			
	B3.e Media / equipment sanitisation		PA		Partially Achieved		Met	Subject to final review			
System security	B4.a Secure by design		PA		Partially Achieved	Yes	Not Met	Subject to final review - no IA issues raised	Yes	Yes	Yes
	B4.b Secure configuration		PA		Partially Achieved		Met	Subject to final review			
	B4.c Secure management		PA		Partially Achieved		Met	Subject to final review			
	B4.d Vulnerability management		PA		Partially Achieved		Met	Subject to final review			
Resilient networks and systems	B5.a Resilience preparation		PA		Partially Achieved	Yes	Not Met	Subject to final review - no IA issues raised	Yes	Yes	Yes
	B5.b Design for resilience	NA			Not Achieved		Met	Subject to final review			
	B5.c Backups			A	Achieved	Yes	Not Met	Subject to final review - no IA issues raised	Yes	Yes	Yes
Staff awareness and training	B6.a Culture		PA		Partially Achieved		Met	Subject to final review			
	B6.b Training			A	Achieved		Met	Subject to final review			
Objective C - Detecting cyber security events											
	C1.a Monitoring coverage		PA		Partially Achieved		Met	Subject to final review			

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Health and Care CAF element		Expected*			Assessed as	Interim Position 06/05/2026				Separate responses log provides details	
Principle	Outcome	NA	PA	A		Incomplete	Draft Status	Review status	Audit	Audit request(s)?	Response sent?
	C1.b Securing logs		PA		Partially Achieved	Yes	Not Met	Subject to final review - no IA issues raised	Yes	Yes	Yes
	C1.c Generating alerts		PA		Partially Achieved		Met	Subject to final review			
	C1.d Identifying security incidents		PA		Partially Achieved		Met	Subject to final review			
Security monitoring	C1.e Monitoring tools and skills	NA			Not Achieved		Met	Subject to final review			
	C2.a System abnormalities for attack detection	NA			Not Achieved		Met	Subject to final review			
Proactive security event discovery	C2.b Proactive attack discovery	NA			Not Achieved		Met	Subject to final review			
Objective D - Minimising the impact of incidents											
	D1.a Response plan		PA		Partially Achieved		Met	Subject to final review			
	D1.b Response and recovery capability			A	Achieved		Met	Subject to final review			
Response and recovery planning	D1.c Testing and exercising			A	Achieved		Met	Subject to final review			
	D2.a Incident root cause analysis			A	Achieved	Yes	Not Met	Subject to final review - no IA issues raised	Yes	Yes	Yes
Lessons learned	D2.b Using incidents and near misses to drive improvements			A	Achieved		Met	Subject to final review			
Objective E - Using and sharing information appropriately											

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Health and Care CAF element		Expected*			Assessed as	Interim Position 06/05/2026				Separate responses log provides details	
Principle	Outcome	NA	PA	A		Incomplete	Draft Status	Review status	Audit	Audit request(s)?	Response sent?
Transparency	E1.a Privacy and transparency information		PA		Achieved	Yes	Not Met	Subject to final review - no IA issues raised	Yes	Yes	Yes
Upholding the rights of individuals	E2.a Managing data subject rights under UK GDPR			A	Achieved		Met	Subject to final review and internal audit recommendation (action) which is being completed	Yes	Yes	Yes
	E2.b Consent			A	Achieved		Met	Subject to final review			
	E2.c National data opt-out policy			A	Achieved	Yes	Not Met	enhancement to provide additional clarity to progress	Yes	Yes	Yes
Using and sharing information	E3.a Using and sharing information for direct care			A	Achieved		Met	Subject to final review			
	E3.b Using and sharing information for other purposes			A	Achieved	Yes	Not Met	Subject to final review - no IA issues raised			
Records management	E4.a Managing records			A	Achieved		Met	Subject to final review			
	E4.b Clinical coding			A	Achieved		Met	Subject to final review	Yes	Yes	Yes

* Expected outcomes for NHS Trusts in 202526 are NA Not Achieved, PA Partially Achieved and A Achieved. These expected outcomes are prescribed centrally and m

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Audit Committee			
Meeting Date:	21 May 2026	**Agenda Reference:**	Bo.5.26.24
Report Title:	Compliance with the Provider Licence (including statement in response to CoS7), Code of Governance, and NED Independence		
Presented by:	Laura Parsons, Associate Director of Corporate Governance / Board Secretary		
Executive Lead:	Sajid Azeb, Chief Operating Officer / Deputy Chief Executive		
Author:	Jacqui Maurice, Head of Corporate Governance		

Report Summary				
Purpose of the paper:	Decision ☒ (approve)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐

Summary of Key Issues/Highlights:

Introduction

The purpose of this paper is to provide the self-certification of compliance with the NHS Provider Licence and the review of compliance with the NHS Code of Governance for NHS Provider Trusts for approval.

a. Self-Certification with regard to the Provider Licence

The NHS Provider Licence is published by NHS England. It forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future. All NHS provider trusts are required to hold a licence.

A review of our compliance with the Provider Licence (including the Guidance on Good Governance and Collaboration) is presented at Appendices 1a and 1b. This has been completed by the relevant Executive Director for each area.

The Executive Team Meeting (ETM) and Audit Committee have reviewed and agreed with the content of the spreadsheets at Appendix 1a and 1b covering the compliance statements provided by Executive Directors in response to the Provider Licence (**Appendix 1a**), and the Guidance on Good Governance and Collaboration which is issued under the Provider Licence (**Appendix 1b**).

The Trust is reporting compliance with all conditions of the licence other than those in regard to which NHS England reported a suspected breach (**see section 4 in Appendix 1a**).

Continuity of Services Condition 7 (CoS7)

Under CoS7, by 31 May each year, the Trust is required to submit to NHS England a certificate as to the availability of the required resources for the next 12 months, by way of confirming one of three statements: (1) the Trust will have the required resources; (2) the Trust reasonably expects to have the required resources but there are some factors which may cast doubt; or (3) the Trust will not have the required resources.

The Board is asked to approve the following statement for 2026/27:

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'After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust Board has approved a financial plan that delivers a breakeven position by 31.3.27. In comparison to recent years this is challenging, with the Trust facing a number of material financial risks, that include:
1. The delivery of a recovery programme in excess of anything delivered historically (i.e. £58m – 7.8% of operational expenditure).
2. Significant uncertainty around inflationary uplifts across all spend categories, due to wider world and economic events.
3. The risk of continued periods of industrial action and the loss of elective activity and impact on capacity.
4. The impact of the subsequent elective recovery associated with (3) and general backlog clearance, both financial and performance and in particular the implications of the Elective Recovery Fund.'

Subject to approval by the Board, the above statement will be signed by the Acting Chair and Chief Executive and will then be published on the Trust's website.

b. Compliance with the NHS Code of Governance for NHS Provider Trusts

The Code of Governance for NHS Provider Trusts (the Code) sets out a common overarching framework for the corporate governance of Trusts, reflecting developments in UK corporate governance and the development of integrated care systems. The Code contains a relatively small number of statutory requirements, which an NHS Trust must comply with. However, in general, the Code provides non-mandatory best practice advice. If our Trust is non-compliant then this does not constitute a breach of the Code and, for the majority of provisions, a Trust is simply required to explain any deviation from the Code within their Annual Report.

A review of compliance with each provision has been undertaken by the Corporate Governance Team, and a summary of compliance against all elements of the code is attached at **Appendix 2**.

There is only one provision where non-compliance is being reported, in relation to NED remuneration, which was increased from £13,785 to £15,000 from January 2026. This is higher than the national rate of £13,000 per annum set out in NHSE issued guidance. Prior to this, there had been no increase in NED remuneration of £13,785 since 2011. In reaching its decision, the Council took account of the annual remuneration benchmarking undertaken by NHS Providers and noted that the NHSE guidance from 2019 has not been subject to the expected review.

ETM, and subsequently, the Audit Committee has reviewed and confirmed

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its agreement with the assessment made against all elements of the Code.

c. NED Independence Test

The Board is asked to note that section B, 2.7 of the Code specifies that:

"At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent."

Section B, 2.6 of the Code of Governance for NHS Provider Trusts specifies that:

"The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:

- *has been an employee of the trust within the last two years*
- *has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust*
- *has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme*
- *has close family ties with any of the trust's advisers, directors or senior employees*
- *holds cross-directorships or has significant links with other directors through involvement with other companies or bodies*
- *has served on the trust board for more than six years from the date of their first appointment*
- *is an appointed representative of the trust's university medical or dental school.*

Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why."

The Chair and Non-Executive Directors were asked to complete an on-line declaration form regarding their independence. All answered no to each of the questions above.

The Board is also asked to refer to the current Board member declarations of interest as attached at agenda item **Bc.5.26.2 - Declarations of Interest**. Declarations of interest continue to be refreshed in year or at least annually where required, and are presented at Board and Committee meetings under a distinct agenda item. They are also available as part of the public register of declarations on the Trust website.

Over the year, the Board has proactively considered the interests of all Board members in its business, as per the inclusion of 'declarations of interest' as standing agenda items for all Board, and Board related meetings. In the conduct of Board business, account has been taken of declarations made and where any conflicts are apparent, or have arisen, mitigations have been applied and recorded.

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	Following its review of NED independence, the Board is asked to confirm if it agrees that the Non-Executive Directors (including the Chair) do demonstrate the required independence (or not). **Where the Board does agree** then the Board is asked to confirm the following statement to be included within the Annual Report 2025/26: *The Board of Directors has considered the independence of the Board at its meeting on 21 May 2026 and confirms that it considers all the Non-Executive directors (including the Chair) to be independent in character and judgement.* *The Board has assured itself that there are no relationships or circumstances which have affected or appear to have affected, the directors' judgement.* **Where the Board does not agree** the Board is asked to confirm the statement to be included in the Annual Report 2025/26.
Recommendation/s: (including any decision/approval required)	The Board is asked to: 1. Consider and approve the Trust's annual self-certification as to compliance with the conditions of the NHS Provider Licence (including the Guidance on Good Governance and Collaboration); 2. Approve the proposed statement in relation to Continuity of Services condition 7; 3. Approve the self-assessment of compliance with the Code of Governance for NHS Provider Trusts; and 4. Confirm the statement regarding NED independence to be included in the Annual Report 2025/26.
Link to Strategic Objective:	N/A
Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	Non-compliance with the Provider Licence conditions leaves Trusts open to enforcement actions taken by NHS England.
Legal/Regulatory:	Requirement to comply with the Provider Licence and the NHS Code of Governance for NHS Provider Trusts
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 27 April 2026 • Audit Committee 12 May 2026

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Good Governance and Collaboration					
Key collaboration function	**Description**	**Executive Lead**	**Illustrative minimum behaviours (examples)**	**Response 2025/26**	**Evidence 2025/26**
Providers will engage consistently in shared planning and decision-making	Participating consistently and constructively with partners in system and place-based partnerships and provider collaboratives (this may include place-based partnerships, provider collaboratives or other clinical networks), and ensuring open sharing of information and appropriate delegations are in place to develop shared plans and priorities and reach shared decisions.	**Director of Strategy and Transformation**	Ensuring the participation of leaders with appropriate authority in system and place-based partnerships, and provider collaboratives to ensure shared or joined-up planning and effective decision-making arrangements, including in respect of capital plans. Committing sufficient resources to, and ensuring digital and data systems enable, system and place-based partnerships, and provider collaboratives to ensure shared planning and decision-making. Sharing sufficient information on a timely basis with partners to support shared planning and decision-making, and having regard to other sources of information such as joint strategic need assessments. Exploring the case for new service delivery models with partners, such as lead provider contracts, service reconfigurations, mergers or other arrangements. Being willing to discuss any relevant issue with partners rather than only those perceived to be in the organisation's immediate interest. Sharing intelligence on quality concerns/risks, and working with partners to mitigate and manage those risks (including with appropriate risk sharing). Having regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources.	Through our Strategic Delivery Groups, the Trust either holds SRO or programme director responsibility or is a represenative for the organisation in these forums. This is where we undertake our strategic planning on a number of areas including service transformation, risks to the system, fragility of services, digital requirements, future planning of estates and various other key areas for our Place. There are also a number of other key areas where we meet such as via our Digital Senior leadership teams collab and our Strategic Estates Group and agree our shared priorities, ways of working and future commitments	ToR for committees such as CIC, Collab Board, POE and SDGs, SEG Minutes of meetings
Providers will consistently take collective responsibility with partners for delivery of services across various footprints including system and place.	Helping enable a shared understanding of performance, supporting arrangements for working together to manage any risks to delivery and contributing to a culture that supports continuous system improvement.	**Director of Strategy and Transformation**	Sharing demand and capacity information, including through system and place-based partnerships, or provider collaboratives, to allow partners to effectively manage risks to delivery of services. Engaging in mutual aid with other providers such as patient redirection, sharing of key workforce and sharing of scarce resources according to need. Seeking peer review and support in a timely manner if their organisation is at risk of failing to deliver its contribution to overall delivery of services. Working collaboratively with partners to improve care quality across pathways and services. Participating in clinical networks to raise standards of clinical practice and deliver benefits from collaborative working. Working with partners to deliver financial objectives in line with any system agreements of which a provider is part.	Through the Airedale and Bradford Collaboration of Acute Services (ABCAS) the Trust is now pursuing more robust mechanisms within which to manage capacity and demand across a number of specialties. For now, this is limited to a small number of services where there is fragility or a shared workfroce, but the intent is for this to be much more integrated in the future. The recent establishment of a Place Clinical Executive Group as well as a more localised acute clinical reference group means we have governance and oversight on quality of care, pathways, as well as focusing on our strategic ambition for transforming care delivery.	ToR Minutes of meetings MoU and operating principles
Providers will consistently take responsibility for delivery of improvements and decisions agreed through system and place-based partnerships, provider collaboratives or any other relevant forums	Ensuring that: organisational plans are integrated with the five-year joint system plan; annual capital plan is agreed with the ICB and its partners; and that the organisation implements shared decisions and plans agreed through all relevant forums in a timely manner.	**Director of Strategy and Transformation**	Clearly articulating how organisational plans integrate with the ICB five-year joint plan and annual capital plan, and other shared plans for delivery of agreed improvements. Active participation in system quality groups to support improvement in care quality. Timely and effective implementation of decisions agreed through system and place-based partnerships and provider collaboratives, or any other relevant forums. Working to deliver the financial duties and objectives for which the provider is collectively responsible with ICB partners. This includes the duty on local resource use not exceeding a limit set by NHS England. Sharing with partners the risks and benefits of agreed improvements or shared decisions. Committing sufficient workforce and resources to deliver agreed improvements.	Providers met and agreed shared narrative on our system wide intentions as part of our planning submission for the 5-year Integrated Delivery Plan	5-year Integrated Delivery Plan
Characteristic	**Description**	**Executive Lead**	**Key Lines of Enquiry (examples)**	**Response 2025/26**	**Evidence 2025/26**
1. Developing and sustaining strong working relationships with partners	The manner of engagement must be consistently constructive and where appropriate proactive.	**Director of Strategy and transformation**	• Do providers consistently engage with partners in a meaningful, effective and constructive way? • Are providers contributing to building a culture of transparency, honesty, and constructive challenge where collective responsibility is taken for problems and conflicts are resolved quickly? • Do providers communicate system vision, values and strategic goals to their staff and other stakeholders?	CiC, POE, Collab Board and other meetings are held system wide. Shared plan set out in 5-year Integrated Delivery Plan.	5-year Integrated Delivery Plan
2. Ensuring decisions are taken at the right level	Decisions should be taken at the most appropriate level (eg ICP, ICB, place-based partnership, provider collaborative, provider board).	**Director of Strategy and Transformation**	• Do providers actively participate in all relevant and appropriate planning and decision- making forums? This may include system and place-based partnerships or provider collaboratives. • Are decisions taken at the most appropriate level given the nature of the issue and are providers working with partners, including NHS bodies, local government and primary care, and engaging staff, patients and the wider public as necessary? • Do providers engage with all relevant organisations and stakeholders on decisions that might affect them?	See above regarding participation in relevant forums. A Strategic Partnering Agreement is in place between health and care partners in Bradford District & Craven place.	ToR for committees such as CIC, Collab Board, POE and SDGs, SEG Minutes of meetings. Strategic Partnering Agreement.

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3. Setting out clear and system-minded rationale for decisions	There should be clear consideration and articulation of why decisions have been made, having regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for al, and sustainable use of NHS resources.	**Director of Strategy and transformation**	• Are providers collaborating to develop the business case for any proposed system improvements, through a structured planning process, and working with patients, workforce and external partners? • Do providers support an open and constructive dialogue regarding any risks or concerns? • Has an equalities and health inequalities impact assessment been conducted where appropriate to inform decision-making? • Have decisions been made with regard to the triple aim duty to support better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources, giving particular attention to reducing health inequalities between communities within the population? • Are providers actively building business intelligence capacity to enable a single shared view of local challenges, performance and progress against delivery?	This work is all underway as part of the ABCAS Programme for clinical acute services, is intrinsically linked to our INH programme which is developing our community based models of care and through our corporate work programme which will support us to deliver more sustainable and aligned corproate provision across Place partners	ToR for committees such as CIC, Collab Board, POE and SDGs, SEG Minutes of meetings
4. Establishing clear lines of accountability for decisions	There must be clear lines of accountability for decisions, taking into account providers' legal responsibilities and internal governance.	**Director of Strategy and Transformation**	• Have providers established clear reporting lines and accountabilities, with timely and effective oversight of their involvement in system and place-based partnerships, and provider collaboratives? • Do providers empower system, place-based and at scale provider decision-making by appropriately delegating responsibility? • Are there appropriate governance mechanisms within the organisation and joint working arrangements with partners, such as dispute resolution or escalation mechanisms, in place and are they well understood and effective? • Are providers' strategic plans integrated with the ICB's five-year joint plan and annual capital plan, and the plans of place-based partnerships and provider collaboratives? • Are providers actively involved in co-producing and driving programmes and plans?	There are clear lines of accountability at all levels. A Strategic Partnering Agreement is in place for the BD&C Place which sets out the operating framework, values, principles and shared ambition of the Partners in supporting work towards the transformation of health and care and better health and wellbeing outcomes for the people who live in Bradford District and Craven through the Place Partnership model. The Trust receives regular updates and reports relating to its involvement in WYAAT. Updates are provided through the Chief Executive's report to the Board, updates presented to Board Committees and a regular update report on the WYAAT collaborative programmes. There are two risks included on the BAF relating to our strategice objective to collaborate effectively with local and regional partners.	Strategic Partnering Agreement WYAAT CIC Terms of Reference and MOU, Board Assurance Framework
5. Ensuring delivery of improvements and decisions	There must be adequate systems and processes to ensure providers follow through on shared decisions so that system and place level improvements are delivered for the benefit of patients and the public.	**Director of Strategy and Transformation**	Are providers committed to enabling the successful delivery of plans, including a willingness to share any risks or benefits that arise from collaboration? • Do providers proactively and openly share high-quality information as appropriate to support planning and/or implementation of improvements for the benefit of patients? • Do providers commit adequate resources and staff to participate in system planning and delivery, such as taking up system leadership roles, embedding or seconding staff to partner organisations, or contributing to funding a joint project management office? • Have providers put in place detailed delivery plans for their own organisations and agreed actions against which progress is regularly monitored, to enable them to identify and manage any risks or challenges that	See above - senior leaders have SRO/Programme Director leadership roles in system-wide programmes	ToR for committees such as CIC, Collab Board, POE and SDGs, SEG Minutes of meetings

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BTHFT Self-certification - NHS Provider Licence Conditions				
Licence Condition	**Definition**	**Executive Lead**	**Response 2025/26**	**Evidence 2025/26**
Section 1 - Integrated Care				
IC1: Provision of Integrated care	1.The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS: i)is integrated with the provision of such services by others, and ii)is integrated with the provision of health-related services or social care services by others and iii)enables co-operation with other providers of health care services for the purposes of the NHS where this would achieve one or more of the objectives referred to in paragraph 2. 2.The objectives are: a.improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision, b.reducing inequalities between persons with respect to their ability to access those services, and c.reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services. 3.The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition. 4.Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests.	**Chief Operating Officer**	The Trust complies with this condition. BTHFT acts as an anchor organisation within the Bradford District and Craven Place footprint and participates fully in partnership working across the Integrated Care System. Priorites in 2025/26 have included provider collaboratives and the development of Integrated Neighbourhood Healthcare. The Trust utilises and provides mutual aid in accordance with NHSE guidelines, and has adopted the same access policy as other acute Trusts in West Yorkshire. The Trust has followed all guidance in support of reducing health inequalities. Access, experience and outcomes are considered when assessing our progress on this agenda and action is coordinated between internal and external stakeholders, with a reducing health inequalities board in place and attendence at partner equivalents.	• ICB structure • Place Leadership Executive structure • ABCAS and INH programmes • WYAAT Elective Care Access Policy • BD&C Reducing Health Inequalities Programme • BTHFT Health Equity Board • Annual statement on Reducing Health Inequalities
IC2: Personalised Care and Patient Choice	1.The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care. 2.Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required. 3.Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found. 4.Information and advice about patient choice of provider made available by the Licensee shall not be misleading. 5.Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services. 6.In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.	**Chief Operating Officer**	The Trust forms part of the Bradford District and Craven Health and Care Partnership and contributes to the related improvement programmes. Through this work we aim to ensure that our patients have the information, choice and control to manage their own health and well-being. The Trust complies with this condition and all its specific responsibilities to ensure legal rights to choice operate effectively as per the NHS Standard Contract. The e-RS directory of services describes all our acute GP referred services.	• Act As One programme of work • NHS e-RS Directory of services
Section 2 – Trusts Working in Systems				
WS1: Cooperation	1.This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS. 2.The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities. 3.Without prejudice to the generality of paragraph 2, the Licensee shall: a.consistently co-operate with: •other providers of NHS services; and •other NHS bodies, including any Integrated Care Board of which it is a partner; i.as necessary and appropriate for the purposes of developing and delivering system plan(s). ii.as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year iii.as necessary and appropriate for the purposes of delivering agreed people and workforce plans b.consistently co-operate with: •other providers of NHS services; •other NHS bodies, including any Integrated Care Board of which it is a partner; and •any relevant local authority in England i.as necessary and appropriate for the purposes of delivering NHS services. ii.as necessary and appropriate for the purposes of improving NHS services. 4.The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either: a.the Secretary of State for Health and Social Care; or b.NHS England. For the purposes of this condition, cooperation is considered synonymous to collaboration. **(NB Also see the separate appendix relating to the Guidance on Good Governance and Collaboration)**	**Director of Strategy & Transformation**	The Trust complies with this condition. BTHFT continues to prioritise its role as an achor organisation within the Bradford District and Craven Place footprint and participates fully in partnership working across the place in order to delivery of the Bradford District & Craven place strategy and operational delivery of smooth pathways for our patients. Partnerships and Health Equity is one of our five strategic objectives: "To collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals".	Multiple board papers on decisions impacting place partnerships and partnership working. Strategic review of partnerships reported to Board every 6 months. Airedale Bradford Collaboration on Acute Services (ABCAS), Corporate Services, Integrated Heatlh and Care Strategic Delivery Group report to Collaboration Board and Act as One Committee.

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Licence Condition	Definition	Executive Lead	Response 2025/26	Evidence 2025/26
WS2: The Triple Aim	1.This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS. 2.When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim. 3.The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act. 4.In this condition, "the triple aim" refers to the aim of achieving: a.better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) b.better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) c.more sustainable and efficient use of resources by NHS bodies, and "duty relating to the triple aim" means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.	**Chief Operating Officer / Chief Finance Officer / Director of Strategy & Transformation**	The Trust complies with this condition. BTHFT continues to prioritise its role as an achor organisation within the Bradford District and Craven Place footprint and participates fully in partnership working across the place in order to deliver the requirements of the triple aim. Airedale and Bradford Collaboration of Acute Services programme is underway which has responsibility for ensuring both trusts deliver sustainable, integrated, safe and effective care that meets the health needs of all the communities we serve. Our services are tailored to meet the diverse population we serve. The Trust continues to follow guidance in support of reducing health inequalities including compliance with the revised Health Inequalities Statement issued in November 2025. Access, experience and outcomes are considered when assessing our progress on this agenda and action is coordinated between internal and external stakeholders. The 3 key shifts as per the 10 year plan (to digital, to community and to prevention) are priorities for the trust with programmes designed to support and embed and deliver the plan.	Multiple board papers on decisions impacting the triple aim, Service development/ Business case governance and approval processes including Post Implementation Reviews, staff survey, Waste Reduction Plans and Quality Impact Assessment and Equality Impact Assessment Processes. NHS Providers self-assessment carried out for the health inequalities' programme. • Health Equity*/Health Inequalities Programme • Health Equity/Health Inequalities - twice yearly reporting to Board • Health Equity Work Plan • Health Inequalities Statement published (as part of the Annual Report) * the Trust reframed its health inequalities work to focus on Health Equity following a Board Development Session in October 2024.
WS3: Digital Transformation	1.This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS. 2.The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2). 3.The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).	**Chief Digital and Information Officer**	The Trust published strategy predates the NHS Long Term plan which identifies the shift of analogue to digital as one of the core tenants of the plan and a key enabler for changing clinical models including the shift of hospital to community and sickness treatment to prevention. Further to the publication of the NHS Long Term Plan, a review of the five core objectives aligned in the digital strategy are in keeping with NHS Long Term Plan. The Digital Team has successfully delivered on its capital programme which was a £10m capital envelope in digital infrastructure for 25/26, much of this investment was received in Q4 of 25/26 and will be fully operationalised in 26/27. Core to this will be an improvement in the cyber security capability of the Trust. The migration from Micrososft Windows 10 to Microsoft Windows 11 operating system was completed in line with the national timetable. The final stages of the network refresh which began in 24/25 is completed with the final step planned to take place at the end of April 2026. The digital team continues to optimise the EpR and have now recruited a Chief Clinical Information Officer who will lead on the clinical engagement and optimisation agenda of the digital systems infrastructure. The governance framework in respect of the Trust digital estate continues to be hardened with the introduction of a Technical Design Authority and an enhanced Change Advisory Board process in support of a strengthened cyber security stance. The Trust Board received National Cyber Security Centre Accredited training. The Trust remains compliant with the DSPT return and retained its ISO27001 status. The Digital Team have now forged strong working relationships with the office of the CMO and the Bradford Institute of Health Research , this is leading to closer working pratcies and a greater undertsanding of the power of clinical data linkages to improve patient outcomes.	Digital Stratgey update to the Quality Committee and Trust Board , capital plan will be available via finance report. DSPT return via board reporting .
SECTION 3 - General Conditions				
G1 – Provision of information (updated)	1.The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition. 2.Information shall be provided in such manner, in such form, and at such place and times as NHS England may require. 3.The Licensee shall take all reasonable steps to ensure that information is: a.in the case of information or a report, it is accurate, complete and not misleading; b.in the case of a document, it is a true copy of the document requested. 4.This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	**Chief Operating Officer**	The Trust complies with this condition as required. All information requested by NHS England is supplied in a timely manner in the format requested.	Information uploaded via the NHSE information portals.

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Licence Condition	Definition	Executive Lead	Response 2025/26	Evidence 2025/26
G2 – Publication of information (updated)	1.The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct. 2.For the purposes of this Condition, "publish" includes making available to the public at large, to any section of the public or to particular individuals.	**Chief Operating Officer**	The Trust complies with this condition as required. Information is published as required in accordance with the Code of Governance and the Annual Reporting Manual.	Self-assessment against the Code of Governance for NHS Provider Trusts; Annual Report; Quality Account.
G3 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar to the functions of, a director)(updated)	1.The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is: a.a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; b.a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986); c.a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it; d.a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person. 2.The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper. 3.For the purposes of paragraph 2, a person is not fit and proper if that person is: a.an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or b.an organisation which is a body corporate, or a body corporate with a parent body corporate: i.where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a); ii.in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;	**Director of HR**	The Trust is compliant with this condition. The Fit and Proper Persons Test changes introduced in the previous year have been embedded and are applicable to all NED and Executive appointments. There is a clear process in place. Oversight of the FPPT sits with the Director of HR. Governors are subject to DBS Checks on initial appointment and at least every three years thereafter.	NED/Executive/Senior Manager (where appropriate)/Governor FPPT checks and documentation. Annual submission to NHS England.
G4 – NHS England guidance (updated)	1.Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act. 2.In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.	**Chief Operating Officer**	The Trust is compliant with this condition. Guidance is studied in detail by the relevant Executive Director and a lead assigned relevant to the subject matter where required. Discussion and approval at Executive Team Meetings / Board Academy / Board Committees / Board of Directors where required.	Self-assessment against the Code of Governance for NHS Provider Trusts; compliance with the Annual Reporting Manual; routine review and compliance with all directives issued by NHS England. Executive Team Meetings / Board Academy / Board Committees / Board of Directors meeting papers.
G5 – Systems for compliance with licence conditions and related obligations	This licence condition requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.	***Refer to lines below for requirements 1 and 2 below***		
G5 (1)	1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: (a) the Conditions of this Licence, (b) any requirements imposed on it under the NHS Acts, and (c) The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.	**Chief Operating Officer**	NHS England has reasonable grounds to suspect that the Trust has provided and is providing healthcare services for the purposes of the NHS in breach of the following conditions of its licence: NHS2.2, 2.4, 2.5(a), (b), (d) and (f) and 2(6) and additional licence conditions have been imposed. The Trust is compliant with the remaining conditions as set out in this spreadsheet, as well as the requirements imposed on it under the NHS Acts and the requirement to have regard to the NHS Constitution.	
G5 (2)	2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and (b) Regular review of whether those processes and systems have been implemented and of their effectiveness.	**Chief Nurse**	The Trust complies with this condition. It has an established system, including a risk escalation framework to identify risks (including financial risks) and their mitigation. The Trust uses a variety of mechanisms to test the effectiveness of the governance system, including Internal Audit, assurance reviews, gap analysis and root cause analysis when issues are identified. The Trust has successfully migrated to PSIRF and LFPSE (Learning from patient safety events).	Risk Management Strategy, Board Assurance Framework, Annual Governance Statement, Quality Account, Internal Investigations, Internal Audit Reports, Academy/Committee and Board reports, Patient Safety Incident, Response Plan.

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Licence Condition	Definition	Executive Lead	Response 2025/26	Evidence 2025/26
G6 – Registration with the Care Quality Commission (updated)	1.The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS. 2.The Licensee shall notify NHS England promptly of: a.any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or b.the cancellation by the Care Quality Commission for any reason of its registration by that Commission. 3.A notification given by the Licensee for the purposes of paragraph 2 shall: a.be made within 7 days of: i.the making of an application in the case of paragraph (a), or ii.becoming aware of the cancellation in the case of paragraph (b), and b.contain an explanation of the reasons (in so far as they are known to the Licensee) for: i.the making of an application in the case of paragraph (a), or ii.the cancellation in the case of paragraph (b).	**Chief Nurse**	The Trust complies with this condition. The Trust is fully registered with the CQC. All sites are registered.	CQC Registration information for BTHFT is available on the CQC website here - https://www.cqc.org.uk/provider/RAE/registration-info
G7 – Patient eligibility and selection criteria	1.The Licensee shall: a.set transparent eligibility and selection criteria, b.apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and c.publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them. 2.“Eligibility and selection criteria” means criteria for determining: a.whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and b.if the person is selected, the manner in which the services are provided to the person.	**Chief Operating Officer**	The Trust complies with this condition. The e-RS directory of services provides patients with easily accessible information by speciality on: • Choice of hospital • Choice of site • Wait times for first appointment • Waiting time in relation to 18 week RTT Patient access and treatment is provided in line with national 18 week RTT standards, cancer waiting time standards and diagnostic waiting time standards. Since March 2022 the Trust's waiting time information has also been published in the MyPlannedCare app. We also provide this information to primary care colleagues across the BD&C footprint.	• Act As One programme of work • WYAAT Elective Care access policy • NHS ERS Directory of services • MyPlannedCare app
G8 – Application of Section 6 (Continuity of Services)	1.The Conditions in Section 6 shall apply: a.whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service, b.whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2, c.where the circumstances set out in paragraph 6 apply (expiry of contract without renewal or extension), d.where the circumstances set out in paragraph 7 apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service), e.whenever the Licensee is determined by NHS England to be a Hard to Replace Provider. 2.A service is designated as a Commissioner Requested Service if: a.it is a service which the Licensee is required to provide to a Commissioner under the terms of a contract which has been entered into between them, and b.the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either c.the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or d.the Commissioner, not earlier than the expiry of the 28th day after making that request to the Licensee, has given to NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4. 3.A notice in accordance with this paragraph is a notice: a.in writing, b.stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and c.setting out the Commissioner’s reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service. 4.An instruction in accordance with this paragraph is an instruction that the Licensee’s refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable. 5.The Licensee shall give NHS England not less than 28 days’ notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed. 6.If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service for the period from the expiry of the contractual obligation until NHS England issues either	**Chief Operating Officer**	The Trust complies with this condition and agrees its Commissioner Requested Services on an annual basis. Schedule 2 of the NHS Standard Contract reflects the list of goods and services the Trust must provide in accordance with their terms of authorisation, this list remained in place for 2025/26.	•NHS e-RS Directory of services
SECTION 4 - TRUST CONDITIONS				

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Licence Condition	Definition	Executive Lead	Response 2025/26	Evidence 2025/26
NHS1: Information to update the register	1.The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence. 2.The Licensee shall make available to NHS England written and electronic copies of the following documents: a.the current version of Licensee's constitution; b.the Licensee's most recently published annual accounts and any report of the auditor on them, and c.the Licensee's most recently published annual report, and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published. 3.Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee. 4.The obligation in paragraph 3 shall not apply to: a.any document provided pursuant to paragraph 2; b.any document originating from NHS England; or c.any document required by law to be provided to NHS England by another person. 5.The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided. 6.When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.	**Chief Operating Officer**	The trust is compliant with this condition	Register of NHS trusts - https://www.england.nhs.uk/publication/bradford-teaching-hospitals-nhs-foundation-trust/ Annual report and accoounts provided in line with reporting timetable published by NHS England and included on the register alongside all other documents referenced.
NHS2: Governance arrangements	1.This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence. 2.The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS. 3.Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a.have regard to such guidance on good corporate governance as may be issued by NHS England from time to time b.have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c.have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and d.comply with the following paragraphs of this Condition. 4.The Licensee shall establish and implement: a.effective board and committee structures; b.clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c.clear reporting lines and accountabilities throughout its organisation. 5.The Licensee shall establish and effectively implement systems and/or processes: a.to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b.for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c.to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d.for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e.to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f.to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g.to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h.to ensure compliance with all applicable legal requirements. 6.The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: a.that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	**Chief Operating Officer**	NHS England has reasonable grounds to suspect that the Trust has provided and is providing healthcare services for the purposes of the NHS in breach of the following conditions of its licence: NHS2.2, 2.4, 2.5(a), (b), (d) and (f) and 2(6) (in red text opposite) and additional licence conditions have been imposed - see below The Trust is compliant with the remaining elements of this licence condition.	

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Licence Condition	Definition	Executive Lead	Response 2025/26	Evidence 2025/26
Additional conditions imposed by NHSE	1. The Licensee must ensure that it has in place sufficient and effective board leadership capacity and capability, as well as an effectively functioning Council of Governors, to enable it to: a. have a Board which functions effectively, including during any period in which the Licensee is conducting, or subject to, or responding to the outcome of: i. investigations into board governance and allegations about conduct of board members, including the independent investigation of concerns regarding race, inequality and victimisation at the Licensee, and ii. inspections by the Care Quality Commission; b. address the issues faced by the Licensee in relation to board governance and the working relationships between board members; and c. address any other issues relating to governance or operations that have caused or contributed to, or are causing or contributing to, or will cause or contribute to, the breach of the conditions of the Licensee's licence. 2. The Licensee's Council of Governors must implement arrangements to ensure it discharges its role and responsibilities effectively, including its duties to hold non-executive directors to account for the performance of the board and representing interests of the Licensee's members, the public and staff.	**Chief Operating Officer**	In May 2024 the Trust was subject to a segment change to NOF 3 of the NHSE oversight framework and this additional licence condition was imposed in August 2024. The Trust has complied with the regime put in place and continues to work with NHS England, reporting through to the Integrated Quality Improvement Group (IQIG). The Board and Council of Governors remain quorate with meetings taking place. An ongoing programme of board development is in place and improvements have continued to be made to governance arrangements during 2025/26 including board committees as part of effectiveness reviews. During 2025/26, the Trust was subject to a well led inspection, the outcome of which was 'Good'.	IQIG minutes and papers Board and committee minutes and papers Annual report Annual Governance Statement Assessment of compliance with Code of Governance Well Led inspection report Board Assurance Framework
SECTION 5 - NHS Controlled Providers Conditions	*Definition of an NHS Controlled Provider: "An organisation which is not an NHS trust or NHS foundation trust but is ultimately controlled by one or more NHS trusts and/or foundation trusts, where 'control' is defined on the basis of IFRS 10."*			
CP1: Governance arrangements for NHS-controlled providers	1.This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence. 2.The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS. 3.Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall: a.have regard to such guidance on good corporate governance as may be issued by NHS England from time to time b.have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health c.have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and d.comply with the following paragraphs of this Condition. 4.The Licensee shall establish and implement: a.effective board and committee structures; b.clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c.clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below). 5.The Licensee shall establish and effectively implement systems and/or processes: a.to operate efficiently, economically and effectively; b.for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c.to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; d.for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e.to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f.to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g.to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h.to ensure compliance with all applicable legal requirements. 6.The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: - that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	**N/A**	N/A	N/A
SECTION 6 - Continuity of Services Condition				

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Licence Condition	Definition	Executive Lead	Response 2025/26	Evidence 2025/26
CoS1 - Continuing provision of Commissioner Requested Services	1.The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition. 2.If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G8(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction. 3.The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except: a.with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or b.at any time when this condition applies by virtue of Condition G8(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or c.if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act. 4.If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within 28 days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature. 5.For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery or provision of that service in a manner which differs from the manner specified and described in: a.the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or b.if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or c.at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.	**Chief Operating Officer**	The Trust complies with this condition. No changes to provision were made during 2025/26	N/A
CoS2 - Restriction on the disposal of assets	1.The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register") 2.The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services. 3.The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional. 4.The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern. 5.The Licensee shall not dispose of, or relinquish control over, any relevant asset except: a.with the consent in writing of NHS England, and b.in accordance with the paragraphs 6 to 8 of this Condition. 6.The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset. 7.Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions. 8.Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where: a.NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to: i.transactions of a specified description; or ii.the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or b.the Licensee is required by the Care Quality Commission to dispose of a relevant asset. 9.In this Condition: "disposal"means any of the following: (a)a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b)a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c)the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d)if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to "dispose" are to be read accordingly;	**Chief Finance Officer**	The Trust Complies with this condition, paragraphs 5 - 8 do not apply	Asset Register maintained by the Capital Team.

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Licence Condition	Definition	Executive Lead	Response 2025/26	Evidence 2025/26
CoS3 - Standards of corporate governance and financial management (updated)	1.The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as: a.suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider, b.providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and c.providing reasonable safeguards against the licensee being unable to deliver services due to quality stress. 2.In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to: a.such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance; b.the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and c.the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.	**Chief Operating Officer/ Chief Finance Officer**	The Trust complies with this condition. It has an established system, including a risk escalation framework to identify risks (including financial risks) and their mitigation. The Foundation Trust uses a variety of mechanisms to test the effectiveness of the governance system, including Internal Audit, assurance reviews, gap analysis and root cause analysis when issues are identified.	Risk Management Strategy, Board Assurance Framework, Annual Governance Statement, Quality Account, Internal Investigations, Internal Audit Reports, Academy and Board reports, Standing Financial Instructions, Scheme of Delegation, Budgetary Management Framework, Capital Programme Management Guidance
CoS4 - Undertaking from the ultimate controller	1.The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"): a.will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and b.will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England. 2.The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee. 3.The Licensee shall: a.deliver to NHS England a copy of each such undertaking within seven days of obtaining it; b.inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and c.comply with any request which may be made by NHS England to enforce any such undertaking. 4.For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if: a.directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and b.that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others. 5.A person is not an ultimate controller if they are: a.a health service body, within the meaning of section 9 of the 2006 Act; b.a Governor or Director of the Licensee and the Licensee is an NHS foundation trust; c.any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or d.a trustee of the Licensee and the Licensee is a charity.	**N/A**	N/A	N/A
CoS5 - Risk pool levy	1.The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid. 2.In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.	**Chief Finance Officer**	The regulatory Risk Pool levy has not come into effect to date. The Trust currently contributes to the NHS Litigation Authority/Resolution risk pool for clinical negligence, property expenses and public liability schemes.	N/A
CoS6 - Cooperation in the event of financial stress	1.The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about: a.the ability of the Licensee to continue to provide commissioner requested services due to quality stress b.the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or c.the ability of the Licensee to carry on as a going concern. 2.When this paragraph applies the Licensee shall: a.provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct; b.allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and c.co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.	**Chief Finance Officer**	The Trust has not received any notice from NHSE regarding the concerns highlighted, the Trust is in National Oversight Framework segment 3 but this has not changed its position as a going concern or reduction of services.	N/A
CoS7 - Availability of resources	1.The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources. 2.The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.	**Chief Finance Officer**	The Trust complies with this condition and has agreements/contracts in place with Commissioners to continue to provide services.	Contracts and SLAs in place. The financial plan and monthly reports to F&P Academy and Board. Capital Programme papers, Treasury Mgt Papers

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Licence Condition	Definition	Executive Lead	Response 2025/26	Evidence 2025/26
CoS7 (3,4,5,6,7,8)	3.The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms: a.“After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.” b.“After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources”. c.“In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate”. 4.The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate. 5.The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution. 6.The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3. 7.The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it. 8.In this Condition: “distribution” includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital; “Financial Year” means the period of twelve months over which the Licensee normally prepares its accounts; “Required Resources” means such: a.management resources including clinical leadership, b.appropriate and accurate information pertinent to the governance of quality c.financial resources and financial facilities, d.personnel, e.physical and other assets including rights, licences and consents relating to their use, f.subcontracts , and ~~g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times~~	**Chief Finance Officer**	The Trust will comply with this condition. In previous years the Trust has been required to complete a template to declare which of the following statements is 'confirmed' and which are not confirmed and submit the formally signed template to NHSI. Since March 2019, the requirement is no longer mandatory however a copy of the template previously provided by NHSI is available for the declarations to be made by Board. NHSE advise that these are not required to be returned to NHS England "unless requested to do so". NHS Improvement will retain the option each year of contacting a select number of foundation trusts to "ask for evidence that they have self-certified, either by providing the completed or relevant board minutes and papers recording “sign-off". The veracity of the statement that the Board will be asked to confirm in May 2025 is evidenced from and within a range of documents.	Internal Audit Reports, Annual Report and Accounts 2025/26, Quality Account 2025/26, A statement regarding self-certification will be added to the Trust website by 31 May 2026.
SECTION 7 - Costing Conditions				
C1: Submission of costing information	1.Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall: a.obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, b.establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition. 2.Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England’s Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines. 3.If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors: a.obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and b.provides that information to NHS England in a timely manner. 4.Records required to be maintained by this Condition shall be kept for not less than six years. 5.In this Condition: “the Approved Guidance” means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs published annually by NHS England. “other relevant information” means such information, which may include quality and outcomes data, as may be required by NHS England for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act and material costs funded through other public sector entities which impact on the accuracy of costing information.	**Chief Finance Officer**	The Trust is compliant with this condition	Internal Audit report on costing process. NCC returns and embedded validation process, paper submitted to F&P committee confirming the output from the costing exercise and national benchmarking presented once made available by the national team. The F&P Committee will be kept up to date through papers through out the costing process.
C2: Provision of costing and costing related information	1.Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed. 2.In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that: a.in the case of information (data) or a report, it is accurate, complete and not misleading; b.in the case of a document, it is a true copy of the document requested; 3.This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.	**Chief Finance Officer**	The Trust is compliant with this condition	Internal Audit report on costing process. NCC returns and embedded validation process, paper submitted to F&P committee confirming the output from the costing exercise and national benchmarking presented once made available by the national team. The F&P Committee will be kept up to date through papers through out the costing process.

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Licence Condition	Definition	Executive Lead	Response 2025/26	Evidence 2025/26
C3: Assuring the accuracy of pricing and costing information	1.Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance. 2.This may include but is not limited to a.Regular assessments by the providers internal and/or external auditor b.specific work by NHS England or NHS England nominated representative on costing related issues and c.use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information. d.Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.	**Chief Finance Officer**	The Trust is compliant with this condition	Internal Audit report on costing process. NCC returns and embedded validation process, paper submitted to F&P committee confirming the output from the costing exercise and national benchmarking presented once made available by the national team. The F&P Committee will be kept up to date through papers through out the costing process.
SECTION 8 - Pricing Conditions				
P1: Compliance with the NHS payment scheme	1.Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.	**Chief Finance Officer**	The Trust is compliant with this condition	Contracting papers and updates are provide to the F&P Committee, Contracts with Commissioners.

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Good Governance and Collaboration					
Key collaboration function	**Description**	**Executive Lead**	**Illustrative minimum behaviours (examples)**	**Response 2025/26**	**Evidence 2025/26**
Providers will engage consistently in shared planning and decision-making	Participating consistently and constructively with partners in system and place-based partnerships and provider collaboratives (this may include place-based partnerships, provider collaboratives or other clinical networks), and ensuring open sharing of information and appropriate delegations are in place to develop shared plans and priorities and reach shared decisions.	**Director of Strategy and Transformation**	Ensuring the participation of leaders with appropriate authority in system and place-based partnerships, and provider collaboratives to ensure shared or joined-up planning and effective decision-making arrangements, including in respect of capital plans. Committing sufficient resources to, and ensuring digital and data systems enable, system and place-based partnerships, and provider collaboratives to ensure shared planning and decision-making. Sharing sufficient information on a timely basis with partners to support shared planning and decision-making, and having regard to other sources of information such as joint strategic need assessments. Exploring the case for new service delivery models with partners, such as lead provider contracts, service reconfigurations, mergers or other arrangements. Being willing to discuss any relevant issue with partners rather than only those perceived to be in the organisation's immediate interest. Sharing intelligence on quality concerns/risks, and working with partners to mitigate and manage those risks (including with appropriate risk sharing). Having regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources.	Through our Strategic Delivery Groups, the Trust either holds SRO or programme director responsibility or is a represenative for the organisation in these forums. This is where we undertake our strategic planning on a number of areas including service transformation, risks to the system, fragility of services, digital requirements, future planning of estates and various other key areas for our Place. There are also a number of other key areas where we meet such as via our Digital Senior leadership teams collab and our Strategic Estates Group and agree our shared priorities, ways of working and future commitments	ToR for committees such as CIC, Collab Board, POE and SDGs, SEG Minutes of meetings
Providers will consistently take collective responsibility with partners for delivery of services across various footprints including system and place.	Helping enable a shared understanding of performance, supporting arrangements for working together to manage any risks to delivery and contributing to a culture that supports continuous system improvement.	**Director of Strategy and Transformation**	Sharing demand and capacity information, including through system and place-based partnerships, or provider collaboratives, to allow partners to effectively manage risks to delivery of services. Engaging in mutual aid with other providers such as patient redirection, sharing of key workforce and sharing of scarce resources according to need. Seeking peer review and support in a timely manner if their organisation is at risk of failing to deliver its contribution to overall delivery of services. Working collaboratively with partners to improve care quality across pathways and services. Participating in clinical networks to raise standards of clinical practice and deliver benefits from collaborative working. Working with partners to deliver financial objectives in line with any system agreements of which a provider is part.	Through the Airedale and Bradford Collaboration of Acute Services (ABCAS) the Trust is now pursuing more robust mechanisms within which to manage capacity and demand across a number of specialties. For now, this is limited to a small number of services where there is fragility or a shared workfroce, but the intent is for this to be much more integrated in the future. The recent establishment of a Place Clinical Executive Group as well as a more localised acute clinical reference group means we have governance and oversight on quality of care, pathways, as well as focusing on our strategic ambition for transforming care delivery.	ToR Minutes of meetings MoU and operating principles
Providers will consistently take responsibility for delivery of improvements and decisions agreed through system and place-based partnerships, provider collaboratives or any other relevant forums	Ensuring that: organisational plans are integrated with the five-year joint system plan; annual capital plan is agreed with the ICB and its partners; and that the organisation implements shared decisions and plans agreed through all relevant forums in a timely manner.	**Director of Strategy and Transformation**	Clearly articulating how organisational plans integrate with the ICB five-year joint plan and annual capital plan, and other shared plans for delivery of agreed improvements. Active participation in system quality groups to support improvement in care quality. Timely and effective implementation of decisions agreed through system and place-based partnerships and provider collaboratives, or any other relevant forums. Working to deliver the financial duties and objectives for which the provider is collectively responsible with ICB partners. This includes the duty on local resource use not exceeding a limit set by NHS England. Sharing with partners the risks and benefits of agreed improvements or shared decisions. Committing sufficient workforce and resources to deliver agreed improvements.	Providers met and agreed shared narrative on our system wide intentions as part of our planning submission for the 5-year Integrated Delivery Plan	5-year Integrated Delivery Plan
Characteristic	**Description**	**Executive Lead**	**Key Lines of Enquiry (examples)**	**Response 2025/26**	**Evidence 2025/26**
1. Developing and sustaining strong working relationships with partners	The manner of engagement must be consistently constructive and where appropriate proactive.	**Director of Strategy and transformation**	• Do providers consistently engage with partners in a meaningful, effective and constructive way? • Are providers contributing to building a culture of transparency, honesty, and constructive challenge where collective responsibility is taken for problems and conflicts are resolved quickly? • Do providers communicate system vision, values and strategic goals to their staff and other stakeholders?	CiC, POE, Collab Board and other meetings are held system wide. Shared plan set out in 5-year Integrated Delivery Plan.	5-year Integrated Delivery Plan
2. Ensuring decisions are taken at the right level	Decisions should be taken at the most appropriate level (eg ICP, ICB, place-based partnership, provider collaborative, provider board).	**Director of Strategy and Transformation**	• Do providers actively participate in all relevant and appropriate planning and decision- making forums? This may include system and place-based partnerships or provider collaboratives. • Are decisions taken at the most appropriate level given the nature of the issue and are providers working with partners, including NHS bodies, local government and primary care, and engaging staff, patients and the wider public as necessary? • Do providers engage with all relevant organisations and stakeholders on decisions that might affect them?	See above regarding participation in relevant forums. A Strategic Partnering Agreement is in place between health and care partners in Bradford District & Craven place.	ToR for committees such as CIC, Collab Board, POE and SDGs, SEG Minutes of meetings. Strategic Partnering Agreement.

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3. Setting out clear and system-minded rationale for decisions	There should be clear consideration and articulation of why decisions have been made, having regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for al, and sustainable use of NHS resources.	**Director of Strategy and transformation**	• Are providers collaborating to develop the business case for any proposed system improvements, through a structured planning process, and working with patients, workforce and external partners? • Do providers support an open and constructive dialogue regarding any risks or concerns? • Has an equalities and health inequalities impact assessment been conducted where appropriate to inform decision-making? • Have decisions been made with regard to the triple aim duty to support better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources, giving particular attention to reducing health inequalities between communities within the population? • Are providers actively building business intelligence capacity to enable a single shared view of local challenges, performance and progress against delivery?	This work is all underway as part of the ABCAS Programme for clinical acute services, is intrinsically linked to our INH programme which is developing our community based models of care and through our corporate work programme which will support us to deliver more sustainable and aligned corproate provision across Place partners	ToR for committees such as CIC, Collab Board, POE and SDGs, SEG Minutes of meetings
4. Establishing clear lines of accountability for decisions	There must be clear lines of accountability for decisions, taking into account providers' legal responsibilities and internal governance.	**Director of Strategy and Transformation**	• Have providers established clear reporting lines and accountabilities, with timely and effective oversight of their involvement in system and place-based partnerships, and provider collaboratives? • Do providers empower system, place-based and at scale provider decision-making by appropriately delegating responsibility? • Are there appropriate governance mechanisms within the organisation and joint working arrangements with partners, such as dispute resolution or escalation mechanisms, in place and are they well understood and effective? • Are providers' strategic plans integrated with the ICB's five-year joint plan and annual capital plan, and the plans of place-based partnerships and provider collaboratives? • Are providers actively involved in co-producing and driving programmes and plans?	There are clear lines of accountability at all levels. A Strategic Partnering Agreement is in place for the BD&C Place which sets out the operating framework, values, principles and shared ambition of the Partners in supporting work towards the transformation of health and care and better health and wellbeing outcomes for the people who live in Bradford District and Craven through the Place Partnership model. The Trust receives regular updates and reports relating to its involvement in WYAAT. Updates are provided through the Chief Executive's report to the Board, updates presented to Board Committees and a regular update report on the WYAAT collaborative programmes. There are two risks included on the BAF relating to our strategice objective to collaborate effectively with local and regional partners.	Strategic Partnering Agreement WYAAT CIC Terms of Reference and MOU, Board Assurance Framework
5. Ensuring delivery of improvements and decisions	There must be adequate systems and processes to ensure providers follow through on shared decisions so that system and place level improvements are delivered for the benefit of patients and the public.	**Director of Strategy and Transformation**	Are providers committed to enabling the successful delivery of plans, including a willingness to share any risks or benefits that arise from collaboration? • Do providers proactively and openly share high-quality information as appropriate to support planning and/or implementation of improvements for the benefit of patients? • Do providers commit adequate resources and staff to participate in system planning and delivery, such as taking up system leadership roles, embedding or seconding staff to partner organisations, or contributing to funding a joint project management office? • Have providers put in place detailed delivery plans for their own organisations and agreed actions against which progress is regularly monitored, to enable them to identify and manage any risks or challenges that	See above - senior leaders have SRO/Programme Director leadership roles in system-wide programmes	ToR for committees such as CIC, Collab Board, POE and SDGs, SEG Minutes of meetings

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Appendix 2 - Principles and provisions from the Code of Governance for NHS Provider Trusts

Provisions where we are compliant are highlighted in GREEN. Provisions where we are partially compliant are highlighted in AMBER. Provisions where the Trust is non-compliant are highlighted in RED.

Section A: Board Leadership and Purpose. *To note the majority of the provisions within section A are new and reflect a focus on responsibilities with regard to system working*

1. Principles

1.1 Every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust as part of the ICS and wider healthcare system in England, generating value for members in the case of foundation trusts, and for all trusts, patients, service users and the public.

1.2 The board of directors should establish the trust's vision, values and strategy, ensuring alignment with the ICP's integrated care strategy and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. The board of directors must satisfy itself that the trust's vision, values and culture are aligned. All directors must act with integrity, lead by example and promote the desired culture.

1.3 The board of directors should give particular attention to the trust's role in reducing health inequalities in access, experience and outcomes.

1.4 The board of directors should ensure that the necessary resources are in place for the trust to meet its objectives, including the trust's contribution to the objectives set out in the five-year joint plan and annual capital plan agreed by the ICB and its partners, and measure performance against them. The board of directors should also establish a framework of prudent and effective controls that enable risk to be assessed and managed. For their part, all board members – and in particular non-executives whose time may be constrained – should ensure they collectively have sufficient time and resource to carry out their functions.

1.5 For the trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the board of directors should ensure effective engagement with them, and encourage collaborative working at all levels with system partners.

1.6 The board of directors should ensure that workforce policies and practices are consistent with the trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The board is responsible for ensuring effective workforce planning aimed at delivering high quality of care.

Provisions under Section A. Board Leadership and Purpose

Provisions	2025/26 Evidence in place / Actions required	Compliant?
2.1 The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Academy/Committee structure in place, risks managed through BAF and high-level risk register. The Trust works in partnership across the ICS, Bradford District and Craven and as part of WYAAT. To be included in annual report 25/26 – risk management arrangements in place, strategy linked into Academy/Committee work plans,	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
	board agendas and BAF.	
2.2 The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.	Corporate Strategy 2022-27 Board approved the Strategic Framework for 2025/6 in March 2025. Reference to Quality, Improvement, People, Partnerships, and Sustainability.	Compliant
2.3 The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Monitored through the People Academy and associated reports including staff survey and FTSU. To be included in annual report. Regular AAA reports to Board from the People Academy Chair covering these areas.	Compliant
2.4 The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	Systems and processes established through regular reporting to Committees and the Board (e.g. monthly finance reports, capital updates, system finance reports (place and ICS), performance reports, quality oversight and assurance profile, dashboards).	Compliant
2.5 In line with principle 1.3, the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	See 2.4 above. Health Inequalities bi-annual reporting takes place to both the Quality Committee and Board.	Compliant
2.6 The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	The Trust's approach to Clinical Governance is set out in the terms of reference for the Quality Committee, the purpose of which is to seek assurance, learn and drive improvement in relation to all aspects of quality within the Trust in line with the NHS Patient Safety Strategy and national quality standards. The Chair of the Committee reports to Board on those matters covered by the terms of reference through a	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
	regular written AAA (alert, advise, assure) report. The Chair of the Committee draws the attention of the Board to any issues that require disclosure or may require further action. The Committee presents a written annual report to the Board summarising the work carried out during the financial year and outlining its work plan for the future year.	
2.7 The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	Engagement activity includes: • Monthly Community Engagement meetings with internal and external stakeholders are in place. • Well established engagement takes place through Maternity Voices Partnership. Other departments and teams across the Trust are being supported by the Maternity team with developing their stakeholder engagement. • Patient Safety Partners at Place have been implemented as part of the national Patient Safety Strategy work. • Bi-annual reports to Board on the delivery of the 2023-28 Patient Experience and Engagement strategy. • Department/Subject specific engagement events have been rolled out across specialties with the support of the Patient Experience Team. • Annual Members Meeting covering 24/25 was held in March 26. BTHFT was well represented across the various Boards and enabling groups across Bradford District and Craven and the West Yorkshire Integrated Care System.	Compliant
2.8 The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.	To be included in annual report. Engagement mechanisms monitored through the Patient Experience and Engagement Strategy and the Communications Strategy (approved in	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
	March 2026).	
2.9 The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	• Freedom to Speak Up arrangements / policy in place. • Freedom to Speak Up quarterly review undertaken at People Academy. • Freedom to Speak Up Annual Report reviewed by People Academy and Board of Directors. • FTSU NED Champion in place.	Compliant
2.10 The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).	• Conflicts of Interest policy in place. • Six monthly report reviewed by ETM. • Annual Report reviewed by ETM and Audit Committee. • Director and Governor declarations are reviewed routinely at CofG meetings and Board of Director meetings. • Committee meetings have a standing item on declarations of interest. • NED terms of engagement make clear disqualifications for the role.	Compliant
2.11 Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	Any concerns raised are discussed at Board level.	Compliant

Section B: Division of responsibilities

1. Principles

1.1 The chair leads the board of directors and, for foundation trusts, the council of governors, and is responsible for its overall effectiveness in leading and directing the trust. They should demonstrate objective judgement throughout their tenure and promote a culture of honesty, openness, trust and debate. In addition, the chair facilitates constructive board relations and the effective contribution of all non-executive directors, and ensures that directors and, for foundation trusts, governors receive accurate, timely and clear information.

1.2 Responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. No individual should have unfettered powers of decision.

1.3 Non-executive directors should have sufficient time to meet their board responsibilities. They should provide constructive challenge and strategic guidance, offer specialist advice and lead in holding the executive to account.

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1.4 The board of directors should ensure that it has the policies, processes, information, time and resources it needs to function effectively, efficiently and economically.
1.5 The board is collectively responsible for the performance of the trust.
1.6 The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust, and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.
1.7 All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.

Provisions under Section B: Division of responsibilities

Provisions	2025/26 Evidence in place / Actions required	Compliant?
2.1 The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	The Chair approves agendas for board and the Council of Governors and ensures adequate time for discussion of all items.	Compliant
2.2 The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	The Chair ensures accurate, timely and clear information is presented at meetings. Governors undertake a comprehensive induction which includes mandated attendance at the NHS Providers 'Governwell' Core Skills session. Additional support/training is provided (both individually and collectively) as required.	Compliant
2.3 The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	Led by the Chair.	Compliant
2.4 A foundation trust chair is responsible for ensuring that the board and council work together effectively.	Led by the Chair. New strategic advisory forums introduced to provide additional opportunity for governors and board to meet, outside of formal COG meetings.	Compliant
2.5 The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	The Trust is compliant with all provisions under this section.	Compliant
2.6 The board of directors should identify in the annual report each non-executive director it considers to be	Included in annual report. NED independence is	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	considered by the board on an annual basis.	
2.7 At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	NED independence considered by the board on an annual basis.	Compliant
2.8 No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	No directors hold the position of governor.	Compliant
2.9 The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	This is captured within the NED Appraisal process and committee memberships are reviewed annually. Diversity is taken into account by the Governors when making NED appointments. The Leeds University NED brings a clinical background.	Compliant
2.10 Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	The Terms of Reference for the Committees reflect this provision.	Compliant
2.11 In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.	Bryan Machin, stood down from role as Audit Committee Chair in September 2025 and was appointed as substantive SID. The Board and the Council supported the appointment. All duties referred to in this section carried out as required.	Compliant
2.12 Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive	NEDs appoint directors through the (Board) Nominations and Remuneration Committee.	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
directors present.	EDs are held to account through Committees and Board meetings. The chair regularly holds meetings with the NEDs without EDs present.	
2.13 The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.	All responsibilities referred to are available in one place on the website. Board and committee responsibilities are agreed through the TORs. Information is routinely included in the annual report as described.	Compliant
2.14 When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	Addressed through the appointment process. No additional material external appointments have been requested. No executive directors are a NED of more than one organisation or hold any chairships.	Compliant
2.15 All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	The job description for the Board Secretary reflects these responsibilities. The Board Secretary is subject to an FPP and The Board NRC has agreed that an Executive and NED should be part of any appointment process.	Compliant
2.16 All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	• Board, Committee and Academy Meetings • Board Effectiveness Review • Executive / NED Appraisal Processes	Compliant
2.17 The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual	The board meets formally at least 6 times per year. The 'Reservation of Powers to the Board and Scheme of Delegation' (SoD) were most recently reviewed and approved by the Audit	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the board of directors.	Committee and the Board in November 2025. The required statements are included.	

Section C: Composition, succession and evaluation

1. Principles

1.1 Appointments to the board of directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for board and senior management. Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. Both appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths (for more information refer to the Equality Act 2010, The NHS' successive Equality Delivery Systems (EDS) and the NHS Workforce Race Equality Standard (WRES)). In particular, the board should have published plans for how it and senior managers will in percentage terms at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher.

1.2 The board of directors and its committees should have a diversity of skills, experience and knowledge. The board should be of sufficient size for the requirements of its duties, but should not be so large as to be unwieldy. Consideration should be given to the length of service of the board of directors as a whole and membership regularly refreshed.

1.3 Annual evaluation of the board of directors should consider its composition, diversity and how effectively members work together to achieve objectives. Individual evaluation should demonstrate whether each director continues to contribute effectively.

Provisions under Section C: Composition, succession and evaluation

Provisions	2025/26 Evidence in place / Actions required	Compliant?
2. NHS foundation trusts board appointments		
2.1 The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.	Standard practice at BTHFT requires selection panels for executives and non-executives that include external assessors in line with the recommendations within the Code.	Compliant
2.2 There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	Two Nominations and Remuneration Committees are in place. All requirements are addressed as part of the remit of the Committees. An annual evaluation of the balance of skills, knowledge, experience and diversity on the board of directors is undertaken.	Compliant
2.3 The chair or an independent non-executive director should chair the nominations committee(s). At the discretion	Terms of Reference for both Nominations	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	Committees are in line with this.	
2.4 The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	Appointment Process for Chair and Non-Executive Directors are regularly reviewed by the Council of Governors. All recommendations must be approved by the full Council.	Compliant
2.5 Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	Two new 'open' NED appointments were made in year, and one NED was appointed by the University of Leeds. The appointments made were in line with the Code. An external agency was engaged to support the open appointments and this will be reported on as required in the annual report.	Compliant
2.6 Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	Terms of Reference for the (Governors) Nominations and Remuneration Committee are in line with this.	Compliant
2.7 When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	Terms of Reference for the Governors Nominations and Remuneration Committee include this requirement.	Compliant
2.8 The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	Three new appointments have been made in year and will be reported on in the annual report. The Terms of Reference for the Governors NRC are published on the Trust's website.	Compliant
2.9 Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information	An election process was launched in January 2026 in line with all requirements set out in the Code.	Compliant
2.10 A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	The committee operates in line with the requirement of the 2006 Act.	Compliant
2.11 It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	These requirements are applied.	Compliant
2.12 The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.	The Council of Governors operates in line with this requirement.	Compliant
2.13 Non-executive directors, including the chair, should be appointed by the council of governors for the specified	Practice is in line with the above which is	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	included in the Constitution.	
2.14 The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.	Disclosures are made to the Council of Governors in line with requirements.	Compliant
3. Provisions for NHS trust board appointments – Not applicable to FTs		
4. Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts		
4.1 Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	The Trust abides by regulatory requirements. Prospective Governors are not confirmed until DBS is completed.	Compliant
4.2 The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	Statement as required will be included in the annual report. Board profiles are posted on the website.	Compliant
4.3 Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.	The Governors NRC and Council of Governors are made aware of this provision when considering NED reappointments. None of the current NEDs have been in post for over 6 years.	Compliant
4.4 Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles	Our constitution stipulates a maximum of three consecutive three-year terms.	Compliant
4.5 There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	Annual effectiveness reviews undertaken for the Audit Committee, Committees and Board. The Leadership Competency Framework for Board members and Chair Appraisals has been adopted. The SID leads the chair appraisal. Individual director performance is assessed through appraisals.	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
4.6 The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	Development programme is in place for the Board based on the outcomes of the Board Effectiveness Survey. The Academy / Committees have reviewed the outcome of the effectiveness review process and are implementing improvements in line with the feedback received.	Compliant
4.7 All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.	The CQC undertook a well-led Inspection in November 2025. The rating received was 'Good'.	Compliant
4.8 Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors • communicating with their member constituencies and the public and transmitting their views to the board of directors • contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors	In 2024 the Council approved a change to the Constitution, increasing the number of Governors by 4. The Council of Governors is reviewing its policies and procedures, and has agreed a revised induction process, lead governor role description, code of conduct and process for managing concerns in relation to the Chair, another NED or a governor. The standing orders, terms of reference, and Council of Governors Engagement Policy will be reviewed during 2026/27. An external company was commissioned to undertake development sessions with the Council regarding roles and responsibilities. NED Chairs routinely report at the Council of Governors meetings on the work of their Academy/Committees. Governors have a rolling programme of attendance at Board meetings and Committees. The meeting papers from the Council meetings are published on the Trust website. The Governors meet annually with the COO and the CFO to discuss operational planning in light of NHSE's published framework.	Compliant
4.9 The council of governors should agree and adopt a clear policy and a fair process for the removal of any	Covered in the 'Process for managing concerns in	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.	relation to the Chair, another NED or a Governor', approved in January 2026.	
4.10 In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.	Covered in the 'Process for managing concerns in relation to the Chair, another NED or a Governor', approved in January 2026.	Compliant
4.11 The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	Addressed through the Nomination and Remuneration Committees.	Compliant
4.12 The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	A risk assessment would be carried out prior to any agreement around full notice not being served.	Compliant
4.13 The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	To be included in the annual report.	Compliant
5. Development, information and support		
5.1 All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	An induction programme remains in place for both Governors and Directors. NHS Alliance induction courses are also made available to new Board members.	Compliant
5.2 The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for	• Board Development Sessions in place • Governor learning and development sessions routinely scheduled in year. • Governor briefings/bulletins provided on	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	regular basis • Access to training and development opportunities provided to Directors and Governors through range of providers. • Equality, diversity and inclusion, and unconscious bias training is required for those involved in recruitment.	
5.3 To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	Addressed through induction and ongoing training.	Compliant
5.4 The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	• Induction programme for NEDs includes engagement with system partners. • Induction programme in place for Governors.	Compliant
5.5 The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	The Chair fulfills this role for the NEDs and CEO. The Chair will liaise directly with the CEO on the training and development needs of the EDs as they relate to their role on the Board of Directors.	Compliant
5.6 A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	Learning and development opportunities continue to be addressed through bespoke sessions and Governwell (national training programme) courses.	Compliant
5.7 The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.	Information provided at • Board of Director Meetings • Council of Governor meetings	Compliant
5.8 The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	Chair ensures accurate, timely and clear information is presented at meetings.	Compliant
5.9 The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	Information flows between Academy / Committees and the Board and, the Council of Governors as appropriate. Agendas include consideration of any matters to share or escalate.	Compliant
5.10 The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of	The board and governor annual self-assessments take account of views on information and support	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	provided. Where required, actions are put in place to address.	
5.11 The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	Non-Executive Directors are advised that if they wish to seek external assurance they may do so.	Compliant
5.12 The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	Non-Executive Directors are advised that if they wish to seek external advice they may do so.	Compliant
5.13 Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	Support provided by the Corporate Governance Team and other teams where required (e.g. Quality Team), with agreed budget to support meetings, training etc.	Compliant
5.14 Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	The Non-Executive Directors chair the Board Committees and Academy and approve their terms of reference and work programmes. NEDs are able to request additional information where required. They are all subject to an annual appraisal which includes the recording of their personal development/learning needs.	Compliant
5.15 Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Where required, Governors are supported to engage with members and the public. Governors were asked to canvass views on the Corporate Strategy during its development.	Compliant
5.16 Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.	At their meeting in January 2026 Governors were advised of the new NHSE five-year planning framework and the priorities for acute providers and our Trust.	Compliant
5.17 The board of directors must have regard to the council of governors' views on the NHS foundation trust's forward plan.	See above	Compliant
5.18 NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper	Governors are indemnified under the same scheme as Trusts' Directors. A statement with	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	regard to indemnity is included within our Constitution.	

Section D: Audit, risk and internal control

1. Principles

1.1 The board of directors should establish formal and transparent policies and procedures to ensure the independence and effectiveness of internal and external audit functions, and satisfy itself on the integrity of financial and narrative statements.

1.2 The board of directors should present a fair, balanced and understandable assessment of the trust's position and prospects.

1.3 The board of directors should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the trust is willing to take to achieve its long-term strategic objectives.

1.4 Organisations should also refer to Audit and assurance: a guide to governance for providers and commissioners.

Provisions under Section D: Audit, risk and internal control

Provisions	2025/26 Evidence in place / Actions required	Compliant?
2.1 The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	Trust has an Audit Committee (AC) in place. Three NEDs are members. Membership rules as listed are satisfied.	Compliant
2.2 The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities.	Audit Committee main roles and responsibilities included within the Audit Committee Terms of Reference.	Compliant
2.3 A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at	The current incumbent was reappointed in 2025/26. The process started towards the end	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.	of 2024/25. The Trust included the Council in the appointment process to support their statutory duty to approve the appointment of the External Auditor.	
2.4 The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Included in the Annual Report.	Compliant
2.5 Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external auditors.	Policy is in place, approved by the Audit Committee.	Compliant
2.6 The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Included in the Annual Report.	Compliant
2.7 The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	The Trust consults with the Annual Reporting Manual and includes the required information in the Annual Report.	Compliant
2.8 The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Reported through the Annual Governance Statement in the Annual Report.	Compliant
2.9 In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare	Reporting is provided within the Annual Report as specified.	Compliant

Section E: Remuneration

Bradford Teaching Hospitals NHS Foundation Trust
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1. Principles

1.1 Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, with the skills and experience required to lead the trust successfully, and collaborate effectively with system partners. Trusts should avoid paying more than is necessary for this purpose and should consider all

relevant and current directions relating to contractual benefits such as pay and redundancy entitlements. Trusts should follow NHS England's Guidance on pay for very senior managers in NHS trusts and foundation trusts and NHS trusts should also follow Guidance on senior appointments in NHS trusts.

1.2 Any performance-related elements of executive directors' remuneration should be transparent, stretching and designed to promote the long-term sustainability of the NHS foundation trust. They should also take as a baseline for performance any required competencies specified in the job description for the post.

1.3 The remuneration committee should decide if a proportion of executive directors' remuneration should be linked to corporate and individual performance. The remuneration committee should judge where to position its NHS foundation trust relative to other NHS foundation trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration despite no corresponding improvement in performance.

1.4 The remuneration committee should also be sensitive to pay and employment conditions elsewhere in the NHS, especially when determining annual salary increases.

1.5 There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding their own remuneration.

1.6 The remuneration committee should take care to recognise and manage conflicts of interest when receiving views from executive directors or senior management, or consulting the chief executive about its proposals (for further information on conflicts of interest see Managing conflicts of interest in the NHS: Guidance for staff and organisations).

1.7 The remuneration committee should also be responsible for appointing any independent consultants in respect of executive director remuneration.

1.8 Where executive directors or senior management are involved in advising or supporting the remuneration committee, care should be taken to recognise and avoid conflicts of interest.

1.9 NHS trusts should wait for notification and instruction from NHS England before implementing any cost of living increases.

Provisions under Section E: Remuneration

Provisions	2025/26 Evidence in place / Actions required	Compliant?
2.1 Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. • Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary. • For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	There are no performance based elements in place.	Compliant

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2.2 Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	The Chair's salary is within the range expected within the NHSE 2019 guidance for Chairs of Trusts within group 4. In year the Council approved an increase to the upper limit of £58,500 per annum. In year the Council approved an increase to NED remuneration to £15,000 (£2,000 above the recommended cap for NEDs within the NHSE Guidance). Prior to this, there had been no increase in NED remuneration of £13,785 since 2011. In reaching its decision, the Council took account of the annual remuneration benchmarking undertaken by NHS Providers and noted that the NHSE guidance from 2019 has not been subject to the promised review. The Trust is not compliant with regard to NED remuneration and an explanation will be provided within the annual report.	Compliant Not compliant
2.3 Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Not applicable	Compliant
2.4 The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice	Claw back would be applied where a director was to return to the NHS. Our contracts don't allow for compensation to be reduced if a director was to leave early however there are some immediate dismissal clauses.	Compliant
2.5 Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).	Would be agreed in principle at the Board Nomination & Remuneration Committee. Discussion would then take place with the NHSE regional director should a severance payment be proposed.	Compliant
2.6 The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	Remuneration Committee for the NEDs is in place in line with the requirements. Terms of Reference are published on the Trust's website.	Compliant
2.7 The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior	The Board Nominations and Remuneration Committee sets remuneration for Executive Directors only. Senior managers are covered by	Compliant

management for this purpose and this should normally include the first layer of management below board level.	Agenda for Change terms and conditions.	
2.8 The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.	Remuneration for NEDs and the Chair is set by the Council of Governors.	Compliant

Appendix B: Council of governors and role of the nominated lead governor

1. Principles

1.1 The powers and obligations of governors of NHS foundation trusts are set out in the 2006 Act, as amended by the 2012 Act. This appendix describes the relevant areas of the governors' role. In addition, *Your statutory duties: A reference guide for NHS foundation trust governors* (August 2013) examines how governors can deliver their duties and an addendum to this document, System working and collaboration: The role of foundation trust councils of governors (October 2022) clarifies how governors can continue to perform their duties within the context of system working.

1.2 The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.

1.3 The council of governors is responsible for representing the interests of NHS foundation trust members, the public at large, and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.

1.4 To discharge their duty to represent the public, councils of governors are required to take account of the interests of the public at large. This includes the population of the local system of which the trust is part and the whole population of England as served by the wider NHS.

1.5 Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members, the public at large, and the stakeholder organisations that either elected or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.

1.6 Governors should discuss and agree with the board of directors how they will undertake these and any additional roles, giving due consideration to the circumstances of the NHS foundation trust and the needs of the system and wider NHS and emerging best practice.

1.7 Governors should work closely with the board of directors and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The governors must be consulted on the development of forward plans for the trust and any significant changes to the delivery of the trust's business plan.

1.8 Governors should use their voting rights to hold the non-executive directors individually and collectively to account and act in the best interest of patients, members and the public at large. If the council of governors does withhold consent for a major decision, it must justify its reasons to the chair and the other non-executive directors, bearing in mind that its decision is likely to have a range of consequences for the NHS foundation trust, the system and the wider NHS. The council of governors should take care to ensure that reasons are considered, factual and within the spirit of the Nolan principles

Provisions under Appendix B: Council of governors and role of the nominated lead governor

Provisions	2025/26 Evidence in place / Actions required	Compliant?
2.1 The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should make every effort to attend these meetings. The NHS foundation trust should take appropriate steps to facilitate attendance.	Council of Governors met formally on 5 occasions (including the Annual Members Meeting).	Compliant
2.2 The council of governors should not be so large as to be unwieldy. The council of governors should be of	The Council undertook a review in October 2024	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
sufficient size for the requirements of its duties. The roles, structure, composition and procedures of the council of governors should be reviewed regularly.	and increased the size of the Council from 20 members to 24 members.	
2.3 The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.	All information required is included within the Annual Report. A record is kept of the attendance of individual governors at meetings of the Council.	Compliant
2.4 The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	The information is provided on the Trust's website at the 'Foundation Trust Membership' pages.	Compliant
2.5 The chair is responsible for leadership of both the board of directors and the council of governors but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive and other executives and non-executives, as appropriate, to their meetings. In these meetings other members of the council of governors may ask the chair or their deputy, or any other relevant director present at the meeting, questions about the affairs of the NHS foundation trust.	All NEDs and EDs including the CEO routinely attend meetings of the Council of Governors.	Compliant
2.6 The council of governors should establish a policy for engagement with the board of directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners. The council of governors should input to the board's appointment of a senior independent director.	The Engagement Policy (between the Board and the Council) is in place. The Council of Governors has had input into the appointment of the SID via the NRC which has delegated authority from the Council of Governors to act on the Council's behalf in this matter.	Compliant
2.7 The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	The Chair routinely meets with the Governors. In year. The Council of Governors meeting agenda is confirmed between the Chair and the Lead Governor. All Board members routinely attend the Council of Governor meetings. The Academy/Committee Chairs routinely report on the work of their Academy/Committees to the Council.	Compliant
2.8 The council of governors should only exercise its power to remove the chair or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chair with the senior independent director in the first instance.	Covered in the 'Process for managing concerns in relation to the Chair, another NED or a Governor', approved in January 2026.	Compliant
2.9 The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, eg clinical statistical data and operational data.	Information to support the discharge of their duties including clinical statistical data and operational data; is included within the Academy and Committee Chair reports received at Council meetings and, the more detailed reports presented at Board.	Compliant
2.10 The chair (and the senior independent director and other directors as appropriate) should maintain regular contact with the governors to understand their issues and concerns	The Chair meets with the governors to provide a 'Board briefing' following the open Board meetings. The SID has met with the full Council at	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
	extraordinary meetings and with the Governors NRC at some of their meetings.	
2.11 Governors should seek the views of members and the public on material issues or changes being discussed by the trust. Governors should provide information and feedback to members and the public at large regarding the trust, its vision, performance and material strategic proposals made by the trust board.	Governors continue to be supported, where required, to engage with members and the public to seek their views. Governors have in year attended community based events. One Governor is a member of our Trust's patient experience group. Members and the public are in receipt of monthly communications providing information on the items described under this provision.	Compliant
2.12 It is also incumbent on the board of directors to ensure governors have the mechanisms in place to secure and report on feedback that enables them to fulfil their duty to represent the interests of members and the public at large.	See above.	Compliant
2.13 The chair should ensure that the views of governors and members are communicated to the board as a whole. The chair should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested to do so by governors. The senior independent director should attend sufficient meetings with governors to hear their views and develop a balanced understanding of their issues and concerns.	The Chair has ensured that the views of the Council and members are shared with the Board of Directors and that they are taken account of as required - as evidenced through: • the chair's reports to both board and Governors • the opportunity for Governors to raise matters from members and the public • through the learning and development sessions scheduled with Governors.	Compliant
2.14 The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	Contact details are available online and are included in the annual report.	Compliant
2.15 The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	The Board of Directors actively engages with the Council of Governors and the respective public stakeholders in the reporting of the financial and performance management of the Foundation Trust and in the management of risks which impact on them. The Council meets five times per year (including the AMM/AGM) and receives reports on performance, quality and safety.	Compliant
3. Additional statutory requirements		
3.1 The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.	Governors attend meetings of the Board of Directors and Board Committees as observers. Governors are in routine receipt of the Board agendas and minutes. A 'holding to account' item is included on	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
	each Council of Governors agenda, where the Non Executive Committee chairs present the 'Alert, Advise, Assure' reports for the Committees. The Council approves the appraisal process for the Chair and the Non-Executive Directors and is in receipt of reports on the outcomes of those appraisals. Governors actively contribute to the appraisals of the Chair and Non-Executive Directors. The Council is in receipt of the Annual Report and Accounts and receives the report from the External Auditor. The Council is also in receipt of the Quality Account.	
3.2 The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the NHS foundation trust annual reporting manual: (a) the annual accounts (b) any report of the auditor on them (c) the annual report.	These documents are received by the Governors at the Annual Members Meeting, and they are available on the Foundation Trust's website.	Compliant
3.3 The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, eg for data protection or commercial reasons. Governors should respect the confidentiality of these documents.	The agenda, approved minutes for open meetings and all documents from open meetings are circulated to the Governors and made available on the Trust website.	Compliant
3.4 The council of governors may require one or more of the directors to attend a meeting to obtain information about the trust's performance of its functions or the directors' performance of their duties, and to help the council of governors decide whether to propose a vote on the trust's or directors' performance.	Both Executive and non-Executive Directors routinely attend meetings of the Council of Governors and provide appropriate information.	Compliant
3.5 Governors should use their rights and voting powers from the 2012 Act to represent the interests of members and the public at large on major decisions taken by the board of directors. These voting powers require: • More than half the members of the board of directors who vote and more than half the members of the council of governors who vote to approve a change to the constitution of the NHS foundation trust. • More than half the governors who vote to approve a significant transaction. • More than half the governors to approve an application by a trust for a merger, acquisition, separation or dissolution. • More than half the governors who vote to approve any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more. For example, governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the trust's	All new powers have been covered in the Foundation Trust's Constitution since September 2013.	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
total income. • Governors to determine together whether the trust's non-NHS work will significantly interfere with the trust's principal purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions.		
3.6 NHS foundation trusts are permitted to decide themselves what constitutes a 'significant transaction' and may choose to set out the definition(s) in the trust's constitution. Alternatively, with the agreement of the governors, trusts may choose not to give a definition, but this would need to be stated in the constitution.	Definition of 'significant transaction' is stated within the Constitution.	Compliant
3.7 In taking decisions on significant transactions, mergers, acquisitions, separations or dissolutions, governors need to be assured that the process undertaken by the board was appropriate, and that the interests of the public at large were considered. A council may disagree with the merits of a particular decision of the board on a transaction, but still give its consent because due diligence has been followed and assurance received. To withhold its consent, the council of governors would need to provide evidence that due diligence was not undertaken.	Governors would be advised of this provision should a significant transaction be required.	Compliant
3.8 The external auditors of a foundation trust must be appointed or removed by the council of governors at a general meeting of the council.	Practice is in place.	Compliant
4. Lead governor		
4.1 The lead governor has a role in facilitating direct communication between NHS England and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chair or the trust secretary, if one is appointed.	Lead Governor is appointed.	Compliant
4.2 It is not anticipated that there will be regular direct contact between NHS England and the council of governors in the ordinary course of business. Where this is necessary, it is important that it happens quickly and in an effective manner. To this end, a lead governor should be nominated and contact details provided to NHS England, and then updated as required. Any of the governors may be the lead governor.	Lead Governor is appointed.	Compliant
4.3 The main circumstances where NHS England will contact a lead governor are where we have concerns about the board leadership provided to an NHS foundation trust, and those concerns may in time lead to our use of our formal powers to remove the chair or non-executive directors. The council of governors appoints the chair and non-executive directors, and it will usually be the case that we will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the trust, and to rectify successfully any issues, and also for the governors to understand our concerns.	Lead Governor is appointed.	Compliant
4.4 NHS England does not, however, envisage direct communication with the governors until such time as there is a real risk that an NHS foundation trust may be in breach of its licence. Once there is a risk that this may be the case, and the likely issue is one of board leadership, we will often wish to have direct contact with the NHS foundation trust's governors, but quickly and through one established point of contact, the trust's nominated lead governor. The lead governor should take steps to understand our role, the available guidance and the basis on which we may take regulatory action. The lead governor will then be able to communicate more widely with other governors. Similarly, where individual governors wish to contact us, this would be expected to be through the lead governor.	Lead Governor is appointed.	Compliant
4.5 The other circumstance where NHS England may wish to contact a lead governor is where, as the regulator, we have been made aware that the process for the appointment of the chair or other members of the board, or	Lead Governor is appointed.	Compliant

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Provisions	2025/26 Evidence in place / Actions required	Compliant?
elections for governors or other material decisions, may not have complied with the NHS foundation trust's constitution, or alternatively, while complying with the trust's constitution, may be inappropriate. In such circumstances, where the chair, other members of the board of directors or the trust secretary may have been involved in the process by which these appointments or other decisions were made, a lead governor may provide us with a point of contact.		

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Board of Directors			
Meeting Date:	21.05.26	**Agenda Reference:**	Bo.5.26.25
Report Title:	Committee Annual Reports, Terms of Reference and Work Plans		
Presented by:	Laura Parsons, Associate Director of Corporate Governance / Board Secretary		
Lead:	Karen Walker, Acting Chair		
Author:	Jacqui Maurice, Head of Corporate Governance		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☐	Action ☒ (review/discuss/ comment)	Information ☐

Summary of Key Issues/Highlights:

The Board of Directors reviews the performance of its Committees annually to determine if they have been effective. One of the key elements of this review is the Annual Report provided by the Committee.

Annual Reports

The Committees considered and agreed their Annual Reports at their meetings held in April and May 2026. The reports were subsequently presented at the Audit Committee for review on 12 May 2026. The Audit Committee derived assurance that the Committees met their Terms of Reference throughout 2025/26. This also supported the Audit Committee in considering the assurances provided within the Annual Governance Statement.

The reports are attached as follows.

- Appendix 1a - People Committee
- Appendix 1b - Quality Committee
- Appendix 1c - Finance and Performance Committee
- Appendix 1d - Charitable Funds Committee
- Appendix 1e - Audit Committee

Terms of Reference

The Terms of Reference have been considered and confirmed by the respective Committees.

Amendments to the Committee Terms of Reference

People Committee

- Change of name from the People Academy to the People Committee.
- An expansion on the 'Purpose of the People Committee'.
- The revision of some duties and the addition of others providing better clarity on the scope of the Committee.
- A key revision to the list of those expected to attend the Committee
- The revised Terms of Reference (with track changes) are attached at **Appendix 2a**.

Finance and Performance Committee

- Change to the 'Purpose' of the Committee so that it refers to 'operational performance' and includes reference to assurance in respect of 'Estates and Facilities'.
- Minor revisions to some duties including the removal of the following two.

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- Review programme updates from the Bradford District and Craven Health and Care Partnership, WYAAT and the ICS to ensure that any related improvements are exploited within the Trust
- Seek assurance regarding the action taken by the Trust to address health inequalities and access to care as this duty is within the remit of the Quality Committee
- The addition of a new duty to approve relevant policies as required on behalf of the Board of Directors.
- The addition of the 'Recovery Board' to the list of sub-groups feeding into the Committee.
- Reduction in those expected to attend all meetings (which is now consistent across all Board Committees).
- The revised Terms of Reference (with track changes) are attached at **Appendix 2b.**

Quality Committee

- An amendment to the 'Purpose of the Committee' whereby the current statement explaining 'what we mean by Quality' and aligned to the World Health Organisation is updated to align with the National Quality Board definition which in turn aligns to the CQC key aspects of Quality Care.
- Under duties, clarification has been provided under a number of the sections on the specific reporting to be received by the committee to address the duty.
- Under sub-groups, the removal of two sub-groups as they do not report into the Quality Committee (Chief Nurse Senior Leadership meeting and EXCEL Programme Board).
- There is the addition of the Chief Digital and Information Officer as a Committee member.
- Addition of the Patient Safety Partner as a routine attendee at the Committee (this is aligned with NHSE's expectations under the Framework for Involving Patients in Patient Safety.)
- Reduction in those expected to attend all meetings (which is now consistent across all Board Committees).
- The revised Terms of Reference (with track changes) are attached at **Appendix 2c.**

Charitable Funds Committee

- Under 'Scope and Objects of the Charity', the final three paragraphs are deleted as the main statement would incorporate the sentiments expressed.
- Under 'duties', a duplicated line has been deleted.
- Under 'in attendance', the Finance Manager, Bradford Hospitals Charity (charity senior leadership team) has been added.
- Other minor amends made under 'meetings' and 'circulation of papers' to bring practices in line with other Board Committees.
- The revised Terms of Reference (with trach changes) are attached at **Appendix 2d.**

Audit Committee

- Minor amends are proposed throughout, with one key amendment on page 3 with the additional responsibility to 'Report to the Council of Governors on the work, fees and performance of the External Auditor and providing an annual statement on the use of external audit to provide non-audit services.'

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	• Further suggested changes under quoracy, frequency of meetings, circulation of papers and reporting bring the terms of reference in line with other Committees. The revised terms of reference are presented at **Appendix 2e**. **Work Plans** The work plans for the Committees have been subject to review. The work plans are attached as follows: • Appendix 3a - People Academy • Appendix 3b - Finance and Performance Committee • Appendix 3c - Quality Committee • Appendix 3d - Charitable Funds Committee • Appendix 3e - Audit Committee
Recommendation/s: (including any decision/approval required)	**1. Annual Reports** The Board is asked to confirm that it derives assurance from the annual reports presented and that the committees have fulfilled their terms of reference. **2. Terms of Reference** The Board of Directors is asked to approve the changes provided to the: • People Committee Terms of Reference • Finance and Performance Committee Terms of Reference • Quality Committee Terms of Reference • Charitable Funds Committee Terms of Reference • Audit Committee Terms of Reference **3. Committee Work Plans** The Board of Directors is asked to approve the work plans associated with each of the Committees.
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:	The Annual Reports, Terms of Reference and work plans have been presented to each respective Committee. All Committee Annual Reports were presented to the Audit Committee on 12 May 2026.

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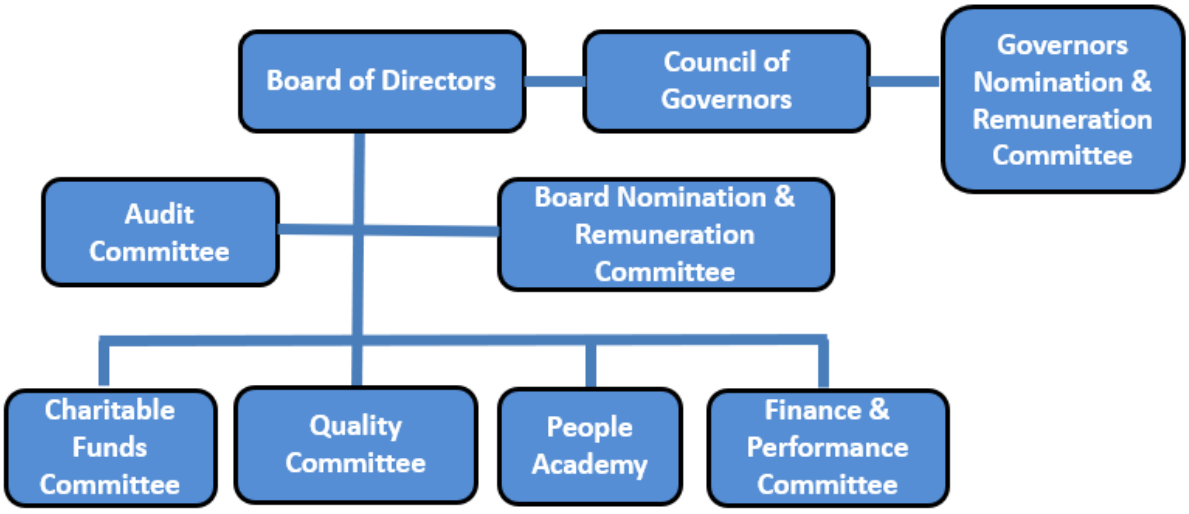
People Academy Annual Report 2025/26

1. Introduction

Good practice requires that the Trust's Board of Directors ('the Board') should review the performance of its Committees and Academies annually to determine whether they have been effective, and whether further development work is required.

1.1 Board Governance Structure

The Board and Committee/Academy Structure is outlined below:



The Terms of Reference for the Academy/Committees and work plans received final approval from the Board in May 2025 following both external and internal reviews of governance arrangements.

1.2 Scope of this Annual Report

This annual report incorporates a summary of the activities of the People Academy. The period reported on is from **April 2025 to March 2026.**

2. People Academy Terms of Reference

The People Academy reports directly to the Board. The Terms of Reference of the Academy approved by the Board in May 2025, and minor amendments were approved in November 2025. The Terms of Reference are attached at Appendix A.

2.1 The role and objectives of the People Academy

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The purpose of the People Academy is to seek assurance, learn and drive improvement in leadership, wellbeing and the performance of our workforce in relation to the people management arrangements within the Trust.

The Academy is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend

the Academy to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate.

The Academy may make a request to the executive management team for legal or independent professional advice. The Academy may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members.

2.2 Reporting requirements

It is the responsibility of the Academy Chair to provide a report to the Board on the Academy's activities on a timely basis.

Reports from the Academy Chair are presented at the public meetings of the Board. These reports highlight the key items discussed and draw attention to any issues that require disclosure or may require executive action.

The Academy is also required to present an annual report to the Board summarising the Academy's activities and, the assurance received.

In this reporting period the Academy had two chairs: Karen Walker and Justine Andrew. The Chairs of the Academy are satisfied that the Academy has fully complied with its reporting requirements during and in respect of 2025/26.

3. Membership and attendance record for 2025/26

Between April 2025 and March 2026, the Academy met 10 times. The membership consists of three Non-Executive Directors (including the Chair), and three Executive Directors. The majority of members attended at least 90% of meetings.

Other relevant staff members routinely attended meetings and/or were invited to attend when appropriate to discuss specific matters related to their remits.

4. Chair's review of 2025/26

Whilst the year 2025/26 was transitional in many ways, our people and the workforce remain at the heart of the Trust strategy and fundamental to the effective; safe and quality delivery of our services to the populations we serve.

The aims of the strategy presented in January 2025 remain, namely:

- Health, wellbeing and belonging – creating an environment where everyone belongs and thrives
- Making BTHFT a great place to work – bringing the values to life, and valuing, supporting and developing people
- People working differently – attracting and retaining the right people with the right skills in the right place now and in the future

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The aims continue to underpin our approach however, the new 5-year strategic plan developed in the latter half of the year contain some challenging workforce targets which will need to be incorporated into our approach in 2026/27, building on the work already completed or in place. These goals include:

- Reduce workforce growth across the Trust by 1.7% in 2026/27

- Strengthen establishment stability and reduce reliance on temporary staffing:
  - Cumulative reduction in bank staffing by 34%.
  - Cumulative reduction in agency use by 86% (above national target) working towards zero spend.
  - Reduction in sickness absence rates from the current 6.5% to 4.8% by March 2029.
  - A strategic growth in Research will increase workforce numbers whist being fully funded.

The five-year plan also focuses on strengthening integration through the ABCAS (Airedale and Bradford Collaboration of Acute Services) and the ongoing work as regards corporate and clinical services, supporting a consistent and efficient service model across the system. It also embeds workforce considerations into the wider service redesign associated with the three major shifts: acute to community, analogue to digital, and treatment to prevention. These changes will have substantial implications for our future workforce; recruitment and training, requiring close collaboration with education teams to ensure a flexible, skilled and resilient workforce.

It is worth reflecting on these future targets in the context of the work that has been done by the Academy in 2025/26.

Many of these issues are intertwined: staff sickness will be impacted by, inter alia, appraisal rates and quality; job planning; training; high workload and turnover. Turnover has remained stable at around 10.5%. Sickness remains stubbornly high with monthly levels consistently between 6 and 7% with a year-to-date figure of 6.46% and requires an integrated approach across prevention, support and intervention to address this. It was raised and discussed throughout the year, and the Academy will continue to focus on this area in 2026/7.

Agency use continues to decrease, and the use of bank staff is monitored, and whilst it remains high, especially in nursing and midwifery, we are assured of the processes in place to manage this alongside patient safety. As the Trust focuses on overall workforce reduction the Academy was assured by the robust processes in place, for example via the EQIA (Equality Impact Assessment) process, to balance efficiency and effectiveness with quality care and will continue to monitor this as we reduce overall workforce numbers.

The diversity of the Trust's people represents the diversity of the Trust's patients, and the proportion of ethnic minority employees now sits at 45%. The proportion of ethnic minority employees in senior leadership roles has risen to 21% but the trajectory to target is more challenging. Women continue to also be proportionately under-represented at senior management levels. This progression at senior levels to reflect our workforce and population will be a focus in 2026/7. Overall, the Academy is assured that the WRES (Workforce Race Equality Standard), WDES (Workforce Disability Equality Standard) and gender equality action plans are having a positive impact and that equity and inclusion for all is high on the Trust's agenda.

We were regularly updated by the Freedom to speak up (FTSU) Guardian. In Q4 2025/6 the Trust received the highest number of concerns (over 50). The Academy was assured that this reflected an open culture and demonstrated a level of trust in the FTSU process from colleagues and the psychological safety this demonstrates. The anonymous app also remains a useful tool. The highest level of concern remains worker safety and wellbeing or other appropriate attitudes or behaviours. The Academy notes the need to continue to ensure issues are resolved in a timely manner and also that we can be confident the increasing number of reports reflect an open culture of reporting rather than systemic concerns. This will be done in conjunction with the Staff Survey action plan. Overall, the Academy is assured by the work of the FTSU Guardians and the many Trust ambassadors, and this was reflected in the CQC well-led report published in Q4.

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The staff survey was presented to the March Academy and there are many positives that the Trust

should welcome and build on in the survey, scoring above the national average on all of the People Promise elements for example . However, there are also some areas of concern around three key areas of **colleague voice, wellbeing, and discrimination**, and the Academy will continue to monitor these areas closely.

The Academy's effectiveness review shows that the Academy continues to improve and develop with a particular focus on more in-depth discussion and deep dives on key topics and utilising data better. The Academy also welcomed the return of Face-to-Face meetings. The effectiveness review also gives an opportunity to review the balance of attendees; Terms of Reference and focus of the Academy which will develop in 2026/7 whilst retaining a focus on becoming one of the best NHS employers, prioritising the health and wellbeing of its people and embracing equality, diversity and inclusion.

5. Summary of the work of the Academy during 2025/26

During the year, the Academy focused on people related items under the following headings within the workplan.

- Equality, Diversity and Inclusion (EDI) Strategy
- Workforce Strategy
- People and Organisational Development Strategy
- People and Workforce Reporting
- Governance, Board Assurance Framework (BAF) and Risk

Items were primarily considered under 'learning and improvement' and 'assurance'.

Following each meeting the Academy Chair presented a report to the Board with an assessment of the meeting that had taken place. The Chair report made use of the 'AAA' reporting template aimed at alerting the Board to any key items arising from the meetings and to advise and assure the Board on the items covered. These reports are all available as part of the Board meetings document packs on the Trust website here.

In line with the workplan (and any exceptional items requested) the Academy addressed the following reporting in year.

5.1 Learning and Improvement

- Academy Effectiveness Review
- Belonging: EDI conference
- Education SAR (self-assessment report)
- Freedom to Speak Up (FTSU) quarterly reporting
- FTSU Annual Report (including Q4 report)
- Healthcare Worker Flu Vaccination Campaign
- International Medical Graduates
- International Recruitment: Retention Data
- International Recruitment: Staff Story
- Leadership Staff Story
- Management/Leadership Development
- National Education and Training Survey (NETS) Feedback
- Pharmacy Case Study
- Senior Leader Engagement Visit
- Talent

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- Thrive Conference Follow Up
- WRES and WDES Annual Data Update

5.2 Assurance

- Violence Prevention and Reduction standard
- Five-Year Plan
- Annual Internal Audit Plan
- Board Assurance Framework (BAF)
- Deanery Visit Action Plan - Response to GMC Ranking
- Education Annual Report
- Equality Delivery System 22 (Domain 3 & 3) update
- Ethnicity/Disability Pay Gap Report
- FTSU (Freedom to Speak Up) Guardian updates
- Gender Pay Gap
- GMC survey feedback
- Guardian of Safe working hours
- Health and Safety reporting to the Academy
- High Level Operational risks
- Limited assurance internal audit reports
- Maternity Incentive Scheme – Element 4 – Workforce Audit/Obstetric/Attendance Audit
- Medical Appraisal and Revalidation
- Medical Appraisal and Revalidation Annual Statement of Compliance
- NHS Job Evaluation
- NHS Long Term Workforce Plan
- Non-Medical Appraisals
- Nursing and Midwifery Staffing Data Publication Report
- Nursing and Midwifery Staffing Establishment Review
- Patient Experience Dashboard and Data Update
- Patient Experience Data Update (from the QC dashboard)
- People Academy & Education Dashboard
- People Academy Governance
- People Employment Risk
- People Strategy Implementation Plan
- Planning Framework - briefing notes
- Professional Nurse Advocate Annual Report 2024/25
- Review of People Academy Terms of Reference
- Sickness Absence
- Sickness Absence: Deep Dive
- Sickness Absence: Plan to Reduce
- Staff Appraisals
- Staff Survey Results and Action Plan
- Strategic Framework 25/26: People Academy Composite Metric
- Triangulation of Data and Information
- Trust Strategic Framework 2025-26
- Violence Prevention and Reduction Standards Progress Update
- Volunteering Services Update
- Workforce Planning Submission
- Workforce Race Equality Standard / Disability Standard – action plans 2025/26
- Workforce Report

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5.3 Internal Audit

The Academy was sighted on 5 reports under its purview. Four significant assurance reports and one limited assurance report were received. Exception reports were provided to the Audit Committee with regard to the limited assurance report – with further assurance reporting provided to the People Academy.

Audit	Assurance Rating*
BH282025 – People Strategy	Significant
BH042026 – Safer staffing: International staff	Significant
BH102026 – Patient Experience in AED	Significant
BH142026 – Absence Management	Significant
BH202026 – Consultant Job Planning	Limited

***Definitions:**
High - High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.
Significant - Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas.
Limited - Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in the system's design and/or operation in core areas to effectively meet the system's objectives.

6. Conclusion

The Academy believes that during 2025/26 it took reasonable steps to perform its duties as delegated by the Board and specified in its terms of reference. The Academy has reviewed all relevant items in line with its Terms of Reference and work plan.

Justine Andrew
People Academy Chair

April 2026

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Appendix A

People Academy
Terms of Reference

Purpose	To seek assurance, learn and drive improvement in relation to the people management arrangements within the Trust.
Responsible to	Board of Directors
Delegated authority	The Academy is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Academy to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The Academy may make a request to the executive management team for legal or independent professional advice. The Academy may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members.
Duties	**Assurance:** • People Dashboard and metrics to include safe staffing • Review, challenge and assess the identification and management of risks within the Academy's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • Delivery of the NHS People Plan • Ensuring compliance with relevant legislation and regulations relating to People. • Ensuring delivery of action plans to include but not restricted to the NHS Staff Survey, WRES and WDES action plans • CQC standards relating to People • Make recommendations to the Audit Committee concerning the annual programme of Internal Audit work and work with the Audit Committee to ensure effective scrutiny of the risks and systems of internal control related to people matters. • Consideration of relevant internal audit reports.

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	• In reviewing the assurances received, the Academy will take into consideration the quality of data presented and any associated issues.
	Learning: To develop good practice and recommend the consideration of innovative approaches to people practices within the Trust • To learn from other Organisations who are considered the 'best' employers in the Trust's ambition to become an outstanding Organisation • To learn from Employment Relations/Employment Tribunal cases to inform policy/practice change • System/partnership working including the Bradford District & Craven Partnership People Committee • To hear and learn from real stories from staff and patients
	Improvement: • Employee Voice - Speak up, Listen up, Follow up. To learn and improve from staff engagement activities, including Freedom to Speak Up, National Education and Training Survey, Guardian of Safe Working Hours, GMC Doctors in Training Survey and staff Surveys etc. • To improve people practices • To oversee the development and implementation of action plans following the NHS Staff Survey results to drive improvement • To ensure the development of a just and compassionate culture within the Trust • To improve leadership capacity and talent management
Sub-Groups	• Workforce of the Future Whilst not reporting to the Academy, the Academy will be mindful of the work of the Equality and Diversity Council (EDC) as it affects people management and practices. A workforce sub-group / reference group will be tasked to lead pieces of work or undertake research, as necessary, which will feed into the People Academy.
Chairing arrangements	The Academy will be chaired by a Non-Executive Director.
Membership	• Up to three Non-Executive Directors (including the Chair) • Chief Medical Officer • Chief Nurse

	• Director of HR Members are normally expected to attend at least 70% of meetings (7) during the year. Deputies may attend on behalf of members subject to the agreement of the Chair.
In attendance	• Associate Director of Corporate Governance/Board Secretary • Head of Corporate Governance • Member of Pharmacy leadership team • Member of Digital leadership team • Head of OD • Assistant Directors of HR • Head of Equality, Diversity and Inclusion • Member of COO leadership team • Deputy Chief Nurse • Associate Chief Nurse Quality and Workforce • Directors of Nursing (Operations) and Director of Midwifery (at least one to attend each meeting) • Head of Education • Voluntary Services Manager • Manager Workplace Health & Well-Being Centre • Partnership Lead • Chair – RESIN Staff Network • Chair – Enable Staff Network • Chair – LGBT Staff Network • Lead AHP • The Academy may invite other guests as appropriate • Any Board member that wishes to attend
Secretary	Secretarial support will be provided by the Executive Assistant to the Chief People and Purpose Officer.
Quorum	A minimum of three members, including at least two NEDs and at least one Executive Director.
Frequency of meetings	Monthly (except August and December) At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of four clear working days in advance of the meeting.

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Reporting	The Chair of the Academy is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. The minutes of the Academy shall also be submitted to the Trust Board for information and assurance. The Chair of the Academy shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The Academy will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.

Date agreed by the Academy:	5 November 2025
Date approved by the Trust Board:	27 November 2025
Review date:	May 2026

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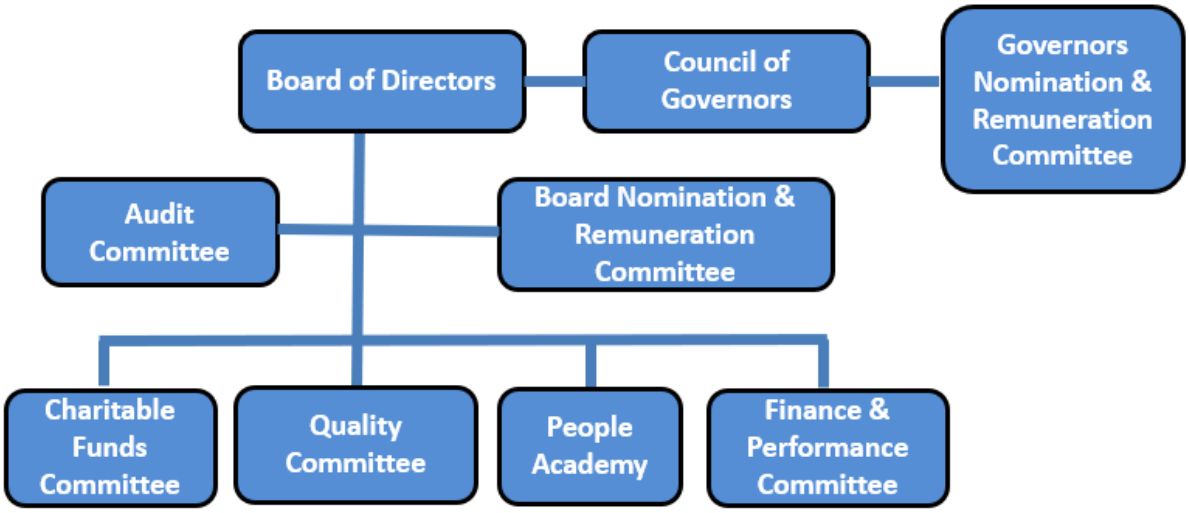
Quality Committee Annual Report 2025/26

1. Introduction

Good practice requires that the Trust's Board of Directors ('the Board') should review the performance of its Academy/Committees annually to determine whether they have been effective, and whether further development work is required.

1.1 Board Governance Structure

The current governance structure is outlined below:



The Terms of Reference and work plans were last approved by the Board in November 2025 following both an external and internal review of governance arrangements at the Trust.

1.2 Scope of this Annual Report

This annual report incorporates a summary of the activities of the Quality Committee. The period reported on is from April 2025 to March 2026.

2. Quality Committee Terms of Reference

The Quality Committee reports directly to the Board. The Terms of Reference of the Committee were last reviewed and approved by the Board in November 2025 and are attached at Appendix A.

2.1 The role of the Quality Committee

The purpose of the Committee is to:

- Seek assurance, learn and drive improvement in relation to all aspects of quality within the Trust in line with the NHS Patient Safety Strategy and national quality standards.
- Provide a space for our staff to share insight into the quality of our services and engender a culture of patient centred improvement where peer challenge and support is offered by all members.

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The Quality Committee defines quality health services in the following ways:
- *Effective: providing evidence-based healthcare services to those who need them;*
- *Safe: avoiding harm to people for whom the care is intended; and*
- *People-centred: providing care that responds to individual preferences, needs and values.*

To realize the benefits of quality health care, health services must be:
- *Timely: reducing waiting times and sometimes harmful delays;*
- *Equitable: providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status;*
- *Integrated: providing care that makes available the full range of health services throughout the life course;*
- *Efficient: maximizing the benefit of available resources and avoiding waste.*

2.2 Reporting requirements

It is the responsibility of the Committee Chair to report to the Board on the Committee's activities on a timely basis.

Reports from the Committee Chair are presented at the public meetings of the Board of Directors. These reports highlight the key items discussed and draw attention to any issues that require disclosure or may require executive action.

The Committee is required to present an annual report to the Board summarising the Committee's activities and, the assurance received.

The Chair of the Committee is satisfied that the Committee fully complied with its reporting requirements in respect of 2025/26.

3. Membership and attendance record during 2025/26

During 2025/26 the Committee met 10 times. The membership consists of three Non-Executive Directors (including the Chair), and three Executive Directors. The majority of members attended at least 74% of meetings.

Meetings were also attended by the Associate Director of Corporate Governance/Board Secretary and Head of Corporate Governance. Other members of staff are invited to attend meetings when appropriate to discuss specific matters related to their roles.

4. Chair's Review of 2025/26

The Quality Committee's role is to seek assurance and to learn and drive improvement in relation to all aspects of quality within the Trust in line with the NHS Patient Safety Strategy and national quality standards. The Committee provides a space for our staff to share insight into the quality of our services and engender a culture of improvement where peer challenge and support is offered by all members.

The Quality Committee has built on the changes made in 2024/25 with a continued focus on ensuring that our work is about learning and improvement as well as scrutiny. The Committee has used the new dashboard, the report on high level risks, and the regular "Profile and Patient Safety Incident Report" to provide a clear overview of ongoing challenges and new issues throughout the Trust, together with a continuing focus on the quality of our Maternity services. We are continuing to make sure that our meetings provide the right balance between comprehensive information and a focus on the most important strategic issues and challenges.

Some of the main Quality Committee themes from 2025/26 include:

- The CQC 'Well Led' Inspection resulting in an overall rating of Good, which is excellent news. This was preceded by a number of unannounced inspections covering Maternity, the Emergency Department (ED), and Outpatients. We were delighted that Maternity services were rated 'Good.' Publication of the ED and Outpatients reports are still awaited. The Committee will receive reports on the action plans to address issues arising from these inspections in the months ahead.
- The Committee noted continuing challenges relating to falls and some pressure ulcer categories. We were assured by the renewed focus being given by Executive leadership, including action to embed the Quality Committee dashboard across wards, a continued focus on effective training, and the planned recruitment of a Falls Improvement Lead.
- The quality of maternity services is a key focus for the Committee. In addition to the recent CQC findings, we are assured by the transparency of maternity and neo-natal data, which we receive monthly, the assurance given by external reports and inspections, the significant reduction in still-births and the ongoing improvement work.
- Throughout the year improvements in coding have seen a reduction in the Summary Hospital-level Mortality Indicator (SHMI) so it is more in line with the crude mortality indicators. This is part of wider ongoing work to improve the quality of coding as part of the digital strategy.
- The Committee alerted the Board to concerns regarding a number of risks relating to respiratory care, linked to high demand, challenges around estates, and long waits for treatment. We were assured about actions being taken but will receive a further deep dive in this area in the coming months.
- The Committee welcomed the work of the Accident and Emergency Department (AED) EXCEL Programme which is taking a strategic and partnership approach to improve patient and staff experience, part of an important response to the challenges and risks caused by the high levels of pressure on our emergency teams.

The 2026 Committee effectiveness review shows that members continue to seek improvements in the functioning of the Quality Committee and are open to views on how we can better deliver in our role. We are in the process of reviewing membership and attendance and further improving the structure of reports and agendas so there is capacity to provide greater focus on specific issues, and particularly to strengthen the focus on learning and improvement.

5. Summary of the work of the Committee 2025/26

5.1. Activity

During the year, the Committee focused on quality related items. Following each meeting the Committee Chair presented a report to the Board with an assessment of the meeting that had taken place. The Chair report made use of the 'AAA' reporting template aimed at alerting the Board to any key items arising from the meetings and to advise and assure the Board on the items covered. These reports are all available as part of the Board meetings document packs on the Trust website here.

In line with the workplan the Committee addressed the following reporting in year.

- Insights Report
- Infection Prevention and Control
- Equality Delivery System 2 (domain 1)
- Maternity and Neonatal Services
- Quality Committee Dashboard
- Quality Oversight & Assurance Profile and Patient Safety Incident Investigation (PSII) report
- Quality Account improvement priorities update

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- Quality Account Production Schedule
- Annual Quality Account
- Safeguarding Adults Annual Report and Update
- Safeguarding Children Annual Report and Update
- Palliative Care Annual Report
- Mental Health Strategy
- Patient Experience Annual Report and Update
- Inpatient Survey
- Health Inequalities
- Nursing and Midwifery Strategy update (including updates on the Bradford Nursing and Midwifery Professional practice model)
- Clinical Audit Annual Report
- Clinical Audit High Priority Plan
- Compliance with National Food standards
- Ward Accreditation
- Digital Report
- Senior Information Risk Officer Report
- Getting it Right First Time
- Improvement Strategy Annual Progress Report
- Annual Review of Internal Audit Plan
- Learning from Deaths and Mortality Review Improvement Programme
- Internal Audit Reports relevant to the Committee
- Internal Audit Annual Plan
- Research Activity in the Trust
- Review of Quality Committee Work Plan / Terms of Reference
- Quality Committee Effectiveness Review
- Quality Committee Annual Report
- Board Assurance Framework - strategic risks relevant to the Committee
- High Level Risks

5.2 Internal Audit

The Committee was sighted on all 16 reports under the purview of the Committee. Two limited assurance reports were received, and an exception report was provided to the Audit Committee regarding this with further reporting provided to the Committee. Two high assurance reports were received and eleven received significant assurance.

Audit	Assurance Rating*
Patient Safety Incidents Response Framework	High
Claims Management	Significant
Ward Accreditation	Significant
PLACE	Significant
DSPT	High
Safer Staffing: International Staff	Significant
ReSPECT	Significant
Virtual Programme	Significant
Cyber Security – third party access controls	Limited
Patient experience in AED	Significant
DSPT thematic report	N/A
Clinical ward stock management	Significant
Data quality depth of coding	Significant
IPC blood culture	Significant

Falls	Limited
PSIFT learning disabilities	Significant

***Definitions:**
High - High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.
Significant - Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas.
Limited - Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in the system's design and/or operation in core areas to effectively meet the system's objectives.

6. Conclusion

The Committee believes that during 2025/26 it took reasonable steps to perform its duties as delegated by the Board and specified in its terms of reference. The Committee has reviewed all relevant items in line with its Terms of Reference and work plan.

Tim Swift
Chair of the Quality Committee

April 2026

Osbourne Sheridan
19/05/2026 08:22:12

Appendix A

Quality Committee Terms of Reference

Purpose	**Committee Meetings:** To seek assurance, learn and drive improvement in relation to all aspects of quality within the Trust in line with the NHS Patient Safety Strategy and national quality standards. To provide a space for our staff to share insight into the quality of our services and engender a culture of patient centred improvement where peer challenge and support is offered by all members. **What do we mean by 'Quality'?**[1] Quality health care can be defined in many ways but there is growing acknowledgement that quality health services should be: • **Effective** – providing evidence-based healthcare services to those who need them; • **Safe** – avoiding harm to people for whom the care is intended; and • **People-centred** – providing care that responds to individual preferences, needs and values. To realize the benefits of quality health care, health services must be: • **Timely** – reducing waiting times and sometimes harmful delays; • **Equitable** – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status; • **Integrated** – providing care that makes available the full range of health services throughout the life course; • **Efficient** – maximizing the benefit of available resources and avoiding waste.
Responsible to	Board of Directors
Delegated authority	The Committee is authorised to commission or receive investigations relating to any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Committee to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The Committee may make a request to the Board for legal or independent professional advice. The Committee may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members.

Osbourne Sheridan
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[1] World Health Organisation definition of Quality of Care

	The Committee will receive mandated highlight reports from the clinical working groups according to the reporting structure and annual work plan.
Duties	• Will receive assurance that the quality of the Trust's services is compliant with national standards and the requirements of NHS regulators and commissioners of services. • Review and provide feedback on quality related submissions required by NHSE or other external organisations, prior to approval through the Trust Board as required. • Make recommendations to the Audit Committee concerning the annual programme of Internal Audit. • Consideration of relevant internal audit reports and commissioning actions in relation to the findings as appropriate. • Oversight of the process for impact assessment (quality and equality) and receive assessments of any Trust developments and cost improvement schemes that are evaluated as high risk. • Oversight of the Trust's objectives relating to quality priorities for inclusion in the Trust's Annual Quality Account. • Oversight of the development and delivery of the Trust's Improvement Strategy. • Oversight of progress towards the Trust's digital and data related objectives through regular reports from the Digital and Data Transformation Committee, and review and provide feedback on Information Governance related submissions required by legislation prior to approval through the Trust Board as required. • Review, challenge and assess the identification and management of risks within the Committee's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • Share learning with partner organisations as appropriate to promote improvement. • Receive highlight reports from the Clinical Outcomes Group about compliance with internal and external quality standards including benchmarking data, learning from deaths and mortality, receive the Trust's Annual Audit Plan and have oversight of the associated improvement plans. • Receive highlight reports from the Patient Safety Group, identifying learning from patient safety incidents and have oversight of the quality improvement programmes associated with a positive patient safety culture.

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	• Receive highlight reports from the Patient Experience Sub-Committee, identifying learning from complaints and other sources of feedback. • Support and facilitate a culture of safety and improvement in line with the NHS Patient Safety Strategy by adopting the principles of Insight, Involvement and Improvement. • Oversight of the development of a suite of metrics to measure a culture of safety, quality and improvement. • Oversight of the Nursing & Midwifery Leadership Council work programmes to ensure successful accreditation for care excellence.
Sub-Groups	Chief Nurse Senior Leadership Meeting Patient Safety Group Clinical Outcomes Group Patient Experience Group Integrated Safeguarding Sub-Committee Digital Strategy Group A&E EXCEL Programme Board
Chairing arrangements	The Committee will be chaired by a Non-Executive Director.
Committee Membership	• Three Non-Executive Directors (including the Committee Chair) • Chief Medical Officer • Chief Nurse • Director of Strategy and Transformation Members are normally expected to attend at least 8 meetings during the year.
In attendance	• Chief Digital and Information Officer • Deputy Chief Medical Officer • Associate Medical Directors (on rotation) • Operations Directors/Deputy COO (on rotation) • Associate Director of Quality • Head of Education • Deputy Chief Nurse • Director of Midwifery • Head of Midwifery • Director of Nursing (Operations) • Head of Equality, Diversity & Inclusion • General Manager, Chief Medical Officer's Team • Deputy Director of Estates and Facilities • Lead AHP • Director of Infection Prevention and Control • Director of Pharmacy • Assistant Chief Nurse Informatics

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	• Associate Director of Corporate Governance/Board Secretary • CSU Quality and Patient Safety Facilitators (on rotation) • Associate Director of Nursing & Quality, Bradford District and Craven Health and Care Partnership • Head of Corporate Governance • Deputy Directors of Nursing (on rotation) • Head of Quality Improvement & Patient Safety (on rotation) • Senior Quality Governance Lead (on rotation) • Patient Safety Specialist (on rotation) • *Any member of staff seeking development opportunities in relation to their role and portfolio.* • *Any non-member NED.* The Committee may invite other employees or external advisors to attend or observe as appropriate
Secretary	Secretarial support will be provided by the Executive Assistant to the Chief Nurse/Chief Medical Officer.
Quorum	A minimum of three members, including at least two NEDs and at least one Executive Director.
Frequency of meetings	10 times per year. At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of four clear working days in advance of the meeting.
Reporting	The Chair of the Committee is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. The minutes of the Committee shall also be submitted to the Trust Board for information and assurance. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure or may require executive action. The Committee will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.

Date agreed by the Committee:	19 November 2025
Date approved by the Trust Board:	27 November 2025
Review date:	May 2026

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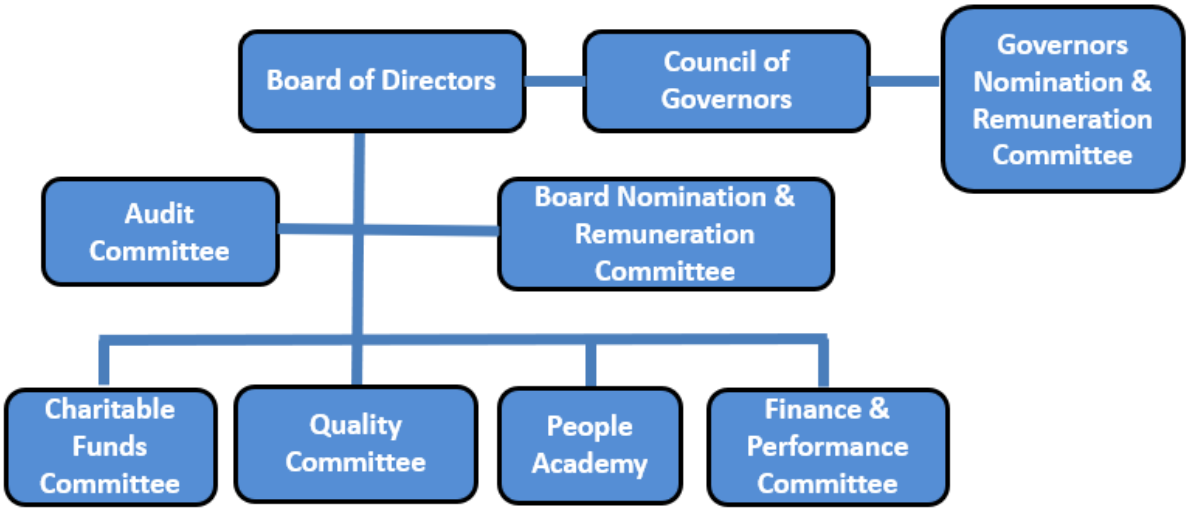
Finance & Performance (F&P) Committee Annual Report 2025/26

1. Introduction

Good practice requires that the Trust's Board of Directors ('the Board') should review the performance of its Committees/Academies annually to determine whether they have been effective, and whether further development work is required.

1.1 Board Governance Structure

The current governance structure is outlined below:



The Terms of Reference and work plans were last approved by the Board in November 2025.

1.2 Scope of this Annual Report

This annual report incorporates a summary of the activities of the Finance and Performance Committee. The period reported on is from April 2025 to March 2026.

2. Finance and Performance Committee Terms of Reference

The Committee reports directly to the Board. The Terms of Reference were last reviewed and approved by the Board in November 2025 and are attached at Appendix A.

2.1 The role of the Finance and Performance Committee

The purpose of the Committee is to seek assurance and, learn and drive improvement in relation to all aspects of finance and performance within the Trust.

2.2 Reporting requirements

It is the responsibility of the Committee Chair to report to the Board on the Committee's activities on a timely basis.

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Reports from the Committee Chair are presented at the public meetings of the Board of Directors. These reports highlight the key items discussed and draw attention to any issues that require disclosure or may require executive action.

The Committee is required to present an annual report to the Board summarising the Committee's activities and, the assurance received.

The Chair of the Committee is satisfied that the Committee fully complied with its reporting requirements in respect of 2025/26.

3. Membership and attendance record during and in respect of 2025/26

During 2025/26 the Committee met 10 times. The membership consists of three Non-Executive Directors (including the Chair), and three Executive Directors. The majority of members attended at least 90% of meetings.

Meetings were also attended by the Associate Director of Corporate Governance/Board Secretary and Head of Corporate Governance. Other members of staff are invited to attend meetings when appropriate to discuss specific matters related to their roles.

4. Chair's Review of 2025/2026

During the year, the Committee has had a new Chair who also joined the Committee for the first time, and another new Non-Executive Director. Throughout the year, whatever the membership, the Committee has focused on seeking assurance about the Trust's business covered under its Terms of Reference and seeking to assist the Trust in continuing to improve.

As the Chair of the Committee reported last year, 2025/26 has been another challenging year for the Trust in meeting its financial targets. The Committee has received comprehensive updates from Executive colleagues and has been involved at Committee and Board level in the decisions required to achieve the best possible outcome.

Operational performance has remained relatively strong across most KPIs. The Committee has received improved narrative reporting during the year which highlights where performance is off-track or where there is a risk to achievement of year end targets. This has helped the Committee assess the efficacy of the actions being taken to achieve the desired outcomes. "Deep dives" into Operational Improvement plans for Urgent Care, Referral to Treatment and Cancer and Diagnostics have provided significant benefits in terms of scrutiny and learning.

The Committee approved several additional documents to ensure compliance with the EPRR (Emergency preparedness, resilience and response) Core Standards.

A new assurance framework is being developed for Estates and Facilities which will significantly improve the Committee's overview of this key risk area for the Trust.

The Committee is determined to keep developing its role in the Trust's governance framework. The recent effectiveness review has highlighted areas to focus on.

5. Summary of the work of the Committee for 2025/26

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19/05/2026 08:22:1

During the year, the Committee focused on finance and performance related items under the following headings within the workplan:

- Finance and Performance
- Estates and Facilities

- Governance, Board Assurance Framework and Risks

Following each meeting the Committee Chair presented a report to the Board with an assessment of the meeting that had taken place. The Chair report made use of the 'AAA' reporting template aimed at alerting the Board to any key items arising from the meetings and to advise and assure the Board on the items covered. These reports are all available as part of the Board meetings document packs on the Trust website here.

In line with the workplan the Committee addressed the following reporting in year.

5.1 Finance and Performance

- Winter Review/Plan
- Bradford Place and ICS System Financial Update
- Budget Setting Process and Timetable
- Budgetary Management Framework
- Capital Plan/Updates
- Contract Update
- Finance Plan/NHSE Operational Plan Submission
- Finance Report
- Pathology Joint Venture
- Procurement Update
- Service Development Post Implementation Reviews
- Treasury Management Update
- Operational Improvement Plan
- Emergency Preparedness, Resilience and Response submission and update
- National Cost Collection
- Medium and Long Term Financial and Operational Strategy
- Closing the Gap
- Operational Highlight Report/Performance Report

5.2 Strategy and Transformation

- WYAAT / ICS Update / Act as One Update
- Green Plan
- Health Inequalities and Access to Care (until February 2025)

5.3 Estates and Facilities

- Premise Assurance Model
- Estates Returns Information Collection
- Health and Safety Committee Update
- Annual Health and Safety Report
- Annual Fire Safety Report
- Annual Security Report
- Violence Prevention and Reduction Standard
- Car Parking Update
- Accommodation Update
- Compliance
- Water and Ventilation (infection prevention) Update
- Medical Engineering Update

Osbourne Stephen 19/05/2025 08:23:51

5.4 Governance, Board Assurance Framework and Risk

- Board Assurance Framework – Strategic Risks relevant to the Committee
- Committee Dashboard
- Committee Annual Report
- Committee Terms of Reference and Workplan
- Committee Effectiveness Review
- High Level Risks
- Nursing and Midwifery Staffing Establishment Review (from February 2025)

5.5 Internal Audit

The Committee was sighted on all 11 reports under the purview of the Committee. One limited assurance report was received, and an exception report was provided to the Audit Committee regarding this with further reporting provided to the Committee. One high assurance report was received and eight reports received significant assurance. One benchmarking report was received.

Internal Audit reports received	Assurance Rating*
BH322025 – Key Financial Controls	Significant
BH342025 - PLACE	Significant
BH062026 – Virtual Programme	Significant
BH072026 – Sessional payments and ad-hoc payments	Significant
BH082026 – Discharge management	Limited
BH132026 – Implementation of actions following external report (PWC	Significant
BH152026 – Delivering Operational Excellence	Significant
BH172026 – Final salary overpayments report (benchmarking report)	N/A
BH192026 – Green Plan	Significant
BH222026 – Estates Procurement	Significant
BH232026 – Working Day One	High

***Definitions:**
High - High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.
Significant - Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas.
Limited - Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in the system's design and/or operation in core areas to effectively meet the system's objectives.

6. Conclusion

The Committee believes that during 2025/26 it took reasonable steps to perform its duties as delegated by the Board and specified in its terms of reference. The Committee has reviewed all relevant items in line with its Terms of Reference and work plan.

Catherine Sheridan
19/05/2026 08:22:12

Bryan Machin
Non-Executive Director and Chair of the Finance & Performance Committee

April 2026

Osbourne Sheridan
19/05/2026 08:22:12

Appendix A

Finance & Performance Committee
Terms of Reference

Purpose	To seek assurance, learn and drive improvement in relation to all aspects of finance and performance within the Trust.
Responsible to	Board of Directors
Delegated authority	The Committee is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Committee to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The Committee may make a request to the executive management team for legal or independent professional advice. The Committee may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members.
Duties	• Review, challenge and assess the identification and management of risks within the Committee's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • Seek assurance regarding the development and maintenance of the Foundation Trust's medium- and long-term financial strategy Seek assurance regarding the development and delivery of the Foundation Trust's annual operational and financial plan and capital plan. • Review and monitor financial plans, including the capital plan, and the Bradford District and Craven and ICS financial position, and their link to operational performance. • Review the budget setting process and timetable prior to approval by the Board of Directors. • Approve the Budgetary Management Framework. • Seek assurance regarding the Trust's compliance with NHS contracting arrangements • Seek assurance regarding post implementation reviews of approved business cases. • Review the performance of the Foundation Trust in achieving National Standards, Contractual Indicators (National and Local) and Trust–defined indicators. • Receive, consider and approve the national cost collection ensuring appropriate application of costing methodologies. • Approve and seek assurance regarding the Trust's investment policy in relation to treasury management (to include cash investments and all other elements of working capital). • Make recommendations to the Audit Committee concerning the

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	annual programme of Internal Audit work and work with the Audit Committee to ensure effective scrutiny of the risks and systems of internal control related to finance and performance matters. • Consideration of relevant internal audit reports. • Seek assurance regarding the operational and financial performance of the Pathology Joint Venture. • Seek assurance regarding the delivery of the Trust's procurement strategy. • Seek assurance regarding the Trust's compliance with Emergency Preparedness, Resilience and Response (EPRR) requirements. • Review the Trust's Winter Plan and seek assurance that appropriate arrangements are in place. • Seek assurance regarding the delivery of the Estates and Facilities function (including the completion of the Premises Assurance Model (PAM) self-assessment and Estates Return Information Collection (ERIC)). • Seek assurance regarding the Trust's performance in relation to environmental sustainability and delivery of the Green Plan. • Review and monitor the delivery of the Closing the Gap and Delivering Operational Excellence programmes. • Review programme updates from the Bradford District and Craven Health and Care Partnership, WYAAT and the ICS to ensure that any related improvements are exploited within the Trust. • Seek assurance regarding the action taken by the Trust to address health inequalities and access to care.
Sub-Groups	Capital Strategy Group Cancer Board
Chairing arrangements	The Committee will be chaired by a Non-Executive Director.
Membership	• Up to three Non-Executive Directors (including the Chair) • Chief Operating Officer • Chief Finance Officer • Director of Strategy and Transformation • Director of Estates and Facilities Members are normally expected to attend at least 70% of meetings (7) during the year.
In attendance	• Chief Digital and Information Officer • Deputy Directors of Finance • Associate Director of Performance • Deputy Medical Directors of Operations • Deputy Chief Operating Officer • Director of Operations • Deputy Director of Operations - Planned Services • Deputy Director of Operations - Unplanned Services • Deputy Director of Operations - Diagnostics and Corporate Operational Services • Deputy Chief Nurse / Directors of Nursing (Operations) (at least one to

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	attend each meeting) • Associate Director of Corporate Governance/Board Secretary • Head of Corporate Governance • The Committee may invite other employees or external advisors to attend as appropriate • Any non-member NED
Secretary	Secretarial support will be provided by the Executive Assistant to the Chief Finance Officer/Chief Operating Officer.
Quorum	A minimum of three members, including two NEDs and at least one Executive Director.
Frequency of meetings	Monthly (except August and December) At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of four clear working days in advance of the meeting.
Reporting	The Chair of the Committee is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. The minutes of the Committee shall also be submitted to the Trust Board for information and assurance. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure or may require executive action. The Committee will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.

Date agreed by the Committee:	19 November 2025
Date approved by the Trust Board:	27 November 2025
Review date:	May 2026

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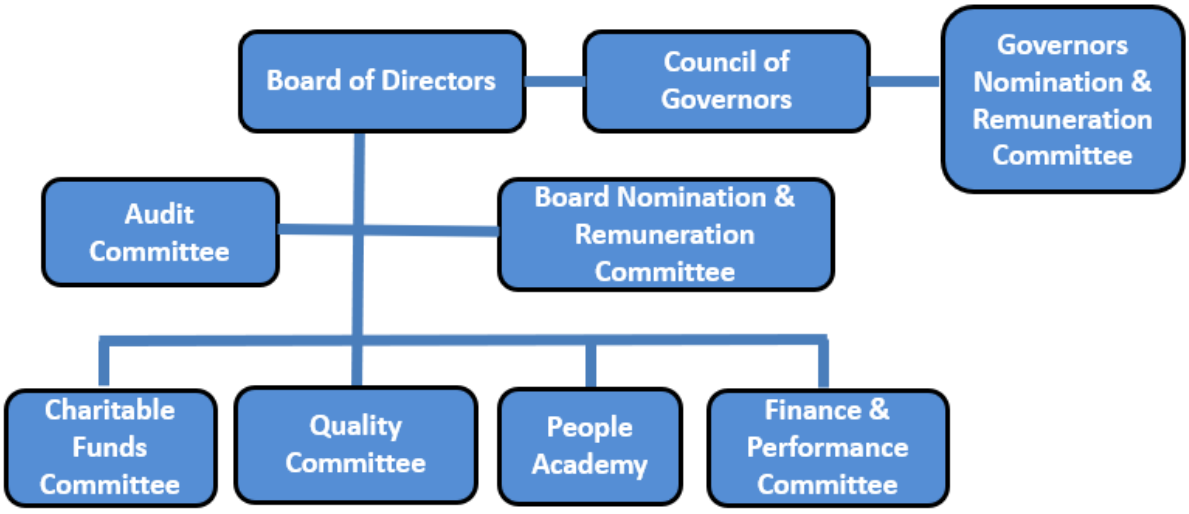
Charitable Funds Committee Annual Report 2025/26

1. Introduction

Good practice requires that the Trust's Board of Directors ('the Board') should review the performance of its Committees/Academies annually to determine whether they have been effective, and whether further development work was required.

1.1 Board Governance Structure

The Board and Committee/Academy Structure is outlined below:



1.2 Scope of this Annual Report

This annual report incorporates a summary of the activities of the Charitable Funds Committee. The period reported on is from **April 2025 to March 2026.**

2. Charitable Funds Committee Terms of Reference

The Committee reports directly to the Board.

The Terms of Reference of the Committee were reviewed and approved by the Board of Directors in November 2025 and are attached at Appendix A.

2.1 The role and objectives of the Committee

The purpose of the Committee is to provide assurance to the Board that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales and to ensure compliance with the charity's own governing document.

Caroline.Shearer 19/05/2026 16:12:11

It does not remove from the Board the overall responsibility for this area but provides a forum for a more detailed consideration of charitable matters and allows for direct contact with the Charity Commissioners where necessary.

2.2 Reporting requirements

It is the responsibility of the Committee Chair to report to the Board on the Committee's activities on a timely basis.

A Chair's report is presented to the Board following each meeting.

Reports from the Chair are presented at the public meetings of the Board. These reports highlight the key items discussed and draw attention to any issues that require disclosure or may require executive action.

The Committee is also required to present an annual report to the Board summarising the Committee's activities and the assurance received.

The Chair of the Committee is satisfied that the Committee fully complied with its reporting requirements during and in respect of 2025/26.

3. Membership and attendance record for 2025/26

Between April 2025 and March 2026, the Committee met four times. The membership consists of three Non-executive Directors (including the Chair), and three Executive Directors. During 2025/26 the majority of members attended at least 96% of the meetings.

The Committee meetings were also routinely attended by the Charity Director, Deputy Director of Finance, the Associate Director of Corporate Governance/Board Secretary and/or the Head of Corporate Governance.

4. Chair's Review of 2025/26

I am pleased to share the significant progress and key highlights from the Charitable Funds Committee over the past year. It has been a transformative period for the Charity as we continue to evolve our governance and fundraising impact.

A major standout has been the exceptional momentum of the **"Home from Home" Neonatal Unit Appeal**. Following its successful launch, we secured a transformational **£1 million gift** from the Harry and Mary Foundation—the largest donation in the charity's history. Additionally, a **£250,000 capital grant** from Sovereign Health Care has further bolstered our efforts to reach our milestones for the unit's planned opening in Autumn 2026.

Our operational robustness has reached a new level now that the **full charity team is in-situ**. We have welcomed key expertise to the senior leadership team, including **Laura Riach** as Charity Director, who has provided much-needed stability. The team has been further strengthened by the appointment of a new **Head of Communications and Marketing, Ellen Hicks** who is already driving essential improvements to our digital accessibility and public engagement.

Regarding our **move to independence**, while we have refined our timeline to ensure a robust transition, we remain firmly on track for the independent charity to be constituted by **April 2027**. A pivotal step in this journey has been the successful recruitment of **Russell Andrews** as the new Chair of Trustees for the independent charity.

Joshua Fisher (1)
10/06/2026 08:21:12

Finally, we have addressed historic challenges with transparency, notably resolving the staff lottery discrepancies and launching a new, more inclusive **Lottery Policy**. I am confident that the Charity is now more resilient, visible, and better positioned than ever to support the Trust's patients and staff.

5. Summary of the work of the Committee during 2025/26

In line with the workplan, the Committee addressed the following reporting in year.

- Finance Report
- Bradford Hospital Charity Reserves Policy
- Bradford Hospitals Charity Treasury Management & Investment Policy
- Bradford Hospitals Charity website urgent review
- Charitable Funds Committee work plan (monthly review)
- Charitable update
- Charity Dashboard
- Charity Independence – progress against plan
- Charity Independence
  a. Update for the next quarter
  b. Trust Fund Consolidation
- Charity Operational Committee report
- Charity Operational Committee report
- Charity Operational Committee Terms of Reference
- Charity staff lottery investigation
- Draft CFC annual report and accounts 2024/25
- Charity Committee Governance
  a. Annual report 2024/25
  b. Effectiveness Review
  c. Annual review of ToRs
  d. Annual review of workplan
- Five-year plan (25/26 – 29/30)
- Fundraising Policy
- Internal audit reports relevant to the committee
- Investment Report
- Lottery Policy
- Neonatal Unit Appeal: key milestones update and NICU appeal update
- Rathbones authorised signatory list

Following each meeting the Academy Chair presented a report to the Board with an assessment of the meeting that had taken place. The Chair report made use of the 'AAA' reporting template aimed at alerting the Board to any key items arising from the meetings and to advise and assure the Board on the items covered. These reports are all available as part of the Board meetings document packs on the Trust website here.

5.1 Internal Audit

The Committee received no internal audit reports during 2025/26.

6. Conclusion

The Committee believes that during 2025/26 it took reasonable steps to perform its duties as delegated by the Board and specified in its terms of reference. The Committee has reviewed all relevant items in line with its Terms of Reference and work plan.

1590 Amended
19/05/2026 08:12:12

Altaf Sadique, Non-Executive Director, Chair of the Charitable Fund Committee

April 2026

Appendix A

Bradford Hospitals Charity

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Charitable Funds Committee
Terms of Reference

Purpose	**Status and overall purpose of the Charitable Fund Committee** Bradford Teaching Hospitals NHS Foundation Trust ("the Trust") is the sole Corporate Trustee of Bradford Hospitals Charity ("the Charity"). The responsibility for the management and use of funds held by the Charity lies with the Trust's Board of Directors. The Charitable Fund Committee ("the Committee") is a Committee of the Board of Directors. Its purpose is to provide assurance to the Board that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales and to ensure compliance with the charity's own governing document. It does not remove from the Board the overall responsibility for this area but provides a forum for a more detailed consideration of charitable matters and allows for direct contact with the Charity Commissioners where necessary. **Scope and Objects of the Charity** The Charity has as its sole objective to use its funds: "For any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by Bradford Teaching Hospitals NHS Foundation Trust". The Charity seeks to achieve this objective, giving consideration to general guidance on public benefit, by two main routes. Firstly, the Corporate Trustee works to identify significant projects to which it can contribute or which it can wholly fund. It actively enhances the refurbishment of wards and clinical areas from basic specifications to higher quality. Secondly, there are hundreds of staff working at a sub-fund level to identify small but valuable differences where Charitable Fund monies can deliver benefits to patients / staff, such as attendances at extra training courses or conferences. **What is Public Benefit?** To be charitable, spending must demonstrate sufficient public benefit in what it aims to achieve.

Osbourne Sheridan
19/05/2026 08:22:12

	Patient focused expenditure within the NHS (unless directed mainly towards private patients) will generally meet this public benefit test.
Responsible to	Board of Directors
Delegated authority	The Committee is authorised by the Board of Directors to monitor all aspects of activity within Bradford Hospitals Charity as set out within its governing document registered with the Charity Commission. The Committee is authorised by the Board of Directors to obtain as and when required external independent professional advice through normal business processes and to secure the attendance of outside parties with relevant experience and expertise if this is considered to be appropriate.
Powers of Trustees and their responsibilities	Trustees have and must accept ultimate responsibility for directing the affairs of a Charity, and ensure that it is solvent, well-run, and delivering the charitable outcomes for which it has been set up. Bradford Teaching Hospitals NHS Foundation Trust is a corporate body and is the Corporate Trustee of the Charity, acting through the Trust's Board of Directors. Members of the Board of Directors and the Committee must act in accordance with the responsibilities and duties of charity Trustees as set out below. 1. Ensure the Charity is carrying out its purposes for the public benefit 2. Comply with the Charity's governing document and the law 3. Act in the Charity's best interests 4. Manage the Charity's resources responsibly 5. Act with reasonable care and skill 6. Ensure the Charity is accountable
Duties	The duties of the Committee are to: • Ensure that the Charity complies with current legislation; • Review new legislation and its impact on the Charity; • Set and review an investment policy for the Charity; • Appoint brokers to manage the Charity's funds if required; • Review the performance of the Charity's investments as managed by its brokers; • Set and review an investment policy including the use of investment gains; • Review individual fund balances within the overall Charity on a regular basis; • Seek expenditure plans from individual fund holders where funds are currently not being used; • Agree guidance and procedures for fund holders; • Review audit recommendations; • Review the Annual Accounts for the Charity; and • Review the Annual Reports for the Charity. The Committee may delegate any of its powers or functions to a subcommittee of two or more members but the terms of any such

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	delegation must be recorded in the minute book. The Committee has the power to delegate all investment decisions to the appointed investment broker. **Financial Controls** Financial controls are an essential part in assuring all stakeholders that a charity's property is safeguarded, is managed efficiently and that sound governance arrangements exist. The Chief Finance Officer is responsible for implementing an internal control system which clearly shows areas of responsibility and lines of authority. These are set out in the following internal documents set by the Committee in the governing document. • Expenditure policy • Investment policy • Reserve policy **Annual Report and Return of Accounts** Acting on behalf of the Corporate Trustee, the members of the Committee must comply with their obligations under the Charities Act 2011 (as amended) with regard to: • the keeping of accounting records for the Charity; • the preparation of annual statements of account for the Charity; • the auditing, or independent examination, of the statements of account of the Charity; • the preparation of an annual report and the sending of it together with the statements of account to the Charity Commission; and • the preparation of an annual return and its transmission to the Charity Commission. Accounts must be prepared in accordance with the provisions of any Standard of Recommended Practice (SORP) issued by the Charity Commission.
Sub-Groups	Charity Operational Committee
Chairing arrangements	General meetings shall be chaired by the Non-Executive Director appointed as Chair of the Committee. If there is no such person or he or she is not present, a Non-Executive Director nominated by the Committee members shall chair the meeting.
Membership Osbourne.Sheridan 19/05/2026 08:22:12	The Committee membership shall comprise: Three Non-Executive Directors, one of whom shall be appointed as Chair of the Committee The Chief Executive The Chief Finance Officer The Director of Strategy & Transformation An individual shall cease to be a member of the Committee if he or she;

	• Ceases to be a Director of the Trust; or • Is disqualified from acting as a Trustee by virtue of section 178 of the Charities Act 2011 (as amended).
In attendance	Those in attendance shall be: The Deputy Director of Finance The Charity Director, Head of Special Projects (charity senior leadership team) Head of Communications & Marketing (charity senior leadership team) Associate Director of Corporate Governance/Board Secretary
Secretary	Secretarial support will be provided by an Executive Assistant.
Quorum	No business shall be transacted at any general meeting unless a quorum is present. A quorum is a minimum of three Committee members including at least one Executive and one Non-Executive Director. Each member shall have one vote but if there is an equality of votes the person who is chairing the meeting shall have a casting vote in addition to any other vote he or she may have.
Frequency of meetings	The Committee shall meet four times per year unless the Committee agrees a different meeting schedule. A minimum period of notice is required to hold any general meetings of the Committee of at least seven calendar days. The members present at a meeting may resolve that the meeting shall be adjourned. At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of four clear working days in advance of the meeting.
Reporting	The Committee must keep minutes of all: • meetings of the Committee and sub-committees including the names of the members present at the meeting; and • the decisions made at the meetings and where appropriate the reasons for the decisions. The Chair of the Committee is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. The minutes of the Committee shall also be submitted to the Trust Board for information and assurance. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The Committee will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Date agreed by the Charitable Fund Committee:	4 November 2025

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Date approved by the Board:	27 November 2025
Review date:	May 2026 The Committee shall review the terms of reference annually, and any amendments required shall be put before a meeting of the Board of Directors for approval.

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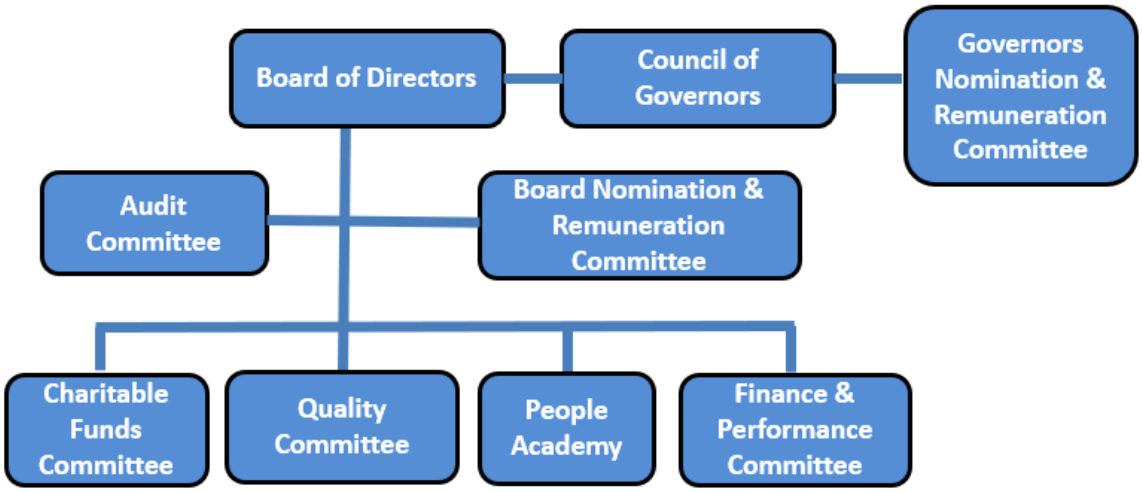
Audit Committee Annual Report: April 2025 to March 2026

1. Introduction

Good practice requires that the Trust's Board of Directors ('the Board') should review the performance of its Committees annually to determine whether they have been effective, and whether further development work is required.

1.1 Board Governance Structure

The Board and Committee/Academy Structure is outlined below:



The Terms of Reference for the Academy/Committees and work plans received final approval from the Board in May 2025 following both external and internal reviews of governance arrangements. Several of the terms of reference were further reviewed by the Board in November 2025 following minor amendments.

1.2 Scope of this Annual Report

This annual report incorporates a summary of the activities of the Audit Committee between **April 2025 to March 2026.**

2. Audit Committee Terms of Reference

The Audit Committee reports directly to the Board. The Terms of Reference of the Committee were approved by the Board in May 2025 and are attached at Appendix A.

2.1 The purpose, objective and role of the Audit Committee

The **purpose** of the Audit Committee ('the Committee') is to provide an independent and objective view of internal control to the Board of Directors and the Accountable Officer. It provides assurance regarding the comprehensiveness and the reliability of assurances on governance, risk management, the control environment and the integrity of financial statements.

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The Committee supports the Board by critically reviewing and reporting on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance.

The **objective** of the Committee is to provide assurance on the adequacy of audit arrangements (internal and external) and on the implications of assurances provided in respect of risk and control, with a view to enabling the Board to assure itself of the effectiveness of the Trust's risk management system and procedures and its internal controls.

The **role** of the Committee, in accordance with its terms of reference is to:

Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives by reviewing the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular, the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors
- The underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statement
- The policies and procedures for ensuring compliance with all relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications including the NHS Provider Licence, guidance on Good Governance and Collaboration, and the Code of Governance for NHS Provider Trusts
- The policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

The Committee reviews, challenges and assess the adequacy and effectiveness of the Trust's risk management systems and processes, including the Risk Management Strategy, and provides assurance to the Board in that respect.

The Committee undertook a 'process assessment' and 'effectiveness assessment' to support the committee's annual effectiveness review. The assessments have utilised the respective checklists from the HFMA Committee handbook. The outcomes will be considered by the Audit Committee at its meeting in May 2026 as part of the Committee effectiveness review.

2.2 Reporting requirements

It is the responsibility of the Committee Chair to provide a report to the Board on the committee's activities on a timely basis which are presented at the public meetings of the Board. These reports highlight the key items discussed and draw attention to any issues that require disclosure or may require executive action.

The Committee is also required to present an annual report to the Board summarising the Committee's activities and, the assurance received.

In this reporting period the Committee had two chairs: Bryan Machin (up to 31 August 2025) and Zafir Ali (from 1 September 2025). The Chairs of the Audit Committee are satisfied that the Committee has fully complied with its reporting requirements during and in respect of 2025/26.

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3. Membership and attendance record during April 2025 to March 2026

During 2025/26 the Committee met 5 times. The membership consists of three Non-Executive Directors (including the Chair). The majority of members attended at least 99% of meetings.

Committee meetings are routinely attended by the Chief Finance Officer, the Deputy Director of Finance, the Associate Director of Corporate Governance/Board Secretary and the Head of Corporate Governance. Other senior Executives and Directors are invited to attend meetings when appropriate to discuss specific matters related to their portfolios. In addition, some meetings of the Audit Committee were also attended by an Executive Director on a rotational basis. In year these included:

- Chief Operating Officer (14 May 2025)
- Chief Nurse (9 September 2025)
- Director of Strategy & Transformation (18 November 2025)
- Director of Estates and Facilities (10 February 2026)

The Chief Executive, as the Trust's Accountable Officer, attends at least one meeting per year and attended on 14 May 2025 to present the Annual Governance Statement.

Representatives of both Internal and External Audit and Counter Fraud also routinely attended the meetings.

In-year, the Committee members also held private meetings with Internal Audit (Audit Yorkshire) and the External Auditor (Deloitte).

4. Chair's Review of 2025/26

The Committee has continued to receive all required reports from both Internal and External Audit, particularly in terms of coverage and assurance of key areas within the Trust, as outlined in the 2025/26 Internal Audit Plan. There has been strong engagement with the Executive, fostering accountability and prompting the required actions for all audits. The Executive Team and other Board Committees have been particularly supportive of the Audit Committee in considering Internal Audit reports that have received Limited assurance.

Encouragingly, the number of overdue recommendations, including those which have been overdue the longest, have significantly decreased compared to the same period last year. Additionally, Internal Audit has been providing valuable root cause analyses of recurring themes identified in audit findings. This allows the Executive to take proactive measures to enhance the overall control environment of the Trust.

The following sections detail the matters considered by the Audit Committee as part of its work to provide assurance in the Trust's governance arrangements.

5. Summary of the work of the Committee during April 2025 to March 2026

5.1 Integrated Governance, Risk Management and Internal Control

During the reporting period the Committee's work plan sought to ensure the acquisition of adequate assurance regarding integrated governance, risk management and internal control. Supplemented by the consideration of assurance provided by internal audit's work to deliver the agreed internal audit plan, counter fraud and external audit. The Committee gained assurance in respect of:

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- Annual Accounts 2024/25
- Annual external audit performance review
- Annual Governance Statement 2024/25
- Annual internal audit & counter fraud performance review
- Annual policy review use of external audit for non-audit purposes

- Annual Report 2024/25
- Annual review of AC terms of reference
- Assurance regarding compliance with risk management strategy
- Assurance: Ledger System incident
- Audit Committee Annual Report 2024/25
- Audit Committee Annual Self-Assessment
- Audit Committee work plan
- BH32/2025 key financial controls
- Charitable Funds Annual Report and Accounts 2024/25
- Committee/Academy Annual Reports 2024/25: Charitable Funds Committee, Finance & Performance Committee, Quality Committee, People Academy
- Compliance with the 'Policy for the Development and Management of Trust Policies'
- Compliance with the Provider Licence and the Code of Governance
- Condemnation, Losses and Special Payments Policy
- Declarations of interest annual report
- Draft Letter of Representation 2024/25
- Exception reports: schedule of losses & special payments and appropriateness of single source tenders
- Partnership arrangements: implications for the Audit Committee
- Proposed changes to Scheme of Delegation/Standing Financial Instructions
- Proposed changes to Standing Orders of the Board of Directors
- Review of external regulatory visits register
- Suspension of standing orders/standing financial instructions
- Trust compliance with Standing Orders, Standing Financial Instructions, Scheme of Delegation (standing item)
- Use of External Audit to provide non audit services – Annual statement to Council of Governors

5.2 Internal Audit (IA) and Local Counter Fraud Services

Internal Audit and Local Counter Fraud Services are provided to the Trust by Audit Yorkshire. The Chief Finance Officer is a member of the Audit Yorkshire Board which oversees Audit Yorkshire at a strategic level.

5.2.1 Internal Audit

The Committee considered and reviewed the following reporting from Internal Audit and Local Counter Fraud:

- Annual Head of Internal Audit opinion 2025/26
- Audit Plan 26-27
- Follow up of Internal Audit Recommendations
- Internal Audit Annual Report and Head of Internal Audit Opinion 2024/25
- Internal Audit Progress Reports
- Limited Assurance Internal Audit Reports

Audit Committee members and regular attendees were also in receipt of the monthly insight reports from The Internal Audit Network (TIAN).

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5.2.2 Head of Internal Audit Opinion

The Head of Internal Audit is required to provide an annual opinion, based upon and limited to the internal audit work performed, on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes. (i.e. the Trust's system of internal control). The 2024/25 opinion was received by the Committee in May 2025. The overall opinion was as follows:

"Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently."

The Head of Internal Audit Opinion contributed to the Committee's and to the Board's assessment of the effectiveness of the Trust's system of internal control and to the completion of the Annual Governance Statement 2024/25.

For 2025/26 the Head of Internal Audit Opinion is expected for review by the Committee in May 2026.

Executive Directors and/or their representatives have attended the Committee and provided updates (where required) on the mitigations and action plans to address areas where limited assurance was provided.

5.3 Local Counter Fraud Service (LCFS)

In respect of the reporting period, the Committee considered and reviewed the following reporting from the Local Counter Fraud representatives:

- Annual Counter Fraud Plan 2025/26
- Counter Fraud Annual Report 2024/25
- Counter Fraud Progress Report
- Counter Fraud Self Review Tool
- Policies and procedures for all work related to counter fraud, bribery and corruption

5.4 External Audit

- External Audit 2026 Planning Report
- External Audit Progress Updates
- ISA 260 – BTHFT NHS Foundation Trust
- Sector Update and Benchmarking Report
- External Auditor Annual Report 2024/25

5.4.1 Appointment of External Auditor

A tender exercise for the appointment of an External Auditor began in February 2025 and concluded in July 2025 with the awarding of the contract to Deloitte LLP. To support the new tender process a working group was established early in 2025 comprising the following:

- Bryan Machin, Audit Committee Chair
- Zafir Ali, Non-Executive Director, Audit Committee member
- Philip Turner, Public Governor
- Ruth Houghton, Staff Governor
- Ben Roberts, Chief Finance Officer
- Michael Quinlan, Deputy Director of Finance

- Support with the procurement process and management of the procurement has been provided by members of the procurement team and the corporate governance team.

The working group operated in line with the Trust's standing financial instructions.

The tender exercise completed in July 2025 following the presentation and approval of a recommendation for appointment to the Council of Governors. The Council approved the appointment of Deloitte LLP as the External Auditor for a 3-year contract term commencing 1 August 2025 with the option to extend for 2 further 12-month periods.

5.4.2 Key reports from External Audit

During and in respect of the reporting period, the Committee considered and reviewed the following reporting from the External Auditors:

- External Audit 2026 planning report
- External Audit progress update
- ISA 260 – Foundation Trust
- Sector update and benchmarking report

5.4.3 External Audit Annual Plan

The Committee received the External Audit Plan for 2025/26 in February 2025. The plan identified the following significant inherent audit risks related to:

- Property valuation
- Capital expenditure
- Management override of controls

6. Use of External Audit to provide non-audit services

Any proposal for the use of the External Auditors to provide non-audit services is required to be reported to the Committee. Dependent upon the nature and/or cost of the services, then Committee approval is required.

The Audit Committee can confirm that there were no such engagements in 2025/26.

7. Other significant assurance functions

During 2025/26, in addition to the assurances provided by Internal Audit, Counter Fraud and External Audit, the Committee has also been sighted on the progress made regarding the development of partnership arrangements and any implications for the Audit Committee.

8. Conclusion

The Committee believes that during the period of reporting it took reasonable steps to perform its duties as delegated by the Board and specified in its terms of reference.

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Zafir Ali
Audit Committee Chair

May 2026

Appendix A

Audit Committee

Terms of Reference

Purpose	The purpose of the Audit Committee ('the Committee') is to provide an independent and objective view of internal control to the Board of Directors and the Accountable Officer. It provides assurance regarding the comprehensiveness and the reliability of assurances on governance, risk management, the control environment and the integrity of financial statements. The Committee supports the Board by critically reviewing and reporting on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance. The objective of the Committee is to provide assurance on the adequacy of audit arrangements (internal and external) and on the implications of assurances provided in respect of risk and control, with a view to enabling the Board to assure itself of the effectiveness of the Trust's risk management system and procedures and its internal controls.
Responsible to	Board of Directors
Delegated authority	The Committee is a non-executive committee of the Trust's Board ('the Board') and has no executive powers, other than those specifically delegated in these terms of reference. The Committee is authorised by the Board to act and investigate any activity within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the exercise of its functions The Committee shall embed the Foundation Trust's vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business. The requirements for the conduct of business as set out in the Foundation Trust Board's Standing Orders are equally applicable to the operation of the Committee.

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Duties	**Governance, risk management and internal control** The Committee will review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy and effectiveness of: • All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors • The underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statement • The policies and procedures for ensuring compliance with all relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications including the NHS Provider Licence, guidance on Good Governance and Collaboration, and the Code of Governance for NHS Provider Trusts • The policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA. The Committee will review, challenge and assess the adequacy and effectiveness of the Trust's risk management systems and processes, including the Risk Management Strategy, and provide assurance to the Board in that respect. In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, other Board Committees and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it. As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages. **Internal Audit** The Committee shall ensure that there is an effective Internal Audit function that meets the *Public Sector Internal Audit Standards, 2017* and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors. This will be achieved by: • Considering the provision of the Internal Audit service and the costs involved. • Reviewing and approving the strategic and annual Internal Audit plan,

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ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.

- Considering the major findings of Internal Audit work (and management's responses) and ensuring coordination between the Internal and External Auditors to optimise the Trust's use of audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.
- Monitoring the effectiveness of Internal Audit and carrying out an annual review.

External Audit

The Committee shall review and monitor the External Auditors' independence and objectivity and the effectiveness of the external audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to, their work. This will be achieved by:

- Considering the appointment and performance of the External Auditors, as far as the rules governing the appointment permit (and make recommendations to the Board of Directors when appropriate).
- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the External Audit annual plan.
- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Reviewing all External Audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside of the annual External Audit plan, together with the appropriateness of management responses.
- Ensuring that there is in place a clear and appropriate policy for the engagement of External Auditors to supply non-audit services.

Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the Trust. These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors - for example, the Care Quality Commission, NHS Resolution, etc. and professional bodies with responsibility for the performance of staff or functions - for example, Royal Colleges, accreditation bodies, etc.

The Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's areas of

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responsibility.

The Committee will have oversight of and receive assurances in relation to compliance with Trust policies and the Fit and Proper Person Framework requirements

Counter fraud
The Committee shall satisfy itself that the Trust has adequate arrangements in place for the prevention and detection of fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas. The Committee shall refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Agency.

The Committee shall receive and consider reports arising from quality inspections by the NHSCFA.

Management
The Committee shall request and review reports, evidence and assurances from Board Committees and Academies, directors and managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the Trust.

Financial reporting and control
The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance. The Committee will ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided. The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

- The Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- The quality of financial reports
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Explanations for significant variances
- Unadjusted misstatements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- The letter of management representation

As regards Standing Orders and Standing Financial Instructions, the Committee shall:

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- Seek assurance regarding the Trust's compliance with Standing Orders and Standing Financial Instructions.
- Consider any proposed changes to Standing Orders and Standing Financial Instructions and, as appropriate, make recommendations to the Board.

The Committee shall review schedules of losses and special payments and review single source tenders.

The Committee shall receive, consider and derive assurance from reports relating to the Trust Charitable Funds Committee with regard to governance, risk management, control, audit and financial reporting.

</td></tr>
<tr><td>Chairing arrangements</td><td>The Chair of the Committee ('the Chair') shall be appointed by the Board of Directors from amongst its independent Non-Executive Directors. The Chair must have recent and relevant financial experience.</td></tr>
<tr><td>Membership</td><td>
<table>
<tr><th>Title</th><th>Role</th></tr>
<tr><td>Non-Executive Director</td><td>Chair
To ensure the Committee functions properly, that there is full participation during meetings, that all relevant matters are discussed and that effective decisions are made and carried out.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Non-Executive Director X2</td><td>To provide independent oversight and challenge</td></tr>
<tr><td colspan="2">Attendees</td></tr>
<tr><td>Chief Finance Officer</td><td>To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan</td></tr>
<tr><td>Associate Director of Corporate Governance/Board Secretary</td><td>To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan

To support the Chair of the Committee in ensuring that the Committee functions properly</td></tr>
<tr><td>Accountable Officer</td><td>To discuss annually with the Committee the process for assurance that supports the Annual Governance Statement. He or she shall also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts</td></tr>
<tr><td>Representative(s)</td><td>To support the purpose and aims of the Committee and to agree</td></tr>
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	from Internal audit	decisions, actions and provide input and feedback on management issues related to the agenda and work-plan
	Representative(s) from external audit	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan
	Assigned Local Counter Fraud Specialist	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan. The assigned Local Counter Fraud Specialist will attend a minimum of two Committee meetings a year.
	Other Executive Directors/Directors	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan as required by the Committee
	The Head of Internal Audit and lead representative of External Audit shall have a right of direct access to the Chair of the Committee. The Chairperson of the Trust shall not be a member of the Committee.	
Secretary	Secretarial support will be provided by the Corporate Governance Team.	
Quorum	A quorum shall consist of two of the three independent members. Members should attend at least 75% of meetings within any calendar year. Attendance will be monitored and addressed by the Chair. Should any member be unavailable to attend, they may nominate a deputy, with full voting rights, to attend in their place subject to the agreement of the Chair. The Committee may ask any of those who are in attendance, but who are not members to withdraw to enable a full and frank discussion of particular matters. Where the Committee is not quorate, the meeting should be rearranged within 2 weeks.	
Frequency of meetings	The Committee will meet at least five times per annum and shall agree a schedule of meetings at least 12 months in advance. The Committee will consider and keep under consideration the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. The Board of Directors, Accountable Officer, External Auditors or Head of Internal Audit may request of the Committee Chair an additional meeting if they consider that one is necessary.	

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	At least once a year the Committee shall meet privately with the external and with the internal auditors. At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange. Normal rules relating to quoracy will apply to the functioning of such a meeting. These meetings will be deemed as standard meetings of the Committee and shall be documented accordingly.
Circulation of papers	The Associate Director of Corporate Governance/Board Secretary will hold an agenda setting meeting with the Chair and/or the Deputy Chair at least 3 weeks before the meeting date. The agenda will be based around the Committee's work plan, matters arising and requests from the Board of Directors or other Board Academies and Committees to consider specific issues. Following approval, the agenda and timetable for papers will be circulated to all Committee members. Agenda items along with accompanying papers to be submitted to the Committee secretary one week prior to meeting dates. The agenda and papers for meetings will be distributed five working days in advance of the meeting. The minutes, highlight report and action log will be circulated to members within seven working days of the meeting to check the accuracy. Members must forward amendments to the Committee secretary within the next seven days.
Reporting	The Committee Chair shall report formally, regularly and on a timely basis to the Board of Directors on the Committee's activities by: • Reporting to the Trust Board on those matters covered by these terms of reference through a regular written report following each meeting, and the presentation of an annual report for each of its operational duties. • The minutes of the Committee's meetings shall be formally recorded by the Secretary and submitted to the Board of Directors. The Chairperson of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board of Directors or require executive action. • Bringing to the Board of Director's specific attention any significant matter under consideration by the Committee. • Ensuring appropriate escalation arrangements are in place to alert the Foundation Trust Board Chair, Chief Executive or Chairs of other

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	relevant Committees of any urgent/critical matters that may compromise the delivery of the Foundation Trust's Strategic Objectives. Reporting to the Board of Directors at least annually on its work in support of the annual governance statement, specifically commenting on: • The fitness for purpose of the assurance framework • The completeness and 'embeddedness' of risk management in the Trust • The integration of governance arrangements • The appropriateness of the evidence that shows the Trust is fulfilling all relevant regulatory requirements and obligations • The robustness of the processes behind production of the Quality Accounts. This Audit Committee Annual Report will also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered and how they were addressed. If, through the course of Committee business an issue is raised which needs immediate escalation, or action taken, which is outside of the remit of the Committee this should be escalated to the appropriate Executive meeting, via the Chair, for discussion and action. The Committee shall undertake an annual self-assessment. It will report thereon to the Board of Directors. These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board of Directors.
Date agreed by the Audit Committee:	14 May 2025
Date approved by the Trust Board:	29 May 2025
Review date:	May 2026

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Bradford Teaching Hospitals
NHS Foundation Trust

People ~~Academy~~Committee
Terms of Reference

Purpose	To seek assurance, learn and drive improvement in leadership, wellbeing and the productivity of our workforce in relation to the people management arrangements within the Trust.
Responsible to	Board of Directors
Delegated authority	The ~~Academy~~ Committee is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Academy to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The ~~Academy~~ Committee may make a request to the executive management team for legal or independent professional advice. The ~~Academy~~ Committee may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members.
Duties	~~Assurance:~~ The Committee will seek assurance across the relevant areas of the Trust and will support a culture of continuous improvement through open dialogue and learning. • To receive the People and Education Dashboards and gain assurance of performance against the people and education related metrics. ~~and metrics to include safe staffing~~ • To receive ~~a quarterly~~ workforce reports and deep dives on key workforce themes and trends. • To ~~R~~review, challenge and assess the identification and management of risks within the ~~Academy's~~ Committee's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • ~~Delivery of the NHS People Plan~~ To seek assurance on the delivery of the agreed targets within the Five Year Integrated

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	Workforce Plan and review the trust's annual workforce planning submission. • ~~Ensuring compliance with relevant legislation and regulations relating to People.~~ • To receive outcomes from the NHS Staff Survey and seek assurance on the delivery of the ~~Ensuring delivery of the~~ action plan.~~s to include but not restricted to the NHS Staff Survey, WRES and WDES action plans~~ • ~~CQC standards relating to People~~ • Make recommendations to the Audit Committee concerning the annual programme of Internal Audit work and work with the Audit Committee to ensure effective scrutiny of the risks and systems of internal control related to people matters. • To C~~c~~onsider~~ation of~~ relevant internal audit reports. • To approve people policies as required on behalf of the Board of Directors. • ~~In reviewing the assurances received, the Academy will take into consideration the quality of data presented and any associated issues.~~
	~~Learning:~~ • To develop good practice and recommend the consideration of innovative approaches to people practices within the Trust • ~~To learn from other Organisations who are considered the 'best' employers in the Trust's ambition to become an outstanding Organisation~~ • To learn from Employment Relations/Employment Tribunal cases to inform policy/practice change • System/partnership working ~~including the Bradford District & Craven Partnership People Committee~~ • To hear and learn from real stories from staff and patients

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Improvement:

- Employee Voice - Speak up, Listen up, Follow up. To seek assurance on the arrangements in place in relation to Freedom to Speak Up.
- To receive the outcomes of the National Education and Training Survey and the GMC Survey and seek assurance on the actions identified. ~~learn and improve from staff engagement activities, including Freedom to Speak Up, National Education and Training Survey, Guardian of Safe Working Hours, GMC Doctors in Training Survey and staff Surveys etc.~~
- To ~~improve people practices~~receive quarterly reports from the Guardian of Safe Working Hours and seek assurance on the arrangements in place.
- ~~To oversee the development and implementation of action plans following the NHS Staff Survey results to drive improvement~~
- To ensure the development of a just and compassionate culture within the Trust.
- ~~To improve leadership capacity and talent management~~To oversee the delivery of the People Strategy including management and leadership development.
- To receive assurance on the organisation's compliance and delivery of Equality, Diversity and Inclusion requirements, including the Trust's Strategy, Equality Delivery System and reporting on WRES, WDES, MWRES, ~~Ethinicity~~Ethnicity/ Disability and Gender Pay Gap.
- To receive assurance on staff appraisal compliance (medical and non-medical).
- To consider the Nursing and Midwifery Staffing Establishment Review and any associated recommendations prior to presentation to the Board of Directors.
- To receive the monthly Nursing and Midwifery Staffing Data Publication Report and seek assurance that appropriate arrangements are in place to ensure safe staffing levels.

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	• To receive the NHS England Education Self-Assessment Report on an annual basis and seek assurance that the trust is compliant with the NHS Education funding agreement and NHSE Education Quality Framework. • To receive an annual Education Assurance Report. • To receive and approve the assessment of compliance against Safety Action 4 of the Maternity Incentive Scheme on an annual basis. • To receive a biannual Health and Safety Report and a Violence Prevention and Reduction report three times per year, to ensure the people impacts are adequately considered. • To receive an annual update on the trust's volunteering service. • To receive an annual Apprenticeship assurance report.
~~**Sub-Groups**~~	~~• Workforce of the Future~~ ~~Whilst not reporting to the Academy, the Academy will be mindful of the work of the Equality and Diversity Council (EDC) as it affects people management and practices.~~ ~~A workforce sub-group / reference group will be tasked to lead pieces of work or undertake research, as necessary, which will feed into the People Academy.~~
Chairing arrangements	The ~~Academy~~ Committee will be chaired by a Non-Executive Director.
Membership	• Up to three Non-Executive Directors (including the Chair) • • Chief Medical Officer • Chief Nurse • Director of HR Members are normally expected to attend at least 70% of meetings (7) during the year. Deputies may attend on behalf of members subject to the agreement of the Chair.

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In attendance	• ~~Associate Director of Corporate Governance/Board Secretary~~ • Head of Corporate Governance • Head of Equality, Diversity and Inclusion • Head of Organisational Development • ~~Member of Pharmacy leadership team~~ • Member of Digital leadership team • Head of OD • ~~Assistant Directors of HR~~ • Head of Equality, Diversity and Inclusion • ~~Member of COO leadership team~~ • Deputy Chief Nurse • ~~Associate Chief Nurse Quality and Workforce~~ • ~~Directors of Nursing (Operations) and Director of Midwifery (at least one to attend each meeting)~~ • Head of Education • ~~Voluntary Services Manager~~ • ~~Manager Workplace Health & Well-Being Centre~~ • ~~Partnership Lead~~ • ~~Chair – RESIN Staff Network~~ • ~~Chair – Enable Staff Network~~ • ~~Chair – LGBT Staff Network~~ • ~~Lead AHP~~ • The ~~Academy~~ Committee may invite other ~~guests~~ attendees as appropriate to present items on the agenda. • Any Board member that wishes to attend
Secretary	Secretarial support will be provided by the Executive Assistant to the ~~Chief People and Purpose Officer.~~Director of HR.
Quorum	A minimum of three members, including at least two NEDs and ~~at least~~ one Executive Director.
Frequency of meetings	Monthly (except August and December) ~~At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange.~~ With the agreement of the Chair Committee members may participate in meetings of the Committee by means of remote access (by way of telephone, video or computer link or otherwise) provided that they can hear, be heard and vote at the meeting in real time. Normal rules relating to quoracy will apply to the functioning of such a meeting. For the avoidance of doubt,

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	presence at a meeting by remote access shall constitute presence at a meeting in person, for the purposes of quoracy. Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of ~~four~~ three clear working days in advance of the meeting.
Reporting	The Chair of the ~~Academy~~ Committee is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. ~~The minutes of the Academy Committee shall also be submitted to the Trust Board for information and assurance~~. The Chair of the ~~Academy~~ Committee shall draw to the attention of the Trust Board any issues that require ~~disclosure, or~~disclosure or may require executive action. The ~~Academy~~ Committee will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.

Date agreed by the ~~Academy~~Committee:	15 April 2026 ~~5 November 2025~~XXX
Date approved by the Trust Board:	21 May 2026 ~~November 2025~~XXX
Review date:	May 2027~~May 2026~~XXX

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Bradford Teaching Hospitals
NHS Foundation Trust

Finance & Performance Committee

Terms of Reference

Purpose	To seek assurance, learn and drive improvement in relation to all aspects of finance, operational ~~and~~ performance, and, ~~estates and facilities,~~ within the Trust.
Responsible to	Board of Directors
Delegated authority	The Committee is authorised to investigate any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Committee to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The Committee may make a request to the executive management team for legal or independent professional advice. The Committee may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members.
Duties	• ~~Review~~Seek assurance on, challenge and assess the identification and management of risks within the Committee's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. • Seek assurance regarding the development and maintenance of the ~~Foundation~~ Trust's medium- and long-term financial strategy. • ~~-~~Seek assurance regarding the development and delivery of the ~~Foundation Trust's~~ financial and operational aspects of the medium-term plan and the ~~annual operational and financial plan and~~ capital plan. • Review and monitor ~~financial plans, including the capital plan, and~~ the Bradford District and Craven and ICS financial position, and ~~their~~ its link to operational performance. • ~~Review~~ Seek assurance on the budget setting process and timetable prior to approval by the Board of Directors. • Approve the Budgetary Management Framework. • Seek assurance regarding the Trust's compliance with NHS contracting arrangements. • Seek assurance regarding post implementation reviews of approved business cases. TBC – for the Committee to consider.

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	• ~~Review~~ Seek assurance on the performance of the ~~Foundation~~ Trust in achieving National Standards, Contractual Indicators (National and Local) and Trust–defined indicators. • Receive, consider and approve the national cost collection ensuring appropriate application of costing methodologies. • Approve and seek assurance regarding the Trust's investment policy in relation to treasury management (to include cash investments and all other elements of working capital). • Make recommendations to the Audit Committee concerning the annual programme of Internal Audit work and work with the Audit Committee to ensure effective scrutiny of the risks and systems of internal control related to finance and performance matters. • ~~Consideration~~ Seek assurance on ~~of~~ relevant internal audit reports. • Seek assurance regarding the operational and financial performance of the Pathology Joint Venture. • Seek assurance regarding the delivery of the Trust's procurement strategy. • Seek assurance regarding the Trust's compliance with Emergency Preparedness, Resilience and Response (EPRR) requirements. • Review the Trust's Winter Plan and seek assurance that appropriate arrangements are in place. • Seek assurance regarding the delivery of the Estates and Facilities function (including the completion of the Premises Assurance Model (PAM) self-assessment and Estates Return Information Collection (ERIC)). • Seek assurance regarding the Trust's performance in relation to environmental sustainability and delivery of the Green Plan. • ~~Review and monitor~~Seek assurance regarding the delivery of the Closing the Gap and Delivering Operational Excellence programmes. • ~~Review programme updates from the Bradford District and Craven Health and Care Partnership, WYAAT and the ICS to ensure that any related improvements are exploited within the Trust.~~ • ~~Seek assurance regarding the action taken by the Trust to address health inequalities and access to care.~~ • Approve relevant policies as required on behalf of the Board of Directors.
Sub-Groups	Capital Strategy Group Cancer Board Recovery Board

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Chairing arrangements	The Committee will be chaired by a Non-Executive Director.
Membership	• Up to three Non-Executive Directors (including the Chair) • Chief Operating Officer • Chief Finance Officer • Director of Strategy and Transformation • Director of Estates and Facilities Members are normally expected to attend at least 70% of meetings (7) during the year.
In attendance	• Chief Digital and Information Officer • Deputy Director~~s~~ of Finance • Associate Director of Performance • ~~Deputy Medical Directors of Operations~~ • Deputy Chief Operating Officer • Director of Operations • Director of Recovery • ~~Deputy Director of Operations - Planned Services~~ • ~~Deputy Director of Operations - Unplanned Services~~ • ~~Deputy Director of Operations - Diagnostics and Corporate Operational Services~~ • ~~Deputy Chief Nurse / Directors of Nursing (Operations) (at least one to attend each meeting)~~ • Associate Director of Corporate Governance/Board Secretary • Head of Corporate Governance • Any non-member NED The Committee may invite other employees or external advisors to attend as appropriate.
Secretary	Secretarial support will be provided by the Executive Assistant to the Chief Finance Officer/Chief Operating Officer.
Quorum	A minimum of three members, including two NEDs and at least one Executive Director.

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Frequency of meetings	Monthly (except August and December) With the agreement of the Chair Committee members may participate in meetings of the Committee by means of remote access (by way of telephone, video or computer link or otherwise) provided that they can hear, be heard and vote at the meeting in real time. Normal rules relating to quoracy will apply to the functioning of such a meeting. For the avoidance of doubt, presence at a meeting by remote access shall constitute presence at a meeting in person, for the purposes of quoracy.~~At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange.~~ Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of three~~four~~ clear working days in advance of the meeting.
Reporting	The Chair of the Committee is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. ~~The minutes of the Committee shall also be submitted to the Trust Board for information and assurance.~~ The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure or may require executive action. The Committee will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.

Date agreed by the Committee:	April 2026~~19 November 2025~~
Date approved by the Trust Board:	May 2026 ~~27 November 2025~~
Review date:	May 202~~6~~

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Bradford Teaching Hospitals
NHS Foundation Trust

Quality Committee

Terms of Reference

Purpose	**Committee Meetings:** To seek assurance, learn and drive improvement in relation to all aspects of quality within the Trust in line with the NHS Patient Safety Strategy and national quality standards. To provide a space for our staff to share insight into the quality of our services and engender a culture of patient centred improvement where peer challenge and support is offered by all members. **What do we mean by 'Quality'?**[1] High-quality, personalised and equitable care for all, now and into the future. In practice this is care that is: • Safe - delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers, supports and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur. • Effective - informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing the wider determinants of health; delivered in a way that enables continuous quality improvements based on research, evidence, benchmarking and clinical audit. • Positive experience. • Responsive and personalised - shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable. • Caring - delivered with compassion, dignity and mutual respect.

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[1] ~~World Health Organisation definition of Quality of Care~~ ~~National Quality Board: Shared Commitment to Quality(2021)The national Quali~~

	• Well-led - driven by collective and compassionate leadership, which champions a shared vision, values and learning; delivered by accountable organisations and systems with proportionate governance; driven by continual promotion of a just and inclusive culture, allowing organisations to learn rather than blame. • Sustainably-resourced - focused on delivering optimum outcomes within financial envelopes, reduces impact on public health and the environment. • Quality care is also equitable - everybody should have access to high-quality care and outcomes, and those working in systems must be committed to understanding and reducing variation and inequalities. ~~Quality health care can be defined in many ways but there is growing acknowledgement that quality health services should be:~~ • ~~**Effective** – providing evidence-based healthcare services to those who need them;~~ • ~~**Safe** – avoiding harm to people for whom the care is intended; and~~ • ~~**People-centred** – providing care that responds to individual preferences, needs and values.~~ ~~To realize the benefits of quality health care, health services must be:~~ • ~~**Timely** – reducing waiting times and sometimes harmful delays;~~ • ~~**Equitable** – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status;~~ • ~~**Integrated** – providing care that makes available the full range of health services throughout the life course;~~ • ~~**Efficient** – maximizing the benefit of available resources and avoiding waste.~~
Responsible to	Board of Directors
Delegated authority	The Committee is authorised to commission or receive investigations relating to any activity within its terms of reference. It is further authorised to seek any information it requires from any employee of the Trust and invite them to attend the Committee to contribute to a discussion or to enable the 'lived experience' to be captured as part of the debate. The Committee may make a request to the Board for legal or independent professional advice.

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	The Committee may request the attendance of external advisers with relevant experience and expertise if it considers this necessary to either contribute to an agenda item or to run development sessions for its members. The Committee will receive mandated highlight reports from the clinical working groups according to the reporting structure and annual work plan.
Duties	• ~~Will r~~Receive assurance that the quality of the Trust's services is compliant with national standards and the requirements of NHS regulators and commissioners of services. Reporting includes: - Committee Dashboard - Quality Oversight and Assurance Profile Maternity and Neonatal Services - Clinical Audit High Priority Plan / Annual Report - Infection Prevention and Control (IPC) - Compliance with National Food Standards - Safeguarding Adults and Children - Palliative Care - Ward Accreditation • Review and provide feedback on quality related submissions required by NHSE or other external organisations, prior to approval through the Trust Board as required. Reporting includes: - Maternity Incentive Scheme - Annual Quality Account - Equality Delivery System (EDS22) • Make recommendations to the Audit Committee concerning the annual programme of Internal Audit. • Consideration of relevant internal audit reports and commissioning actions in relation to the findings as appropriate. • Oversight of the process for impact assessment (quality and equality) and receive assessments of any Trust developments and cost improvement schemes that are evaluated as high risk. Reporting includes:

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- Impact assessment (quality and equality) of Trust developments and cost improvement schemes evaluated as high risk (when required)

- Quarterly ~~O~~oversight of the Trust's objectives relating to quality priorities for inclusion in the Trust's Annual Quality Account.

- Oversight of the development and delivery of the Trust's Improvement Strategy.

- Oversight of progress towards the Trust's digital and data related objectives through regular reports from the Digital and Data Transformation Committee, and review and provide feedback on Information Governance related submissions required by legislation prior to approval through the Trust Board as required. Reporting includes:

  - Digital Report (including Digital Strategy)
  - Senior Information Risk Officer (SIRO) Report
  - Data Protection Officer Annual Report
  - Data Security and Protection Toolkit
  - Digital & Data Transformation Committee highlight report (AAA)

- Review, challenge and assess the identification and management of risks within the Committee's remit on the High Level Risk Register and the BAF, to provide assurance to the Board that all relevant risks are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled. Reporting includes:

  - Board Assurance Framework
  - High Level Risk Register

- ~~Share learning with partner organisations as appropriate to promote improvement.~~

- Receive a quarterly insight report bringing data together relating to claims, litigation, inquests, CQC inquiries, Learning from Deaths Programme and triangulate with, Incident reports, PALs and Complaints.

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	• Receive highlight reports from the Clinical Outcomes Group about compliance with internal and external quality standards including benchmarking data~~., learning from deaths and mortality, receive the Trust's Annual Audit Plan and have oversight of the associated improvement plans.~~ • Receive highlight reports from the Patient Safety Group, identifying learning from patient safety incidents and have oversight of the quality improvement programmes associated with a positive patient safety culture. • Receive highlight report~~s~~ from the Patient Experience ~~Sub-Committee~~Group, identifying learning from complaints and other sources of feedback. Reporting includes: - Inpatient Survey – Patient Experience bi-annual report ~~• Support and facilitate a culture of safety and improvement in line with the NHS Patient Safety Strategy by adopting the principles of Insight, Involvement and Improvement.~~ ~~• Oversight of the development of a suite of metrics to measure a culture of safety, quality and improvement.~~ • Oversight of the delivery of the Nursing & Midwifery ~~Leadership Council work programmes to ensure successful accreditation for care excellence.~~Strategy. • Receive assurance of the Trust's research activity. • Receive assurance on the programmes of work in place to tackle health inequalities. • Approve relevant policies as required on behalf of the Board of Directors.
Sub-Groups	~~Chief Nurse Senior Leadership Meeting~~ Patient Safety Group Clinical Outcomes Group Patient Experience Group Integrated Safeguarding ~~Sub-Committee~~Group Digital Strategy Group ~~A&E EXCEL Programme Board~~

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Chairing arrangements	The Committee will be chaired by a Non-Executive Director.
Committee Membership	• Three Non-Executive Directors (including the Committee Chair) • Chief Medical Officer • Chief Nurse • Director of Strategy and Transformation • Chief Digital and Information Officer Members are normally expected to attend at least 8 meetings during the year.
In attendance	~~• Chief Digital and Information Officer~~ • Deputy Chief Medical Officers ~~• Associate Medical Directors (on rotation)~~ ~~• Operations Directors/Deputy COO (on rotation)~~ • Associate Director of Quality ~~• Head of Education~~ • Deputy Chief Nurse • Patient Safety Partner • Director of Midwifery ~~• Head of Midwifery~~ ~~• Director of Nursing (Operations)~~ ~~• Head of Equality, Diversity & Inclusion~~ ~~• General Manager, Chief Medical Officer's Team~~ ~~• Deputy Director of Estates and Facilities~~ ~~• Lead AHP~~ ~~• Director of Infection Prevention and Control~~ ~~• Director of Pharmacy~~ ~~• Assistant Chief Nurse Informatics~~ • Associate Director of Corporate Governance/Board Secretary ~~• CSU Quality and Patient Safety Facilitators (on rotation)~~ • Associate Director of Nursing & Quality, Bradford District and Craven Health and Care Partnership • Head of Corporate Governance ~~• Deputy Directors of Nursing (on rotation)~~ ~~• Head of Quality Improvement & Patient Safety (on rotation)~~ ~~• Senior Quality Governance Lead (on rotation)~~

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	~~• Patient Safety Specialist (on rotation)~~ • *Any member of staff seeking development opportunities in relation to their role and portfolio.* • *Any non-member NED.* • The Committee may invite other employees or external advisors to attend or observe as appropriate
Secretary	Secretarial support will be provided by the Executive Assistant to the Chief Nurse/Chief Medical Officer.
Quorum	A minimum of three members, including at least two NEDs and at least one Executive Director.
Frequency of meetings	Monthly (except August and December) ~~10 times per year.~~ ~~At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange~~. With the agreement of the Chair Committee members may participate in meetings of the Committee by means of remote access (by way of telephone, video or computer link or otherwise) provided that they can hear, be heard and vote at the meeting in real time. Normal rules relating to quoracy will apply to the functioning of such a meeting. For the avoidance of doubt, presence at a meeting by remote access shall constitute presence at a meeting in person, for the purposes of quoracy. ~~–~~Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of ~~four~~ three clear working days in advance of the meeting.
Reporting	The Chair of the Committee is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. ~~The minutes of the Committee shall also be submitted to the Trust Board for information and assurance.~~ The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The Committee will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.

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Date agreed by the Committee:	~~19 November 2025~~
Date approved by the Trust Board:	~~27 November 2025~~
Review date:	~~May 2026~~ May 2027

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Bradford Hospitals Charity

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Charitable Fund Committee
Terms of Reference

Purpose	**Status and overall purpose of the Charitable Fund Committee**
	Bradford Teaching Hospitals NHS Foundation Trust ("the Trust") is the sole Corporate Trustee of Bradford Hospitals Charity ("the Charity"). The responsibility for the management and use of funds held by the Charity lies with the Trust's Board of Directors. The Charitable Fund Committee ("the Committee") is a Committee of the Board of Directors. Its purpose is to provide assurance to the Board that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales and to ensure compliance with the charity's own governing document. It does not remove from the Board the overall responsibility for this area but provides a forum for a more detailed consideration of charitable matters and allows for direct contact with the Charity Commissioners where necessary. **Scope and Objects of the Charity** The Charity has as its sole objective to use its funds: "For any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by Bradford Teaching Hospitals NHS Foundation Trust". ~~The Charity seeks to achieve this objective, giving consideration to general guidance on public benefit, by two main routes.~~ ~~Firstly, the Corporate Trustee works to identify significant projects to which it can contribute or which it can wholly fund. It actively enhances the refurbishment of wards and clinical areas from basic specifications to higher quality.~~ ~~Secondly, there are hundreds of staff working at a sub-fund level to identify small but valuable differences where Charitable Fund monies can deliver benefits to patients / staff, such as attendances at extra training courses or conferences.~~ **What is Public Benefit?** To be charitable, spending must demonstrate sufficient public benefit in what it aims to achieve. Patient focused expenditure within the NHS (unless directed mainly towards private patients) will generally meet this public benefit test.

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Responsible to	Board of Directors
Delegated authority	The Committee is authorised by the Board of Directors to monitor all aspects of activity within Bradford Hospitals Charity as set out within its governing document registered with the Charity Commission. The Committee is authorised by the Board of Directors to obtain as and when required external independent professional advice through normal business processes and to secure the attendance of outside parties with relevant experience and expertise if this is considered to be appropriate.
Powers of Trustees and their responsibilities	Trustees have and must accept ultimate responsibility for directing the affairs of a Charity, and ensure that it is solvent, well-run, and delivering the charitable outcomes for which it has been set up. Bradford Teaching Hospitals NHS Foundation Trust is a corporate body and is the Corporate Trustee of the Charity, acting through the Trust's Board of Directors. Members of the Board of Directors and the Committee must act in accordance with the responsibilities and duties of charity Trustees as set out below. 1. Ensure the Charity is carrying out its purposes for the public benefit 2. Comply with the Charity's governing document and the law 3. Act in the Charity's best interests 4. Manage the Charity's resources responsibly 5. Act with reasonable care and skill 6. Ensure the Charity is accountable
Duties	The duties of the Committee are to: • Ensure that the Charity complies with current legislation; • Review new legislation and its impact on the Charity; • ~~Set and review an investment policy for the Charity;~~ • Appoint brokers to manage the Charity's funds if required; • Review the performance of the Charity's investments as managed by its brokers; • Set and review an investment policy including the use of investment gains; • Review individual fund balances within the overall Charity on a regular basis; • Seek expenditure plans from individual fund holders where funds are currently not being used; • Agree guidance and procedures for fund holders; • Review audit recommendations;

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- Review the Annual Accounts for the Charity; and
- Review the Annual Reports for the Charity.

The Committee may delegate any of its powers or functions to a subcommittee of two or more members but the terms of any such delegation must be recorded in the minutes ~~book~~.

The Committee has the power to delegate all investment decisions to the appointed investment broker.

Financial Controls

Financial controls are an essential part in assuring all stakeholders that a charity's property is safeguarded, is managed efficiently and that sound governance arrangements exist.

The Chief Finance Officer is responsible for implementing an internal control system which clearly shows areas of responsibility and lines of authority. These are set out in the following internal documents set by the Committee in the governing document.

- Expenditure policy
- Investment policy
- Reserve policy

Annual Report and Return of Accounts

Acting on behalf of the Corporate Trustee, the members of the Committee must comply with their obligations under the Charities Act 2011 (as amended) with regard to:

- the keeping of accounting records for the Charity;
- the preparation of annual statements of account for the Charity;
- the auditing, or independent examination, of the statements of account of the Charity;
- the preparation of an annual report and the sending of it together with the statements of account to the Charity Commission; and
- the preparation of an annual return and its transmission to the Charity Commission.

Accounts must be prepared in accordance with the provisions of any Standard of Recommended Practice (SORP) issued by the Charity Commission.

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Sub-Groups	Charity Operational Committee
Chairing arrangements	General meetings shall be chaired by the Non-Executive Director appointed as Chair of the Committee. If there is no such person or he or she is not present, a Non-Executive Director nominated by the Committee members shall chair the meeting.
Membership	The Committee membership shall comprise: • Three Non-Executive Directors, one of whom shall be appointed as Chair of the Committee • The Chief Executive • The Chief Finance Officer • The Director of Strategy & Transformation (lead executive) An individual shall cease to be a member of the Committee if he or she; • Ceases to be a Director of the Trust; or • Is disqualified from acting as a Trustee by virtue of section 178 of the Charities Act 2011 (as amended).
In attendance	Those in attendance shall be: • The Deputy Director of Finance • The Charity Director, • Head of Special Projects (charity senior leadership team) • Head of Communications & Marketing (charity senior leadership team) • Finance Manager, Bradford Hospitals Charity (charity senior leadership team) • Associate Director of Corporate Governance/Board Secretary
Secretary	Secretarial support will be provided by an Executive Assistant.
Quorum	No business shall be transacted at any general meeting unless a quorum is present. A quorum is a minimum of three Committee members including at least one Executive and one Non-Executive Director. Each member shall have one vote but if there is an equality of votes the person who is chairing the meeting shall have a casting vote in addition to any other vote he or she may have.

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Frequency of meetings	The Committee shall meet four times per year unless the Committee agrees a different meeting schedule. A minimum period of notice is required to hold any general meetings of the Committee of at least seven calendar days. The members present at a meeting may resolve that the meeting shall be adjourned. With the agreement of the Chair Committee members may participate in meetings of the Committee by means of remote access (by way of telephone, video or computer link or otherwise) provided that they can hear, be heard and vote at the meeting in real time. Normal rules relating to quoracy will apply to the functioning of such a meeting. For the avoidance of doubt, presence at a meeting by remote access shall constitute presence at a meeting in person, for the purposes of quoracy. ~~At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange.~~ Normal rules relating to quoracy will apply to such meetings. These meetings will be deemed as standard meetings of the Committee.
Circulation of papers	Papers will be distributed a minimum of ~~four~~ three clear working days in advance of the meeting.
Reporting	The Committee must keep minutes of all: • meetings of the Committee and sub-committees including the names of the members present at the meeting; and • the decisions made at the meetings and where appropriate the reasons for the decisions. The Chair of the Committee is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. ~~The minutes of the Committee shall also be submitted to the Trust Board for information and assurance~~. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure, or may require executive action. The Committee will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.
Date agreed by the Charitable Fund Committee:	5 May 2026~~4 November 2025~~

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Date approved by the Board:	~~27 November 2025~~21 May 2026
Review date:	May 202~~6~~7 The Committee shall review the terms of reference annually, and any amendments required shall be put before a meeting of the Board of Directors for approval.

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Bradford Teaching Hospitals
NHS Foundation Trust

Audit Committee

Terms of Reference

Purpose	The purpose of the Audit Committee ('the Committee') is to provide an independent and objective view of internal control to the Board of Directors and the Accountable Officer. It provides assurance regarding the comprehensiveness and the reliability of assurances on governance, risk management, the control environment and the integrity of financial statements. The Committee supports the Board by critically reviewing and reporting on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance. The objective of the Committee is to provide assurance on the adequacy of audit arrangements (internal and external) and on the implications of assurances provided in respect of risk and control, with a view to enabling the Board to assure itself of the effectiveness of the Trust's risk management system and procedures and its internal controls.
Responsible to	Board of Directors
Delegated authority	The Committee is a non-executive committee of the Trust's Board ('the Board') and has no executive powers, other than those specifically delegated in these terms of reference. The Committee is authorised by the Board to act and investigate any activity within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the exercise of its functions The Committee shall embed the Foundation Trust's vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business. The requirements for the conduct of business as set out in the Foundation Trust Board's Standing Orders are equally applicable to the operation of the Committee.
Duties	**Governance, risk management and internal control**

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The Committee will review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors
- The underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statement
- The policies and procedures for ensuring compliance with all relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications including the NHS Provider Licence, guidance on Good Governance and Collaboration, and the Code of Governance for NHS Provider Trusts
- The policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA.

The Committee will review, challenge and assess the adequacy and effectiveness of the Trust's risk management systems and processes, including the Risk Management Strategy, and provide assurance to the Board in that respect.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, other Board Committees and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages.

Internal Audit

The Committee shall ensure that there is an effective Internal Audit function that meets the *Public Sector Internal Audit Standards, 2017* and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors. This will be achieved by:

- Considering the provision of the Internal Audit service and the costs involved.
- Reviewing and approving the ~~strategic and~~ annual Internal Audit plan, ensuring that this is consistent with the audit needs of the organisation as

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identified in the assurance framework.

- Considering the major findings of Internal Audit work (and management's responses),-and ensuring coordination between the Internal and External Auditors to optimise the Trust's use of audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.
- Monitoring the effectiveness of Internal Audit and carrying out an annual review.

External Audit

The Committee shall review and monitor the External Auditors' independence and objectivity and the effectiveness of the external audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to, their work. This will be achieved by:

- Considering the appointment and performance of the External Auditors, as far as the rules governing the appointment permit (and make recommendations to the Board of Directors when appropriate).
- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the External Audit annual plan.
- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Reviewing all External Audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside of the annual External Audit plan, together with the appropriateness of management responses.
- Ensuring that there is in place a clear and appropriate policy for the engagement of External Auditors to supply non-audit services.
- Reporting to the Council of Governors on the work, fees and performance of the External Auditor and providing an annual statement on the use of external audit to provide non-audit services.

Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the Trust. These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors - for example, the Care Quality Commission, NHS Resolution, etc. and professional bodies with responsibility for the performance of staff or functions - for example,

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Royal Colleges, accreditation bodies, etc.

The Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's areas of responsibility.

The Committee will have oversight of and receive assurances in relation to compliance with Trust policies and the Fit and Proper Person Framework requirements

Counter fraud
The Committee shall satisfy itself that the Trust has adequate arrangements in place for the prevention and detection of fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas. The Committee shall refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Agency.

The Committee shall receive and consider reports arising from quality inspections by the NHSCFA.

Management
The Committee shall request and review reports, evidence and assurances from Board Committees ~~and Academies, directors~~and directors and managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the Trust.

Financial reporting and control
The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance. The Committee will ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided. The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

- The Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- The quality of financial reports
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Explanations for significant variances
- Unadjusted misstatements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit

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- The letter of management representation

As regards Standing Orders and Standing Financial Instructions, the Committee shall:

- Seek assurance regarding the Trust's compliance with Standing Orders and Standing Financial Instructions.
- Consider any proposed changes to Standing Orders and Standing Financial Instructions and, as appropriate, make recommendations to the Board.

The Committee shall review schedules of losses and special payments, and review single source tenders.

The Committee shall receive, consider and derive assurance from reports relating to the Trust Charitable Funds Committee with regard to governance, risk management, control, audit and financial reporting.

</td></tr>
<tr><td>Chairing arrangements</td><td>The Chair of the Committee ('the Chair') shall be appointed by the Board of Directors from amongst its independent Non-Executive Directors. The Chair must have recent and relevant financial experience.</td></tr>
<tr><td>Membership</td><td>
<table>
<tr><th>Title</th><th>Role</th></tr>
<tr><td colspan="2"><u>Members</u></td></tr>
<tr><td>Non-Executive Director</td><td>Chair
To ensure the Committee functions properly, that there is full participation during meetings, that all relevant matters are discussed and that effective decisions are made and carried out.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Non-Executive Director X2</td><td>To provide independent oversight and challenge</td></tr>
<tr><td colspan="2">Attendees</td></tr>
<tr><td>Chief Finance Officer</td><td>To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan</td></tr>
<tr><td>Associate Director of Corporate Governance/Board Secretary</td><td>To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan

To support the Chair of the Committee in ensuring that the</td></tr>
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	Committee functions properly
Accountable Officer	To discuss annually with the Committee the process for assurance that supports the Annual Governance Statement. He or she shall also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts
Representative(s) from Internal audit	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan
Representative(s) from external audit	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan
Assigned Local Counter Fraud Specialist	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan. The assigned Local Counter Fraud Specialist will attend a minimum of two Committee meetings a year.
Other Executive Directors/Directors	To support the purpose and aims of the Committee and to agree decisions, actions and provide input and feedback on management issues related to the agenda and work-plan as required by the Committee

The Head of Internal Audit and lead representative of External Audit shall have a right of direct access to the Chair of the Committee.

The Trust Chairperson ~~of the Trust~~ shall not be a member of the Committee.

The Committee may invite other attendees as appropriate

Secretary

Secretarial support will be provided by the Corporate Governance Team.

Quorum

A quorum shall consist of two of the three ~~Independent~~ members.

Members should attend at least 75% of meetings within any calendar year. Attendance will be monitored and addressed by the Chair.

~~Should any member be unavailable to attend, they may nominate a deputy, with full voting rights, to attend in their place subject to the agreement of the Chair.~~

The Committee may ask any of those who are in attendance but who are not members to withdraw to enable a full and frank discussion of particular matters.

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	Where the Committee is not quorate, the meeting should be rearranged within 2 weeks.
Frequency of meetings	The Committee will meet at least five times per annum and shall agree a schedule of meetings at least 12 months in advance. The Committee will consider and keep under consideration the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. The Board of Directors, Accountable Officer, External Auditors or Head of Internal Audit may request of the Committee Chair an additional meeting if they consider that one is necessary. At least once a year the Committee shall meet privately with the external and with the internal auditors. With the agreement of the Chair Committee members may participate in meetings of the Committee by means of remote access (by way of telephone, video or computer link or otherwise) provided that they can hear, be heard and vote at the meeting in real time. Normal rules relating to quoracy will apply to the functioning of such a meeting. For the avoidance of doubt, presence at a meeting by remote access shall constitute presence at a meeting in person, for the purposes of quoracy. ~~At the request of the Chair, the Committee may hold meetings by telephone, video link or by email exchange.~~ Normal rules relating to quoracy will apply to ~~the functioning of~~ such ~~a~~ meetings. These meetings will be deemed as standard meetings of the Committee. ~~and shall be documented accordingly.~~
Circulation of papers	~~The Associate Director of Corporate Governance/Board Secretary will hold an agenda setting meeting with the Chair and/or the Deputy Chair at least 3 weeks before the meeting date.~~ ~~The agenda will be based around the Committee's work plan, matters arising and requests from the Board of Directors or other Board Academies and Committees to consider specific issues. Following approval, the agenda and timetable for papers will be circulated to all Committee members.~~ ~~Agenda items along with accompanying papers to be submitted to the Committee secretary one week prior to meeting dates.~~ The agenda and papers for meetings will be distributed a minimum of three ~~five~~ clear working days in advance of the meeting. ~~The minutes, highlight report and action log will be circulated to members within seven working days of the meeting to check the accuracy.~~ ~~Members must forward amendments to the Committee secretary within the next seven days.~~

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Reporting	The Chair of the Committee is responsible for reporting to the Trust Board on those matters covered by these terms of reference through a regular written report. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure or may require executive action. The Committee will present a written annual report to the Trust Board summarising the work carried out during the financial year and outlining its work plan for the future year.~~The Committee Chair shall report formally, regularly and on a timely basis to the Board of Directors on the Committee's activities by:~~ ~~• Reporting to the Trust Board on those matters covered by these terms of reference through a regular written report following each meeting, and the presentation of an annual report for each of its operational duties.~~ ~~• The minutes of the Committee's meetings shall be formally recorded by the Secretary and submitted to the Board of Directors. The Chairperson of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board of Directors, or require executive action.~~ ~~• Bringing to the Board of Director's specific attention any significant matter under consideration by the Committee.~~ ~~• Ensuring appropriate escalation arrangements are in place to alert the Foundation Trust Board Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise the delivery of the Foundation Trust's Strategic Objectives.~~ ~~Reporting to the Board of Directors at least annually on its work in support of the annual governance statement, specifically commenting on:~~ ~~• The fitness for purpose of the assurance framework~~ ~~• The completeness and 'embeddedness' of risk management in the Trust~~ ~~• The integration of governance arrangements~~ ~~• The appropriateness of the evidence that shows the Trust is fulfilling all relevant regulatory requirements and obligations~~ ~~• The robustness of the processes behind production of the Quality Accounts.~~ ~~This Audit Committee Annual Report will also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered and how they were addressed.~~ ~~If, through the course of Committee business an issue is raised which needs immediate escalation, or action taken, which is outside of the remit of the Committee this should be escalated to the appropriate Executive meeting, via the Chair, for discussion and action.~~ ~~The Committee shall undertake an annual self-assessment. It will report~~

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	~~thereon to the Board of Directors. These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board of Directors.~~
Date agreed by the Audit Committee:	1<u>2</u>~~4~~ May 202<u>6</u>~~5~~
Date approved by the Trust Board:	2<u>1</u> ~~9~~<u>M</u>~~-~~May 202<u>6</u>~~5~~
Review date:	May 202<u>7</u>~~6~~

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People Committee Work Plan 2026-27

Item	Regulatory requirement	Lead	Report Author	Report to Board	Notes	2026 Apr	May	Jun	Jul	Sep	Oct	Nov	2027 Jan	Feb	Mar
Apprenticeships		Director of HR	Georgi Dyson			x									
Education Annual Report		Chief Medical Officer	Faye Alexander	x			x								
Education SAR	Yes	Chief Medical Officer	Faye Alexander	x						x					
Equality Delivery System 22 (domain 2 and 3) Update	Yes	Chief Operating Officer	Ruth Haigh & Kez Hayat			x				x				x	
Ethnicity/Disability Pay Gap		Chief Operating Officer	Ruth Haigh & Kez Hayat										x		
FTSU Quarterly Updates & Annual Report	Yes	Chief Nurse	Sue Franklin	x			Q4		Q1			Q2		Q3	
Future Workforce Planning - next 3 years		Director of HR	Faeem Lal							x					
Gender Pay Gap (inc 6 mth update)	Yes	Chief Operating Officer	Ruth Haigh & Kez Hayat	x					x						x
GMC Survey Feedback	Yes	Chief Medical Officer	Faye Alexander							x					
Guardian of Safe Working Hours Quarterly Updates & Annual Report	Yes	Chief Medical Officer	Dr Ajay Sudd	x			AR			Q1		Q2		Q3	
Health & Safety		Director of Estates and Facilities	Caroline Nicholson					x					x		x
Just Culture - reporting TBC															
Maternity Incentive Scheme – Element 4 – Workforce Audit/Obstetric Attendance Audit	Yes	Chief Nurse (Sara Hollins/Nada Sabir)	Nada Sabir	x				x				x			
Medical Appraisal and Revalidation Annual Report	Yes	Chief Medical Officer	Remi Akerele Noorzana Azam	x				x							
Medical Appraisal and Revalidation Annual Statement of Compliance	Yes	Chief Medical Officer	Remi Akerele	x						x					
National Education & Training Survey (NETS) Feedback	Yes	Chief Medical Officer	Faye Alexander			x									
Nursing and Midwifery Staffing Data Publication Report	Yes	Chief Nurse	Laura Loveday			x	x	x	x	x	x	x	x	x	x
Nursing and Midwifery Staffing Establishment Review	Yes	Chief Nurse	Laura Loveday	x					x				x		
People Committee and Education Dashboard		Director of HR	Faeem Lal	x		x	x	x	x	x	x	x	x	x	x
Progression of under represented groups in the workforce		Chief Operating Officer	Kez Hayat						x				x		
Staff Survey and Action plan	Yes	Director of HR	Cat Shutt	x				x		x					x
Violence Prevention and Reduction Standard		Director of Estates and Facilities	William Hall				x			x					x
Volunteering Services Annual Update		Chief Nurse	Clare Bancroft								x		x		
Workforce Performance Metrics (rolling programme: Reduction in Workforce; Sickness; Bank and Agency Staffing) (scheduling tbc)		Director of HR	Faeem Lal / Samia Hussain	x			X B&A	X S	X RW	X B&A	X S	x RW	x B&A	X S	X RW
Workforce Planning Submission		Director of HR	Faeem Lal	x								x		x	
Disciplinary and Grievance Casework		Director of HR	Faeem Lal								x				

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WRES and WDES - Annual Data Update	Yes	Chief Operating Officer	Ruth Haigh & Kez Hayat	x			x								
WRES and WDES - Approval of Action Plans	Yes	Chief Operating Officer	Ruth Haigh & Kez Hayat	x					x						
Governance, Board Assurance Framework (BAF) and Risk															
People Committee Annual Report to Board		Board Secretary	Laura Parsons	x		x									
People Committtee Annual Review of ToRs		Board Secretary	Laura Parsons	x		x									
People Committee Effectiveness Review		Board Secretary	Laura Parsons	x		x									x
People Committee Work Plan - Annual Review		Board Secretary	Laura Parsons	x		x									
Annual Internal Audit Plan		Chair	Laura Parsons											x	
High Level Operational Risks		Director of HR	Faeem Lal	x		x	x	x	x	x	x	x	x	x	x
BAF - strategic risks relevant to the Committee		Board Secretary	Laura Parsons	x			x		x			x	x		
Policies for approval (as required)		Various	Various			x	x	x	x	x	x	x	x	x	x
Items for information only															
Internal Audit Reports relevant to the Committee (for information only unless limited assurance reports)		Director of HR	Faeem Lal			x	x	x	x	x	x	x	x	x	x
People Committee Work Plan		Board Secretary	Laura Parsons				x	x	x	x	x	x	x	x	x
Number of items per month (excluding the items for information)						**12**	**13**	**11**	**13**	**15**	**9**	**12**	**13**	**12**	**12**

Key:

Item reports through to Board of Directors
Planned item deferred to future meeting
Planned item cancelled and not rescheduled (state reason in notes)
Item discussed at the meeting

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Finance and Performance Committee Work Plan 2026-2027

Item	Lead	Report author	Report to Board	2026 Apr	May	Jun	Jul	Sep	Oct	Nov	2027 Jan	Feb	Mar
Finance and Performance													
Winter Review/Plan	COO	Saj Azeb	x					x					
Budget Setting Process and Timetable	CFO	Chris Smith	x							x			
Capital Plan	CFO	Michael Quinlan	x								x		x
Contract Update	CFO	Jacqui Griffin						x					x
Medium Term Plan	CFO/COO	Ben Roberts/Saj Azeb	x			x		x			x		x
Monthly Finance Report (including Closing the Gap, Capital, Treasury Management, Budgetary Management Framework and Place/ICS financial update) (Priority Initiative - Closing the Gap)	CFO	Chris Smith	x	x	x	x	x	x	x	x	x	x	x
Financial Recovery Update	CFO	Chris Danson			x	x	x	x	x	x	x	x	x
Pathology Joint Venture - Financial and Performance Position	CFO	Ben Roberts			x	x				x			
Procurement Update	CFO	Shahid Nazir		x				x					x
Service Development Post Implementation Reviews - TBC	DoS&T	Naveed Saddique			x	x				x			
Operational Improvement Plan (Delivering Operational Excellence) (Priority Initiative - Outpatient Transformation)	COO	Saj Azeb		RTT	C&DP	U&EC	RTT	C&DP	U&EC	RTT	C&DP	U&EC	RTT
EPRR Update and Submission	COO	Steve Amos	x	x				x				x	
National Cost Collection	CFO	Chris Smith				x					x		
Medium and Long Term Financial Strategy	CFO	Ben Roberts				x							
Operational Highlight Report / Performance Report	COO	Carl Stephenson	x	x	x	x	x	x	x	x	x	x	x
Estates and Facilities													
Green Plan (Priority Initiative)	DoEF	David Moss	x			x					x		
Premises Assurance Model (PAM)	DoEF	David Moss	x							x			
Estates Returns Information Collection (ERIC)	DoEF	David Moss	x				x						
Health and Safety Committee Update	DoEF	Caroline Nicholson								x			
Annual Health and Safety Report	DoEF	Caroline Nicholson	x		x								
Annual Fire Safety report	DoEF	Darren Mitchell	x			x							
Annual Security Report	DoEF	William Hall	x					x					
Assurance Map	DoEF	Chris Davies			x		x		x		x		x
Parking	DoEF	David Moss		x									
Accommodation	DoEF	David Moss						x					
Compliance	DoEF	David Moss				x				x			
Water and Ventilation (infection prevention)	DoEF	David Moss		x					x				
Medical Engineering	DoEF	David Moss		x									
Governance, Board Assurance Framework (BAF) and Risk													
Board Assurance Framework - strategic risks relevant to the Academy	CN	Laura Parsons	x		x		x			x	x		
Finance, Performance and Estates & Facilities Dashboards	CFO/COO/ DoEF	Vikki Lewis / David Moss	x	x	x	x	x	x	x	x	x	x	x
Annual Internal Audit Plan	Chair	Alastair Cockroft										x	
Committee Annual Report	Board Secretary	Laura Parsons	x	x									
Committee Terms of Reference and Committee Workplan Review	Board Secretary	Laura Parsons	x	x									
Committee Effectiveness Review	Chair	Laura Parsons	x	x	x								x
High Level Risks	CFO/COO	Laura Parsons	x	x		x	x	x	x	x	x	x	x
Nursing & Midwifery Staffing establishment review	CN	Karen Dawber	x				x				x		
Policy approvals - as required													
Items for Information													
Cancer Board minutes	COO	Saj Azeb		x	x	x	x	x	x	x	x	x	x
Internal Audit Reports relevant to the Academy (except limited assurance reports which go on main agenda)	Chair	Laura Parsons		x	x	x	x	x	x	x	x	x	x
Finance and Performance Committee Work Plan	Board Secretary	Laura Parsons			x	x	x	x	x	x	x	x	x
Number of items per month (excluding the items for information)				15	14	17	13	16	11	16	16	11	15

Key:

- Item reports through to Board of Directors
- Planned item deferred to future meeting
- Planned item cancelled and not rescheduled (state reason in notes)
- Item discussed at the meeting

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Quality Committee Work Plan

Item	Regulatory requirement	Lead	Report Author	Report to Board	Notes	2026 Apr	2026 May	2026 Jun	2026 July	2026 Sep	2026 Oct	2026 Nov	2027 Jan	2027 Feb	2027 Mar
Insights Report (including Learning from Deaths and Mortality Review Improvement Programme)		CN	Nick Rushton		Quarterly (Q4 is AR)		**Q4(AR)**			**Q1**		**Q2**		**Q3**	
Infection Prevention and Control	Yes	CN	Muhammad Yaseen	**X**	Quarterly		**Q4**			**Q1**		**Q2**		**Q3**	
Equality Delivery System 2 (domain 1)	Yes	COO	Kez Hayat / Ruth Haigh		Annual	**X**								**X**	
Maternity and Neonatal Services (inc. Maternity Incentive Scheme)	Yes (elements)	CN	Sara Hollins	**X**	Monthly	**X**	**X (inc MIS)**	**X**	**X**	**X**	**X**	**X (inc MIS)**	**X**	**X**	**X**
Quality Committee Dashboard	Yes (elements)	CN/CMO	Nicholas Rushton	**X**	Monthly	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Quality Oversight & Assurance Profile and Patient Safety Incident Investigation (PSII) report	Yes (elements)	CN	Byron Johnson		Alternate meetings		**X**		**X**	**X**		**X**	**X**		**X**
Quality Account improvement priorities update (Priority Initiative - Martha's Rule)		CMO/CN	Byron Johnson		Quarterly	**Q4**			**Q1**		**Q2**		**Q3**		
Clinical Outcomes Group highlight report (AAA)		CMO	Nick Rushton / Padma Munjulurui		Alternate meetings	**X**	**X**		**X**	**X**		**X**	**X**		**X**
Patient Experience Group highlight report (AAA)		CN	Ruth Tolley		Alternate meetings		**X**		**X**	**X**		**X**	**X**		**X**
Patient Safety Group highlight repoort (AAA)		CMO	Louise Horsley		Alternate meetings		**X**		**X**	**X**		**X**	**X**		**X**
Quality Account Production Schedule		CMO/CN	Jacqui Maurice		Annual									**X**	
Annual Quality Account	Yes	CMO/CN	Jacqui Maurice	**X**	Annual (draft May, final June)		**X**	**X**							
Safeguarding Adults bi-annual report	Yes	CN	Sarah Turner	**X**	AR June - update in Dec			**AR**					**X**		
Safeguarding Children bi-annual report	Yes	CN	Liz Ward	**X**	AR June - update Dec			**AR**					**X**		
Palliative Care Annual Report		CN	Victoria Ali		Annual				**x (25/26)**						
Patient Experience (AR and 6 mthly update)		CN	Ruth Tolley		Bi-annual		**AR**					**X**			
Inpatient Survey	Yes	CN	Karen Bentley		Annual					**X**					
Health Equity and Inequalities bi-annual report (Priority Initiative)		Dir S&T	Naveed Saddique / Alison Smith / Kez Hayat		Bi annual					**X**					**X**
Nursing and Midwifery Strategy update (to include the Bradford Nursing and Midwifery Professional practice model)		CN	Amy Hunter		Bi annual				**X**					**X**	
Clinical Audit Annual Report		CMO	Nick Rushton / Padma Munjulurui		Annual		**AR**								
Clinical Audit High Priority Plan	Yes	CMO	Nick Rushton		Annual		**X**								
Compliance with National Food standards	Yes	CN	Jane Kingsley		Annual						**X**				

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Ward Accreditation		CN	Laura Loveday		Annual	X									
Digital Report (including Digital Strategy) (Priority Initiative)		CDIO	Vikki Lewis		Bi annual reporting	X					X				
Senior Information Risk Officer (SIRO) Report	Yes	CDIO	Jenny Pope	X	Bi annual			X				X			
Data Protection Officer Annual Report	Yes	CDIO	Jenny Pope	X	Annual					X					
Data Security and Protection Toolkit	Yes	CDIO	Jenny Pope	X	Annual		X								
Digital Strategy Group report		CDIO	Rachel Pyrah		Bi annual					X					X
Improvement Strategy bi-annual report		Dir of S&T	Liz Tomlin		Bi annual		X								
Impact assessment (quality and equality) of Trust developments and cost improvement schemes evaluated as high risk (as and when required)		CMO/CN													
Internal Audit Annual Plan		Board Secretary	Laura Parsons		Annual									X	
EXCEL Programme (Priority Initiative)		COO	Vaqass Akhtar / Sam Khan		Quarterly	X			X		X		X		
Antimicrobial Resistance (AMR)		CMO	TBC	X	Annual		X								
First 72 Hours Standards - dates TBC		CMO	TBC	X	Bi-annual										
Research Activity in the Trust		CMO	John Wright / Tracy Watson	X	Bi annual					X					X
Governance and Risk															
Quality Committee Terms of Reference		COO	Laura Parsons	X	Annual	X									
Quality Committee Effectiveness Review		COO	Laura Parsons	X	Annual	X									X
Quality Committee Annual Report		COO	Laura Parsons	X	Annual	X									
Quality Committee Work Plan		Board Secretary	Laura Parsons		Monthly		X	X	X	X	X	X	X	X	X
BAF (Strategic Risks relevant to the Committee)		COO	Laura Parsons	X	Quarterly		Q4		Q1			Q2	Q3		
High Level Risks		CN/CMO	Laura Parsons	X	Monthly	X	X	X	X	X	X	X	X	X	X
Policies for approval (as required)		Various	Various		As required										
Items for information															
Bradford District & Craven Quality Committee (highlight report/minutes)		CN/CMO	Karen Dawber		Alternate meetings		X		X	X		X	X		X
West Yorkshire Health & Care Partnership System Quality group minutes		CN	Karen Dawber		Monthly	X	X	X	X	X	X	X	X	X	X
Number of items per month (excluding the items for information)						13	20	10	13	17	9	15	15	11	14

Key:

Item reports through to Board of Directors
Planned item deferred to future meeting
Planned item cancelled and not rescheduled (state reason in notes)
Item discussed at the meeting

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CHARITABLE FUNDS COMMITTEE WORK PLAN 2026-27

Item	Lead	Reporting through to Board	May 26	Aug 26	Nov 26	Feb 27	Notes
GOVERNANCE							
CFC Terms of Reference	Board Secretary		x		x		
CFC Committee Annual Report	Board Secretary		x				
CFC Committee Effectiveness Review	Board Secretary		x				
Bradford Hospitals' Charity Treasury Management & Investment Policy	Deputy Director of Finance			x			
Bradford Hospitals' Charity Policy	Deputy Director of Finance				x		
Bradford Hospitals' Charity Expenditure Policy	Deputy Director of Finance				x		
Bradford Hospitals' Charity Reserves Policy	Deputy Director of Finance			x			
CFC Work Plan	Board Secretary		x	x	x	x	
External Reports/Regulatory Matters (only when arises)	Deputy Director of Finance / Board Secretary		x	x	x	x	
Charity Independence	Director of Strategy and Transformation		x	x	x	x	
Internal audit reports relevant to the Committee (when arises)	Director of Strategy and Transformation / Chief Finance Officer		x	x	x	x	
One Year Operational Plan (annual)	Charity Director		x				
Fundraising Policy	Charity Director						Reporting date / frequency tbc
Lottery Policy	Charity Director			x			
Charity Risk Register	Charity Director			x			
Deep Dive: Charity Independence (August 26)	Charity Director			x			30 minute slot to be allocated on agenda
Deep Dive: Home From Home (November 26)	Charity Director				x		30 minute slot to be allocated on agenda
Deep Dive: Corporate Relationships (February 27)	Charity Director					x	30 minute slot to be allocated on agenda
FINANCE							
Finance Report	Deputy Director of Finance		x	x	x	x	
Investment Report (bi-annual)	Deputy Director of Finance				x		Biannual - Nov 26 and May 27
Annual Report & Accounts	Deputy Director of Finance			x			To be agreed via e-mail if not presented at Aug or Nov meeting
Five Year Plan	Deputy Director of Finance		x				
Delivery of Five Year Plan (quarterly)	Deputy Director of Finance			x	x	x	Following consideration of five year plan - this item to be scheduled on agenda - first report in August 26
Approval of Expenditure Requests (only when arises)	Deputy Director of Finance		x	x	x	x	
FUNDRAISING							
Fundraising, Communications and Marketing Strategy	Charity Director			x			First report in August after it has been through the Charity Operational Group.

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CHARITABLE FUNDS COMMITTEE WORK PLAN 2026-27							
Item	**Lead**	**Reporting through to Board**	**May 26**	**Aug 26**	**Nov 26**	**Feb 27**	**Notes**
OPERATIONAL COMMITTEE							
Charity Operational Committee Report	Director of Strategy and Transformation		x	x	x	x	

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Audit Committee work plan 2026/27

Source	Assurance / Approval / Information	Lead	Reports through to Board	12/5/26	18/06/26 accounts sign off	08/09/26	27/11/26	09/02/27
GOVERNANCE				May	June	September	November	February
Annual Governance Statement	For approval	Chief Executive		**X (Draft)**	**X(Approve)**			
Trust's Annual Self - Certification as to the compliance with the conditions of the NHS Provider Licence, guidance on Good Governance and Collaboration and Code of Governance for NHS Provider Trusts	For assurance	Board Secretary		**X**				
Compliance with Fit and Proper Person Framework requirements	For assurance	Board Secretary				**X**		
Assurance regarding compliance with Risk Management Strategy	For assurance	Board Secretary / Associate Director of Quality				**X**		**X**
Partnership Arrangements: Implications for the Audit Committee	For information	Board Secretary		**X**		**X**	**X**	**X**
Annual report - Conflict of interest (declare)	For assurance	Board Secrretary				**X**		
Review of External Regulatory Visits register	For assurance	Board Secretary / Associate Director of Quality		**X**		**X**	**X**	**X**
Monitoring compliance with regard to the 'Policy for the Development and Management of Trust Policies' and, compliance with Trust Policies	For assurance	Board Secretary					**X**	
INTERNAL AUDIT				May	June	September	November	February
Annual Internal Audit Performance Review	For assurance	Chief Finance Officer / Internal Audit / Audit Committee				**X**		
Annual Internal Audit Plan (including IA Charter)	For approval	Internal Audit						**X**
Internal Audit Progress Reports	For assurance	Internal Audit		**X**		**X**	**X**	**X**
Internal Audit Recommendations report	For assurance	Internal Audit		**X**		**X**	**X**	**X**
Annual Head of Internal Audit Opinion and Internal Audit Annual Report	For assurance	Internal Audit		**X**	**X**			
EXTERNAL AUDIT				May	June	September	November	February
Annual External Audit performance review	For assurance	Chief Finance Officer/Audit Committee/External Audit				**X**		
External Audit Annual Plan	For approval	External Auditor						**X**
External Audit Sector Development Report	For information	External Auditor		**X**		**X**	**X**	**X**
Annual External Auditor Report	For assurance	External Auditor			**X**			
ISA 260 – Foundation Trust	For assurance	External Auditor			**X**			

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Annual statement to council of governors regarding external audit	For approval	Chair of Audit Committee				X		
Annual policy review - use of external audit for non audit purposes	For approval	Chief Finance Officer / External Auditor					x	
Private meeting(s) with External Audit - In respect of Annual Accounts	For assurance	External Auditor / Audit Committee		X				
OTHER BOARD COMMITTEES				**May**	**June**	**September**	**November**	**February**
Annual Reports from Committees: Charitable Funds / People Committee / F&P / Quality	For assurance	Board Secretary		X				
COUNTER FRAUD				**May**	**June**	**September**	**November**	**February**
Policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA	For assurance	Local Counter Fraud Service		X				
Counter Fraud Annual Plan	For approval	Local Counter Fraud Service		X				
Counter Fraud Self Review Tool	For assurance	Local Counter Fraud Service		X				
Counter Fraud Updates (progress report)	For assurance	Local Counter Fraud Service		X		X	X	X
Counter Fraud Annual Report	For assurance	Local Counter Fraud Service		X				
FINANCIAL REPORTING AND CONTROL				**May**	**June**	**September**	**November**	**February**
Annual Report and Financial Statements	For assurance	Chief Finance Officer / External Auditor		X	X			
Final annual accounts	For approval	Chief Finance Officer			X			
Draft letter of representation	For approval	Chief Finance Officer			X			
Reservation of Powers to the Board and Scheme of Delegation Policy review	For approval	Chief Finance Officer					X	
Exception reports - Schedules of losses and special payments	For assurance	Chief Finance Officer		X		X	X	X
Appropriateness of single source tenders	For assurance	Strategic Head of Procurement		X		X	X	X
Charity accounts Audit	For apprpoval	Chief Finance Officer		X		X		
Charitable Funds Annual Report and Accounts	For assurance	Chief Finance Officer				X		
REPORTING				**May**	**June**	**September**	**November**	**February**
Audit Committee Annual Report to Board	For approval	Chair of Audit Committee		X				
MONITORING AND REVIEW				**May**	**June**	**September**	**November**	**February**
Annual Audit Committee Annual Self-Assessment	For assurance	Chair of Audit Committee		X				

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Annual review of terms of reference and submission to Board	For assurance	Chair of Audit Committee		X				
Audit Committee Work Plan	For approval	Chair of Audit Committee		X		X	X	X

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BOARD WORK PLAN 2026/27

Item	Lead	31 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	
Green Plan	Director of Estates & Facilities			x			x		
Communications - Annual Update	Chief Executive	x						x	
Digital Strategy	CDIO				x			x	
Improvement Strategy	Director of Strategy & Transformation	x			x			x	
Patient Experience & Engagement Strategy	Chief Nurse			x			x		
EDI Strategy	Chief Operating Officer		x			x			
People Strategy	Director of HR								Date TBC
Strategy - Emerging Issues	All	x	x	x	x	x	x	x	
QUALITY		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						Only when there is relevant information to report
Infection Prevention & Control Q4 Report (Annual Report)	Chief Nurse		x						
Maternity and Neonatal Services Update	Chief Nurse	x	x	x	x	x	x	x	
Maternity Incentive Scheme	Chief Nurse						x		Every January
Inpatient Survey	Chief Nurse					x			
Adults & Children Safeguarding Annual Reports (to include Mental Health Strategy)	Chief Nurse			x					
Antimicrobial Resistance (AMR)	Chief Medical Officer		x						
First 72 Hours Standards	Chief Medical Officer		x						
Research Activity in the Trust	Chief Medical Officer	x			x*			x	*Presentation from Research Team
PEOPLE		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						Presentation
Equality & Diversity Council (quarterly reporting - update)	Chief Executive	x	x		x	x		x	
Staff Survey Results	Director of HR			x					
Freedom to Speak Up	Chief Nurse		x			x			
Nursing & Midwifery Staffing Establishment Review	Chief Nurse			x			x		
Guardian of Safe Working Hours annual report	Chief Medical Officer		x						
Medical Appraisal & Revalidation Annual Report & Statement of Compliance	Chief Medical Officer				x				
Gender Pay Gap Report	Chief Operating Officer	x						x	
Education Annual Report	Chief Medical Officer		x						
Education Self Assessment Report (SAR)	Chief Medical Officer				x				
FINANCE & PERFORMANCE		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	
Performance Report	Chief Operating Officer	x	x	x	x	x	x	x	
Integrated Dashboard	All	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

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BOARD WORK PLAN 2026/27

Item	Lead	31 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 Nov 26	28 Jan 27	30 Mar 27	Notes
Capital Programme	Chief Finance Officer	x						x	
Budget setting process & timetable	Chief Finance Officer					x			
Winter Plan	Chief Operating Officer					x			
Charity ISA 260, Draft Annual Report & Accounts and draft Letter of Representation	Chief Finance Officer						x		
PARTNERSHIPS		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	
Partnerships - strategic view	Director of Strategy & Transformation	x		x		x		x	
GOVERNANCE / ASSURANCE		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		
High Level Risk Register	Chief Nurse	x	x	x	x	x	x	x	
Review of Standing Orders/SFIs/Scheme of Delegation	Chief Finance Officer					x			
Constitution review	Chief Operating Officer		x	x					
Self Certification of Provider Licence	Chief Operating Officer		x						
NED Independence Test	Chief Operating Officer		x						
Compliance with NHS Code of Governance	Chief Operating Officer		x						
Well Led Review & Board Self Assessment	Chief Operating Officer								Date TBC
Annual Report from Committees	Committee Chairs		x						
Risk Appetite Review	Chief Nurse		x						
Annual Fire Safety Report	Director of Estates & Facilities			x					
Annual Health & Safety Report	Director of Estates & Facilities		x						
Premises Assurance Model Progress Report	Director of Estates & Facilities					x			
Annual Security Report	Director of Estates & Facilities				x				
Violence Prevention & Reduction Standard	Director of Estates & Facilities		x		x				Sept - part of Annual Security Report
Data Security & Protection Toolkit	CDIO		x						
DPO Annual Report	DPO				x				
SIRO Report	CDIO			x		x			
Emergency Preparedness, Resilience & Response & NHSE Core Standards	Chief Operating Officer				x				
Use of the Trust Seal	Chief Operating Officer				x				
NED Champion Roles - annual review	Chair			x					
Fit and Proper Person Test - annual review	Chair		x	x					
Modern Slavery Statement	Chief Operating Officer					x			
COG Engagement Policy	Chief Operating Officer			x					
SID Role & Appointment Process	Chair								Due for review Nov 2027
STANDING ITEMS		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	
Getting to know the CSUs	Chief Operating Officer/Chief Medical Officer/Chief Nurse		x		x		x		
Chair's Report	Chair	x	x	x	x	x	x	x	
Chief Executive's Report	Chief Executive	x	x	x	x	x	x	x	
Chair's report from Committees	Committee Chairs	x	x	x	x	x	x	x	

Key:

Planned item

Planned item deferred to future meeting

BOARD WORK PLAN 2026/27									
Item	Lead	31 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 Nov 26	28 Jan 27	30 Mar 27	Notes
Planned item cancelled and not re-planned in / state reason in notes									
Item discussed at the meeting									

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