NHS
Bradford Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC
AGENDA

Date:	23 July 2026	**Time:**	09:30 – 12:05
Venue:	Conference Room, Field House, BRI	**Chair:**	Bryan Machin, Non Executive Director

- 9:50 – 10:05 – Julie Pearce, Ward Manager Neonatal Services for Bo.7.26.7 -Patient Story
- 10:15 – 10:35 - Sara Hollins, Director of Midwifery for Bo.7.26.9 - Maternity and Neonatal Services update
- 10:35 – 10:55 – Sara Hollins, Director of Midwifery and Carly Stott, Head of Midwifery for Bo.7.26.11b – Bi-annual perinatal workforce report

Observers:
- Shak Rafiq, Strategic Communications & Engagement Lead
- Andy Waller and John Waterhouse, Governors
- Thomas Foulcher, Anaesthetist

No.	Agenda Item	Lead	Outcome	Papers attached
09:30 Section 1: Opening matters				
Bo.7.26.1	Apologies for absence • Karen Walker, Acting Chair • Vikki Lewis, Chief Digital & Information Officer • David Moss, Director of Estates & Facilities	Chair	For information	Verbal
Bo.7.26.2	• Declarations of interest • Board Code of Conduct	Chair	For information	Bo.7.26.2
Bo.7.26.3	Minutes of the meeting held on 21 May 2025	Chair	For approval	Bo.7.26.3
Bo.7.26.4	Matters arising	Chair	For information	Verbal
09:35 Section 2: Business Reports				
Bo.7.26.5	Report from the Chair	Chair	For assurance	Bo.7.26.5
Bo.7.26.6	Report from the Chief Executive	Chief Executive	For assurance	Bo.7.26.6
09:50 Section 3: Patient Care				
Bo.7.26.7	Patient Story	Chief Nurse	For assurance	Bo.7.26.7
Bo.7.26.8	Report from the Chair of the Quality Committee a. June & July 2026 *Reports from the Quality Committee for noting by the Board:* b. Adults & Children Safeguarding Annual Reports c. Improvement Strategy update d. Patient Experience & Engagement Strategy update e. SIRO Report	Chair of the Quality Committee	For assurance	Bo.7.26.8a Bo.7.26.8b Bo.7.26.8c Bo.7.26.8d Bo.7.26.8e
Bo.7.26.9	Maternity and neonatal services update • Independent Investigation into Maternity and Neonatal Services in England	Chief Nurse	For assurance	Bo.7.26.9

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10:35 Section 4: People				
Bo.7.26.10	Report from the Chair of the People Committee: a. June & July 2026 *Reports from the People Committee for noting by the Board:* b. Staff survey results and action plan c. Resident Doctor 10 Point Plan – Board Assurance Framework	Chair of the People Committee	For assurance	Bo.7.26.10a Bo.7.26.10b Bo.7.26.10c
Bo.7.26.11	a. Nursing & Midwifery Staffing Establishment Review b. Bi-annual Perinatal Workforce Report – June 2026	Chief Nurse	For approval For assurance	Bo.7.26.11a Bo.7.26.11b

BREAK 10:55 –11:10

11:10 5 Section 5: Finance and Performance				
Bo.7.26.12	Report from the Chair of the Finance & Performance Committee a. June & July 2026 *Reports from the Finance & Performance Committee for noting by the Board:* b. Integrated Dashboard c. Finance Report d. Performance Report e. Annual Health & Safety Report f. Annual Fire Safety Report g. Anchor Institution h. Green Plan 2025-2028	Chair of the Finance and Performance Committee	For assurance	Bo.7.26.12a Bo.7.26.12b Bo.7.26.12c Bo.7.26.12d Bo.7.26.12e Bo.7.26.12f Bo.7.26.12g Bo.7.26.12h

11:25 Section 6: Strategy & Partnerships				
Bo.7.26.13 Bo.7.26.13a	Partnerships – strategic view a. Strategic Partnering Agreement	All Director of Strategy & Transformation	For information For approval	Bo.7.26.13 Bo.7.26.13a
Bo.7.26.14	Trust Stategic Framework 2026/27 update	Director of Strategy & Transformation	For approval	Bo.7.26.14

11:40 Section 7: Audit & Assurance				
Bo.7.26.15	Report from the Chair of the Audit Committee – 17 June 2026	Chair of the Audit Committee	For assurance	Bo.7.26.15

11:45 Section 8: Governance				
Bo.7.26.16	Board Assurance Framework and high-level risks	Chief Nurse	For assurance	Bo.7.26.16
Bo.7.26.17	NED Champion Roles annual review	Associate Director of Corporate Governance/Board Secretary	For approval	Bo.7.26.17
Bo.7.26.18	Fit and Proper Person Test annual review	Associate Director of Corporate Governance/Board Secretary	For assurance	Bo.7.26.18

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12:00 Section 9: Board Meeting Outcomes				
Bo.7.26.19	Any other business	Chair	For information	Verbal
Bo.7.26.20	Issues to refer to Committees or elsewhere	Chair	For approval	Verbal
Bo.7.26.21	Review of meeting	Chair	For information	Verbal
Bo.7.26.22	Date and time of next meeting: • 24 September 2026 – 9.30-12.30	Chair	For information	Verbal

Annexes for the meeting of the Board of Directors 23 July 2026

Annex 1: For Information				
Bo.7.26.23	Board of Directors work plan	Associate Director of Corporate Governance/Board Secretary	For information	Bo.7.26.23

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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	2020/21,2021/22,2022/23,2023/24	Outside Employment		industrial member	GS1	0
Altaf Sadique	Non-Executive Director	01.06.2021	2021/22,2022/23,2023/24	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 N(	Ibox Healthcare (part of IHG Group ltd)	0
Altaf Sadique	Non-Executive Director	08.12.2021	2021/22,2022/23,2023/24	Loyalty Interests		Full member 6G health institute (EU)_	6G Health for Institute (EU)	0
Altaf Sadique	Non-Executive Director	01.09.2022	2022/23,2023/24	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
Altaf Sadique	Non-Executive Director	04.01.2026	2025/26	Outside Employment		AI Start up for developing tooling for legal professional to make debt recovery more productive.	Debt Flow Automation Ltd	0
Altaf Sadique	Non-Executive Director	01.04.2026	2026/27	Outside Employment		Ibox have been appointed to the NHS NHP program recently, as Director of Ibox healthacare and NED at BTHFT could be conflicted in relation to Airedale new build.	Ibox Healthcare participatent in the NHS New Hospital Progra	0
Benjamin Roberts	Chief Finance Officer	01.09.2006	2015/16 & before,2016/17,2017/18,2018/19, 2019/20,2020/21,2021/22,2022/23, 2023/24,2024/25,2025/26	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 & before,2016/17,2017/18,2018/19, 2019/20,2020/21,2021/22,2022/23, 2023/24,2024/25,2025/26	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	2020/21,2021/22,2022/23,2023/24, 2024/25,2025/26	Outside Employment	31.05.2026	Trustee (Vice chair)	St Annes Community Services	0
Bryan Machin	Non-Executive Director	01.09.2020	2024/25,2025/26	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	2022/23,2023/24,2024/25,2025/26	Loyalty Interests		Chair of Northern and Yorkshire HEFMA	HEFMA	0
David Moss	Director of Estates	01.12.2022	2022/23,2023/24,2024/25,2025/26	Loyalty Interests		National Chair of HEFMA	HEFMA	0
David Moss	Director of Estates	14.10.2025	2025/26	Hospitality		Ticket to the Charity Ball and accommodation (accepted accommodation as on call the day after and I live 90 minutes away from the venue)	Robertson	160
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	2016/17,2017/18,2018/19,2019/20, 2020/21,2021/22,2022/23,2023/24, 2024/25,2025/26	Outside Employment		Director of family owned company.	Vikmara Property Development Company	0
Helen Lewis	Chief Digital & Information Officer	02.01.2018	2017/18,2018/19,2019/20,2020/21, 2021/22,2022/23,2023/24,2024/25, 2025/26	Loyalty Interests		Son is a robotics engineer for Medtronic UK.	Medtronic UK	0
John Bolton	Medical Director	18.04.2019	2019/20,2020/21,2021/22,2022/23, 2023/24,2024/25,2025/26,2026/27	Loyalty Interests		I hold a commission in the British Army.	British Army	0
John Bolton	Medical Director	13.11.2023	2022/23,2023/24,2024/25,2025/26,2026/27	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	2026/27	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
Justine Andrew	**Non-Executive Director**	**10.07.2026**	**2026/27**	**Outside Employment**		**From 1st August I will be chair of YSJ University. The role is approximately 4 days/month and is remunerated.**	**York St John University**	**0**
Karen Dawber	Chief Nurse	01.09.2022	2022/23	Loyalty Interests		Honorary Professor	University of Bradford	0
Karen Dawber	Chief Nurse	12.11.2022	2022/23	Loyalty Interests		Member of Professional Body, was previously the RCN but changed to MIP	Member of MIP - trade union / professional body	0
Karen Dawber	Chief Nurse	01.11.2021	2021/22	Loyalty Interests		Ellie is my daughter and a volunteer in the Trust	Ellie Dawber	0
Karen Dawber	Chief Nurse	14.03.2024	2023/24	Loyalty Interests		Mind in Bradford is a local mental health charity that provides free mental health support to everyone living in Bradford District and Craven. Trustee post.	MIND in Bradford	0
Karen Walker	Non-Executive Director	01.07.2022	2022/23	Outside Employment		Chair of WYCA Patient Experience and Strategy Group (voluntary NED role)	West Yorkshire Cancer Alliance	0
Karen Walker	**Non-Executive Director**	**24.09.2025**	**2025/26**	**Outside Employment**		**Independent Parliamentary Standards Authority**	**Chief Executive Officer**	**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	2020/21,2021/22,2022/23,2023/24, 2024/25,2025/26,2026/27	Loyalty Interests		Mel is Honorary Professor at the University of Bradford.	University of Bradford	0
Melany Pickup	Chief Executive	18.12.2023	2020/21,2021/22,2022/23,2023/24, 2024/25,2025/26,2026/27	Loyalty Interests		Trustee	Bradford City of Culture 2025	0
Sajid Azeb	Chief Operating Officer	12.10.2020	2020/21,2021/22,2022/23,2023/24, 2024/25,2025/26	Loyalty Interests		Wife own optometry business which hold NHS England Contract	Optometry Business	0
Sajid Azeb	Chief Operating Officer	12.10.2020	2020/21,2021/22,2022/23,2023/24, 2024/25,2025/26	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	2020/21,2021/22,2022/23,2023/24, 2024/25,2025/26	Outside Employment		Family Property businesses	Directorship at Greenroyd Ltd and Skircoat Development Ltd	0
Sajid Azeb	Chief Operating Officer	12.10.2020	2024/25,2025/26	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
Sajid Azeb	**Chief Operating Officer**	**09.06.2026**	**2026/27**	**Hospitality**		**Gatenby Sanderson Round table discussion for aspiring CEOs over dinner in Manchester prior to Expo.**	**Gatenby Sanderson**	**50**
Timothy Swift	**Non-Executive Director**	**01.05.2003**	**2015/16 & before,2016/17,2017/18,2018/19, 2019/20,2020/21,2021/22,2022/23, 2023/24,2024/25,2025/26**	**Outside Employment**	**07.05.2026**	**Elected councillor**	**Calderdale MBC**	**0**
Timothy Swift	**Non-Executive Director**	**01.04.2017**	**2017/18,2018/19,2019/20,2020/21, 2021/22,2022/23,2023/24,2024/25, 2025/26**	**Outside Employment**	**07.05.2026**	**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	2016/17,2017/18,2018/19,2019/20, 2020/21,2021/22,2022/23,2023/24, 2024/25,2025/26	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 Authori	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:	Thursday 21 May 2026	**Time:**	09:30 – 13:00
Venue:	Conference Room, Field House, BRI	**Chair:**	Karen Walker, Acting Chair
Present:	**Non-Executive Directors:** - Karen Walker (KW) - Bryan Machin (BM) - Altaf Sadique (AS) (for items Bo.5.26.1 – Bo.5.26.16) - Tim Swift (TS) - Justine Andrew (JA) - Zafir Ali (ZA) **Executive Directors:** - Professor Mel Pickup, Chief Executive (MP) - Sajid Azeb, Chief Operating Officer / Deputy Chief Executive (SA) - Dr John Bolton, Chief Medical Officer (JB) - Professor Karen Dawber, Chief Nurse (KD) - Mark Hindmarsh, Director of Strategy and Transformation (MHi) - Ben Roberts, Chief Finance Officer (BR)		
In Attendance:	- Faeem Lal, Director of HR (FL) - Vikki Lewis, Chief Digital, and Information Officer (VL) - David Moss, Director of Estates and Facilities (DM) - Laura Parsons, Associate Director of Corporate Governance / Board Secretary (LP) - Debbie Earnshaw, Corporate Governance Manager (DE) - Graham Prestwich, Chair – Integrated Oversight Group (GP) *for item Bo.5.26.5 only* - Karen Conway, Investigation Team – Integrated Oversight Group (KC) *for item Bo.5.26.5 only, via MS Teams* - Lauren Banner, Investigation Team – Integrated Oversight Group (LB) *for item Bo.5.26.5 only, via MS Teams* - Yaseen Muhammad, Director of Infection, Prevention and Control (YM) *for items Bo.5.26.8 and Bo.5.26.9 only* - Alison Haigh, Lead Pharmacist Antimicrobial Therapy (AH) *for item Bo.5.26.9 only* - Sara Hollins, Director of Midwifery (SH) *for item Bo.5.26.13 only* - Kez Hayat, Head of Equality, Diversity & Inclusion (KH) *for item Bo.5.26.16 only* - Tabitha Lawreniuk, Personal Business Manager as Secretariat		
Observing:	- John Waterhouse, Public Governor - Emma Fleary, Staff Governor - Mark Silver, Internal Communications Officer		

No.	Agenda Item	Action
Section 1: Opening Matters		
Bo.5.26.1	**Apologies for Absence** There were no apologies for absence.	

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No.	Agenda Item	Action
Bo.5.26.2	**Declarations of Interest** No declarations were raised in relation to the items on the agenda. **Code of Conduct** The code of conduct was noted by the Board.	
Bo.5.26.3	**Minutes of the Meeting held on 31 March 2026** The minutes of the meeting held on 31 March 2026 were approved as a true and accurate record.	
Bo.5.26.4	**Matters Arising** The following actions were reviewed, outcomes noted and confirmed as closed: - Bo250014 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. Included in the report. Action closed. - Bo26002 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. Work plan updated. Action closed.	
Section 2: Business Reports		
Bo.5.26.5	**Independent Oversight Group (IOG) Update** GP joined the meeting to present an update from the Independent Oversight Group. LB and KC also joined to observe this item. The presentation provided high-level contextual background to the events and allegations that led to the establishment of the IOG and the Race Inequality and Victimisation (RIV) investigation report. GP acknowledged the progress made by the Board in responding to the report recommendations, including notable improvements in Board effectiveness. Significant progress in equality, diversity and inclusion across the Trust was also recognised. It was noted that Board development requires continual improvement and the Board was committed to this. In summary, GP advised that the Trust had gone beyond the requirements associated with the RIV report recommendations and had demonstrated the value of effective and compassionate communication. This enabled the IOG to complete its work. GP thanked the Trust and the members of the IOG for their efforts through this process. AS reflected that as one of the initial NEDs who had raised concerns around race and inequality, he had found GP's engagement to be helpful. He also acknowledged that the Trust has undertaken significant work to improve since the allegations were first raised, and indeed, had felt sufficiently assured by the Board's actions to enable him to return to Board meetings and being an active NED within the Trust. KW thanked AS for re-engaging with the Board throughout the process. It was noted that the presentation would be shared with Board members following the meeting.	**Bo26004 Associate Director of Corporate Governance**

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	The Board thanked GP for the update and for his support to the Trust during this period.	
Bo.5.26.6	**Report from the Chair** KW gave a brief overview of the Chair's report, highlighting that: - The Employment Tribunal brought by the former Chairman against the Trust had concluded on 5 May 2026 and found in favour of the Trust. Communications had been shared with local MPs and other stakeholders. - The national proposal to remove Councils of Governors by April 2027 had created uncertainty. Further guidance was awaited, but in the meantime business would continue as usual. - Mark Chambers had been reappointed as Lead Governor, Helen Rushworth had joined the Governors Nominations and Remuneration Committee membership, and two new governors had been elected, with their induction due to commence in the following month. - The most recent Strategic Advisory Forum had been successful and had showcased innovation across the Trust. - The schedule for the 15 Steps Challenge had been circulated, and all Board members and governors had been asked to commit to at least one visit during the year. KW also extended thanks to the Yorkshire Sikh Forum for inviting her, MP and KH to attend the Vaisakhi celebration the previous evening. The Board noted the update.	
Bo.5.26.7	**Report from the Chief Executive** MP introduced the report which was largely taken as read, highlighting several key updates since publication: - Since the local elections on 7 May 2026, there had been changes both locally and nationally. Locally, Councillor Place (Reform UK) had been elected as Leader of the Council and the Trust would seek to establish a positive working relationship with him. MP noted that leading a Council without a clear majority would be challenging and this was likely to affect the way in which the Trust engaged with the Council. - Nationally, there was a new Secretary of State (James Murray), replacing Wes Streeting. At the Chief Executive briefing held on the preceding Monday, Jim Mackey had advised that the intention was to continue the trajectory set out in the ten-year plan under the previous Secretary of State, with the same overarching ambitions remaining in place. The report was noted by the Board.	
Section 3: Patient Care		
Bo.5.26.8	**Report from the Chair of the Quality Committee: April and May 2026** TS gave an overview of the report from the Quality Committee meetings held in April and May 2026. The report alerted the Board to several key issues: - Sustained workforce and financial pressures continue to present a risk to maintaining quality and patient safety standards. Particular concern was	

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	highlighted regarding medical staffing gaps in Obstetrics and Gynaecology and ongoing Emergency Department (ED) capacity pressures. - 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. - Maternity Services reported 11 stillbirths year-to-date compared to 15 across the whole of 2025, which triggered a Level 1 Maternity Outcomes Signal System (MOSS) trigger. 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. The Board received the report and noted the 'alert' items and the assurance provided. **Infection Prevention & Control Q4 Report:** The report was received and noted by the Board.	
Bo.5.26.9	**Antimicrobial resistance** YM and AH joined the meeting to present an update on the Trust's response to the recently published national report on antimicrobial resistance, including the Trust's current position against national targets. AH outlined three priorities for the Trust in delivering against those 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. - Reduction in the number of blood stream infections due to Gram negative bacteria. The next steps would be to establish a working group to respond to these priorities, define measurable objectives, and agree reporting mechanisms. The Board recognised the complexity of the challenge, particularly given the strong interdependencies with behaviours in the community. AS referred to cultural practices in which people may bring antibiotics back from abroad for self-administration, noting the difficulty of influencing this. It was suggested that a broader place-based approach may be required, acknowledging the wider system responsibility in responding to this issue. JB confirmed that he would act as Executive lead for this work and looked forward to working with Infection Prevention and Control and Pharmacy colleagues. Progress would be reported through the Quality Committee going forward and the work plan would be updated accordingly. The Board noted the update and thanked AH and YM for their work.	**Bo26005 Associate Director of Corporate Governance**
Bo.5.26.10	**Baseline report - Self-assessment tool for standards for care of acutely unwell patients in their first 72 hours in hospital** JB presented the report which sought 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, including any gaps in provision and associated actions. JB highlighted that there was partial achievement	

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No.	Agenda Item	Action
	against 14 of the 15 standards. He noted that full compliance would require significant further work, with particular focus on data collection, EPR processes, organisational processes including patient flow, and workforce utilisation. MP advised that this had been discussed by the Executive Team at a recent meeting and it had been agreed that delivery would be taken forward through the EXCEL programme, with the Chief Medical Officer acting as Executive lead. The development of tangible metrics would support demonstration of progress through EXCEL and enable clearer focus for the programme. BM queried the threshold for compliance and partial compliance. JB advised that there was no prescribed guidance or timeline and that this was therefore an initial self-assessment to support focus on this patient group. He also noted that there remained uncertainty as to what other trusts would publish, and therefore limited understanding at this stage of what benchmarking information would show. It was agreed that progress would be reported through the Quality Committee on a biannual basis, with an annual report to the Board. The work plans would be updated as appropriate.	**Bo26006 Associate Director of Corporate Governance**
Bo.5.26.11	**CQC well led action plan** KD presented the proposed action plan to address identified areas for improvement as identified within the recent CQC Well-Led Report. It was recognised that the action plan appeared process-focused, however, this reflected the need for the plan to align directly with the CQC report findings. A number of wider initiatives, such as work to reduce sickness absence, were already underway. It was agreed that these would be referenced within the action plan, and links provided where appropriate. The Board approved the associated action plan with the amendment noted above.	**Bo26007 Chief Nurse**
Bo.5.26.12	**CQC statement of purpose** KD presented the paper which sought Board approval of the refreshed CQC Statement of Purpose. The Board approved the refreshed CQC Statement of Purpose.	
Bo.5.26.13	**Maternity and Neonatal services update** SH joined the meeting to present the update, providing assurance that a review of maternity and neonatal quality and safety activity relating to March and April 2026 was presented to the Quality Committee. The following key elements were discussed: - Feedback from the March Local Maternity and Neonatal System (LMNS) Assurance visit was positive. No formal recommendations were made, although a number of 'even better if' suggestions had been identified for consideration. Work was underway with the Maternity and Neonatal Voices Partnership (MNVP) to consider how these could be addressed.	

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No.	Agenda Item	Action
	- A Maternity Outcomes Signal System (MOSS) level 1 trigger was received 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. A critical safety check had been submitted within the required eight-day timeframe, and no further feedback had yet been received. - The team's 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 the intrapartum service, with a plan of action already in place and progressing as planned. The safety issues identified relate to ongoing improvement work around the documentation of SBAR (situation, background, assessment, recommendation) handovers, 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. - On 14 April 2026, the service received a formal escalation letter from the Yorkshire and Humber Maternal Medicine Network (MMN), regarding a low number of referrals from Bradford to the Leeds tertiary centre. Some conditions, although managed appropriately within the Trust, 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. - On 7 May 2026, the service conducted a tabletop, thematic review of the 12 stillbirths occurring between January and April 2026, on the basis that there had been an increase in the number of stillbirths at term, and an overall increase in stillbirths compared to the same period in 2025. The review team concluded that the 50% reduction in stillbirths during 2025 was likely to be an anomaly, and the number of stillbirths 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 was 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 review outcomes would be reported to the Quality Committee in June 2026. KW commented that the stillbirth desktop review had been very well attended and had been both robust and thorough. KD echoed this and noted the reference to the junior workforce which highlighted the importance of the legacy midwife role. MP referred to the establishment of the Place clinical leadership group, describing it as the first such system meeting to bring clinical issues together for a coordinated system response. This could help support communications in relation to reduced foetal movements. She encouraged SH and KD to engage through this forum for support required. The Board: • confirmed that they were assured that Quality Committee had 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;	

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	• noted Appendix 5, the completed MOSS Critical Safety Checklist, and the rating of Green/Amber, with risks being monitored via Women's Core Governance Group; • noted the actions agreed with the Maternal Medicine Network regarding the receipt of information about women who are suitable to be managed at BTHFT; • noted the initial findings and proposed actions following the thematic tabletop review of stillbirths January to April 2026; and • noted that the second Maternity Incentive Scheme, Year 8, Training Compliance Checkpoint is agreed as 1 July 2026.	
Section 4: People		
Bo.5.26.14	**Report from the Chair of the People Academy: April and May 2026** JA gave an overview of the reports from the People Academy meetings held in April and May 2026, confirming that there were no matters to alert to the Board. JA highlighted the comprehensive wellbeing and attendance management plan, which demonstrated a step in change in the approach to sickness management and was welcomed by the Committee. KW noted the need to manage employee expectations appropriately, recognising that this is a busy hospital and that workloads reflect this, particularly in the current financial context. MP also reflected on the potential need to consider alternative and transformational workforce models that may help to alleviate some of these pressures, with the Hospital at Night initiative used as an example. The Board received the report and noted the assurance provided. **Freedom to Speak Up (FTSU) Q4 Report:** JA introduced the report which gave an overview of the work of the FTSU team throughout quarter 4 of 2025/26. The Board recognised the need for effective communications to ensure great feedback is shared which encourages other colleagues to use the service. The FTSU Guardian had also asked that executives promote the service via meetings with individual Clinical Service Units, which was agreed. The Board noted the report and the assurance provided. **Guardian of Safe Working Hours Annual Report:** JB introduced the annual Guardian of Safe Working Hours report, highlighting that exception reports have reduced compared to previous years, and this appears to correlate to a reduction in the number of hours that Resident Doctors are asked to work. The Board noted the report and the assurance provided. **Education Annual Report:** The Board noted the report and the assurance provided. **Violence Prevention & Reduction Standard:** The Board noted the report and the assurance provided.	
Bo.5.26.15	**Equality & Diversity Council quarterly report** MP presented the report which sought to update the Board on the work of the Equality and Diversity Council (EDC) and provide an overview of the key areas of focus since the last update in November 2025. MP noted that the EDC had	

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	been established in January 2021 and had met on a quarterly basis since then. The April 2026 meeting had been the first for which she had submitted apologies due to an Employment Tribunal, and the meeting had therefore been chaired by KD. ZA asked whether the EDC had considered the new makeup of Bradford Metropolitan District Council and the potential impact of this. MP advised that this was a very recent development and the EDC would keep the matter under review. She emphasised the importance of building relationships and maintaining an apolitical stance. The Board noted the update.	
Bo.5.26.16	**Equality, Diversity & Inclusion (EDI) update** KH joined the meeting to provide an update on the work of the EDI team over the previous six months. The presentation included a reminder of the Trust's strategic approach to EDI, together with the key impacts and achievements over that period. It also provided an update on progress in refreshing the EDI strategic objectives, including the planned launch of the 'plan on a page' in August 2026. The next steps for the team included refreshing the EDI strategic objectives by July 2026, adopting the NHS Race and Health Observatory's seven anti-racist principles, addressing bullying, harassment and discrimination in the workplace, and developing targeted EDI action plans for CSUs and departments. MHi referred to the forthcoming health inequalities statement, noting that it would provide a much more comprehensive and expansive account of the organisation's work in the EDI space than in previous years, in line with revised guidance from NHS England. He highlighted, in particular, performance relating to elective surgical waits for patients with learning disabilities. JA and SA recognised the importance of embedding this work within organisational culture. JA welcomed the development of the 'Thrive' Management Essentials course, which would support managers to hold challenging conversations. KD referred to a forthcoming piece of work in which the Trust had been selected as one of 45 places nationally to participate in a clinical leaders excellence programme. This 12-month programme would focus on addressing health inequalities. KD would attend and had convened a group across the Bradford system to consider how this could be developed on a system-wide basis. The Board thanked KH and noted the update provided.	
Section 5: Finance and Performance		
Bo.5.26.17	**Report from the Chair of the Finance and Performance Committee: April and May 2026**	

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	BM gave an overview of the report from the Finance and Performance Committee meeting held in April 2026. He alerted the Board to a number of performance challenges, noting that these would be addressed further under the appended performance report. BM also highlighted the residual risk score of 15 relating to ventilation, noting that this risk could not be materially reduced without significant estate replacement programmes. BM also provided a verbal update from the Committee meeting held on 20 May 2026, during which there was significant discussion regarding financial recovery and recognition that delivery of the closing the gap target would be challenging and might not be achieved in full. He advised that the Board would need to give serious consideration to the compromises required in order to meet expectations and that this would involve difficult decisions. The Board received the report and noted the 'alert items' and the assurance provided. **Integrated Dashboard:** The Board noted that a revised dashboard was in development and welcomed receiving this to future Committee and Board meetings in due course. Due to the linkages between the different areas, JA requested that each of the individual committee dashboards be updated to include the six targets from the five year plan. SA confirmed that this would be the year 1 targets from the three year numerical plan. The Board received the report and noted the assurance provided. **Finance Report:** BR introduced the paper. He acknowledged the £2.9m deficit in month 1 which was in line with plan and included industrial action costs. The year-to-date cash balance stood at £11.2m, which was £5.9m ahead of the planned position of £5.3m, reflecting payment timings. Further cash support would still be required, and a cash application had been submitted to the national team for review. The Board received the report and noted the assurance provided. **Performance Report:** SA introduced the operational highlight report which was largely taken as read. He highlighted strong performance across areas such as the Emergency Care Standard (ECS) and within some elective standards. He also acknowledged areas requiring improvement, including the six-week diagnostic standard (DM01). Additional capacity for Non-Obstetric Ultrasound (NOUS), Audiology and Neurophysiology was in place, but current trajectories suggested recovery would not be achieved without further investment. This would need consideration by the Executive Team. The Board received the report and noted the assurance provided.	**Bo26008 Chief Digital and Information**
Section 6: Strategy & Partnerships		
Bo.5.26.18	**Strategy – emerging issues** MHi referred to the recently published communications around the Health Bill, which was discussed at a recent Executive Meeting including its implications for acute trusts. In particular, he noted the transfer of certain responsibilities to central government rather than NHS England, which would enable the Secretary of State to intervene more directly in trusts. Work remained ongoing in relation to the Place Provider Partnership and the Strategic Partnering Agreement, both of which would be brought to the June Board development session for further consideration.	

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	MHi also reported that a significant amount of partnership working was taking place across the system, with particularly positive discussion at the Executive meeting that week regarding Integrated Neighbourhood Health and the publication of a new national framework setting out a number of key measures and metrics. Changes arising from colleagues leaving the ICB had created some challenges in relation to Integrated Neighbourhood Health leadership, and a working group would therefore be established within the Trust to ensure appropriate coordination of the various engagement opportunities. MHi and DM had also visited Westbourne Green Community Hospital, one of the Trust sites designated nationally as a neighbourhood health centre, to meet with the Chief Executive of Community Health Partnerships and hear about the developments planned for the building. The Board noted the update provided.	
Section 7: Audit and Assurance		
Bo.5.26.19	**Report from the Chair of the Audit Committee – 12 May 2026** ZA presented the report from the Audit Committee meeting held on 12 May 2026, noting that the Committee sought to alert the Board to the 'low assurance' opinion in relation to the Closing the Gap audit. The Committee had received some assurance from the Chief Finance Officer that measures were being put in place to strengthen the Closing the Gap governance structure and increase accountability for delivery. ZA also noted that the volume of overdue audit recommendations continues to reduce due to the direct intervention of the Chief Finance Officer. There were no overdue recommendations which was noted by the Committee as a significant achievement during 2025/26. The Board noted the report and the assurance provided.	
Bo.5.26.20	**Report from the Chair of the Charitable Funds Committee – 5 May 2026** AS presented the report from the Charitable Funds Committee meeting held on 5 May 2026. AS provided feedback from the 'Home from Home' groundbreaking event held on 20 May 2026, describing it as a highly successful occasion attended by more than 200 members of the community and key stakeholders. He acknowledged the passion and commitment shown by both the patrons and the Charity, noting that over £2m had now been raised in donations, with a further £750k still required, which was considered achievable. The Board noted the report and the assurance provided.	
Section 8: Governance		
Bo.5.26.21	**Risk Management Strategy (inc. risk appetite statement)** KD presented the updated Risk Management Strategy and Policy 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. KD confirmed that the updated strategy reflected the comments received during the recent Board Development Session.	

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	KD advised that the revised approach would not change the process for reporting risks and issues, but that a new drop-down option would be incorporated into IRIS to distinguish between a 'risk' and an 'issue', thereby improving clarity and separation. KD also confirmed that further work was required to develop the risk appetite statement due to the evolving financial context, and suggested that it be considered by each committee before being presented to the Board for approval. ZA requested that the Risk Committee Terms of Reference include a review of Committee effectiveness. Further consideration would also be given to the role of a Non-Executive Director in observing the Committee, whether this be via regular or ad-hoc attendance. The Terms of Reference should also be reviewed to ensure its purpose does not overlap that of the Audit Committee. KD agreed to review and update this accordingly. The Board approved the risk management strategy and policy subject to the amendments noted above.	**Bo26009 Chief Nurse**
Bo.5.26.22	**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). The BAF had been reviewed and updated by the Executive leads to reflect the position at the end of Q4 2025/26, and there had been no changes in risk score since the last report. The BAF template for 2026/27 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 and is now formally presented for approval by the Board. The Board: • was assured that the risks on the BAF and High-Level Risk Register were appropriately recognised and recorded, and all appropriate actions were being taken within appropriate timescales where risks were not appropriately controlled; • noted the updated 2026/27 BAF reporting template, as discussed at the Board Development Session held on 29 April 2026; and • approved the Strategic Risks for 2026/27, as presented to the Board Development Session on 29 April 2026.	
Bo.5.26.23	**Cyber Assessment Framework aligned Data Security & Protection Toolkit interim position 2026** VL introduced the paper which provided the Board with the interim position for the 2025/26 cyber assessment framework submission. It sought to provide assurance of the activities that had taken place to date and the steps prior to final submission on 30 June 2026. The Board:	

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	• noted the current position and progress/activities to date and planned; and • delegated final 'sign off' to the Quality Committee on 18 June 2026.	
Bo.5.26.24	**Compliance with the Provider Licence (including statement in response to CoS7), Code of Governance, and NED Independence** LP presented the paper which sought 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. Specific comments against each were noted as below: - Provider Licence: The Trust is reporting compliance with all conditions of the licence other than those in regard to which NHS England reported a suspected breach. - 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 Trust intends to submit on the basis of statement (2). - Code of Governance: 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. - NED Independence: The Chair and Non-Executive Directors were asked to complete an on-line declaration form regarding their independence. All had completed and declared full independence. The Board: • considered and approved 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); • approved the proposed statement in relation to Continuity of Services condition 7; • approved the self-assessment of compliance with the Code of Governance for NHS Provider Trusts; and • confirmed the statement regarding NED independence to be included in the Annual Report 2025/26, as set out in the report.	
Bo.5.26.25	**Committee annual reports, terms of reference and work plans** LP introduced the annual reports for each Committee of the Board, the revised terms of reference (in particular the change from People 'Academy' to People 'Committee') and the revised workplans. The Board: • confirmed it was assured by the annual reports of the Committees and that the Committees had fulfilled their terms of reference; and • approved the revised terms of reference and updated work plans for each Committee.	

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No.	Agenda Item	Action
Section 9: Board Meeting Outcomes		
Bo.5.26.26	**Any Other Business** TS Public Service: KW thanked TS for his 22 years of service to Calderdale Council and the public.	
Bo.5.26.27	**Issues to Refer to Board Committees/Academies or elsewhere** There were no issues to refer elsewhere.	
Bo.5.26.28	**Review of Meeting** There were no comments in relation to review of the meeting.	
Bo.5.26.29	**Date and Time of Next Meeting** 30 July 2026 – 9.30am	

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ACTIONS FROM BOARD OF DIRECTORS OPEN MEETING – 21 MAY 2026

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
Bo250016	Bo.5.25.17	**Strategic Partnering Agreement Refresh 2024/25:** A revised document reflecting the updated changes to be brought back to Board in November 2025.	Director of Strategy and Transformation	July 2026	Included on agenda for approval. Action closed.
Bo26004	Bo.5.26.5	**Independent Oversight Group (IOG) Update:** IOG presentation to be shared with Board members following the meeting.	Associate Director of Corporate Governance	July 2026	Presentation has been circulated. Action closed.
Bo26005	Bo.5.26.9	**Antimicrobial Resistance:** Progress would be reported through the Quality Committee going forward and the work plan updated to reflect.	Associate Director of Corporate Governance	July 2026	Add to Quality Committee work plan. Action closed.
Bo26006	Bo.5.26.10	**Baseline report - Self-assessment tool for standards for care of acutely unwell patients in their first 72 hours in hospital:** Progress would be reported through the Quality Committee on a biannual basis, with an annual report to the Board. The work plans would be updated as appropriate.	Associate Director of Corporate Governance	July 2026	Added to Quality Committee work plan. Action closed.
Bo26007	Bo.5.26.11	**CQC well led action plan:** Initiatives such as the sickness absence management plan to be referenced within the action plan, and links provided where appropriate.	Chief Nurse	July 2026	As part of regular engagement with CQC, the Chief Nurse will update on other relevant initiatives in the Trust, for example wellbeing and attendance management. Action closed.
Bo26008	Bo.5.26.	**Performance report:** First page of each of the individual committee dashboards to be updated to include the six key targets from the three year numerical plan.	Chief Digital & Information Officer	July 2026	Dashboards have been updated to include the targets on the cover page. Action closed.
Bo26009	Bo.5.26.21	**Risk Management Strategy (inc. risk appetite statement):** KD to review and update the Risk	Chief Nurse	July 2026	Terms of reference have been updated. Action closed.

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Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
		Committee terms of reference in response to comments raised around the implementation of a Committee annual review, the attendance of NEDs, and a need to ensure the purpose does not overlap that of the Audit Committee.			
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:	23 July 2026	**Agenda Reference:**	Bo.7.26.5
Report Title:	Report from the Acting Chair		
Presented by:	Bryan Machin, Senior Independent Director		
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 report provided in May 2026. The report covers: 1. July Council of Governors meeting update 2. Changes to our Council of Governors 3. Strategic Advisory Forum: Voluntary Sector and Communities 4. 15 Steps Challenge 5. Feedback to the Council following Board of Directors meetings 6. Key communications			
Recommendation/s: (including any decision/approval required)	The Board of Directors is asked to derive assurance from the report.			
Link to Strategic Objective:	N/A			
Link to Priority Initiatives 2025/26:	N/A			

Implications	
Risk:	N/A
Legal/Regulatory:	N/A
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/A

Assurance Route	
Meeting/s where content has been discussed previously:	N/A

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22/07/2026 09:58:21

Report on behalf of the Acting Chair

1. July Council of Governor meeting

Unfortunately, our Council of Governors meeting scheduled for 1 July was unexpectedly stood down. We are seeking an alternate date in August. Once it has been confirmed the website will be updated and the papers for the meeting reissued.

2. Changes to our Council of Governors

Welcome to Daniel and Zulf. I am sure you will join me in providing a warm welcome to our two new Governors Daniel Balaz and Zulfiqar Ahmed (Zulf) who have now formally joined our Council. They both bring a wealth of community experience that is an asset to our Council. I have included links to their online information on our website to help you to get to know them better. To further support their induction into the Council.

Farewell to Anne. We are also saying farewell to Professor Anne Forster, Partner Governor Leeds University. Anne will officially finish at the end of July when she retires from her role as Deputy Director, Leeds Institute of Health Sciences, Academic Unit for Ageing and Stroke Research, University of Leeds. Anne joined our Council in May 2021. I would like to put on record our thanks to Anne for her service as a Council member and I am sure the Board will join me in also thanking Anne for her commitment to the role and wish her the very best in her retirement.

3. Strategic Advisory Forum: Voluntary Sector and Communities

Our next 'Strategic Advisory Forum' covering 'Voluntary Sector and Communities' is scheduled for Thursday 3 September from 9.30 to 11.30. We are very pleased that this session will be delivered from the Cellar Trust, Farfield Road, Shipley. I would like to encourage as many of our Board members to attend, where diaries permit. The preceding three SAFs have been extremely insightful and informative. The programme is currently being finalised and is led by Mark Hindmarsh, Director of Strategy and Transformation.

4. 15 Steps Challenge

Just a reminder that the annual schedule for these visits is now set and being recirculated monthly for any revisions. All are encouraged to undertake at least one visit per year in support of the programme. Further information about the 15 Steps Challenge – which is a nationally recognised and supported programme is available on-line here. Here at our Trust the programme is managed by Nazzar Butt, Moving to Outstanding Lead from our Trust's Quality Team. Once you have signed up the Quality Team will provide you with tailored information to support each of the individual visits.

5. Feedback to the Council following Board of Directors meetings

The next feedback session (from the Board meeting on 23 July) is in diaries for Tuesday, 4 August from 5pm to 6pm (via ms teams). Bryan Machin, Senior Independent Director will lead this meeting on behalf of Karen Walker, Acting Chair.

6. Key communications

The most recent communications to our Foundation Trust members (and the public) is available online here. Key communications also continue to be shared with Governors so that they remain in touch with developments here at our Trust. Governors also continue to have access to Let's Talk (staff newsletter) and global emails containing a range of updates to staff.

Submitted by Jonathan
25/07/2022 09:58:21

Board of Directors				
Meeting Date:	23 July 2026		**Agenda Reference:**	Bo.7.26.6
Report Title:	Report from the Chief Executive Officer			
Presented by:	Professor Mel Pickup, Chief Executive			
Executive Lead:	Professor Mel Pickup, Chief Executive			
Author:	Executive Directors and Corporate Governance Manager			
Report Summary				
Purpose of the paper:	Decision ☐ (Approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (Review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	The report provides the Board with a summary position regarding our Patients, People, Place and Partners since the last report to the Board in May 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

Performance against the standards measured within the NHS Oversight Framework 2025/26 were recently published for quarter 4 (Jan-Mar). The Trusts average score improved by 0.11 to 2.19 with its overall ranking improving by 2 places to 56 of 134 Acute Trusts (which includes specialist centres). Performance ranked above peer and national average for the majority of Key Performance Indicators (KPIs) although we were in the lowest quartile for Variance to Finance Plan, Implied Productivity, Sickness Rate, and E-Coli Rate.

23/07/2026 09:08:21 Jacqueline Sheard

The financial position resulting in a segmentation override take the trust into segment 3, which has been the case throughout 2025/26. The recovery programme, established during this same period, is targeting

improvements against these measures whilst further improving operational performance; demonstrating the programmes alignment to national priorities.
The NHSE Oversight Framework will evolve in 2026/27 to include additional measures. The Framework is to remain an integral part of the new operating model by providing clarity around accountability and the approach to oversight and intervention. The measures are selected across the domains of access, quality, productivity, people, and finance to provide an assessment of performance in line with priorities set out in the medium-term planning framework. Organisations are expected to use these and other metrics recommended in the insightful board documents to drive tangible improvement in delivery of services. NHS England will use these measures and the assessment of an organisation's capability (using self-assessment and regional team reviews) to guide oversight intensity, incentives, support and (where necessary) intervention.

Performance has improved for a range of KPIs in Q1 2026/27, although there are also some emerging pressures particularly in relation to growing non-elective demand.

Daily attendances to the Emergency Department (ED) have tracked above expected levels for each month since April, with some of the highest daily numbers on record. Both overall Emergency Care Standard (ECS) 4-hour performance and 12-hour performance has deteriorated in this same period. Paediatric attendances and performance have mirrored this trend. 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. All CSU teams enacted three priority actions and measured their impact using PDSA cycles during a reset week at the end of June, the findings of which have been collated to inform wider adoption and scaling of benefit.

Referral to Treatment (RTT) waits over 52 weeks remained at reduced levels, with the Trust close to upper decile performance amongst Acute Trusts. Average waiting times for treatment also improved and we are tracking ahead of target for overall RTT performance. Outpatient and elective activity were impacted by Resident Doctors industrial action in April, the late cancellation of the action planned for June, and an indirect impact on capacity from time owed following additional working to cover shifts during industrial action. Overall, we estimate RTT performance would increase by 0.8% if this capacity had not been lost.

Outpatient and Theatre productivity programmes are progressing 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. This aligns strongly with the recently published standards for patient experience when waiting for elective appointments. Targeted work to deliver service specific transformation plans is being accelerated using a best practice model for assessing and improving resource utilisation. Both programmes feed into the Trust recovery structure.

Improving the time to inform patients of whether they have cancer or not in no more than 28 days remained a priority and performance for the related Faster Diagnosis Standard (FDS) measure is being sustained at levels above target in Q1. 62-day first treatment performance improved to above target in April and will be in line with plan for May, although tumour group specific pressures remain and ongoing transformation work will continue in line with the National Cancer Plan.

2. People

Equality, Diversity and Inclusion

Pride month and the Rainbow Badge re-launch
June was Pride Month, and to mark the occasion, the rainbow flag has been proudly flying across the Trust in support of our LGBT+ colleagues, patients and communities. Our Comms team have been sharing updates about events taking place across the region and we have been showcasing a refreshed Pride screensaver to raise the profile of LGBT+ equality.

Agenda Item 2/10 2026-0158-01

On Monday 29th June our LGBT Staff Network held an impactful Pride Month event on BRI main concourse. The event which was led by our LGBT+ staff network and was organised in collaboration with colleagues from Bradford Hospitals Charities. The event was a celebration with a number of activities that attracted a great deal of interest, including a quiz, some colourful and meaningful community artwork that colleagues could contribute to and there were lots of great giveaways, including delicious home-made cake! It was fantastic opportunity for colleagues to learn more about the staff network, which is open to anyone, including allies to join. The network is exploring ways of showcasing the artwork produced at the event on a more permanent basis in the Trust.

Project Search Graduation
On 25th June the Trust held an event in the Sovereign lecture theatre to mark the graduation of our 8 successful Project Search Interns. Interns were joined by family members, colleagues and members of staff from across the Trust to celebrate this fantastic achievement and were presented with their award by Kez Hayat, Head of EDI, who is the 'Business Host' for Project Search. 9 new interns have been recruited for 2026/27.

Home from Home Appeal
In a milestone moment for the Home from Home appeal, we broke ground at an event on 20th May 2026 marking the start of the build. Key donors were in attendance alongside dignitaries like celebrity Michael Crawford and The Lord Lieutenant of West Yorkshire. Feedback from the day has been overwhelmingly positive, with people saying there was a 'buzz in the air'. Mobilisation has begun on site with F Parkinson Ltd commencing formal building works week commencing 8th July. Further information is available via the Bradford Hospitals Charity website Neonatal Appeal - Bradford Hospitals Charity

3. Place

National organisational change update
The King's Speech in May 2026 confirmed the NHS Modernisation Bill, which will abolish NHS England and transfer its functions into DHSC. The Bill strengthens ICBs as strategic commissioners, including taking on primary care, dentistry, ophthalmology, and pharmacy commissioning from NHS England. It also introduces the Single Patient Record, starting with maternity and frailty care by 2028, and removes the requirement for foundation trusts to have a council of governors.

West Yorkshire ICB
ICB leadership changes are in progress, with Mark Chamberlain as Chair, Nadira Mirza as Vice Chair, and recruitment continuing for a permanent Chief Executive. At year end the West Yorkshire system reported a £28m deficit against plan, driven by industrial action and delivery pressures, while the ICB itself achieved a £21.4m surplus. A compliant 2026/27 financial plan has been submitted to NHSE.

System performance remains strong nationally on planned care and cancer, though diagnostics continue to be constrained by MRI capacity at Mid Yorkshire.

ICB organisational change update
A further round of colleagues is leaving the ICB in July. The new ICB operating model begins from September, reducing the organisation from 1,064 wte to 688 wte and retaining 35 Bradford District and Craven Place-facing posts.

Bradford District and Craven Partnership
Bradford District and Craven partnership development is moving toward a more formal provider partnership model, with Bradford District Care Foundation Trust identified as host or lead provider. The partnership remains in shadow form whilst governance, delivery arrangements, and contract responsibilities are prepared for April 2027.

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The partnership is also supported by Bradford's role as one of three West Yorkshire sites in the National Neighbourhood Health Implementation Programme, where early work is showing reduced average bed days for end-of-life and frail patients aged 65 and over. Next steps are to strengthen shared governance,

clarify provider responsibilities, and align neighbourhood health work with the wider place-based operating model before the partnership takes on contracts from April 2027.

4. Partners

West Yorkshire Association of Acute Trusts (WYAAT) Programme Executive Meeting, 2nd June 2026 and 7th July 2026

I attended the WYAAT Programme Executive Meetings on both 2nd June and 7th July.

At the June meeting, there was an ICB and system update, along with a focused discussion on management of headcount reductions. We also received an update on job planning, and on the microbiology consolidation feasibility assessment. The usual collaborative report was also received.

The meeting in July received updates from Trusts, most particularly around planning delivery and oversight, and system / place developments. We had further updates on job planning and the microbiology consolidation feasibility assessment and discussed the findings from the Cancer Alliance review. We briefly discussed strategic direction and executive engagement and considered the draft agenda for the upcoming Committee in Common meeting.

NHS Leadership Event in London, 30th June 2026

Sajid Azeb, Deputy Chief Executive attended the above NHSE national event that took place in London on the 28th of April 2026, where a range of speakers updated on several topics including national context and key priorities, finance and delivery, strategy across UEC, outpatients and neighbourhoods, and mental health. The afternoon was a workshop session focused around urgent actions needed to improve maternity and neonatal care, drawing on the findings of the recent Baroness Amos Review.

5. National Reports

Letter from the Rt Hon James Murray MP, Secretary of State for Health and Social Care
On 27 May 2026 NHS leaders received a letter from the Rt Hon James Murray MP thanking all colleagues for the extraordinary work undertaken every day for patients, residents, families and communities across NHS England. Looking ahead, priorities remain cutting waiting times further, embracing innovation and delivering the 10 Year Health Plan.

The letter acknowledged that technology, digitisation and artificial intelligence continue to help build a modern health and care system to free up clinicians and care workers to spend more time on what they do best: caring for patients and residents.

Lord Mann Review
On 4 June 2026 Sir Jim Mackay, Chief Executive NHS England and Danny Mortimer Director General for People, NHS England wrote to all NHS Chief Executives following publication of the Lord Mann Review.
Lord Mann review on antisemitism and other forms of racism in the NHS - GOV.UK
The letter set out a series of immediate actions for NHS organisations including to join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles.

In response, the Trust has reviewed its position and can demonstrate that a significant proportion of the required actions are either already in place or are progressing through existing equality, diversity and inclusion (EDI) infrastructure. This includes established governance through the Strategic Equality and Diversity Council, ongoing workforce development in civility and inclusive leadership, and strong engagement with staff networks and communities. Work is underway to align with national requirements, including progressing adoption of the NHS Race and Health Observatory anti-racism principles, strengthening implementation of the Violence Prevention and Reduction Standard, preparing for

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forthcoming NHS Staff Standards, and ensuring high compliance with mandatory equality training. Preparations are also in place for the introduction of new national training modules and Board-level anti-racism development. Targeted engagement will need to take place with staff groups to inform local approaches, alongside development of a coordinated communications and engagement plan. Staff survey findings relating to discrimination have been reviewed, with actions in place to address priority areas and monitor improvement.

There will be further actions subject to national guidance, including a new uniform policy and the implementation of the forthcoming NHS Staff Standards, that will require careful, phased delivery supported by clear communication and engagement.

Board and Executive Assurance – Cyber Security Risk
On 10 June 2026 NHS England wrote to Trust and ICB Chairs and Chief Executive Officers to ask Boards and executives to assure themselves that cyber security risks are being managed effectively with clear and sustained programmes for improvement; to be considered in Data Security and Protection Toolkit Submissions (DSPT) due at the end of June 2026. New cyber policies are also expected from September 2026. The Trust's Chief Digital and Information Officer presented an assurance report to the Trust Board of Directors at a private board meeting held on 24 June 2026.

NHS Oversight Framework 2026/27 and NHS Trust performance league tables
Further to the update provided in the Patient section above, the process and league tables, including the trust's quarterly position can be found via the NHS England website - NHS England » NHS oversight framework – NHS trust performance league tables process and results.

The NHS Oversight Framework 2026/27 is an integral part of NHS England's operating model and provides clarity around accountability and the approach to oversight and intervention. In 2026/27 the NHS Medium Term Planning Framework will bring together measures of access, quality, productivity, people and finance and board guidance is available via NHS England » Insightful board guidance which sets out in one place what ICB boards and providers should be looking at and how to use this to drive better outcomes, better productivity and better decisions.

NHS England Nottingham Maternity Review Findings on Post Death care and Key actions required following the Fuller Inquiry
On 26 June 2026 the Chief Nursing Officer for England and Chief Operating Officer for NHS England wrote to NHS Trusts and ICBs following the distressing findings of Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (NUH), stating that trusts should consider recommendations alongside the Phase 2 report of the Fuller Inquiry.The letter recognises that although work has already been done in response to the Fuller recommendations there is still more work to do, emphasising that we owe it to those who have died, and to their families and loved ones to ensure the findings of the Donna Ockenden review, the Human Tissue Authority's report on NUH, and the Fuller Inquiry recommendations lead to meaningful and lasting change.

Publication of Baroness Amos' independent investigation into maternity and neonatal services in England
Following publication of the findings of the independent investigation NHS England has created a 10 Point Plan for maternity and neonatal services Final Reports - National Maternity and Neonatal Investigation taking elements from Baroness Amos' national investigation and Donna Ockenden's recent review. Trusts have been requested to review the set of urgent actions in response to the recommendations in both reports and work within the wider system to prioritise these urgent actions.

As you will be aware Bradford Teaching Hospitals NHS Foundation Trust was one of 12 trusts asked to be part of Baroness Amos' national maternity and neonatal investigation. We fully embraced and welcomed the opportunity to take part.

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The report has now been published with a set of national recommendations. We accept the recommendations in full. Bradford Teaching Hospitals NHS Foundation Trust has not had any specific actions or recommendations in our report.

Every year thousands of women give birth in our care, and we want each one of those women to receive excellent care and have a positive experience with us. In the majority of cases this is happening, but not always and we know that isn't good enough.

We acknowledge the bravery of the families involved and recognise the trauma and hurt they still experience. It has also been important that we actively encouraged our colleagues to share their experiences, highlighting good practice as well as challenges they face when delivering care.

We have made many improvements in our maternity and neonatal services. Our mission is that every single family receives excellent care and has a positive experience with us and do so in an environment that our colleagues are proud to work in.

We will take some time to reflect on the recommendations - which we accept in full - and demonstrate our focus on delivering lasting change.

We would like to once again thank all those who have bravely shared their experiences.

Minimum Standards of Patient Experience – Electives
Sir Jim Mackay, Chief Executive Officer NHS England wrote to Trust Chairs and Chief Executives outlining the need for improvement of patient experience with the NHS and a need to fix the basics, starting with how we treat people from first contact and throughout their journey NHS England » Reforming elective care for patients

The planned care minimum standards NHS England » Minimum standards for planned patient care set out in a simple and clear way the very minimum a patient should experience when their referral has been accepted in secondary care along with expectations of acute trusts and their boards. Trust boards will be expected to publish a statement in 2026/27 setting out their approach to complying with the minimum standards, followed by an annual statement reflecting their assessment of progress against them.

The letter also acknowledges the huge strides taken in improving elective performance and reducing waiting lists, but too many patients still don't feel informed or involved whilst waiting for their appointments.

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Meeting Title	Board of Directors		
Date	23rd July 2026	Agenda item	Bo.7.26.8a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality Committee
Date of meeting: 18th June 2026

Key escalation and discussion points from the meeting

Alert:

- **Maternity Theatres Risk (2787):** This is a high level risk relating to maternity theatre staffing. The risk rating has recently been increased. A £900k business case has been submitted and referred to the Private Board for consideration due to the current financial environment.
- **Internal Audit Opinions:** Two recent internal audits received limited assurance opinions: Sepsis Management and, the Quality of Local Incident Investigations. The Committee will receive follow-up updates in six months for Sepsis and through routine reporting for incident investigations.
- **High-Level Operational Risks - Risk 290:** Clinical critical infrastructure risk remains high with a mitigation date of March 2031 due to the ageing estate.

Advise:

- **Falls Audit:** Audit Yorkshire issued a limited assurance opinion regarding falls due to gaps in MASA (multifactorial assessment to optimise safe activity) compliance. All recommendations from the audit have since been addressed.
- **Risk 40: Personalised care plan mitigation** has been delayed by procurement issues.
- **Safeguarding Service Integration:** Plans are underway in 2026 to bring the Maternity, Children's, and Adults safeguarding teams together under a single head of service to manage shared priorities.
- **Neonatal Consultant Staffing:** Early concerns were noted regarding neonatal consultant staffing. A risk assessment is in place, and the maternity and neonatal team will maintain oversight.
- **Maternity Regulatory Reports:** The Committee noted the forthcoming publication of the **Ockenden Report** and the **AMOS review**. A deep dive into maternity patient experience and complaints is scheduled for September 2026.
- **Information Governance (IG) Incident:** One externally reportable IG breach occurred in Q1 2026 involving patient identifiable information being sent to a personal email account; internal management and communication awareness pieces are in progress.
- **Organ Donation Reporting:** Following a new Memorandum of Understanding, reporting lines for the Organ Donation Committee are being firmed up to align with the Quality Committee rather than reporting directly to the Board.
- **Dashboard Development:** Work continues to align the Quality Committee dashboard with recovery plans and other committee metrics (Finance, Performance, and People) to ensure a "quality lens" is maintained in performance monitoring.

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Meeting Title	Board of Directors		
Date	23rd July 2026	Agenda item	Bo.7.26.8a

Assure:

- **Falls Reduction:** The average number of total falls for the past 12 months (April 2025 – March 2026) was 109.3, representing a 10.8% decrease from the previous year. Additionally, 95% of falls resulted in no or low physical harm.
- **Readmission Rates**: Patient readmissions are at their lowest level in three years and are lower than the same period last year.
- **Data Security:** The Trust anticipates full compliance ("Standards Met") for its Data Security and Protection Toolkit (Cyber Assurance Framework) submission due in late June 2026.
- **Pressure Ulcer Improvement:** There has been a noted improvement in Category 3 and above hospital-acquired pressure ulcer incidents over the past six months.
- **Quality Account:** The Quality Committee approved the 2025/26 Quality Account for final Board approval following positive responses from external stakeholders.
- **Mortality Indicators:** The SHMI (Summary Hospital-level Mortality Indicator) continues to improve, and crude mortality remains at or below average.
- **Safeguarding Innovation:** The Trust is participating in a national research project using the “My Voice Matters” tool, which helps neurodiverse children express themselves during medical examinations.

Report completed by:

Tim Swift
Committee Chair and Non-Executive Director
21st June 2026

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Quality Committee			
Meeting Date:	18.06.2026	**Agenda Reference:**	QC.6.26.8
Report Title:	Safeguarding Adults Annual Report Update		
Presented by:	Liz Ward, Named Nurse Safeguarding Children		
Executive Lead:	Professor Karen Dawber, Chief Nurse		
Author:	Sarah Turner, Assistant Chief Nurse Vulnerable adults		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	• During 2025/26, the Safeguarding Adults Team received 861 referrals relating to safeguarding concerns, representing a slight decrease of 10 compared to the previous year. • The most frequently recorded categories of abuse were domestic abuse, neglect, and self-neglect. This pattern is consistent with the previous reporting period. • Data for the period April 2025 to March 2026 outlines Section 136 attendances to the Accident and Emergency Department (AED). The graph demonstrates the number of individuals detained under Section 136 who presented to AED. Since October 2025 we have seen a change in the numbers of attendances who do have a medical reason for attending AED and not just attending due to lack of an alternative place of safety. • The Mental Health Lead Nurse completed a fellowship as part of the Improving Population Health Fellowship Programme (2025/26), with a focus on adversity, trauma, and resilience. This work was specifically centred within the Accident and Emergency Department, supporting a greater understanding of how trauma impacts patient presentation and care. • In addition, the Mental Health Lead Nurse is actively involved in strengthening trauma-informed practice across the Trust. This includes contributing to policy development and supporting the embedding of trauma-informed training initiatives for staff.			
Recommendation/s: (including any decision/approval required)	The Trust has historically operated three separate safeguarding teams: Maternity, Children's, and Adults. In recent years, shared agendas have led to closer collaboration between these teams, while increasing demand has highlighted the need to review how we continue to meet our statutory and regulatory safeguarding responsibilities going forward. The plan for 2026 is to bring these teams together into a single Integrated Safeguarding Team. Each area will retain its specialist expertise, while shared priorities will be collectively managed across the service. This approach will strengthen collaboration, improve consistency in practice, and support a more coordinated, "Think Family" approach to safeguarding. In addition, the integrated model will enhance resilience across the service, broaden practitioners' exposure to a wider range of safeguarding issues, and support workforce development and succession planning for the future.			
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness			

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Link to Priority Initiatives 2025/26:	Health Equity and Health Inequalities
Implications	
Risk:	Without the safeguarding team function BTHFT would be at risk of not meeting the statutory requirements and regulations set out below.
Legal/Regulatory:	The report provides assurances to the Quality Committee that BTHFT is meeting the statutory requirements and regulations in relation to safeguarding as set out in: The Care Act 2014, CQC standards 9 & 13, The Mental Capacity Act 2015, The Mental Health Act 1983 (amended 2007)
Quality & Patient Safety:	Safeguarding is a statutory requirement on all NHS providers and a regulatory measure and directly contributes to quality patient care.
Equality, Diversity and Inclusion and Health Equity:	EDI is considered within safeguarding and cultural competency of staff in addressing safeguarding concerns has been a recommendation from a number of independent reviews.
Resources:	
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	

Report content
Appendices Appendix 1 - Annual report Appendix 2 - Mental Health, Learning Disability and Neuro diversity strategy Appendix 3 - Commissioning standards – available in the reading room here.

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Bradford Teaching Hospitals Foundation Trust, Safeguarding Adults' Annual Report 2025/26

This Annual report provides information regarding activity within Safeguarding Adults in Bradford Teaching Hospitals NHS Foundation Trust between April 2025 and March 2026. The report is for assurance that the statutory responsibilities are being met and to identify key areas of development and risk.

Activity in relation to Mental Health and Learning Disabilities will also be identified in this paper, and although not necessarily 'safeguarding' there are shared complexities and activity specifically in relation to legislation.

The report will focus on the specific areas of work that have been identified as priorities in last years annual report and that were requested for updates from the ICB following the mid-year report.

	Background/Context

All individuals have the right to live their lives free from violence and abuse. This right is underpinned by the Human Rights Act (1998), which places a duty on public sector organisations to intervene proportionately to protect individuals and uphold their rights as citizens (ADASS, 2005 *Safeguarding Adults*).

The Care Act 2014, implemented in April 2015, represents the first piece of legislation specifically focused on safeguarding adults. The Act not only emphasises the importance of reducing risk, preventing harm, and responding effectively to abuse and neglect, but also promotes the active involvement of the individual in the safeguarding process. This ensures that safeguarding is undertaken *with* people, rather than *to* them, reinforcing a person-centred and collaborative approach.

Safeguarding is everyone's responsibility. All staff have a duty to help prevent abuse and to respond promptly and proportionately where concerns arise. Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) is responsible for ensuring that robust arrangements are in place to support staff in meeting their safeguarding obligations.

The principles set out within the Care Act 2014 underpin all safeguarding practice within the Trust:

- Empowerment
- Protection
- Prevention
- Partnerships
- Proportionality
- Accountability

The Trust's policies and procedures are aligned with the West Yorkshire, North Yorkshire and York Multi-Agency Safeguarding Adults Policy and Procedures, ensuring a consistent and coordinated approach across the system.

Safeguarding adults remains a high priority for the Trust. Over the past year, there has been a continued increase in the breadth and complexity of safeguarding activity across all areas of the organisation.

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Section 42 of the Care Act 2014 sets out the criteria for when a safeguarding enquiry must be undertaken and defines both an Adult at Risk (AaR) and a Person Alleged to Have Caused Harm (PATCH).

A Section 42 enquiry duty applies where an individual:

- Has care and support needs (whether or not these needs are being met by the local authority),
- Is experiencing, or is at risk of, abuse or neglect,
  and
- As a result of those needs, is unable to protect themselves from the abuse, neglect, or risk of it.

Governance arrangements

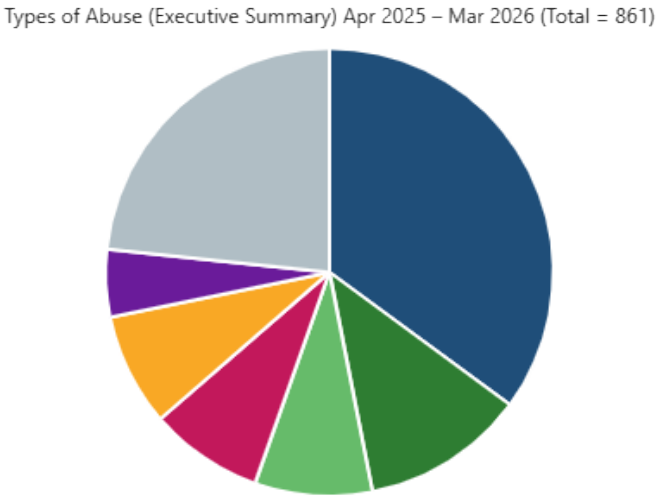
Safeguarding Governance Structure



All safeguarding activity within the Trust is reported via the Safeguarding meeting, which reports to the Integrated Safeguarding meeting, which in turn reports to Quality committee. This changed in 2025. Prior to this there were three separate safeguarding meetings, Maternity, Childrens and Adults. The separate meetings often had similar representation and covered similar topics just from a different perspective ie unborn, child or adult. In recognition of the increasing shared business and drive to improve efficiency and capacity the decision was made to combine the meetings. The safeguarding meeting is operationally focussed, and the integrated meeting strategic, there is representation from the designated safeguarding nurses from the ICB at the Integrated meeting.

Safeguarding Adult Activity

Figure 1



During 2025/26, the Safeguarding Adults Team received 861 referrals relating to safeguarding concerns, representing a slight decrease of 10 compared to the previous year. The most frequently recorded categories of abuse were domestic abuse, neglect, and self-neglect. This pattern is consistent with the previous reporting period.

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Figure 1 shows the 6 highest reported types of abuse referred to the team, the largest grey section is the accumulative total of the remaining types. In order of highest to lowest :- Domestic abuse (blue) accounted for **303** referrals, neglect (dark green) for **105**, and self-neglect (light green) for **71**, collectively representing **51%** of all concerns raised. The remainder is comprised of sexual (pink), financial (yellow), physical (purple) and then the remainder of all the other types (grey).

Making Safeguarding Personal (MSP) remains a central principle of safeguarding practice, as set out in the Care Act 2014. MSP emphasises the importance of understanding and respecting the views, wishes, and desired outcomes of the Adult at Risk (AaR). In line with this approach, the Safeguarding Adults Team at BTHFT ensures that individuals are actively involved in decisions about how concerns are managed.

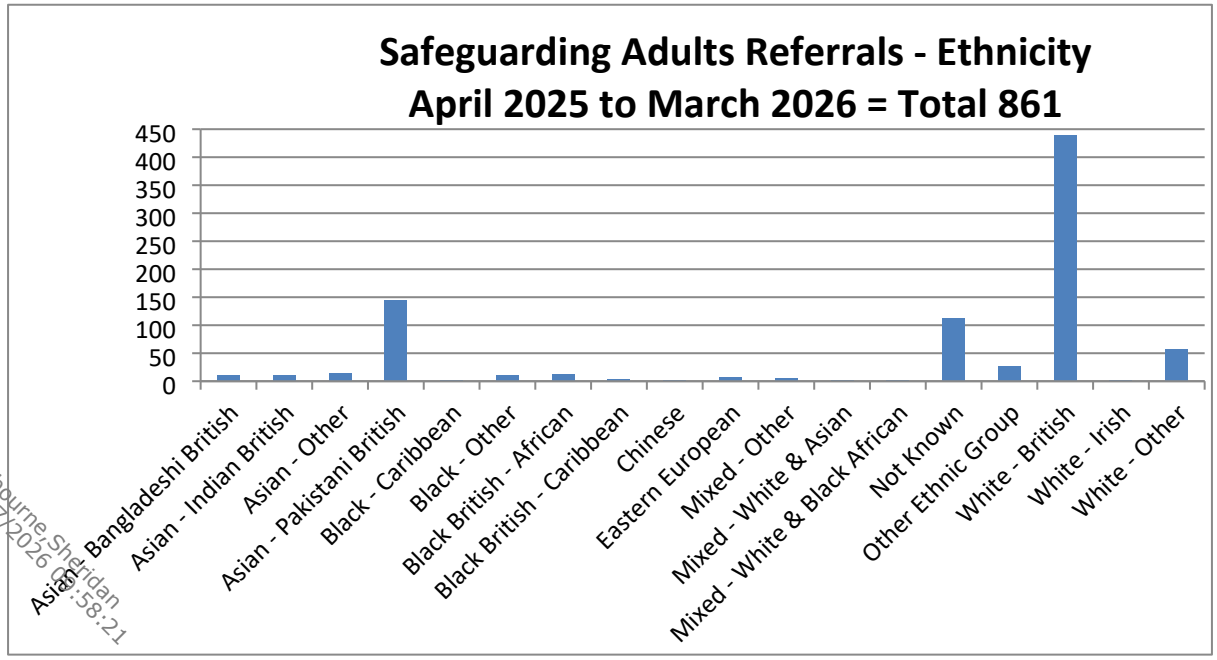
Where an individual with capacity expresses a wish for no further action to be taken, and there is no identified risk to others, this decision is respected. However, these discussions are revisited throughout the individual's care to ensure that any change in circumstances or wishes is acted upon appropriately.

Where further action is agreed, responses can include referral to specialist support services, escalation to the Local Authority for a multi-agency safeguarding response, reporting to the Police, and liaison with carers and families as appropriate.

The Safeguarding Adults Team maintains a visible presence on wards, providing direct support to patients who disclose abuse. The team works with individuals to explore options, explain potential next steps and outcomes, and ensure that their views are central to any intervention. This reflects the core safeguarding principle of "no decision about me, without me."

In addition to supporting patients, the team provides comprehensive support to staff. This includes advice on managing safeguarding concerns, delivery of training, supervision, and debriefing following complex or distressing cases. The team also supports staff who may themselves be experiencing abuse, ensuring they have access to appropriate specialist services and feel safe within the workplace.

Figure 2



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Figure 2, identifies the ethnicity of the person referred for safeguarding support. The team started collating this data in 2023 to enable more analysis of themes and trends. This has enabled more targeted work and training to be developed.

Safeguarding Adult Reviews (SAR's)

Safeguarding Adult Reviews (SARs) are multi-agency reviews that examine the circumstances leading to the death of an individual with care and support needs, or where serious harm has occurred. Their purpose is to identify learning and improve future practice. SARs are a statutory requirement under Section 44 of the Care Act 2014.

The Assistant Chief Nurse for Vulnerable Adults is the Vice Chair of the multi-agency SAR Subgroup, a subgroup of the Bradford Safeguarding Adults Board (BSAB), and participates in the panels for individual reviews. This role provides the Trust with oversight of emerging themes and enables the early identification of learning, which is fed back into the organisation to inform priorities, training programmes, and service development.

For example, a SAR undertaken during 2024/25 identified a lack of clear intra- and inter-agency pathways for the care and management of patients identified as bariatric. In response, work has progressed throughout 2025 to develop a clear, coordinated pathway. This has involved collaboration across a range of clinical and non-clinical teams and is being led by the Trust's Ergonomics Advisor, Helen Naylor.

A further SAR, commissioned and completed in 2025 ("Bella"), highlighted gaps in service provision for individuals with learning disabilities who may be experiencing domestic abuse. The findings of this review have been shared with the Trust to support consideration of how services can be strengthened to better meet the needs of this vulnerable group.

Domestic Abuse and Multi Agency Risk Assessment Conference (MARAC)

Domestic abuse is recognised as a category of abuse within the Care Act 2014. However, it is not always reported as a safeguarding concern to the Local Authority where the individual does not meet the threshold of having care and support needs, as required under Section 42.

The Safeguarding Adults Team provides direct support to both patients and staff who disclose domestic abuse, including offering advice and facilitating access to specialist community support services. In collaboration with the Safeguarding Children's Team and the Safeguarding Midwife Team, the team gathers and shares relevant information for individuals discussed at the Multi-Agency Risk Assessment Conference (MARAC). MARAC is a multi-agency forum where information is shared on high-risk domestic abuse cases. Attendees include representatives from police, probation, health, children's services, adult social care, housing, Independent Domestic Violence Advisors (IDVAs), and other specialist services. Each case typically involves at least two individuals, but often includes wider family members, including children. MARAC meetings are held weekly across the Bradford District.

In addition to contributing information on relevant presentations to BTHFT services, the Safeguarding Adults Team is responsible for ensuring that appropriate risk flags are applied and removed from the Electronic Patient Record (EPR) in a timely manner. These flags alert staff to potential risks and create opportunities for sensitive & routine enquiry, enabling practitioners to consider presentations through a domestic abuse lens and apply professional curiosity in their assessment and response.

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During the 2025/26 period, a total of 993 cases were discussed at MARAC. There has been a sustained increase in reported domestic abuse incidents both locally and nationally since 2019. This increase is understood to reflect, in part, greater confidence among victims in coming forward, alongside improved recognition and response from services.

In response to rising demand, discussions have taken place with partner agencies to explore opportunities to strengthen support provision. A Hospital Independent Domestic Violence Advisor (HIDVA) role was introduced in April 2021, providing support to both patients and staff, delivering training, and contributing to MARAC processes. Although the initial pilot funding was extended to July 2024, it was confirmed in October 2024 that the role would not continue beyond July 2025 due to funding constraints.

Recognising the potential impact of this loss of provision, this was formally risk-assessed, and a business case was developed. As a result, the Trust agreed to establish the role on a permanent basis within the Safeguarding Adults Team. The service has since been further strengthened with the addition of both a dedicated Domestic Abuse Practitioner and a Domestic and Sexual Violence Specialist Practitioner. These roles have been pivotal in ensuring that both staff and patients experience the Trust as a safe and supportive environment.

During 2025/26, the Safeguarding Adults Team received **303** domestic abuse referrals, originating from disclosures by both patients and staff. In addition, the team provided support to 49 members of staff experiencing domestic abuse during 2025/26, highlighting the importance of maintaining robust internal support mechanisms.

As part of the Trust's ongoing commitment to multi-agency working in this area, one of the team's specialist advisors also undertakes the role of MARAC Chair, further strengthening the Trust's contribution to partnership governance and coordinated responses to high-risk cases.

Domestic Homicide Reviews (DHR's)

A domestic homicide review is a multi-agency review of circumstances relating to a person's death where there has been known domestic abuse. They are not investigations but are to identify learning which can be embedded and hopefully prevent further deaths. The scope has been widened now to include an individual who has died by suicide, and where it was known that they experienced domestic abuse. These reviews are known as domestic abuse related death reviews (DARDR's). The Safeguarding Adults' team undertake and coordinate involvement in these reviews, providing information, identifying learning and providing constructive challenge and feedback to the independent authors commissioned to produce the reports. The learning from these reviews is fed into training and becomes the focus for the workplan in relation to domestic abuse within the Trust.

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Figure 3

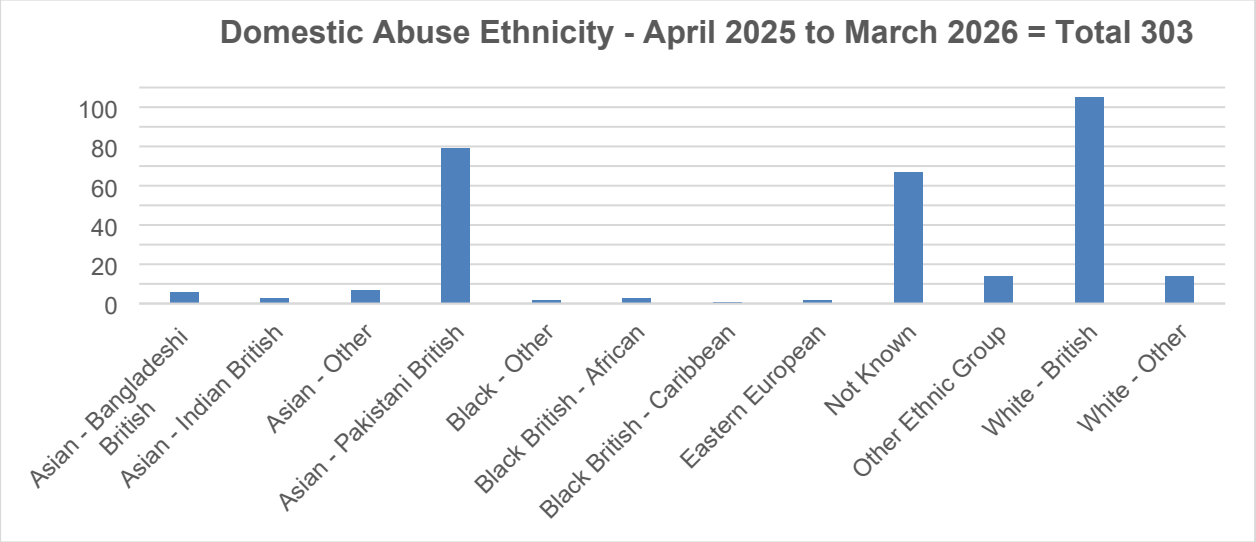


Figure 3 shows the ethnicity of people experiencing domestic abuse. As with the safeguarding ethnicity recording, understanding of this facilitates greater understanding of themes and trends and therefore the ability to undertake more 'targeted' work both in practice and in training.

Figure 4

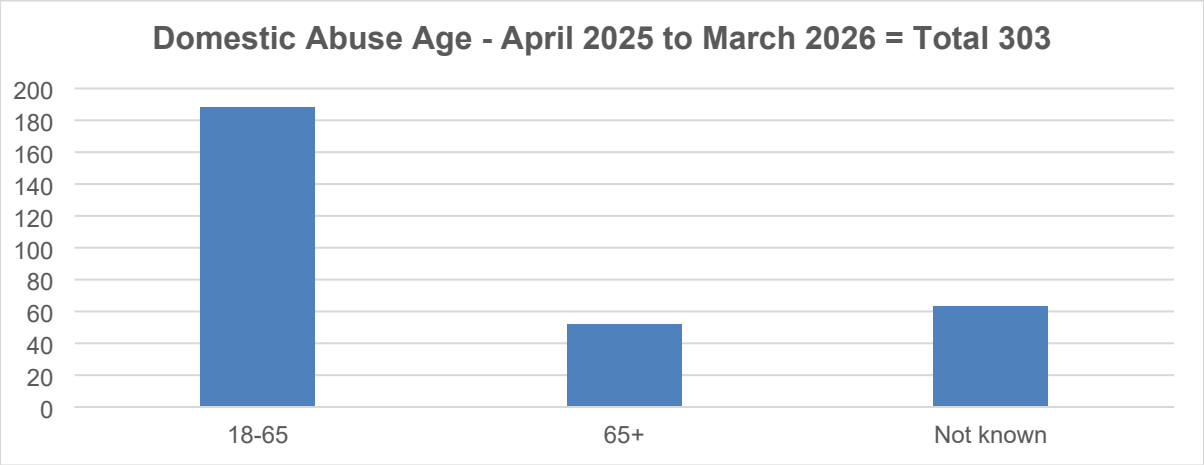


Figure 4 displays the age range of people who have disclosed domestic abuse. This data is important in ensuring we do not lose sight of potential 'hidden victims'. Of note the number of victims over the age of 65 is increasing. This may be due to increase confidence in reporting or may be as a result of other potential contributing factors such development of medical conditions that impact on a person's cognition and behaviour. In recognition of this the domestic abuse advisor has identified further training available to look at this issue.

Mental Health Act compliance

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A Service Level Agreement (SLA) with Bradford District Care Foundation Trust (BDCFT) remains in place to support BTHFT in meeting its statutory responsibilities under the Mental Health Act (MHA). This includes the scrutiny of documentation, provision of training, and

access to an appeals panel hosted by BDCFT for patients wishing to challenge their detention under the Act.

To support effective oversight, the Safeguarding Adults Administrator meets monthly with the Mental Health Act Administrator from BDCFT to review records, ensure accuracy, and identify and address any areas of concern or required change. In addition, the Mental Health Lead provides expert advice to staff, liaises closely with BDCFT to ensure safe and effective communication and handover of patients subject to the Act, and supports ongoing monitoring of compliance.

Historically, Trust monitoring of MHA activity has not included Section 136 detentions, as these are initiated by the Police. However, an observed increase in Section 136 attendances has necessitated greater focus both within the Trust and across system partners. Section 136 data is now routinely collected and monitored in recognition of the impact on Trust services, particularly where individuals are conveyed to the Accident and Emergency Department (AED) as a place of safety despite not having an acute medical need. During a Section 136 detention, Police are required to remain with the individual until assessment is completed.

It is important to acknowledge that, although AED is designated as a ‘place of safety’ within legislation, it is not always an appropriate or therapeutic environment for individuals experiencing acute mental health distress. The busy, noisy, and often overstimulating nature of AED, combined with the lack of specialist mental health resources, can present challenges in delivering optimal care.

The monitoring of this data has gained further significance following the implementation of the Right Care, Right Person (RCRP) model. RCRP is an operational approach designed to ensure that individuals receive support from the most appropriate service, rather than defaulting to a Police response for health-related needs. This model aims to improve outcomes for individuals, reduce demand on emergency services, and ensure that care is delivered by the most appropriate professionals.

The Assistant Chief Nurse for Vulnerable Adults attends, and now chairs, the regional forum aligned to this agenda as part of the Criminal Justice and Mental Health workstreams within the West Yorkshire Combined Authority. During 2025, this forum was reviewed and refreshed in response to challenges with multi-agency engagement. These challenges reflect the complexity of the system, with multiple Trusts, Integrated Care Boards (ICBs), and Local Authorities operating within West Yorkshire, alongside single Police and Ambulance services covering the entire region. A key focus has been on strengthening commitment from health and local authority partners and ensuring representation at a senior level to drive the necessary operational change.

Work relating to Section 136 and RCRP has been a significant focus within the Trust. Incidents involving individuals detained under Section 136 are reviewed collaboratively with partner agencies to identify learning and improve practice. Close liaison with the Chief Inspector for Mental Health within West Yorkshire Police has strengthened inter-agency communication and contributed to improved outcomes for patients.

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Figure 5

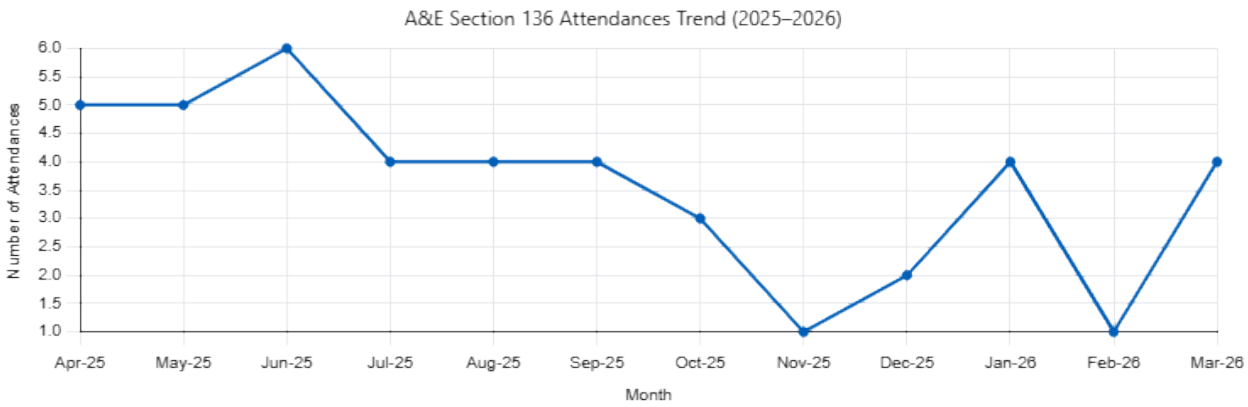


Figure 5 shows the number of Section 136 detentions attending the accident and emergency department (AED)from April 2025- March 2026.

There were **43** Section 136 detentions recorded, representing a decrease of **53** compared to the previous year. This data is important in understanding system capacity for individuals experiencing a mental health crisis, as well as the availability of appropriate places of safety while awaiting further assessment.

Where both Section 136 suites are occupied, Police are required to identify an alternative place of safety. Police custody is no longer considered appropriate for this purpose; therefore, the Accident and Emergency Department (AED) is currently the only available alternative within the system.

Figure 6

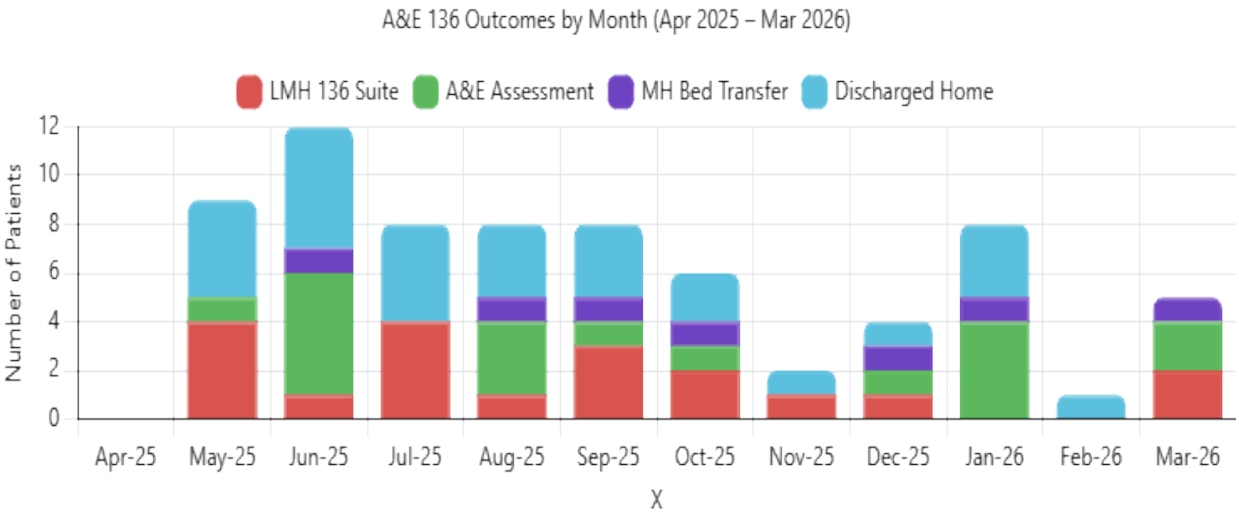


Figure 6, Data for the period April 2025 to March 2026 outlines Section 136 attendances to the Emergency Department. The graph demonstrates the number of individuals detained under Section 136 who presented to AED. Since October 2025 we have seen a change in the numbers of attendances who do have a medical reason for attending AED and not just attending due to lack of an alternative place of safety. This is directly attributable to changes at BDCFT which resulted in the suite being able to be accessed more frequently and appropriately.

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A proportion of individuals were transferred directly to the Lynfield Mount Hospital (LMH) Section 136 suite prior to MHA Assessment within AED. Consequently, outcome data for these cases, including whether a mental health inpatient admission was required, is not available within this dataset.

For those assessed within the Emergency Department, the data illustrates the number of individuals requiring admission to a mental health inpatient bed, compared to those who were discharged back into the community.

Work is ongoing at a regional level, under the oversight of the Combined Authority, to explore the development of alternative therapeutic environments. This includes consideration of voluntary sector “safe spaces” to better meet the needs of individuals in crisis and reduce pressure on acute hospital services.

Building on the work relating to Section 136, Bradford was selected as a pilot site for the Police in introducing the ‘Webley’ handover process. This process facilitates the formal sharing of information about individuals where there are known risks associated with their mental health, ensuring that receiving professionals are appropriately informed and able to respond safely. It is important to note that the ‘Webley’ process is not intended for individuals subject to Section 136 detention.

During the pilot phase, the handover process relied on paper documentation and email communication. This has since been enhanced, with Police now able to complete and securely transmit forms directly from electronic devices to AED. Following the success of the pilot, this process is now being rolled out across the wider Police force.

Mental Health

The increase in activity relating to complex mental health needs within the Trust has been recognised. In response, and in line with the organisational strategy, a Mental Health Oversight Group has been established. The purpose of this group is to bring together the range of work being undertaken across the Trust in relation to mental health, providing clear organisational oversight, identifying risks and barriers to progress, and reducing duplication of effort.

The Mental Health Lead Nurse has also been working closely with Maternity Services to support expectant mothers with identified mental health needs. This collaboration has led to attendance at the Maternity Complex Multidisciplinary Team (MDT) meetings, enabling earlier identification of risk and the development of more proactive and coordinated care plans.

In addition, the Mental Health Lead Nurse is supporting the Safeguarding Children Practitioner who leads on children’s mental health. This work focuses on strengthening involvement and improving care planning for children with mental health needs during hospital admissions, ensuring that their needs are recognised early and that appropriate support is in place throughout their care journey.

Trauma Informed

There is increasing recognition across health and social care of the need to adopt trauma-informed approaches. Within safeguarding, this is consistently highlighted in national reports and reviews. Being trauma informed means recognising the impact of trauma and adversity on individuals and ensuring that, as service providers, we actively seek to avoid re-traumatisation in the way care and support are delivered.

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The Mental Health Lead Nurse completed a fellowship as part of the Improving Population Health Fellowship Programme (2025/26), with a focus on adversity, trauma, and resilience. This work was specifically centred within the Accident and Emergency Department, supporting a greater understanding of how trauma impacts patient presentation and care. In addition, the Mental Health Lead Nurse is actively involved in strengthening trauma-informed practice across the Trust. This includes contributing to policy development and supporting the embedding of trauma-informed training initiatives for staff.

Recognising the importance of a trauma-informed approach for specific patient groups, a dedicated group has been established to support patients with eating disorders, where trauma is often a significant contributing factor.

Trauma-informed principles are now considered across all aspects of safeguarding practice. Further work is planned to enhance staff understanding, including the development of targeted training and a focus on creating psychologically and physically safe environments for both patients and staff.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are intended to ensure that patients who lack mental capacity are kept safe and that any restrictions imposed are in their best interests and are authorised through the appropriate process. The Mental Capacity Act and DoLS legislation was not intended to replace the Mental Health Act and there are often occasions when deciding which legal framework is most appropriate to deliver care can prove a challenge for staff. This is recognised nationally, and the Safeguarding Adults' Team provide assistance with this as required.

The Safeguarding Adults' Team undertake the administrative functions relating to the DoLS process and offer support and advice to staff. The team successfully recruited to a specific Mental Capacity Act specialist practitioner in 2024. There were **510** urgent authorisations for Dols in the period 2025/26 which is an increase of **41** on the previous 12 months. Paperwork is scrutinised for accuracy and liaison with the Local Authority DoLS team when escalation for assessment needs to occur. This ensures the best Interests of the patient are maintained and any deprivations of their liberty are lawful. The outcomes of DoLS authorisations are audited and cases are discussed directly with matrons should concerns arise. Cases are also discussed when there have been differences in opinion between whether a patient should have been detained under the Mental Health Act or an application for a DoLS authorisation.

The threshold for a DoLS authorisation to be made is referred to as the 'Acid test' and was a result of the Supreme Court judgement on the 'Cheshire West Case', which since then has included patients:

- *who lack capacity.*
- *are subject to supervision and control (even if this is to enhance their freedom).*
- *are not allowed to leave hospital (even if they are not asking to leave).*

It is a statutory duty under the Mental Capacity Act (2005) that the Foundation Trust has a system in place to appoint and instruct Independent Mental Capacity Advocates (IMCAs). This applies for all patients who lack capacity to make important decisions about serious medical treatment, changes of accommodation or safeguarding concerns and who have no family or friends with whom it would be appropriate to consult.

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Learning Disabilities

The Safeguarding Adults Team was previously notified of all patients admitted to the Trust who have a learning disability. This process ensured that staff were supported with appropriate advice, access to specialist services, and the implementation of reasonable adjustments to provide safe and effective care.

The introduction of the national Learning Disability Standards and associated national audits has increased scrutiny on the quality and consistency of services provided to patients with a learning disability.

In response, the Learning Disability Lead Nurse has played a key role in working directly with patients and their carers, supporting staff to better understand individual needs. This has included promoting the use of patient-held information such as VIP passports, facilitating engagement and distraction activities, providing alternative communication tools (e.g. picture boards), and liaising with specialist services to ensure patient safety both during admission and on discharge. Where concerns regarding care have been identified, these have been addressed promptly, with direct feedback provided to staff and escalation of recurring themes or trends to the Deputy Director of Nursing or Medical Director as appropriate.

To further strengthen this work, an Additional Needs Care Navigator role was established. This has enabled a more consistent presence on wards to support patients with additional needs, including learning disabilities and mental health conditions. The role focuses on ensuring smooth transitions into and out of hospital, including pre-admission planning, support during inpatient stays, and post-discharge follow-up to address concerns and ensure continuity of care.

There has been a noticeable increase in requests for support for patients with neurodiversity, including autism and ADHD. The team has begun to explore how best to meet this growing need and is working with the Patient Engagement Team to identify and develop appropriate specialist support and reasonable adjustments. This work is being progressed in line with the key themes of the Learning Disability, Mental Health, and Neurodiversity Strategy. This work is also linked to the ongoing work in relation to reasonable adjustments and how flags reflecting needs can be added to EPR.

The Health and Care Act 2022 introduced a statutory requirement for all regulated service providers to ensure their staff receive training in learning disability and autism, with the Oliver McGowan Training programme identified as the preferred national standard. Implementation of this programme is ongoing, with Tier 1 training now a mandatory requirement for all staff.

Engagement with experts by experience—who support delivery of Tier 2 training—was undertaken in early 2025 in partnership with Bradford District Care Foundation Trust (BDCFT) and Airedale General Hospital (AGH). To date, 518 members of staff have completed Tier 2 training, supporting improved awareness, confidence, and quality of care for patients with learning disabilities and autism.

Training

There has been a significant shift in how compliance with Safeguarding Adults training is delivered and monitored. A re-levelling exercise was undertaken in collaboration with the Education team to ensure that all staff are assigned the appropriate level of training in line with national standards.

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To support this, the Safeguarding Adults Team aligned with the approach already established by the Safeguarding Children Team by introducing a self-declaration model for Level 3 compliance. A key driver for this change was the recognition that, given the complexity and breadth of safeguarding, it is essential for staff to access a variety of learning approaches. The self-declaration model encourages attendance at external learning opportunities, enabling staff to engage with professionals from different agencies and disciplines, and to benefit from wider discussions on safeguarding challenges and approaches.

Following evaluation, the self-declaration process was further strengthened by amending the form to promote reflective practice. Staff are now supported to consider the impact of their learning and how it will influence their future practice. Emphasising the importance of the “so what” question in safeguarding encourages practitioners to think more broadly and adopt a more person-centred approach.

To further support compliance, the Safeguarding Adults Team has refreshed its training offer in collaboration with the Safeguarding Children Team, reinforcing a “Think Family” approach. This has included the introduction of seven-minute briefings, topic-specific sessions, and full-day learning events. Larger events, such as Safeguarding Week (June 2025) and the 16 Days of Action (November 2025), have focused on key themes including domestic abuse & learning disabilities, and sexual violence. External speakers were commissioned, and attendance was opened to wider system partners. These initiatives were informed by learning from Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs).

All staff are required to complete Prevent Basic Awareness training, while those identified at Levels 3 and 4 for Safeguarding Adults must also complete Level 3 e-learning. Current compliance stands at 94%, exceeding the NHS England minimum expectation of 85%.

All training devised by the team is in response to learning identified from statutory reviews such as DHR’s and SAR’s and from themes and trends identified from IRIS reports and incidents within the Trust. This ensures the training offered remains relevant for staff and informs their practice.

Sexual Safety Charter

NHS England in June 2023 outlined their intention to develop a sexual safety charter. The intention of the charter was to ensure that every part of the NHS takes a systematic zero tolerance approach to sexual misconduct and violence.

A joint report published by the British Medical Journal and the Guardian, found that 35,606 cases of sexual misconduct or sexual violence were recorded on health service premises between 2017 and 2022. 22,143 of those cases were relating to staff experiences, of those 20,928 were staff being abused by patients, 902 by other staff members and 313 by visitors. The staff survey has included questions in relation to whether staff have experienced sexual misconduct in the workplace, on review of these results there have been people who identified they have.

NHS England produced guidance in late 2024 in relation to expectations of health in how they deliver the charter. A task and finish group was established and has been working on reporting mechanisms, policy and training. The group was chaired by the Assistant Chief Nurse Vulnerable adults and included leads for Occupational Health, Human Resources, Childrens safeguarding, Equality diversity and Inclusion, Freedom to speak up, staff side representatives and Organisational development.

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The work in relation to the sexual safety charter has been cognisant of trauma informed work and where possible being minded of the 6 principles associated with this, namely:

- safety.
- trust.
- choice.
- collaboration.
- empowerment.
- cultural consideration.

Whilst the sexual safety charter is a process it must be able to be flexible in ensuring it listens to and is constantly mindful of the views and experiences of the person experiencing the misconduct.

There is ongoing work in relation to support for staff reporting concerns, witnesses and the accused. Work has also commenced linked to this agenda with the University of Leeds Medical School, to raise awareness amongst Student Doctors and ensure our processes are aligned. This is due to be launched in Summer 2026.

Multi agency working

Multi agency working is crucial in ensuring effective safeguarding practice, as it allows a broader understanding of situations and greater ability to provide an effective outcome. Safeguarding is strengthened by effective multi agency working relationships, these are only able to be facilitated by a shared understanding of risk and a commitment to working together. Consistent representation in multi-agency forums allows greater confidence in those relationships. Progress this year in certain areas of business has only been possible due to commitment from partners, specifically in relation to domestic abuse and Right Care Right Person.

Bradford Safeguarding Adults' Board (BSAB)

The introduction of the Care Act 2014 made the Local Authority Safeguarding Adults' Boards statutory. The Foundation Trust provides assurance to the Bradford Safeguarding Adults' Board through the membership and attendance of the Chief Nurse. During 2024/25 the Assistant Chief Nurse Vulnerable Adults attended the Safeguarding Adults' Board subgroups quarterly.

The current subgroups are:

- Performance, Quality and Assurance Group (PQAG)
- Communications and Engagement
- Training
- Safeguarding Adult Reviews (SAR)
- All age exploitation

As part of the commissioning standards for provider organisations, the Safeguarding Adult Team previously had ensured a proportionate contribution to the delivery of local multi-agency training programmes, as required by the Safeguarding Adults' Board.

Domestic and Sexual Violence Board

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The Assistant Chief Nurse Vulnerable Adults is a member of the Domestic and Sexual Violence Strategy Board with the Safeguarding Adults' Specialist Practitioner attending a number of the subgroups. Work from these groups is discussed at the Trust's Safeguarding

Subgroup. Specialist practitioners attend the subgroups which offer a more direct look at operational challenges and ensure more timely changes to practice as and when needed.

	Next steps

The Trust has historically operated three separate safeguarding teams: Maternity, Children's, and Adults. In recent years, shared agendas have led to closer collaboration between these teams, while increasing demand has highlighted the need to review how we continue to meet our statutory and regulatory safeguarding responsibilities going forward.

The plan for 2026 is to bring these teams together into a single Integrated Safeguarding Team. Each area will retain its specialist expertise, while shared priorities will be collectively managed across the service. This approach will strengthen collaboration, improve consistency in practice, and support a more coordinated, "Think Family" approach to safeguarding.

In addition, the integrated model will enhance resilience across the service, broaden practitioners' exposure to a wider range of safeguarding issues, and support workforce development and succession planning for the future.

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NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Mental Health, Learning Disabilities & Neurodiversity Strategy (2024-2028)

OUR VISION

Promote and prioritise improvements in access to and delivery of, care for patients with a learning disability, mental health condition or who are neurodiverse.

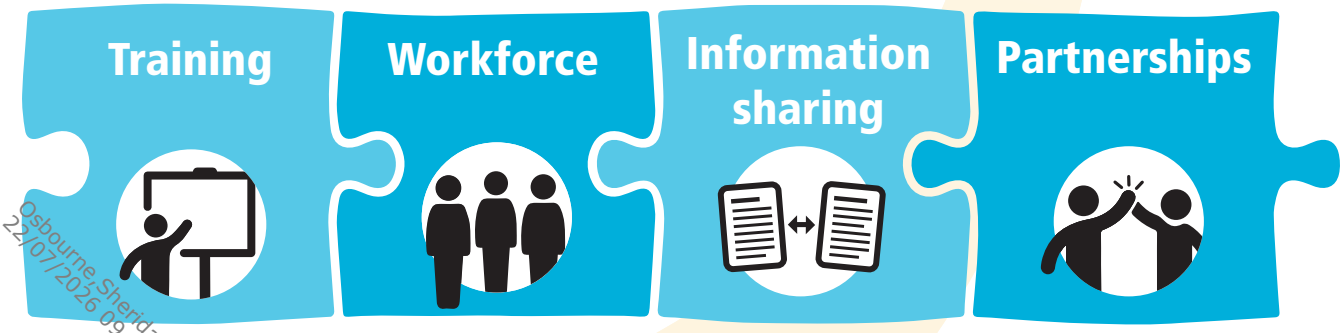
OUR VALUES

- We care
- We value People
- We are one team

STRATEGIC OBJECTIVES

- To deliver outstanding care
- To be continually learning organisation
- To collaborate effectively with partners

PRIORITIES



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MID24100904 • S. Turner • Published October 2024

Quality Committee			
Meeting Date:	18.06.26	**Agenda Reference:**	QC.6.26.9
Report Title:	Safeguarding Children Annual Report		
Presented by:	Liz Ward, Named Nurse Safeguarding Children Dr Jo Sims Named Doctor Safeguarding Children		
Executive Lead:	Professor Karen Dawber, Chief Nurse		
Author:	Liz Ward, Named Nurse, Drs Jo Sims and Lauren Hill, Named Doctors Safeguarding Children		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	• Assurance for the Quality Committee that the Safeguarding Children's Team are working to ensure the Trust remains compliant with all relevant safeguarding legislation • Activity continues to increase in all areas of safeguarding particularly where children are attending with mental health as a presentation • The workplan for 26/27 includes plans to improve data collection both for activity and training reporting • A review of the requirements of the Intercollegiate Document is to be undertaken for all levels of staff • Engagement with the Safeguarding Children's Steering Group and Integrated Safeguarding Group has been poor with some meetings not quorate			
Recommendation/s: (including any decision/approval required)	*The Quality Committee is asked to:* 1. Going forward a joint report will be produced which will contain the assurance for safeguarding midwifery, children and adults 2. Quality Committee to recommend to all areas the importance of engagement with BTHFT safeguarding strategic meetings 3. Provision and importance of reflective safeguarding supervision is recognised and championed by Quality Committee			
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness			
Link to Priority Initiatives 2025/26:	Health Equity and Health Inequalities			

Implications	
Risk:	Without the safeguarding team function BTHFT would be at risk of not meeting the statutory requirements and regulations set out below.
Legal/Regulatory:	The report provides assurances to the Quality Committee that BTHFT is meeting the statutory requirements and regulations in relation to safeguarding children as set out in: • Children Act 1989, 2004. • Working Together to Safeguarding Children 2026. • Safeguarding children, young people and adults at risk in the NHS – Safeguarding Accountability and Assurance Framework 2024. • Accountable to The Bradford Partnership – Working Together to Safeguard Children (via Section 11 of the Children Act). • Accountable to the Integrated Care Board for safeguarding contracts and activity.

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	• SAFE domain as part of Bradford Teaching Hospitals NHS Foundation Trust overall inspection process, to provide assurance that safeguarding policy and procedures are deeply embedded into the Trust's operating practice. • Joint Targeted Area Inspection (JTAI) - The joint inspection process for safeguarding children services carried out by: o Ofsted - for Children's Social Care. o Care Quality Commission for Health. o Her Majesty's Inspectorate of Constabulary for Police. o Her Majesty's Inspectorate of Probation for Probation Services.
Quality & Patient Safety:	Safeguarding children is a regulatory measure and directly contributes to quality patient care.
Equality, Diversity and Inclusion and Health Equity:	EDI is considered within safeguarding and cultural competency of staff in addressing safeguarding concerns is a recommendation from Child Safeguarding Practice Reviews locally and nationally.
Resources:	Meeting the increasing needs and complexities of children attending BTHFT with their primary reason for attendance being a mental health need is directly impacting the current safeguarding team resource.
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	Safeguarding Children's Team meetings – Monthly Safeguarding Steering Group – Quarterly Integrated Safeguarding Group - Quarterly

Report content

1. Purpose

This annual report covers the period between the 1st April 2025 and 31st March 2026. It provides information and assurance for Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) including activity, achievements and mitigation of risks relating to children's safeguarding.

The report also provides feedback on specific queries received from the Designated Nurse for Bradford District and Craven Health and Care Partnership when they reviewed the Safeguarding Children and Adults mid-year report for 2025/26. The feedback recognised the diligence and commitment of the safeguarding teams in relation to safeguarding children and adults in BTHFT.

2. Background/context

The key issues that need to be understood by the committee remain largely unchanged and relate to the increasing complexity of children and families seeking care from BTHFT and capacity/appropriateness of the safeguarding team to support staff to meet these needs.

There is a reduction in the percentages relating to compliance with mandatory training. Some of this was expected and related to the introduction of the Self Declaration method of reporting and some relates to the ability of departments to release staff for training for a variety of reasons.

There has been some improvement in the accuracy of the activity data collected by the safeguarding children's team, we have a new administrator in post. Data collection and presentation is an ongoing area of work and is identified on the annual work plan for 2026/2027.

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3. Assessment

The report will provide information and data showing the activity and work of the safeguarding children's team. The activity, training offered and evaluated, supervision offer and audits completed provide

assurance to the organisation that children attended will be safeguarded appropriately. The report will include the feedback from the Integrated Care Board Designated Nurse and address any queries raised within the feedback.

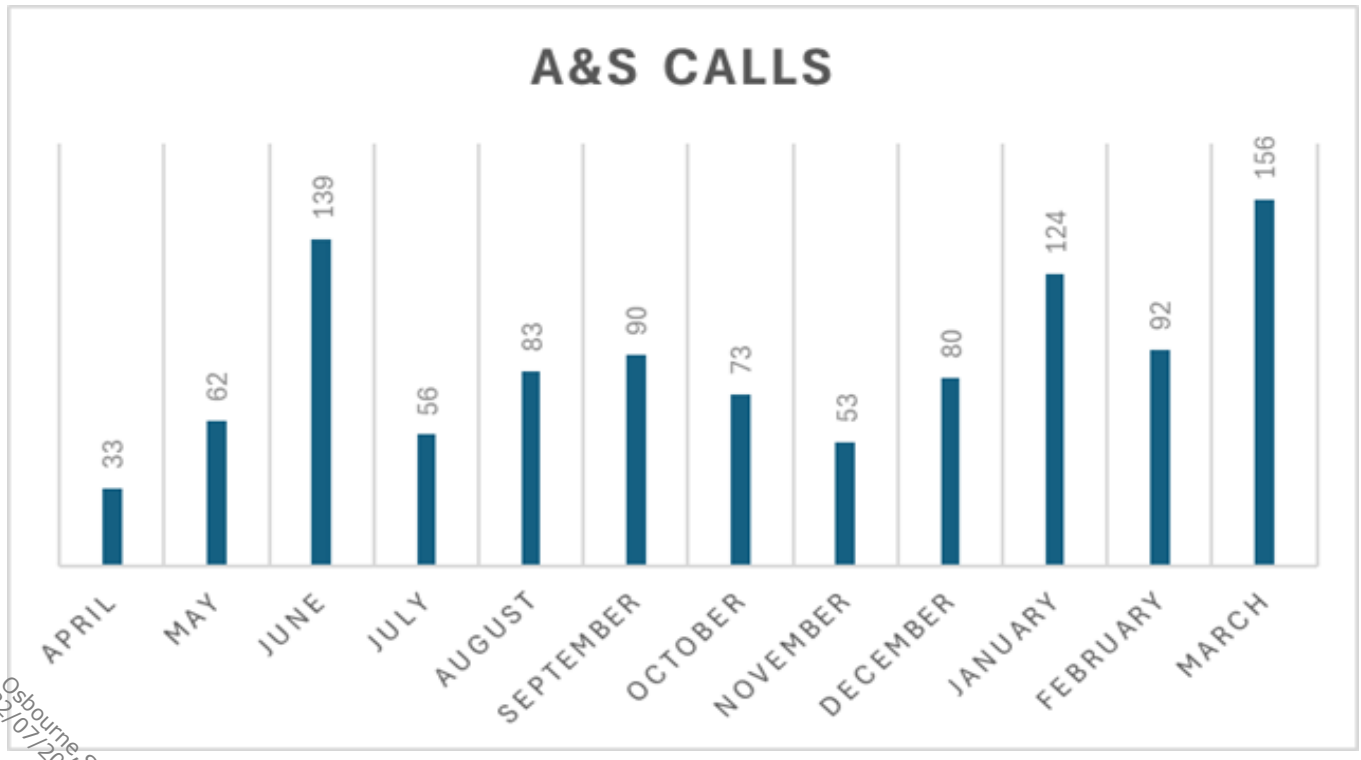
Activity Data

Advice and Support - In the mid-year report it was reported that there were issues with data capture for activity and this has improved with the appointment of a new team administrator. Advice and support activity (see Table 1) has increased by 19% in the 12-month period. In all training and supervision sessions we encourage all levels of staff to call to discuss cases and any queries and these calls are used to educate, offer supervision and for reflection and to guide as to next steps and required referrals.

The activity data relates to the work of the safeguarding nursing team and doesn't reflect the similar activity of the Named Doctors. We are keen to refine the data further and it this forms part of the work plan for the team for 2026/27. A large number of calls and emails come from the Children and Families Trust and demonstrates the strong relationship and open dialogue the team have with one of our key partner agencies.

Emergency Department Attendances and Screening – Table 2 shows the numbers of under 18's screened by the safeguarding children's team set against the numbers of under 18's attending for care. The team RAG rate attendances against a stringent criteria ensuring the most at risk children are identified – this includes screening all children under 1 and all aged 14 and above. The team also receive notifications from our Emergency Department team where there are safeguarding concerns for a child who falls outside the criteria and for adults where there is child behind them who maybe at risk of harm. The team have also begun collecting data on the numbers of children on adult wards whose attendance is also screened by the safeguarding team. These children may have been admitted via the emergency department but also maybe a direct admission for a planned procedure – this data is shown in Table 3.

Table 1



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Table 2

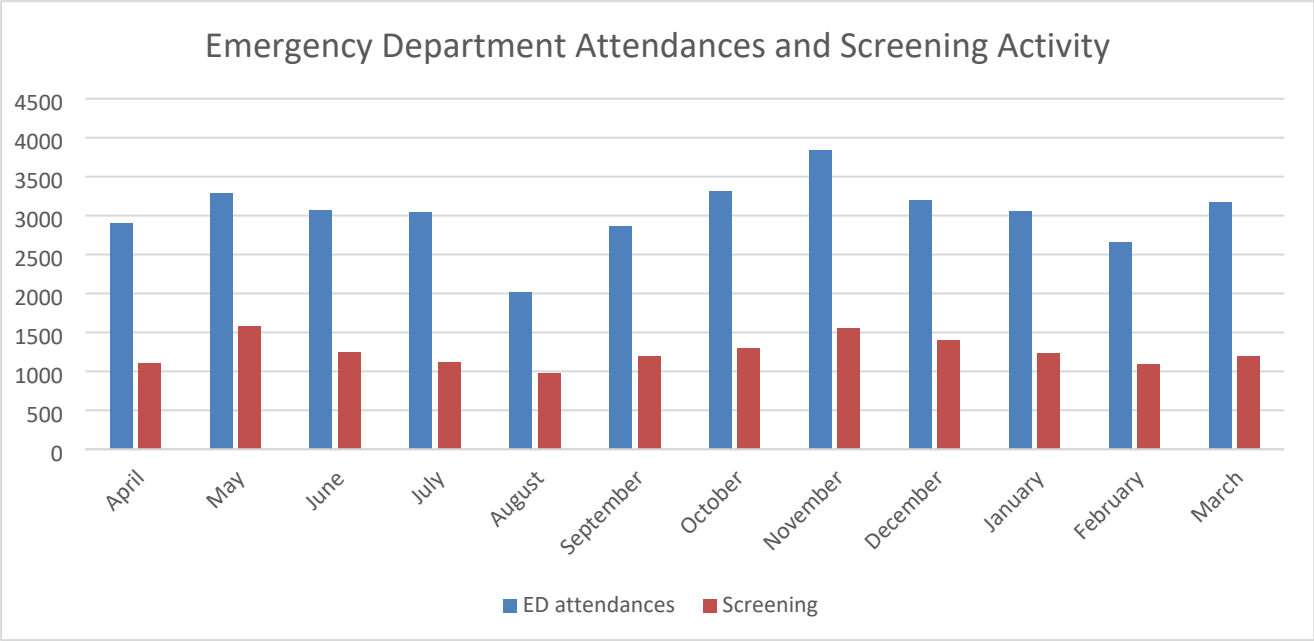
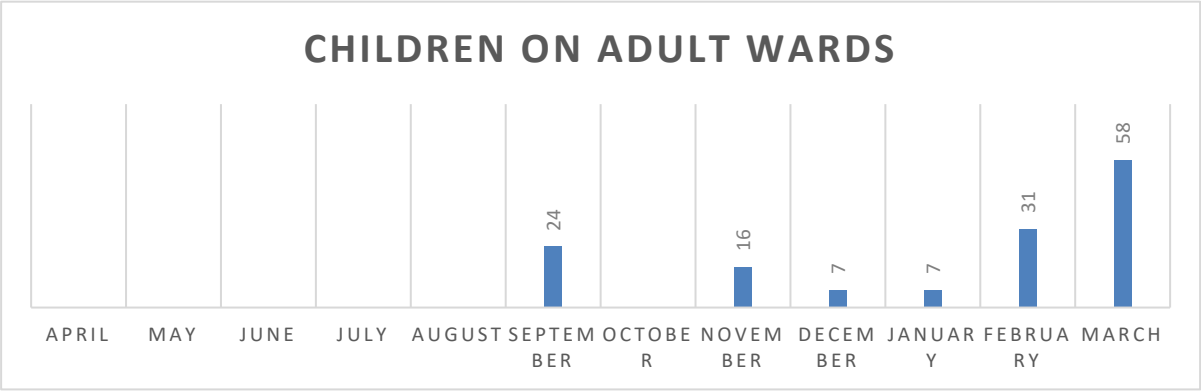


Table 3



Training

Compliance with training - Figures as of 31.03.26

Level 1 – 97%
Level 2 – 96%
Level 3 – 75%
Level 3S – 80%
Level 4 – 82%

Level 3 and 3S are noted to have dropped which is attributed and expected due to the introduction of self-declaration of training compliance. Compliance and data is recorded by the education department but there is some assurance provided by the safeguarding team who review and advise on individual self-declarations. During the final 2 quarters of the year the data has been explored and discrepancies identified which have affected the percentages particular at L3. Similar to level 4 the team has highlighted that some staff are incorrectly levelled and that automatic compliance for L3 is not being recorded when staff complete the required training for L3S. This and the L4 concerns are included in the workplan – staff remain incorrectly levelled at L4, we are confident that all staff who require training at this level are 100% compliant.

Training compliance and requirement across BTHFT is being reviewed in line with the newly published Intercollegiate Document (2025) Safeguarding children and young people & children and young people in care: Competencies for health care staff. Whilst this document retains details of levels of training required it moves away from required numbers of hours of training but focusses on demonstration of competence. The workplan for 2026/27 includes further work to understand what implications this has for BTHFT and there is a plan to review alongside the new mandatory training framework which is due for publication in 2026. The new document identifies core competencies for Senior Managers and Executives and the team are going to be offering specific training sessions for the board members at BTHFT which is a mandatory requirement in the new Incollegiate document.

Discussions are ongoing as to the impact of training on practice – it is acknowledged that this is not easily measurable for any safeguarding services. As a team we continue to pursue/explore this and use evaluations in all training sessions.

A range of accessible training opportunities is provided to support staff in meeting these requirements. This includes weekly two-hour safeguarding training sessions, alongside a monthly session delivered via Microsoft Teams to maximise accessibility across the workforce. In addition, regular “lunch and learn” sessions offer flexible one-hour learning opportunities that enable staff to update and enhance their safeguarding knowledge within the working day. Training content is regularly reviewed to reflect learning from recent national safeguarding children practice reviews and emerging safeguarding themes. Topics delivered during the reporting period have included hidden adults, child exploitation, Think Family approaches, and reinforcing the fundamental principles and basics of safeguarding practice. This approach ensures that safeguarding training remains relevant, responsive and grounded in lessons learned, supporting staff to recognise vulnerability, consider the wider family context and respond effectively to safeguarding concerns.

Recent training within BTHFT has been developed in line with recommendations from Child Safeguarding Practice Reviews and forms part of any internal action plans. Child 6 – Adrian, Henry and Sam action plan is included as an appendices. The action plan was developed directly from the recommendations included in the Child Safeguarding Practice review and includes training on Adultification. Our L3 training sessions have focussed on adultification in Q4 and have also been delivered to BTHFT staff via the Grand Round and there are plans to deliver to our sexual health partners early into 2026/7.

The Named Doctors both had poster presentations accepted for the Royal College of Paediatrics & Child Health Annual Conference in Glasgow, March 2025. In addition, they were invited to give an oral presentation about the Trust’s Safeguarding Simulation training, which received very positive feedback and resulted in a number of requests for our team to share resources for this style of training. Details of the SIMS training were published Archives of Disease in Childhood June 2025

They were also able to support the ALSG (Advanced Life Support Group) in running mini-Child Protection, Recognition and Response training at various points during the conference.

Organisational Safeguarding Assessment (OSA)

We can confirm there were no gaps in the OSA and we were involved in the ‘deep dive’ into the evidence demonstrating compliance with the voice of the child section organised by the Quality Impact Performance subgroup of the safeguarding partnership. We are awaiting feedback from this and Dr Jo Sims is actively pursuing this.

Child Protection Medical Information

This information was requested for inclusion by the Designated Professionals providing feedback on the mid-year report.

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These statistics are obtained through the annual completion of a database by the Named and Designated Doctors for Safeguarding Children. Data is available back to 2016. **ALL** children and young people who undergo a child protection medical are logged in the database and cross-checks are made at the time of data collection to ensure no cases are missed. We also collect information about medicals that are declined and reasons for this – a few are inappropriate referrals but all require discussion with children's social care to ascertain what information they are seeking from a medical and to decide if this is needed. Many of the declined medicals are for chronic neglect, a few are called through for sexual abuse medicals but that service is provided by Mountain Healthcare.

Every two years, the Named Doctors carry out a more detailed audit of child protection medical reports, looking specifically at the language used, the readability and the standard of the opinion. On the last two occasions this is also involved dual assessment with a principle social worker also reviewing the quality of the medicals using our standard tool.

Key findings

- The total number of child protection medicals fell considerably from 2023 to 2024 (437 vs 302) and the highest number was in 2022 when we saw a record 522 children. In 2025 we saw a total of 372 children which is much more in keeping with our usual numbers.
- Over the last 3 years, less medicals have been declined, hopefully due to effective joint working with social care and better understanding of the role of the medical, particularly with regard to neglect
- We continue to carry out low numbers of medicals where neglect is the only concern, and this is entirely appropriate. However we do pick up considerable neglect and dental neglect, in other medicals.
- We continue to see significant abuse in those with complex needs and neurodisability.
- 20% had no physical injury – these medicals were done because of concern about possible abuse. Lack of injury does not equate to lack of abuse.
- Categories of abuse remain similar – most are seen for physical injuries or where there is a disclosure
- We have had only possible abusive head trauma in 2025 [REDACTED]. This was a highly complex case with fantastic joint working with other agencies.

Total numbers (Table 4)

Year	BTHFT
2016	334
2017	389
2018	448
2019	414
2020	429
2021	392
2022	522
2023	437 (& 66 requests declined)
2024	302 (& 26 declined)
2025	372 (& 14 declined)

Having seen a significant drop in numbers of medicals in 2024, our numbers have upturned to more normal levels this year. We generally expect to carry out around 400 per year. We postulated that the drop in 2024 may be due to less medicals for large sibling groups and less medicals for neglect. We have been trying to move away from doing medicals solely for neglect, for a number of years and have worked together with social care managers and the safeguarding partnership in this regard. We know that seeing children for a one off medical is rarely helpful following chronic neglect – it is purely a snapshot, and often the neglect is not necessarily physically evident. For these children, long term information is required from all health sources and education to build up a picture of evidence over time, often with the use of a chronology. Specific information about weight/height, immunisations and dental hygiene can be obtained from other sources such as the GP, BDCT, Community Dentist. Occasionally an acute medical for neglect is useful, if for example the child has been left home alone and found by police with clear signs of neglect and they are brought promptly to see us.

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Declined Medicals

There has been a further reduction in declined medicals this year, which would suggest that the vast majority of referrals are appropriate. This would support that the document “Guidance for Social workers for CP medicals” is being followed within the Children and Family Trust.

Within our electronic patient record, we have a standard template for recording requests for CP medicals and within this is a section for Paediatricians to document discussions with social care where a medical is declined. We also record those cases on our database.

Source of referral

The spread of referrals is very similar to previous years, with 69% coming from children’s social care as expected. As previously, around 1/3 are from within the Trust - usually via the Emergency Department or incidental findings on the ward.

Time seen

In 2025, one third of medicals took place out of hours. This is similar to last year. For the last 2 years, the paediatric consultants have been following a rota which now includes an evening “surge” shift from 1630-2130. Approximately 12% of all medicals were carried out during these evening shifts and 19% carried out during the night from 2130-0830. This is still a considerable burden for out of hours care, at a time when there is a lone consultant caring for the ward, the assessment unit, short stay ward and covering emergencies with the Tier 2 resident. We do encourage referrals as early as possible in the day, but sometimes strategy discussions happen late in the day due to professionals’ availability, particularly the police. Whilst we will carry out medicals in the evening when required, where possible and appropriate (depending on timing of injury), we will refer many to the next day as long as they are in a place of safety overnight.

Primary Reason for Referral (Table 5)

The majority of referrals are for concerns around physical abuse and injuries to non-mobile babies. The number of medicals for neglect is static and remains low, following proactive steps to explore a different way of gathering information for these children, as discussed above.

	Physical abuse	Immobile Babies	Neglect	Sibling	Other
2016	200		59	63	2
2017	253		35	49	
2018	343		47	50	36
2019	259	42	34	76	8
2020	258	72	38	92	11
2021	200	72	40	72	8
2022	278	53	66	125	6
2023	209	73	51	97	25
2024	145	79	34	47	7
2025	183	83	35	66	6

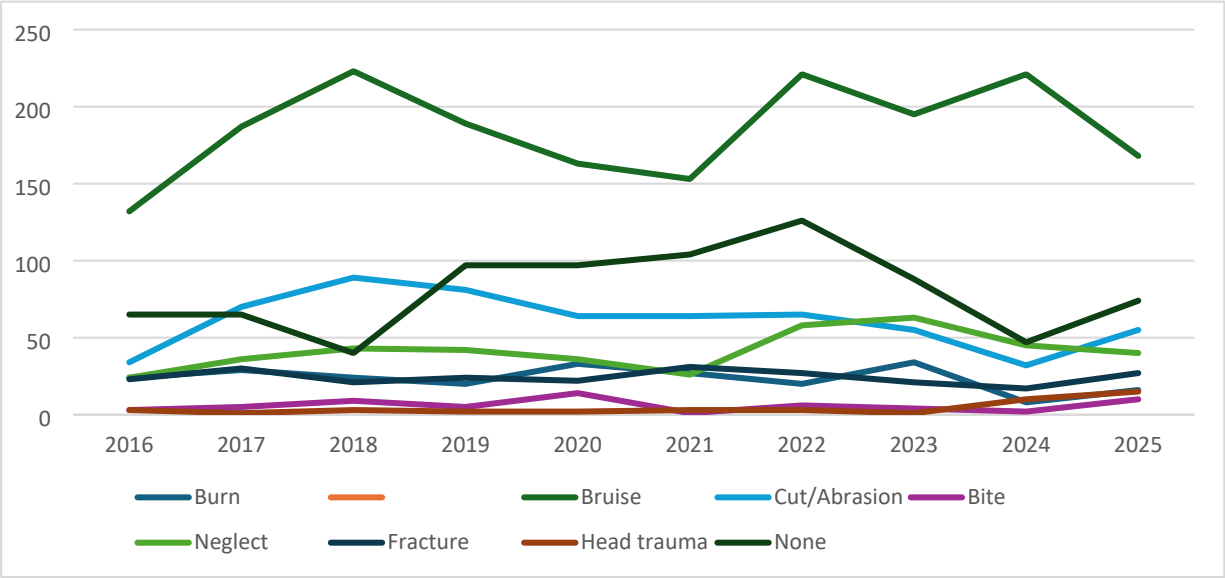
35 children (9.4%) were known to have a background of complex needs/neurodisability/neurodiversity. We have done some work in the department to improve the experience of children with neurodiversity, along with being in a working group to create a guideline specifically for arranging and preparing for medicals in this group. Occasionally we carry out ad hoc medicals within a special school, where a child is not felt able to tolerate coming to hosptial.

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We know that children with complex needs are at least 3x more likely to be abused or neglected than their peers. With that in mind, we hold 2 monthly safeuarding supervision sessions for our child development centre staff, including the community and specialist nurses. Much is discussed in these meetings in terms of

neglect, parental engagement and views, threshold and previous actions. As these cases are more chronic without a specific injury, this work is not captured in our database as these children are not attending for medicals. Neverthless it takes up a considerable amount of time for the CDC paediatrician and Named Doctors, in discussing the case, holding professionals meetings, collating chronologies and where needed, providing professional challenge to children's social care.

Types of Injuries (Table 6)



In terms of the type of abuse found, bruising is most common, but we see many children with multiple injuries and sometimes of various types e.g. burn and bruising. Note that children presenting with burns often go direct to Pinderfields Burns Unit and have their child protection medical there.

20% of children had no physical injury, however it is important to point out that the lack of visible injury is not necessarily reassuring and we are clear to social workers and police that no injury does not equal no abuse.
We saw 10 babies with significant head injury [REDACTED]. The Bradford Safeguarding Children Board Quality & Improvement in Practice subgroup carried out a multi-agency report of management of immobile babies with injuries in 2025.

We are still finding a need to challenge social care with regard to concerns about sexual abuse. We do not carry out medicals for child sexual abuse, as this is a service from a private provider (Mountain Healthcare). We continue to advocate for these children in terms of having SARC (Sexual Assault Referral Centre) presence on strategy discussions and considering the child holistically with ALL risk aspects, whether they have disclosed or not.

Non Mobile babies

The Trust has a guideline for non-mobile babies with injuries, which is aligned with the West Yorkshire Multi-agency Procedures. This means that due to their elevated risk and high index of suspicion, (supported by research evidence), all of this group (not walking/crawling/cruising independently) will undergo a medical and a professional discussion with children's social care will take place.

The total number of CP medicals for non-mobile babies is similar to previous years. Of 83 non-mobile babies with injuries, 37 (approximately 45%) had full medical investigations i.e. CT head looking for abusive head trauma, ophthalmology review for retinal haemorrhages and skeletal survey for bony injury (includes two sets of X-rays 10-14 days apart). This is a higher proportion than previously, perhaps reflecting the anxiety about this high risk group and increasing socail factors determining risk level.

Oct 2025 Safeguarding Children Board 10.0 Item 10.1

Overall outcomes and other information

The outcome categories do overlap so many children are experiencing both physical abuse and neglect. Overall 26.5% of children were felt to be experiencing abuse and 15% neglect – very similar statistics to last year. The proportion felt to be "uncertain" has been very static at aout 15-16% over the last 3 years and this is reassuring.

Whilst there have been 10 episodes of head injury in babies, none of them were thought to be abusive and all were associated with a significant fall from height eg slipped out of parents arms w13 children were recorded as having evidence of dental neglect on our database, but we suspected this is under-recorded on our excel sheet. We know that Bradford is statistically one of the highest areas in the country for childhood dental neglect. The Lead Dentist for Safeguarding at Horton Park has recently developed a new pathway to enable direct referral fto an appopriate dental service or children seen for a child protection medical. This can be done by a social worker or paediatrician.

We continue to encourage our residents working on the Tier 2 rota to observe and carry out medicals appropriately supervised. With the new Progress+ curriculum from the Royal College, more junior trainees (ST3 and above) are needing to acquire this skill early in their training. We are clear about the level of supervision required and all trainee reports require a consultant sign-off (enabled through T Pro with help from IT).

Peer review for child protection medicals is now a weekly process, in line with the high numbers of medicals we carry out. We know this is extremely valued by our colleagues and is an essential part of our safeguarding work.

Collective work is being undertaken with partners in social care and education to improve the experience for neurodiverse children undergoing child protection medicals.

A new process for ensuring consultant sign-off for child protection medicals has been implemented with IT via the T-pro dictation process.

Additional Named Doctor Activity

The Named Doctors have supervised 3 medical students from The University of Leeds in formulating, carrying out and writing up/presenting their ESREP projects. One of those students has submitted their report for the Simon Newell and Leeds Hospital Charity Child Health Research Prize ran by Child Health Outcomes Research at Leeds (CHORAL) and was selected as the prize winner. A summary of the report will be published on the CHORAL website in due course. A further ESREP project is under way with a 4th student this year. We have found it a valuable experience for all parties.

We have been involved in a National Research Project for use of a new visual tool to enable "Voice of the Child" to be captured during safeguarding conversations. This is in its final phase of data collection and will hopefully be published in the future. Talks are ongoing with the Royal College about rolling out the tool for routine use – we have certainly found it very helpful in our department.

One of the Named Doctors sits on the Working Group for the Child Protection Recognition and Response course (through ALSG) and is heavily involved in re-writing the course. Both Named Doctors continue to teach on this course in Leeds twice a year.

One of the named Doctors has primary responsibility for running the PRoTECT training for resident doctors in Yorkshire – this is aimed at middle grade doctors (ST3 and above) and is an advanced level training programme and ongoing accreditation for these doctors in training within paediatrics.

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The Named Doctors continue to have active roles in the Yorkshire and Humber Named and Designated Doctors Network which meets bi-monthly.

We have met with Named GPs and Leads for safeguarding in education about improving information sharing between health and education.

We have completed and analysed the child protection medicals database for 2025, in order to inform teaching and training and provide assurance to the Trust and External Partners.

Audit Work

The whole team are involved in audit of practice and audit work can be demonstrated through the following recent audits:
Non-mobile babies (Multiagency) – lead by the safeguarding children partnership Quality Impact and Performance sub-group – BTHFT reviewed the same 10 cases as partner agencies we await the final report.

Child Sexual abuse (Multiagency) - lead by the safeguarding children partnership Quality Impact and Performance sub-group – BTHFT reviewed the same 10 cases as partner agencies we await the completed report.

Was not brought audit – was completed for paediatric services internally and written up but the team aim to add data from 16-17 year olds attending adult clinics for completeness. The results show good compliance with the Was Not Brought guidance but there is room for improvement and recommendations include a relaunch of the Was Not Brought Guidance and ensuring Was Not Brought and its links to neglect are highlighted at all training sessions and in supervision.

Our routine 2 yearly deep dive into child protection medicals has been carried out in summer- autumn 2025 and is being finalised.

Team Visibility and Engagement

Staffing in the team has had an impact on the progress of this element of work, it will be a priority for the team in 2026/27. There is a plan to survey staff before and after interventions. Since the mid-term report the team have introduced a 'weekly walk around' offering support to wards and departments providing care for children and also a weekly presence on the paediatric ward on the same day every week, getting to know staff and providing support and ad hoc advice and support and supervision. So far this has supported staff with training queries, engaged with play staff and teachers on the ward and provided an opportunity to discuss individual children. The team have also linked more closely with the Audiology team providing support to review cases where there is a safeguarding concern.

The operational level safeguarding children steering group has not been well attended by teams outside the safeguarding arena. This has been escalated to the Integrated Safeguarding Committee and reminders of the importance of attendance sent out. There is a plan to relaunch the operational group as a whole approach safeguarding group, including maternity, children and in March 2026 with invites sent to matrons of the CSUs.

Supervision

The senior members of the team are now all trained as supervisors and are working on the roll out of the offer of supervision and a review of the safeguarding supervision policy is ongoing with the revised policy in draft form and awaiting ratification at our internal integrated safeguarding group. A questionnaire has been circulated to all levels of staff regarding understanding and access to supervision – this is awaiting analysis.

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4. Options analysis/Proposal

- Next years report to be a whole safeguarding activity report including Children, Maternity and Adults.

- There is an ongoing review of the new Intercollegiate document published December 2025 and the NHS England mandatory training recommendations. It is possible there will changes to training requirements linked to roles and there will be a larger focus on staff safeguarding competencies.
- The mental health role within the Children's Safeguarding team continues to be developed and a multi-agency review of the Crisis Pathway has commenced.
- Relaunch of the whole safeguarding operational group and monitoring of attendance.

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Quality Committee			
Meeting Date:	14/05/2026	**Agenda Reference:**	QC.5.26.15
Report Title:	Improvement Strategy Bi-Annual Report		
Presented by:	Liz Tomlin, Head of Improvement		
Executive Lead:	Mark Hindmarsh, Director of Strategy and Transformation		
Author:	Liz Tomlin, Head of Improvement		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	This paper reports on the progress on implementing the Trust's Improvement Strategy (2023-2028) for the reporting period 2025/26. It includes progress made against next steps outlined in the paper presented to the Quality Committee in February 2026. The next steps to support the delivery of the Improvement Strategy for 2026/27 are: • To continue to deliver our in-house training programme and continue to extend the offer to our partner organisations; Airedale NHS FT and Bradford District Care Trust. • To continue building a climate for improvement within services and teams by enabling staff to lead on meaningful improvement work, as well as sharing work via the peer network for improvement. • To measure improvement training, activity and impact by capturing details centrally about small scale improvement projects. This will demonstrate how success will be measured at the start of a project and the use of trusts tools and templates and Model of Improvement framework. This sets an expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplaces. The Quality Committee is asked to take note of the progress and plan for following year 2026/27.			
Recommendation/s: (including any decision/approval required)	*The Quality Committee is asked to:* 1. Note the progress against the Improvement strategy to date.			
Link to Strategic Objective:	Improvement - To be a continually learning organisation and recognised as leaders in research, education and innovation			
Link to Priority Initiatives 2025/26:	N/A			

Implications	
Risk:	Not associated with any risks.
Legal/Regulatory:	N/A
Quality & Patient Safety:	The Improvement Strategy provides a framework to ensure our quality management system is linked to quality control, planning, assurance and improvement.

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Equality, Diversity and Inclusion and Health Equity:	Ensuring all staff have an equitable access to training and support for improvement work.
Resources:	No additional resources required at this time.
Environmental sustainability:	No direct impact on environmental sustainability.
Assurance Route	
Meeting/s where content has been discussed previously:	Progress update to be presented ETM end of Q1 2026/27.

Report content

1. **Purpose**
   This paper reports on the progress on implementing the Trust's Improvement Strategy (2023-2028). It includes a summary of work undertaken over the reporting year and considers the next step proposed in the February 2026 paper (QC.2.26.10). The Quality Committee is asked to take note of the progress and plan for next steps.

2. **Background/context**
   The Improvement Strategy (2023-2028) provides a framework to develop a culture of continuous improvement to support meeting the Trusts' strategic objectives. There are five components that underpin NHS IMPACT's systematic approach which have been incorporated into the Trust's Improvement Strategy (2023-2028) key objectives:

   1. Building a shared purpose and vision
   2. Investing in people and culture
   3. Developing leadership behaviours
   4. Building improvement capability and capacity
   5. Embedding improvement into management systems and processes

   The improvement team continues to provide project management and improvement support to priority initiatives for 2026/27. This Includes, the EXCEL programme, Outpatients Transformation Programme and the new Theatres Improvement programme.

3. **Assessment**
   An updated plan for 2026/27 has been developed to be able to assess the success and impact of the improvement strategy in Appendix 1. This in response to feedback from the Quality Committee in February on the previous plan and is informed by best practice suggested by NHS IMPACT. As set out in February 2026 the next steps for Q4 2025/26 were:

   - **To continue to deliver our in-house training programme and seek external offers via NHS IMPACT which are cost neutral/free at the point of access.**

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   Update: In-house improvement training
   We use the IHI Model of Improvement (MfI) as our improvement methodology which is supported by a 7-week service improvement training (SIT) programme and a shorter 2 hour SIT course ('Good-to-Go'). This provides an easy introduction to the MfI and key tools and templates to get

started with a local project. We have upskilled our colleagues in the Education Team who are delivering the 2-hour SIT course as part of the preceptorship programme for newly qualified staff.

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

Table 1 Improvement training from January 2025 to March 2026

In-house Improvement Training	Number of staff Jan-Dec 25	Number of staff Jan-March 26
SIT 7-week programme~	n=119	n=29
SIT 'Good-to-Go' 2-hour course	n=118	n=86
QI Foundation*	n=273	
External Training		
NHS Impact	n=16	
Total	**n=526**	**n=641**

**The QI Foundation was delivered by the Quality Improvement team up until July 2025 and was similar content to the 2 hour Good-to-Go training.*
~ Please note fall in terms of training numbers for February owing to pause on all non-mandatory training. Most candidates moved to May training session (n=60).

A full list of all the events that have been delivered and supported by the improvement team are detailed in Appendix 2.

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

Following a successful application to our regional NHSE Learning and Improvement Network (LIN), Children's CSU have taken up this opportunity to improve the Autism referral pathway. A small team clinically led by Dr Thopte, to part in a regional rapid improvement sprint. As a result of this work the team have reduced the waiting list time for 61 children and young adults with first appointment waiting times reduced from 46 to 44 weeks so far. The team continue to test ideas to reduce the waiting time and will present their work at a shared learning and improvement event in June.

- **To continue building a climate for improvement within services and teams by enabling staff to lead on meaningful improvement work, as well as sharing work via the peer network for improvement.**

Improvement Network

Quarterly meetings are held with on average 40 people in attendance from multi-professional backgrounds. The meetings are recorded and shared with the network and available on the trust intranet site. Monthly emails are sent to the network signposting and sharing information about improvement activity from a national and local perspective (See Appendix 2 and 3).

Feedback on Improvement training and support

The improvement team are conducting an evaluation of the effectiveness of the improvement training we are delivering. This is to understand any barriers and/or facilitators to improvement work and adapt to meet the needs of the staff and trust. This survey is open from April to 20 May 2026 and has been sent to everyone within the network, as staff have recently undertaken the training

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and expressed an interest in quality improvement as part of everyday work. The analysis and findings will be shared at the next Improvement Network to help inform recommendations and improvements to our training plan.

- **To provide a named improvement specialist from the Improvement team for each CSU to foster closer working relationships to help understand key issues and support improvement activity.**

A member of the improvement team has been aligned to the current CSU structure as a point of contact and provide advice and signposting to resources for improvement training an improvement work at a local CSU/Service level (See Table 2) Louise Middleton co-ordinates and manages the improvement training schedule, improvement network and improvement small scale projects as an outcome of training.

Table 2 Improvement team Support for CSUs 2026/27

CSU Structure		Improvement Team - designated contact
Planned services	Theatres, Critical Care & Day Cases	James Wright/Zak Rehman
	Surgery and Digestive Diseases	Leah Pollard
	MSK and Therapies	James Wright/Zak Rehman
Unplanned Services	Urgent Care, Elderly and Intermediate Care UEC	Vaqass Aktar
	Women's	Caroline Singleton/Becky Palethorpe
	Children's	Leah Pollard
Diagnose & Corporate services	Outpatients & Patient Support Services (OPSS)	Andrew Mullan
	Radiology and Imaging	Hannah Penney
	Spec Medicine	Andrew Mullan

- **To measure improvement training, activity and impact by capturing details centrally about small scale improvement projects.**

We are testing ways to capture local improvement activity in a reliable and accessible way for the improvement team and working with our corporate services and CSU's. This includes reviewing the use of LifeQI which we have used over the past few years as an app to record and monitor improvement activity. However, this currently comes at a cost of about £5K for 200 user licences a year and has been sporadically used by teams and services.

The improvement team are also looking at Microsoft 365 apps that are available trust wide, such as 'lists' where you can create a repository of projects and documents that can be shared with others.

The aim is to have interim way to capture smaller scale improvement work by the end of June 2026 to demonstrate successes and impact on the quality of care including patient experience and staff satisfaction.

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4. Options analysis/Proposal

The Improvement Capability self-assessment (key activities identified by NHS IMPACT) has remained unchanged (See Appendix 4). Therefore, the next steps for 2026/27 are:

- To continue to deliver our in-house training programme and continue to extend the offer to our partner organisations; Airedale NHS FT and Bradford District Care Trust.

- To continue building a climate for improvement within services and teams by enabling staff to lead on meaningful improvement work, as well as sharing work via the peer network for improvement.

- To measure improvement training, activity and impact by capturing details centrally about small scale improvement projects. This will help to demonstrate the use of the Model for Improvement and standardised tools and templates and how success will be measured at the start of a project. This sets an expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplaces.

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Appendix 1 April 2026 – Improvement Strategy 2023-2028 – Progress against delivery of key objectives

Improvement Strategy Objective	How we will meet the objective *Informed by NHS IMPACT – guidance and best practice https://www.england.nhs.uk/nhsimpact/about-nhs-impact/	Progress 2025/26 ✓ Completed ✓ In Progress	Links to Trust strategic objectives
1. Building a Shared Purpose and Vision	*We will:* a. Create a vision and shared purpose for improvement in an inclusive and open way with our staff, patients and the public, and our partners across the local system. b. Involve our local communities and people with lived experience as partners in the design of the vision and shared purpose. c. Ensure the vision and shared purpose are lived everyday by its people and are underpinned by core values. d. Ensure improvement work is aligned to strategic objectives and priorities for the Trust, meeting the needs of our local population. e. Provide a purpose-driven context for improvement work so that people are engaged are empowered to improve. f. Understand the world in which frontline staff are working, their challenges, their successes, and the improvement they would like to see to guide the vision and shared purpose. Methods of co-design and collaboration like crowd sourcing platforms or running engagement events can be used. g. Celebrate and share good practice and learning from improvement activity	✓ The Improvement strategy was approved by Board in Nov 2023. It was developed collaborating with stakeholder groups, drawing upon best evidence for improvement practice and learning from existing improvement and transformation plans. The vision and shared purpose has been summarised into an infographic to be shared across the Trust to ensure continues engagement and understanding what we are trying to achieve ✓ December 2025 Showcase event – Sharing large and smaller scale improvement work using The Trust's approach to improvement. ✓ Improvement Network Quarterly meetings to share and celebrate improvement work – next meeting May 2026 ✓ Identifying areas for improvement based on the latest Care Quality Commission reports	• Improvement • Partnership
2. Investing in People and Culture	*We will:* a. Work with clinical staff, our healthcare partners and those with lived experience to design and implement the improvements based on what matters to them. b. Encourage opportunities for people to visit other systems and organisations to understand different ways of operating and different organisational cultures.	✓ EXCEL programme – community and partnership engagement work to understand how to decompress and improve the experience of care in ED for patients and staff.	• Quality • Improvement • People • Partnership

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	c. Invest and support people to understand and own their work enabling them to make improvements in everyday work. d. Support teams and services to use our improvement methodology, tools and templates to carry out tests of change. This means demonstrating use of the IHI Model for Improvement: identifying smart aims, measures for improvement, generating ideas and running PDSA (plan, do, study, act) cycles. e. Develop a way to measure and assess organisational improvement culture.		
3. Developing Leadership Behaviours	*We will:* a. Have a clear leadership development plan in place outlining capability requirements and access to training. b. Support leaders across the system to live the values and behaviours of the organisation and hold leaders to account for behaviours. c. Clearly advertise and make accessible the support available for people to improve their own services. d. Provide training and development for everyone who has a formal leadership role so they have skills and experience of delivering improvements and can role model 'leading for improvement'. e. Encourage board development to better understand how current leadership behaviours are demonstrating organisational values, identifying strengths and gaps. f. Engage with peer support networks to understand different approach to the issues and leadership behaviours. g. Empower and enable frontline teams to carry out improvement projects. h. Ensure senior and executive leadership to attend performance/ Quality and Safety huddles and workplace visits to engage and staff who are delivering care on the frontline.	✓ Daily huddles embedded across the organisation at an Executive Team level, Quality and Safety and tactical/operational level ✓ Executive Team – Visiting local teams, active programme supported by OD team ✓ Northeast Yorkshire LIN (NEY LIN) - Improvement Sprint – working with other organisations in the region ✓ New Consultant Development Programme - working with Chief Medical Office with refreshed programme and approach ✓ New NHS Leadership framework 2026/27– Strategy and Transformation to work with HR/OD and Education Teams to support the delivery ✓ To work with OD and Board Development programme	• Quality • Improvement • People • Partnership • Sustainable

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4. Building Improvement Capability and Capacity	*We will:* a. Identify an improvement methodology to use across the whole Trust, ensuring a local and systemic way of practising improvement. b. Give all people access to improvement training and support, so that everyone can run improvement projects and continuously improve their daily work. c. Determine how success will be measured at an early stage, use appropriate tools and frameworks, and include feedback from people working at the point of care and people with lived experience. d. Demonstrate the impact of co-producing quality improvements with people who use services as an integral part of daily work. e. Set an expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplace. f. Create and embed a training strategy to increase improvement capability. g. Leaders attend teams daily huddle boards and work to unblock issues which teams are facing.	✓ Model for Improvement From July 2025, we launched our refreshed 'Way of Improvement'. We standardised our in-house improvement training offer and re-built our local network of improvers. ✓ Capturing information centrally about small scale improvement projects to demonstrate the use of the Model for Improvement and standardised tools and templates. This sets expectation that there is an organisational focus on data and all staff are empowered to make and track changes in their workplaces.	• Quality • Improvement • People • Partnership • Sustainable
5. Embedding Improvement into Management Systems and Processes Osbourne-Sheridan 22/07/2026 09:58:21	*We will:* a. Ensure the Trust's quality management system aligns with the strategy, vision and purpose of the organisation at board level and throughout all workforce structures and functions. b. Ensure our systems in place identify and monitor early warning signs and quality risks with clear processes of how to respond to these. c. Ensure the quality management system operates to enables continuous improvement of access, quality, experience, and outcomes. d. Ensure our quality management system can respond to any system changes and national priorities. e. Display evidence how performance and improvement in a clear and visual way to be able to track progress easily.	✓ Work to strengthen the Quality Management system with the Quality Governance Team, Chief Nurse Office and Chief Medical Office	• Quality • Improvement • People • Partnership • Sustainable

Appendix 2 – Building Improvement Capacity and Capability 2025/26

Date	Event	Notes
07/04/25	**Chief Nurse Senior Leadership Team – Bespoke Training**	Introduction To SPC Charts
30/04/25	**May Training Cohort Starts – Session 1**	50+ colleagues on 7-week SIT online course.
7/04/25	**May Training Cohort – Session 2**	Model For Improvement & PDSA
14/04/25	**May Training Cohort – Session 3**	How To Undertake a PDSA Cycle
21/04/25	**May Training Cohort – Session 4**	Collecting & using data to measure improvement
28/04/25	**May Training Cohort – Session 5**	Helping people through change
04/05/25	**May Training Cohort – Session 6**	Thinking differently
11/05/25	**May Training Cohort – Session 7**	Process Mapping
18/05/25	**May Training Cohort – Ends**	Celebration of achievement
13/06/25	**First "Good To Go" trial session delivered to ED**	Rolling ED programme every fortnight over summer
20/06/25	**Consultant Development Training Programme delivered**	Session 10: Quality & Improvement
24/06/25	**Orthopaedic Pathway - Process Mapping**	Introduction To Process Mapping
04/07/25	**Good To Go – AED Band 6/7**	Introduction To Service Improvement
25/07/25	**Bespoke Improvement Training for Finance Dept**	Ongoing programme of support for Nicola Foulds / Ben Roberts
01/08/25	**Good To Go – AED Band 6/7**	Introduction To Service Improvement
07/08/25	**Improvement intranet pages launch**	Presented to HMG
08/08/25	**Improvement Network Launch**	Email to 450+ BTHFT colleagues + intro to new intranet pages
15/08/25	**Improvement Network Email**	The Model For Improvement
22/08/25	**Improvement Network Email**	September Training Course + training videos on intranet
29/08/25	**Improvement Network Email**	Resources available on intranet
	Improvement Network Emails now move to monthly	
04/09/25	**Let's Talk – Improvement Network Article**	Promotion of Improvement Network, Training opportunities and new intranet site
w/c 8-12/09	**National QI Week**	
08/09/25	**GMTS – Introduction To Service Improvement**	Good To Go Training for new Graduate Management Trainees - Christos Fysarakis co-ordinating
12/09/25	**Radiology – Good To Go Training**	Simon Kirk co-ordinating
17/09/25	**ED Trainee Doctors – Good To Go Training**	Dr Tom Morris co-ordinating
17/09/25	**September Training Cohort – Drop in Session**	Informal session prior to course starting
24/09/25	**September Training Cohort Starts – Session 1**	60+ colleagues on 7 week online course. Introduction To Improvement
26/09/25	**Improvement Network – First monthly email**	Add September cohort onto Improvement Network email list. NHS Impact Training + promote Improvement Stall on concourse
30/09/25	**Concourse Event – Improvement Promo Stall**	Model For Improvement, Feb Training, Improvement Network, NHS Impact training ++ ED Excel programme, Innovation
01/10/25	**September Training Cohort – Session 2**	The Model For Improvement & PDSA Cycles

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02/10/25	**Strategy & Transformation Team – Good To Go**	Team to experience new 2 hour **Good To Go** training so we can confidently talk about content and help to deliver
03/10/25	**Tissue Viability Conference**	Improvement Stall in SLT
06/10/25	**CTG Improvement Week**	Training/Improvement Coaching Promo in VRI Hub
08/10/25	**September Training Cohort – Session 3**	How to undertake a PDSA Cycle
14/10/25	**Trauma & Ortho – First Good To Go Training**	Tom White
15/10/25	**September Training Cohort – Session 4**	Collecting & Using Data To Measure Improvement
22/10/25	**September Training Cohort – Session 5**	Helping People Through Change
29/10/25	**September Training Cohort – Session 6**	Thinking Differently
30/10/25	**Improvement Network – Second monthly email**	Invite to Improvement Network virtual meeting
30/10/25	**Bespoke Training – Dieticians Improvement Group**	Sam Francis BNDRG
05/11/25	**September Training Cohort – Session 7**	**NEW** How To Use Improvement Tools (Reworked)
06/11/25	**Improvement Network First Virtual Meeting** Quarterly – Next in February	Open Teams call to all Network members: **Agenda:** Martha's rule – Caroline Patient Involvement – George R Health on the Highstreet - Sophia 3rd December event
12/11/25	**Celebration of Achievement & Certificates**	Close of September training cohort
14/11/25	**Improvement Network – Third monthly email**	Invite to Celebration & Learning Event on 3rd December and lightning round
17/11/25	**NHS IMPACT Training**	25 reps confirmed by KPMG. Email sent re joining instructions for the course on 28th.
28/11/25	**NHS IMPACT Training Commences – First Group**	25 representatives from 7 key areas
03/12/25	**Improvement Celebration & Learning Event in SLT**	Showcase of improvement Keynote Speaker: John Ashcroft, NHS IMPACT
5-7/12/25	**Create dedicated intranet page for Events**	Populated with Dec 3rd event details + email with link sent out
08/12/25	**Redevelop session 7 to include key tools for improvement**	To replace existing Process Mapping module. All slide sets updated.
19/12/25	**Improvement Network – monthly email**	Festive greetings and thanks for engagement this year.
January 26		
05/01/26	**Improvement Network – monthly email**	New year, new improvements
07/01/26	**CDC Process Mapping – Finance & Endoscopy Pathway**	Training Julie & Kevin to conduct 4 hour process mapping course
14/01/26	**CDC Process Mapping – Finance & Cardio/Respiratory**	Supporting Julie & Kevin to conduct 4 hour course
28/01/26	**SIT Training – Optional Pre-meet with candidates**	Orientation for candidates before start of Feb course
04/02/26	**February Training Cohort – Session 1**	30+ colleagues on 7 week online course. Introduction To Improvement
11/02/26	**February Training Cohort – Session 2**	How To Use The Model For Improvement + PDSA Cycle
13/02/26	**Improvement Network – monthly email**	Promote Network second meeting on 19th February
18/02/26	**February Training Cohort – Session 3**	How To Undertake a PDSA Cycle

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19/02/26	**Improvement Network Second Virtual Meeting** Quarterly – Next in May	Open Teams call to all Network members: **Agenda:** T-Pro Right Patient, Right Chair Digital Menus Finance automation NHS Excellence Awards
25/02/26	**February Training Cohort – Session 4**	Collecting & Using Data To Measure Improvement
04/03/26	**February Training Cohort – Session 5**	Helping People Through Change
11/03/26	**February Training Cohort – Session 6**	Thinking Differently
18/03/26	**February Training Cohort – Session 7**	Invite to Improvement Network virtual meeting
25/03/26	**Celebration of Achievement & Certificates**	Close of February training cohort

Appendix 3 Network Meetings held to date:

Meeting 1 – 6 November 25
Topics:

- Martha's rule – Caroline Singleton
- Patient Involvement – George Reynolds
- Health on the Highstreet – Sophia Hussain
- 3 December Showcase Event

Meeting 2 – 19 February 26
Topics:

- Excel x Airedale Digital Care Hub – Jeremy Till
- Innovation – Maulik Gandhi
- Right Patient, Right Chair – Shirley Horsfall/Helen Naylor
- T-Pro Digital Dictation – Andrew Mullan/James Wright
- NHS Excellence Awards

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Feedback from the network sessions
We asked: 'Tell us what you thought of today's session?'

- *Really great to be part of a network. All the info shared was relevant and informative Looking forward to the next one*

- *Very informative, important information explained well. A nice variety of speakers with a similar thread running them all. Very good*
- *Great session, good content and engagement!*
- *Excellent session and very informative.*
- *I found this extremely interesting Thank you, it's good to know what work is being done in the background and how we can improve on our current care*
- *Very interesting to hear about the various improvements that are taking place Thank you*
- *Very inspiring to see some of the QI projects across the organisation. The single point of access project offers so many benefits across the system*
- *All sessions were informative. I found the session on Excel and the digital dictation particularly useful. Great future scanning information provided.*

Meeting 3 – 21st May 26 – Results of the training survey and panel discussion on use of training once back in the workplace.

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Appendix 4 Improvement Capability Progress -Self-assessment - March 2026

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

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Quality Committee			
Meeting Date:	14 May 2026	**Agenda Reference:**	QC.5.26.13
Report Title:	Patient Experience and Engagement Annual Report (including Complaints and PLACE)		
Presented by:	Sarah Freeman, Acting Deputy Chief Nurse		
Executive Lead:	Professor Karen Dawber, Chief Nurse		
Authors:	Ruth Tolley, Quality Lead for Patient Experience and Helen Sutcliffe, Quality Lead for Patient information and Engagement.		

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 annual update on the work that has taken place in relation to Patient Experience and Engagement (PEE) and the work streams that feed into the Patient Experience Group (PEG). It gives clear examples of how the Patient Experience and Engagement Strategy has been adhered to under each of the strategy aims.			
Recommendation/s: (including any decision/approval required)	• The Quality Committee is asked to note the recommendations in the report: • Support is required from all areas to promote and endorse the Patient Experience and Engagement Strategy 2023-2028. • Continue to strengthen capturing EDI demographics and work within all service areas in the portfolio. • Continue promoting the use of real time feedback via FFT to react and make timely improvements, particularly since the introduction of the Insight reports. • Use of QI methodology for tests of change. • National Survey (CQC) action plans to be monitored via the Patient Experience (PE) Group for improvement, led by the designated area lead once complete. • Ongoing promotion and development of FFT data, evidence of “You said we did". • Continue collaboration work with Bradford District and Craven Health Care Partnership to improve collective and consistent improvements. • Benchmark against other Trusts that are doing well or significantly better in key PE areas. • There is the requirement for a tight grip to remain on the handling and processing of complaints to enable Key Performance Indicators (KPI) to be met. These will be monitored via the Clinical Service Unit (CSU) at their performance meetings. • PHSO standards to be implemented for early resolution. • Learning from complaints to be strengthened and made transparent for the public. • Compliments to be captured and celebrations and acknowledgement of these to be developed. • Development of compliance repository for shared Trust wide learning.			
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:	No risks have been identified and there are no risks in relation to complaints on the risk register.
Legal/Regulatory:	CQC Regulation 16. AIS guidance updated. The Trust has a new revised policy to reflect this.
Quality & Patient Safety:	No concerns identified.
Equality, Diversity and Inclusion and Health Equity:	Patient stories for the Trust Board represent a diverse demographic to maximise learning from all communities. The implementation of the digital leaflet library will allow patients and carers to view information electronically which can be translated and also enable the use of screen readers for those who are visually impaired. The Patient and Public Engagement Team continue to link with accessible needs groups as part of their community engagement work. The complaints team now collate EDI demographics from patients at the outset of the complaints process
Resources:	Not applicable.
Environmental sustainability:	The implementation of the digital leaflet library supports the Trust's Green Plan in the aim to provide information electronically to reduce printing costs and the use of paper. Patients can be signposted to view the information on line rather than being handed a printed copy of the information.
Assurance Route	
Meeting/s where content has been discussed previously:	Monthly Patient Experience Group. Monthly Community Engagement Meeting. Bimonthly Accessible Information Standard Meeting. Community Engagement Group. Complaints Steering Group. Quality Committee receives a monthly AAA report. CQC Inpatient Steering Group

Report content

Introduction

This report provides an annual update on the work that has taken place in relation to Patient Experience and Engagement (PEE) and the work streams that feed into the Patient Experience Group (PEG) and the Community Engagement Group (CEG) in line with the Patient Experience and Engagement Strategy 2023-28.

Patient Experience and Engagement

The annual report focuses on activity that has taken place under the headings of the Patient Experience and Engagement Strategy. The report details more examples of work that has taken place to widen the engagement element of the strategy.

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Quality Committee

Patient Experience and Engagement Annual Report including Complaints and PLACE

May 2026

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Together, putting patients first

Headlines

Bradford Teaching Hospitals
NHS Foundation Trust

Analysis of the Patient Experience and Engagement Annual report holds the following headlines:

- 89% of FFT responses received reported *Good* or *Very Good* feedback.
- Complaints has seen an increase of around 23% compared to the last financial year.
- PALs have seen an increase by 12% from previous years.
- There have been 4 complaints graded as High during 2025/26.
- The Trust has received 11 new enquiries during 2025/26 from the PHSO.
- Interpreting services have provided over 57,000 sessions.
- Advances in the patient information library to have a better governance process, a digital focus to reduce printing costs and be greener and more sustainable.
- Work continues in the Trust towards compliance with the Accessible Information Standard.
- Continued work with community groups to improve the quality and experience of care in an equitable and sustainable way.

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Learning

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Several ways that the teams and services demonstrate learning:

- FFT improvements has enabled feedback for ward areas to focus on improving patient experience projects.
- Joint work with the Palliative Care and EDI team has resulted in learning around community needs/wishes in relation to EOL and visiting.
- The Trust took part in a " Perfect Complaints Week"
- A total of 134 staff members have undertaken complaints training since August 2025
- The Complaints Team has produced it's first newsletter to share learning identified across the CSU's
- Learning has been supported by a Kindness clip that has been produced and now shown at HCA induction to reinforce values and behaviours at an early stage.
- Learning from complaints "*You said we did"* templates from Healthcare comms are being displayed widely
- Feedback from CQC IP survey resulted in learning, enhanced patient information and discharge advise.
- Continual learning from the Patient Stories presented to the Trust Board Meetings. With patients detailing their experience of care, from their own perspective, on what it is like to be a patient in the organisation.
- Ongoing work by the Patient and Public Involvement Team to support services to improve the patient's experience through project work.
- Learning from our Community Engagement groups of what and how we can improve from their feedback.
- Feedback from PLACE assessors during the PLACE programme on the hospital environment, quality of care and hospital food.

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Improvement

Bradford Teaching Hospitals NHS Foundation Trust

Parliamentary and Health Service Ombudsman

Examples of Improvement:

- CSU's are more actively involved in preparing complaint responses, supporting ownership and learning.
- Relaunch of the Trusts *Good Night Sleep Tight* campaign.
- Bereavement policy updated and circulated
- Joint discharge meeting held monthly to focus on partnership improvements between hospital and community regarding communication of needs of patients due for discharge.
- Improved quality of data collection and EDI metrics (Dashboard).
- Complaints newsletter developed and shared
- Flagging of Veterans to further support their needs.
- Kindness video filmed and shared. ESR module built and available
- Continued work to understand best practice in relation to AIS.
- Continued work with specialties to undertake engagement projects to identify areas for improvement in patient care.
- Work undertaken in the ENT & Eye OPD regarding the environment and accessibility for those with accessible needs.
- Improvement to the patient information leaflet library to make it accessible for all.



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Together, putting patients first

Assurance » Learning » Improvement = Quality

Assurance

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The teams and services demonstrate assurance:

- Presentation of PE work to Quality Committee (PEG updates), Executive Team Management and Board.
- Requests for CSUs to provide assurance and activity to PEG.
- Learning from complaints spot check audit and plans for wider learning via the PPI team.
- Daily huddles with the Quality team to review themes and trends and provide assurance that any incidents requiring logging are identified and escalated appropriately.
- Regular SLT meetings with the CSU's to identify and address any barriers to progressing complaints, ensuring investigations are reviewed promptly.
- Use of different PE/I feedback and metrics to deep dive further into areas of concern (the use of FFT data).
- Significant Assurance on external audit (PLACE, Complaints).
- Continue to promote and embed the Patient Experience and Engagement Strategy and ensure that we are meeting the objectives.
- Partnership working with local Healthwatch.
- Partnership working with local accessible needs groups.
- PLACE Lite programme.
- Governor, Patient Representatives and PSP are PEG members.

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PLACE

Bradford Teaching Hospitals
NHS Foundation Trust

Patient Led Assessment of the Care Environment 2025 results.

- The PLACE results for 2025 showed an **increase** across all hospital sites in the scoring for:
  - food
  - dementia
  - disability
- The PLACE results for 2025 showed a **decrease**, across all hospital sites in the scoring for:
  - cleanliness
  - privacy, dignity and wellbeing
  - condition, appearance and maintenance
- New car parking infrastructure in place at SLH and the BRI.
- IPC staff are part of PLACE assessment team and steering group.
- PLACE steering group held on a quarterly basis to oversee the Trust's Action plan.
- Joint commitment from CNO/E&F to continued improvement.
- PLACE Lite programme continues to run throughout the year, undertaking a minimum of 4 assessments a year.

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Improvement: next steps 2026/27

Bradford Teaching Hospitals NHS Foundation Trust

- Improvement work to create Dashboard of PE/I metrics.
- Bereavement services to develop family aftercare support.
- Martha's Rule, continued to work with the QI team re worries and concerns.
- Development of newsletter for Patient Experience/Engagement portfolio.
- Development of a PALS clinic
- The Central Complaints Team to focus on learning from complaints and provide assurance that actions agreed by the Trust have been completed, evidenced, and have resulted in meaningful improvement.
- To routinely review data and deliver meaningful dashboards to support insight and assurance.
- Work with legal and governance team to triangulate incidents, claims and complaints.
- Continue to improve patient experience and engagement by advancing Equality Diversity and Inclusion.
- Continue with engagement work with community groups to enhance the patient experience for those with accessible needs.
- Launch of the patient leaflet library with improved governance to reduce providing outdated information.

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Quality Committee			
Meeting Date:	18 June 2026	**Agenda Reference:**	QC.6.26.13
Report Title:	Senior Information Risk Owner IG Update		
Presented by:	Vikki Lewis, Chief Digital Information Officer and Senior Information Risk Owner (SIRO)		
Executive Lead:	Vikki Lewis, Chief Digital Information Officer 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 Senior Information Risk Owner (SIRO) is required to regularly report to the Board of Directors to identify information governance risks and action taken. A report from the SIRO was last presented to Quality Committee in November 2025. This report is a six-month update for the period December 2025 to May 2026. The Annual IG and Data Protection Officer report for 2025/26 will be presented to Board post June 2026. This is to align with the end date of the annual Toolkit assessment.			
Recommendation/s: (including any decision/approval required)	The Quality Committee is asked to note the current position.			
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness			
Link to Priority Initiatives 2025/26:	Digital Strategy			

Implications	
Risk:	Not Applicable
Legal/Regulatory:	Well Led, Data Protection Act/GDPR
Quality & Patient Safety:	Not Applicable
Equality, Diversity and Inclusion and Health Equity:	Not Applicable
Resources:	Not Applicable
Environmental sustainability:	Not Applicable

Assurance Route	
Meeting/s where content has been discussed previously:	Information Governance Group 20/05/2026

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Report content

1. Purpose

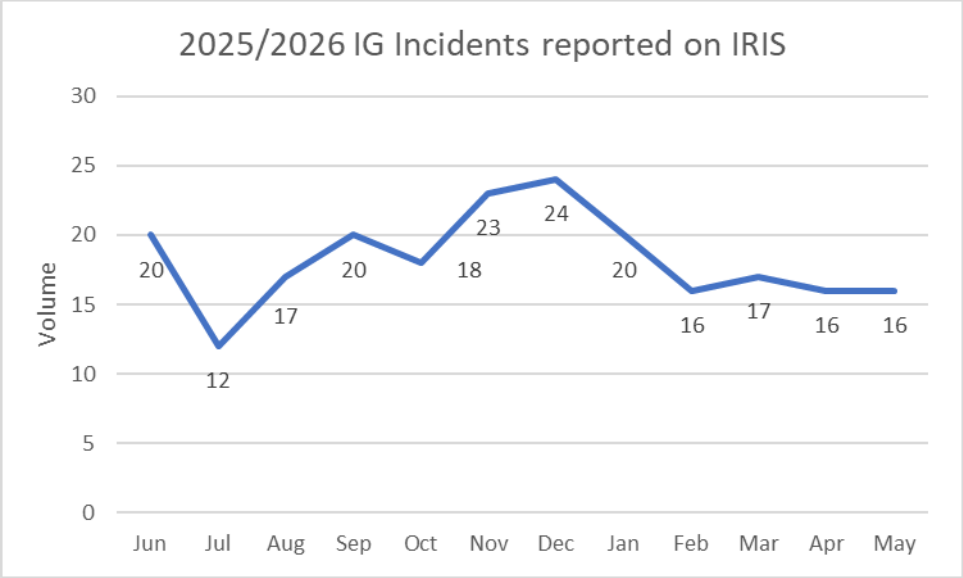
The Senior Information Risk Owner (SIRO) is required to regularly report to the Board of Directors to identify information governance risks and action taken. This paper is an update for the period December 2025 to May 2026.

An Annual IG and Data Protection Officer report for 2025/26 will be presented to Board post June 2026. This is to align with the end date of the annual Toolkit assessment.

2. Background/context

Incidents

There was 1 externally reportable Information Governance incident in the period (in Q1 of 2026). This was reported in May 2026 (ICO Ref 47887 Our ref 35354). It involved a member of staff sending emails from their work to their Gmail account [REDACTED]. The incident is over with the data deleted and confirmed as not further shared. [REDACTED]. At the time of this report the ICO had not responded to the Trust.



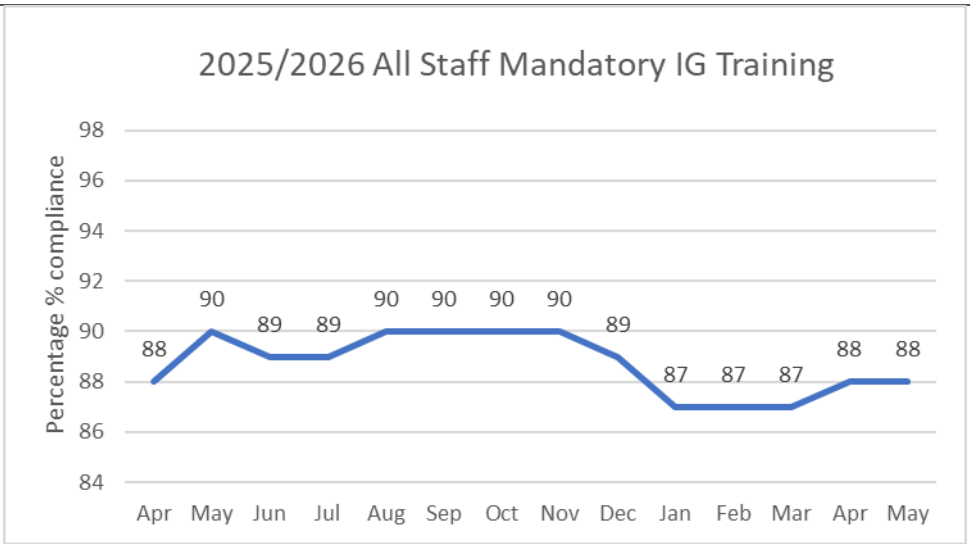
Externally reportable incidents plus all lower-level IG related incidents are reported on the Trust incident reporting system, reviewed by IG and advice is given as appropriate. Where actions are necessary, these are set out. Any learning required is built into communications and awareness activities, with involvement of Caldicott Guardian.

There are currently no particular 'hot spots' of teams or services however there have been instances of staff accessing patient records inappropriately and as a consequence the related IG incidents risk score remains at 12. Awareness communications have been issued and will be repeated.

Training

90% of staff are required to be in date with mandated Information Governance training. The latest position is included.

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The Trust has sustained high levels of training compliance across most areas of the organisation. There was a notable drop in one area (Estates and Facilities) to 59% in January 2026. This was due to the area losing their designated Trainer who has since been replaced. This was noted and steps taken to improve this. Support was provided by the Education Lead to E&F. IG offered to deliver training, but it was felt they should take responsibility for their own training. At the end of March this had risen to 74%. Work continues to bring this area into line with the rest of the Trust levels. The teams have evaluated different methods to deliver training. A number of options have been considered and a blended approach of online modules, face-to-face and workbook materials is available. This ensures there are alternatives to the national eLearning. The Trust training plan and needs analysis has been reviewed and reflects this.

The IG Team are in discussions with Education regarding reintroduction of IG presence in some form at Induction as we are of the view that this is creating issues for new staff in understanding their responsibilities regarding information governance.

Data Quality

The data quality work continues through ongoing operational monitoring and management. Business Intelligence/Information Services is represented at the Information Governance Group meeting and reports directly to SIRO and Digital.

Security

The Trust has continued to ensure that the systems and processes to identify, intercept and manage attacks are robust and raising staff awareness is ongoing.

The Head of IT and Cyber Security Manager are represented at the Information Governance Group meeting and reports directly to SIRO and Digital. The Head of IT owns the majority of the CAF aligned Data Security and Protection Toolkit requirements, as below.

Subject Access Requests

Month (2025-2026)	Number of SARs	Completed in 20 working days (%)
December	297	100%
January	356	100%
February	371	100%
March	332	100%

Joshua Sheridan 13/04/2026 09:58:21

There were no breaches of timescale, or unfulfilled requests. There were no cases that were subject to significant escalation or review by the Caldicott Guardian.

Freedom of Information

Overall, 83 per cent of FOI requests received during 2025/26 were responded to within the statutory deadline or an agreed extension.

While this is below the expected standard, delays have primarily been driven by capacity pressures within key information-providing teams, along with periods of reduced staffing availability (e.g. paternity and maternity leave). This has particularly affected more complex requests requiring specialist input.

Performance in this area will continue to be monitored.

The majority of requests come from Public Individuals and the trend over the last year has seen common themes recurring in requests, such as:

- Finance and expenditure on agency staff
- Use of locum and agency staff
- Procurement and expenditure on equipment
- Corporate policies
- Salaries, staffing and workforce
- Contracts (IT / telephony)
- Medication issued for specific conditions

Cyber Assurance Framework (CAF) aligned Data Security and Protection Toolkit (DSPT)

The CAF based DSPT self-assessment tool is still managed and hosted by NHS England on behalf of the Department of Health. Whilst it still includes broader Information Governance requirements, the focus is information security/cyber which means increased ownership by Head of IT and cyber team. Owners for the standards attend IG Group meetings, as well as separate assurance meetings and provide assurance to the SIRO. The deadline for the 2025/26 submission is 30 June 2026. Internal Audit's review has been completed with a score of Moderate Risk and High Assurance (noting the annual assessment year runs 1 July to 30 June). A separate report is provided to the Committee for the Toolkit.

Ongoing Maturity

The Trust continues to improve and mature information governance understanding and working practices, in pursuit of a high depth of compliance to the General Data Protection Regulation and Data Protection Act, and its general commitment to safeguarding patient and service user information, including the quality of its data.

Information Assets

Work is continuing to enhance the Information Asset Owners (IAO) management of information assets although delayed due to the capacity of the IG team.

Further work is needed to engage with IAOs to help them understand their own and the Trust's obligations, though we have made good progress on the review of the Information Asset Register. Mapping work continues to take place so progress has been made.

Information Governance Risks

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The SIRO and IG Team monitors and reports incident related and other IG related risks reported on the Trust risk register routinely.

Current Risks are the

- Risk of IG Breaches

- Risk related to limited IG resources across BTHFT and AGH, and
- Risk of failure to complete CAF aligned DSPT.

The SIRO is responsible for overseeing the development and implementation of information risk strategy. The SIRO is supported in this by the IG team and by Information Asset Owners (IAO) within each business area. The IAO is responsible for managing information risks to the assets within their control. The IG team support IAOs in achieving this objective.

Information Commissioner's Office (ICO)

The ICO continue to publish Data Protection/GDPR guidance. This supports us in reviewing, enhancing and/or introducing and implement policies, guidance and processes to improve the information governance provision and be compliant with relevant legislation and standards. The new Data Use and Access Act legislation in 2025 with some elements being phased in over a period of time means the ICO are in the process of updating some of its guidance.

Data Protection Officer (DPO)

The Data Protection Officer (DPO) provides an annual report update to the Board of Directors in keeping with the role's mandate.

3. Assessment

The report presents the current position of Information Governance at the Trust for the six month period December 2025 to May 2026.

4. Options Analysis/Proposal

This report provides positive assurance on the current Information Governance position of the Trust, notwithstanding the need to maintain or improve the overall training compliance level and continue to raise awareness of learning from incidents to aim to reduce avoidable data breaches. The risk position of the Trust in this regard is unchanged.

The Committee is asked to note the current position of Information Governance in the Trust.

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22/07/2026 09:58:21

Board of Directors			
Meeting Date:	23.07.26	**Agenda Reference:**	Bo.7.26.9
Report Title:	Maternity and Neonatal (Perinatal) Board Assurance May/June 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 the Trust Board with the assurance that a monthly review of maternity and neonatal quality and safety relating to May and June 2026 activity, was presented and key elements discussed including: • The number of harms occurring in May and June, 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 0 completed MNSI reports and recommendations in May and 3 in June. • No Maternity Outcomes Signal System (MOSS) triggers were received in May, and a further level 1 trigger was received on 21 June and returned within the required 8 working days. This paper also includes: • An update on the Ockenden and Amos reports published in June. • MOSS Critical Safety Check response completion. • Confirmation that the Maternity Incentive Scheme, Year 8, agreed 2nd checkpoint date for training compliance of 90% was achieved.			
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 May and June 2026 Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. 2. Note the narrative regarding the Ockenden and Amos reports and the immediate actions required. 3. Note Appendix 5, completed MOSS Critical Safety Checklist, and the unchanged rating of Green/Amber, with risks monitored via Women's Core Governance Group. 4. Note that the 2nd Maternity Incentive Scheme, Year 8, Training Compliance Checkpoint was achieved.			
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:	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, June and July 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.

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 private Trust Board, in addition to any completed Maternity and Neonatal Safety Investigations (MNSI) and internal Patient Safety Incident Investigation (PSII) reports.

Submitted 25/07/2026 18:21

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

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

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

Background/context
The May and June updates and associated appendices were discussed in May and June 2026 Quality Committees respectively.

The key elements of the papers discussed included:

- The number of harms occurring in May and June, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of MNSI and PSSI cases were discussed and are available to the private Board meeting.
- There were 0 completed MNSI reports and learning/recommendations to share in May and 3 in June.
- In June and July, the 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 the Trust Board on the following specific items:

Ockenden and Amos National Reports:
Donna Ockenden's 4-year independent review report into failings in maternity and neonatal care at Nottingham University Hospitals, was published on 24 June 2026. The report acknowledges the stories, losses, and harms of more than 2,500 Nottingham families, and as a service we are keeping these families at the forefront of our minds as we work through the details and the immediate and essential actions.

The report concludes with 8 key headings for Immediate and Essential Actions:
1. Listening to Women & Families
2. Workforce Planning & Safe Staffing
3. Training & Multi-Professional Learning
4. Risk Assessment Throughout Pregnancy
5. Incident Investigation & Family Involvement
6. Governance & Board Accountability
7. Culture, Teamwork & Psychological Safety
8. Mothers Who Have Died and Post Death Care

These recommendations, alongside those resulting from the Amos Investigation, will be reviewed by the National Maternity and Neonatal Taskforce and contribute towards a national suite of recommendations.

The Government issued 3 immediate actions:

- Roll out of Martha's Rule to all maternity and neonatal settings in England
  - Martha's Rule has been partially rolled out in maternity and neonatal (postnatal inpatient) areas at BTHFT but needs further work and clarification. To date, no families have used this process to obtain a 2nd opinion.

Osbourn-Shaw (1)
22/07/2026 08:38:2

  - Consideration as to how Martha's Rule can be considered for babies on the Neonatal Unit as this would be likened to second opinions on an adult intensive care unit.
  - The service needs to audit service users' knowledge of the process.
  - Posters are currently in English only, consider producing in other frequently used languages.

- Strengthening candour and cooperation in future reviews
  - Refers to enactment of the Public Office Accountability Law/Hillsborough Law.
  - At service level we must continue to promote a culture of openness, honesty and co-operation, particularly listening and responding to families when things go wrong.

- Human Tissue Authority (HTA) action requiring all Trusts to review mortuary records
  - Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve.
  - All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement by 31 July 2026.
  - Chief Operating Officer will be responsible for the completion and oversight of the review

Baroness Valerie Amos' Independent Investigation into Maternity and Neonatal Services in England, was published on 30 June 2026.
The report is comprised of 2 parts, the Final Report and Recommendations, and 12 Individual Trust Reports, of which Bradford is one. The overarching report describes concerns raised by families including:

- Women and birthing people not being listened to, heard, or believed.
- Racism, discrimination and structural inequalities embedded throughout the maternity and neonatal system.
- Services not designed in a way that ensures consistent safety.
- A fragmented system and care inconsistent.

The Final Report has 8 key recommendations:
1. Creating a statutory national Maternity and Neonatal Commissioner.
2. Systematically listening to the voices of women, birthing people and families.
3. Improving how the system responds and learns when something goes wrong.
4. Creating a Modern Service Framework which sets out national standards to consistently achieve high-quality maternity and neonatal care.
5. Tackling racism, discrimination and inequality.
6. Improving system governance and accountability structures and regulatory oversight.
7. Improving culture and teamworking, and strengthening leadership at all levels of the system and across professions.
8. Delivering estates and digital systems that are fit for modern maternity and neonatal care.

The report acknowledges that the scale of the action required will take time to implement but issued some recommendations which should be acted on immediately. Many of the recommendations/actions require further guidance and progression from the Department of Health and Social Care (DHSC) and NHS England, but at Trust level there will be a requirement to:

- Complete a board-level audit within the next three months of current triage provision, with particular attention given to staffing, including medical staffing at appropriate seniority, 24 hours a day, 7 days a week. The results of this audit must be reported to regions and DHSC/NHSE.
- The service will also need to ensure we have sufficient antenatal bed capacity to admit women for support in early labour.

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The Bradford Report (Appendix 6 and 7) is difficult to read in parts, particularly where service users have described poor experiences of care. The service have asked the Amos team to reach out to any service users contributing to the investigation, on our behalf, to offer an opportunity for us to listen to their experiences first hand, and whilst we cannot undo any harm or repair a poor experience, we may be able to share where improvements have been made, and use their experiences to further improve our services.

Maternity Outcomes Signal System (MOSS):

- The maternity service received a 2nd level 1, MOSS signal trigger on 21 June, triggered by 2 term neonatal deaths in addition to the rolling number of term stillbirths reviewed in the April critical safety check.
- 1 NND was the expected death of a baby on the Butterfly palliative care pathway. The 2nd baby was an unexpected death of a baby born in good condition at 3 hours of age. This case has been referred to the coroner and to MNSI for investigation.
- 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. The 2 NND were discussed and no safety issues relating to intrapartum services were identified. 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 5.
- 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, along with the Executive and Non-Executive Perinatal Safety Champion prior to their approval and sign off.
- The team assessment is that following review of the term neonatal deaths alongside the critical safety checklist completed in April, intrapartum services at Bradford continue 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.

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 2nd checkpoint, declared in advance through Quality Committee, this was agreed as 1 July 2026.
- The service can confirm that 90% or above compliance was achieved for all relevant staff groups by 1 July 2026, meeting the MIS standard.

- **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.

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- **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, May 2026 – available in the reading room here
- Appendix 2 - Maternity and Neonatal (Perinatal) Services Update, June 2026 – available in the reading room here
- Appendix 3- Closed Board Harms May 2026 – available in the reading room here
- Appendix 4- Closed Board Harms June 2026 – available in the reading room here
- Appendix 5- MOSS Critical Safety Checklist Response – available in the reading room here
- Appendix 6 – BTHFT National Maternity & Neonatal Investigation report – available here
- Appendix 7 – BTHFT National Maternity & Neonatal Investigation report Annexes – available here

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Meeting Title	Board of Directors		
Date	23 July 2026	Agenda item	Bo.7.26.10a

Committee Escalation and Assurance Report (AAA)

Report from the: People Committee

Date of meeting: 10 June 2026

Key escalation and discussion points from the meeting

Alert:

- **Workforce reduction plan**: good work is ongoing in this space - the Committee will need to keep an ongoing focus on the **balance between workforce reduction plans (and cost); workload and patient outcomes and experience**. This complex balance of productivity; efficiency; quality of care and culture is top of mind for the executive, but the Committee will also need to ensure assurance as we progress through the next year and monitor operational impact. The Trust remains in the highest percentile for workload at the same time as we are reducing workforce, and more work is scheduled for the Committee to be assured on this difficult balance.

Advise:

- **Dashboard**: work remains ongoing – especially around tracking of the workforce reduction plans across bank and agency use; sickness reduction; vacancy holds; MARS and other activities. An agreed 'single version of the truth', including recruitment, will be brought to the next meeting in July. The workforce reduction plan as presented gave no option for tracking of progress and this will be addressed.
- **Staff Survey:** we spent a good amount of time on the action plan for the staff survey, including a wider group and the leads for the staff networks. We should keep top of mind the positive results in many areas whilst not shying away from areas of concern. An open and constructive discussion was held. The actions remain critical to continuing to focus on the **culture** of the Trust; emphasising some of the excellent practice we have and moving the dial on the areas of focus - wellbeing; listening & learning and discrimination & belonging. The actions need to sit within the CSUs and be embedded operationally and visible progress on a few key areas is preferable to trying to do too much. The Committee will continue to monitor this alongside other related actions.
- **Policies**: the committee is concerned about the length of time taken for policies to go through governance and be rolled out to the Trust. Examples include revised sickness / absence policy and the Civility and Respect policy. These policies often underpin mitigations on risks and so these delays have an impact of effectiveness.

Assure:

- We were given early update on the Lord Mann review on anti-semitism and racism and will continue to monitor as we understand how it will be addressed within the Trust. This is also linked to the wider Uniform policy and a refreshed approach will be brought to Committee.
- **Training DNA'a (did not attend)** remains high, and in particular for nursing bank staff: measures have been put in place to address this where the training is mandatory.
- We were assured by the Trusts excellence - with the Trust identified as one of the best-performing acute trusts in the country in relation to **medical appraisal and revalidation** and noted responsibility for this had, appropriately moved from HR to the CMO.

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Meeting Title	Board of Directors		
Date	23 July 2026	Agenda item	Bo.7.26.10a

- We were broadly assured by the **Health and Safety report** with some further requests to triangulate data on MSK injuries / sickness and the staff survey actions on violence to avoid duplication.
- As an additional item, the Committee received a briefing from the Head of EDI and Professor Louise Bryant, Deputy Dean: EDI, Faculty of Medicine and Health, University of Leeds on the joint Task and Finish Group established between the University of Leeds and Bradford Teaching Hospitals, focusing on addressing and preventing harassment and **sexual misconduct during clinical placements**. Members welcomed the work and recognised its relevance, particularly in light of emerging themes relating to sexual safety within staff survey data and training environments. The Committee acknowledged that the initiative addressed both a national priority and local need. The Committee agreed that the work should be formally presented through the appropriate executive route to ensure awareness, alignment, and engagement, including involvement of relevant leads and staff-side representatives.

Report completed by:

Justine Andrew
Committee Chair and Non-Executive Director

21st June 2026

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22/07/2026 09:58:21

Meeting Title	Board of Directors		
Date	23 July 2026	Agenda item	Bo.7.26.10a

Committee Escalation and Assurance Report (AAA)

Report from the: People Committee

Date of meeting: 15th July, 2026

Key escalation and discussion points from the meeting
Alert:
The board is asked to note that the Trust wishes to retain a **flexible bank model**, in regard to HCA staff. The flexible bank model has been in operation for some time and has been a deliberate part of the Trust's workforce model. It provides a lower cost, flexible and sustainable model and, in the short term, mitigates against the relatively high vacancy and sickness rate in this cohort of colleagues. It also means the Trust is able to attract individuals who require greater flexibility than a permanent position can offer. Whilst the Trust will continue to make reductions in other areas of bank usage, it is proposed that the HCA bank model is retained. This is supported by People Committee As this is different from the overarching request from NHSE (NHS England) to reduce bank staff and therefore needs to be agreed at Board before reporting back to NHSE.
Advise:

• Following a series of meetings discussing a plethora of People related action plans the Committee is moving to a **consolidated approach to actions** that will hopefully support prioritised and focused delivery of fewer more impactful actions. This covers, inter alia, Staff Survey action plan; WRES (Workforce Race Equality Standard), WDES (Workforce Disability Equality Standard), the People Strategy, attendance management plan, gender pay gap and disability-related plans.
• Good progress has been made on **workforce reduction** with a reported reduction of 225 so far this year against a year-end target of 185 and a Q1 target of 40. As sickness has not yet substantively reduced this is primarily vacancy control, and as such needs to be carefully monitored across financial and quality metrics as well as progress on productivity. The Committee noted the risks inherent in the plan and a substantive and constructive discussion was had on the balance and impact. The Committee also noted the need for a longer-term strategic workforce plan whilst noting the capacity constraints and strain on delivering business as usual.
• The Committee received an update on progress against the **Wellbeing and attendance management action plan** update presented in May. This is against a backdrop of sickness absence rates that slightly increased in month. Three key points to note:
  ○ It will take time for the action to impact on the numbers and we need to hold our nerve on the plans
  ○ That said there needs to be more of a focus and urgency on a few key activities that (it is believed) will have an impact on sickness in the short to medium-term with a more explicit focus on actions that will make a difference – such as the centralisation of sickness management. This is being progressed through ETM (Executive Management Team) as will require some investment.
  ○ Finally, the approach needs to be underpinned by not just policy change but a wider cultural change that challenges bad behaviours. Whilst this will also take time it cannot be led by HR (Human Resources) / OD (Organisational Development) and needs to be

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Meeting Title	Board of Directors		
Date	23 July 2026	Agenda item	Bo.7.26.10a

supported by robust communications; strong leadership support and ongoing and repeated messaging across all areas of the Trust.

- The Committee spent a substantive amount of time across three separate but linked reports: the **nursing staffing data publication** that comes to committee each month; the **biannual nursing establishment review** and a detailed paper on the **maternity and perinatal workforce.**
  - These are at the nexus of complex decisions the Trust leadership is making every day on finance, staffing and patient care. The Committee was broadly assured by the levels of quality control and daily operational meetings based on acuity, staffing and patients.
  - The **maternity and perinatal report** covered (for the first time) a combined view across obstetrics, neonates, anaesthetics, anaesthetic nurse staffing and maternity and is clearly timely and relevant in the light of the Ockenden and Amos reviews. The report reflected some of the known risks, such as gaps in maternity theatre workforce, but also provided assurance that the risks were being managed in the short term. There were seven specific asks made of committee, including supporting re-submission of business cases to address the staffing gaps more systemically. Given the potential cost these will need to go through the right assurance routes, including discussion at Board for some items. It was noted that these are hard decisions in the current financially constrained climate that may require the Trust to invest less elsewhere and therefore need to be duly considered by Board. The Committee approved progressing all of the asks.
- The Committee received the **Q1 FTSU (Freedom to Speak Up)** report and was assured by the ongoing efforts of the Guardians and Champions. It was noted there were, unusually, three claims of detriment reported that are being further investigated and will be reported back to Committee.

Assure:

- The **dashboard** has been refreshed for this series of meetings and provides a more cohesive view across people, quality and financial metrics for all committees. The workforce and sickness tracking data is also substantively improved. Whilst there is still work to do to confirm the accuracy of the numbers reported (for example if training posts are included in overall established workforce numbers or not) the Committee took greater assurance from the data provided.
- The Committee was further assured by:
  - The updated and refreshed **BAF**.
  - The Trust's response to the nationally mandated **Resident doctors 10-point plan**
  - The progress on the Respect, Civility and Resolution policy that will be launched in August with training to follow.
  - An update on the Supreme Court ruling on **gender and biological sex** which outlined the Trust's current position; the legal position and the approach the wider NHS is taking. We will maintain a watching brief on this as a Committee.
- The Board should be advised that the Trust is considering its response to and implementation of the **Lord Mann independent review** into antisemitism and wider racism across the NHS. The response, following wider NHS guidance, will come to the Committee in September.

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Report completed by:

Justine Andrew
Committee Chair and Non-Executive Director

20th July 2026

Board of Directors			
Meeting Date:	30/07/2026	**Agenda Reference:**	Bo.7.26.10b
Report Title:	NHS Staff Survey 2025 **|** Benchmarked Results and Action Plan		
Presented by:	Lisa Falkingham, Senior OD Manager		
Executive Lead:	Mel Pickup, Chief Executive Officer		
Author:	Catherine Shutt, Head of Organisational Development Lisa Falkingham, Senior OD 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 Staff Survey benchmarked report (found here) provides us with our staff survey data at an organisational level compared to both our previous years scores and also in comparison to the 120 other Acute and Acute Community Trusts that participated in this years' survey. This enables us to explore the data in more detail – identifying any areas we are performing particularly well in, and areas where we are outliers compared to other Trusts in our sector. Analysing this data enables us to better understand our colleagues' experiences of work and helps us to identify the priorities we will focus on for the remainder of 2026/2027. This paper provides a summary of the benchmarking report organised via highlights and areas of focus and presents the agreed organisational action plan. Key headlines from the benchmarked report include: • Our 2025 response rate was 43%, with 3236 colleagues completing the survey. This was 4% lower than the national response rate for Acute and Acute and Community Trusts (47%); • We have scored above the national average on all of the overall People Promise elements and themes; • Comparing results from 2024 to 2025, four themes have increased positively (we are always learning, we work flexibly, engagement and morale), one remains the same (we are safe and healthy) and four have slightly decreased since 2024, although the report states that these changes are not statistically significant; • There are 21 sub-themes which sit under the overall People Promise elements and themes. We have scored above the national average on them all. • Since 2024, the biggest areas of growth in the sub-themes are 'appraisals' (+0.10), 'support for work-life balance' (+0.05) and 'flexible working' (+0.05); • The main themes to celebrate are around career progression and flexible working (two of the key areas of the 2024 action plan), as well as achieving above the national average in all areas of the People Promise and all sub-themes;			

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	• The main themes to focus on for improvement are: discrimination, colleague voice and wellbeing; • Analysing the results and trends over the past five years shows steady improvement in all People Promise themes, however progress is now starting to plateau. The organisational action plan is themed into three key areas: • Creating a sense of belonging by tackling any form of discrimination; • Improving how we hear from our colleagues (listening and learning); *and* • Further developing our wellbeing support. The plan has been co-created by colleagues through a number of listening sessions and with the support of colleague networks.
Recommendation/s: (including any decision/approval required)	It is recommended that Board: • Note the contents of report.
Link to Strategic Objective:	People - To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion
Link to Priority Initiatives 2025/26:	Thrive
Implications	
Risk:	The survey enables us to identify areas of focus and prioritise actions which will have an impact on engagement, morale, and performance – and in turn, creating a happy and healthy workforce who want a career at BTHFT and can thrive in their role by being recognised, valued, listened to and developed. Understanding the data better and acting upon it therefore also has an effect on retention and sickness absence – and associated financial impacts.
Legal/Regulatory:	It is a requirement from NHS England for the annual staff survey to be completed.
Quality & Patient Safety:	Decrease / loss of engagement of the workforce can lead to a decrease in performance and impacts on patient safety and quality.
Equality, Diversity and Inclusion and Health Equity:	Inconsistency in colleague experience can lead to many EDI challenges and it is vital we learn and understand these to support our people in the best way. The results also demonstrate key areas to prioritise to improve our colleagues experience at the organisation, some of which are unique to our organisation and require sustained focus.
Resources:	Our people are our biggest asset, and we have a duty to support them to do their roles in the best way possible. We risk colleagues choosing to leave the organisation / not apply for roles at BTHFT if we fail to listen and act upon their feedback.
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	Executive Team Meeting – March 2026 People Academy – March 2026 Executive Team Meeting – May 2026 People Committee – June 2026

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Report content

1. Purpose

The purpose of the paper is to:

- Share the results and key themes from the 2025 NHS Staff Survey; *and*

- Share the organisational level action plan.

2. Background/context

The survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. The survey is aligned to the NHS People Promise. The aggregated survey results are official statistics, providing a rich source of data that is used by a wide range of NHS organisations to inform understanding of staff experience locally, regionally and nationally.

BTHFT commissioned IQVIA (formally Quality Health) to conduct the NHS Staff Survey on its behalf. The survey was completed between September and November 2025. BTHFT results are placed in the comparator group entitled 'Acute and Acute and Community Trusts'. All data is anonymised.

3. Assessment

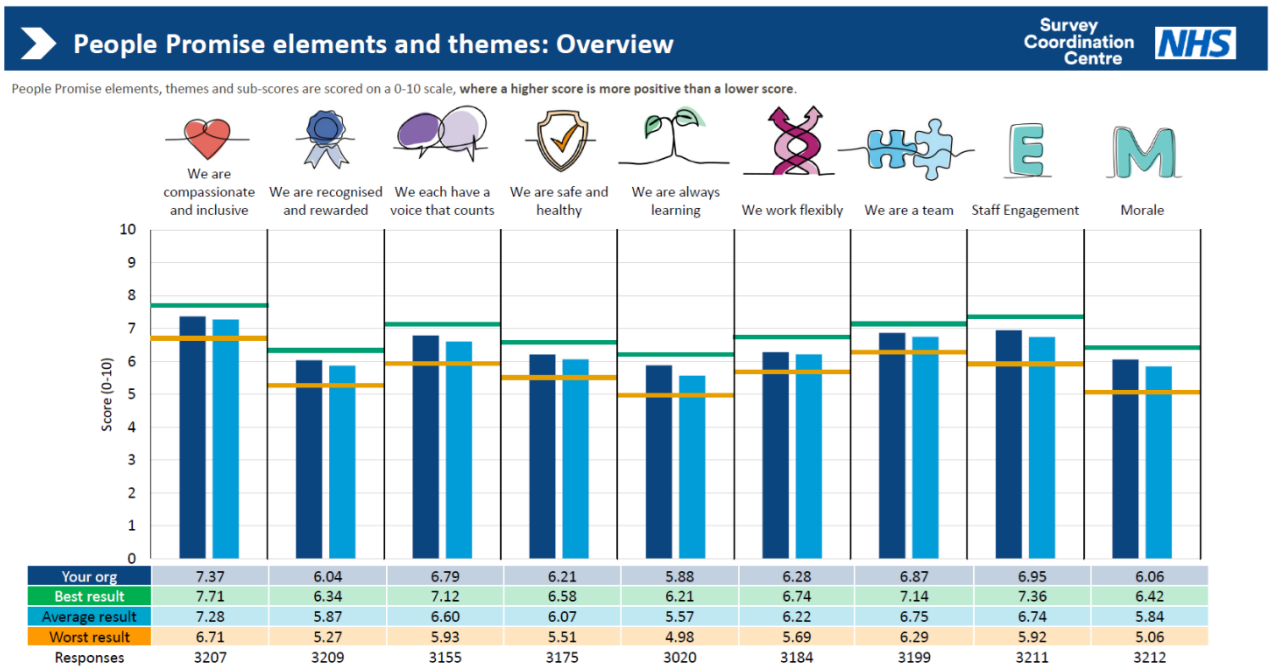
3.1 Response Rate

The national response rate for Acute and Acute and Community Trusts was 47%.
The 2025 BTHFT response rate was slightly lower at 43% (3236 respondents) which is a 7% decrease compared to 2024 (50%).

At BTHFT, registered nurses and midwives were the largest responding occupational group followed by Admin and Clerical and Allied Health Professionals.

3.2 People Promise Themes (BTHFT vs Comparators)

With regards to the People Promise overall elements and themes, we have scored above the national average on all of the themes.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.37	6.04	6.79	6.21	5.88	6.28	6.87	6.95	6.06
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	3207	3209	3155	3175	3020	3184	3199	3211	3212

Figure 1: Overview of People Promise elements and themes – BTHFT vs best/aveage/worst national results for Acute and Acute and Community Trusts.

There are also 21 sub-themes which sit under the overall People Promise elements and themes. We have scored above the national average on them all. Since 2024, the biggest areas of growth are 'appraisals' (+0.10), 'support for work-life balance' (+0.05) and 'flexible working' (+0.05). The sub-themes of 'raising concerns' (-0.03), 'line management' (-0.03), and 'thinking of leaving' (-0.04), show the biggest decreases over the last year.

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3.2.1 Five-year trends

This year, we have completed some extra analysis to explore the trends of our results over the past five years. This shows steady progress across all areas which is something we should be particularly proud of – especially the progress made to support our workforce to move forward following the Pandemic. We are placed in a good position nationally and our Provider has commented that the hard-work committed to the people agenda has shone through our five-year results. However, this progress is now beginning to stabilise and it is especially important to keep the momentum going on areas now that look like they are scoring well to ensure we continue to make improvements and innovations for our workforce.

3.3 Highlights and areas of focus

3.3.1 Questions compared to sector averages

The questions that show a score that is statistically significant (4% or higher) compared to the average result are:

Question	% higher
I am enthusiastic about my job	+5.23%
I have a choice in deciding how to do my work	+5.13%
I have adequate materials, supplies and equipment to do my work	+5.06%
I am involved in deciding changes introduced that affect my work / area / team / department	+4.84%
(My appraisal) has helped me to improve how I do my job	+4.26%
I have opportunities to improve my knowledge and skills	+4.5%
Care of patients / service users is my organisations top priority	+4.21%
Teams within this organisation work well together to achieve their objectives	+4.05%
There are opportunities for me to develop my career in this organisation	+4.0%

Figure 2: Questions that BTHFT have scored significantly higher (+4%) than the national average for Acute and Acute and Community Trusts

The questions that are significantly lower than the national average are:

Question	% lower
The last time you experienced physical violence at work, did you or a colleague report it	-7.87%
On what grounds have you experienced discrimination – sex	-4.65%
On what grounds have you experienced discrimination – race	-8.29%
On what grounds have you experienced discrimination – religion or belief	-14.62%

Figure 3: Questions that BTHFT have scored significantly lower (+4%) than the national average for Acute and Acute and Community Trusts

3.3.2 Questions compared to 2024 scores

We can also summarise the questions that show improvements or declines since our 2024 national NHS Staff Survey. As very few questions show a significant change (classed as 4% +/- change), the tables below summarise the questions that are 2% higher/lower:

Question	% change
Teams within this organisation work well together to achieve their objectives	+3.12%
The organisation is committed to helping me balance my work and home life	+2.43%
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework development review? (yes)	+2.09%

Figure 4: Questions that have increased positively (+2%) since 2024 BTHFT scores

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Flexible working and appraisals (the design and launch of dynamic conversations) were key focuses in the 2024 survey action plan and it is encouraging to see improvements in these areas that demonstrate the impact of this work.

Question	% change
The last time you experienced physical violence at work, did you or a colleague report it (yes)	-9.78%
I am able to make suggestions to improve the work of my team / department	-2.79%
I feel a strong personal attachment to my team	-2.25%
As soon as I can find another job, I will leave this organisation	-2.18%
There are opportunities for me to develop my career in this organisation	-2.08%

Figure 5: Questions that have declined (-2%) since 2024 BTHFT scores

Question 11b, relating to MSK issues has changed this year from:
'In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?'

In 2025 the question has been rephrased to:
'In the last 12 months have you experienced MSK problems as a result of work activities? Examples may include back pain, neck or arm strains and joint pain.'
39.90% of respondents answered 'yes' to this question in 2025, compared to 27.45% in 2024 (+12.45% increase) suggesting that more colleagues are aware of what an MSK issue is classified as and despite this not being a directly comparable question, the response clearly show that this is an area for focus.

3.3.3 Discrimination

Questions relating to discrimination are also classed as 'non comparable' due to the different use of descriptors of the protected characteristics. However, we can summarise helpful information which will support our learning and focus for the year ahead.

466 colleagues stated that they had experienced discrimination at work, slightly more identified that this was from patients / service users, their relatives or other members of the public (9.57%) compared to experiencing discrimination from manager/team leader or other colleagues (9.28%).
The table below summarises the grounds of which colleagues have experienced discrimination *(NB: a + score indicates that we are achieving better than the national average, a - score indicates we are below the national average):*

Grounds of discrimination	2025 score (answering yes)	Comparator average result	BTHFT vs average difference
Age	17.18%	17.46%	+0.28%
Disability	10.88%	10.47%	- 0.41%
Gender reassignment	1.50%	1.25%	- 0.25%
Marriage and civil partnership	1.68%	1.23%	- 0.45%
Pregnancy and maternity	1.87%	2.83%	+0.96%
Race	60.29%	52.0%	- 8.29%
Religion or belief	21.49%	6.87%	-14.62%
Sex	20.40%	15.75%	- 4.65%
Sexual orientation	2.22%	3.12%	+0.90%
Other	16.67%	21.87%	+5.2%

Figure 6: Table to summarise the grounds of disrimnination compared to sector averages

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3.3.4 Other important indicators

Areas we have previously focused on in recent years include bullying and harassment, speaking up, burnout/stress and unwanted behaviour of a sexual nature.

With regards to colleagues experiencing **harassment, bullying, or abuse** at work:

- More staff are responding to say that in the last 12 months they have personally experienced harassment, bullying or abuse at work from managers (+1.33%), colleagues (0.30%) and patients / service users / relatives (+0.26%);
- There has been a very small decrease (-1.43%) in colleagues stating that the last time they experienced it, they reported it.

With regards to **speaking out**:

- There has been a very small decrease in colleagues agreeing that the organisation encourages them to report errors, near misses or incidents (-0.17%);
- There has been a very small decrease in colleagues agreeing that they feel secure in raising concerns about unsafe clinical practice (-0.69%);
- When thinking about that concern, there has been a very small decrease in colleagues stating that they feel confident that the organisation would address their concern (-0.69%);
- There has been a very small decrease in colleagues agreeing that they feel safe to speak up about anything that concerns them in the organisation (-0.58%);
- When thinking about speaking up about something that concerned them, there has been a very small decrease in colleagues stating that they feel confident that the organisation would address their concern (-0.20%);
- However, all of these scores remain about the national average for our comparator group.

With regards to **stress / burnout:**

- There has been a very small increase in colleagues stating that during the last 12 months they have felt unwell as a result of work related stress (+0.24%);
- There has been a very small decrease in colleagues stating that they 'often' or 'always' feel burnt out because of work (-0.23%).

With regards to unwanted behaviour of a **sexual nature:**

- There have been very small decreases in colleagues stating that they have experienced at least one incident of unwanted behaviour from both patients/service users/ relatives (-0.28%) and staff / colleagues (-0.33%).

It is important that momentum is maintained on these key areas going forward to ensure that clear improvements are felt by colleagues.

4. Organisational Action Plan

4.1 Identifying key themes

This year we have three key areas of focus to ensure capacity can be utilised effectively and make the biggest impact on improving colleague experience. These are aligned with the aims of the People Strategy and other people objectives. They are:

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

4.2 Listening sessions and improvement suggestions from colleagues

To support the creation of the organisational action plan and to sense check these themes, four dedicated listening sessions were held, facilitated jointly by OD and EDI colleagues. In addition, a 'team brief' session was held by Mel Pickup and sessions have been held with all four colleague networks. All colleague network Chairs were also consulted and very generous with their time and meaningful feedback. The aim of all the sessions was to further interrogate the staff survey results and reach better understanding of what the Trust can do with regards to the three main areas of focus.

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Appendix A summarises the feedback from these sessions on each area of focus – the key themes that have arisen, what colleagues say this feels like in our organisation, and their suggestions for improvement.

4.3 Action Plans

The organisational level action plan can be found in **Appendix B.** The plan identifies actions, describes what we plan to do, names the owner, timescales and how success will be measured. It has been approved by Executive Management Team and People Committee.

Progress with the action plan will be monitored through People Committee on a regular basis. Colleagues in the People Directorate are also exploring the opportunity to combine the staff survey action plan with other people plans (eg WRES, WDES, Attendance Management, People Strategy) so that we are cohesively working towards one plan and set of metrics, with short, medium and long term goals.
CSUs and Corporate Teams have also created their own action plans which are monitored via Executive Directors.

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Appendix A – Outputs of Listening Sessions

The tables below summarise the key themes that have arisen, what colleagues say this feels like in our organisation, and their suggestions for improvement.

Area of Focus 1: Creating a sense of belonging by tackling any form of discrimination

Key themes	What colleagues say this feels like	Suggestions for improvement
-Experiences of discrimination, racism, sexism -Perceived bias and favouritism in recruitment and progression -Students and staff feeling belittled undervalued, or excluded - Low levels of disclosure (especially disability, sexuality) due to fear and lack of trust - Behavioural issues tolerated despite organisational values	-Not being treated with fairness or respect -Feeling invisible or overlooked -Losing confidence and withdrawing ("keeping my head down") -Deciding not to stay, apply, or return to the organisation	-Be clear, discrimination a behaviour and treat as such -Increase diversity and representation on recruitment panels -Review recruitment practices - Deliver training on sexism, racism, and discrimination with focus on how to act -Create safe spaces -Support intersectional staff experience - Improve visibility and celebration of diversity (disability, neurodiversity)

Area of Focus 2: Improving how we hear from our colleagues (listening and learning)

Key themes	What colleagues say this feels like	Suggestions for improvement
-Low psychological safety and fear of speaking up -Lack of trust that feedback leads to change -Reliance on informal conversations rather than formal routes	-"What's the point of telling you?" -Feeling unheard, dismissed, or unsafe -Learning that silence is safer than honesty -Easier to sometimes go off sick	-Communicate what happens when someone speaks up -Strengthen psychological safety -Demonstrate visible leaning and action -Feedback in a timely way -Use methods like schwartz rounds/People forum for ongoing organisational learning -Improve Executive / Board level engagement, visibility, curiosity, model for improvement, and inclusive behaviours

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-Surveys and listening events seen as tick-box if no follow-up occurs -Staff networks feeling under-used and reactive rather than influential -Inconsistent leadership engagement and feedback loops		-Use staff networks as advisory groups -Visibility and protected time for staff networks -Share examples of listening leading to change to rebuild trust

Area of Focus 3: Further develop our wellbeing support offers

Key themes	What colleagues say this feels like	Suggestions for improvement
-Increasing stress, sickness absence, and burnout -Loss or restriction of flexible working -A reactive rather than preventative approach to wellbeing -Managers feeling unsupported and fearful when trying to do the right thing -Poor environments and system pressures undermining wellbeing messages	-Wellbeing is talked about but not prioritised -Flexibility depends on who your manager is -Support comes too late, when people are already unwell	-Focus on prevention and early intervention -Introduce mental well being first aiders and/or advocates -Promote simple everyday wellbeing practices -Re-establish flexible working as core enabler -Support managers to prioritise wellbeing -Do few things well -Improve physical environment -Build confidence in discussing wellbeing, especially neurodiversity and long-term conditions

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A strong message heard throughout all the listening events and subsequent conversations was that behaviours, words and actions need to align, and that trust matters more than policy, training, or frameworks. Colleagues experience belonging, listening and wellbeing through what happens day-to-day, particularly:

- How mangers act;
- How leaders respond; *and*
- Whether action aligns with values.

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Appendix B
NHS Staff Survey: Organisational Action Plan 2025-26

Creating a sense of belonging by tackling any form of discrimination				
Action	**What we will do**	**Owner**	**Timescale**	**How success will be measured**
1. Strengthen inclusive recruitment practice	Build on existing inclusive recruitment approaches by expanding proven initiatives Embed annual refresher opportunities to support managers to recruit confidently and inclusively Further develop targeted approaches that enhance opportunities for ethnically diverse staff	EDI / HR	Q2–Q3 2026	• Increased positive responses in Staff Survey relating to fairness and inclusion • Continued progress in WRES/WDES indicators • Positive candidate feedback highlighting transparency and inclusivity of processes • Stronger narrative and evidence of equitable recruitment practice
2. Embed positive behaviours and shared standards	Build on our values-led culture by strengthening clarity and accountability for inclusive behaviours Further embed Dignity and Respect in the Workplace through refreshed conversations and tools Relaunch the People Charter to reinforce shared expectations and strengths	HR / OD / EDI	Q2 2026 onwards	• Increased confidence among managers in addressing behaviours constructively • Reduction in escalation of concerns through early, effective resolution • Positive qualitative feedback on team culture and behaviours
3 Grow confidence and capability in inclusion Osbourne-Sheridan 22/07/2026 09:58:21	Deliver organisation-wide learning focused on practical, real-life situations that colleagues encounter Develop *Thrive Management Essentials* offer to support inclusive leadership capability Adopt and embed the NHS Race & Health Observatory 7 Principles to strengthen our anti-racism approach	OD / EDI	Q3–Q4 2026	• Strong engagement with training and learning offers • Improved confidence in applying inclusive practices in day-to-day work • Increased sharing of colleague stories and learning across the organisation

4. Build trust and confidence in sharing personal data	Strengthen transparency about how workforce data is used and actively demonstrate the positive changes it informs	HR / Comms / Colleague Networks	Q3 2026	• Increased confidence in sharing personal data, reflected in declaration rates • Growth and engagement in colleague networks (e.g. Enable network) • Positive feedback on understanding how data drives change
Improving how we hear from our colleagues (listening and learning)				
Action	**What we will do**	**Owner**	**Timescale**	**How success will be measured**
5. Strengthen confidence in speaking up	Enhance understanding of FTSU roles and protections, building confidence for colleagues to raise concerns safely	FTSU / Comms	Q2 2026	• Improved Staff Survey scores relating to confidence in speaking up • Increased use of speaking up channels as a sign of trust in the process
6. Deepen engagement through visible action	Embed a consistent **"You said – We did – We couldn't"** approach to demonstrate responsiveness. Actively involve colleagues in shaping and delivering action plans following feedback	Exec Team / Comms	Q2 2026	• Increased colleague confidence that feedback leads to action • Strong participation rates in surveys and listening activities • Improved engagement scores and trust indicators
7. Grow the impact of colleague networks	Build on the strengths of colleague networks by enhancing their role as trusted advisory partners in policy, change and people initiatives	Colleague Networks / People Committee/ EDI	Q2 2026	• Increased engagement and visibility of colleague networks • Evidence of meaningful network contributions shaping policy and initiatives • Positive narratives demonstrating the impact of network involvement

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8. Create and sustain reflective learning spaces	Develop safe, structured spaces (e.g. Schwartz-style rounds / People Forums) to support shared learning on wellbeing, inclusion and lived experience	OD / Exec Sponsors / Colleague Networks	Q3 2026	• Strong participation in learning spaces and forums • Rich qualitative feedback demonstrating psychological safety and value • Evidence of actions and improvements arising from shared learning
9. Strengthen managers' listening capability	Deliver Thrive Management Essentials modules that build confidence in communication, coaching, compassionate leadership and meaningful conversations	OD / Comms	Q1-Q2 2026	• Positive feedback on manager capability and communication • Evidence of earlier resolution of issues and reduced escalation • Strong evaluation and impact from Thrive Management Essentials • Increased consistency and quality in appraisal conversations
10. Build a culture of continuous listening	Introduce regular pulse checks to maintain an ongoing understanding of colleague experience across teams and services	OD / Comms	Q2-Q3 2026	• High engagement and response rates in pulse checks • Clear evidence of insight being used to inform local and organisational action • Positive movement in related Staff Survey indicators over time
Further develop wellbeing support *(NB: also see wellbeing and attendance management plan – May 2026)*				
Action	**What we will do**	**Owner**	**Timescale**	**How success will be measured**
11. Enhance preventative wellbeing approaches	Build on existing wellbeing initiatives by expanding preventative and early support offers Continue to evolve the Thrive Portal to improve accessibility and clarity	OD	Q3 2026 onwards	• Positive trends in wellbeing indicators and survey responses • Increased awareness and early use of wellbeing support offers

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	Align and enhance the wellbeing offer in line with the NHS Wellbeing Framework, ensuring it reflects diverse colleague needs			• Sustained reduction in sickness absence through preventative approaches • Strong engagement with wellbeing initiatives
12. Expand peer wellbeing support networks	Develop and scale a visible network of wellbeing advocates, building on successful models already in place	OD / OH / Psychology Teams	Q3 2026	• Growing visibility and utilisation of wellbeing advocates • Active and engaged peer support network across services • Positive stories demonstrating impact on wellbeing and return-to-work experiences
13. Strengthen a flexible working culture	Reinforce a positive and balanced approach to flexible working that supports wellbeing while meeting service needs Provide clear guidance that enables consistent and fair decision-making	HR	Q2–Q3 2026	• Consistent and equitable application of flexible working approaches • Improved colleague experience reflected in survey responses • Positive contribution of flexible working to wellbeing and attendance
14. Grow manager capability in supporting wellbeing	Expand Thrive Management Essentials to equip managers with the confidence and skills to support health, wellbeing, neurodiversity, and inclusion in everyday practice	OH/EDI/OD Teams	Q1-Q2 2026	• Increased manager confidence in supporting wellbeing and adjustments • Strong participation and feedback on Thrive learning modules • Positive impact on colleague experience through consistent manager support

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People Committee			
Meeting Date:	15/07/2026	**Agenda Reference:**	PC.7.26.17
Report Title:	Resident Doctor 10 Point Plan Board Assurance Framework		
Presented by:	Faye Alexander, Head of Education		
Executive Lead:	Dr John Bolton, Chief Medical Officer		
Author:	Faye Alexander, Head of Education		

Report Summary				
Purpose of the paper:	Decision ☐	Assurance ☒	Action ☐	Information ☐
Summary of Key Issues/Highlights:	• NHS England (NHSE) introduced the Resident Doctor 10 Point Plan to improve the working lives of resident doctors through ten priority areas, supported by a national Board Assurance Framework (BAF). • Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) has been implementing the programme over the last nine months through a collaborative programme involving Medical Education, Medical HR, operational teams and resident doctors. • The attached BAF demonstrates that the Trust is compliant with all the national requirements. • Alongside meeting the national requirements, the Trust has invested in several additional initiatives to further improve the experience of resident doctors, including refurbishment of the Doctors' Mess, additional lockers, and regular Resident Doctor Forums. • The Trust continues to support the expansion of postgraduate medical training, including recent Foundation Year expansion and ongoing engagement with NHS England and Yorkshire and Humber Deanery regarding further core training expansion for 2026 onwards.			
Recommendation/s: (including any decision/approval required)	*The People Committee is asked to:* 1. Receive assurance that appropriate arrangements are in place to support delivery of the NHS England Resident Doctor 10 Point Plan. 2. Note the progress made to date. 3. Recommend the paper to Trust Board.			
Link to Strategic Objective:	People - To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion			
Link to Priority Initiatives 2025/26:	N/A			

Implications	
Risk:	The Resident Doctor 10 Point Plan forms part of NHSE's Education Quality Framework, with Board assurance expected through the national BAF. This paper provides assurance that the Trust has appropriate arrangements in place to mitigate risks relating to resident doctor experience, education quality and workforce sustainability.
Legal/Regulatory:	Supports compliance with NHSE expectations regarding implementation of the Resident Doctor 10 Point Plan and Board oversight of the associated Assurance Framework.

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Quality & Patient Safety:	Improving the working environment and experience of resident doctors supports safer staffing, improved education and training, recruitment, retention and ultimately patient care.
Equality, Diversity and Inclusion and Health Equity:	The 10 Point Plan aims to improve the experience of all resident doctors through fair access to facilities, support, education and wellbeing initiatives.
Resources:	Most improvements have been delivered within existing resources. Some investment has been made to improve resident doctor facilities, including refurbishment of the Doctors' Mess and provision of additional lockers.
Environmental sustainability:	No significant implications.
Assurance Route	
Meeting/s where content has been discussed previously:	Resident Doctor Forum Medical Education Governance Executive Team Meeting People Committee

Report content

1. Purpose

This paper provides assurance on BTHFT's implementation of the NHSE's Resident Doctor 10 Point Plan and the associated BAF.

2. Background/context

The NHSE Resident Doctor 10 Point Plan was introduced to improve the working lives of resident doctors, recognising the importance of working environment, wellbeing, education and organisational culture in supporting recruitment, retention and high-quality patient care.

The programme is supported by a national BAF which sets out the expectations of Trust Boards across ten priority areas. Delivery of the framework will also form part of the NHSE Education Quality Framework and Provider Self-Assessment process.

BTHFT has been progressing this work over approximately the last nine months, working collaboratively across Medical Education, Medical HR, operational services and resident doctor representatives.

3. Assessment

Over the past nine months, the Trust has worked collaboratively to implement the NHSE Resident Doctor 10 Point Plan. This has involved Medical Education, Medical HR, operational colleagues, resident doctor representatives and the Director of Medical Education, with progress monitored through established governance arrangements.

The attached Board Assurance Framework (Appendix 1) demonstrates that the Trust is compliant with all requirements of the NHSE framework and is able to provide full assurance that appropriate arrangements are in place to support delivery of the Resident Doctor 10 Point Plan.

Progress since the baseline assessment is summarised in Figure 1. The baseline assessment was completed in September 2025, with a follow-up 12-week assessment undertaken in November/December 2025. At that stage, the Trust achieved an overall score of 89%, representing a 13-percentage point improvement from baseline. Since then, work has continued, with the Trust now demonstrating full compliance with the NHSE BAF.

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Figure 1. Baseline and 12-week assessment results (September–December 2025)

Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST

Amenities	Baseline survey	12-week progress
Access to Lockers	Yes, <50%	Yes, >50%
Rest facilities	Yes	Yes
Designated on-call parking access	Plan to	Yes, >50%
Access to hot and cold food 24/7	Yes	Yes
Access to cold food 24/7	Yes	Yes
Inductions specifically designed to meet the needs of Resident Doctors	Yes	Yes
Beds/sleeping pods available free of charge	Yes	Yes
Are Resident doctors able to work from home for portfolio and self-directed learning?	Yes, <50%	Yes, >50%
Access to free psychological support treatment?	Yes	Yes
Positive feedback mechanisms in place to reward and promote staff?	Yes	Yes
Protected breaks?	Yes	Yes, >50%
Do you promote the Safe Learning Environment Charter?	Yes	Yes
Sexual safety/harassment training and awareness?	Plan to	Plan to

Annual Leave	Baseline survey	12-week progress
Is there a local policy to encourage good annual leave management which references resident doctors?	Yes	Plan to
Good annual leave practice covered at resident doctor induction?	Plan to	Yes
Allow resident doctors to carry over annual leave between rotations?	Yes (internal rotations)	Yes (internal rotations)
Do rostering systems for Resident Doctors allow for self/preferential rostering?	No	Yes

Payroll and Expenses	Baseline survey	12-week progress
Implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	Plan to	Plan to
Changes in payroll errors over the last 12 months?	No change	No change
Processing of course related expenses?	After course attendance	When course is booked

Appointing senior leads to take action on Resident Doctor issues	Baseline survey	12-week progress
Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	Yes	Yes
Has your Trust Board appointed a Resident Doctor Peer Lead?	Yes	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (None, Executive team, Trust Board, People Committee, Two out of Three, or All)		
GMC Training survey	All	All
NETS survey	All	All
National Staff Survey		All
National Student Survey		None

Mandatory Training & Learning	Baseline survey	12-week progress
Do you accept resident doctors' mandatory training from other sites and follow the People Policy Framework (May 2025)?	Yes, both	Yes, both

Does the Resident Doctor Peer Lead support the findings as set out in this survey?	Fully supports

* 12-week progress survey 89% (Improvement of 13pp)

* The survey score is calculated by averaging the percentage scores of each scored question. . Please refer to the points scheme for specific scoring criteria.

Key developments include:

- Appointment of both a Senior Accountable Resident Doctor Lead and Resident Doctor Peer Lead
- Regular monthly Resident Doctor Forums to provide ongoing engagement and co-production with resident doctors
- Implementation of national guidance relating to recognition of mandatory training completed at other organisations
- Implementation of revised study leave reimbursement arrangements, enabling approved course fees to be reimbursed at the point of booking in line with national expectations.
- Exploration of a dedicated Resident Doctor Annual Leave Policy to further strengthen local arrangements and align with emerging national guidance.
- Full adoption of the national terminology of 'Resident Doctor' across Trust documentation, communications and governance, replacing the previous term 'Junior Doctor'.
- Continued monitoring of resident doctor experience through local and national feedback, including the GMC National Training Survey and NETS.

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Alongside delivery of the national requirements, the Trust has continued to invest in improving the working environment for resident doctors. This includes refurbishment of the Doctors' Mess, installation of additional lockers, resident doctor parking and continued improvements to rest facilities. These investments demonstrate the Trust's commitment to improving the day-to-day experience of resident doctors beyond the minimum national requirements.

The Trust has also continued to support the expansion of postgraduate medical education. During 2026, Foundation Year training capacity was expanded, and the Trust is currently working with NHS England and Yorkshire and Humber Deanery to explore opportunities for further expansion of core training posts as part of the national 1,000 postgraduate training post expansion programme.

Overall assurance

The Trust can provide full assurance that the requirements of the NHS England Resident Doctor 10 Point Plan and associated Board Assurance Framework have been met.

4. Next Steps

Whilst the Trust is compliant with the national framework, improving the working lives of resident doctors remains an ongoing priority. Future work will focus on:

- Submitting the completed Board Assurance Framework to NHS England
- Continuing investment in resident doctor wellbeing and facilities
- Exploring the development of a dedicated Resident Doctor Annual Leave Policy to complement existing Trust arrangements
- Working with the Yorkshire and Humber Deanery to support the expansion of postgraduate medical training opportunities where appropriate.

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Resident Doctor Board Assurance Framework v1.0

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance Rating
1. Workplace wellbeing – Ensuring that audit has taken place and improvement plans developed to address any gaps, supported by Resident Doctor Peer Lead.						
Organisational or board systems and process should be in place to ensure that:						
1.1	Completed baseline audit	Yes - completed in September 2025.				3. Compliant
1.2	Approved improvement plan in place	Yes - 12 week progress survey completed in November 2025, which demonstrated an achieved an overall improvement score of 89%, representing a 13 percentage point improvement from baseline.			Improvements have been made across a number of areas, including resident doctor amenities, governance, study leave expenses and mandatory training arrangements.	3. Compliant
2. Rota transparency – Compliance with 8-week schedules, 6-week rotas with improvement plans in place where performance needs to improve.						
System and process are in place to ensure that:						
2.1	Compliant with 6- and 8-week rota standards	Yes - Medical HR and Roster teams are complaint with standards.				3. Compliant
2.2	Clear monitoring of compliance and reported at Board sub-committee level	Yes - reports to People Committee.				3. Compliant
3. Annual leave reform – Adoption of minimum standards for annual leave for resident doctors.						
NHS England » Minimum standards for annual leave for resident doctors						
System and process are in place to ensure that:						
3.1	Adopted the minimum standards for annual leave for resident doctors	Yes fully adopted.			Currently there is one annual leave policy across the organisation for all employees - however, work currently underway to develop a separate annual leave policy specific for Resident Doctors to mirror good practice demonstrated in other Trusts.	3. Compliant
3.2	Provision of rota coordination training	Yes - provided by the Workforce Information and Flexible Workforce Team .				3. Compliant
4. Board-level leadership – Senior leads and peer representatives are in place						
System and process are in place to ensure that:						
4.1	Appointed Resident Doctor Senior Board Lead and a Non-Executive Director for Resident Doctors'	Yes: Senior Board Lead: Chief Medical Officer - Dr John Bolton. Non Executive Lead: Altaf Sadique				3. Compliant
4.2	Appointed Resident Doctor Peer Lead and they are engaged in line with national guidance	Yes: Chief Registrar has been appointed as Peer Lead.			Dr Victoria Printz until August 2026. Dr Rebecca Tremain starts 5th August 2026 and handover planned.	3. Compliant
4.3	Robust progress updates in place which involve Resident Doctor	Monthly meetings in place with Medical HR, Head of Education, and Resident Doctor Peer Lead. CMO briefed on progress.				3. Compliant
4.4	Clear support plan in place to assist the RDPL	RDPL has regular meetings with CMO and attends monthly meetings on 10 Point Plan. Support offered through CMO office.				3. Compliant
5. Payroll accuracy – Trusts have commenced payroll improvement activity and are monitoring						

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System and process are in place to ensure that:						
5.1	Implementing payroll improvement methodology	Payroll providers only report overpayments for all colleagues. We now extract resident doctor data separately to analyse trends and introduce new ways of working. We have identified that resident doctors are at higher risk of underpayments due to missing rota information on new starter forms. The Medical Workforce team now scrutinise all new starter forms and contact managers to ensure the correct rota details are captured, reducing the risk of underpayments.				3. Compliant
5.2	Reduction in payroll errors	No material change noted.				3. Compliant
5.3	Monthly error reporting compliance undertaken	Monthly error reporting compliance is undertaken and payroll errors are reported to the executive team on a quarterly basis.				3. Compliant
6. Mandatory Training – no unnecessary duplication and MLOGs in place and working with RDs						
System and process are in place to ensure that:						
6.1	Signed MoU and processes in place for monitoring that no unnecessary training is being repeated	Signed and monitored via the Postgraduate Medical Education Team and Mandatory Training Team.			Mandatory training reviewed at all local induction points to ensure no repetition. There is some BTHFT specific training that must be completed.	3. Compliant
6.2	Mandatory Training Local Oversight Group (MLOG) in place	MLOG Meetings in place on quarterly basis with clear Terms of Reference.			Membership includes Head of Education and Director of Education from CMO office.	3. Compliant
6.3	The MLOG involves Resident Doctors in ensuring that local STATMAN requirements are necessarily and proportionate	The Director of Medical Education is a core member of the MLOG group and reports on any concerns raised via the Resident Doctor Forum. Resident Doctor Peer Lead invited to attend MLOG when required.				3. Compliant
7. Exception reporting – Adoption of new national framework						
System and process are in place to ensure that:						
7.1	Clearly communicated new approach and local processes to all Resident Doctors	New National Framework has been adopted by Trust. Communications sent out to all Trust Resident Doctors and discussed at Induction.			Also included in the Resident Doctor Handbook.	3. Compliant
7.2	Implemented local and national data reporting requirements	Guardian of Safe Working Report which covers all exception reporting is scheduled quarterly at the Trus People Committee which is sub committee of Trust Board.				3. Compliant
8. Expense reimbursement – Adoption of fast-track course costs						
System and process are in place to ensure that:						
8.1	Adopted new reimbursement process	Postgraduate Medical Education Team have fully adopted new process with finance and payroll teams.				3. Compliant
8.2	Meeting target reimbursement time of 6 weeks.	Process and pay reimbursement at the point the course is booked/expense is incurred.				3. Compliant
8.3	Doctor satisfaction meeting ≥80% target	Yes			Monitored via Postgraduate Medical Education team.	3. Compliant

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Board of Directors			
Meeting Date:	23.07.26	**Agenda Reference:**	Bo.7.26.11a
Report Title:	Nursing and Midwifery Establishment Strategic Staffing Review - July 2026		
Presented by:	Professor Karen Dawber, Chief Nurse		
Executive Lead:	Professor Karen Dawber, Chief Nurse		
Author:	Sarah Freeman, Deputy Chief Nurse Laura Loveday, Associate Chief Nurse for Quality and Workforce		

Report Summary				
Purpose of the paper:	Decision ☒ approve	Assurance ☐	Action ☐	Information ☐
Summary of Key Issues/Highlights:	The Board of Directors is required to receive a biannual Nurse Establishment Review in line with NHS Improvement (2018) and the National Quality Board (NQB) (2016) safe staffing guidance. These frameworks set out expectations for robust, evidence-based workforce reviews to ensure staffing is safe, effective, and sustainable. The Chief Nurse's recommendations are: Approve: • Cost-neutral establishment changes Ward 17 and Ward 33. • Workforce reallocation Ward 9 to Ward 6. • Removal of underutilised posts – Ward 27 and Ward 14. Support: • The requirement for two further Safer Nursing Care Tool (SNCT) data collection cycles (6 months apart, across 2 distinct seasons) to enable robust, evidence-based decision making. • The development of formal business cases relating to high-risk services (including, but not limited to, the Emergency Department, Neonatal Services, Paediatric Services, and The Meadows Chemotherapy Day Case Unit), in accordance with the Trust's approved Business Case Process and governance framework. PLEASE NOTE – This paper is being reviewed by the Finance and Performance Committee on 22 July 2026 and a verbal update will be provided regarding the Committee's discussion.			
Recommendation/s: (Decision/approval/ assurance required)	The Board of Directors is asked to support the recommendations of the Chief Nurse for the 6 monthly strategic nursing and midwifery staffing review for July 2026, as outlined above. The recommendations will be presented to the Board for approval on 23 July 2026.			
Link to Strategic Objective:	People - To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion			
Link to Priority Initiatives 2025/26:	N/A			

Implications	
Risk:	In April 2026, the nursing and midwifery staffing risk on the Risk Register was reviewed. As a result of this review, the previous risk (Risk ID 187/3732) was closed, and a revised risk was opened to more accurately reflect the current workforce challenges associated with vacancies and sickness

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	absence. The current risk score is 12 (Risk ID 2895). The risk reflects the nursing and midwifery staffing shortages arising from vacancies and sickness absence, there is a risk that the Trust is unable to deliver consistent, high-quality, safe and effective care across planned and unplanned services. This may result in harm to patients, staff and visitors, deterioration in patient experience and outcomes, increased incidents, complaints and claims, heightened staff stress and sickness levels, reduced staff morale and retention, and a negative impact on the Trust's reputation, regulatory compliance and financial sustainability.
Legal/Regulatory:	This report fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (2016 and 2018): How to ensure the right people, with the right skills, are in the right place at the right time and 'Safe, sustainable and productive staffing.
Quality & Patient Safety:	There is a risk to patients and staff is safe staffing levels are not maintained resulting in poor patient experience of care, potential patient harm, increased staff and patient dissatisfaction, complaints, incidents, increased sickness levels, claims and poor retention of staff.
Equality, Diversity and Inclusion and Health Equity:	There is a continued focus on recruitment and progression of the nursing and midwifery workforce to be reflective of the local community and to offer opportunities for growth and development in the organisation as an anchor institution.
Resources:	Where risks are identified there are processes in place to identify and report staffing gaps and where possible, ensure mitigation is in place to provide safe patient care. There continues to be recruitment of new nurses, retention of existing staff and efficiency of staff deployment.
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	Executive Team meeting – 6 July 2026 People Committee – 15 July 2026 - PC.7.26.15a Finance and Performance Committee – 22 July 2026

Report content

1. Purpose

This paper presents the biannual Nursing and Midwifery Strategic Staffing Review in line with NHS Improvement (2018) and National Quality Board (NQB) (2016; 2018) guidance on safe, sustainable, and productive staffing.

This paper sets out:

- An interim position on nurse and midwifery establishments
- Outcomes of the May 2026 establishment review
- Proposed recommendation to be made to the Board for approval and support

The review reflects a risk-managed, interim approach, recognising that:

- The Trust is in early stages of SNCT data maturity
- Workforce decisions must balance:
  - Emerging acuity evidence
  - Professional judgement
  - Operational risks
  - Financial considerations and risks

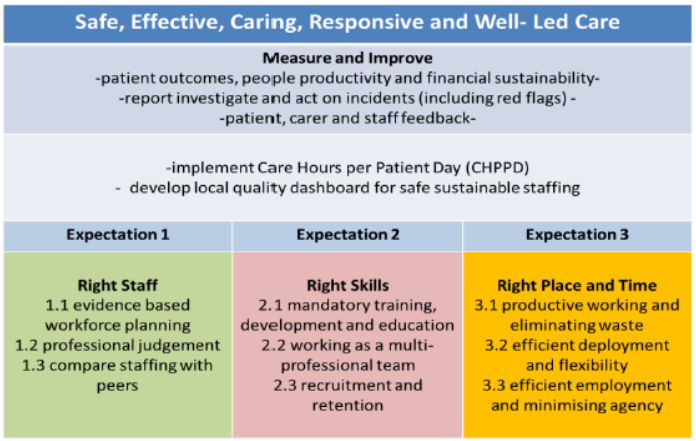
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The recommendations in this paper seek to balance patient safety, quality outcomes, workforce sustainability, and financial stewardship within a managed risk framework.

2. Background/context

The National Quality Board (NQB) safe staffing framework (2016) provides a key foundation for ensuring our workforce is safe, sustainable, and able to deliver high-quality, productive care. The framework comprises a core set of principles, supported by a suite of complementary resources designed to drive continuous improvement across organisations. At its core, the NQB expectations establish a framework that supports the consistent delivery of care that is:

- Right first time, in the right place
- Focused on minimising avoidable harm
- Maximising the value of available resources



A triangulated approach to nurse workforce establishment planning is used in line with NQB recommendations. This includes:

- Twice-yearly review of nursing establishments using an evidence-based acuity tool such as the Safer Nursing Care Tool (SNCT).
- Daily analysis of the Allocate E Roster Safe Care results, which provide three times a day breakdown of patient acuity, completed by a Senior Nurse.
- Bi-annual Deputy Chief Nurse led review of staffing establishments.
- Monthly analysis of Care Hours Per Patient Day (CHPPD).
- Daily monitoring of staffing capacity versus demand with triangulation against harms/quality metrics and the relationship to staffing.

3. Assessment

Workforce Review and Staffing Assurance

Robust processes are in place to manage safe staffing:

- Twice daily staffing huddles (SafeCare supported)
- Daily safety huddles at ward level
- Matron-led validation of SNCT scoring
- Confirm and Challenge meetings within CSUs
- Senior Nurse Approval process for Over Cap Agency Requests (Renal Dialysis Only)
- Daily cross site Staffing huddles in theatres reviewing next 48 hours
- Triangulation of:
  - SNCT
  - Quality indicators (falls, incidents, complaints)

- Workforce metrics (vacancies, sickness, redeployment)

For inpatient wards, the staffing model of one Band 7 nurse providing 0.5 WTE supervisory time is shared between the Band 7 and at least two Band 6 registered nurses to ensure clinical leadership and support. Nursing establishments include headroom allowances of 21.5% across all areas, with a higher rate of 24.3% applied to maternity services to reflect their specific needs. Areas with High Dependency beds and our assessment units plan to run on a Band 6 on duty 24/7 (Ward 5 and Ward 3, Acute Medical Unit (AMU) 1&4 and Respiratory High Dependency Unit (RHDU), Coronary Care Unit (CCU) and Hyper-Acute Stroke Unit (HASU)).

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

The Trust has an open workforce risk (score 12), reflecting:

- Risk to safe and effective care delivery
- Potential impact on:
  - Patient outcomes
  - Staff wellbeing and retention
  - Regulatory compliance

The Safer Nursing Care Tool (SNCT) was developed to ensure the right staff, with the right skills are in place to support safe patient care. It measures patient acuity and/or dependency to support evidence-based staffing and workforce decisions.

Evidence based tools are available for:

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

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

These tools support the establishment review process to triangulate data with quality indicators, finance and professional judgement. Reporting these reviews to Trust Boards is a requirement set out in the Developing Workforce Safeguards, published by NHS Improvement in 2018.

The Trust is currently undertaking the first cycles data collection using the updated licenced SNCT. The Emergency Department undertook a data collection in January 2026 and have completed a second data collection in June 2026. The inpatients wards first data collection will be undertaken in July 2026 for adult inpatient areas and August/September 2026 for children and young persons inpatient areas.

National guidance requires before establishment changes are agreed:

- Minimum 2–3 SNCT cycles
- Triangulation with quality and workforce data
- Use of professional judgement

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Enhanced Therapeutic Observations and Care (ETOC)

Enhanced Therapeutic Observations of Care (ETOC) provides focused and continuous observation to patients requiring additional therapeutic support. This targeted approach enhances patient safety by ensuring close and consistent monitoring, allowing clinical teams to respond promptly to changing patient needs. ETOC is often referred to as enhanced care, 1:1s or specialising, is an intervention which is intended to reduce the factors that contribute towards increased risk to and from an individual or others. ETOCs should promote recovery and wherever possible, preserve dignity.

In September 2024, NHS England launched the ETOC programme to support providers in improving their ETOC provision. NHSE require organisations to report their ETOC hours as part of our standard contract. Currently at BTHFT we are able to report on those temporary staff who are additional to the ward establishment who deliver ETOC, however we are not able to report those substantive staff who are delivering ETOC within their establishments. The introduction of enhanced SNCT categories (1c and 1d) will strengthen the Trust's ability to quantify and manage this demand.

A 12-month quality improvement plan is in place to support this vital work (Appendix 1).

Establishment Review Process
The establishment reviews undertaken in May 2026 to inform this Nursing and Midwifery Strategic Staffing Review covered inpatient wards, maternity and paediatric services, the Emergency Department, and day case areas.

All clinical areas are required to complete a standardised establishment review template (Appendix 2) in advance of a formal review meeting, chaired by the Deputy Chief Nurse. Ward Managers/Department Leads and Matrons present their current establishments, drawing on a triangulated approach that incorporates workforce data, professional judgement, and quality indicators.

These multidisciplinary review meetings are also attended by representatives from the Chief Nurse Team, flexible workforce team, finance, and Deputy Directors of Nursing. A range of supporting data is considered, including SafeCare analysis (Appendix 3), red flag indicators (Appendix 4), and required versus actual staffing (Appendix 5).

This structured process supports detailed and robust discussion, ensuring that establishment decisions are informed through the integration of quality, workforce, and demand data, in line with national safe staffing guidance. It is further strengthened by having that direct engagement with the Ward Managers/Department Leads and Matrons providing a richer understanding of the operational context beyond quantitative data. These discussions offer valuable insight into factors such as estate footprint and ward layout, staff wellbeing and morale, patient flow and discharge challenges, and feedback from complaints and compliments. This combined qualitative and quantitative approach ensures that decisions are grounded not only in data, but also in the lived experience of teams and patients, supporting more balanced, realistic, and sustainable workforce planning.

Outcomes Approved from Nursing and Midwifery Strategic Staffing Review (December 2025)

- **Ward F5**
  Recruitment of an additional RN (Increase of 2.4 WTE, costing £124,256).

- **Emergency Department**
  Business Case presented to ETM in December 2025. Increased establishment by an additional four Band 5 RN's on every shift (21 WTE including uplift) Total costing - £1,161,355.

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

Summary of Nursing and Midwifery Strategic Staffing Review May 2026

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The following principles have been consistently applied:

- **Deferred decisions:**
  Deferred decisions require completion of two further SNCT data cycles (6 months apart) to achieve sufficient data maturity to ensure reliability, trend analysis, and triangulation prior to any establishment changes being approved.

- **Approved changes**:
  Where proposals are cost-neutral, test of change or improve deployment

- **Workforce optimisation**:
  Removal of underutilised posts and reallocation to higher-risk areas

Emergency Department (ED)

Outcome: Deferred – further SNCT data required

- No immediate uplift approved, uplift agreed at last establishment review is not yet fully embedded or evaluated.
- Workforce model (including NIC supervisory capacity and Matron support) recognised as unsustainable
- **Action**: Develop full business case supported by two additional SNCT cycles and strengthened SafeCare data

Acute Medical Unit (Wards 1 & 4)

Outcome: Deferred – further SNCT data required

- Request for additional 24/7 HCA support not approved at this stage
- Increasing acuity, variability, and downstream flow constraints acknowledged
- **Action**: Further SNCT cycles required to evidence sustained requirement before establishment uplift

Ward F6

Outcome: Deferred – Further SNCT data required.

- Request for 1 HCA (long days) not approved at this stage.
- Risk relation to frailty, delirium, falls, and escort requirements recognised.
- **Action:** Strengthen evidence through SNCT.

Maternity Services

Ward M4

- **Outcome: No change** – recent uplift not yet embedded or evaluated

Ward M3

Outcome: Deferred – further data required

- Request for 1 WTE Maternity Support Worker (24/7)
- Persistent red acuity acknowledged; to evaluate the uplift on M4

Neonatal Services (NICU)

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Outcome: Deferred – data validation required

- Request for 4.76 WTE Band 5 RNs to meet BAPM standards
- Significant patient safety and compliance risks acknowledged, including MIS requirements
- **Action:** Further data triangulation required to support formal Board decision

Paediatric Emergency Department (PED) & Children's Decision Area (CDA)

Outcome: Deferred – further SNCT data required

- The Paediatric Emergency Department and Children's Decision Area operate as an integrated urgent care model, managing approximately 25,000 attendances annually, with continued growth in demand
- Workforce gaps, lack of senior oversight
- Initial requests (RN, HCAs, play specialist) not approved at this stage

- **Action:**
  - Complete SNCT cycles
  - Strengthen demand capture and workforce modelling
  - Develop revised model (including Band 6 leadership focus)
  - Agreement to undertake a full, multi-area review across paediatric services (including Ward 30, Ward 32, Ward 12, Children's Outpatients and the ED interface), with a focus on developing an acuity-based, flexible workforce model.

Paediatric Inpatients (Wards 30 & 32)

Outcome: Deferred – further SNCT data required

- Requirement for additional RN capacity (1 per shift) acknowledged
- Significant acuity, HDU workload, and workforce gaps recognised

Action:
- Agreement to undertake a full, multi-area review across paediatric services (including Ward 30, Ward 32, Ward 12 and the ED interface), with a focus on developing an acuity-based, flexible workforce model. Extraordinary establishment review planned for September 2026

The Meadows (Oncology/Outpatients)

Outcome: No immediate uplift approved

- Agreement that issues are system-wide and not resolvable through incremental staffing increases

Action:
- Develop comprehensive business case (workforce, estate, booking systems, capacity)

Ward 6 (HASU)

Outcome: Deferred – further SNCT data required and evaluate the test of change at next review

- Proposed Skill mix change Day shift: Increase RN from 6 to 8, reduce HCAs from 6 to 4, Night shift: Increase nurses from 5 to 7, reduce HCAs from 5 to 4 – not approved.
- Supported via workforce reallocation from Ward 9 (see below) as a test of change to evaluate at the next establishment review.

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Ward 9 (Stroke Rehabilitation)

Outcome: Approved – post reallocation as a test of change to Ward 6

- Removal of 1 RN (night post) from establishment
- Post identified as not consistently utilised and frequently redeployed
- Reallocation to Ward 6 to support higher acuity demand
- Formalises flexible stroke workforce model across pathway

Ward 14 (Orthopaedics)

Outcome: Approved – Removal of underutilised post – HCA (3.47 WTE)

- Reduction of 1 HCA per shift and convert 1. 0 WTE band 5 vacancy to fund 1.0 WTE Band 6 ERAS nurse,
  Action: Funding of 1.0 WTE ERAS nurse would need to be considered by the CSU as a business case.

Ward 16 (Gastroenterology)

Outcome: Deferred – further SNCT data required

- Identified need for increased RN from 3 to 4 (long day) 7 days per week
- Significant mismatch between acuity and staffing acknowledged

Action: SNCT cycles and option appraisal before decision

Ward 17

Outcome: Approved – test of change (cost-neutral)

- Reallocation of RN from night to day shifts
- No increase in HCA establishment
- Review planned at next establishment cycle to assess impact

Ward 27 (MOFD)

Outcome: Approved – Removal of underutilised post – one HCA on night shift (2.5 WTE)

- Reduction of 1 HCA on night shifts
- Day model unchanged
- Reflects benchmarking and reduced night demand

Ward 29 (Elderly Care)

Outcome: Deferred – further SNCT data required

- Ongoing review of Band 4 to Band 5 RN conversion for nights
- Night staffing model recognised as misaligned with patient safety requirements
- **Action:** Further data and modelling required

Ward 33 (Haematology)

Outcome: Approved – test of change to optimise RN deployment across the day

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- Conversion of early RN shift to long day
- Staffing model aligns RN capacity with peak chemotherapy delivery demand (e.g. 12:00–20:00)
- Ensures consistent cover of three RNs across the chemotherapy delivery window
- Strengthens patient safety and improves separation from day case/oncology workload

Quality Impact Assessments

Quality Impact Assessments (QIAs) have been completed for all areas where establishment decisions have been deferred, where posts have been removed, or where cost-neutral workforce changes have been proposed. The purpose of the QIA process is to provide a structured assessment of any potential impact on patient safety, quality of care, patient experience, workforce wellbeing, and operational delivery. Completion of these assessments has ensured that proposed changes have been subject to appropriate clinical scrutiny, with identified risks reviewed and mitigating actions agreed where required. This provides assurance that decisions have been made using a triangulated approach, incorporating quality, workforce, operational and financial considerations, and that no changes have been supported where an unacceptable risk to patient safety or service quality was identified.

Areas with no change to their establishment

A number of areas made no requests to change their establishment review:

- Cardiac Day Case Unit
- ENT Day Case Unit
- Elderly Assessment Unit (Ward 3)
- ICU
- GATU (Ward 25)
- Medical Day Case Unit
- The Meadows
- Wards 2, 5, 7, 8, 11, 15,18, 19, 20, 21, 22, 23, 24, 26, 28, 31, F5, Westbourne Green and Westwood Park.

However, even within these areas, hidden pressures and data limitations were noted, particularly around:

- Workforce wellbeing
- Administrative burden
- Off ward activity (for example; paracentesis on ward 16 and ENT assessment chair on ward 18).
- Increasing complexity not fully reflected in establishment review

Overall Position

Most clinical areas are currently operating within their funded establishments. However, consistent themes have emerged highlighting increasing patient acuity, workforce fragility, and a growing misalignment between existing staffing models and service demand.

Patient Safety Risk

A number of areas, notably the Emergency Department, Acute Medical Units, and Paediatric Urgent Care are operating at elevated levels of risk. In these services, current staffing models do not consistently meet patient demand, creating potential impacts on safety, quality, and flow.

Data Maturity

While workforce planning tools (including SafeCare and SNCT) are improving, they do not yet fully capture the complexity of care delivery. Key gaps include:

- Enhanced care requirements
- Incidents of violence and aggression
- Patient flow and discharge pressures
- Indirect workload such as communication and coordination activities

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Notwithstanding these challenges, the Trust has robust systems and controls in place to maintain safe staffing and mitigate risk. This includes daily oversight of staffing levels and patient acuity through

SafeCare, twice-daily staffing reviews, and clear escalation processes where gaps are identified. These are supported by established governance through Matron oversight, Confirm and Challenge processes, and regular triangulation of workforce, quality, and safety data. Where risks are identified, mitigating actions such as redeployment, use of temporary staffing, and operational support are deployed to maintain safe care. These arrangements provide ongoing assurance that patient safety, staff wellbeing, and the quality of care delivery is a priority.

4. Options analysis/Proposal

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

To approve:

- Cost-neutral establishment changes - Ward 17.
- Workforce reallocation - Ward 9 to Ward 6.
- Removal of underutilised posts – Ward 27 and Ward 14

To support the requirement for two further SNCT data collection cycles (6 months apart) to enable robust, evidence-based decision making.

To support the development of any formal business case relating to high-risk services (including, but not limited to, the Emergency Department, Neonatal Services, Paediatric Services, and The Meadows Chemotherapy Day Case Unit) being undertaken in accordance with the Trust's approved Business Case Process and governance framework.

Appendix 6 - Safer Nursing Finance summary

			259.10	253.39	-5.71	11,533,637	11,361,717	-171,920	-171,920	
Area	Specialty	Ward - Current	Current WTE	Final New Total	Change - WTE	Current Budget	Proposed Budget	Change - £	Staffing Review Request	Comments
UEC Eld	Intermediate	Ward 17	44.50	44.76	0.26	2,072,159	2,072,159	0	0	Increase in WTE but cost neutral - Reallocation of RN from night to day shifts
UEC Eld	Intermediate	Ward 9	44.22	41.73	-2.49	2,003,402	1,868,774	-134,628	-134,628	Removal of 1 RN (night post) from W9 establishment and reallocate to W6 to support higher acuity demand
UEC Eld	Intermediate	Ward 6	68.43	70.92	2.49	2,877,418	3,012,046	134,628	134,628	Add 1 RN (night post) Ward 6 to support higher acuity demand from removal of 1RN (night post) from W9 establishment.
Speciali	Respiratory	Ward 27 - Spec Med	48.72	46.22	-2.50	2,206,362	2,105,287	-101,075	-101,075	Reduce Night by 1
Speciali	Haematology	Ward 33 - Haematology	22.55	22.55	0.00	1,055,388	1,055,388	0	0	Realign Shift
MSK	Trauma & Orth	Ward 14	30.68	27.21	-3.47	1,318,908	1,248,063	-70,845	-70,845	Funding from reducing B2 from 3,3,2 to 2,2,1
			259.10	253.39	-5.71	11,533,637	11,361,717	-171,920	-171,920	

Appendices

- Appendix 1 – Implementation of Enhanced Therapeutic Observations of Care Quality Improvement Plan
- Appendix 2 – Example Ward 15 – Nurse Staffing Establishment Review Tool
- Appendix 3 – Example Ward 15 SafeCare Analysis
- Appendix 4 - Example Ward 15 Red Flags
- Appendix 5 - Example Ward 15 Required vs Actual Staffing
- Appendix 6 – Safer Nursing Finance summary

Appendices 1-5 are available in the reading room here.

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Board of Directors			
Meeting Date:	23/07/2026	**Agenda Reference:**	Bo.7.26.11b
Report Title:	Bi-annual Perinatal Workforce Report – June 2026		
Presented by:	Carly Stott, Head of Midwifery		
Executive Lead:	Professor Karen Dawber, Chief Nurse		
Author:	Carly Stott, Head of Midwifery		

Report Summary				
Purpose of the paper:	Decision ☒ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	This report provides assurance that the Trust continues to maintain effective oversight of perinatal workforce planning in accordance with the requirements of the Maternity (Perinatal) Incentive Scheme Year 8. However, the report also demonstrates that significant workforce risks remain. Sustained pressures within the obstetric, neonatal, anaesthetic and ward-based workforces continue to require daily operational mitigation and are reflected in the Trust's corporate risk register. While these risks have been effectively managed through established escalation processes, staff redeployment and system collaboration, these measures represent interim mitigations rather than sustainable long-term solutions. Recent national maternity reviews, including the Independent Investigation into Maternity and Neonatal Services in England, and the Ockenden Review of Nottingham NHS Trust, reinforce the importance of ensuring workforce establishments are sufficient to provide safe, responsive 24/7 care across all professional groups. The workforce pressures described within this report align with these national findings, particularly in relation to consultant obstetric, anaesthetic, neonatal and ward workforce capacity. Approval of the business cases and proposed workforce investments would strengthen the sustainability of maternity and neonatal services, reduce reliance on temporary mitigations, improve patient flow and responsiveness, and support delivery of the Trust's strategic commitment to providing safe, high-quality care for women, babies and families. The Board is therefore asked to note the assurance provided within this report and give due consideration to the workforce recommendations presented, recognising that timely investment in these key areas will support both national policy expectations and the long-term resilience of the Trust's maternity and neonatal services. PLEASE NOTE – This paper is being reviewed by the Finance and Performance Committee on 22 July 2026 and a verbal update will be provided regarding the Committee's discussion.			

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Recommendation/s: (including any decision/approval required)	The Board is asked to: 1. Note the contents of this report and be assured that the Trust has effective arrangements in place for monitoring perinatal workforce capacity, risks and mitigations, in line with the requirements of the Maternity (Perinatal) Incentive Scheme Year 8. 2. Support the resubmission of the business case for an additional 3.0 WTE Consultant Obstetricians and Gynaecologists, recognising the ongoing high-level workforce risk, the reliance on consultants working beyond planned job plans, and the national recommendations for enhanced senior obstetric presence. 3. Consider and defer to a wider Board discussion an increase of 1.0 WTE Band 3 Maternity Support Worker on Ward M3 to address the sustained mismatch between patient acuity and workforce capacity, improve patient experience, and release registered midwives to focus on higher-acuity clinical care. 4. Consider and defer to a wider Board discussion an uplift of 4.76 WTE Band 5 Registered Neonatal Nurses to align the neonatal nursing establishment with British Association of Perinatal Medicine (BAPM) standards and strengthen resilience within the Neonatal Intensive Care Unit as requested in the Trust Nursing establishment review. 5. Support consideration of the obstetric anaesthetic out-of-hours staffing business case, once completed, recognising the operational and patient safety risks associated with the current staffing model, including delays in epidural provision, limited resilience to manage concurrent obstetric emergencies, and the impact of cross-site staff redeployment on wider Trust theatre capacity. 6. Support the implementation of the maternity theatre workforce review recommendations, subject to approval of the associated Theatre Workforce business case, to achieve compliance with national perioperative staffing standards and reduce reliance on interim staffing mitigations. 7. Note that the Quality Committee and Board will receive ongoing assurance through the monthly Maternity and Neonatal (Perinatal) Services Update on progress against approved workforce actions, and compliance with standards outlined in the recently published Independent Investigation into Maternity and Neonatal Services in England, and the Ockenden Review of Nottingham NHS Trust.
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness
Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	The related risks are described in the paper.
Legal/Regulatory:	This report fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB)2016

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	and 2018): How to ensure the right people, with the right skills, are in the right place at the right time and 'Safe, sustainable and productive staffing.
Quality & Patient Safety:	There is a risk to patients and staff is safe staffing levels are not maintained resulting in poor patient experience of care, potential patient harm, increased staff and patient dissatisfaction, complaints, incidents, increased sickness levels, claims and poor retention of staff.
Equality, Diversity and Inclusion and Health Equity	There is a continued focus on recruitment and progression of the perinatal workforce to be reflective of the local community and to offer opportunities for growth and development in the organisation as an anchor institution.
Resources:	Where risks are identified there are processes in place to identify and report staffing gaps and where possible, ensure mitigation is in place to provide safe patient care. There continues to be recruitment of new midwives, retention of existing staff and efficiency of staff deployment.
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	ETM 06/07/2026 People Committee 15.07.26 - PC.7.26.15b Finance and Performance Committee – 22.07.26

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Background:

This bi-annual Perinatal Workforce report provides an update on the perinatal workforce position for 2026 to date and builds on the previous report presented to the People Committee and Trust Board. Whilst previous reports focused primarily on the midwifery workforce, this report has been broadened to reflect the publication of the Maternity (Perinatal) incentive scheme year 8 guidance in March 2026, with a greater emphasis on the wider perinatal workforce.

In addition to the bi-annual midwifery staffing reports, the Quality Committee and Trust Board have continued to receive monthly updates on the perinatal workforce position as part of the Maternity and Neonatal Services reporting process, providing ongoing assurance regarding workforce capacity, risks, and mitigations.

The January 2026 report highlighted that all newly qualified midwives are appointed at Band 5 and, following completion of an 18 month to 2-year preceptorship programme, automatically progress to Band 6. However, the budget allocation did not align with the workforce profile, resulting in a recurrent cost pressure due to the higher proportion of Band 6 midwives in post compared with the funded establishment.

The Clinical Service Unit (CSU) worked collaboratively with Finance colleagues to address this structural misalignment through the 2026/2027 budget-setting process. As a result, the funded establishment has been realigned to better reflect workforce progression, support service requirements, and improve the long-term sustainability of the workforce budget.

The January 2026 report also reaffirmed the service's commitment to retaining staff through robust preceptorship, pastoral support, and professional development. This included a continued focus on strengthening recruitment and retention initiatives, enhancing staff experience, and improving the diversity of the perinatal workforce.

The January 2026 report outlined ongoing work to develop a sustainable model of care for maternity theatres to meet national standards for theatre recovery care. Collaborative working between the maternity and general theatre teams was established to mitigate identified risks, with a high-level risk recorded on the Trust risk register pending implementation of a longer-term solution.

The report also provided an update on the recruitment of a Consultant Midwife with a strategic focus on reducing health inequalities. This role supported the Trust Board's commitment to the Royal College of Midwives' Leadership Manifesto and delivery of the relevant Ockenden recommendation.

In addition, the Trust Board approved an increase in the Maternity Support Worker establishment. Approval was granted for Option 2, providing a workforce uplift of 5.33 WTE Band 3 Maternity Support Workers to deliver additional 24-hour cover on M4, strengthening staffing resilience and supporting the safe delivery of care.

The purpose of this report is to:

Provide assurance to enable the Trust Board to maintain effective oversight of multidisciplinary (MDT) workforce and capacity planning. This includes ensuring that funded establishment for obstetric, midwifery, neonatal, anaesthetic, and perioperative teams are aligned with nationally recognised workforce standards and are sufficient to support the safe delivery of care.

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This report provides the minimum evidential required to demonstrate compliance with the Maternity Incentive Scheme (MIS), Year 8, Safety Action A, relating to workforce and

capacity. It also provides assurance that workforce planning arrangements are subject to regular Board oversight and support the delivery of safe, high-quality maternity and neonatal services.

Current Midwifery Staffing Position:

A Birthrate Plus® assessment was undertaken in July 2024 to determine the required midwifery establishment. The Trust Board endorsed the recommendations and approved an increase in the funded establishment to support safe staffing levels based on the current model of care, including the provision of 10% Continuity of Carer (CoC) delivered through three CoC teams.

The midwifery workforce position improved significantly during the latter part of 2025/26 following the recruitment of 31 Newly Qualified Midwives (NQMs), equating to 27.96 WTE, who commenced employment in Quarter 3 and Quarter 4. This recruitment has strengthened workforce capacity and reduced reliance on temporary staffing.

As of June 2026, the vacancy against the funded establishment is 5.64 WTE midwives. This represents a change from the position reported in January 2026, when the service was 2.34 WTE over its funded establishment. However, when maternity leave is considered, the service has 10.3 WTE midwives on maternity leave, resulting in an effective safe staffing gap of 15.94 WTE.

Workforce figures presented within this report are derived from locally held workforce data, which provides a more timely and accurate reflection of the current staffing position than the Electronic Staff Record (ESR).

Current Obstetric Workforce position:

Consultant Rota

The perinatal service is currently operating one consultant below establishment following a retirement in October 2025, resulting in skills gaps in reproductive medicine and fetal medicine. Recruitment has been successful for a substantive consultant with maternal medicine expertise, who is due to commence in October 2026.

A high-level risk (Risk Register Ref. 3816) remains on the Women's Services risk register with a current risk score of 15. A business case (Appendix 1) has been developed to address the consultant workforce deficit by requesting an additional 3.0 WTE consultant obstetricians and gynaecologists. This investment is required to enable the delivery of planned obstetric and gynaecology services while maintaining safe emergency and acute care.

The business case was submitted but was not approved. Consequently, the service continues to rely on the existing consultant workforce undertaking activity beyond their agreed job plans to maintain the safe delivery of Women's Services. This reliance is not sustainable and increases both workforce and patient safety risks.

These concerns are reinforced by the recently published *National Maternity and Neonatal Investigation, Independent Investigation into Maternity and Neonatal Services in England,* and the *Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust* (Donna Ockenden), both of which concluded that insufficient senior obstetric staffing is a major contributor to unsafe maternity care. Furthermore, the National Maternity and Neonatal Investigation's Immediate Actions recommend that organisations review consultant rotas to ensure obstetric consultants are available on delivery units 24 hours a day, seven days a week, to provide timely senior clinical decision-making and intervention.

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In addition, the NHS England Chief Executive's Immediate 10-Point Plan for Maternity and Neonatal Services requires all Trust Boards to take accountability for ensuring safe and effective maternity service arrangements. This includes reviewing workforce capacity to ensure appropriate 24/7 availability and responsiveness across key workforce groups.

Given the continuing high-risk position, the reliance on consultants working beyond their planned commitments, and the clear national expectations arising from recent maternity reviews and NHS England guidance, the service requests that the business case for an additional 3.0 WTE consultant obstetricians and gynaecologists be reconsidered for approval to support the safe, sustainable delivery of maternity and gynaecology services.

Consultant job plans include provision for compensatory rest following non-resident on-call duties where overnight activity impacts their ability to undertake scheduled duties the following day. For obstetric weekend on-call, direct clinical care (DCC) sessions are routinely cancelled on Mondays to facilitate this. Where the gynaecology consultant is required to be resident overnight, the following day's DCC activity is either cancelled or alternative clinical cover is arranged.

There has been no requirement to use agency locum consultants in the last 6 months.

Obstetric Consultants	Month				
	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Funded WTE	25	25	25	25	25
Contracted WTE	24	24	24	24	24
Vacancy WTE	1	1	1	1	1
Sickness (WTE lost in Month)	0.71	1.90	0.24	0.33	0.48

Middle Grade Rota

The service is funded for a 19 WTE middle-grade (ST3-7) rota, with 14 WTE expected to be provided through the Deanery. Due to ongoing vacancies, the rota is currently operating with 16 doctors, limiting the ability to implement a full 24/7 two-tier registrar rota and requiring single registrar cover during weekend day shifts.

In addition, the high proportion of non-entrustable resident doctors requires senior on-site supervision, increasing reliance on locum medical cover to maintain safe staffing. As of June 2026, the service has 11.0 WTE doctors in training (excluding maternity leave), compared with 11.8 WTE in September 2025.

To improve middle-grade workforce resilience, the service has recruited three locally employed doctors and plans to recruit a further two doctors through the RCOG Medical Training Initiative (MTI) programme, alongside four Specialty and Specialist (SAS) doctors. In the interim, a regular agency locum has been retained to provide senior support and maintain entrustability requirements, with reliance on this post expected to cease by September 2026. The locum has been embedded within the service, and their appointment is managed in line with RCOG guidance for the engagement of long-term locums in maternity services.

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Obstetric Resident Doctors Middle Grade Rota	Month				
	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Funded WTE	19.0	19.0	19.0	19.0	19.0
Contracted WTE	12.4	15.0	15.0	14.0	14.0
Vacancy WTE	6.6	4.0	4.0	5.0	5.0
Sickness (WTE lost in Month)	1.29	0.95	0.24	0.19	1.05

First on call rota

The first on-call medical rota is currently operating with near full establishment, with no rota compliance issues identified during the reporting period.

Obstetric Resident Doctors First on call Rota	Month				
	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Funded WTE	17.6	17.6	17.6	17.6	17.6
Contracted WTE	16.9	15.9	14.9	14.9	14.9
Vacancy WTE	0.7	1.7	2.7	2.7	2.7
Sickness (WTE lost in Month)	0.33	0.24	0.52	0.19	0.05

Anaesthetic workforce:

Anaesthetics - a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and has clear lines of communication to the supervising anaesthetic consultant.

Month	Jan 2026	Feb 2026	March 2026	April 2026	May 2026
% compliance	100%	100%	100%	100%	100%

Trained Anaesthetic Assistant available 24/7 in line with ACSA standards 1.3.1.2.

Month	Jan 2026	Feb 2026	March 2026	April 2026	May 2026
% compliance	100%	100%	100%	100%	100%

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Out of hours, the current obstetric anaesthetic staffing model provides sufficient capacity to safely operate a single obstetric theatre only. Where a woman requires an epidural or a second obstetric theatre is needed concurrently, additional anaesthetic and anaesthetic assistant support must be redeployed from the main theatre. This can adversely affect the Trust's ability to respond to emergency and urgent surgical activity elsewhere in the hospital and may also impact planned operating lists the following day.

The operational and patient safety risks associated with this staffing model are recorded on the Trust's High-Level Risk Register (Ref. 2787) and are described in further detail in Appendices 6 and 7.

The current staffing model offers limited resilience to manage concurrent obstetric emergencies while maintaining timely access to epidural analgesia, resulting in an ongoing reliance on cross-site staff redeployment. This approach is not sustainable and requires consideration as part of the Trust's implementation of the 10-Point Plan for Maternity and Neonatal Services, which places accountability on Trust Boards to ensure safe and effective maternity services through appropriate 24/7 workforce capacity across key professional groups.

The risks associated with out-of-hours anaesthetic assistant cover would be mitigated through approval of the Theatre Workforce business case. In addition, approval of the obstetric anaesthetic out-of-hours business case would provide the resilience required to improve timely epidural provision, support concurrent obstetric activity, and reduce the wider operational impact on emergency and elective theatre services.

Neonatal workforce position:

The Neonatal Service currently has a registered neonatal nurse vacancy of 4.95 WTE, which continues to contribute to workforce pressures and reliance on temporary staffing.

The medical workforce is also under significant pressure. The service is funded to provide 7.0 WTE Neonatal Consultants; however, a consultant retirement in February 2026, a period of maternity leave commencing in May 2026, and a further planned maternity leave from August 2026 have created, or will create, a 2.4 WTE consultant staffing gap.

These nursing and medical workforce vacancies reduce staffing resilience and increase the challenge of maintaining safe staffing levels, particularly during periods of high neonatal acuity, increased activity, and ongoing operational pressures.

Risk assessments (Risk assessment Ref. 2911 & 3157) for both the neonatal medical and nursing workforce are recorded on the Trust risk register. The Neonatal Consultant staffing risk is currently rated as high, with a risk score of 15, reflecting the significant impact of consultant workforce gaps on service resilience and delivery. The Neonatal Nurse staffing risk is rated as moderate, with a risk score of 12, recognising the ongoing challenges associated with nursing vacancies, sickness absence, and the reliance on temporary staffing to maintain safe care.

These risks continue to be actively monitored, with mitigating actions in place to support safe service delivery while substantive recruitment and workforce planning initiatives progress.

The Maternity (Perinatal) Incentive Scheme – Year 8 requires Trusts to have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant British Association of Perinatal Medicine (BAPM) standards for the unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU) or Special Care Unit (SCU)) and the recommendations of the Neonatal Nursing Workforce Calculator (2020).

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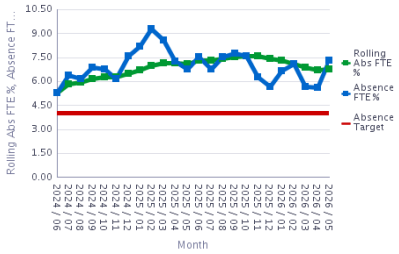
A recent review of the neonatal workforce has compared the Trust's funded establishment with the staffing levels recommended by the BAPM standards and the Neonatal Nursing Workforce Calculator. The findings of this review have been incorporated into the Trust's overarching Nursing and Midwifery Establishment Review, to which this report is appended.

The review identified a requirement to increase the Neonatal Intensive Care Unit nursing establishment by 4.76 WTE Band 5 Registered Nurses. Approval is therefore sought for this establishment uplift to enable compliance with BAPM nurse-to-patient ratios, based on the unit's commissioned cot capacity and activity over the previous financial year.

Sickness and Absence:

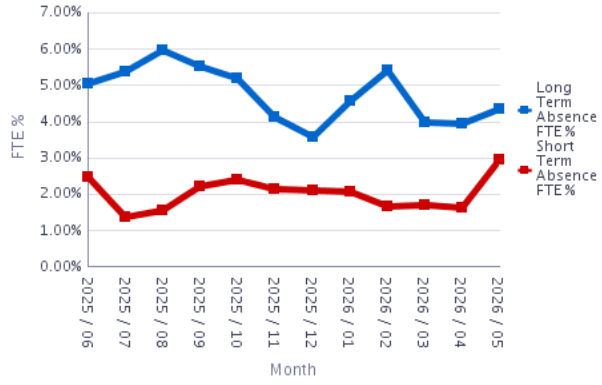
The latest Women's Services monthly figure for May 2026 was 7.32% (April 2026 – 5.71%). The year-to-date figure was at 6.78% as of May 2026 (April – 6.74%).

The monthly and YTD sickness rates for the last 12 months are:



Long-Term sickness accounts for 4.35% of sickness in May 2026 and short-term sickness 2.97%.

Long-term sickness rates fell between August and December 2025 but then increased over January and February 2026. Following 2 months of falling rates again over March and April 2026, there was a slight increase in long-term sickness in May 2026. Short-term sickness rates increased July to October 2025. Since then, short-term sickness rates have generally fallen.



Sickness rates for the various wards/departments within the CSU as of May 2026 were as follows (rates above the 5.98% target are highlighted in yellow):

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	FTE Days Sickness	FTE Days Available	% FTE Days Sickness	Year to Date %
389120003 Central Costs-Obs & Gynae	0.00	341.00	0.00%	0.08%
389120319 Med Staff-Obs/Gynaecology	14.69	1,787.11	0.82%	1.90%
389120508 Med Secs - Obs & Gynae	92.84	583.41	15.91%	10.62%
389121012 Ward 25 - GATU	60.04	712.69	8.42%	6.27%
389121202 Maternity Assessment Centre	0.00	164.41	0.00%	9.37%
389121203 Mat-Ward M3	30.48	279.79	10.89%	7.10%
389121204 Mat-Ward M4	117.44	535.13	21.95%	22.48%
389121205 Labour Ward	60.67	793.39	7.65%	7.59%
389121207 Mat - Del Suite Theatre	7.00	197.16	3.55%	4.32%
389121208 Women's Health Unit	36.84	650.69	5.66%	11.14%
389121211 Antenatal Clinic	0.96	234.36	0.41%	10.17%
389121212 Community Midwifery	29.56	437.00	6.76%	7.05%
389121215 Mat - Midwifery Admin	6.00	70.27	8.54%	1.03%
389121224 Birth Centre	23.52	185.07	12.71%	15.27%
389122019 Pat Admin-BRI Maternity	44.91	493.11	9.11%	7.40%
389124321-Midwives	529.72	6,850.74	7.73%	6.32%
389M20899 Community Admin	18.07	186.00	9.71%	3.19%
389M24485 Specialist Midwife	51.40	757.47	6.79%	5.24%
389M24486 Smoking Cessation Team	0.43	107.47	0.40%	2.10%

Top 5 Absence Reasons for the Year Women's Services:

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	85	103	3,258.23	27.1
S12 Other musculoskeletal problems	65	83	1,872.95	15.6
S98 Other known causes - not elsewhere classified	85	100	1,248.02	10.4
S25 Gastrointestinal problems	210	278	1,187.26	9.9
S13 Cold, Cough, Flu - Influenza	204	258	787.29	6.5

The Matrons continue to closely manage long term sickness and absence alongside HR and health and wellbeing colleagues in line with Trust policy.

The Outstanding Maternity Services Workforce work stream also continues with several wellbeing initiatives such a 'wellbeing tea trolleys' which have been positively evaluated by staff. The service also actively engages with the Trust Thrive initiatives.

Neonatal workforce sickness and absence:

Between 1 January and 31 May 2026, Neonatal Services recorded a total of 7,309 hours of sickness and absence. This equates to an average of 9.3 WTE absent each week, representing 10.8% of the workforce on average, based on an establishment of 85.89 WTE in post at 31 May 2026.

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Recruitment of Newly Qualified Midwives

For the 2026/27 recruitment cycle, the service has adopted a revised approach to the recruitment of Newly Qualified Midwives (NQMs), moving away from the previous West Yorkshire and Harrogate Local Maternity and Neonatal System (LMNS) centralised recruitment model.

Recruitment leads across the LMNS have worked collaboratively to develop a coordinated approach that provides greater flexibility for individual organisations whilst maintaining consistency across the region. Under the revised process, each Trust has undertaken local advertising and shortlisting, with interview dates aligned across participating organisations to ensure a coordinated recruitment timetable.

This approach enables the Trust to tailor recruitment to local workforce needs while continuing to work collaboratively with partner organisations to attract and appoint high-quality candidates.

The service is confident that the current recruitment process will enable all substantive vacancies, including maternity leave backfill, to be filled. Based on current applicant numbers across the Local Maternity and Neonatal System (LMNS), there is also an expectation that the number of appointable candidates will exceed the total vacancies available across participating Trusts.

Maternity Workforce Initiatives:

Midwifery Apprenticeship Pathway:

The service continues to invest in developing its future workforce through the Midwifery Apprenticeship Pathway. Two Apprentice Midwives, both previously employed as substantive Maternity Support Workers (MSWs), are progressing successfully through the programme and are expected to qualify at the end of 2026, at which point they will transition into substantive Band 5 midwifery posts.

The apprenticeship pathway demonstrates the service's commitment to developing a sustainable "grow our own" workforce model by creating internal career progression opportunities for existing staff. This approach supports workforce sustainability, improves retention, and enables experienced MSWs to progress into registered midwifery roles while retaining valuable organisational knowledge.

There continues to be strong interest from the existing MSW workforce in pursuing this career pathway. However, further expansion is currently constrained by the financial implications of the apprenticeship model and is not sustainable within existing funding arrangements. Future growth will therefore be dependent on the availability of additional external funding, including support from NHS England (NHSE).

MSc Midwifery (Shortened Programme):

As part of the service's commitment to developing a sustainable workforce, two Registered Nurses commenced the NHS England (NHSE)-funded MSc Midwifery (Shortened Programme) in March 2025. This two-year blended learning programme provides an alternative route into the midwifery profession for registered nurses.

One participant chose to withdraw from the programme shortly after commencing. The remaining trainee is progressing well and is expected to qualify in 2027, when they will join the substantive midwifery workforce.

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This programme provides an additional workforce pipeline into midwifery, broadening entry routes into the profession and supporting the long-term sustainability and resilience of the maternity workforce.

Midwife Sonographer Development:

The service secured NHS England (NHSE) funding to support one existing registered midwife to undertake training as a Midwifery Sonographer. The midwife commenced the programme at the end of 2025 and is expected to complete their training in 2027, at which point they will transition into a substantive Band 7 Midwifery Sonographer role, supporting the delivery of obstetric ultrasound services.

Developing this role enhances the multidisciplinary workforce and strengthens the sustainability of the maternity ultrasound service by creating an internal career progression pathway while increasing specialist workforce capacity.

The importance of this role has been reinforced by the Ockenden Report: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust. Immediate and Essential Action 2 states that "Obstetric sonographers must be included within workforce and staffing models to reflect the increasing complexity of cases and increasing workload." The development of this role demonstrates the Trust's commitment to responding proactively to national recommendations and ensuring the workforce is equipped to meet future service demands.

The service remains committed to developing internal talent pipelines and will continue to work with system partners to identify funding opportunities that would support the expansion of this successful workforce initiative.

Midwifery Continuity of Carer (MCoC):

In September 2022, the National Maternity Transformation Programme confirmed that the national target to achieve Midwifery Continuity of Carer (MCoC) as the default model of care for all women by 2024 had been withdrawn. Trusts were instead asked to prioritise the delivery of safe and sustainable staffing levels.

Whilst the implementation target has been removed, continuity of carer remains the national ambition. Trusts are expected to continue developing the infrastructure and workforce required to support future implementation when it is safe and sustainable to do so. This remains the approach adopted by BTHFT.

The Trust continues to prioritise the established Acorn MCoC team, which provides continuity of care for women from vulnerable backgrounds. In addition, the Jasmine Team, a new mixed-risk geographical continuity team, commenced case loading in April 2025 and provides an on-call service to support continuity during labour and birth. The Home Birth Team also delivers continuity of care from the point of referral through pregnancy, birth, and the postnatal period for women choosing this care pathway.

Royal College of Midwives (RCM) Leadership Manifesto:

In July 2025, the Trust Board endorsed alignment with the Royal College of Midwives (RCM) Leadership Manifesto and the corresponding Ockenden recommendation to appoint a Consultant Midwife focused on reducing inequalities. The job description and person specification are being developed and require job matching prior to the post being advertised. Recruitment for this post will commence in Quarter 2 or 3 of 2026/2027.

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Midwifery Retention and Pastoral Support

The service has continued to prioritise the retention and wellbeing of newly qualified midwives through a comprehensive programme of pastoral and professional support. This includes regular one-to-one engagement with line managers, dedicated support from the Specialist Midwife for Pastoral Support and the Legacy Midwife, and early identification and intervention where personal or professional challenges arise.

These structured support mechanisms have contributed to excellent retention outcomes, with all but one of the 31 newly qualified midwives recruited during 2025/26 remaining in post. Following extensive support, including opportunities to rotate through different clinical areas, one midwife chose to leave the profession as midwifery was not the right career for them.

This proactive approach aims to enhance the early career experience, reduce the risk of attrition, and strengthen the long-term sustainability of the midwifery workforce.

Midwifery workforce turnover has remained low, with a rolling 12-month turnover rate of 8.8%, which is below the Trust target and reflects continued workforce stability.

The Outstanding Maternity Service Workforce workstream continues to lead quality improvement initiatives focused on staff wellbeing, engagement and retention. Current priorities include improving staff access to uninterrupted meal breaks and implementing local action plans developed by Matrons and Ward Managers in response to the findings of the NHS Staff Survey. These initiatives are intended to improve staff experience and create a positive working environment that supports recruitment and long-term retention.

Midwifery Rotation and Skills Maintenance:

Work continues to strengthen and standardise midwifery rotation arrangements to ensure all midwives maintain the skills, competence and confidence required to deliver the full scope of midwifery care across all care settings. This approach provides assurance that clinical competencies are maintained and supports the delivery of safe, high-quality care.

The enhanced rotation model also responds to the recommendations arising from the Prevention of Future Deaths (PFD) Report issued by the Senior Coroner for Manchester North following the deaths of a mother and baby after a home birth. The report highlighted the importance of maintaining competence across all areas of midwifery practice and raised wider national considerations regarding safety and quality standards.

Community midwives continue to undertake regular rotational placements within the Birth Centre to maintain intrapartum care skills and clinical exposure. Evaluation of this approach has been overwhelmingly positive, with staff reporting increased confidence and competence in intrapartum care, while supporting greater flexibility and resilience across the maternity workforce.

Planned versus Actual midwifery staffing levels:

Appendix 2 demonstrates that planned midwifery staffing levels were consistently maintained at broadly 90% or above across most maternity areas between January and May 2026. Where registered staffing fell below planned levels, this was mitigated through safe staffing escalation processes. Overall, staffing levels enabled the service to continue to provide safe care, with workforce pressures actively managed through daily operational oversight and escalation arrangements.

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Maternity Safe Staffing Mitigation:

Safe staffing is maintained across all areas of the maternity unit through daily workforce redeployment, flexible management of inpatient beds to preserve safe staffing ratios, and the deployment of specialist and non-clinical midwives into clinical roles where required.

Where activity levels or clinical acuity exceed available staffing, the maternity escalation policy is implemented. As a final measure, and only where clinically appropriate and operational feasible, women may be diverted to alternative maternity units to maintain patient safety.

Staffing gaps arising from vacancies and long and short-term sickness absence are routinely escalated to the internal staff bank to maximise workforce availability and minimise service disruption.

The National Maternity and Neonatal SitRep is completed daily by 11:30, and an Operational Matron from each hospital attends the LMNS Staffing Acuity Huddle each weekday at 10:30. These forums provide system wide oversight of workforce pressures and enable mutual aid arrangements where capacity is available.

Real-time staffing requirements are monitored using the Birth Rate Acuity (BRA) application, which assesses workforce needs based on the clinical acuity of women and babies across intrapartum and postnatal/antenatal ward areas. Together with daily operational oversight, these measures support the delivery of safe, effective, and responsive maternity care, enabling the service to respond promptly to fluctuations in activity, staffing, and clinical acuity.

Maternity Management of Staffing Versus Acuity

The Birthrate Plus Acuity App provides real-time assessment of staffing requirements based on the clinical acuity of women and babies across intrapartum, antenatal and postnatal areas. Alongside daily operational oversight, it supports the delivery of safe, effective, and responsive maternity care by enabling staffing to be adjusted in line with changes in activity and clinical need.

Rostered staffing data does not reflect the dynamic redeployment of staff undertaken in response to changes in clinical acuity. From Monday to Friday (08:00 and 16:00), daily staffing and patient flow are coordinated by a Band 7 midwife (Specialist Midwife or Ward Manager), while the Maternity Matron provides senior operational oversight, acting as the bed manager guidance and overarching oversight. Both roles undertake prospective reviews of staffing levels and capacity to identify anticipated shortfalls and implement timely mitigation measures.

Birthrate Plus Acuity data is recorded at scheduled intervals throughout the 24-hour period, with additional assessments undertaken whenever changes in clinical activity or acuity indicate that staffing requirements should be reviewed. Appendix 3 summarises reporting compliance, presents the percentage of acuity against staffing across each clinical area, and details reported staffing factors together with the associated clinical and the managerial actions taken.

Reporting compliance remains strong across most clinical areas. Compliance within the Birth Centre has improved since the previous reporting period but remains under 80%. Compliance on M3 has also slightly reduced to 76%. Reporting compliance is monitored through the Women's Services Business Meeting, where performance is reviewed and actions to improve compliance are agreed and monitored.

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The intrapartum areas continue to demonstrate a more favourable acuity position than the antenatal and postnatal ward areas, reflecting the priority given to maintaining one-to-one midwifery care during established labour. The most frequently reported staffing factors affecting workforce capacity were unexpected midwife absence due to sickness (22%), the inability to fill vacant shifts (17%), and the absence of an emergency scrub practitioner (18%), all of which have been highlighted elsewhere in this report.

The most commonly reported clinical action was the delay of induction of labour on the labour ward (72%), while staff redeployment remained the principal management action undertaken to mitigate staffing pressures (80%).

Acuity across the antenatal and postnatal wards (M3 and M4) remains consistent with the previous reporting period and continues to fall within the red category, indicating that staffing levels do not consistently meet the clinical acuity of women requiring care. The increasing complexity of the maternity population, alongside workforce pressures, has been recognised nationally in the Ockenden Report: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust. Essential Immediate Action (IEA) 2 recommends the development and implementation of a robust, evidence-based workforce planning tool across perinatal services that extends beyond birth rates alone to reflect population complexity, including maternal age, co-morbidities, deprivation, clinical acuity, and service configuration. The continued disparity between ward acuity and staffing reinforces the importance of adopting workforce planning approaches that better reflect the complexity of care required within antenatal and postnatal settings.

Following consideration of the previous report, the Trust Board approved an increase in the establishment to provide an additional Band 3 Maternity Support Worker (MSW) on Ward M4, delivering 24-hour support to address workload pressures on the postnatal ward. However, the equivalent request for additional MSW provision on Ward M3 was not approved.

Workforce acuity data continues to demonstrate that Ward M3 experiences sustained staffing pressures, with demand consistently exceeding available staffing. In light of the ongoing mismatch between clinical acuity and workforce capacity, Maternity Services is seeking approval to increase the establishment.

Recommendation

Approval is requested to increase the establishment by:

- 1 x WTE Band 3 Maternity Support Worker (MSW) for Ward M3 (mixed antenatal and postnatal).

Expected Benefits

The proposed increase in support staffing is expected to:

- Improve delivery of fundamental care for mothers and newborns.
- Enhance patient experience, particularly for women undergoing induction of labour, through improved responsiveness and continuity of care.
- Reduce the number of formal complaints associated with delays in care and patient experience.

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- Release registered midwives from non-registered duties, enabling them to focus on the delivery of higher-acuity clinical care and improve overall workforce efficiency.
- Strengthen resilience within the ward workforce and support safer staffing in response to fluctuations in activity and clinical acuity.

Planned versus Actual Neonatal staffing levels:

Between 1 January and 31 May 2026, there were 366 unfilled 11.5-hour shifts, equating to an average of 73.2 unfilled shifts per month.

To maintain financial stability, the service will, on occasion, cancel non-essential bank shifts when staffing levels exceed the recommended BAPM standards. These cancelled bank shifts are subsequently recorded as 'unfilled' at the close of the roster, which can result in a small overstatement of unfilled shifts within the reported data.

Audit records of these occasions have been maintained throughout the reporting period. However, given the sustained high patient acuity and limited cot availability during this period, it is considered unlikely that more than a small number of bank shifts were intentionally cancelled.

During the same period, the service utilised 6,887.5 hours of bank staffing, equivalent to an average of 8.8 WTE per week, demonstrating a continued reliance on temporary staffing to support safe service delivery and mitigate workforce shortfalls.

Neonatal Staffing Capacity & Acuity:

The NICU Capacity and Acuity Dashboard is provided in Appendix 4. The dashboard demonstrates that High Dependency Unit (HDU) occupancy has consistently exceeded commissioned capacity throughout the reporting period, with sustained congestion within Special Care (SC) indicating ongoing constraints in patient flow. Intensive Care Unit (ICU) demand has remained variable but continues to place intermittent pressure on the service.

Capacity pressures are frequently exacerbated by constraints across the neonatal network, including limited availability of cots within receiving units and delays in repatriating infants from Bradford's HDU and SC cots to Level 2 Local Neonatal Units (LNUs) and Level 1 Special Care Baby Units (SCBUs) when clinically appropriate.

To maintain patient flow and support safe, family-centred care, the NICU continues to maximise the use of Transitional Care and the Neonatal Outreach Service, enabling infants to step down from neonatal cots at the earliest clinically appropriate opportunity. Despite these measures, sustained occupancy above commissioned capacity continues to present a significant operational risk and places ongoing pressure on staffing, bed availability, and patient flow.

Appendix 5 presents daily neonatal activity, staffing and operational data for January to March 2026, illustrating the relationship between patient acuity, staffing levels and operational pressures within the Neonatal Intensive Care Unit (NICU). Overall, the data demonstrates that the service experienced sustained periods of high occupancy and patient acuity, with High Dependency activity frequently exceeding commissioned capacity and ongoing pressure across the neonatal pathway.

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Current challenges:

Obstetric Theatre

Recent recruitment resulted in the successful appointment of 3.0 WTE theatre nurses, bringing the obstetric theatre nursing workforce to its funded establishment. This has significantly improved staffing resilience within maternity theatres and has reduced the impact on midwifery staffing previously reported to the Trust Board.

Whilst this represents a significant improvement, midwifery staffing continues to be affected when a second obstetric theatre is required to be operational, as national staffing standards for theatre recovery and perioperative care cannot always be consistently achieved.

A high-level risk therefore remains on both the local and corporate risk registers and continues to receive Executive Team oversight. A comprehensive workforce review of general theatre services, including maternity theatres, has been completed with external peer support. A supporting business case has subsequently been developed, setting out recommendations to align the maternity theatre workforce and competency model with national standards. The recommendations are currently awaiting Trust Board consideration and approval.

Pending implementation of the proposed workforce model, maternity and general theatre teams continue to work collaboratively to mitigate identified risks and maintain safe service delivery. Key mitigating actions include:

- Three-times-daily theatre safety huddles attended by maternity matrons to identify and escalate staffing risks in real time.
- Ongoing incident reporting where the second Labour Ward Coordinator is required to undertake the theatre scrub practitioner role because of staffing shortfalls. This provides continued assurance that staffing pressures are monitored, escalated and inform organisational risk management.

These measures provide interim assurance while the longer-term workforce solution is progressed through the Trust's governance and approval processes.

Midwife to Birth ratio:

A review of the previous 12-month period is as follows:

January	February	March	April	May
1:20	1:20	1:20	1:20	1:20

The ratio is calculated on the number of midwives employed and does not account for any monthly variations in staffing due to sickness and absence. Please note that this ratio is a Birth: Midwife (excluding Band 8 midwives). This differs from the skill mixed numbers in the Birth Rate Plus tool.

Maternity Annual Training Needs Analysis:

The 'Three Year Delivery Plan for Maternity and Neonatal Services' published in March 2023 requires trusts to undertake an annual training needs analysis and ensure training is available to all staff in line with the National maternity core competency framework version 2

Osbourne Quinlan
22/07/2026 08:58:21

(v2). Compliance with the core competency framework v2 is one of the safety standards within the Maternity Incentive Scheme (MIS).

A training needs analysis and a 3-year training plan is in place which meets the requirements of the National Maternity core competency framework v2 and is delivered over 5 days (39 hours) per year. This is required for each midwife employed, not whole time equivalent. This does not include any dedicated protected time for Trust mandatory training or any additional individual training needs, for example leadership development, newborn examination training, professional midwifery advocate training, university modules or external training courses.

Releasing midwifery staff to attend 5-days of training days per month remains challenging as maintaining a safe clinical service is paramount. Training compliance is monitored monthly at the Quality & Safety governance meeting and compliance with core maternity training has remained high throughout 2025.

Number of Maternity Red Flag Incidents

Maternity red flag incidents remain subject to routine review through the Women's Services Business Meeting, with detailed data provided in Appendix 6. Between 1 January and 31 May 2026, 121 red flag incidents were reported across maternity services. The most common themes related to delays in providing pain relief, workforce pressures impacting the provision of continuous 1:1 care in labour, and staffing acuity. Improvement actions are underway, including a quality improvement project to reduce delays in pain relief and a business case to increase obstetric anaesthetic capacity.

In view of the frequency of delays in providing pain relief, the findings of the epidural response audit (Appendix 7), and the risks associated with limited out-of-hours obstetric anaesthetic cover, the maternity service recommends that the Trust gives due consideration to the obstetric anaesthetic staffing business case once it has been completed. Strengthening anaesthetic capacity, particularly out of hours, would support timely access to pain relief, reduce patient safety risks, and improve compliance with national standards and recommendations.

Supernumerary labour ward coordinator status and the provision of one-to-one care in labour were previously reported as separate sections within this report. As both are reportable maternity red flag incidents, they have now been incorporated into the maternity red flag data presented in Appendix 6.

Maternity Unit ‘Closures’

Appendix 8 demonstrates that, between 1 January and 31 May 2026, there were no full maternity unit closures. During this period, there were three partial diverts and one attempted divert where the unit remained open because neighbouring organisations were unable to accept admissions. Two women were diverted to alternative units for care, and no harm to mothers or babies was reported during periods of escalation.

There were also five home birth suspensions during the reporting period, comprising three in January, one in February and one in April.

All episodes are reviewed through the quarterly Maternity Services Divert Report, with learning shared at the Women's Service Business Meeting to strengthen operational management, escalation processes and documentation.

Osborne-Sheridan
22/07/2026 09:58:21

Neonatal Unit Cot Closures & Staffing related transfers

Appendix 9 summarises neonatal unit operational pressures between January and May 2026, demonstrating periods of Operational Escalation Level (OPEL) 4 due to high patient acuity, capacity pressures and workforce constraints. During this period, the unit experienced 40 full days of admission closures (14 in January, 7 in February, 8 in March, 9 in April and 2 in May) while managing between 33 and 45 admissions per month. The majority of escalation episodes were associated with high numbers of intensive and High dependency care patients, nurse staffing pressures and bed closures due to Infection Prevention Measures. The appendix also details ex-utero transfers, including clinically indicated surgical and repatriation transfers, together with a small number of capacity transfers to other neonatal units. Although transfers out are included within the closure data, the available information does not distinguish those undertaken specifically because of staffing pressures from clinically appropriate step-downs or repatriations.

Incident reports/safety events:

Maternity Staffing/Capacity Related Incidents:

Safety events associated with midwifery staffing are reported through the InPhase incident reporting system and are subsequently reviewed by the maternity team.

A total of 22 maternity incidents were reported between January and May 2026 (Appendix 10). The majority (68%) related to operational pressures, predominantly staffing shortages, theatre capacity, and service resilience. Recurring themes included suspension of the home birth service, maternity unit capacity/diversion, and workforce shortages requiring midwives to undertake theatre roles. Six incidents related to care and treatment, with only two recording low physical harm; the remainder resulted in no or no recorded patient harm. Overall, incidents reflect ongoing operational and workforce pressures rather than significant patient safety events.

It is important to note that data from the InPhase system alone does not provide an accurate measure of staffing pressures, acuity, or their full impact on patient care. However, these factors are considered as contributing elements during the review of all clinical incidents.

Neonatal Unit Incidents:

Between 1 January and 31 May 2026, a total of eight IRIS incidents relating to staffing and capacity pressures were reported. These comprised three incidents in January, two in February, two in April, and one in May (Appendix 11).

The majority of incidents related to an inability to meet Infection Prevention and Control (IPC) isolation guidance due to insufficient nurse staffing. Additional contributing factors included neonatal unit overcapacity, the requirement for three additional Transitional Care Unit (TCU) beds, and room closure for essential maintenance works.

These incidents reflect the sustained operational pressures experienced by the service during the reporting period, with workforce shortages and high clinical demand impacting the unit's ability to consistently meet IPC standards and safely accommodate activity.

Conclusion:

Osbourne, Stella
22/07/2026 08:21

This report provides assurance that the Trust continues to maintain effective oversight of perinatal workforce planning in accordance with the requirements of the Maternity (Perinatal) Incentive Scheme Year 8. Significant progress has been made in strengthening the multidisciplinary workforce through targeted recruitment, improved retention, investment in

workforce development, and enhanced governance arrangements. These measures have improved staffing resilience and supported the continued safe delivery of maternity and neonatal services.

However, the report also demonstrates that significant workforce risks remain. Sustained pressures within the obstetric, neonatal, anaesthetic and ward-based workforces continue to require daily operational mitigation and are reflected in the Trust's corporate and corporate risk registers. While these risks have been effectively managed through established escalation processes, staff redeployment and system collaboration, these measures represent interim mitigations rather than sustainable long-term solutions.

Recent national maternity reviews, including the Independent Investigation into Maternity and Neonatal Services in England, and the Ockenden Review of Nottingham NHS Trust, reinforce the importance of ensuring workforce establishments are sufficient to provide safe, responsive 24/7 care across all professional groups. The workforce pressures described within this report align with these national findings, particularly in relation to consultant obstetric, anaesthetic, neonatal and ward workforce capacity.

Approval of the business cases and proposed workforce investments would strengthen the sustainability of maternity and neonatal services, reduce reliance on temporary mitigations, improve patient flow and responsiveness, and support delivery of the Trust's strategic commitment to providing safe, high-quality care for women, babies and families.

The Board is therefore asked to note the assurance provided within this report and give due consideration to the workforce recommendations presented, recognising that timely investment in these key areas will support both national policy expectations and the long-term resilience of the Trust's maternity and neonatal services.

Appendices:

Appendix 1 – Women's CSU Consultant Staffing Business Case v4

Appendix 2 - Maternity Planned vs Actual

Appendix 3 - BR+ acuity app data

Appendix 4 - Neonatal Capacity & Acuity Dashboard

Appendix 5 - Neonatal Staffing vs Acuity

Appendix 6 - Red flag report 1.1.26 to 31.05.26

Appendix 7 - Epidural audit BRI 2026

Appendix 8 - Maternity Closure & Divert report Jan - May 26

Appendix 9 - Neonatal Cot closures

Appendix 10 - Maternity Incidents

Appendix 11 - Neonatal Incident

Osbourne Sheehan
22/07/2026 09:58:21

The appendices are available in the reading room here.

Meeting Title	Board of Directors		
Date	23 July 2026	Agenda item	Bo.7.26.12a

Committee Escalation and Assurance Report

Report from the: Finance and Performance Committee

Date of meeting: 17 June 2026

Key escalation and discussion points from the meetings

Alert:

Operational Performance KPI exceptions:
June's Committee considered the full suite of Operational Performance metrics for May (April for cancer). Only one KPI was of concern, an early warning on the level of Emergency Department attendances. Demand was higher than expected with increased pressures seen within Care of the Elderly and Paediatrics - operational insight suggests a portion of attendances remain appropriate for GP management which is a focus for the EXCEL programme.

Financial Position
The financial position at May was of concern with a range of risks, mitigations and potential outcomes fully assessed. The Committee asked for continued reports on progress on income delivery of the workforce plan and Closing the Gap delivery. The Board will be receiving more up to date information at its meetings on 23 July.

Recovery Programme
Whilst the Committee noted the significant progress since the May report, there was still a significant risk of a shortfall in delivery. The recovery strategy and the governance structure is in place but delivery at pace is yet to give confidence. The Committee supported the prioritisation of Counting and Coding, Workforce plan delivery and Theatre productivity improvement. The Board will receive information on further developments concerning deficit support funding and the outcome of other conversations with reginal colleagues at its meetings on 23 July.

Space Utilisation
The Director of Estates and Facilities responded to a Limited Assurance Internal Audit Report on Space Utilisation. In accepting the report, he noted that some immediate actions had already commenced but a longer-term plan would be needed, embracing the required cultural change across the Trust to maximise rationalisation of non-clinical space. Ultimately, a revised estate strategy would need to address this issue as part of a wider consideration of the Trust estate.

Advise:

Operational Performance KPI watch list

- **Emergency Care Standard (ECS):** Performance had dropped slightly below plan, although remains in the best decile nationally and actions were in place to support improvement into June. High attendances, Resident Doctor Strike, IPC Ward restrictions and bed occupancy correspond with this trend.

Osbourne Shuttle
23/07/2026 09:18:2

Meeting Title	Board of Directors		
Date	23 July 2026	Agenda item	Bo.7.26.12a

- **12-hour ECS:** There had 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.
- **RTT Total WL Size**: Increasing size of waiting list is an early warning that RTT improvements may not be sustainable. This also provides an opportunity, as if additional productivity gains are made in line with plan and targeted at reducing waits over 18 weeks the overall waiting list profile will be better split by over and under 18 weeks.

Pathology Joint Venture
A more positive report was received than had been the case at recent Committee meetings. Nevertheless, the Committee would still be expecting to receive regular reports on progress to assure itself about the impact on Trust performance, particularly where there had been significant concern previously, particularly on histology.

Business Case Post Implementation Review
The Committee received the first of a new report on post implementation reviews of business cases. Whilst the information was helpful and did indicate that some required outcomes had been delivered, there was clearly further improvement required in evidencing that investments had more fully delivered the outcomes expected.

Infrastructure and Capital Risk
The Director of Estates and Facilities detailed the current Estates risk position, including the scale of backlog and its implications for patient safety, compliance and operational resilience. He explained how the Trust used independent six-facet surveys and other expert inputs to prioritise capital spend and backlog mitigation. Although progress was being made and backlog maintenance had begun to reduce slightly, the Trust still faced a substantial gap between need and available funding. The Committee was assured to learn that the Trust was not relying solely on its own internal judgement but received a range of independent external reports. The Committee members will continue to seek greater understanding, not simply of the technical state of the estate, but of the practical implications flowing from that and, what decisions were being taken as a result.

Estates and facilities Assurance Map Red Rating Analysis
This report focussed the Committee's attention on the red rated elements of the assurance map. Given our knowledge of the age of much of the estate and limited capital funding there will continue to be areas that remain red rated. Assurance would continue to be sought about the mitigation of such risks, including separate reports that had come to recent Committees and those that had been received on the June agenda - Fire Safety and Health and Safety.

Assure:

Operational Performance KPI good performance

- **Referral to Treatment (RTT):** Performance improved further in May and is currently ahead of plan. The rate of improvement is ahead of national trend meaning our relative performance ranking will increase, potentially into the upper quartile.

Catherine Sheridan 21/07/2026 09:16:24

Meeting Title	Board of Directors		
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- **52 Weeks Incomplete RTT:** Following validation the final position for May was ahead of the planning target set in line with the ambition to improve further this year. Performance is upper decile for Acute Trusts nationally.
- **Cancer Wait Time (CWT):** Performance improved in April for FDS and 62-day, with both standards meeting the planned trajectory. Indicative performance for May show's some pressure within 62-day performance but YTD will remain green.
- **Operational Productivity**: In line with the recovery priorities for 2026/27 the CSU teams, a range of Executive led programmes are focussed on increasing operational productivity. The position in May for both outpatient and inpatient activity remains positive in comparison to agreed improvement trajectories.
- **LoS >21 days:** Previously reported as a concern due to increasing trend. May performance is an improvement and now below expected levels, but this metric will be closely monitored and may increase with bed occupancy being high.

Theatre Improvement Programme
The Theatres Improvement Programme focuses on recovery productivity and sustainability. A presentation included an update on each of the sub-workstreams (workforce, utilisation, pre-assessment), the trajectory for recovery and highlighted risks in delivery. The next steps included continuation of mobilisation of all workstreams and implementation of highlight reporting. It was noted that whilst there are vacancies, they are lower than they have been previously and so the workforce position is improving. Confidence is high that these vacancies will be filled and therefore bank and agency spend will reduce. In addition, a business case had been developed and was shortly due for presentation to the Executive team which focused on conversion of bank and agency posts to substantive positions.

Green Plan
The Committee received an update on progress against the Trust's Green Plan, including recent sustainability achievements, secured external funding, and the recalculation of the Trust's greenhouse gas (GHG) assessment to include emissions from revenue and capital purchases. The paper also sought support for the continued development of climate-related financial disclosures and associated governance arrangements. There will be a challenge around decarbonisation of the BRI estate by 2040 given the limited investment available to support this.

Fire Safety Annual Report
The report provided the Committee with annual assurance of fire safety compliance with Firecode HTM 05-01 and the Regulatory Reform (Fire Safety) Order 2005.

Health and Safety Annual Report
The report provided a comprehensive overview of health and safety performance for the Trust during the 2025/26 year. The largest risks for the Trust sit within fire, medical devices and general maintenance and age of the building, which is impacting on electrical safety, ventilation, roof safety and working at height.

Osbourne-Sheridan 23/07/2026 09:13:22

Estates Operations Compliance Assurance
The paper sought to provide assurance on Estates operational compliance and highlighted improvements since the last reporting period. The Committee noted that overall, the Estates service is able to provide reasonable assurance that governance,

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Date	23 July 2026	Agenda item	Bo.7.26.12a

risk management and compliance systems are in place and operating effectively. This assurance is supported by structured governance arrangements, robust risk management processes and strengthening compliance performance across all service disciplines.

Report completed by:

Bryan Machin
Committee Chair and Non-Executive Director
20 July 2026

Osbourne Sheridan
22/07/2026 09:58:21

BTHFT Business Intelligence

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

June 2026

Osbourne Sheridan
22/07/2026 09:58:21

Trust Recovery Summary - June 2026

Net Income & Expenditure Position

Measures the delivery of income and expenditure, which incorporate cost improvement and productivity plans, against finacial targets

-£8.17m	
-24.9%	▼
Vs Target	Vs Last Month

Net I&E position at the end of the reported month and variance to the fiscal year-to-date target

Total Headcount Reduction

Tracks progress against the workforce reduction targets (Substantive, Agency & Bank) which underpin our sustainability plans

7,285.2	-276.8
-3.0%	▼
Vs Target	Vs Last Month

Headcount reported (and change to March 2026) and variance to headcount plan for month end

Clock Stopping Activity Delivered

Monitors delivery against activity targets for New Outpatients, Daycase & Elective Inpatient Spells and Outpatient Procedures.

69,342	
+3.1%	▲
Vs Target	Vs Last Month

Volume of activity and variance to planned activity volume for the fiscal year-to-date

Quality Access Standards Achieved

Assess compliance against agreed targets for the national constitutional standards which are reported in the NHS Oversight Framework

5 out of 8	
39 of 123	▼
National Rank	Vs Last Month

The number of Constitutional Standards that have been met and BTHFT's rank compared to other NHS Acute Trusts (lower number indicates better performance)

Key: ■ *Positive vs expectation* ■ *Negative vs expectation* ■ *Not positive or negative* ▲ *Improved Position* ▲ *Trended Up* ▼ *Trended Down* ◀▶ *No Change*

Osbourne,Sheridan
22/07/2026 09:58:21

National Oversight Framework – Acute Trusts

Trust: Bradford Teaching Hospitals NHS Foundation Trust
Current Data: Q4 2025-26
Published Date: 11 June 2026

Average score

2.19

Lower by 0.11 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

3 - Below average and/or financial deficit

Previous quarter's segment: 3

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

56 out of 134

Previous quarter's rank: 58 out of 134

Each trust is ranked first on segment and then average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 134 (segment four trust with the highest average score).
How has rank been calculated?

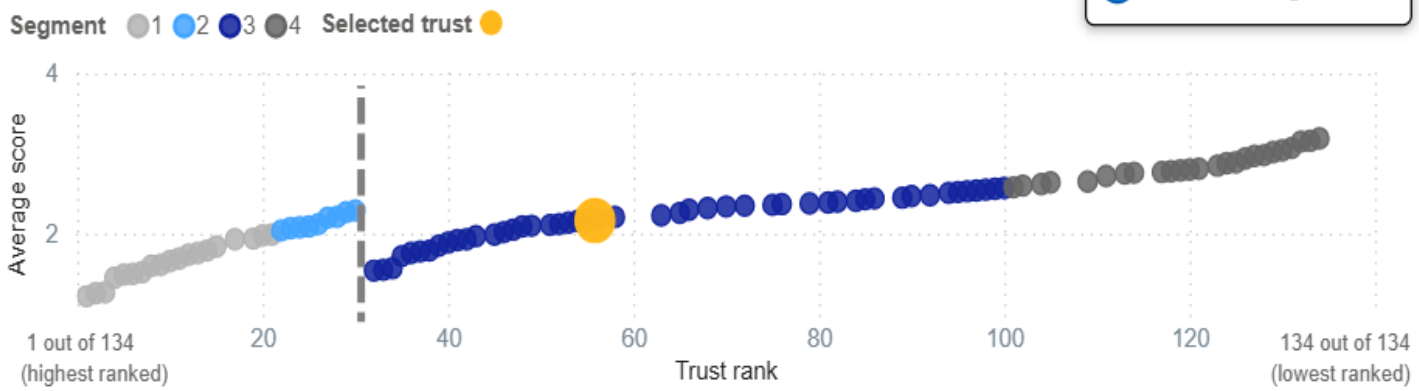
Performance domains

Access to services	1 - High performing
Finance and productivity	4 - Low performing
Effectiveness and experience	2 - Above average
Patient safety	2 - Above average
People and workforce	3 - Below average

Osbourne Sheridan 22/09/2026 08:58:21

Average score by trust rank placement

View full league table



BTHFT Business Intelligence

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

Finance & Performance - June 2026

Osbourne Sheridan
22/07/2026 09:58:21

Finance & Performance
Headline KPI Summary

BTHFT Business Intelligence

Headline KPI	Latest Month	BTHFT Plan	Perf.	3-Month Trend	Q4 NOF Rank	Year to Date	Year End Target	Year End RAG
Average Ambulance Handover	Jun-26	18:00	17:22	↑	N/A	17:21	18:25	G
Emergency Care Standard	Jun-26	83.10%	81.46%	↓	8 of 123	82.38%	83.00%	A
12 Hour LoS in Emergency Department	Jun-26	5.84%	9.38%	↓	36 of 123	9.81%	7.31%	A
Length of Stay ≥21days	Jun-26	82	85	↑	N/A	N/A	82	G
Average Delay Post Discharge Ready Date	Jun-26	3.7	3.5	↑	N/A	3.4	3.7	G
18 Week RTT Incomplete	Jun-26	67.67%	69.31%	↑	54 of 130	N/A	73.71%	A
18 Week RTT Incomplete vs Plan	Jun-26	-	+1.64%	-	92 of 130	-	-	-
52 Week RTT Incomplete	Jun-26	0.21%	0.17%	↓	19 of 130	N/A	0.22%	G
52 Week Community Waits	Jun-26	-	0.00%	-	1 of 78	N/A	0	-
New Outpatients (ERF) vs Plan	Jun-26	100.00%	100.09%	-	N/A	103.08%	100.00%	G
Elective Activity vs Plan	Jun-26	100.00%	104.59%	-	N/A	105.10%	100.00%	G
6 Week Diagnostic Standard (DM01)	Jun-26	84.38%	88.12%	↑	N/A	N/A	94.65%	R
Cancer 28 Day Faster Diagnosis Standard	May-26	80.44%	82.29%	↑	53 of 118	80.84%	80.03%	G
Cancer 31 Day General Treatment	May-26	93.36%	98.46%	↑	N/A	96.82%	94.95%	G
Cancer 62 Day General Treatment	May-26	73.89%	74.34%	↓	56 of 118	76.52%	77.41%	G
Variance to Financial Plan (£m)	Jun-26	£0.0m	-£1.3m	↓	108 of 134	-£1.6m	£0.0m	R
Planned surplus/deficit	Jun-26	-£1.17m	-£2.5m	↓	52 of 134	-£8.17m	£0.0m	R
Delivery of CTG Target	Jun-26	£4.89m	£3.91m	-	N/A	£10.58m	£58.4m	R
Delivery Capital Plan	Jun-26	£1.32m	£0.14m	↓	N/A	£1.24m	£34.38m	
Delivery Cash Plan	Jun-26	£11.3m	£11.2m	↓	N/A	£11.2m	£4.4m	R

Osbourne Sheridan 22/07/2021 09:55:21

Key

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

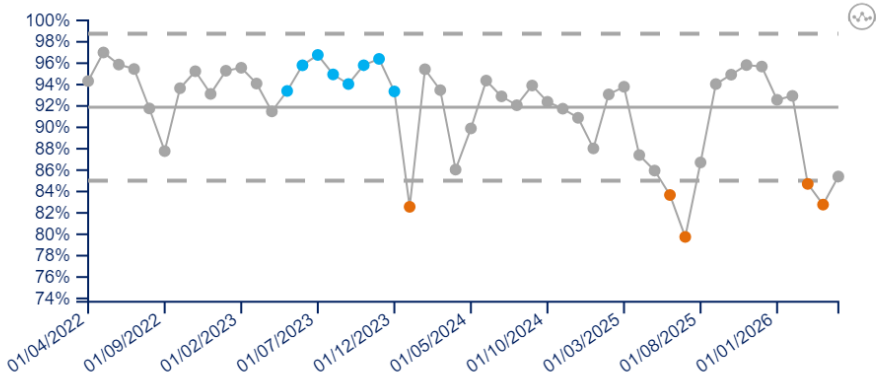
Green = expected to meet target

Finance & Performance
Cancer

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
May 2026	91.9%	85.4%	82.8%	+2.6 ▲

Cancer 2 Week Wait Referrals

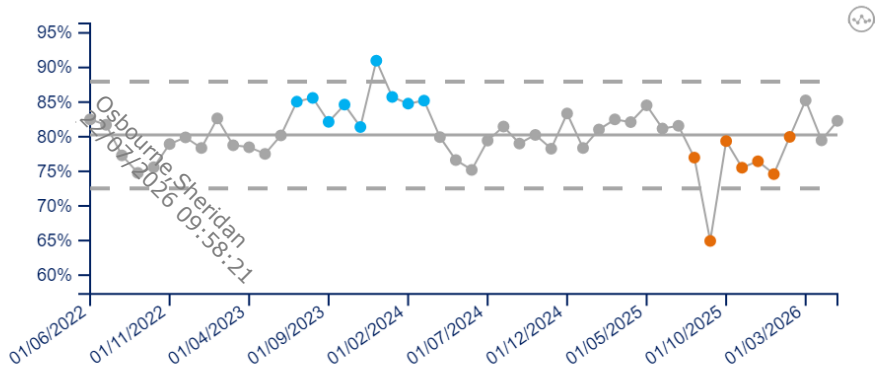


Shift Trend: None – performance remains within expected variation

	Latest Commentary
2026-May	
Cancer - 2 Week Wait Referrals	
Analysis	Performance has deteriorated in recent months following a previous period of recovery
Risks, Mitigations & Assurance	Breast backlog created during bank holidays has not yet been cleared but additional capacity being planned in support of this. Loss of Locum capacity in Oral has created a deteriorating trend, replacement resource being sourced but not yet in place Skin booking at day 20 with a growing WL. This is teething issues with referrals and triaging from skin AI. Additional capacity due to come online in July/August to clear this issue.
Benchmarking	Performance has dropped from upper quartile to 60th centile in the latest national ranking.

Latest Period	Mean	Latest Value	Previous	vs Previous
May 2026	80.3%	82.3%	79.5%	+2.8 ▲

Cancer 28 Day Faster Diagnosis

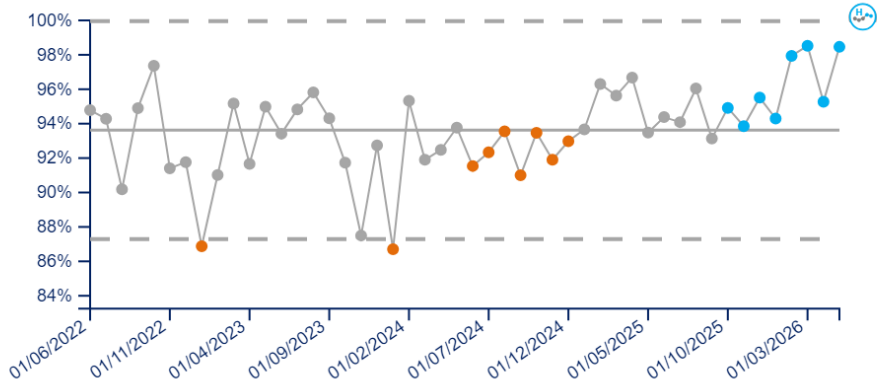


Shift Trend: None – performance remains within expected variation

	Latest Commentary
2026-May	
Cancer - 28 Day FDS	
Target	NHSE submitted planning targets have been achieved during Q1
Analysis	There are some delays in specific pathways and capacity issues are having prolonged impact in some areas due to the challenges in recruiting or securing additional capacity in the current financial climate.
Risks, Mitigations & Assurance	Haematology performance is currently impacted by delays in informing patients of benign results, driven by a preference for FTF clinic consultations. Management are exploring ways to adopt proven, streamlined communication methods, such as telephone appointments and letter, with clinical support from other specialties. 2WW performance pressures impact on H&N (Oral) and Skin performance. Tumour group level benchmarking analysed at most recent Cancer Board to promote specific learning from "best in class" Trusts
Benchmarking	Overall performance is in the 66th centile. 6 of 9 tumour groups are in the upper quartile

Latest Period	Mean	Latest Value	Previous	vs Previous
May 2026	93.6%	98.5%	95.3%	+3.2 ▲

Cancer 31 Day First Treatment

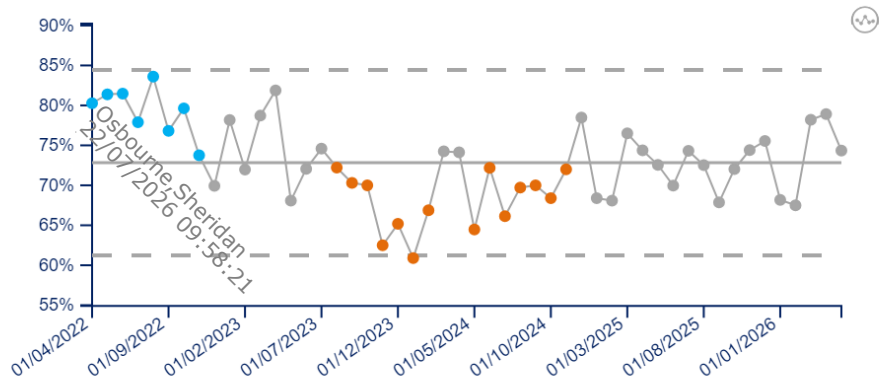


Shift Trend: Improvement – performance above average for 7 consecutive periods

Latest Commentary	
2026-May	
Cancer - 31 Day 1st Treatment	
Target	Performance remains better than agreed NHSE target
Benchmarking	The Trust is in the upper quartile nationally for this KPI

Latest Period	Mean	Latest Value	Previous	vs Previous
May 2026	72.8%	74.3%	78.9%	-4.6 ▼

Cancer 62 Day Standard



Shift Trend: None – performance remains within expected variation

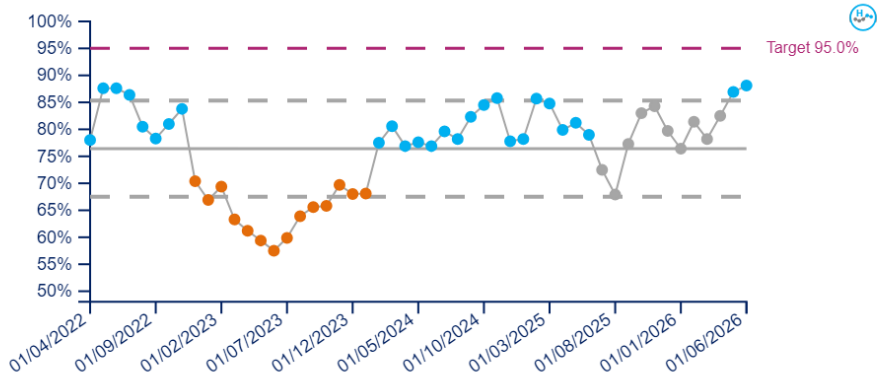
Latest Commentary	
2026-May	
Cancer - 62 Day Standard	
Target	Performance in May met the target agreed with NHSE, although this is slightly below the 75% standard
Analysis	Complex diagnostic pathways are still impacting performance. Across most pathways, administrative delays, outpatient capacity and patient compliance issues are also noted as an overarching challenges.
Risks, Mitigations & Assurance	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.
Benchmarking	Latest performance is at the 64th centile nationally

Finance & Performance
Diagnostic

BTHFT Business Intelligence

Latest Period	Target	Latest Value	vs Target	vs Previous
Jun 2026	95.0%	88.1%	-6.9 ▼	+1.2 ▲

Diagnostic Waiting List % <6 Weeks

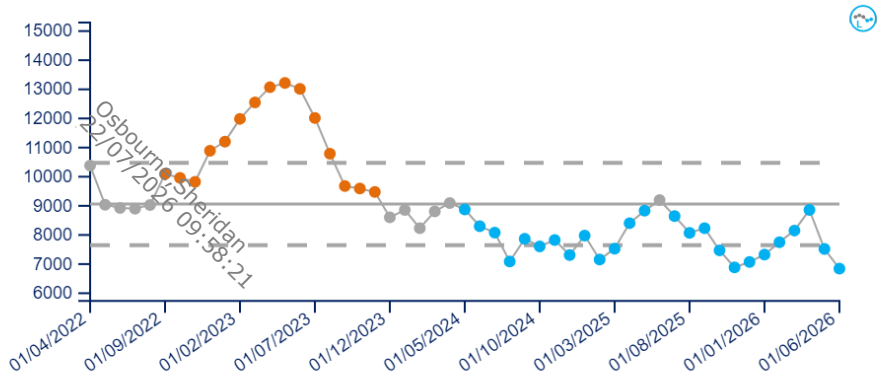


Shift Trend: None – performance remains within expected variation

Latest Commentary	
2026-Jun	
Diagnostic - % < 6Wks	
Target	Performance is ahead of the NHSE agreed planning target which is a trajectory back to 95% by year end
Analysis	DM01 performance for June remained above plan with significant improvements in Non-obstetric ultrasound and Neurophysiology. Performance for Audiology remains a challenge with likely deterioration, along with Trust performance, once planned patients are included in the submission to align with WYAAT and NHSE. Recovery modelling indicates performance will only recovery if recruitment is approved for full establishment.
Risks, Mitigations & Assurance	Non-obstetric ultrasound has recovered in Q1. Locums continue to cover maternity leave, and the service have appointed new sonographers who are due to start in the coming months. Neurophysiology have recovered in line with plan. The insourcing contract has now ended but the locum will be available to cover annual leave later in the year. In Urodynamics, a recovery plan with Medical Physics support remains on track with recovery expected by March 2027. The newly opened Endoscopy Unit has now increased to 8 rooms (100%) allowing the service to book 4 weeks out with activity improvements expected from the end of July. Alongside the recent JAG accreditation, this represents a significant milestone in our continued provision of high-quality services.
Benchmarking	We are tracking via recovery to be in the upper quartile of Trusts by July 2026

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	9,062	6,844	7,518	-674 ▼

Diagnostic Waiting List

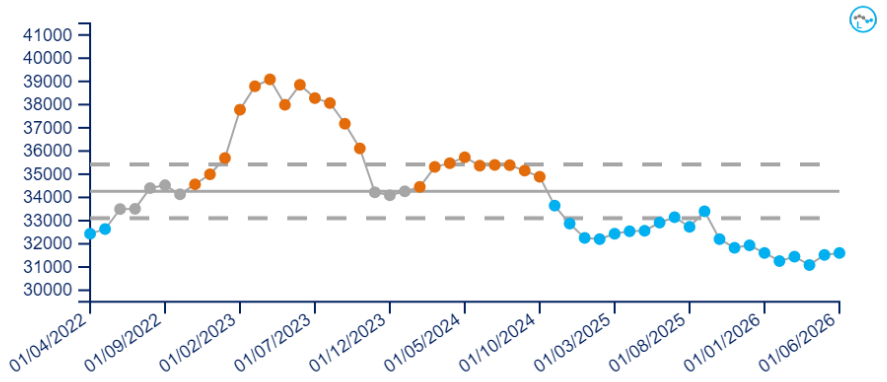


Shift Trend: Improvement – performance below average for 7 consecutive periods

Latest Commentary	
2026-Jun	
Diagnostic - Waiting List	
Analysis	The waiting list has reduced in line with recovery plans.
Risks, Mitigations & Assurance	Audiology requires both a backlog reduction and a saustainable capacity plan. This is with the Exec team for consideration as would be at additional cost and increase in WTE.

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	34,265	31,604	31,523	+81 ▲

RTT 18 Weeks Total Pathways

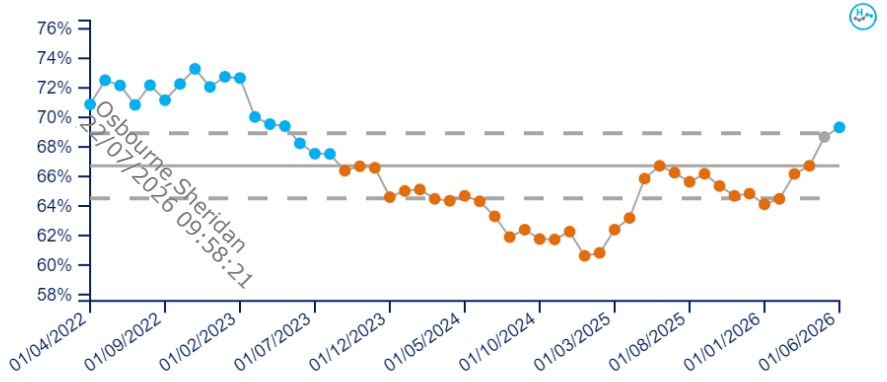


Shift Trend: Improvement – performance below average for 7 consecutive periods

	Latest Commentary
2026-Jun	
RTT - 18 Wk Total Pathways	
Target	Total RTT WL size is c.1600 above plan
Analysis	Increased demand (clock starts) has offset delivery of planned activity and clock stops.
Risks, Mitigations & Assurance	Planned growth in clock stopping activity will still provide the expected benefit by year end provided demand stablises. If it continues to grow it is likely the WL size will prevent RTT performance from hitting 73.7%.
Benchmarking	National trend matches the Trust position with escalation via regional teams to all Trusts during July

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	66.7%	69.3%	68.7%	+0.7 ▲

RTT 18 Weeks Performance %



Shift Trend: None – performance remains within expected variation

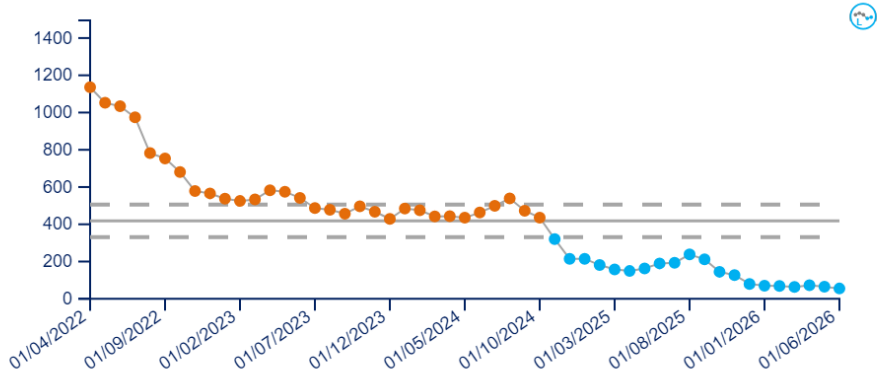
	Latest Commentary
2026-Jun	
RTT - % 18 Wks	
Target	Performance is ahead of the NHSE agreed planning target
Analysis	RTT performance improved in June to 69.3%. Referral demand has increased the number of waits under 18 weeks and we have seen continued improvements in activity and clock stops over 18 weeks, particularly for admitted Plastic Surgery pathways.
Risks, Mitigations & Assurance	Despite cancelled industrial action in June, there is escalating operational concern regarding the high volume of TOIL accrued by consultants providing strike cover. Managing this liability presents a growing risk to long-term capacity and future activity delivery. Clock stopping activity needs to increase from July to match the improvement trajectory set. Outpatient and Inpatient productivity is being improved via dedicated programmes of work.
Benchmarking	Performance is in the upper quartile of acute trusts

Finance & Performance
RTT

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	418	55	65	-10

RTT 52 Week Breaches

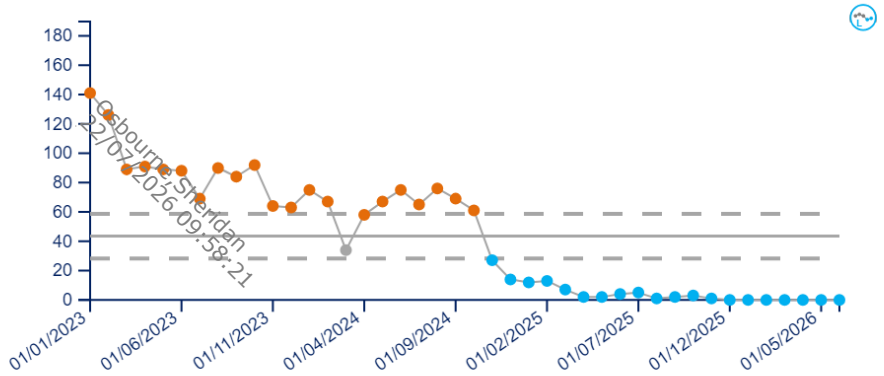


Shift Trend: Improvement – performance below average for 7 consecutive periods

	Latest Commentary
2026-Jun	
RTT - 52 Wk Breaches	
Target	Performance has improved to be ahead of trajectory and NHSE agreed target
Risks, Mitigations & Assurance	Long wait management at all levels of operations continues to maintain positive performance against this standard. T&O remain a concern due to sub-specialty capacity for both elective and trauma patients. The service are working with senior operational colleagues to explore options to better flex operating list use to match demand.
Benchmarking	The Trust are in the best decile for this KPI amongst acute trusts

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	43	0	0	0

RTT 65 Week Breaches



Shift Trend: Improvement – performance below average for 7 consecutive periods

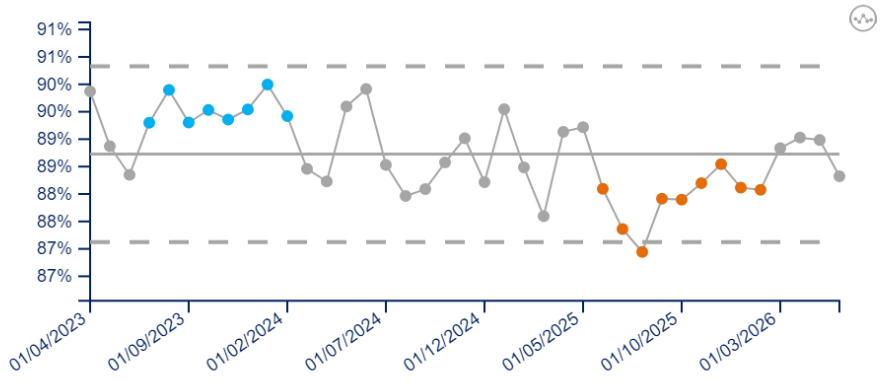
	Latest Commentary
2026-Jun	
RTT - 65 Wk Breaches	
Target	Target is zero and we reported zero
Analysis	We continue to meet this target
Risks, Mitigations & Assurance	Long wait management processes are helping sustain this position with 65 week risks mitigated monthly. Improvement work relating to the prevention of RTT recording errors and the work in T&O will help reduce the need for expediting treatment.

Finance & Performance
Elective

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	88.7%	88.3%	89.0%	-0.7 ▼

Day Case Rate

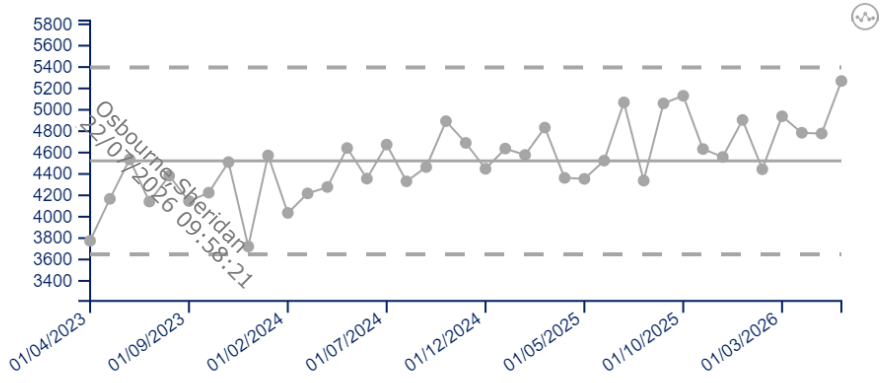


Shift Trend: None – performance remains within expected variation

Latest Commentary	
2026-Jun	
Elective - Day Case Rate	
Analysis	This metric is measured against our planning return and is within control limits
Risks, Mitigations & Assurance	EL/DC activity is increasing and keeping DC rate within control limits is a positive sign that this relates to theatre productivity and RTT clock stops
Benchmarking	Model hospital data suggests we could improve our relative position but this needs internal verification

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	4,524	5,270	4,778	+492 ▲

Elective Ordinary & Day Case



Shift Trend: None – no improvement direction applied

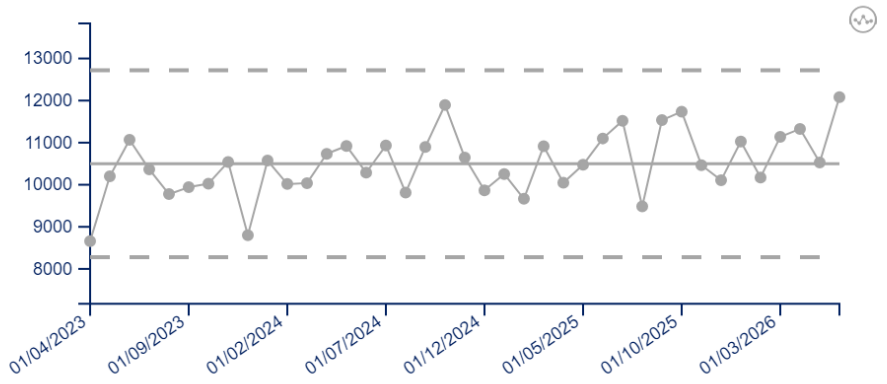
Latest Commentary	
2026-Jun	
Elective - Elective Ordinary & Day Case	
Target	Activity was 5.1% ahead of plan for Q1
Analysis	Theatre productivity accounts for some but not all of this improvement. Non-Theatre activity also increased and there is some benefit from counting and coding changes (urgent electives)
Risks, Mitigations & Assurance	Plan phasing increases from July with the continued growth in productivity, additional working days, and the opening of the endoscopy unit resulting in a significant change which early indications suggest we will struggle to deliver. Capacity lost to TOIL and reduced demand for high volume lists are contributing to this.

Finance & Performance
Outpatients

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	10,502	12,082	10,528	+1,554 ▲

Outpatient Attendances New

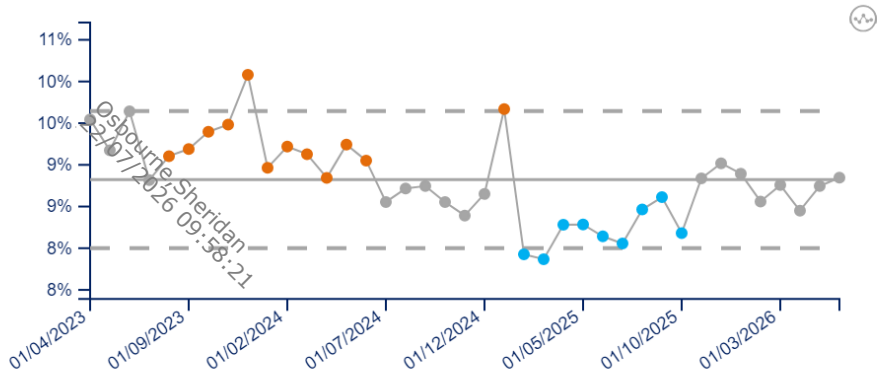


Shift Trend: None – no improvement direction applied

	Latest Commentary
2026-Jun	
Outpatients - Attendance (New)	
Target	Performance has met planned target in each month of Q1
Analysis	Increased new activity correlates with an overall increase in clinics run (first:follow up ratios havent changed)
Risks, Mitigations & Assurance	Follow up demand remains high which is preventing full benefit realisation from outpatient transformation work; optimisation is being revisited by a dedicated programme using a big 5 proven methodology.
Benchmarking	Follow up volumes are higher than peer average

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	8.8%	8.8%	8.7%	+0.1 ▲

DNA Rate All

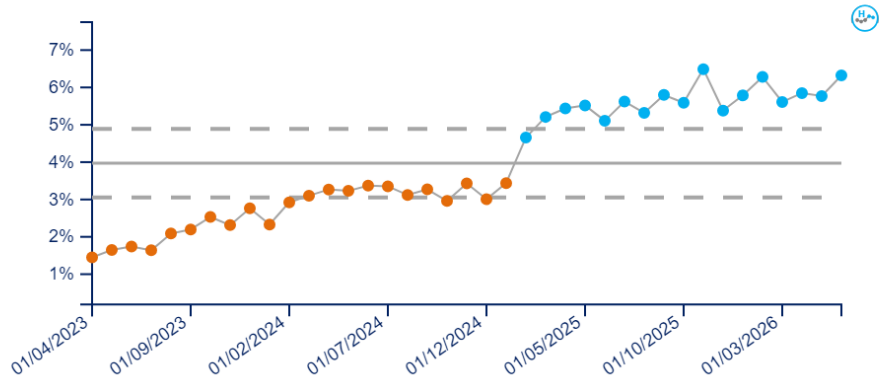


Shift Trend: None – performance remains within expected variation

	Latest Commentary
2026-Jun	
Outpatients - DNA Rate (All)	
Analysis	Performance has remained at average levels in recent months
Risks, Mitigations & Assurance	Service led transofrmation work appears to have slowed. This is also being revsiting by the optimisaiton workstream.
Benchmarking	DNA rates are higher than peer average.

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	4.0%	6.3%	5.8%	+0.6 ▲

PIFU %



Shift Trend: Improvement – performance above average for 7 consecutive periods

Latest Commentary	
2026-Jun	
Outpatients - PIFU %	
Target	Delivery is above target and in line with agreed planning targets
Analysis	Following a step change in early 2025 performance has improved but at a modest rate. Adoption is high for all key specialties.
Benchmarking	Above peer average

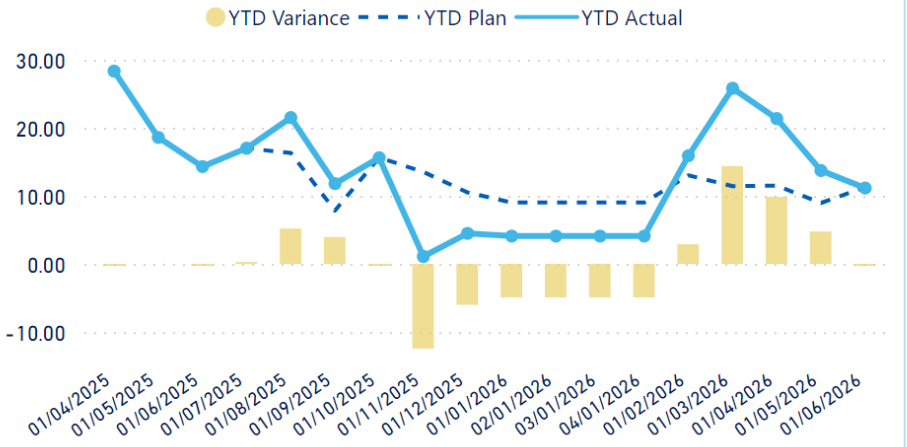
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Finance & Performance
Delivery Cash & Capital Plan

BTHFT Business Intelligence

Period	YTD Plan	YTD Actual	YTD Variance	Status
Jun 2026	£11.27	£11.15	(0.13)	Below Plan

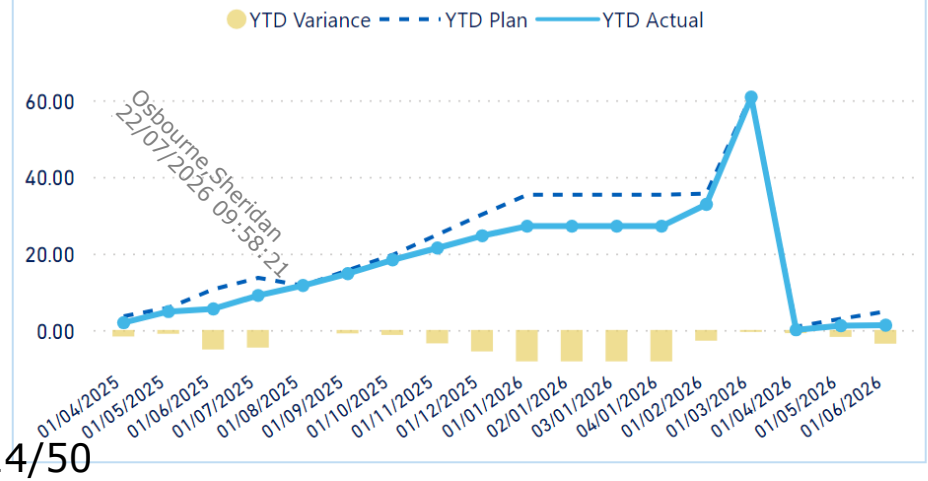
Delivery of Cash Plan (YTD)



	Latest Commentary
2026-Jun **Delivery Cash Plan** Analysis	Year to date I&E operational cash is £1.6m below plan, reflecting the Trust's Month 3 deficit of £8.2m, which is £1.6m adverse to plan. The variance is primarily driven by lower Deficit Support Funding and the impact of industrial action. Forecast operational cash remains broadly in line with plan, supported by a forecast breakeven year-end position. However, the Trust will need to generate cash surpluses over the remainder of the year to recover the £6.2m cash deficit incurred in Quarter 1 and deliver the planned cash position. Year to date I&E working capital cash is £2.2m favourable to plan, primarily reflecting the receipt of £2.4m Elective Recovery Funding and £1.9m additional Research and Development income, which have improved cash balances. This is partially offset by the receipt of £3.0m less PDC cash support than planned in Month 03. Forecast working capital cash is £6.3m below plan, mainly due to lower levels of cash support than originally anticipated. The forecast assumes repayment of all in year NHSE cash support received, resulting in a position £9.1m below plan, subject to Board approval.

Period	YTD Plan	YTD Actual	YTD Variance	Status
Jun 2026	£4.82	£1.24	(3.58)	Below Plan

Delivery of Capital Plan (YTD)



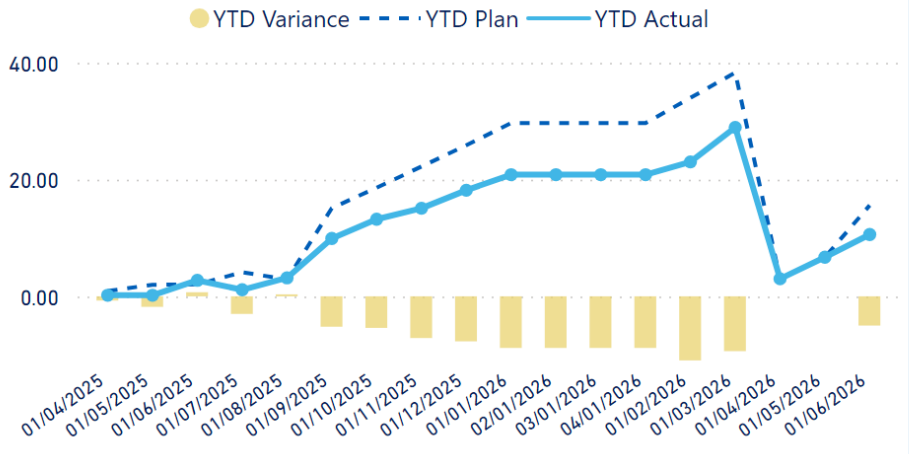
	Latest Commentary
2026-Jun **Delivery Capital Plan** Analysis	Capital expenditure is £1.3m year to date, which is £2.3m below plan, reflecting a slower than anticipated start to the year. The variance is primarily due to normal programme phasing, including procurement timelines and project mobilisation activities. The full-year capital forecast has been revised to £0.7m below budget to support the funding of the WYAAT Aseptic Unit at LTHT. The Trust remains confident in delivering its capital programme in full by year end. There is an emerging risk of a further £2.6m capital underspend. The Capital Strategy Group is reviewing the reserves list to identify schemes that can be delivered this year to mitigate the risk.

Finance & Performance
CTG & I&E

BTHFT Business Intelligence

Period	YTD Plan	YTD Actual	YTD Variance	Status
Jun 2026	£15.58	£10.58	(5.00)	Below Plan

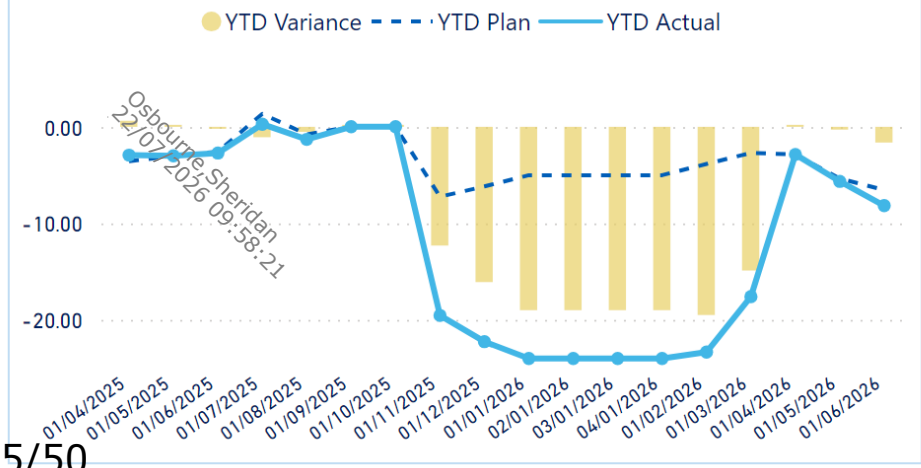
Closing the Gap (YTD)



	Latest Commentary
2026-Jun **Closing the Gap** Analysis	The Closing the Gap programme is reported as behind plan by £1m in Month 3; this continues to be supported by a number of non-recurrent measures which have yet to progress through the CTG gateway process in full. Delivery of recurrent savings remains dependent on the successful implementation and embedding of schemes, representing a key risk to plan.

Period	YTD Plan	YTD Actual	YTD Variance	Status
Jun 2026	£-6.54	£-8.17	(1.63)	Below Plan

Delivery of Income & Expenditure Plan (YTD)



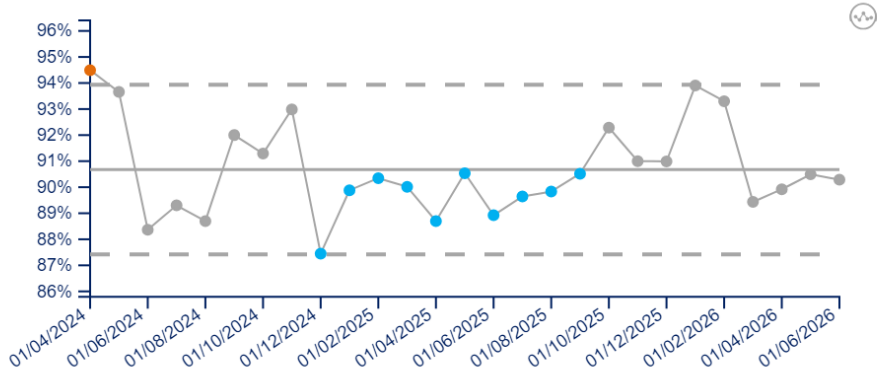
	Latest Commentary
2026-Jun **Income & Expenditure Plan** Analysis	The Trust is reporting a Month 3 deficit of £8.2m, this is £1.6m worse than plan. The two main drivers of variance at month 3 are the Deficit Support Funding (£0.6m) and the impact of industrial action (£1m). The monthly run rate continues to improve but it isn't improving at the pace required to align to the profiling of the breakeven plan. NHSE has notified the Trust that its planned DSF allocation of £2.3m for the year will be withheld for Quarters 1 & 2 due to concerns about the level of risk to delivery of the plan. This decision was based on Month 2 reporting and the board assurance statements submitted. The impact of this is a loss of £0.6m for Quarter 1. The Trust is formally 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.

Finance & Performance
Bed Occupancy & LoS

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	90.7%	90.3%	90.5%	-0.2

Bed Occupancy %

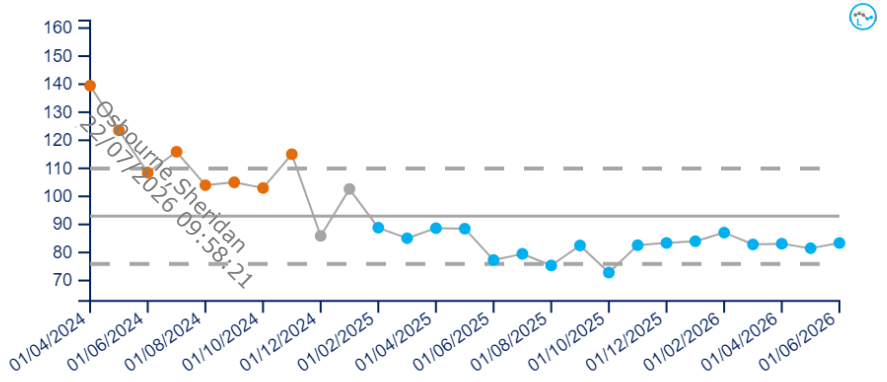


Shift Trend: None – performance remains within expected variation

Latest Commentary	
2026-Jun	
Bed Occupancy %	
Target	Occupancy is higher than expected / submitted levels
Analysis	Increased length of stay, high UEC demand,and some discharge delays all correlate with his position, although admission have started reducing in June

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	93	83	82	+2

Average Patients LoS 21+ Days



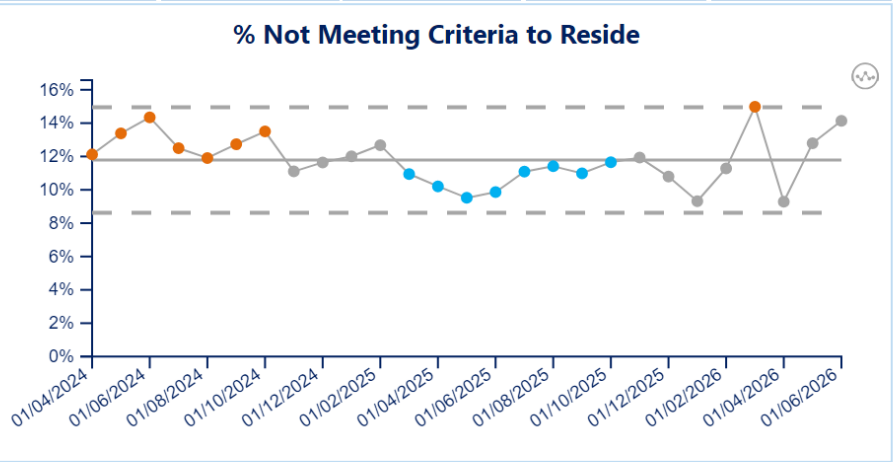
Shift Trend: Improvement – performance below average for 7 consecutive periods

Latest Commentary	
2026-Jun	
LoS - Avg Patients LoS 21+ Days	
Target	Performance for June is above agreed planning target
Risks, Mitigations & Assurance	Delays linked to the Local Authority Bed Bureau and Care Act Choice continue to affect flow. Inefficient referral processes mean IMC Local Authority beds remain underutilised, requiring renewed senior-level engagement to progress previously agreed improvement actions, while Trust IMC beds continue to provide contingency capacity. Planned changes to six Local Authority unit beds will repurpose them for early packages of care, creating a step-up pathway intended to improve overall discharge flow despite reducing direct hospital access. Referrals to VRI continue to increase following the closure of overnight assess-to-discharge beds, helping reduce pressure on inpatient services. OPTICA has improved visibility of discharge delays and MAIDT coordination, with the next phase focused on embedding its data into ward-level processes to drive further improvements.

Finance & Performance
NMCTR

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	11.8%	14.1%	12.8%	+1.3 ▲



Shift Trend: None – performance remains within expected variation

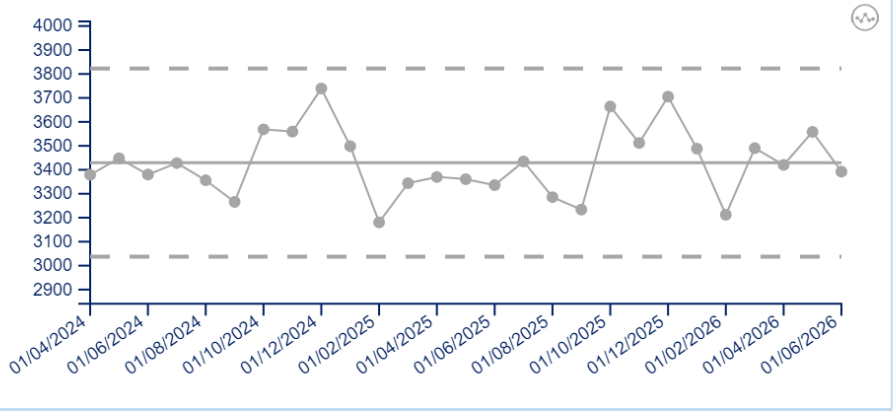
Latest Commentary	
2026-Jun	
NMCTR - % Not Meeting Criteria to Reside	
Analysis	NMCtR performance increased from 12.8% in May to 14.1% in June. Data is being reviewed through OPTICA to determine whether this reflects a genuine performance change or improved recording and richer data capture.

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Finance & Performance
Ambulance Arrivals

BTHFT Business Intelligence

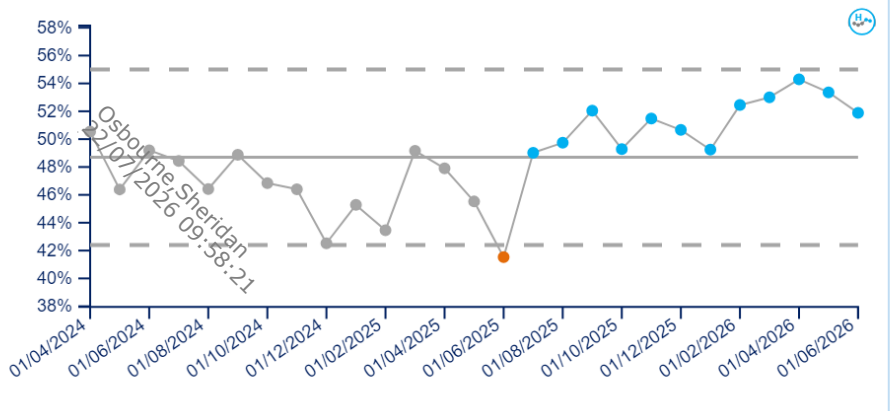
Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	3,430	3,393	3,558	-165 ▼



Shift Trend: None – no improvement direction applied

Latest Commentary	
2026-Jun	
Ambulance - Arrivals	
Target	N/A
Analysis	Within control limits

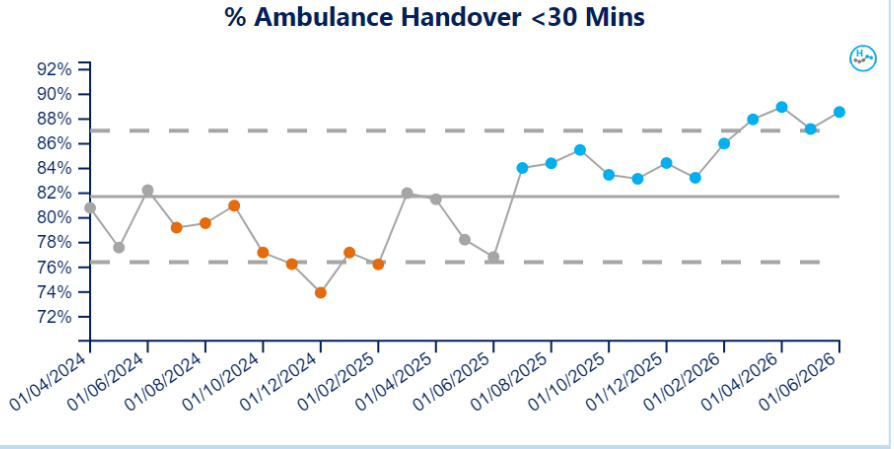
Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	48.7%	51.9%	53.4%	-1.5 ▼



Shift Trend: Improvement – performance above average for 7 consecutive periods

Latest Commentary	
2026-Jun	
Ambulance - Handover <15 min	
Target	Above planning target
Analysis	15-minute handover performance fell to 51.9% in June (53.4% May), primarily due to bed waits and bed blocks impacting patient flow.
Risks, Mitigations & Assurance	The CSU continues to prioritise escalation of flow and bed capacity issues to improve handover performance.

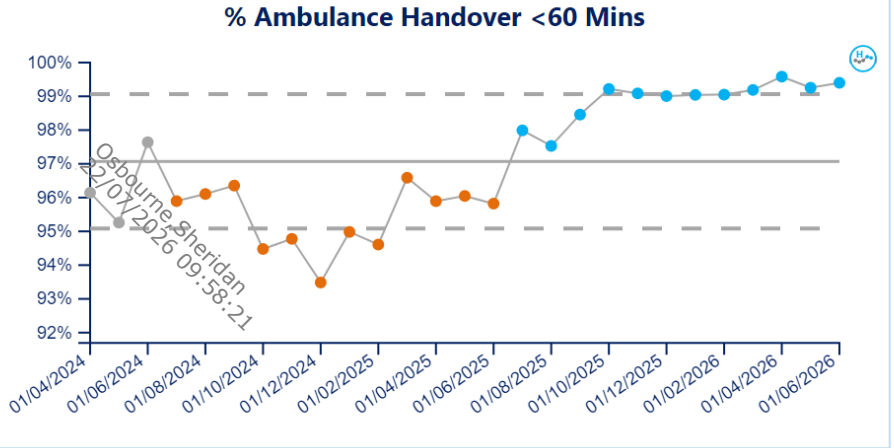
Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	81.7%	88.6%	87.2%	+1.4 ▲



Shift Trend: Improvement – performance above average for 7 consecutive periods

	Latest Commentary
2026-Jun	
Ambulance - Handover <30 min	
Target	N/A
Analysis	Performance sustained at improved levels

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	97.1%	99.4%	99.3%	+0.1 ▲



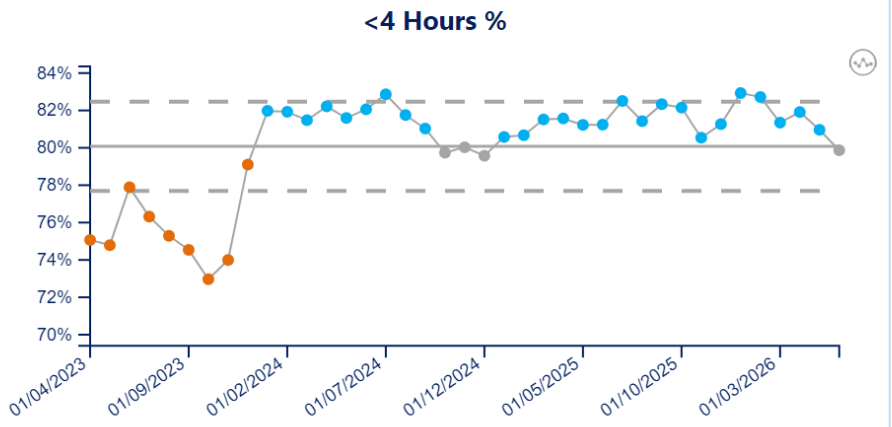
Shift Trend: Improvement – performance above average for 7 consecutive periods

	Latest Commentary
2026-Jun	
Ambulance - Handover <60 min	
Target	N/A
Analysis	Performance sustained at improved levels

Finance & Performance
Emergency Care Standard

BTHFT Business Intelligence

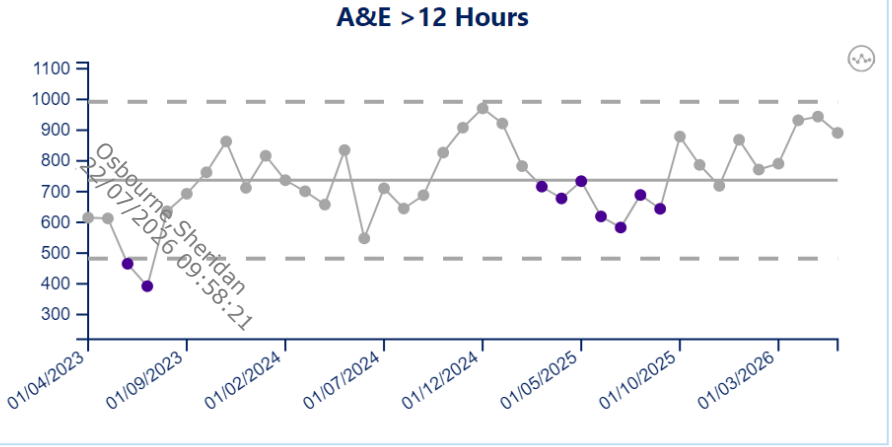
Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	80.1%	79.9%	81.0%	-1.1



Shift Trend: None – performance remains within expected variation

Latest Commentary	
2026-Jun	
ECS - <4 Hours %	
Target	Performance has dropped to below agreed NHSE target
Analysis	June had record attendances (+20 patients/day vs May) across all acuities, increasing operational pressure. Paediatric performance and performance after 5pm deteriorated in the same period.
Risks, Mitigations & Assurance	UEC Access Meetings will launch in August/ September alongside new Power BI dashboards, while Thalam AI will strengthen coding quality and operational intelligence.
Benchmarking	Performance is in the upper quartile nationally.

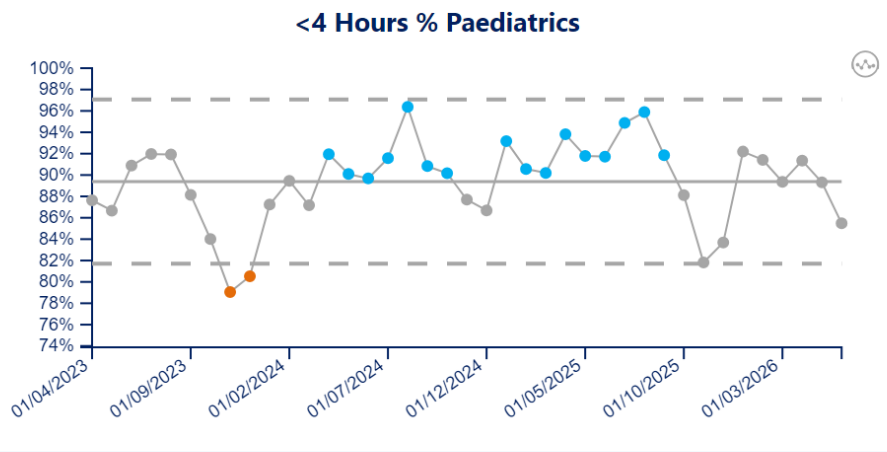
Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	737	891	944	-53



Shift Trend: None – performance remains within expected variation

Latest Commentary	
2026-Jun	
ECS - A&E > 12 Hours	
Target	Performance is worse than NHSE agreed target
Analysis	Similar pressures to 4-hour plus high bed occupancy, particularly for key admission areas.
Risks, Mitigations & Assurance	Focus remains on improving ED and inpatient pathways, particularly the first 72 hours of care. A Senior Decision Maker-led Rapid Assessment and Treatment (RAT) test of change will commence in July to improve early assessment, reduce ED congestion, improve 4-hour performance and reduce >12-hour stays, supported by ED refurbishment, digital patient communications and a live operational dashboard.
Benchmarking	Performance is above peer average

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	89.4%	85.5%	89.3%	-3.8



Shift Trend: None – performance remains within expected variation

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22/07/2026 09:58:21

Latest Commentary

2026-Jun	
ECS - <4 Hours % Paediatrics	
Target	Performance is behind trajectory to meet the September target
Analysis	Detailed analysis was presented to a task and finish group on 16/07. Increased complexity can be observed and some changes to attendance times.
Risks, Mitigations & Assurance	Paediatric ECS improvement plans are under review and will be strengthened to ensure recovery to plan by September.
Benchmarking	N/A

BTHFT Business Intelligence

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

Quality - June 2026

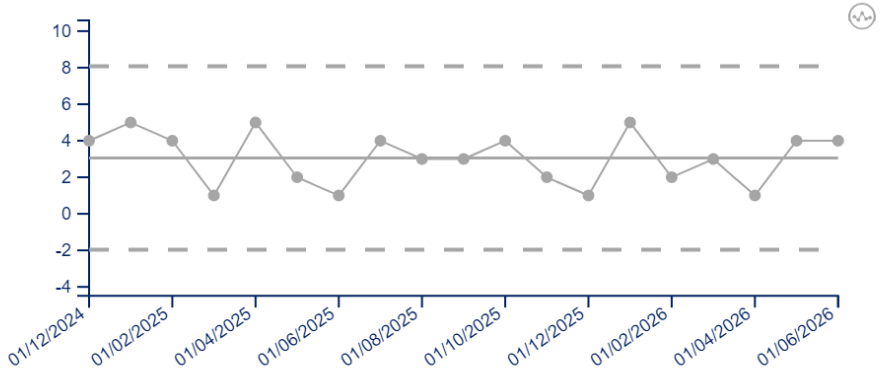
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Quality
Infection Prevention Control

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	3	4	4	0

C. Difficile

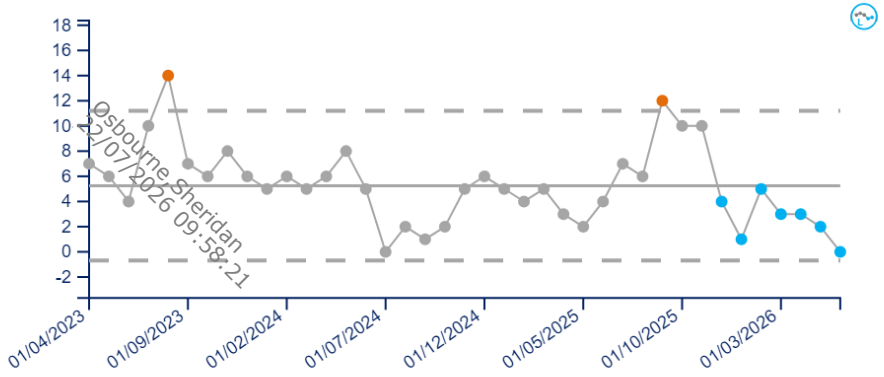


Shift Trend: None – performance remains within expected variation

	Latest Commentary
2026-Jun	
IPC - C. Difficile	
Analysis	A decrease in the number of C. diff infection cases has been observed since Feburary 2026. 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.
Risks, Mitigations & 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

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	5	0	2	-2

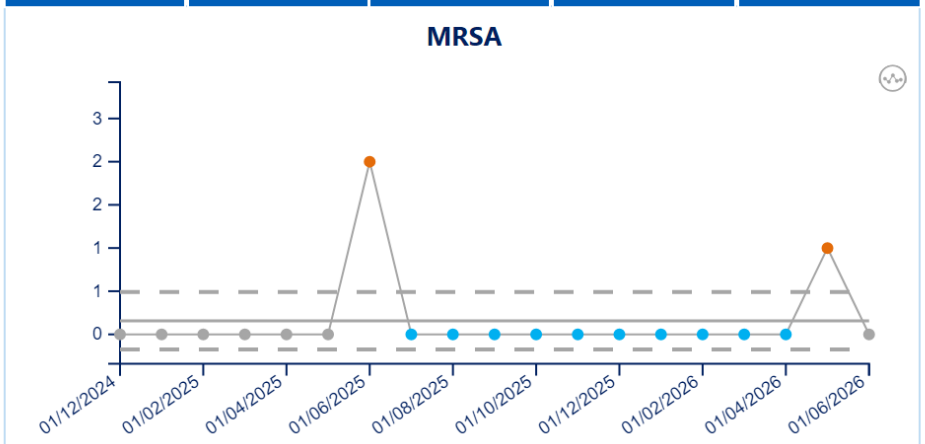
E. Coli



Shift Trend: Improvement – performance below average for 7 consecutive periods

	Latest Commentary
2026-Jun	
IPC - E. Coli	
Analysis	An improvement in E. coli bacteraemia has continued after a peak in November 2025.
Risks, Mitigations & Assurance	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

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	0	0	1	-1



Shift Trend: None – performance remains within expected variation

Latest Commentary	
2026-Jun	
IPC - MRSA	
Analysis	MRSA Bacteraemia Just one MRSA bacteraemia case has been observed in the last 12 months.

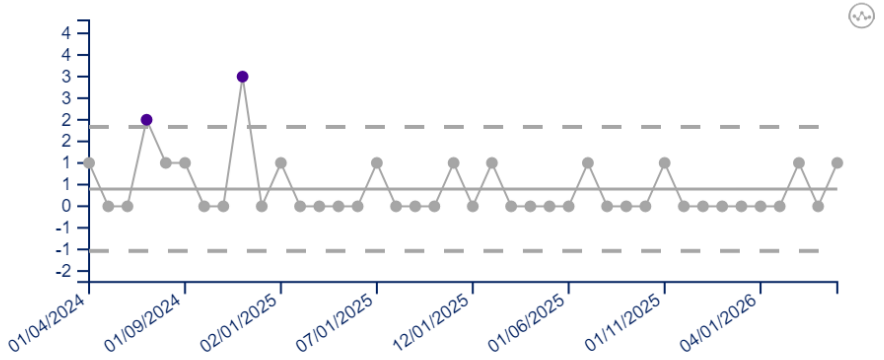
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Quality
Cooling Babies & Stillbirths

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
May 2026	0	1	0	+1 ▲

Cooling Babies

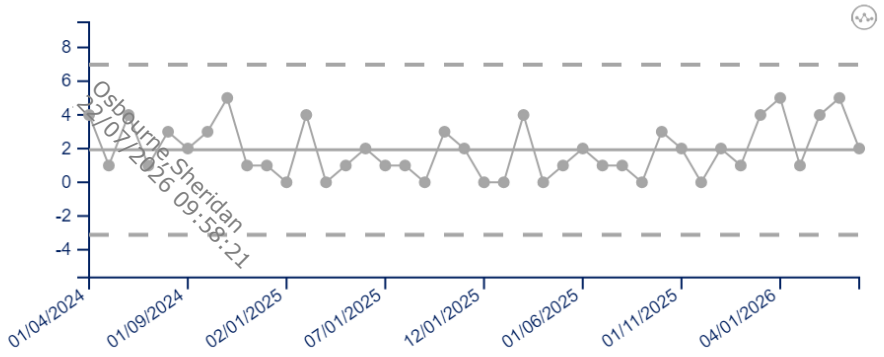


Shift Trend: None – no improvement direction applied

	Latest Commentary
2026-Jun	
Cooling Babies	
Analysis	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.

Latest Period	Mean	Latest Value	Previous	vs Previous
May 2026	2	2	5	-3 ▼

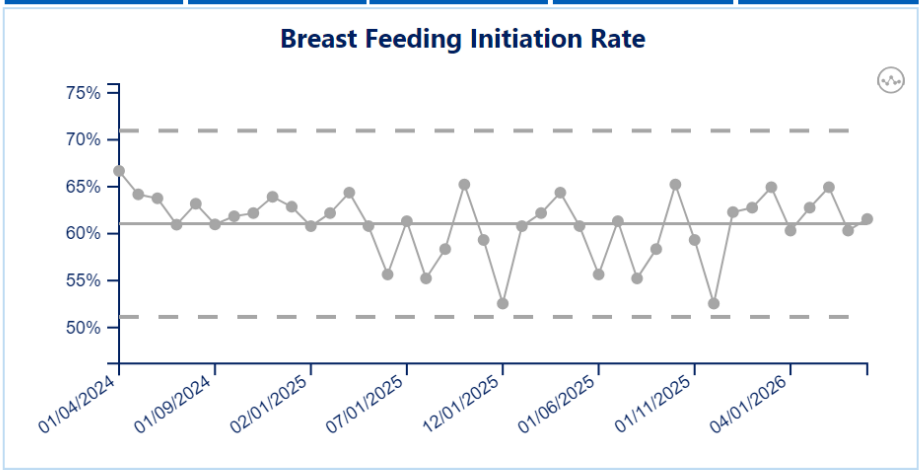
Stillbirths



Shift Trend: None – performance remains within expected variation

	Latest Commentary
2026-Jun	
Stillbirths	
Analysis	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.
Risks, Mitigations & Assurance	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 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.

Latest Period	Mean	Latest Value	Previous	vs Previous
May 2026	61.1%	61.6%	60.3%	+1.2 ▲



Shift Trend: None – performance remains within expected variation

Latest Commentary

2026-Jun

Breast Feeding Initiation Rate

Analysis

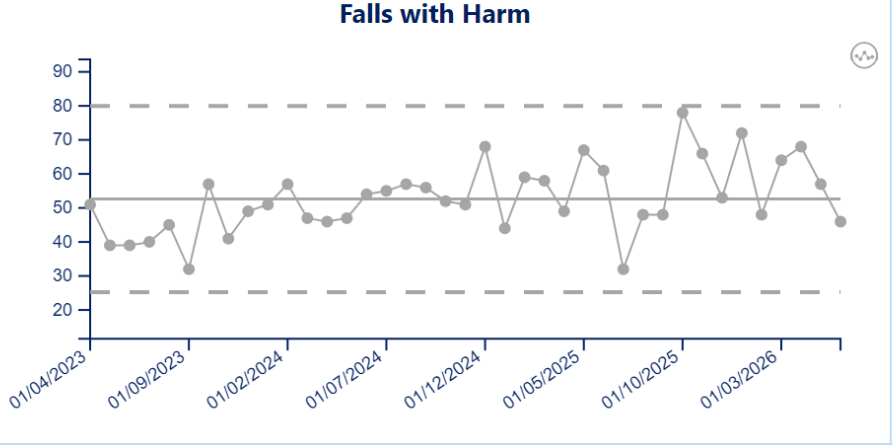
The Specialist Midwife for infant feeding continues to prepare teams for UNICEF BFI accreditation later in the year.

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Quality
Falls with Harm

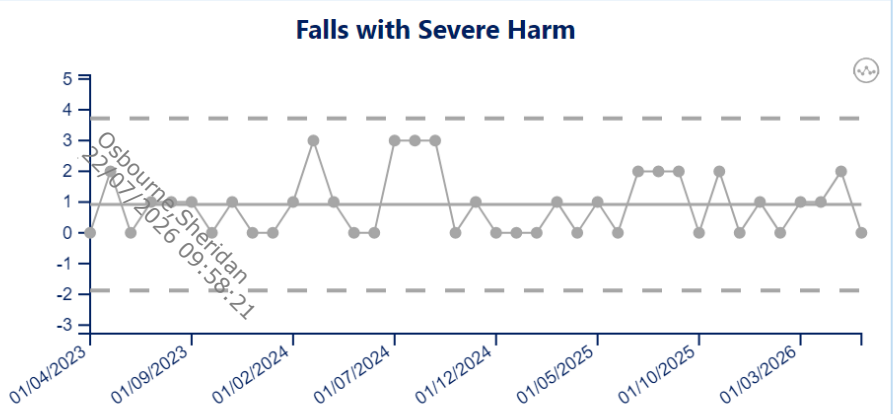
BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	53	46	57	-11



Shift Trend: None – performance remains within expected variation

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	1	0	2	-2



Shift Trend: None – performance remains within expected variation

Latest Commentary

2026-Jun

Falls With Harm

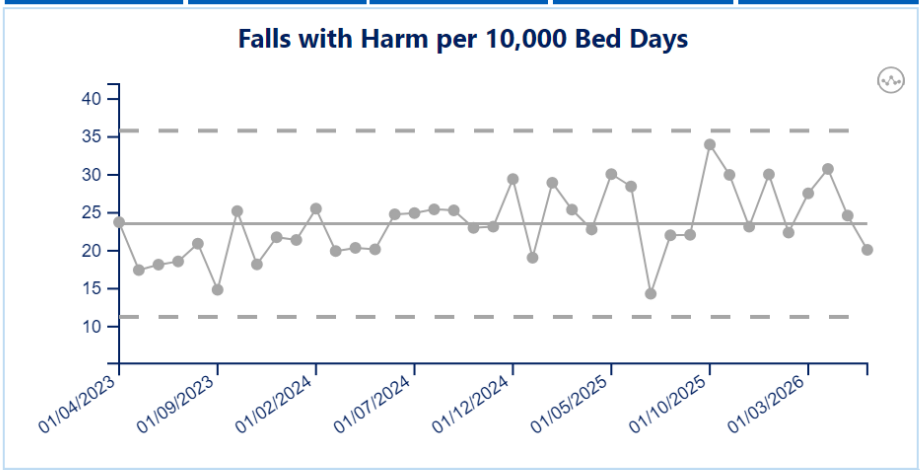
Analysis

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.
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.

Quality
Falls with Harm

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	23.56	20.12	24.64	-4.52 ▼



Shift Trend: None – performance remains within expected variation

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Latest Commentary

2026-Jun

Falls With Harm

Analysis

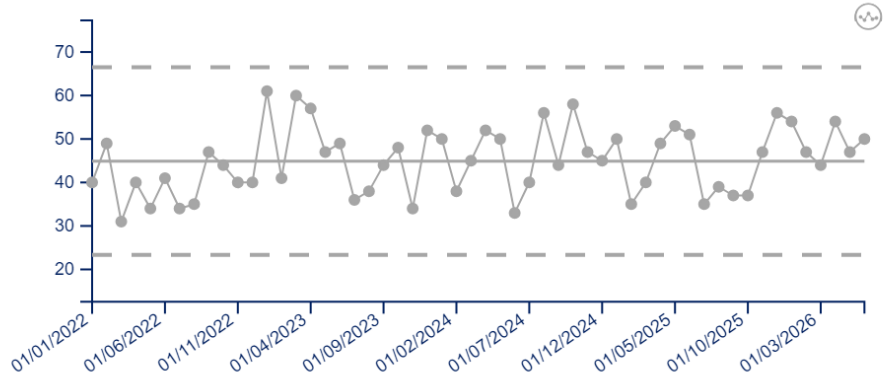
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Quality
Pressure Ulcers All

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	45	50	47	+3 ▲

Pressure Ulcers All Categories

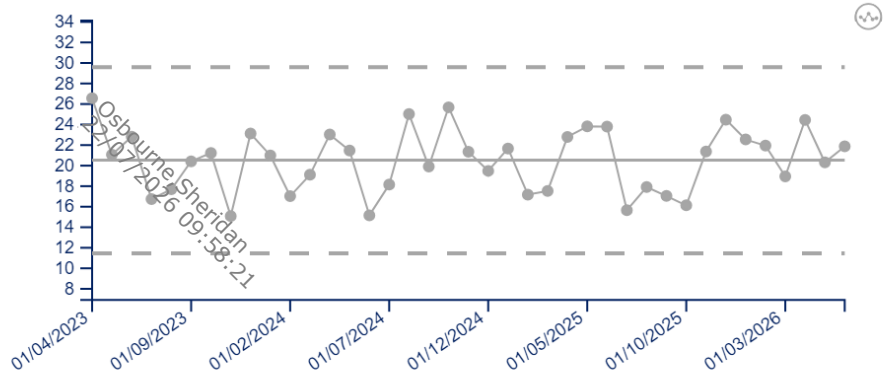


Shift Trend: None – performance remains within expected variation

	Latest Commentary
2026-Jun	
Pressure Ulcers - PU All Categories	
Analysis	In June 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: Ward 26 & 28 had the highest number of incidents which is a consistent pattern. Recent increase in incidents in ED, AMU 4 & wards 29 & 31.
Risks, Mitigations & Assurance	Mitigations: Planned collaboration with Calderdale and Huddersfield NHS Trust is planned regarding improving the accurate completion of the risk assessment tool on EPR (PURPOSE T). 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. 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: Education and training is being delivered to new starters and existing staff (e.g. HCA bootcamp, e-learning modules)

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	20.53	21.87	20.31	+1.55 ▲

Pressure Ulcers All Categories per 10,000 Bed Days



Shift Trend: None – performance remains within expected variation

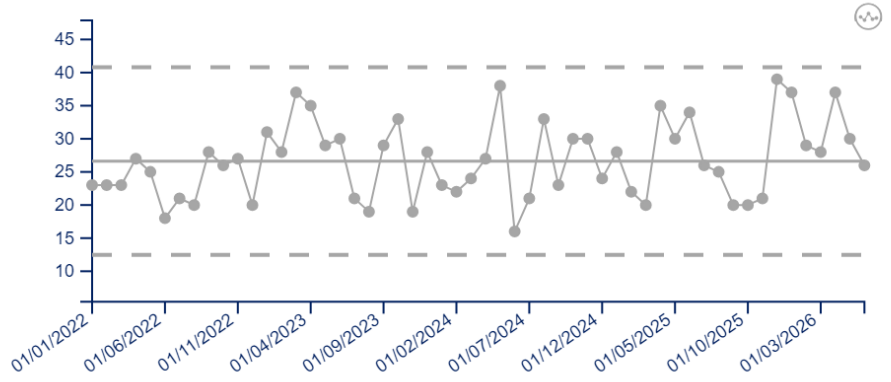
	Latest Commentary
2026-Jun	
Pressure Ulcers - PU All Categories Bed Days	
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Quality
Pressure Ulcers Cat 2 & 3+

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	27	26	30	-4

Pressure Ulcers Category 2

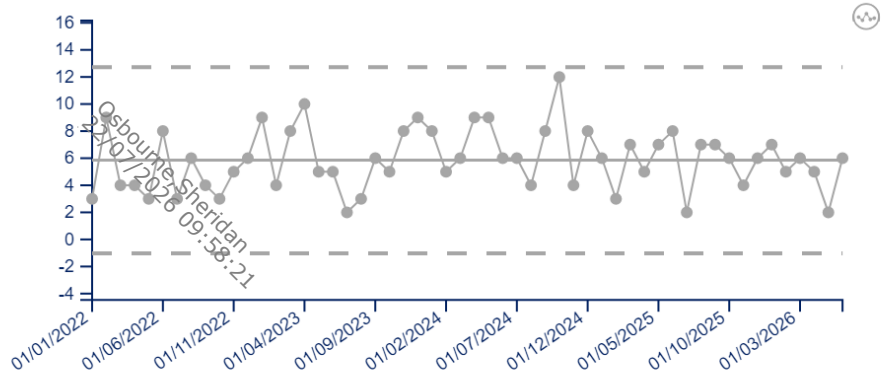


Shift Trend: None – performance remains within expected variation

	Latest Commentary
2026-Jun	
Pressure Ulcers - PU Category 2	
Analysis	In June the number of pressure ulcers per 10,000 bed days remained above the control limit. Category 2 incidents have decreased but Category 3+ incidents have seen increase.
Risks, Mitigations & Assurance	Risks: Ward 26 & 28 had the highest number of incidents which is a consistent pattern. Recent increase in incidents in ED, AMU 4 & wards 29 & 31. Mitigations: Planned collaboration with Calderdale and Huddersfield NHS Trust is planned regarding improving the accurate completion of the risk assessment tool on EPR (PURPOSE T). 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. 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: Education and training is being delivered to new starters and existing staff (e.g. HCA bootcamp, e-learning modules)

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	6	6	2	+4

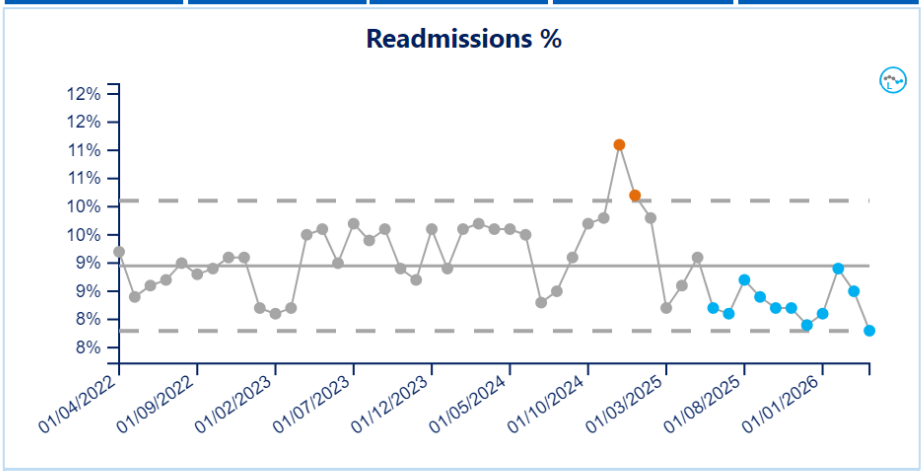
Pressure Ulcers Category 3+



Shift Trend: None – performance remains within expected variation

	Latest Commentary
2026-Jun	
Pressure Ulcers - PU Category 3+	
Analysis	In June the number of pressure ulcers per 10,000 bed days remained above the control limit. Category 2 incidents have decreased and Category 3+ incidents have increased.
Risks, Mitigations & Assurance	Risks: Ward 26 & 28 had the highest number of incidents which is a consistent pattern. Recent increase in incidents in ED, AMU 4 & wards 29 & 31. Mitigations: Planned collaboration with Calderdale and Huddersfield NHS Trust is planned regarding improving the accurate completion of the risk assessment tool on EPR (PURPOSE T). 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. 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: Education and training is being delivered to new starters and existing staff (e.g. HCA bootcamp, e-learning modules)

Latest Period	Mean	Latest Value	Previous	vs Previous
Apr 2026	9.0%	7.8%	8.5%	-0.7 ▼



Shift Trend: Improvement – performance below average for 7 consecutive periods

Latest Commentary	
2026-Jun	
Readmissions %	
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.
Risks, Mitigations & 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.

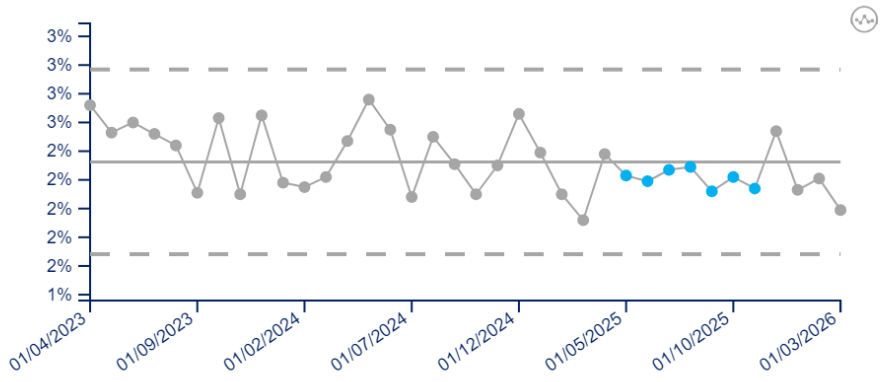
Osbourne,Sheridan
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Quality
Mortality

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Mar 2026	2.33%	1.99%	2.21%	-0.22 ▼

Crude Mortality (Monthly)

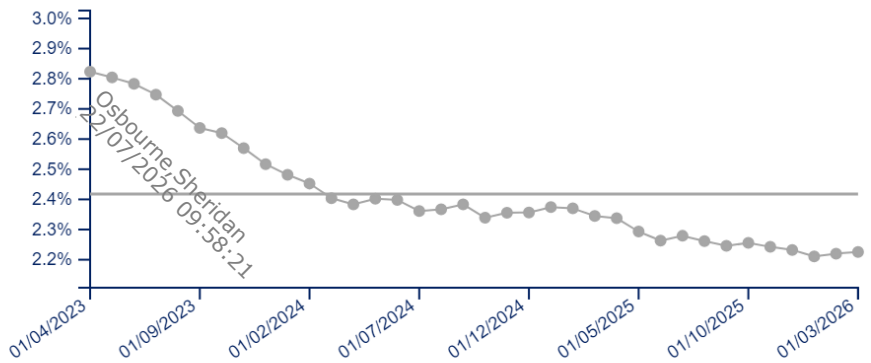


Shift Trend: None – performance remains within expected variation

Latest Commentary	
2026-Jun	
Mortality - Crude Mortality (Monthly)	
Analysis	Our crude mortality rate decreased to 1.99% for the month of March 2026, the latest reported figure (reported in June 2026). This rate is lower than the national figure (2.09%) and is the lowest crude mortality rate in West Yorkshire for the month.
Risks, Mitigations & 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.

Latest Period	Mean	Latest Value	Previous	vs Previous
Mar 2026	2.42%	2.23%	2.22%	+0.01 ▲

Crude Mortality (Rolling 12 Months)



Shift Trend: Improvement – performance below average for 7 consecutive periods

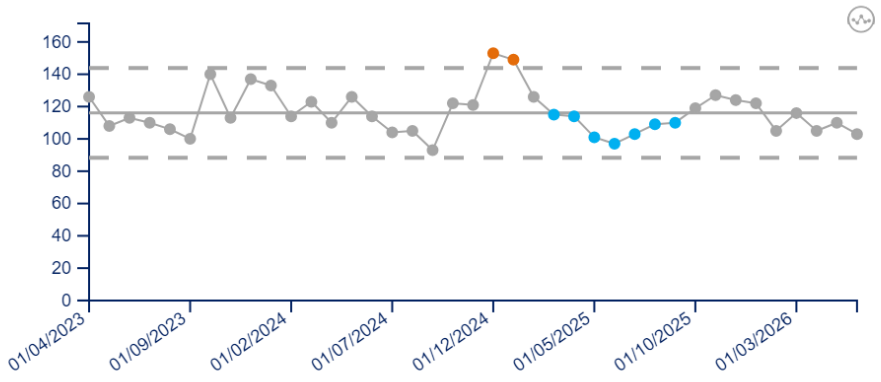
Latest Commentary	
2026-Jun	
Mortality - Crude Mortality (Rolling 12 months)	
Analysis	As a 12-month rolling average, BTHFT currently has a mortality rate of 2.23%, lower than the national average of 2.42% and well below the average for the rest of the West Yorkshire region, which has an average rate of 2.86%.
Risks, Mitigations & 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.

Quality
Mortality & SHMI

BTHFT Business Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Jun 2026	116	103	110	-7

Adult Inpatient Deaths at BTHFT

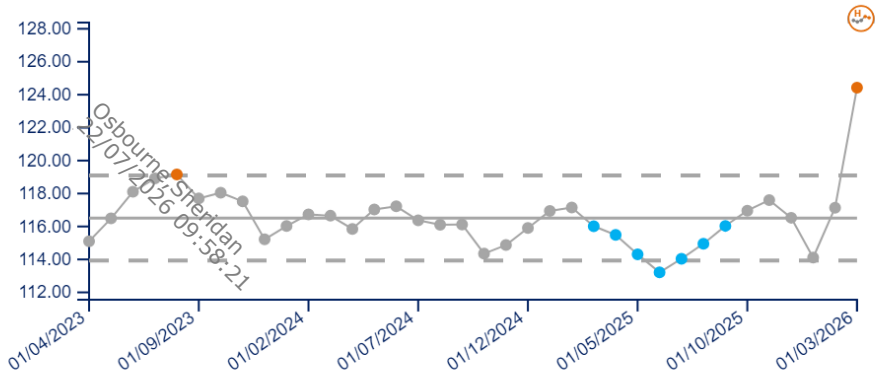


Shift Trend: None – performance remains within expected variation

Latest Commentary	
2026-Jun	
Mortality - Inpatient Deaths	
Analysis	In June 2026, the Trust saw 103 adult inpatient deaths. This is a slight decrease and in line with what we observe at this time of year.

Latest Period	Mean	Latest Value	Previous	vs Previous
Mar 2026	116.51	124.42	117.14	+7.29

SHMI (Rolling 12 Months)



Shift Trend: None – performance remains within expected variation

Latest Commentary	
2026-Jun	
SHMI (Rolling 12 months)	
Target	100
Analysis	The increase in SHMI is attributable to a known SUS data submission issue affecting February and March data, rather than a deterioration in mortality performance. This is reflected in the marked rise in the monthly SHMI from 98.3 in January to 190.3 in February, which is inconsistent with underlying clinical performance and inflating the 12 month SHMI to 124.2.
Risks, Mitigations & Assurance	The submission issues have been resolved with HES colleagues; however, the annual HES refresh was completed before the corrected data was available. NHS England has confirmed that a Month 13 refresh has been undertaken on the 26th of June using the corrected submissions. Following national processing, the revised data is expected to be reflected in the November HED release. In the interim, 12-month SHMI values will remain artificially elevated until the corrected data is incorporated. Monthly SHMI will become once again recognisable with the release of HED metrics for April. Based on current analysis, the Trust is assured that this reflects a data quality issue rather than a genuine change in mortality performance.

BTHFT Business Intelligence

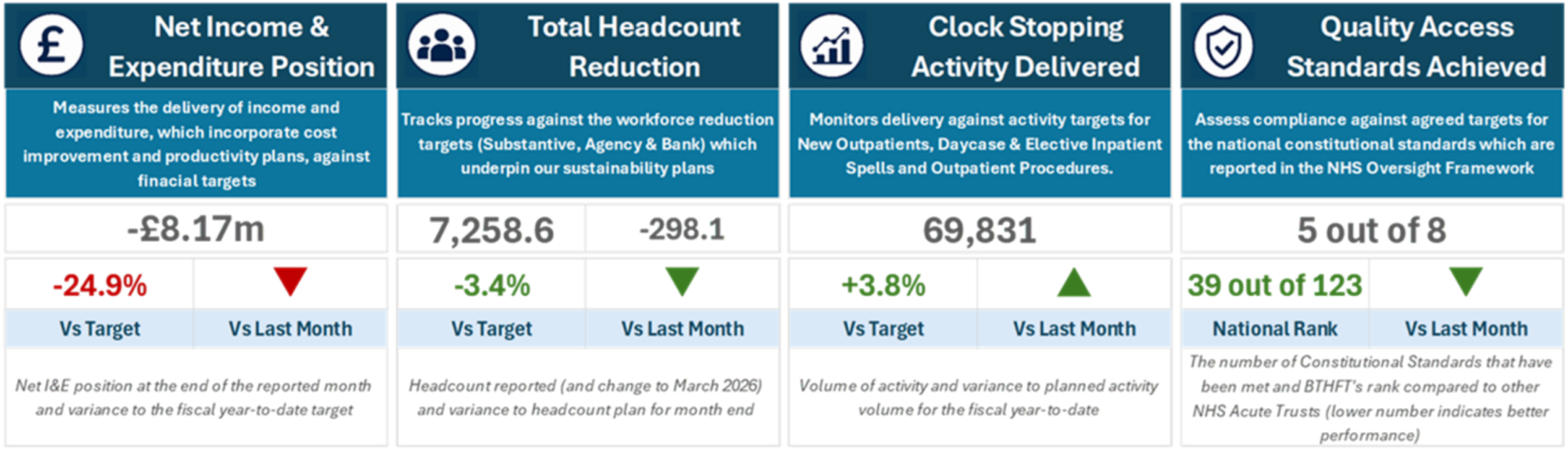
NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

People - June 2026

Osbourne Sheridan
22/07/2026 09:58:21

Headline Recovery Metrics



Osbourne,Sheridan
22/07/2026 09:58:21

People Committee Headline Metrics

Bradford Teaching Hospitals NHS Foundation Trust

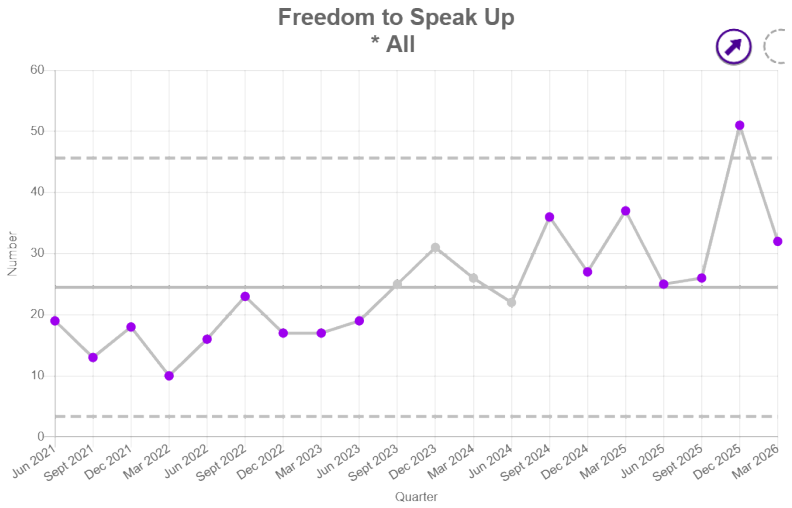
Metric	Period	Latest Value	Target	Variation	Assurance	Mean
Agency - %	May-26	0.28%				2.10%
Appraisal Rate - Non-Medical	May-26	81.6%	85%			75.36%
BAME Split - Band 8+	Mar-26	21.1%	28%			17.45
BAME Split - Bands 1-5	Mar-26	53.1%	39%			43.91
BAME Split - Bands 6-7	Mar-26	32.0%	39%			25.57
BME - * All	Mar-26	45%	39%			38.47
Core Manadatory Training - * All	May-26	92.0%	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	May-26	42.0%				49%
Job Planning - Medics	May-26	69.0%	90%			25%
Job Planning - Nurses	May-26	5%				60%
Nursing Agency Fill Rate - %	May-26	5.6%				11.8%
Nursing Bank Fill Rate - %	May-26	72.5%				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	May-26	6.52%	5.50%			6.3%
Staff Stability - * All	May-26	99.25%				98.8%
Staff Turnover - * All	May-26	10.38%	10%			11.1%

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22/07/2026 09:58:21

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

Bradford Teaching Hospitals NHS Foundation Trust

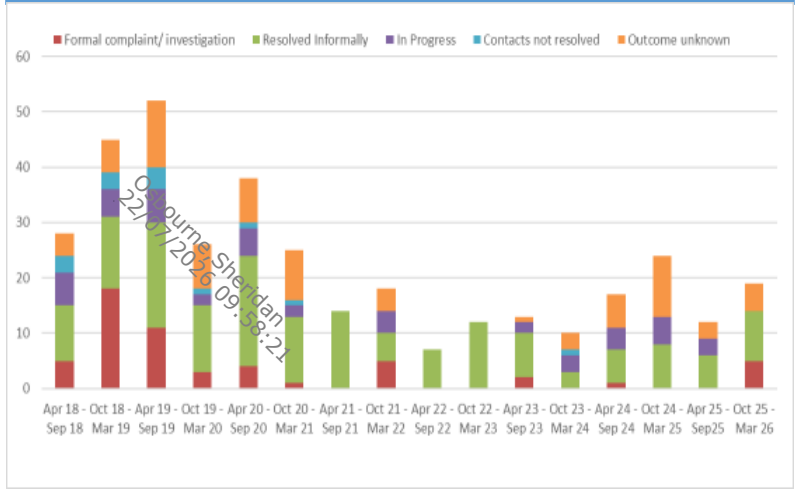
2025/26 Quarter 4 - 32



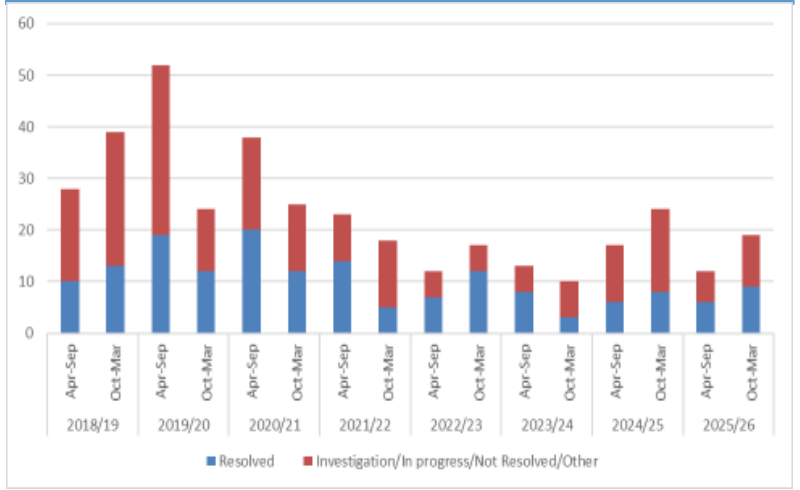
2025/26 April to March– Staff Advocacy

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

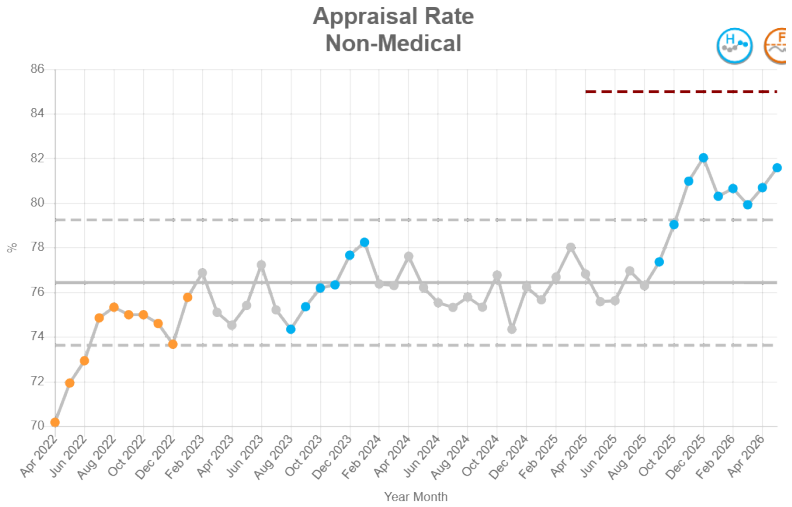
Harassment & Bullying Outcomes: Harassment & Bullying Outcomes: Colleagues are working collaboratively to develop a suite of training for managers and staff around developing cultures of Dignity & Respect in the workplace, including informal conflict resolution. Following our staff survey results, this 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.

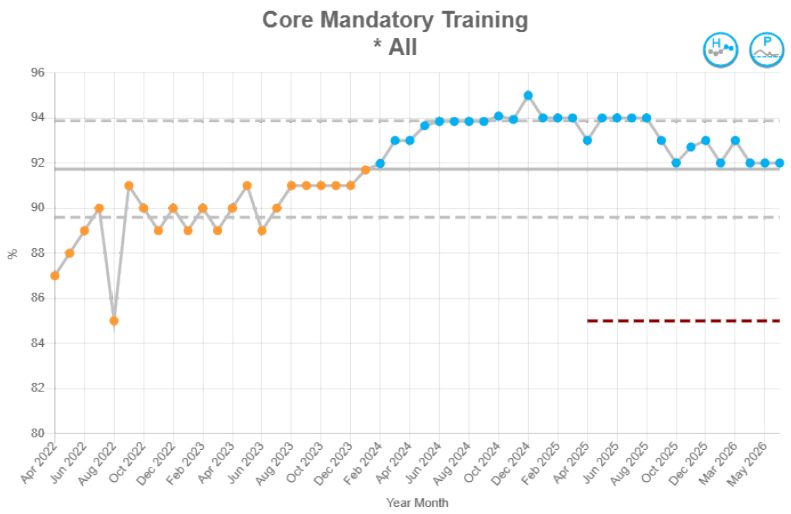
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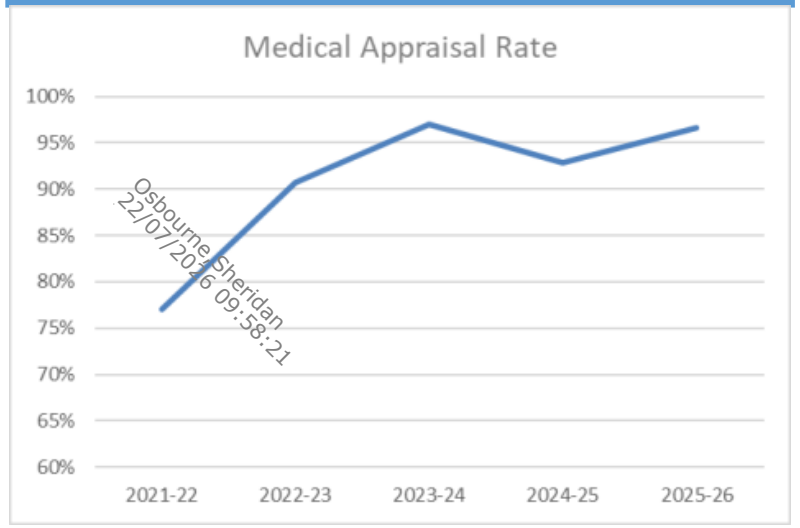
May – 81.59%
Special cause variation of an **improving** nature



June 2026 – 92%
Special cause variation



March 2026 – 96.6%



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 2025 to 31st March 2026 96.6% of doctors received an Outcome Measure 1 (Completed appraisal).
3.4% of doctors were allocated an Outcome Measure 2 (Approved Missed appraisal).

Risks, Mitigations and Assurance

Core Mandatory Training
Overall compliance for June was 92%, no change from May. The majority of subjects maintained compliance from last month.
Equality & Diversity and Safeguarding Adults L2 saw a 1% increase from last month.
Basic Life Support compliance increased by 1% to 81%. 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.
Audit Yorkshire have concluded their audit of non-medical appraisals and have identified some discrepancies in data held and a number of colleagues who haven't had a timely appraisal. This is being investigated and recommendations are currently being drafted in response.
Dynamic Conversations Appraisals are also now a core part of the Thrive Management Essentials offer which launches from 14 July 2026. This creates more opportunities for colleagues to access the development support through virtual and face to face sessions as well as a new recording of the session available via the Thrive portal.

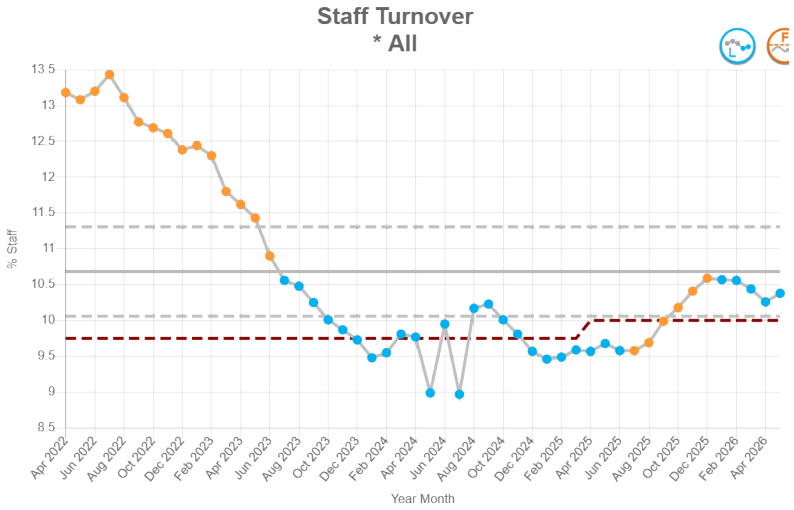
The new 'Thrive Management Essentials' programme of development for managers will launch in June 2026. Dynamic Conversations Appraisals is a 'core' module – recommended for all managers to complete. Appraisals are also being incorporated into 'Flourish' – our new career progression platform which supports BTHFT to grow our own talent and provides consistency and fairness in career progression.

Appraisal compliance has increased slightly this month, to 80.7% (last month: 79.9%)

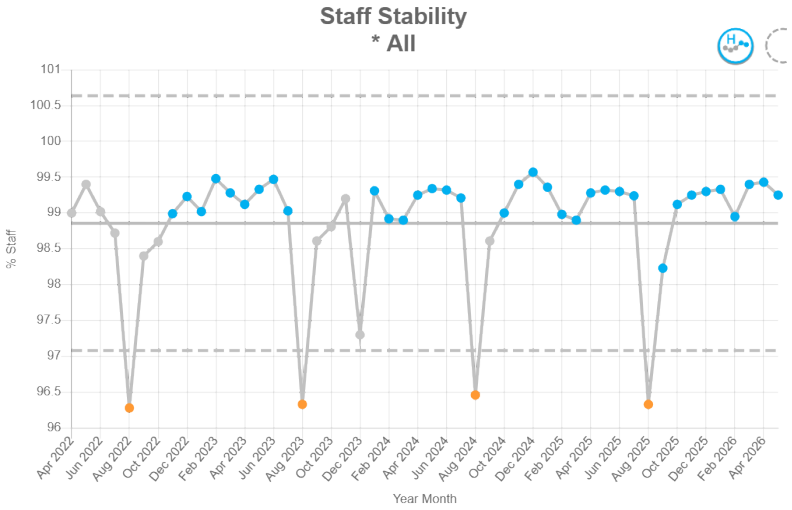
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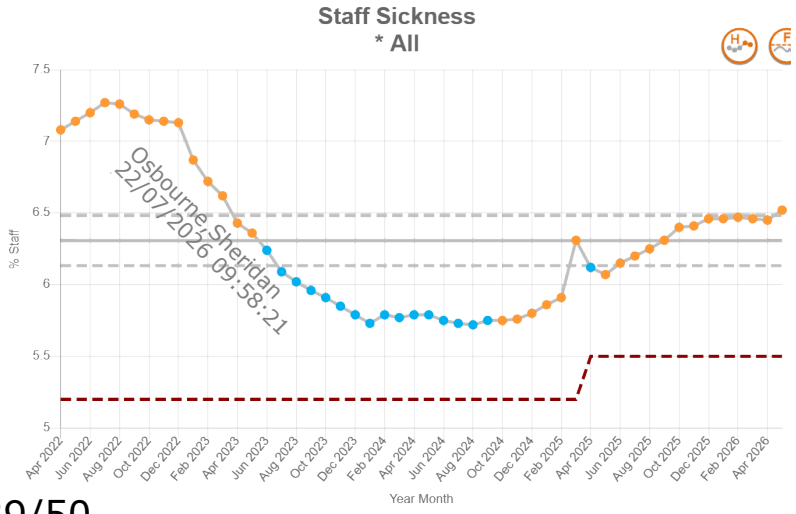
May 2026 – 10.38%
Common cause variation



May 2026 – 99.25%
Common cause variation



May 2026 (rolling 12 months) – 6.52%
Common cause variation



Analysis

Sickness
Since June 2025 the Trust continued to see an increase in sickness absence levels with monthly rates steadily rising, with a recent spike in May 2026. The Trust wide figure for May is 6.52% compared to April 2026 which was 6.07%. The year-to-date figure stands at 6.52%, which is slightly higher than April 2026 at 6.45%.

The staff groups with the highest sickness rates are Additional Clinical Services at 10.76%, Estates and Ancillary at 9.30%, Additional Professional Scientific and Technical at 8.70%, Admin & Clerical at 6.42%, Allied Health Professionals at 6.61%, and Nursing and Midwifery at 5.71%. The only staff groups whose sickness remains below target in May 2026 were Healthcare Scientists and Medical & Dental with rates of 1.14%, 2.40% respectively. The overall YTD sickness % has remained consistently above 5.5%.

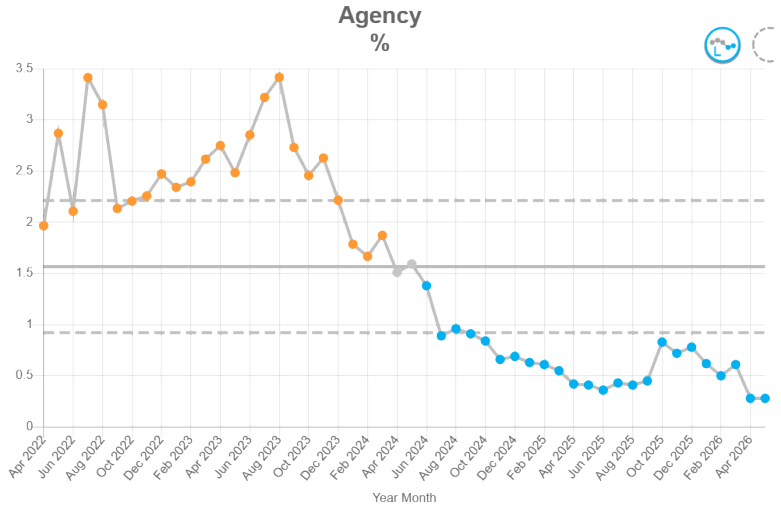
Turnover & Stability
There has been a slight increase in turnover in May 2026 though the rate remains below 10.5%. It continues to remain relatively static when compared to previous months.
The stability index shows the percentage of all colleagues including rotational doctors and fixed-term appointments who are still in post at the end of the month and who were in post at the start of the month. Following a slight reduction to 99% in February 2026 due to changeover of rotational doctors, the stability index for May 2026 is marginally lower than April but remains above the February low.

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%.

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May 2026 – 0.28%
Common cause variation of an **improving** nature



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NHS Foundation Trust

Analysis

Agency
Overall, Trust wide there has been a slight increase agency use from 28.19 WTE in April to 28.55 WTE in May .
There have been decreases in the following areas:-
Unplanned Services from 6.65 in April to 6.30 in May, Diagnostic & Corporate Operational Services 9.81 in April to 8.27 in May.

With increases in the following area:-
Planned Services from 10.21 in April to 12.02. Estates and Facilities from 1.52 in April to 1.91 in May. Corporate Services 0 in April to 0.05 in May.

Using no agency are the following areas:-
Research.

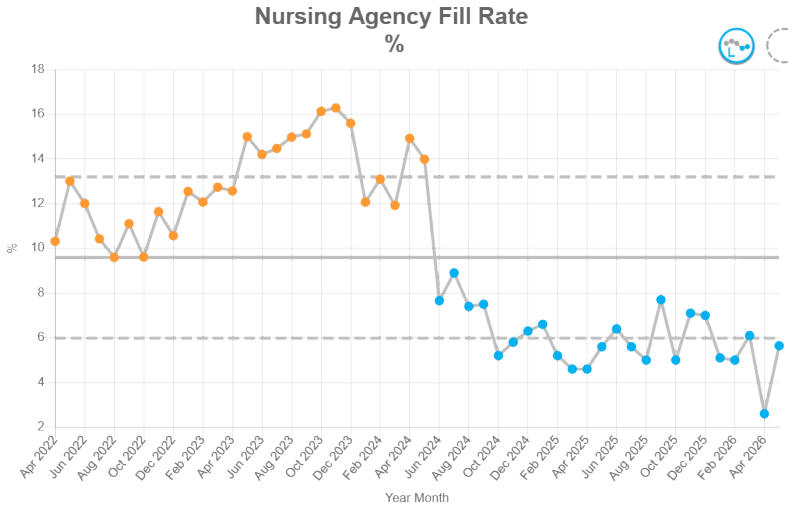
Risks, Mitigations and Assurance

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

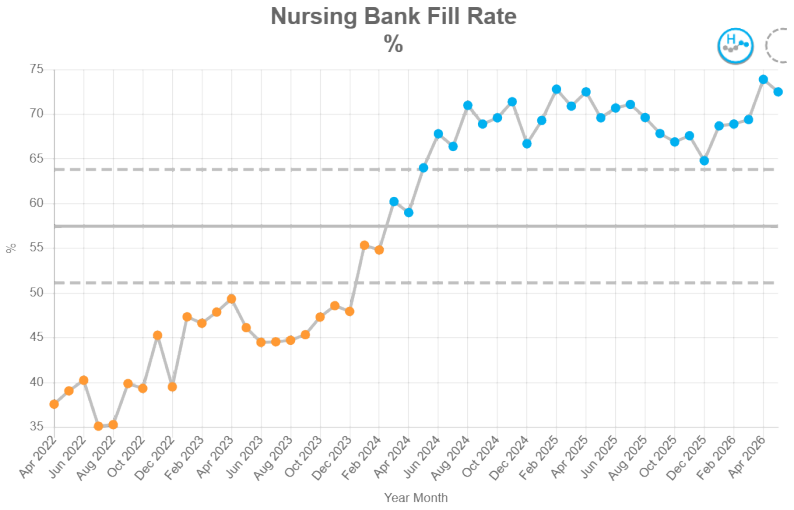
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May 2026 – 5.64%
Common cause variation



May 2026 – 72.5%
Special cause variation of an **improving** nature



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Analysis

Bank Staffing Nursing
In May, the total number of requests sent to bank was 8842 compared with April requests of 7782 an increase of 1060 requests. This is split as 3792 requests for registered staff and 5050 requests for unregistered staff. Of those 3792 registered requests a total of 2732 were filled by bank staff which is 72.5% compared with 73.9% in April an increase of 1.4%. Out of the 5050 requests for unregistered staff 3495 were filled by bank which is 69.2% compared to April which was 71.6% an increase of 2.4%.

Agency Nursing
Agency shifts filled for May were 214. This is split 214 registered and 0 unregistered staff. Out of the 214 filled registered shifts, 169 were filled with registered theatre staff. There has been an increase in Nursing agency from 2.6% in April to 5.6% in May. Unregistered remains at zero agency usage.

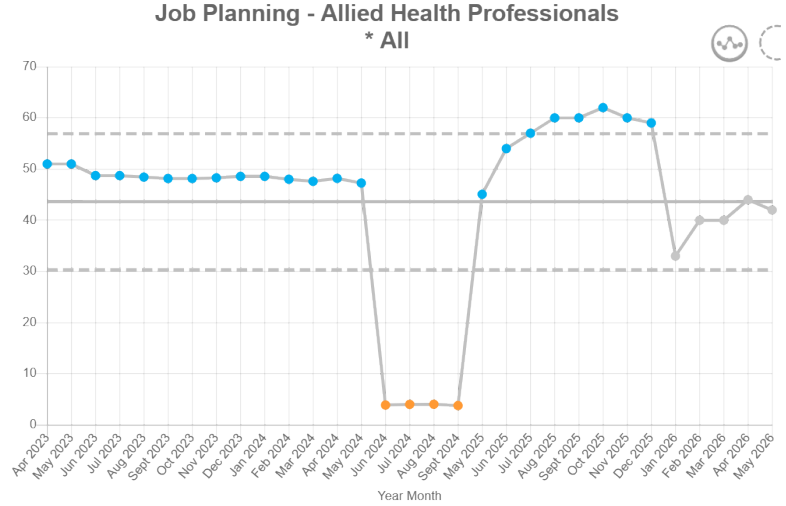
Risks, Mitigations and Assurance

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 produced on a monthly basis with Nursing workforce lead.

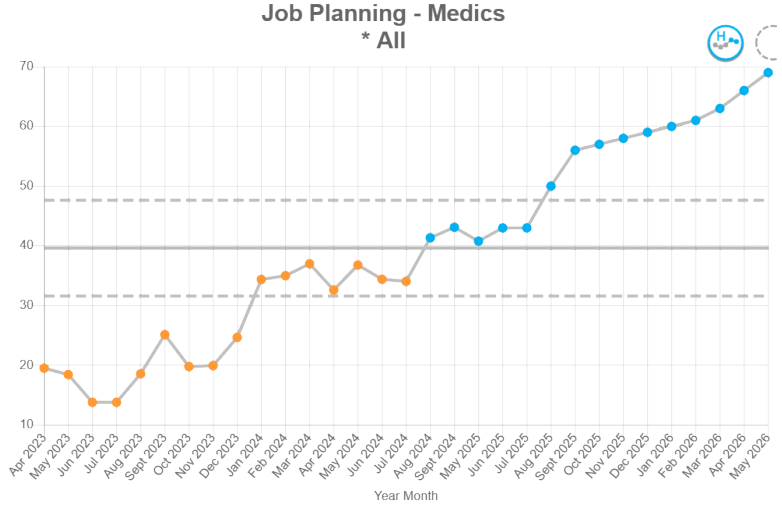
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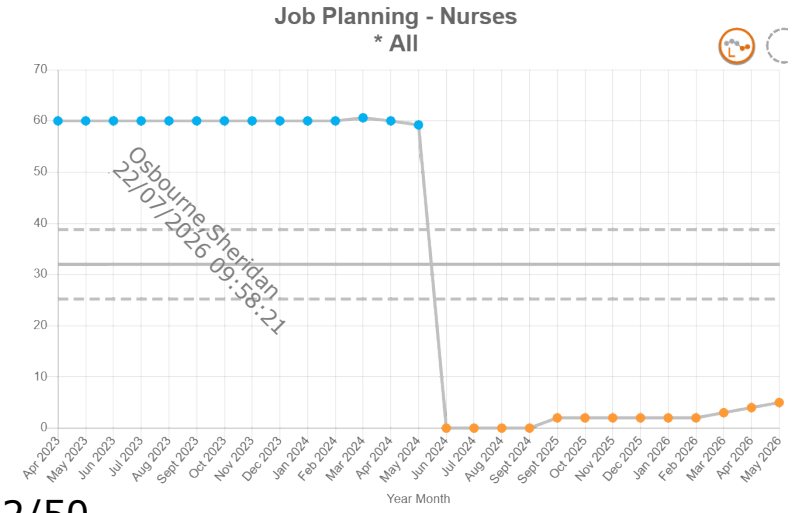
May 2026 – 42%
Common cause variation



May 2026 – 69%
Special cause variation of an **improving** nature



May 2026 – 5.0%
Special cause variation of an **improving** nature



Analysis

Medics – There are currently 460 Medics registered within the system and 319 signed off, which is 69%.

AHP – There are currently 424 AHPs registered within the system and 176 are signed off, which is 42%.

CNS – There are currently 258 CNSs registered within the system and 13 signed off, which is 5%.

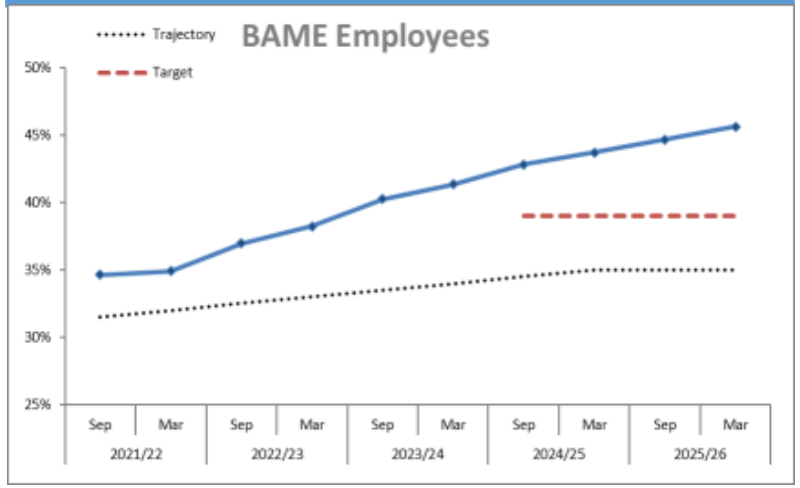
Risks, Mitigations and Assurance

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.

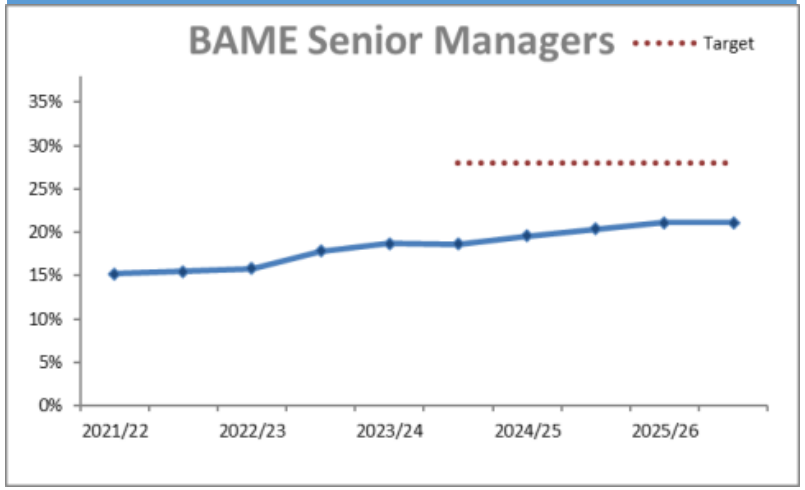
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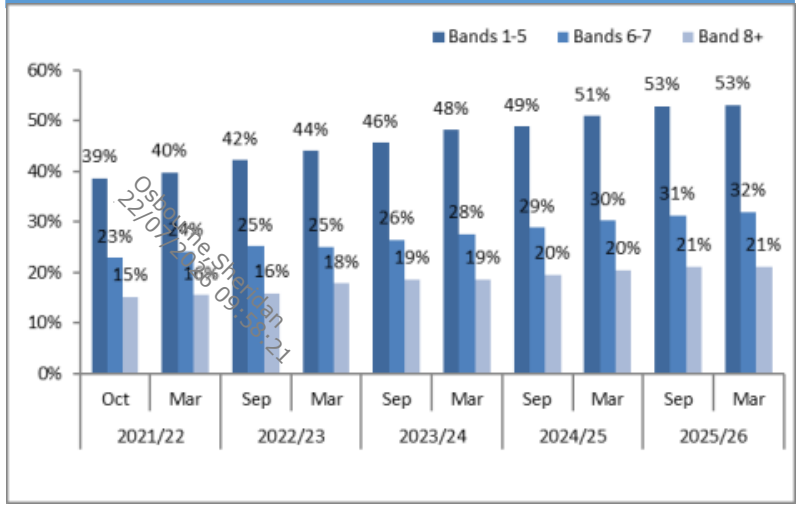
2025/26 Quarter 4 - 45.61%



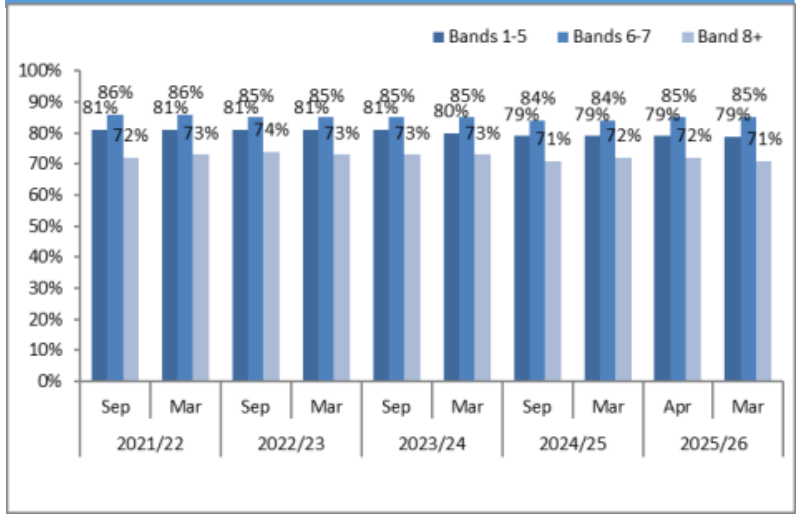
2025/26 Quarter 4 – 21.12%



2025/26 Quarter 4 – BAME employee % by band



2025/26 Quarter 4 – 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

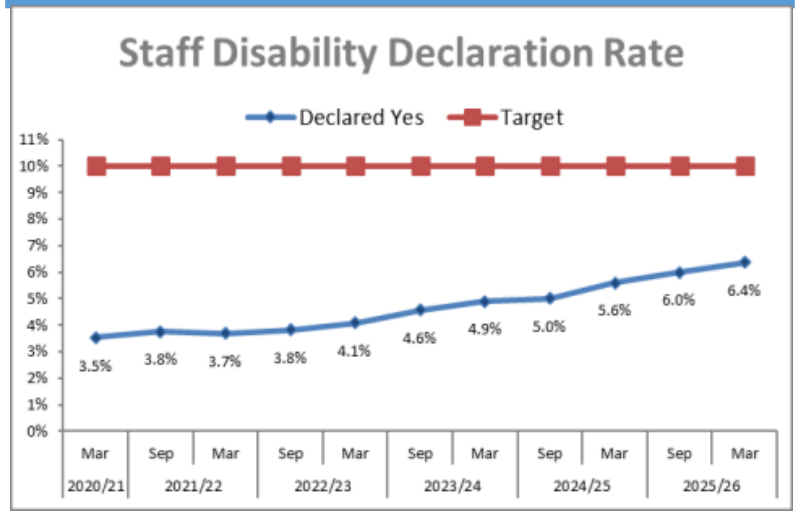
We know that achieving our ambitions around senior leadership representation continues to an area of focus. In 2025 (as part of the new People Strategy Launch) we set ourselves a refreshed target of 28% representation at Bands 8a+ by Sept 2027 and our activity over the next 12 months will be pivotal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

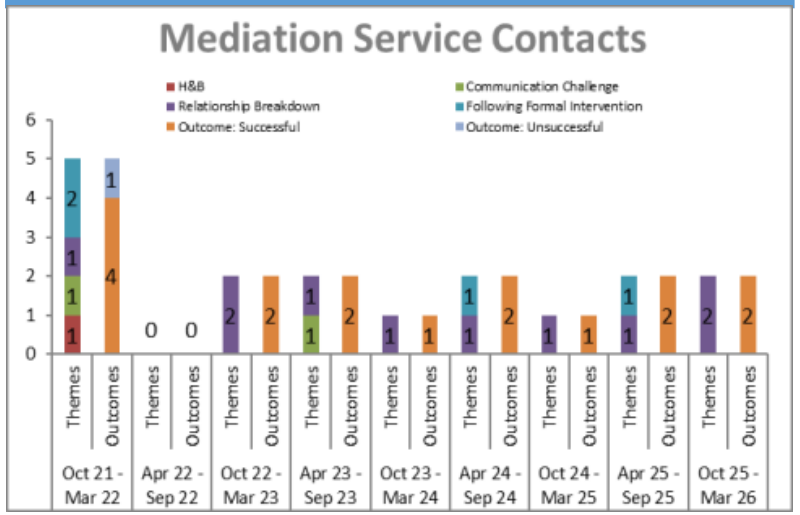
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2025/26 Quarter 4 – 6.4%



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.

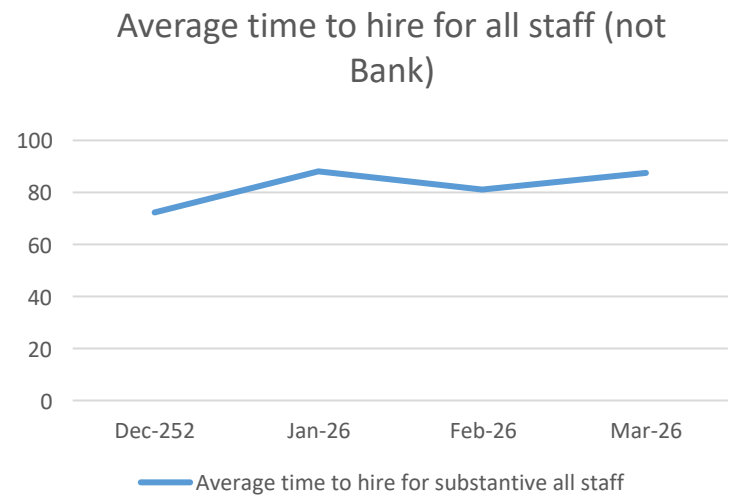
Mediation continues to provide a crucial role in supporting staff to deal with any workplace disagreements/conflict and is an important tool for 'nipping issues in the bud' and repairing relationships that may have been damaged by long standing issues or formal processes. The mediation service will become 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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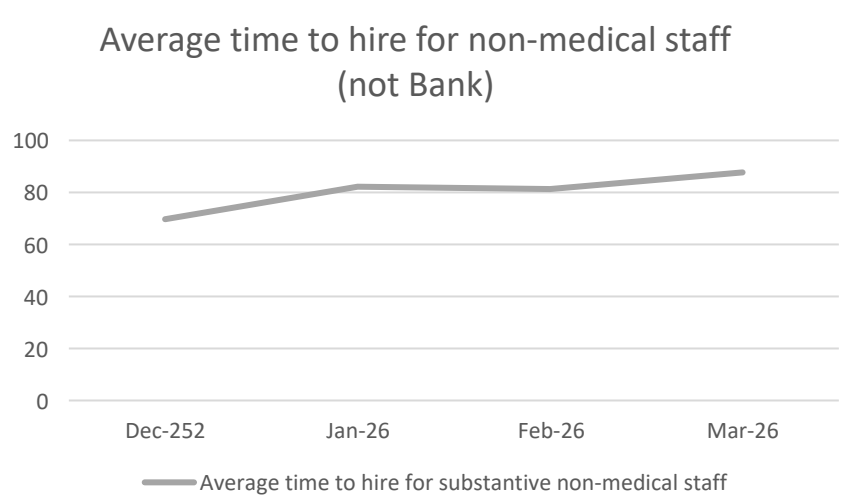
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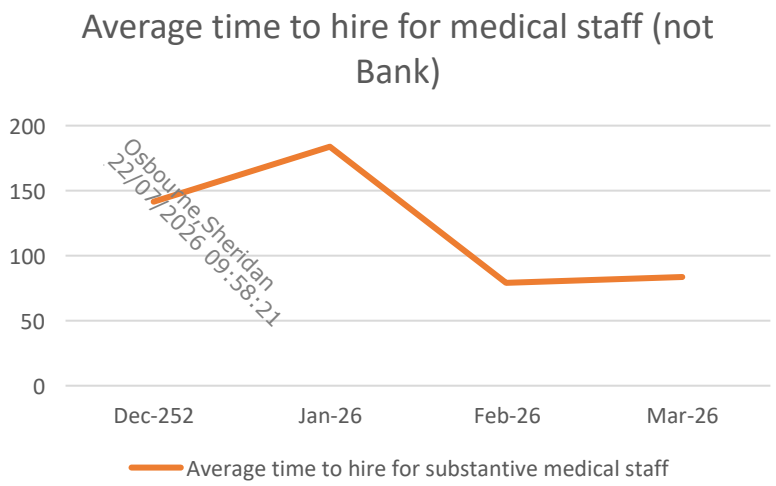
March 2026 Total substantive staffing – 87.5 working Days
Special cause variation of a **deteriorating** nature



March 2026 Recruitment – 87.7 Working Days
Special cause variation of a **deteriorating** nature



March 2026 Medical – 83.6 working days
Special cause variation of a **deteriorating** nature



Analysis

Time to hire for May 26 (AfC) currently stands at 84.1 days. This data reflects Advert Close to Candidate Start date. This is an increase of 3.8 days from April. May saw 40 candidates starting within month and others with agreed start dates in the future. Pre-employment checks were completed for AfC staff in 35.6 days in May. We saw in increase of 5.3 days in the time taken to receive OH clearance however, this element of the process is out of our control. The team currently has 1 staff member redeployed to other HR teams to provide support, and 2 have now left the Trust and a further 2 leaving in July & August, so we are working on significantly reduced staffing which is also having an impact.

May's TTH for Medical has seen a large decrease to 80.6 days from 95.8. The decrease is primarily due to the time between Conditional offer sent & Checks complete as this reduced from 90.4 days to 31 days. The introduction of the workflow rota has continued to lend to the improved processing times elsewhere within the Recruitment process. The rota allows all workflows to be actioned daily, therefore ensuring that work is prioritised accordingly and bottlenecks are identified and addressed immediately. This way of working is streamlining the processes and creating more transparency within the team to better identify the current needs.
August/Sept rotation work is currently underway.

Risks, Mitigations and Assurance

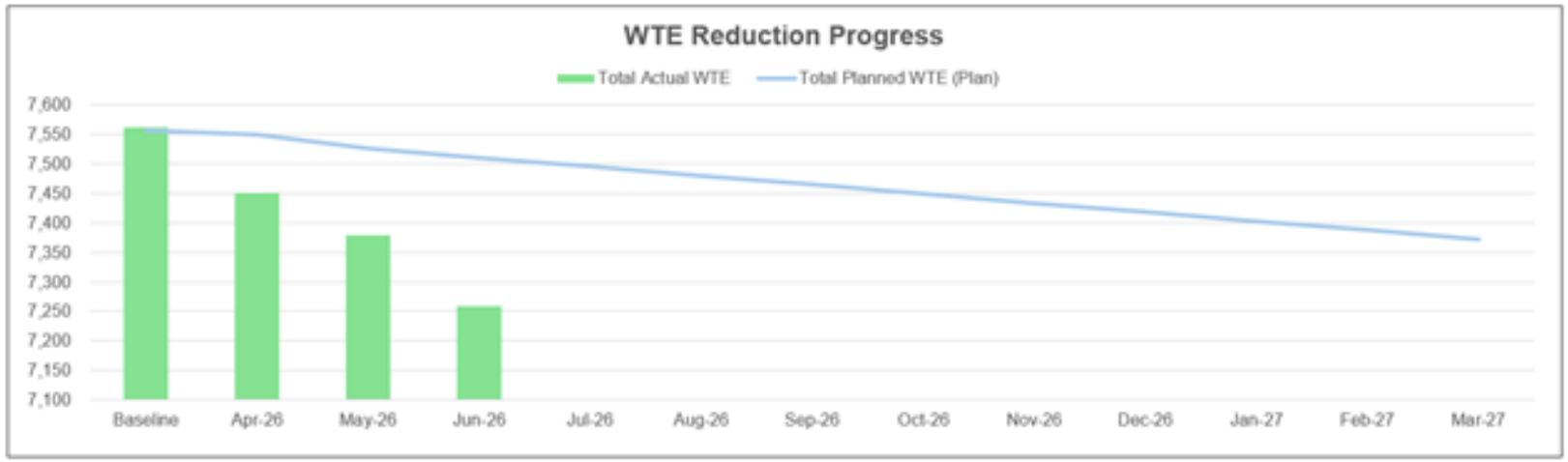
Despite showing improvements in our overall TTH figure, we are still striving to further reduce figures where we have direct influence or where we can automate the process. We are continuing to review and monitor our processes and seek improvements. The Recruitment team continues to use "chasing workflows" 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 automate further functions within the Trac system, including interview outcomes at source and occupational health referrals, to decrease the TTH figure. These functions are currently being identified and tested.

People – Workforce Planning

Bradford Teaching Hospitals
NHS Foundation Trust



	Baseline	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Substantive WTE (Plan)	6,835.16	6,831.66	6,811.82	6,800.15	6,788.48	6,776.81	6,765.14	6,753.47	6,741.80	6,730.13	6,718.46	6,706.79	6,695.12
Bank staff WTE (Plan)	671.27	668.77	666.27	663.77	661.27	658.77	656.27	653.77	651.27	648.77	646.27	643.77	641.27
Agency staff WTE (Plan)	50.20	48.95	47.70	46.45	45.20	43.95	42.70	41.45	40.20	38.95	37.70	36.45	35.20
Total Planned WTE (Plan)	7,557	7,549	7,526	7,510	7,495	7,480	7,464	7,449	7,433	7,418	7,402	7,387	7,372
Substantive WTE (Act)	6,778.20	6,752.55	6,723.25	6,699.18									
Bank staff WTE (Act)	748.00	659.95	621.08	534.67									
Agency staff WTE (Act)	35.76	38.27	35.31	24.32									
Total Actual WTE	7,562	7,451	7,380	7,258									
Variance	*(5.33)*	*98.61*	*146.15*	*252.20*									

To note on the variance (Brackets) are bad
Source: PWR

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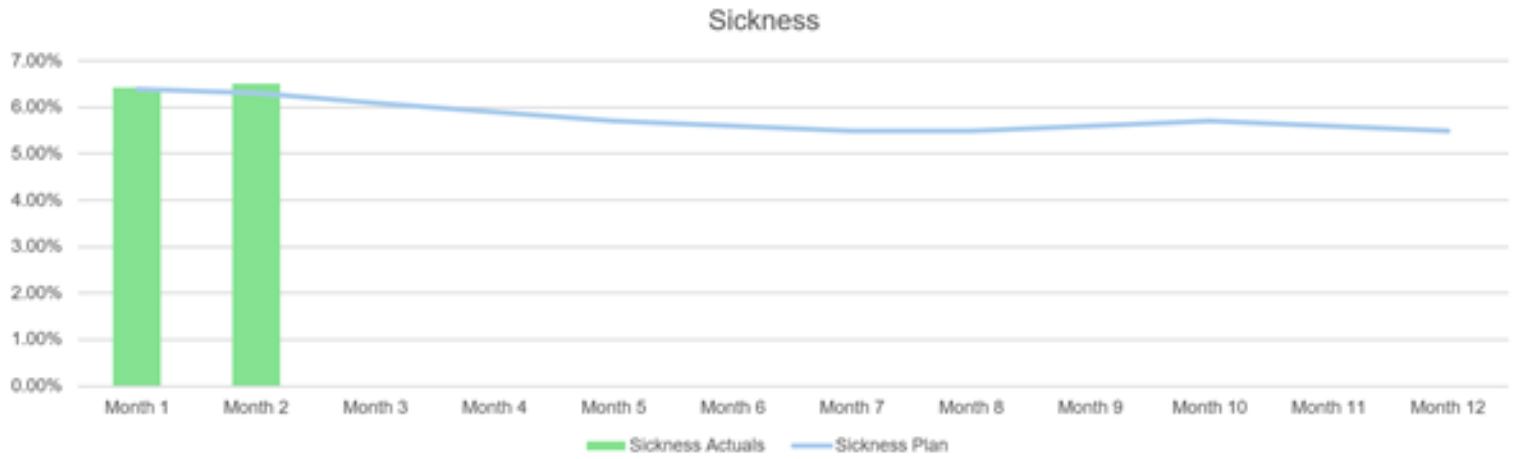
Analysis

Workforce Plan Briefing – Current Position
This position represents the Trust-level Workforce Plan based on the PWR framework. This reflects the current trajectory and assumptions being used across the organisation.
These targets are being produced at CSU level. Each CSU has been assigned specific WTE staffing reduction and sickness absence reduction targets to be achieved by March 2026 – 185 net reduction and sickness target of 5.45%
Progress against these targets will be monitored through regular reviews involving CSU leadership teams, Finance Business Partners and HRBPs. HRBPs will provide assurance and report any areas where CSUs are not delivering against plan enabling timely intervention and support where required.
This approach will ensure clear accountability, robust performance management and alignment between workforce, operational, and financial improvement objectives across the Trust.

Risks, Mitigations and Assurance

People – Workforce Planning

Bradford Teaching Hospitals
NHS Foundation Trust



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Sickness Plan	6.40%	6.30%	6.10%	5.90%	5.70%	5.60%	5.50%	5.50%	5.60%	5.70%	5.60%	5.50%
Sickness Actuals	6.43%	6.52%	TBC									
Variance	-0.03%	-0.22%	#VALUE!									

To note on the variance minus values are bad
Source: PWR

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Analysis

Workforce Plan Briefing – Current Position
This position represents the Trust-level Workforce Plan based on the PWR framework. This reflects the current trajectory and assumptions being used across the organisation.
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Risks, Mitigations and Assurance

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

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Further Reading / other resources

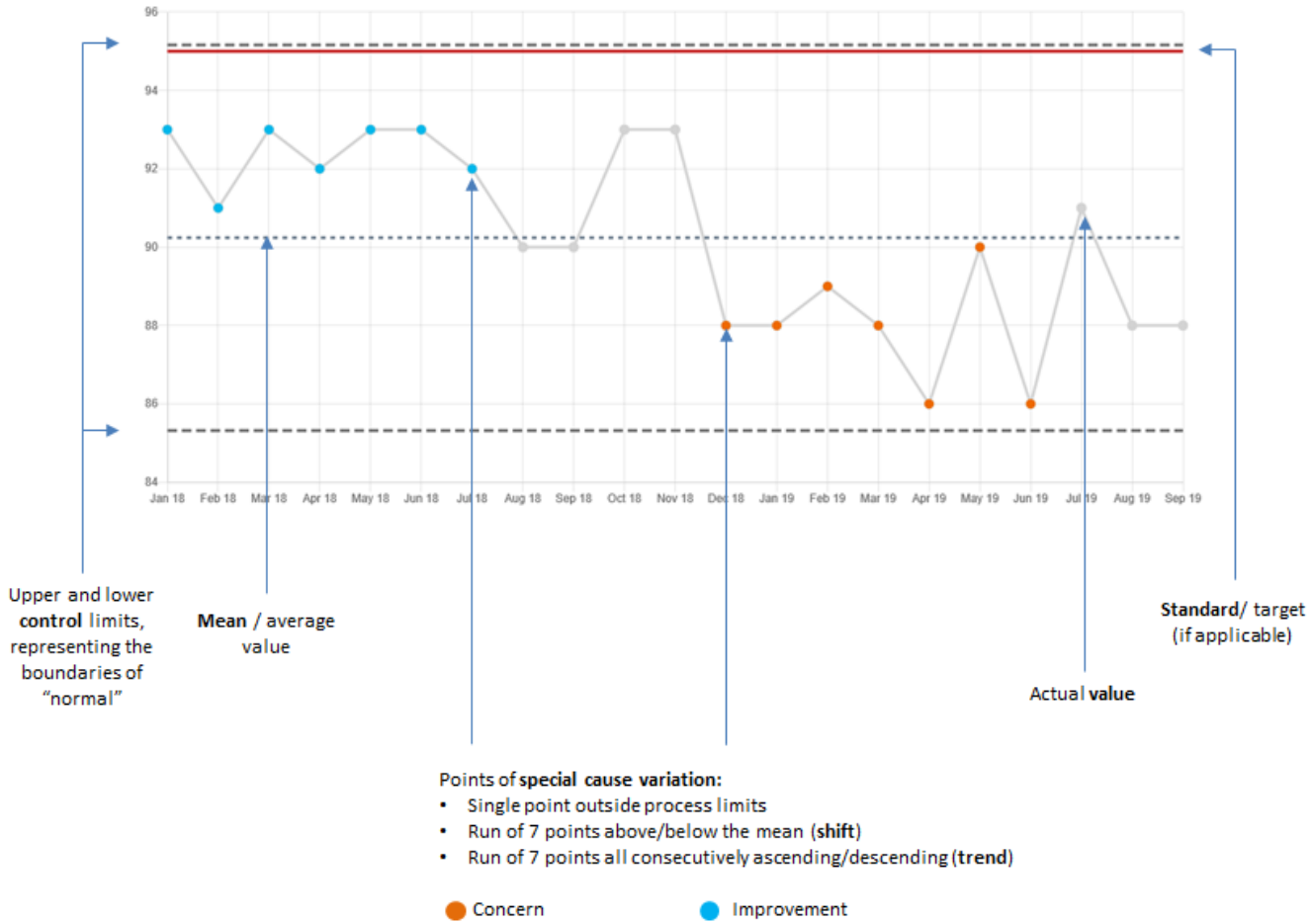
The NHS England website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://www.england.nhs.uk/publication/making-data-count/

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.

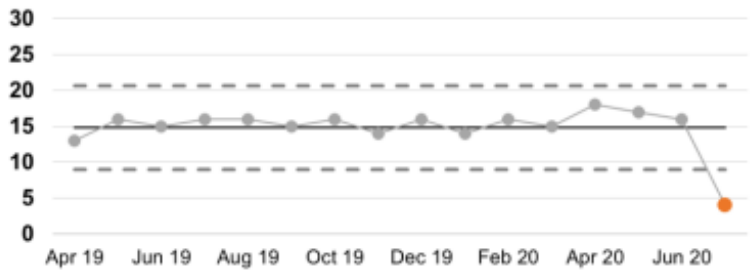
SPC charts



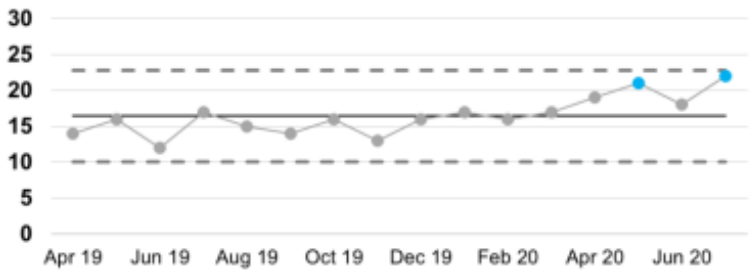
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SPC rules : special cause variation

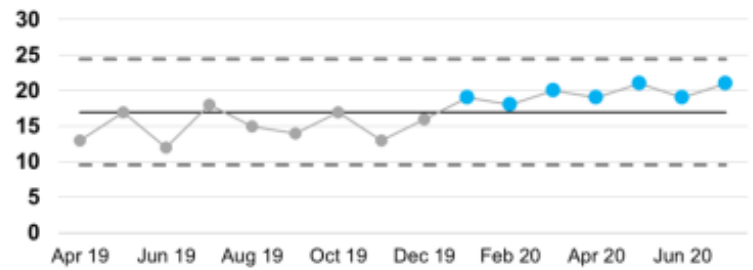
A single point outside the process limits



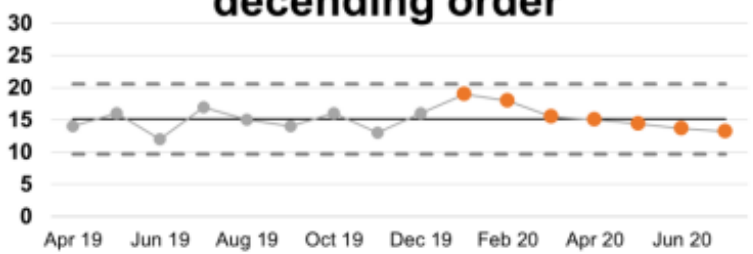
Two out of three points close to a process limit



A shift of points above / below the mean



A run of points in consecutive ascending or decending order



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Board of Directors			
Meeting Date:	23/07/2026	**Agenda Reference:**	Bo.7.26.12c
Report Title:	Month 3 Finance Report		
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 3 deficit of £8.2m, this is £1.6m worse than plan. The two main drivers of variance at month 3 are the Deficit Support Funding (£0.6m) and the impact of industrial action (£1m).
- The monthly run rate continues to improve but it isn't improving at the pace required to align to the profiling of the breakeven plan.
- NHSE has notified the Trust that its planned DSF allocation of £2.3m for the year will be withheld for Quarters 1 & 2 due to concerns about the level of risk to delivery of the plan. This decision was based on Month 2 reporting and the board assurance statements submitted. The impact of this is a loss of £0.6m for Quarter 1.
- The Trust is formally 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 behind plan by £1m in Month 3; this continues to be supported by a number of non-recurrent measures which have yet to progress through the CTG gateway process in full. Delivery of recurrent savings remains dependent on the successful implementation and embedding of schemes, representing a key risk to plan.
- The underlying run rate improved moderately in Month 3 and there is credible evidence that the Elective Recovery Fund income position may improve in Month 4 by at least £1.7m. The mid-case scenario forecast has therefore improved since Month 2 reporting, although this remains significantly off plan at £23m deficit.

Capital Expenditure

- Capital expenditure is £1.3m year to date, which is £2.3m below plan, reflecting a slower than anticipated start to the year. The variance is primarily due to normal programme phasing, including procurement timelines and project mobilisation activities.
- The full-year capital forecast has been revised to £0.7m below budget to support the funding of the WYAAT Aseptic Unit at LTHT. The Trust remains confident in delivering its capital programme in full by year end.
- There is an emerging risk of a further £2.6m capital underspend. The Capital Strategy Group is reviewing the reserves list to identify schemes that can be delivered this year to mitigate the risk.

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Cash

- Total Cash is £11.2m which is £0.1m less than plan (£11.3m). Forecast cash is £4.4m which is £8.8m less than plan.
- Not receiving the full amount of cash support requested from NHS E has not reduced payments in the month due additional Research cash of £1.9m and not needing to make forecasted repayments in the month as expected.

I&E Operational Cash

- Year to date I&E operational cash is £1.6m below plan, reflecting the Trust's Month 3 deficit of £8.2m, which is £1.6m adverse to plan. The variance is primarily driven by lower Deficit Support Funding and the impact of industrial action.
- Forecast operational cash remains broadly in line with plan, supported by a forecast breakeven year-end position. However, the Trust will need to generate cash surpluses over the remainder of the year to recover the £6.2m cash deficit incurred in Quarter 1 and deliver the planned cash position.

I&E Working Capital Cash

- Year to date I&E working capital cash is £2.2m favourable to plan, primarily reflecting the receipt of £2.4m Elective Recovery Funding and £1.9m additional Research and Development income, which have improved cash balances. This is partially offset by the receipt of £3.0m less PDC cash support than planned in Month 03.
- Forecast working capital cash is £6.3m below plan, mainly due to lower levels of cash support than originally anticipated.
- The forecast assumes repayment of all in year NHSE cash support received, resulting in a position £9.1m below plan, subject to Board approval.
- The 2026/27 plan assumes repayment of 80% (£4.4m) of the £5.5m national brokerage funding received in 2025/26, with repayments forecast to be made during Quarters 3 and 4.

Capital Cash

- Year to date capital cash is £7.3m, £0.7m below plan, primarily due to capital expenditure being behind plan and lower capital payables at month end.
- The capital programme is currently £2.5m behind plan, reflecting normal expenditure phasing and a slower start to the year.
- The year end capital cash balance is forecast to be £4.3m, £2.0m below plan, primarily due to lower depreciation than anticipated and movements in capital payables.

Cash Support

- **I&E Distress Funding** - The Trust is not eligible for the £9.1m of planned cash distress support due to its forecast breakeven financial position and has instead been offered repayable working capital PDC.
- **I&E Working Capital Cash Support** -The forecast assumes repayment of the £2.5m working capital PDC in March 2027; however, the timing of

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	any repayment will be subject to approval by both the Board and NHS England. - The June 2026 cash support request was reduced from £5.5m to £2.5m, £3.0m below plan, resulting in a forecast nil I&E cash balance at both September 2026 and March 2027. This increases liquidity risk, particularly in relation to the timely settlement of supplier payments. - To deliver its forecast breakeven I&E position, the Trust will need to generate £21.5m of net operating cash during the remainder of the financial year. - Should the Trust fail to deliver its forecast financial performance during Quarter 2, an additional working capital cash support request may be required in August 2026 for drawdown in September 2026. - **Capital Cash Support** - It is not anticipated that the Trust will require capital cash support during 2026/27
Recommendation/s: (including any decision/approval required)	The Board is asked to: 1. Note the content of this report 2. Support further cash applications
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 5 on the Board Assurance Framework, Reference SR08. **Strategic Risk: 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.
Legal/Regulatory:	Requirement from NHSE to deliver the financial plan
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/a
Assurance Route	
Meeting/s where content has been discussed previously:	N/A

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Finance and Performance Committee			
Meeting Date:	22 July 2026	**Agenda Reference:**	FC.7.26.15
Report Title:	Operational Performance Highlight Report		
Presented by:	Carl Stephenson, Director of Planning and Performance		
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 where available.

Year-end forecasts are derived from current performance, trends, and the measurable actions that are planned and will impact on the KPI within these timescales.

Assurance provided through the exception report and the recovery actions being progressed.

Performance across the Headline KPI (which align to the NHS Oversight Framework and our medium-term planning commitments) is broadly positive when compared to target, plan and peer benchmarking. The Trust is meeting 10 of the 14 selected KPI in this report and has improvement plans in place for delivery of year end targets.

Headline KPI:
Emergency Care Standard (ECS): Performance has dropped slightly below plan, although remains in the best decile nationally and actions are in place to support improvement. High attendances, IPC ward restrictions and high bed occupancy correspond with this trend.

LoS >21 days: The number of long length of stay patients is increasing with performance now off plan. There is a multi-discipline team reviewing the current processes related to the KPI, which include NCTR recording, discharge planning and coordination alongside partners.

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 June for both outpatient and inpatient activity remains positive in comparison to agreed improvement trajectories, although it should be noted that monthly requirements significantly increase from July.

Year End:
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.

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	On the balance of all year end forecasts the Trust is likely to meet most of its planning targets and improve its NOF ranking if current performance trends are sustained. Additional information to aid the understanding of current and forecast positions and support the assurance provided by the exception report is included in objective based highlight reports.
Recommendation/s: (including any decision/approval required)	*The Committee 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	
Risk:	This paper demonstrates our understanding of the KPI that underpin our short-term response and shape our longer-term plans related to delivering improvement within item 7 of the BAF.
Legal/Regulatory:	The operational priorities covered by this report include those which form part of NHSE contract, annual planning, and performance assessment frameworks.
Quality & Patient Safety:	Failure to deliver improvements in the KPI covered by this report in line with our agreed plans will have a direct impact on patient experience and outcomes related to timely access to services.
Equality, Diversity and Inclusion and Health Equity:	Failure to address issues or deliver the improvements outlined for 2025/26 may have a disproportional impact on some communities and demographics where access to services correlates with poorer long-term health outcomes.
Resources:	
Environmental sustainability:	
Assurance Route	
Meeting/s where content has been discussed previously:	This report aligns to the performance and accountability framework and specifically the operational performance domain of the balanced scorecard. This report has been informed by and the content discussed at the various meetings set out in this framework for overseeing and improving performance.

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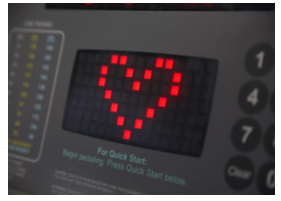
Operational Performance Highlight Report

Finance & Performance Committee

June 2026 Performance





Headline KPI Summary

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Headline KPI	Latest Month	BTHFT Plan	Perf.	3-Month Trend	Q4 NOF Rank	Year to Date	Year End Target	Year End RAG
Average Ambulance Handover	Jun-26	18:00	17:22	↑	N/A	17:21	18:25	G
Emergency Care Standard	Jun-26	83.10%	81.46%	↓	8 of 123	82.38%	83.00%	A
12 Hour LoS in Emergency Department	Jun-26	5.84%	9.38%	↓	36 of 123	9.81%	7.31%	A
Length of Stay ≥21days	Jun-26	82	85	↑	N/A	N/A	82	G
Average Delay Post Discharge Ready Date	Jun-26	3.7	3.5	↑	N/A	3.4	3.7	G
18 Week RTT Incomplete	Jun-26	67.67%	69.31%	↑	54 of 130	N/A	73.71%	A
18 Week RTT Incomplete vs Plan	Jun-26	-	+1.64%		92 of 130			-
52 Week RTT Incomplete	Jun-26	0.21%	0.17%	↓	19 of 130	N/A	0.22%	G
52 Week Community Waits	Jun-26	-	0.00%		1 of 78	N/A	0	-
New Outpatients (ERF) vs Plan	Jun-26	100.00%	100.09%		N/A	103.08%	100.00%	G
Elective Activity vs Plan	Jun-26	100.00%	104.59%		N/A	105.10%	100.00%	G
6 Week Diagnostic Standard (DM01)	Jun-26	84.38%	88.12%	↑	N/A	N/A	94.65%	R
Cancer 28 Day Faster Diagnosis Standard	May-26	80.44%	82.29%	↑	53 of 118	80.84%	80.03%	G
Cancer 31 Day General Treatment	May-26	93.36%	98.46%	↑	N/A	96.82%	94.95%	G
Cancer 62 Day General Treatment	May-26	73.89%	74.34%	↓	56 of 118	*76.52%*	77.41%	G

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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

June 2026 Highlight Report

Bradford Teaching Hospitals NHS Foundation Trust

Operational Performance Summary

Performance across the Headline KPI (which align to the NHS Oversight Framework and our medium-term planning commitments) is broadly positive when **compared to target, plan and peer benchmarking**. The Trust is meeting 10 of the 14 selected KPI in this report and has improvement plans in place for delivery of year end targets.

Headline KPI Trends

Emergency Care Standard (ECS): Performance has dropped slightly below plan, although remains in the best decile nationally and actions are in place to support improvement. High attendances, IPC ward restrictions and high bed occupancy correspond with this trend.
LoS >21 days: The number of long length of stay patients is increasing with performance now off plan. There is a multi-disciplinary team reviewing the current processes related to the KPI, which include NCTR recording, discharge planning and coordination alongside partners.
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 June for both outpatient and inpatient activity remains positive in comparison to agreed improvement trajectories, although it should be noted that monthly requirements significantly increase from July.

Early Warnings

Paediatric ECS: Attendances have increased in line with seasonal trend and performance has deteriorated. If performance had been in line with previous years overall ECS would be 1-2% better, showing the impact Paediatric attendances are having. Given the national ambition to improve performance for this KPI to 95% by September a Task & Finish group has been established to better understand the drivers and establish additional actions to recover and then improve delivery for this cohort of patients.
RTT Total WL Size: Increasing size of waiting list is an early warning that RTT improvements may not be sustainable. This has been identified nationally as a major concern across all providers. At the end of June our RTT incomplete waiting list was 1,600 greater than plan.
Operational Productivity: The opening of 2 additional endoscopy rooms, additional working days, and the required productivity improvements combine to significantly increase the activity targets for July. Early indications from delivered sessions and upcoming leave suggest this will be a challenge for Day-case and Elective spells, although July will still be an improvement on previous months. The pace of improvement across both Theatres and Outpatients is being monitored via the Trust Recovery programme.

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Year End Summary

Bradford Teaching Hospitals NHS Foundation Trust

Operational Performance Summary

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 most 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 June improved and remained above plan. Due to the ongoing challenges in Audiology for which there isn't a fully funded recovery plan at present the year end position is currently rated as red. Further to the underlying capacity gap within this service and the existing backlog of patients on DM01 reportable pathways there is also a national requirement to increase the number of patients being included which would reduce Trust performance by c.7% when implemented. Exec level conversations are underway regarding the recovery plan for this service.

4-hour Emergency Care Standard (ECS): The average performance required to meet the 2026/27 planning targets is in line with our out-turn position from last year. With increased demand and multi-factor challenges across UEC impacting on these metrics we are escalating both as amber. Our track record with improvement gives confidence that these will recover to plan but there is a risk that estate constraints, staffing challenges, and patient volume/ case complexity require longer term transformative action to resolve.

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.

Whilst not yet flagging as concern it's worth noting that further Industrial Action, and the indirect impact of IA on staff availability (through the owing of time off in lieu) could impact productivity, RTT, and potentially Cancer Wait Times in future months.

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Summaries by overarching objectives

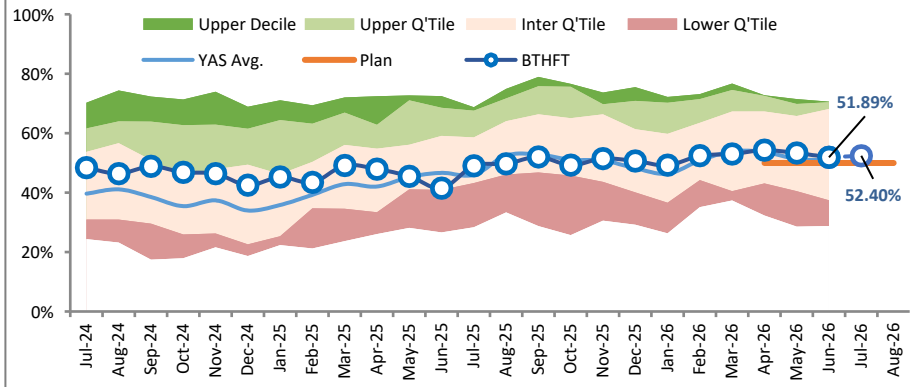
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1. Ambulance Handover Performance

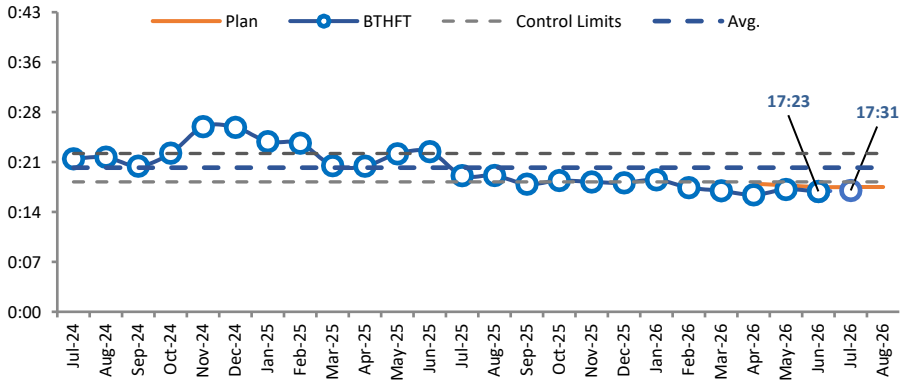
Bradford Teaching Hospitals NHS Foundation Trust

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

		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Avg. Daily Arrivals	-	111	106	108	118	117	120	113	115	113	114	115	113
Avg. Handover Time (MM:SS)	-	19:39	19:40	18:25	18:56	18:44	18:36	19:03	17:55	17:28	16:53	17:39	17:22
Avg. Crew Clear Time (MM:SS)	-	26:28	27:02	26:50	26:36	25:23	24:43	25:00	25:08	26:25	26:42	25:27	26:55
Total Turnaroud Time (MM:SS)	-	45:57	46:34	45:04	45:18	44:07	43:01	43:55	42:53	43:43	43:21	42:57	44:06
% <60 mins	-	98.0%	97.5%	98.5%	99.2%	99.1%	99.0%	99.0%	99.1%	99.2%	99.6%	99.3%	99.4%
% Handover <45 Mins	-	94.4%	93.8%	95.3%	94.9%	94.0%	95.8%	95.2%	96.8%	97.0%	97.9%	96.5%	97.6%
% Turnaround <45 Mins	-	54.2%	52.6%	54.6%	55.1%	56.7%	60.3%	58.2%	60.6%	58.3%	59.4%	60.5%	56.8%

Latest position

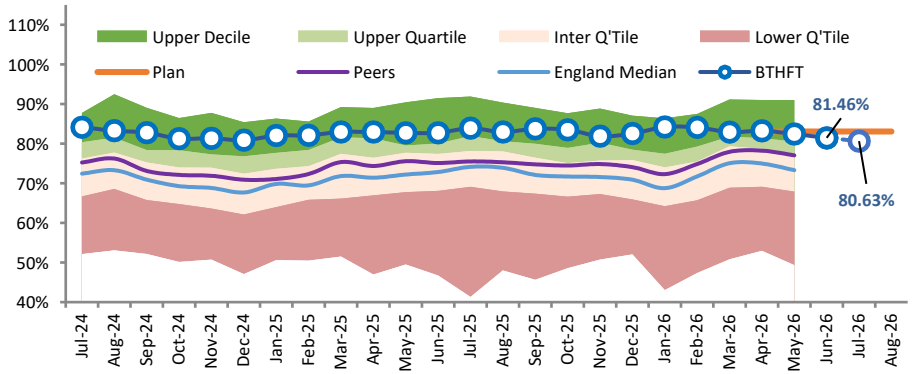
- **15-minute handover** performance fell to 51.9% in June (53.4% May), primarily due to bed waits and bed blocks impacting patient flow. The CSU continues to prioritise escalation of flow and bed capacity issues to improve handover performance.
- Weekday **live validation** (Mon–Fri, 09:00–17:00) continues to improve data quality, with validated delays increasing from 10 in May to 38 in June. Out-of-hours and weekend validation is still not in place. Implement seven-day validation to improve oversight, data accuracy and timely identification of delays.
- The PFC continues proactive engagement with crews to identify and resolve delays regarding **crew clear**. Crews taking breaks on the ambulance ramp continue to obstruct the entrance and create avoidable congestion. The CSU reinforce operational expectations around ramp use while maintaining proactive PFC oversight to reduce crew clear delays.
- Performance reduced to 57% in June (61% May). Although increased crew clear times are a key contributor, YAS remains accountable for **45 mins turnaround** performance. Sustained high ED attendances continue to delay transfers from the handover area despite stable ambulance arrivals.

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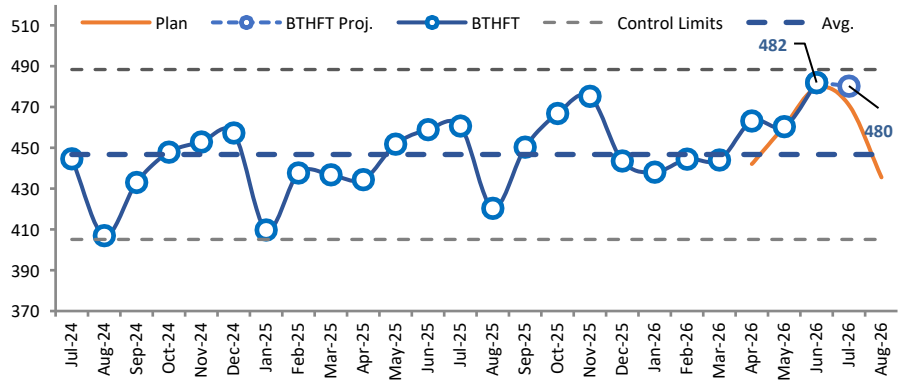
2. Emergency Care Standard (ECS)

Objective: Sustain ECS performance

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



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



2.3 Additional Emergency Department Metrics

		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Type 1 Performance	-	76.2%	74.7%	75.9%	76.1%	74.0%	75.3%	77.0%	77.1%	75.2%	74.9%	73.2%	71.7%
Arrival to Assessment	-	00:17	00:17	00:17	00:21	00:20	00:18	00:18	00:18	00:17	00:15	00:15	00:16
Assessment to Treatment	-	03:07	03:18	02:42	03:04	03:03	02:54	03:00	02:57	03:02	02:56	02:42	02:52
Treatment Length	-	01:50	01:56	01:53	02:35	01:57	01:58	02:03	02:01	01:59	02:01	01:59	01:52
% Patients Streamed	-	47.0%	47.1%	47.0%	46.7%	44.4%	45.5%	50.8%	48.4%	47.0%	46.6%	47.9%	49.1%

Latest position

- Type 1 **ECS performance** has declined from 77% (January) to below 72% (June), with overall ECS reducing from 83.3% (April) to 81.5% (June) and July projected below 81%. Paediatric performance has been affected by validation changes, changing attendance patterns and the current consultant/ SDM model. An ETM review (w/c 20 July) will consider these factors, with recovery actions expected to stabilise performance. Two administrators are being seconded under DDO oversight to standardise breach validation and patient record corrections, improving timeliness, data accuracy and paediatric performance reporting.
- June had record **attendances** (+20 patients/day vs May) across all acuities, increasing operational pressure. UEC Access Meetings will launch in August/September alongside new Power BI dashboards, while Thalam AI will strengthen coding quality and operational intelligence.
- **EXCEL Programme**: Focus remains on improving ED and inpatient pathways, particularly the first 72 hours of care. A Senior Decision Maker-led Rapid Assessment and Treatment (RAT) test of change will commence in July to improve early assessment, reduce ED congestion, improve 4-hour performance and reduce >12-hour stays, supported by ED refurbishment, digital patient communications and a live operational dashboard.

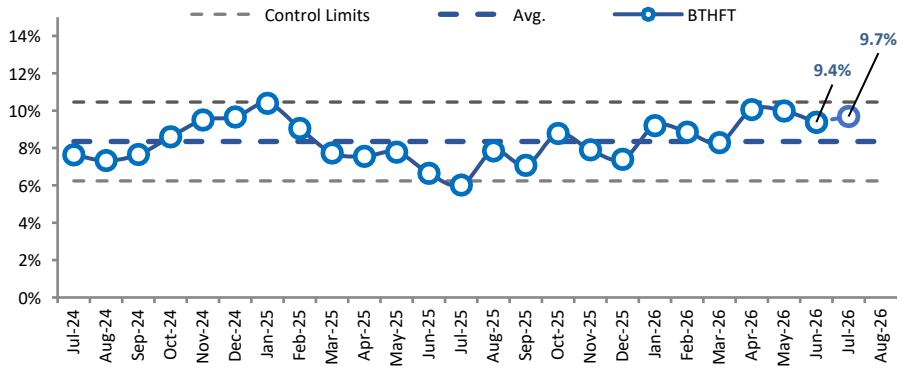
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3. Emergency Department (ED) Length of Stay

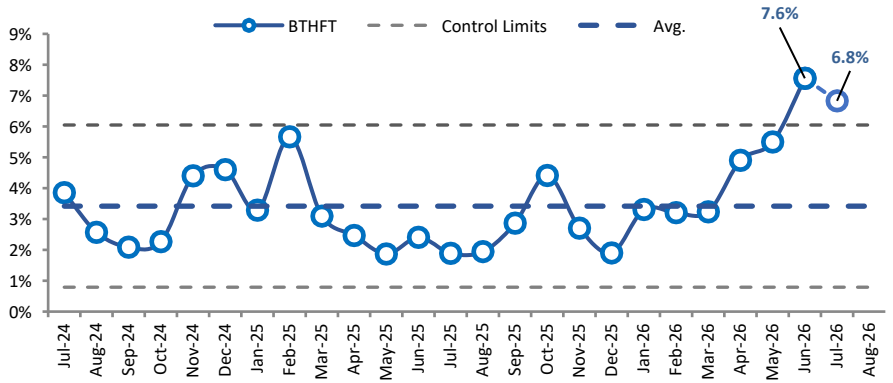
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Objective: Improve Patient Experience in ED

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

		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Avg. # Daily Admissions	-	86	81	88	87	85	84	80	84	85	85	87	86
Avg. Wait DTA to Admit	-	04:30	05:06	05:05	06:21	06:02	05:38	07:02	06:40	05:58	05:47	05:59	06:02
LoS (Admitted P'ts)	-	06:47	07:31	07:14	08:10	08:19	07:30	08:21	08:08	07:42	07:38	07:41	07:59
LoS (Discharged Pts)	-	02:52	02:50	02:56	03:08	03:08	03:03	03:00	02:58	02:56	02:59	02:54	02:50
LoS (Admitted & Discharged Pts)	-	03:40	03:49	03:51	04:09	04:08	03:57	04:03	04:01	03:55	03:54	03:53	03:50
% Patients Admitted	-	20.4%	21.0%	21.3%	20.0%	19.3%	20.4%	19.7%	20.4%	20.8%	19.7%	20.5%	19.3%

Latest position

- **12-hour DTA**: The June Reset Week delivered encouraging improvements, with July performance projected to improve from 7.6% to around 6.8%. Successful interventions are now being incorporated into the EXCEL Programme to support sustained improvement.
- A review of the night-time consultant workforce model will be presented to ETM (20 July), formalising consultants coming off nights. Daytime capacity is not expected to reduce, with locums supporting overnight cover and consultant DCC returning to day/evening activity. The potential return of ED consultants to **SDEC** is also being considered.
- Cause-and-effect relationships affecting performance have been identified through programme analysis by the **EXCEL Programme**, although consistent measurement of these impacts remains under development to better target future improvement work.

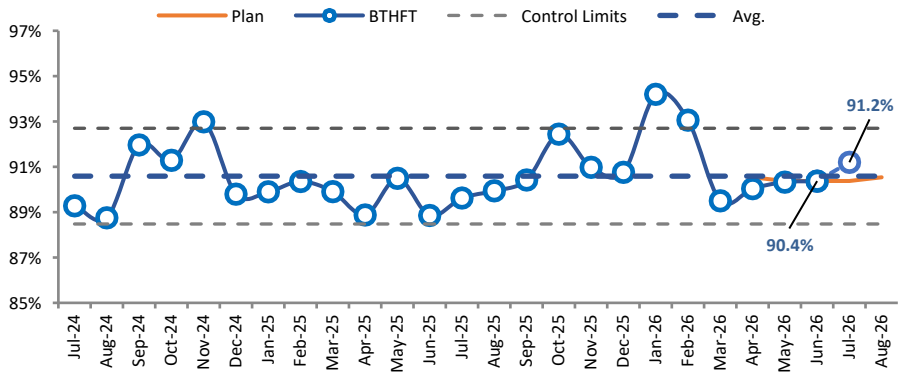
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4. Inpatient Length of Stay (LoS)

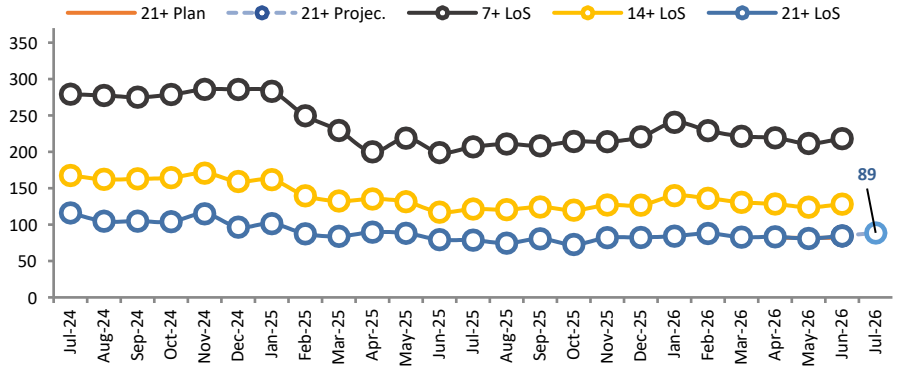
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Objective: Maintain Hospital capacity for daily admissions

4.1 Bed Occupancy



4.2 Patient LoS Profile *(Source: EPR)*



4.3 Additional Inpatient LoS Metrics

		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Avg. Inpatient LoS	-	4.6	4.8	4.6	4.5	4.5	4.8	4.7	5.0	4.8	4.6	4.8	4.8
% Patients Discharged <4PM	-	39.9%	38.7%	40.7%	38.3%	36.8%	42.2%	40.1%	37.9%	39.9%	40.0%	40.3%	42.8%
# NEL Admissions	-	4,348	3,987	4,175	4,378	4,208	4,372	4,197	3,921	4,347	4,083	4,221	4,123
7+ LoS	-	207	211	208	214	214	221	241	229	221	219	212	218
14+ LoS	-	121	121	124	120	127	127	140	136	131	128	124	128
21+ Los	-	79	75	81	73	82	82	84	88	83	83	81	85

Latest position

- **General & Acute**: Although non-elective admissions reduced slightly in June, length of stay increased across all reporting periods. Positively, 42% of patients were discharged before 4pm, supporting earlier patient flow despite sustained pressures.
- **H-FAST** has expanded within the Shipley area through revised referral criteria, enabling hospital Trusted Assessors to complete assessments in patients' homes and improving access for people with a learning disability. The impact is being monitored, with the expectation of increased H-FAST activity as the new model embeds.
- Delays linked to the **Local Authority Bed Bureau and Care Act Choice** continue to affect flow. Inefficient referral processes mean IMC Local Authority beds remain underutilised, requiring renewed senior-level engagement to progress previously agreed improvement actions, while Trust IMC beds continue to provide contingency capacity. Planned changes to six Local Authority unit beds will repurpose them for early packages of care, creating a step-up pathway intended to improve overall discharge flow despite reducing direct hospital access.
- Referrals to **VRI** continue to increase following the closure of overnight assess-to-discharge beds, helping reduce pressure on inpatient services. **OPTICA** has improved visibility of discharge delays and MAIDT coordination, with the next phase focused on embedding its data into ward-level processes to drive further improvements.

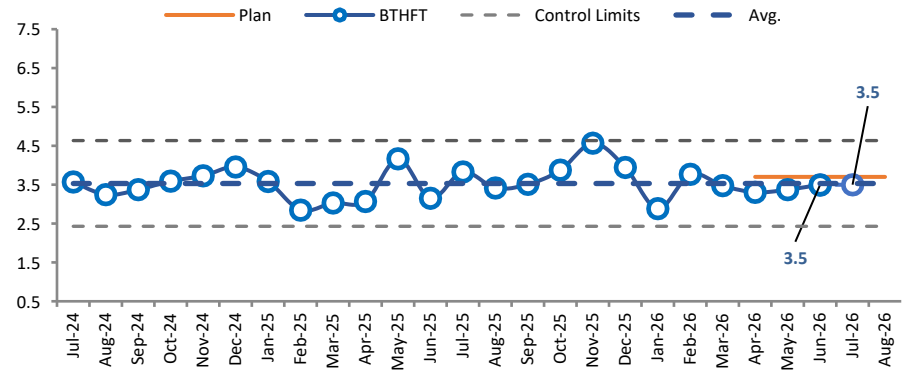
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5. Discharge Processes

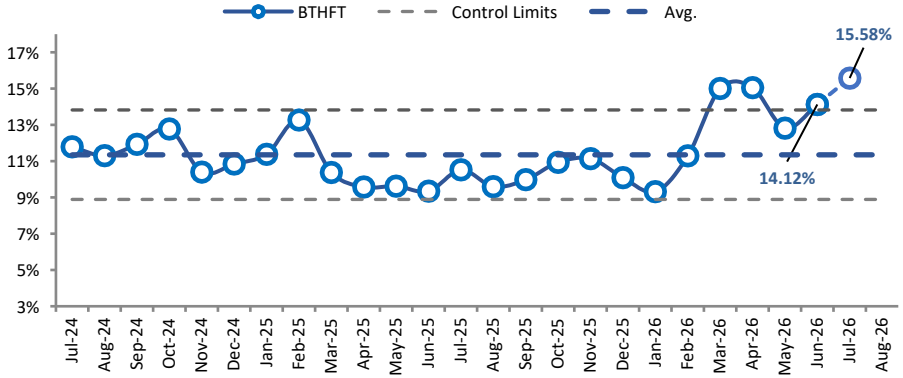
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Objective: Ensure Timely Discharge

5.1 Average Delay Past Discharge Ready Date



5.2 % Patients Not Meeting Criteria to Reside (NCtR)



5.3 Additional Discharge Metrics

		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
% of Pts with Discharge Ready Date	-	93.9%	93.7%	94.9%	95.8%	95.6%	94.9%	95.6%	95.3%	95.5%	95.7%	95.8%	95.7%
% of Pts Discharged on/before DRD	-	80.4%	79.8%	78.4%	79.4%	80.4%	78.5%	78.1%	80.7%	79.0%	80.1%	77.0%	74.9%

Latest position

- **NMCtR** performance increased from 12.8% in May to 14.1% in June, exceeding SPC control limits. Data is being reviewed through OPTICA to determine whether this reflects a genuine performance change or improved recording and richer data capture.
- A **therapy** review identified significant workforce gaps, with current capacity meeting only ~40% of demand overall and ~20% for physiotherapy, even at full establishment. A business case is being developed for submission to ETM.
- **Discharge Ready Date**: A re-audit of the SOP has highlighted the need to strengthen monitoring and ward-level accountability, with the CSU taking forward actions to improve compliance and consistency.

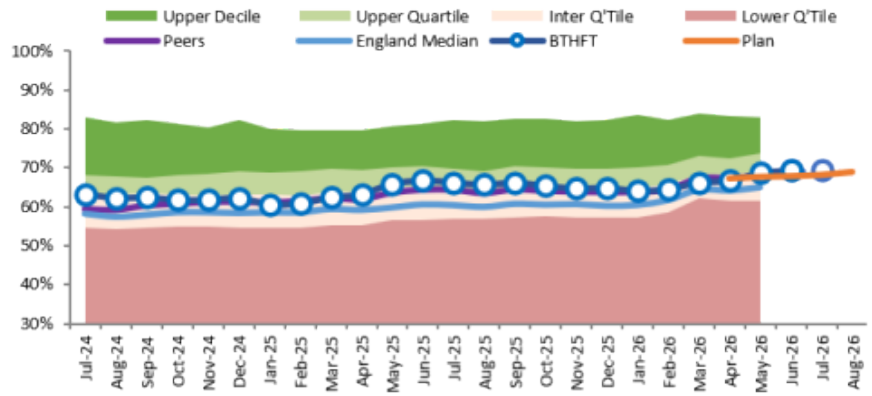
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6. Referral to Treatment (RTT)

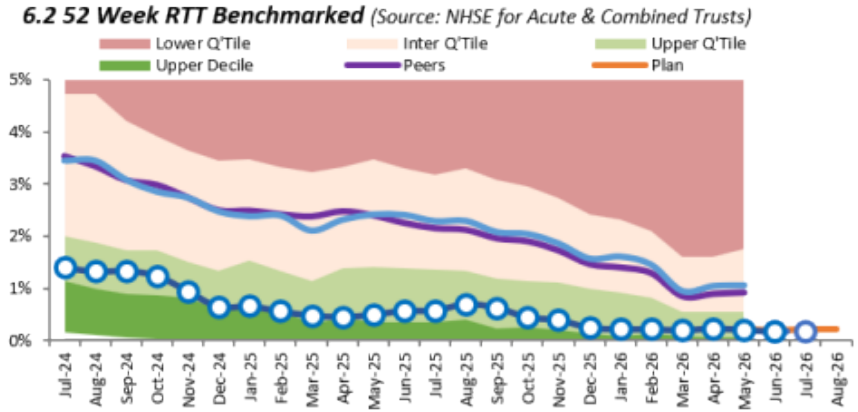
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Objective: Deliver RTT Improvements

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

		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Waiting List Size	-	33,149	33,705	33,406	32,206	31,833	31,932	31,610	31,263	31,444	31,093	31,525	31,606
Waiting List Change	-		+556	-299	-1,200	-373	+99	-322	-347	+181	-351	+432	+81
% New RTT Within 18 Weeks	-	68.9%	67.9%	67.0%	68.1%	67.3%	67.0%	66.7%	67.7%	70.0%	69.7%	72.1%	72.0%
Incomplete (52+)	-	193	238	212	145	127	80	70	69	63	73	65	55

Latest position

- **RTT performance improved** in June to 69.3%. Referral demand has increased the number of waits under 18 weeks and we have seen continued improvements in activity and clock stops over 18 weeks, particularly for admitted Plastic Surgery pathways. The overall waiting list size now needs to reduce to sustain this level of performance.
- **RTT over 52 weeks** waits has reduced in June. Challenges are ongoing in Trauma & Orthopaedics to stabilise the long wait position. No patient was waiting over 65 weeks at month end; the Trust continues to benchmark just below the upper decile for 52-week RTT.
- Despite cancelled industrial action in June, there is escalating operational concern regarding the high volume of TOIL accrued by consultants providing strike cover. Managing this liability presents a growing risk to long-term capacity and future activity delivery.
- Clock stopping activity needs to increase from July to match the improvement trajectory set. Outpatient and Inpatient productivity (described on later slides) is being improved via dedicated programmes of work.

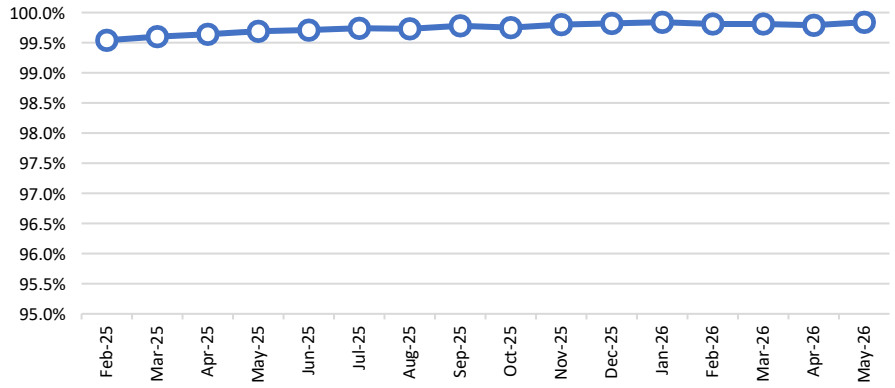
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7. Waiting List Management and Validation

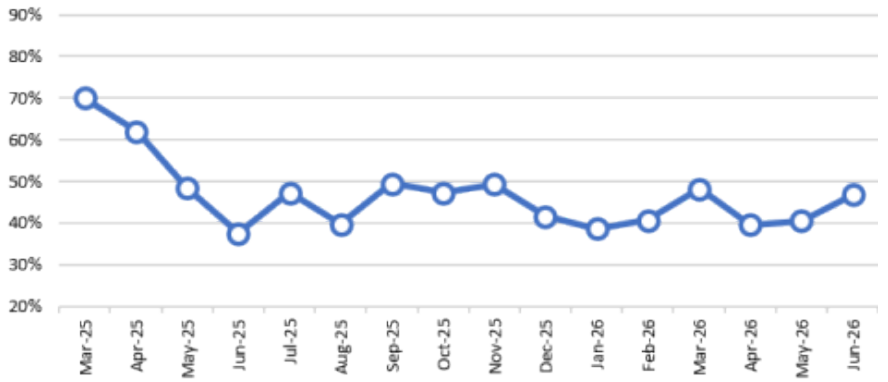
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Objective: Reduce Errors to Improve Wait Times

7.1 RTT Waiting List Confidence Level



7.2 Correction Rate



7.3 Additional WL Management and Validation Metrics

		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
RTT LUNA DQ Metrics	-	590	660	567	647	503	456	425	489	468	533	508	
Correction Rate - Non RTT	-	41.97%	23.36%	14.94%	15.28%	20.20%	23.09%	19.21%	14.80%	26.76%	14.42%	15.48%	27.31%
Non-RTT DQ Process Failures	-	23,825	21,160	20,130	19,644	18,922	18,738	19,088	19,019	19,662	19,127	18,304	18,776

Latest position

- June 2026 data on national Luna dashboard has not yet been published. However previous months trend shows that confidence in the RTT waiting list remains high. 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. This is an extremely positive position and places the Trust amongst the best nationally.
- Validation of patients currently on active monitoring with no activity since being on active monitoring is being conducted.
- The Data Quality Intervention Specialist (DQIS) team is work on DQ prevention with admin teams 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.

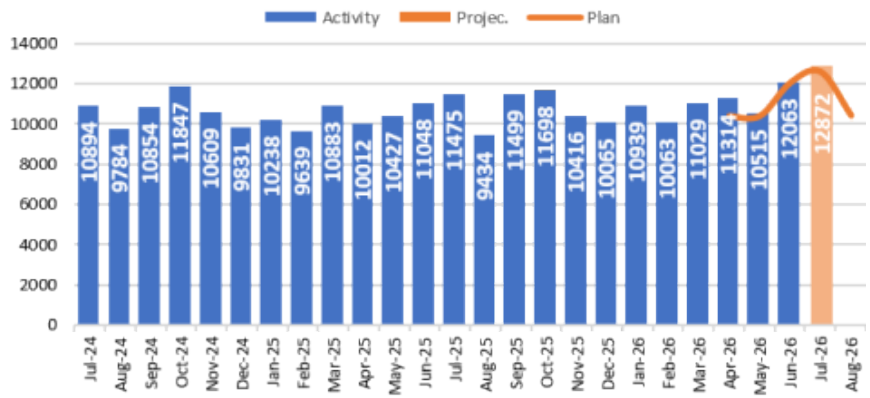
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8. Outpatient Productivity

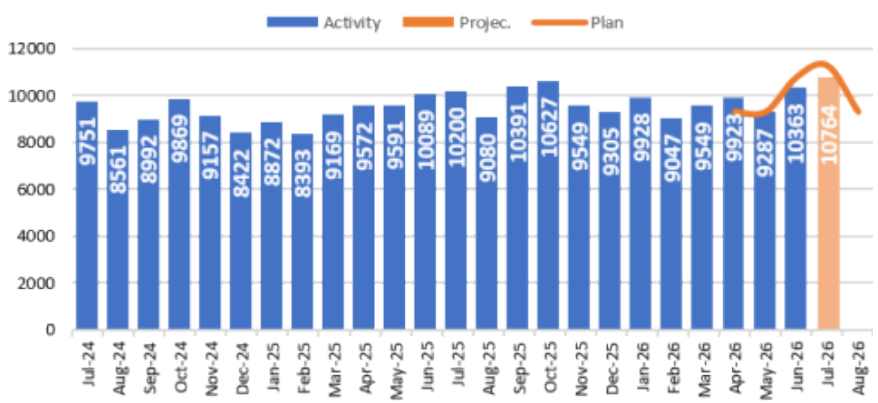
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Objective: Improve Non-Admitted Productivity

8.1 New Outpatient Activity (ERF)



8.2 Outpatient with Procedure (ERF)



8.3 Additional Outpatient Metrics

		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
% of Clock Stops and DTA per OPA		25.59%	24.36%	25.32%	25.26%	24.80%	24.68%	24.87%	25.15%	24.86%	24.80%	24.50%	24.43%
DNA Rate	-	7.46%	7.80%	7.93%	7.56%	8.12%	8.27%	8.17%	7.89%	8.05%	7.79%	8.03%	8.24%
Follow Up Orders	-	29,061	24,072	29,817	30,505	27,810	27,373	29,530	26,835	28,298	28,578	26,446	31,033
PIFU %	-	4.75%	4.52%	4.99%	4.88%	5.85%	4.71%	5.23%	5.78%	5.09%	4.59%	5.23%	5.79%
PIFU % (including Therapies)	-	5.67%	4.88%	5.16%	5.63%	6.50%	5.34%	5.35%	6.29%	5.60%	5.08%	5.76%	6.32%
First to Follow Up Ratio	-	2.69	2.79	2.68	2.73	2.74	2.83	2.80	2.79	2.70	2.68	2.75	2.75

Latest position

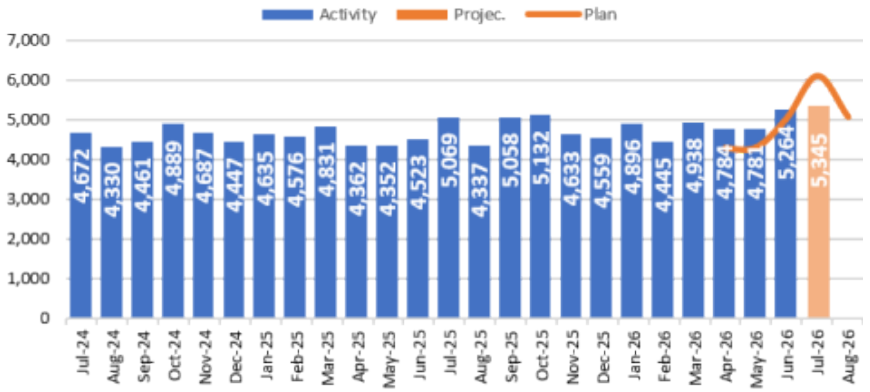
- New outpatient appointments (ERF) achieved plan in June. Operational teams continue to focus on identifying year one productivity objectives, whilst this KPI is being tracked weekly through recovery meetings.
- The straight to A&G process has been rolled out in several areas already with promising 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.
- 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.

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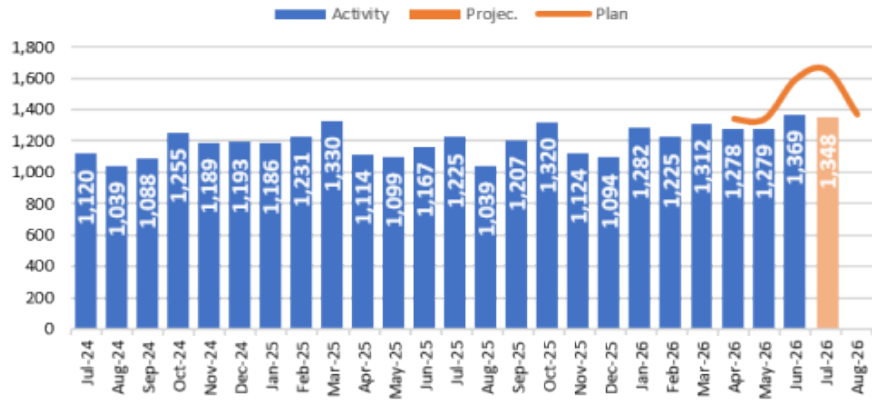
9. Inpatient Productivity

Objective: Increase Elective Ordinary and Day Case Volumes

9.1 Elective Activity



9.2 Elective Activity in Theatres



9.3 Elective Activity

		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Admitted Clock Stops	-	1,275	1,425	1,100	1,315	1,391	1,245	1,226	1,421	1,284	1,449	1,332	1,363
Daycase Rate	-	87.6%	86.6%	88.3%	87.9%	87.7%	88.5%	88.3%	87.9%	89.2%	89.2%	88.5%	88.5%
Number of Lists Run	-	618	549	645	695	585	573	667	621	640	615	589	660
Patients Per List	-	2.0	1.9	1.9	1.9	1.9	1.9	1.9	2.0	2.1	2.1	2.2	2.1
Reportable Cancellations	-	66	45	45	56	44	28	58	57	62	45	36	62
28-day Rebooking Breaches	-	7	13	17	7	4	8	7	2	12	13	9	12

Latest position

- Activity exceeded plan in June although theatre activity remains below plan. The capacity gap from the SLH DCU delay continues to be supported using Medinet weekend lists, with this metric increasing towards plan.
- The **Theatre Improvement Programme** has continued, 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. Early priorities include improved data visibility, theatre workforce establishment, reduction in cancellations through targeted actions and establish and embed a 6-week scheduling process across theatres and pre assessment.
- Significant improvements can be seen in the number of weekly theatre sessions running. 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. Activity targets increase throughout the year based on expected benefits from this work.
- The opening of two additional endoscopy rooms in July will support additional day-case procedures to be undertaken.

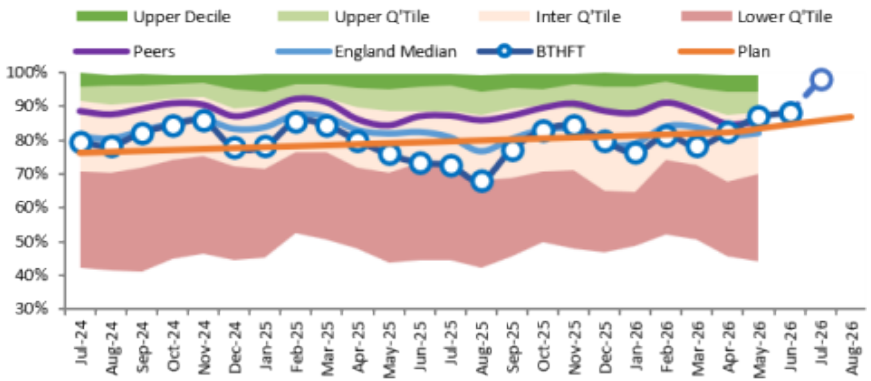
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10. Diagnostic Waiting Times

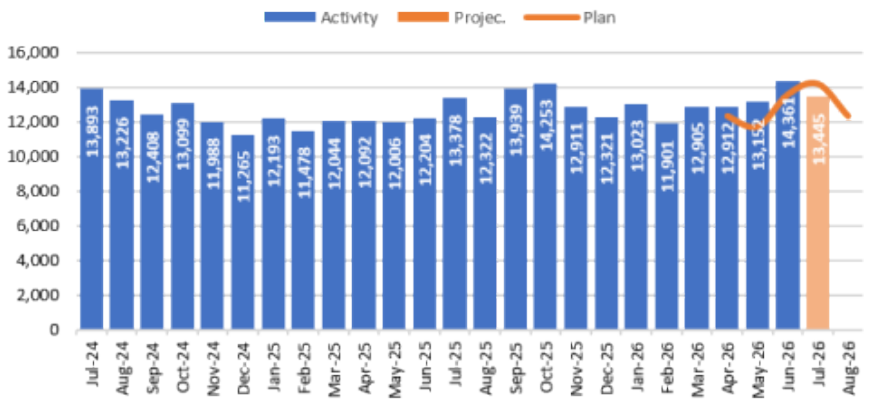
Bradford Teaching Hospitals NHS Foundation Trust

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

		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
(Phys. M'ment) Activity	-	1,872	1,711	1,862	2,035	1,740	1,539	1,734	1,450	1,544	1,692	1,620	1,987
(Phys. M'ment) Performance		59.1%	60.5%	70.2%	70.8%	69.1%	58.3%	55.5%	63.9%	63.1%	61.8%	70.0%	70.0%
(Imaging) Activity	-	9,792	9,174	10,270	10,536	9,577	9,262	9,716	9,145	9,876	9,726	9,965	10,693
(Imaging) Performance	-	76.3%	68.4%	77.7%	85.2%	87.7%	84.5%	80.9%	85.1%	82.1%	90.2%	93.5%	96.7%
(Endoscopy) Activity	-	1,714	1,437	1,807	1,682	1,594	1,520	1,573	1,306	1,485	1,494	1,567	1,681
(Endoscopy) Performance	-	82.7%	82.5%	92.8%	92.4%	92.6%	89.5%	86.7%	90.8%	88.3%	84.0%	89.5%	89.0%

Latest position

- DM01 performance for June remained above plan with significant improvements in Non-obstetric ultrasound and Neurophysiology. Performance for Audiology remains a challenge with likely deterioration, along with Trust performance, once planned patients are included in the submission to align with WYAAT and NHSE. Recovery modelling indicates performance will only recovery if recruitment is approved for full establishment.
- Non-obstetric ultrasound has recovered in Q1. Locums continue to cover maternity leave, and the service have appointed new sonographers who are due to start in the coming months.
- Neurophysiology have recovered in line with plan. The insourcing contract has now ended but the locum will be available to cover annual leave later in the year.
- In Urodynamics, a recovery plan with Medical Physics support remains on track with recovery expected by March 2027.
- The newly opened Endoscopy Unit has now increased to 8 rooms (100%) allowing the service to book 4 weeks out with activity improvements expected from the end of July. Alongside the recent JAG accreditation, this represents a significant milestone in our continued provision of high-quality services.

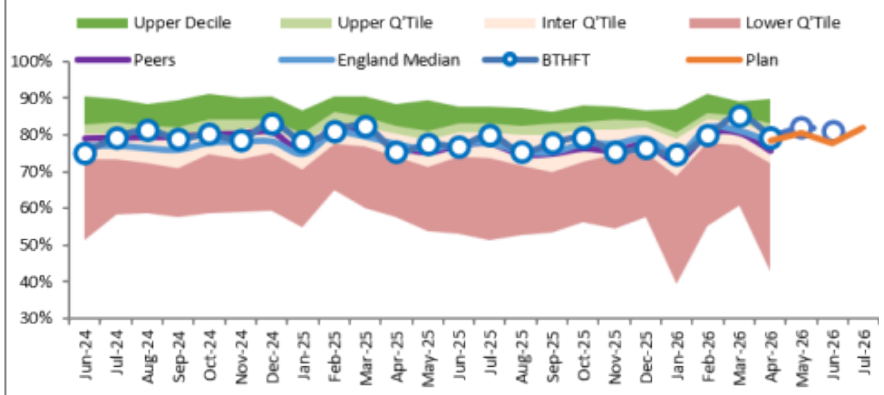
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11. Cancer Diagnostic Phase

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 Plan (Source: PPM)

	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Trust	76.5%	74.6%	80.0%	85.3%	79.5%	82.3%	81.2%
Breast	95.6%	94.6%	97.5%	98.3%	96.0%	97.7%	97.5%
Gynaecology	68.1%	63.2%	81.9%	73.0%	77.2%	79.2%	78.8%
Haematology	50.0%	45.5%	50.0%	61.5%	47.6%	40.0%	19.0%
Head & Neck	83.6%	73.2%	75.3%	85.0%	82.1%	72.0%	72.1%
Lower GI	71.7%	63.7%	75.4%	78.1%	75.4%	83.2%	79.4%
Lung	87.8%	87.5%	85.7%	98.1%	92.6%	92.3%	95.2%
NSS	95.0%	100.0%	93.3%	100.0%	93.3%	90.0%	100.0%
Upper GI	77.9%	84.6%	88.9%	87.3%	81.2%	93.7%	88.4%
Skin	62.1%	58.3%	66.5%	77.4%	64.9%	68.3%	72.5%
Urology	72.0%	71.8%	79.5%	87.2%	75.2%	79.5%	80.5%

11.3 Additional Cancer Diagnostics

		Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
# 2WW Refs	-	2,050	2,067	1,736	2,123	1,976	1,822	1,739	2,000	1,825	2,029	1,858	1,824	2,074
% 2WW Performance	-	83.7%	79.8%	83.8%	94.0%	94.9%	94.8%	95.7%	92.6%	92.9%	84.8%	81.8%	85.5%	
# Total Patients Seen FDS	-	1,917	2,106	1,982	2,080	2,020	1,872	1,742	1,879	1,889	1,798	1,848	1,722	1,823
# Undiag, unbooked >28 days	-	213	349	273	317	358	282	307	275	172	231	245	254	320

Latest position

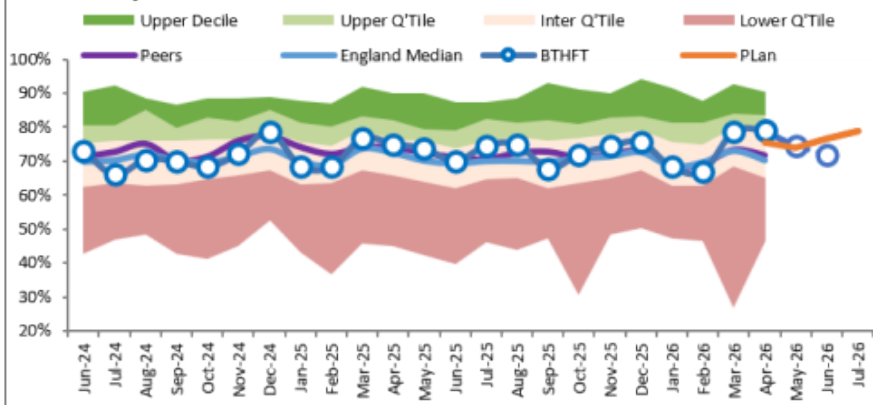
- Overall performance remains above plan. There are some delays in specific pathways and capacity issues are having prolonged impact in some areas due to the challenges in recruiting or securing additional capacity in the current financial climate.
- Haematology performance is currently impacted by delays in informing patients of benign results, driven by a preference for FTF clinic consultations. Management are exploring ways to adopt proven, streamlined communication methods, such as telephone appointments and letter, with clinical support from other specialties.
- OMFS (impacting H&N performance) currently have a consultant vacancy. Unfortunately, there have been no applicants for the substantive post. Without additional support the service will continue to perform below target, options for securing this capacity are being explored with senior operational input.
- The Skin pathway continues to be impacted by capacity backlogs however a second AI clinic is due to start mid July with a specialist doctor joining the service in the next month. The full benefit of **Skin AI** cannot yet be realised due to implementation issues with the referral process. The service are working with the relevant stakeholders in primary care to improve the referral form. Once these issues are resolved the number of biopsies required is expected to reduce which will reduce the burden on histopathology and the overall Skin pathway length.

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)*

	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Trust	75.5%	68.3%	67.3%	78.7%	78.9%	74.3%	71.9%
Breast	84.7%	77.5%	72.1%	93.7%	76.9%	64.0%	69.7%
Gynaecology	60.0%	80.0%	33.3%	93.3%	70.0%	50.0%	52.2%
Haematology	86.7%	82.1%	69.0%	71.4%	92.9%	89.5%	95.5%
Head & Neck	18.8%	61.1%	42.1%	61.5%	87.0%	63.0%	40.7%
Lower GI	42.9%	53.6%	35.0%	65.2%	80.8%	57.9%	48.3%
Lung	42.9%	30.0%	44.8%	48.3%	26.7%	37.1%	46.7%
Upper GI	77.8%	50.0%	85.7%	71.4%	81.5%	100.0%	69.2%
Skin	96.9%	76.9%	84.8%	84.6%	87.5%	87.2%	85.7%
Urology	81.5%	72.4%	76.8%	74.5%	77.6%	83.1%	88.7%

12.3 Additional Cancer Treatment Metrics

		Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
# 31 Day Treatments	-	249	254	232	277	295	260	245	263	243	271	275	259	306
31 Day Performance	-	94.4%	94.1%	95.7%	93.1%	94.9%	93.8%	95.5%	94.3%	97.9%	98.5%	95.3%	98.5%	95.1%
62 Day Backlog	-	53	50	89	87	63	50	70	84	44	47	50	62	49

Latest position

- May performance against the 62 Day standard exceeded plan but is a deterioration on April. June performance is predicted to reduce below plan as the backlog is cleared.
- 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.

Public Trust Board 03-07-2025 09:30

Finance and Performance Committee			
Meeting Date:	17/06/2025	**Agenda Reference:**	FC.6.26.19
Report Title:	Health and Safety Annual report 2025-26		
Presented by:	Caroline Nicholson (Head of Non-Clinical Risk)		
Executive Lead:	David Moss (Director of Estates and Facilities)		
Author:	Caroline Nicholson (Head of Non-Clinical Risk)		

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 the Board of Directors with an overview of the health and safety performance for Bradford Teaching Hospitals NHS Foundation Trust during the 2025/2026 financial year. It details strategic risk management, regulatory compliance, and work stream progress. The detail compliance inline with key health and safety legislation.

Key Achievements

- **Fire Safety:** Achieved 100% completion of fire risk assessments across all designated high-risk areas.
- **Strategic Integration:** Embedded health and safety protocols into core management decisions and corporate Strategic Objectives.
- **The risks for the Trust:** Key risks for the Trust are monitored and gaps are captured.
- **Communication and Relationships:** relationships with enforcement agencies and regional health and safety colleagues remain strong.

Current Challenges & Operational Impacts

- **Financial Restrictions:** Wider NHS and Trust-specific budget limits delayed the execution of several 2025/2026 action items.
- **Carried Forward Actions:** Unresolved objectives from the past year have been formally moved into the 2026/2027 action plan.

Primary Trust Risks

The highest areas of risk for the organisation currently sit within three core domains:

- **Fire Safety** (remediation and infrastructure maintenance)
- **Medical Devices** (compliance, maintenance, and tracking)
- **General Estates Maintenance** (backlog upkeep and facility safety)

The Health and Safety Annual Report is available in the reading room.

Recommendation/s: (including any decision/approval required)

The Finance and Performance Committee is asked to:

- **Approve** the report as an accurate reflection of health and safety performance across the Trust.
- **Formally adopt** this document as the Trust's official Annual Health and Safety Board Report.

Osbourne Sheridan
22/07/2026 09:[illegible]:21

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

Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	The gap analysis and actions within this report helps to inform the risk register and BAF.
Legal/Regulatory:	Health and Safety Executive The Health and Safety at Work etc. Act 1974 (HASWA) The Health and Safety (Consultation with Employees) Regulations 1996
Quality & Patient Safety:	Unsafe hospital environments and practices can have Implications for patient safety.
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	None
Environmental sustainability:	Lack of resources is impacting the maintenance of an aging facility and this can affect health and safety compliance
Assurance Route	
Meeting/s where content has been discussed previously:	Health and safety Committee June Governance route to Finance and Performance

Osbourne.Sheridan
22/07/2026 09:58:21

Report content

1. Purpose

The purpose of the 2025/2026 annual report is to provide the Trust's Board of Directors with an overview of health and safety performance for Bradford Teaching Hospitals NHS Foundation Trust ('The Trust') during the year and to summarise The Trusts key risks to achieving its objectives.
This report provides an assessment of the level of compliance with health and safety legislation and to identify areas which require further attention to improve compliance. This report therefore provides analysis of health and safety performance across the Trust for the year April 2025 to March 2026 by reviewing and assessing:

- The internal structure for the management of health and safety
- The arrangements in place to identify and remove/reduce significant risks.
- How the Trust is performing year on year (both internally and benchmarking with similar organisations)
- Compliance with relevant health and safety legislation
- Consultation with employees
- External stakeholders/influences (e.g. HSE, Estates and Facilities alerts, best practice)

This report is being presented for assurance and approval by the finance and Performance Committee, before it is presented to the Board.

2. Background/context

The report provides details of the work undertaken during the financial year 2025/26 and key areas of consideration for 2026/27. The Health and Safety annual report provides summary information relating to principal activities associated with the management and promotion of Health and Safety issues during 2025/26 in relation to Health and Safety. It also highlights the current key priorities for the Health and Safety team during this current financial year. The report provides a summary of a gap analysis undertaken in relation to key areas of health and safety regulation and legislation and Trust performance. This approach of identifying gaps and risks associated with any health and safety regulations benefits the Trust as it provides a clear picture of health and safety compliance.

The Health and Safety risk profile across the Trust has a clear defined governance structure, including a Health and Safety Committee. The Committee provides the Trust's Board with assurance, through the work of the Finance and Performance Committee.
Whilst the Trust's performance in relation to Health and Safety is generally good, there are opportunities for change and improvement.

3. Assessment

All matters relating to health and safety are essential factors and are integral to all corporate and management decisions, and as such are embedded within the Strategic Objectives of the organisation.

During 2025/26 the Health and Safety Committee have had a challenging year reviewing all areas of health and safety and refocusing what on what is required to move the Trust forward.
The Health and Safety Team have worked closely with the Care Groups and Corporate Departments,
The report highlights any gaps in health and safety that the Trust need to be aware of as well as providing detail of what has moved forwards such control of substances hazardous to health, staff working at height and a more in-depth focus on health surveillance and hand arm vibration and whole body vibration exposure for estates staff.

Osbourne Sterland
07/07/2026 09:55:04

Unfortunately, several of the actions from the 2025/26 action plan have not been completed with the outstanding actions going forward onto 2026/27. Some of these actions are actions that require more than a financial year to implement or they have been impacted by the financial constraints of the Trust and the wider NHS.

The largest risks for the Trust sits within Fire, medical devices and general maintenance and age of the building, which is impacting of electrical safety, ventilation, roof safety and working at height. The impact of financial challenges is evident with the reduction of several of the RAG ratings within the risk profiling. There are several risks such as violence and aggression to staff that are impacting on health a wellbeing of staff.

Improvements have been made with Control of Substances Hazardous to Health (COSHH) with more engagement with the end user. Relationships with enforcement agencies and regional health and safety colleagues remain strong with regular communication.

Maintaining health and safety performance is an organisational challenge due to the resource constraints. There is a requirement to reprioritise resources and it is recognised that this may impact some of the targets and deliverables in this report. The Trust has a good overall health and safety position but the impact of an ageing facility with resource constraints is resulting in increased challenges for maintenance and this will impact safety.

The report details changes in legislation that have taken place during 2025/26 or planned to take place in 2026/27. The Trust has appropriate Health and Safety policies and procedures in place.

4. Options analysis/Proposal

It is proposed that this report is shared with the Board of Directors to provide them with an overview of the Trusts performance for Health and Safety for 2025/26 in line with the Health and Safety at Work Act 1974 and ING417- Leading health and safety at work.

Osbourne Sheridan
22/07/2026 09:58:21

Finance and Performance Committee			
Meeting Date:	17/06/2026	**Agenda Reference:**	FC.6.26.18
Report Title:	Annual Fire Safety Report 2025		
Presented by:	Darren Mitchell, Fire Safety Manager		
Executive Lead:	David Moss, Director of Estates & Facilities		
Author:	Darren Mitchell, Fire Safety 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 **annual assurance of fire safety compliance** with Firecode HTM 05-01 and the Regulatory Reform (Fire Safety) Order 2005.
- The Trust maintains **robust fire safety governance**, including policy, training, fire risk assessments, and an active Fire Safety Group reporting into Health & Safety Committee.

Performance and assurance

- Only **1 fire incident occurred in 2025**, with no injuries and effective response by the Fire Response Team.
- Fire safety training reached **90% compliance (6,587 of 7,351 staff)**, supported by ward-level drills and targeted training programmes.
- 154 fire risk assessment reviews completed, with compliance reported across all areas.

Key risks and challenges

- **Unwanted Fire Signals (UwFS) remain above national thresholds**, driven by accommodation misuse, smoking/vaping, and manual call point activation, creating operational disruption and risk of alarm fatigue.
- External audit identified **significant gaps in estate baseline data**, including outdated fire drawings and absence of derogation schedules, impacting risk management and capital planning.
- **Fire safety infrastructure risks** remain, including fire doors, compartmentation, damper maintenance, emergency lighting compliance, and Penthouse Level 3 escape arrangements.
- **Obstructions on hospital streets and inappropriate use of cooking equipment in offices** present ongoing fire risks.

Improvement activity

- Continued investment in **fire alarm upgrades, compartmentation works, and estate improvements** across sites.
- Establishment of a **Fire Safety Action Plan and Gap Analysis** targeting key high-risk areas including UwFS, estate data, governance alignment, and maintenance compliance.
- Planned alignment to **updated 2026 HTM 05-01 guidance**, including strengthened governance arrangements and clearer fire safety roles.

Osbourne.Sheridan 22/07/2026 09:58:21

	Assurance provided: The report provides **moderate to high assurance** that fire safety risks are being actively managed, with: • Strong governance, policy compliance, and training performance • Minimal fire incidents and effective emergency response • Ongoing investment in estate improvements However, assurance is **tempered by key areas requiring improvement**, particularly: • Reduction of unwanted fire signals • Accuracy of fire safety estate data and drawings • Completion of fire safety infrastructure upgrades • Alignment to updated national guidance (HTM 05-01, 2026)
Recommendation/s: (including any decision/approval required)	*The Finance and Performance Committee is asked to:* • ***Note** the contents of the report* • ***Take assurance** on the Trust's fire safety arrangements* • ***Support** the delivery of the Fire Safety Action Plan and required investment to address identified gaps*
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness
Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	Fire safety remains a **high-risk area on the Estates Risk Register**, including issues relating to UwFS, compartmentation, fire doors, and escape routes.
Legal/Regulatory:	• Compliance with **Fire Safety Order 2005 and NHS Firecode (HTM standards)** • Supports **CQC safety and well-led domain**
Quality & Patient Safety:	Critical to ensuring safe evacuation, reduced fire risk, and protection of patients, staff, and visitors
Equality, Diversity and Inclusion and Health Equity:	No specific adverse impacts identified
Resources:	Ongoing **capital and maintenance investment required** to address infrastructure gaps and maintain compliance
Environmental sustainability:	Limited direct impact; however, some works (e.g. infrastructure upgrades) align with broader estate improvement programmes
Assurance Route	
Meeting/s where content has been discussed previously:	• Fire Safety Group • Health & Safety Committee

Report content
Please see main report

Osbourne Sheehan
22/07/2026 09:58:21

2025

Fire Safety Annual Report



Osbourne Sheridan
22/07/2026 09:58:21

Caroline Heaton

Bradford Teaching Hospitals Foundation Trust

Introduction

It is a statutory requirement for all public bodies to take the necessary precautions to ensure that their premises are safe, suitable and sufficient regarding fire management. Failure to provide adequate fire management can lead to public prosecution, including imprisonment or fines for the Trust's Responsible Person/s, enforcement orders from the fire authority and an increased risk of fire.

The Bradford Teaching Hospitals NHS Foundation Trust has a statutory responsibility to ensure that all the premises owned and/or operated by it comply with current fire safety legislation. The Bradford Teaching Hospitals NHS Foundation Trust must ensure that suitable and sufficient arrangements are in place for the management of fire safety and for the implementation of any necessary improvements relating to increased fire safety measures as required under the Regulatory Reform (Fire Safety) Order 2005 (RRO).

The Chief Executive Officer is responsible for ensuring that, through appropriate delegation of responsibility within the organisation, current fire legislation is met and that, where appropriate, Firecode guidance is implemented in all premises owned or occupied by Bradford Teaching Hospitals NHS Foundation Trust.

An Annual Statement of Fire Safety 2025 has been completed to provide assurance that risks arising from fire are effectively managed in line with the RRO. As the organisation is a Foundation Trust, the requirement to complete an Annual Statement of Fire Safety is not mandatory, however, the Board previously agreed to continue the process as it is considered best practice. Based on assurances given by the Director of Estates & Facilities, the Chief Executive has signed the Annual Statement of Fire Safety for 2025.

Note:
The outcome of this report should be used as the basis on which to formulate the annual statement of fire safety, which is to be retained by the organisation and may be presented to the CQC along with supporting documentation as evidence of performance against Outcome 10 of the "Essential standards of quality and safety".

Osbourne Sheridan
22/07/2026 09:58:21

Executive Summary

This report covers fire safety for period of Jan-Dec 2025. Good management of fire safety is essential to ensure that fires are unlikely to occur; that if they do occur, they are likely to be controlled or contained quickly, effectively and safely; or that, if a fire does occur and grow, everyone in the premises can escape to a place of total safety easily and quickly.

The following summary gives brief details of this Trusts development towards compliance with the mandatory requirements for the NHS in England (considered as best practice for NHS Foundation Trusts).

REQUIREMENT	PROGRESS	R	A	G
Clearly defined fire policy.	Compliant			✔
Board Level Director accountable to the Chief Executive for fire safety.	Compliant			✔
Fire Safety Manager to take the lead on all fire safety activities.	Compliant			✔

Have an effective fire safety management strategy which enables:

REQUIREMENT	PROGRESS	R	A	G
Preparation and upkeep of the organisation's fire safety policy.	Fire Policy was last reviewed in 2025			✔
Adequate means for quickly detecting and raising the alarm in case of fire.	Estates - Compliant			✔
Means for ensuring emergency evacuation procedures are suitable and sufficient for all areas, without reliance on external services.	Fire Safety Dept. - Compliant			✔
Staff to receive fire safety training appropriate to the level of risk and duties they may be required to perform.	ESR training ensures all staff have access to correct fire safety training required for their place of work. Additional training sessions for fire wardens and evacuation aids provided to improve resilience in community premises.			✔
Fire Risk Assessments are carried out and reviewed.	Department Managers and Fire Safety Dept. - Compliant			✔
Fire Drills are carried out in all Departments and Ward.	Department Managers and Fire Safety Dept. - Compliant			✔
Reporting of fires and unwanted fire signals.	Fire Safety Dept. - Compliant			✔

Osbourne Sheridan 22/07/2026 09:58:24

REQUIREMENT	PROGRESS	R	A	G
Partnership initiatives with other bodies and agencies involved in the provision of fire safety.	Compliant			✔

Trust Fire Safety Policy and Procedures

The Bradford Teaching Hospitals NHS Foundation Trust Fire Safety Policy was reviewed in 2025, and due its next review in 2028.

Wards and Departments have individual procedures for respective area kept within their Fire Logbook and mounted in prominent positions in each area. Evacuation drawing and instructions are being developed to improve staff knowledge of their area.

Fire Safety Training

110 fire safety awareness training were delivered in 2025 through the Trust's Mandatory Training programme.

The fire safety training figures presented by Mandatory & Statutory Training (MaST), for December, show there are 7351 total number of staff required to carry out training and 6587 have completed it, giving an overall completion of 90%.

The figures are broken down as follows;

Refresher compliance for Core Training - December 2025	Unplanned Services	Denominator	Planned Services	Denominator	Diagnostics and Corporate Ope	Denominator	Corporate Services	Denominator	Estates & Facilities	Denominator	Research Directorate	Denominator	Trust Total
Fire Safety													
Fire Safety	91%	2140	90%	2175	89%	1414	88%	783	81%	602	96%	257	90%

Table 1: Trust Fire Safety Training Figures As Of December 2025

In addition, fire evacuation training has taken place on all Wards & Departments. Either actual drills or walk through instruction for all available staff.

The Fire Safety Team continues to monitor the effectiveness of fire safety training, liaising with the Education & Training teams to rationalise and improve the uptake of training. One cannot overstate the importance of effective training, both to prevent fires and to react correctly if a fire does occur. Training includes initial induction training, followed at set intervals by mandatory training designed specifically for staff with either patient-contact or no patient-contact. Patient-contact does not necessarily mean clinical: it includes porters, cleaners, housekeepers and any persons who work regularly in a patient area

Osbourne Emerson
22/07/2026 08:58

Fire and Unwanted Fire Signals

During 2025 one major fire incident was reported. This occurred in the Penthouse area. The cause was food left cooking unattended in a microwave; the fire was dealt with by the Fire Response Team and no injuries occurred.

Unwanted Fire Signals (UwFS) are incidents that result in the undesirable activation of fire detection and alarm systems. A significant proportion of UwFS result from working practices that adversely affect automatic fire detection equipment. Typical sources are the use of cooking equipment (toasters, kettles, microwaves, etc.), smoking/vaping, and by contractors working in live areas.

Inappropriately triggered fire signals are a matter of concern and a subject of management focus. They generate and reinforce a reduced 'reaction culture' among those who are repeatedly affected by such fire signals (the "crying wolf" reaction). This significantly increases the overall risk if a fire does break out. They lower public and patient confidence in the Trust's fire safety and fire control systems. They are disruptive to normal working and can be irritating to our patients and staff. They divert manpower and time resources from patient care and creates unnecessary expenditure.

The number of UwFS in 2025 is shown in **Table 2**. Despite the improvements of late, the number remains higher than the requirements of NHS Guidance [Firecode HTM 05-03 Part H].

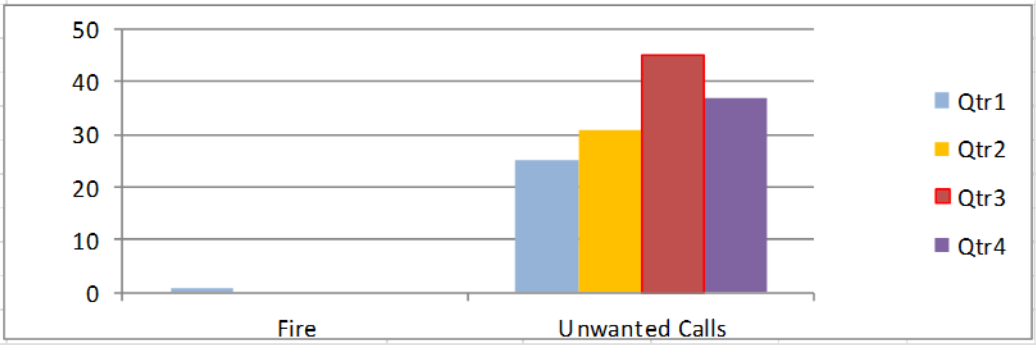
Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
6	6	13	7	15	9	10	24	11	12	13	12

Table 2: UwFS 2025

The causes of the UwFS can be seen in **Table 3.** As stated UwFS numbers remain above HTM 05-03 Part H thresholds. Investigations are carried out on all UwFS and causes are varied. The main reasons are attributed to malicious/accidental use on red manual call point boxes (usually by patients to let themselves out of wards that are secure), illicit smoking or vaping in toilets, and one of the most significant causes is occupants in staff accommodation flats, leaving the appliances unattended and burning food. The flats have been the cause of more than 19 UwFS in last few months. This issue is compounded by residents wedging open doors in their flats allowing smoke to spread throughout the flat, increasing life safety risk.
The Fire Safety Team have on several occasions suggested communal safety talks with the residents, but it has now been decided by Senior Management that the Fire Team compile a safety letter to put through each door as a first step approach. The Fire Team believe this is unsuitable and insufficient. The letter has been produced and passed to Facilities to distribute.

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FIRES & UNWANTED CALLS 2025



Type	Qtr1	Qtr2	Qtr3	Qtr4	Total
Fire	1	0	0	0	1
Unwanted Calls	25	31	45	37	138

FIRE CAUSES

CAUSES	Qtr1	Qtr2	Qtr3	Qtr4	Total
Arson	0	0	0	0	0
Electrical (Mains)	0	0	0	0	0
Electrical (Cooking)	1	0	0	0	1
Smoking Related	0	0	0	0	0
Equipment Failure	0	0	0	0	0
Totals	**1**	**0**	**0**	**0**	**1**

UNWANTED CALL CAUSES

CAUSES	Qtr1	Qtr2	Qtr3	Qtr4	Total
Unknown	1	6	9	4	20
Good Intent	0	1	0	0	1
HPV	0	0	0	0	0
Cooking	4	5	4	12	25
Smoking/Vaping	5	3	6	6	20
Steam/Water Leak	5	6	3	3	17
Aerosol	0	0	3	1	4
Covered/Faulty Detector	0	1	0	2	3
Contractors	2	0	2	1	5
Faulty Electrical Equipment	2	0	4	0	6
Broken Manual Call Point	6	8	12	8	34
System Fault	0	1	2	0	3
Totals	**25**	**31**	**45**	**37**	**138**

INCIDENT OUTCOMES

	Qtr1	Qtr2	Qtr3	Qtr4	Total
No Injury	0	0	0	0	0
Injury	0	0	0	0	0
Fatality	0	0	0	0	0
Disruption to Services	26	31	45	37	139
Damage	0	0	0	0	0
Totals	**26**	**31**	**45**	**37**	**139**

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Table 3: Causes of UwFS 2025

Bradford Teaching Hospitals NHS Foundation Trust have a commitment to reduce UwFS and have a working agreement with West Yorkshire Fire & Rescue Service (WYF&RS) in where, if it can be accurately determined it is a UwFS and there is no fire, no call is put through to WYF&RS. WYF&RS were not called to any UwFS in 2025.

Fire Safety Group Meetings

The Fire Safety Group has continued to meet every three months and the Bradford Teaching Hospitals NHS Foundation Trust's Fire Safety Advisor also presents an updated report at each Resilience Meeting as a standing agenda item. The Fire Safety Group report is presented at the Estates Health & Safety meeting, for progression through to Board.

Fire Risk Assessments (FRA) and Fire Drills

The Bradford Teaching Hospitals NHS Foundation Trust now has in place fire risk assessments for Wards and Departments in all buildings on the Bradford Royal Hospital & St Luke's Hospital sites and we also hold copies of risk assessments for off-site premises. A total of 154 fire risk assessment reviews were undertaken across the Trust in line with HTM 01-03 Part K. The Trust is fully compliant with all fire risk assessments. Reviews are carried out as a rolling programme annually or sooner where significant actions are required to be addressed.

Hospital streets are wide enough to house beds in the event a ward needs to be evacuated. Therefore, blocking this space means patients would need to be moved further (most likely to an adjacent ward) which would increase the time taken to evacuate and thereby increasing the risk of harm. However, considering the issue was reported as longstanding it is recommended that resources be provided to review and resolve any storage issues.

It has been noted the prevalence of cooking equipment being utilised in office areas. These add an unwanted risk of false alarms and potential fires. The fire safety department have been proactive in issuing notices for these items to be removed in all areas whilst conducting fire risk assessment reviews.

Fire Drills are carried out at least once a year on all Wards and Departments and are carried out on a rolling annual programme with assistance from department Fire Wardens. These are recorded on a fire department annual planner and reports are sent to each ward/department so can be added to Fire Safety Logbook (See FRA Schedule 2025, above).

There are several fire safety risks on the Estates Risk Register, these include fire compartmentation, fire doors, fire alarm system, use of extension leads and the use of Penthouse on level 3 Block13 (unsatisfactory secondary means of escape).
See Appendix A for **Estates Fire Safety Action Plan & Gap Analysis**

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Significant changes to Fire Safety Guidance

Health Technical Memorandum (HTM) 05-01 Managing Healthcare Fire Safety was updated in 2026. Some significant amendments are made in the new document and are as follows:

Changes in Legislation
One of the most significant changes since the last edition is the inclusion of the Building Safety Act 2022 as a new piece of primary legislation governing fire and building safety. This Act expands the statutory framework previously limited to the Building Regulations 2010 and the Regulatory Reform (Fire Safety) Order 2005, adding a third foundational legal pillar. It imposes specific duties on those involved in the design and construction of higher-risk buildings, and separate duties on those managing such buildings once they are occupied. It may also require healthcare organisations to appoint new statutory roles such as Accountable Persons and Principal Accountable Persons. Where applicable, the HTM provides references or guidance on incorporating the requirements of the Act into the management of buildings, fire safety and daily operations – particularly during construction and refurbishment – while ensuring the golden thread of safety information is maintained accurately and kept up to date.

Authorising Engineer role
In this revision of HTM 05-01, the responsibilities previously associated with the Authorising Engineer (Fire) are now separated into two defined roles: the Independent Expert Adviser (Authorising Engineer) and the specialist Fire Engineer. The Independent Expert Adviser (Authorising Engineer) role focuses on auditing fire safety management systems. Although previous Firecode guidance has assigned the auditing function to the Authorising Engineer – which required Chartered Engineer status – the nature of auditing does not typically require the engineering competencies defined by the Engineering Council for chartership. In practice, these audits are often conducted by experienced fire safety professionals who are not Chartered Engineers, with input from a chartered individual where necessary. As such (unlike other HTM disciplines such as electrical services, ventilation or medical gases), fire safety auditing is not an engineering task, and the use of the Authorising Engineer title is therefore not considered appropriate. In contrast, where detailed fire engineering solutions are needed – such as in complex building designs or fire strategy work – a specialist Fire Engineer, often chartered or incorporated depending on the complexity and risk profile of the project, is the appropriate source of technical advice.
For both roles, the person should be a member of a relevant professional organisation with an established code of conduct in the healthcare or fire safety sector. Examples include the Institute of Healthcare Engineering and Estate Management (IHEEM), the Institute of Fire Safety Managers (IFSM) or the Institution of Fire Engineers (IFE).
This new structure matches each role to the right set of skills and competencies, making the approach more practical and proportionate. It helps healthcare organisations bring in the right expertise for both oversight and technical advice, improving how fire safety is managed overall.

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The Authorising Engineer title will continue to apply in other HTMs, in line with HTM 00 – ‘Policies and principles of healthcare engineering’, but fire safety is considered an exception due to the distinct separation between audit and engineering functions.

Application and scope of HTM 05-01

This edition provides guidance for all healthcare organisations. Its principles are applicable across the healthcare sector but are most directly relevant to complex healthcare organisations such as acute trusts or mental health trusts, where the guidance should be applied in full.

The 2013 version outlined three levels of fire safety management, indicating which level might be appropriate for each premises type, including Level 3 for small GP practices. This revised edition has omitted Level 3 from its examples and suggests that for smaller, less complex organisations, like GP practices or ambulance trusts, it may not be necessary to adopt every role or process described in full. Instead, organisations should implement the vi

relevant concepts from this guidance at an appropriate scale. Where additional support is required, reference may also be made to alternative guidance such as BS 9997 or the MHCLG’s (2023) ‘A guide for persons with duties under the Regulatory Reform (Fire Safety) Order 2005 (as amended) and the Fire Safety (England) Regulations 2022’. These sources can complement the HTM by providing proportionate approaches to fire safety management in less complex environments. This reflects a more flexible, risk-based approach where the most complex parts of the organisation set the standard, and simpler parts can follow a more proportionate route.

A revised exemplar fire safety management structure diagram replaces the diagram that appeared as Appendix C in the 2013 edition. Informed by the principles in HTM 00, the revised diagram helps to clarify roles, lines of responsibility and reporting relationships, offering more targeted and practical guidance than the diagram in the 2013 edition.

Authorised Person (Fire) roles and new Senior Fire Safety Adviser role

The revised HTM 05-01 formalises and clarifies four distinct designations under the Authorised Person (Fire) role (i.e. the Fire Safety Adviser). These include three specialisms: fire risk assessment, fire training and fire projects – as well as the separate role of Authorised Person (Fire Safety Maintenance). While these functions were touched on in the 2023 revision of HTM 05-03 Part B, their inclusion in HTM 05-01 provides a more structured framework for assigning responsibilities and ensuring appropriate competencies. In complex healthcare organisations, the role of Senior Fire Safety Adviser may also be designated. This is an experienced Fire Safety Adviser with extensive knowledge of healthcare fire safety who typically coordinates a team of Fire Safety Advisers. While holding similar core competencies, the Senior Fire Safety Adviser brings additional expertise and may take on some responsibilities of the Fire Safety Manager. The role exists to provide leadership and oversight within more structured fire safety management arrangements.

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Clarification on Competent Person (Fire)/competent person terminology

Throughout the Firecode suite of guidance, the term “Competent Person (Fire)” is capitalised to distinguish it as a defined role within the NHS fire safety management structure. This role refers to individuals who can provide professional services in

relation to passive and active fire safety systems (such as fire alarm system installations and maintenance).
By contrast, the term “competent person” (lower case) is used in the Regulatory Reform (Fire Safety) Order 2005 (FSO) across several articles, where it refers to individuals nominated to carry out specific fire safety functions:

- Article 13(3)(b) – competent persons nominated to implement firefighting measures.
- Article 15(1)(b) – competent persons nominated to implement evacuation procedures in the event of serious and imminent danger.
- Article 18 – competent persons appointed to assist the responsible person in undertaking preventive and protective fire safety measures (for example, risk assessment, fire safety planning).

In the context of HTM 05-01, the Fire Safety Adviser (Authorised Person (Fire)) is expected to fulfil the Article 18 “competent person” role – supporting the responsible person. Meeting their statutory obligations under the FSO. Other competent person roles (Articles 13 and 15) may be assigned to trained NHS staff or contractors, depending on local fire safety arrangements.
It is important for readers to distinguish between the capitalised “Competent Person (Fire)” as defined in HTM guidance and the statutory “competent person” roles described in the FSO.

Fire Safety Group
This edition replaces the term “Fire Safety Committee” (used in the previous edition) with Fire Safety Group (FSG) and provides more detailed guidance on its role. (This approach is in line with other Health Technical Memoranda (HTMs), which also establish dedicated safety groups such as water, ventilation and medical gas safety groups, as part of their governance structures.) The FSG is now expected to approve fire safety protocols, meet at least quarterly (or more often if needed), and cover a broader range of issues such as unwanted fire signals and capital works. It also introduces the ability to form subgroups for specific tasks and allows external stakeholders, like the local fire and rescue service, to attend meetings.

Changes to fire safety information documentation
This edition sets out a different way of organising fire safety information, replacing the single “fire safety information manual” from the 2013 edition with two separate, clearly defined documents. The original manual – used to communicate local fire safety arrangements – has evolved into the “departmental fire safety file”, which continues to support staff by providing area-specific emergency procedures, risk information and records. In addition to this, this edition introduces “site/building fire information manuals”, containing technical fire safety information required for compliance with Regulation 38 of the Building Regulations and forming part of the golden thread of information. Introduced in response to the Grenfell Tower Inquiry, this emphasises accurate, accountable and accessible safety information throughout a building’s life cycle. It reflects current regulatory requirements and improves clarity, accountability and the practical use of fire safety information across healthcare settings.

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Training
The 2013 edition of HTM 05-01 included a dedicated chapter on training (Chapter 11). In this revision, that chapter has been removed, and all relevant training requirements are now covered in HTM 05-03 Part A – ‘Training’. HTM 05-01

continues to define the requirement for training as part of the fire safety management system, including responsibilities for delivery and arrangements for reporting and audit. Detailed operational guidance, such as training needs analysis (TNA) and fire drills, is now addressed in HTM 05-03 Part A.

Fire safety policy guidance
The “Department of Health fire safety policy”, previously presented as Chapter 2 in the 2013 edition, is no longer included as a standalone chapter in the main text. Instead, this content has been updated, renamed and moved to Appendix A. (At the time of writing, fire safety policy is overseen by NHS England (or its relevant replacement body/ organisation) rather than the Department of Health.) Additionally, revised fire safety policy guidance is also set out in Chapter 5 of this edition (previously Chapter 4 “NHS fire safety policies”), aligning the guidance with current governance arrangements and strategic responsibilities across the NHS.

There are enhanced requitements on the Trust Board to demonstrate meaningful oversight and understanding of fire safety outcomes and escalations, not just procedural compliance like the policy. The Fire Safety Team will ensure any changes needed or any gap analysis for operational and compliance improvements (such as any changes to the Trust policies and protocols to reference the revised HTM, revalidation of FRA’s and strengthened training programmes) are made to make sure the Trust remains compliant with all Fire Safety Regulations.

Fire Service Audits and Enforcement Notices

During this period no buildings were subject to Fire Safety Audits by the Local Authority Fire Service.

Fire Safety Maintenance

An in-year internal Firecode compliance review described several issues relating to regular maintenance, testing, and inspection of the following fire systems:

- Emergency escape lighting. A scheme is proposed to upgrade all emergency lighting to P4.
- Fire door inspection and maintenance. A scheme is underway to refurbish or replace all damaged fire doors, commencing with BRI Hospital Streets 60-minute fire doors.
- Fire damper inspection and testing.
- Heating and ventilation systems.

This leads to Estates not complying with HTM horizontal/linear evacuation requirements, implying:

- Unnecessary designation of fire doors (number of actual fire doors can be reduced affecting costly maintenance).
- Positioning of fire dampers (number of actual dampers and in a lot of cases access to allow maintenance).
- Possible over-spending on upgrades that may not be required.

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Many of these items were being addressed although some actions were required and the Estates Operational Team has responded by reviewing the Planned Preventative Maintenance (PPM) resources, and by prioritising these resources to carry out these works.

Fire Safety External Audit

An External Audit was carried out for the Trust in 2025 by the Trusts Approved Engineer (Fire) from OFR Consultants. Their report presents the findings of an audit of how Bradford Teaching Hospitals NHS Foundation Trust manages the fire safety compliance across the organisation. This was commissioned by the Estates Department and is intended to be presented to the Board Level Director with fire safety responsibility as per HTM05-01.
The audit was broken down into sections that align with the applicable legislative requirements and industry best practice including the relevant Health Technical Memorandum's (HTM's).

This was the first audit commissioned by the Bradford Teaching Hospitals NHS Foundation Trust. It is based on experiences gained through a review of the available documentation, interviews with members of staff who have fire safety responsibilities, as well as more general experience working with the Trust on capital projects and general estate management.

The overriding legislation that governs fire safety in existing buildings, the Fire Safety Order 2005 (FSO) requires employers to take general fire precautions so far as is reasonably practicable, i.e. time, money and manpower should be proportionate to the benefits of risk reduction, rather than stipulating how the employer must meet prescriptive requirements. This requirement forms the benchmark of the audit along with comparison against contemporary standards / industry best practice.
The findings are detailed within their report, but the key points can be summarised as follows:

Positive observations:

- All staff met during the audit process had a positive attitude, were forthcoming with information and it was clear all staff fully acknowledged and understood their roles and responsibilities in relation to fire safety.
- Staff in estates stated they had witnessed an increase in the budget to support their efforts in the delivery of fire safety whilst no concerns were held at senior levels regarding budgetary restraints.
- Positive measures have been implemented recently, and positive signs include high levels of fire safety training attendance, investment in works to improve fire compartmentation, fire doors and dampers, the appointment of an Authorising Engineer for fire safety, no serious fire incidents were reported, and no enforcement actions are in place.

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Areas requiring action:

- The baseline data on the estate was poor, with drawings being out of date, no derogation schedules to inform risk assessments, emergency planning, PPM and capital works.
- Linked to the above, from a preliminary review of drawings, the estate doesn't appear to comply with the linear route set out in HTM guidance with areas appearing to have potentially unnecessary fire doors, fire dampers etc. This presents a significant operational fire risk. This is compounded due to underspend in maintenance and lack of capital investment. Whilst works are in progress to upgrade the estate, in places this may lead to funds being poorly deployed, e.g. the replacement of fire doors that are not required to be fire resisting. Where drawings are outdated or incomplete impacts elements such as
    - Fire risk assessments
    - Emergency planning
    - Compartmentation integrity
    - PPM accuracy
    - Capital Planning
    - Evacuation drills and training
    - No derogation schedules available to support risk-based decision making.

This undermines our ability to plan and prioritise risk and comply effectively.
The estate visually appeared in a tired condition, as exemplified by fire doors on the wards which were noted as being in poor condition. The issues were also noted in the fire risk assessments. It is positive to hear however, that works are planned, but it is also recommended that a review be conducted of how the estate has potentially degraded so that operational measures can be implemented to prevent the same happening in the future. This is reflected in the Authorised Engineer audit that states "funds may be poorly deployed".

Capital Refurbishments and Fire Safety Works completed in 2025

Gamma Camera

Total reconfiguration of spaces to accommodate the replacement of a Gamma Camera in a compliant room and the supporting equipment room.

OMS

Refurbishment of 4no distinct areas across the maternity block and a new extension.

X-Ray Room 5

Complete refurbishment of the X-Ray Room 5 including the machine.

Snowdrop Suite

Refurbishment of rooms to support families who have lost loved one.

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Haemobanks Blood Fridges
Introduction of blood fridges to 5no different locations. Works included strengthening of floors, introduction of power and data.

Emergency Department Amber Zone

DCU at SLH
A new two theatre Day Case Unit.

LED Lighting
Replacement of lighting with new LED (energy efficient) on the SLH site.

Fieldhouse courtyard
Redesign and develop unused area for staff including access for all.

R&D Centre - Kitchen
Installed new kitchen in a challenging area including substantial associated works.

Fire Alarm Infrastructure Upgrades
Completed the fire alarm upgrades to individual blocks at BRI. Wider programme is ongoing to all satellite buildings, and then to bring hospital up to L1 fire alarm standard by installing further cabling and detection.

Fire Compartmentation
Completed the fire compartmentation works to individual blocks at BRI. Wider programme is ongoing including replacement or refurbishment of fire doors, where deemed required.

Lift Replacement
Replacement of Lift 1 & 2 Horton Wing replacement at SLH.

Recommendations

Although further improvements have been carried out to fire safety, i.e. the replacement of existing fire alarm systems, some aspects of fire safety still require attention. Fire safety drawings urgently require attention, once completed this will give a baseline for all other active and passive fire protection measures to be addressed. These include fire compartmentation, fire door upgrade, emergency lighting replacement etc.

UwFS numbers remain above HTM 05-03 Part H thresholds, although all instances are investigated it is difficult to actively resolve the majority of causes. Attention needs to be highlighted around those that cannot be resolved i.e. smoking/vaping, using manual call points and cooking etc.

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As highlighted in this report beds and equipment being stored on hospital street are becoming more of a problem, it is recommended that resources be provided to review and resolve any storage issues in an attempt to keep corridors clear of obstructions.

The Bradford Teaching Hospitals NHS Foundation Trust Board is asked to:

- Note the contents of this report and acknowledge the work being undertaken to deliver a robust system of the fire safety management across the Trust.

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Appendix A – Estates Fire Safety Action Plan & Gap Analysis

Top risks at a glance (RAG)

#	Gap (what the report shows)	RAG	Timeframe suggestion
1	**Unwanted fire signals (UwFS) above HTM 05-03 Part H thresholds** (138 incidents in 2025; multiple causal factors incl. staff accommodation and MCP misuse)	Elevated life-safety risk due to alarm fatigue; operational disruption	**Red**
2	**Out-of-date/as-built fire drawings; no derogation schedules**; "baseline data on the estate was poor" per external audit	Undermines FRAs, PPM accuracy, capital planning, evacuation planning; potential mis-spend	**Red**
3	**Governance & roles not yet aligned to 2026 HTM 05-01** (e.g., "Authorising Engineer (Fire)" still referenced; new split into *Independent Expert Adviser* and *Fire Engineer* not evidenced as implemented)	Role clarity & competence are explicit expectations in the revised HTM; audit/assurance gap	**Amber/Red**
4	**Means of escape defects**: "Penthouse L3 Block 13 – unsatisfactory secondary means of escape	Direct life-safety non-conformance	**Red**
5	**Maintenance/testing gaps** (emergency lighting upgrade to P4 outstanding; fire door condition/PPM; fire damper inspection/testing; HVAC interfaces)	Compromises horizontal/linear evacuation strategy and compartmentation reliance	**Red**

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#	Gap (what the report shows)	RAG	Timeframe suggestion
6	**Hospital street obstructions (beds/equipment)** and cooking appliances in offices	Obstructed egress and raised ignition/smoke risk	**Amber/Red**
7	**Policy & procedures**: Policy reviewed in 2025 and next due 2028; report acknowledges 2026 HTM 05-01 changes requiring updates (training, role definitions, documentation structure) but not yet enacted	Policy misalignment with current HTM weakens assurance	**Amber**
8	**Data integrity inconsistencies**: e.g., "Trust is fully compliant with all fire risk assessments" vs. audit stating drawings out of date, and a typo citing *HTM 01-03 Part K* for FRA reviews (likely 05-03)	Undercuts Board confidence in controls and audit trail	**Amber**

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Detailed gap register with evidence and actions

1) Unwanted Fire Signals (UwFS) exceed HTM thresholds
Evidence: Monthly UwFS total 138 in 2025; causes include malicious/accidental MCP use, illicit smoking/vaping, and frequent incidents in staff accommodation (doors wedged, cooking left unattended). Management letter drop chosen, though Fire Team considers it insufficient; WYFRS not mobilised for UwFS by local agreement.
Compliance impact: HTM 05-03 Part H targets continued reduction of UwFS and prescribes a structured reduction plan; high volumes create *alarm fatigue* and increased life risk.
Actions:

- Implement a **tiered UwFS reduction plan**: (a) risk-based MCP covers or delay in vulnerable areas (with staff training); (b) **staff accommodation**: in-person briefings + tenancy conditions update, heat-detector substitution where appropriate, door closer checks, and zero-tolerance on wedging with enforcement; (c) contractor hot-work permitting and shadowing in live areas; (d) smoke-free enforcement in toilets with targeted detection strategies.
- **Metrics to Board:** UwFS/100 beds/month and per building, with Pareto of causes; trajectory target (e.g., –40% in 9 months).
- Consider **alarm filtering** rules review jointly with WYFRS to ensure patient safety isn't compromised by call challenge.

2) Fire strategy information: out-of-date drawings; no derogation register
Evidence: External audit found poor baseline data, outdated/incomplete drawings, and absence of derogation schedules; warns risk of **unnecessary** fire doors/dampers; this compromises FRAs, PPM, capital planning and evacuation planning, with risk of **mis-spend**.
Compliance impact: HTM 05-01 (2026) requires accurate, accessible **site/building fire information manuals** forming the "golden thread," plus clear derogation governance. Report itself flags the need to "urgently" address fire safety drawings.
Actions:

- Commission a **Trust-wide fire strategy refresh**: compartmentation plans, hospital street strategy, progressive horizontal evacuation sectors, door & damper *need* review.
- Create a **Derogation Register** with risk rationale, interim measures, and approval route via Fire Safety Group (FSG).
- Establish **document control** (CDE) for fire information (as-built, O&M, Reg 38 packs), linked to capital and PPM.

3) Roles & governance alignment with HTM 05-01 (2026)
Evidence: Report describes the new split between the **Independent Expert Adviser (Authorising Engineer)** and **Fire Engineer**, plus clarified AP(Fire) specialisms and potential **Senior Fire Safety Adviser** role, but your governance still references the old "Authorising Engineer (Fire)" and doesn't confirm redesignation or appointment against the new framework.
Compliance impact: Governance/competence is explicitly strengthened in the 2026 HTM; lack of

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alignment is an assurance gap.

Actions:

- Update **role descriptions** and letters of appointment; appoint/designate Independent Expert Adviser and Fire Engineer; define AP(Fire) specialisms (FRA, training, projects, maintenance) and, if needed, **Senior FSA**.
- Update **Terms of Reference** for the **Fire Safety Group** (meeting at least quarterly; authority to approve protocols and form sub-groups — both reflected in practice per your report).

4) Means of escape – Penthouse L3 Block 13
Evidence: Estates Risk Register includes "unsatisfactory secondary means of escape."
Compliance impact: Direct life-safety non-compliance if secondary MOE doesn't meet strategy.
Actions:

- Immediate **interim controls** (occupancy limits, fire watch, local detection, remove ignition sources).
- **Permanent remedy** with design sign-off by Fire Engineer and acceptance by FSG.

5) Asset maintenance/testing gaps (lighting, doors, dampers, HVAC)
Evidence: Internal Firecode review lists issues with **emergency lighting** (upgrade to P4 proposed), **fire door** inspection/maintenance backlog (ward doors "in poor condition"), **fire damper** inspection/testing, and **HVAC** interfaces; it notes this leads to **non-compliance with horizontal/linear evacuation requirements**, and possible **overspending** on upgrades not required.
Compliance impact: Compartmentation and wayfinding lighting are critical for progressive horizontal evacuation; testing regimes are mandated through HTM 05-03 operational parts and linked standards.
Actions:

- Run a **risk-based PPM blitz** focused on life-safety assets (P4 testing, door remedials, damper access/testing).
- Use refreshed drawings (Action 2) to **rationalise** which doors/dampers are *actually* required, cutting avoidable lifecycle cost.
- Report monthly **PPM compliance** (critical vs non-critical) to FSG/Board.

6) Hospital street obstructions & cooking in office areas
Evidence: Hospital streets used for bed/equipment storage; cooking devices common in offices; notices being issued to remove items.
Compliance impact: Obstructed escape routes lengthen evacuation time; office cooking increases UwFS and ignition risks.
Actions:

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- **Zero-tolerance** clearance standard for hospital streets; partner with Ops to provide alternative decant/storage; weekly audits with photo-evidence.
- **Acceptable use policy** for electrical/cooking appliances, with enforcement and PAT/admin controls.

7) Policies & procedures not yet updated to the 2026 HTM structure
Evidence: Fire Policy reviewed 2025, next due 2028; report states new 2026 HTM requires changes (policy references, retriage of FRAs, training programme strengthening, documentation split into *departmental fire safety files* and *site/building fire information manuals*).
Compliance impact: Policy misalignment with current HTM weakens audit defensibility.
Actions:

- **Bring forward** policy review to align wording, roles, document sets, reporting, and FSG remit; issue **implementation note** to all directorates.

8) Data integrity, assurance & editorial issues
Evidence: (a) Statement "Trust is fully compliant with all fire risk assessments" conflicts with audit findings on drawings baseline; (b) FRA reviews cited as "HTM **01**-03 Part K" (likely meant **05**-03), risking confusion in external assurance; (c) governance section lists committees but leaves approval dates blank.
Compliance impact: Weakens traceability and governance evidence.
Actions:

- Correct **citations** and reconcile narrative (clarify that all *areas* have FRAs, but actions remain open pending updated strategy/drawings).
- Populate **approval dates** and store Board/Committee papers in the evidence pack.

9) Training & drill coverage – largely positive, but clarify scope
Evidence: 110 awareness sessions delivered; 90% completion (6,587/7,351); drills at least annually across wards/departments.
Potential gap: HTM 05-03 Part A expects training tailored to risk and roles; ensure **AP(Fire) specialism – Training** oversight, and drill records align to revised sectorisation once strategy/drawings are updated.
Actions:

- Add **role-specific competencies** tracking (porters/theatres/ICU/night staff).
- After strategy refresh, **re-validate drill routes** and record timings/lessons learned.

10) Fire Service engagement & audits
Evidence: WYFRS not called to UwFS in 2025 by agreement; no Fire Service audits occurred during the period.
Potential gap: While call-challenge is legitimate, consider periodic **joint reviews** of high-risk areas and a proactive **engagement note** to WYFRS on strategy refresh outcomes.
Actions:

- Invite WYFRS to **FSG (by exception)** when UwFS spikes or major changes land; maintain minutes as assurance.

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90-day action plan (pragmatic and sequenced)

1. **Stabilise immediate life-safety** (Weeks 1–4)
    - Penthouse L3 interim controls; remove hospital street obstructions; quick wins on accommodation (door closers, MCP covers).
    - PPM blitz on emergency lighting (critical areas), ward fire doors, highest-risk dampers.
2. **Fix the foundation (Weeks 2–12)**
    - Commission and mobilise the **fire strategy refresh** and production of **as-is drawings**; stand up the **Derogation Register**; establish CDE for fire info.
    - **Update policy & roles** to HTM 05-01 (2026): redesignate AE to Independent Expert Adviser; appoint Fire Engineer; define AP(Fire) specialisms and (if needed) Senior FSA; refresh FSG ToR.
3. **Drive UwFS down (Weeks 1–12)**
    - Execute targeted **UwFS reduction programme** for top three causes (accommodation, MCP misuse, smoking/vaping), with monthly Pareto reporting to Ops and FSG.
4. **Tidy the assurance story (Weeks 1–8)**
    - Correct **report citations**, reconcile FRA compliance statements, populate committee approval dates, and compile an **evidence pack** for CQC/Board.

Items to highlight to the Board

- **We are improving** (training coverage 90%; major alarm & compartmentation upgrades underway; positive external feedback on culture).
- **But:** UwFS remains high; parts of the estate and asset records are **not fit-for-purpose**, creating risk of both **life-safety** and **mis-investment** (unnecessary doors/dampers).
- **Immediate fixes in hand** (PPM blitz, obstructions cleared, accommodation enforcement) while we **reset the foundation** (drawings, derogations, policy & roles aligned to 2026 HTM 05-01).
- **Measured outcomes** in next 6–9 months: ≥40% UwFS reduction, complete suite of fire strategy drawings & manuals, PPM compliance back above target, and clear closure path for the Penthouse MOE issue.

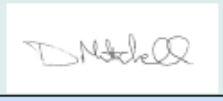
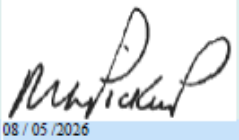
Osbourne.Sheridan
22/07/2026 09:58:21

Appendix B – Annual Statement of Fire Safety for 2025

Osbourne Sheridan
22/07/2026 09:58:21

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Annual Statement of Fire Safety 2025

NHS Organisation: Bradford Teaching Hospitals NHS Foundation Trust		
I confirm that for the period 1 January 2025 to 31 December 2025, all premises which Bradford Teaching Hospitals NHS Foundation Trust owns, occupies or manages have had fire risk assessments undertaken in compliance with the Regulatory Reform (Fire Safety) Order 2005, and (please tick the appropriate boxes):		
1	There are no significant risks arising from the fire risk assessments.	✓
2	Bradford Teaching Hospitals NHS Foundation Trust has developed a programme of work to eliminate or reduce to a reasonably practicable level the significant risks identified by the risk assessment.	✓
3	Bradford Teaching Hospitals NHS Foundation Trust has identified significant risks and does have a programme of work to mitigate those significant risks in the backlog maintenance programme.	✓
	Where a programme to mitigate significant risks has not been developed, please insert the date by which such a programme will be available, taking account of the degree of risk.	✓
4	During the period covered by this statement, Bradford Teaching Hospitals NHS Foundation Trust has not been subject to any enforcement action by the fire and rescue authority. Please outline details of enforcement action in Annex A Part 1.	✓
5	Bradford Teaching Hospitals NHS Foundation Trust has not got any ongoing enforcement action pre-dating this Statement. Please outline details of ongoing enforcement action in Annex A Part 2.	✓
6	Bradford Teaching Hospitals NHS Foundation Trust achieves compliance with the Department of Health's fire safety policy by the application of Firecode or some other suitable method.	✓
Chief Executive Officer:	Mel Pickup	
Director of Estates & Facilities	David Moss 	
Fire Safety Manager:	Darren Mitchell 	
Contact details:	E-mail:darren.mitchell@bthft.nhs.uk Telephone:01274 364229 Mobile: 07973 375892	
Signature of Chief Executive		
Date:	08 / 05 /2026	
Completed statement to be retained for future audit.		

Osbourne Sheridan
22/07/2026 09:58:21

Bradford Teaching Hospitals
NHS Foundation Trust

ANNEX A

Part 1 – Outline any enforcement action taken during the past 12 months and the action taken or intended by the organisation. Include, where possible, an indication of the cost to comply.

None

Part 2 – Outline any enforcement action ongoing or unresolved from previous years including the original date, and the action the organisation has taken so far. Include any proposed action needed. Include an indication of the cost incurred so far and, where possible, an indication of costs to fully comply.

None

Osbourne Sheridan
22/07/2026 09:58:21

Osbourne Sheridan
22/07/2026 09:58:21

Finance and Performance Committee			
Meeting Date:	22 July 2026	**Agenda Reference:**	FC.7.26.14
Report Title:	Anchor Institution		
Presented by:	Mark Hindmarsh, Director of Strategy and Integration		
Executive Lead:	Mark Hindmarsh, Director of Strategy and Integration		
Author:	Molly Corner, Policy Manager		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐

Summary of Key Issues/Highlights:

This paper is to provide an update to the Finance and Performance Committee on the Trust's work as an Anchor Institution.

Social impact is increasingly prominent in plans across Government and is included in CQC's well led assessment framework. Contractually, the Trust is obliged to deliver a programme of social value work to meet the requirements of the NHS contract, and the NHS England Board Assessment Framework makes reference to the requirement for Trust Boards to act as an anchor organisation in several domains. The 10-year plan for health also includes a requirement for provider organisations to increase their work on social impact and social mobility, particularly as services move out of hospitals and into the community.

The Committee was last updated on this work in November 2025. Since then we have:

- Identified 4 clear priorities for 2026:
  - Maximising the opportunities presented through Health on the High Street
  - Connecting with the University of Bradford and developing joint work, especially around education and training for those out of work.
  - Exploring links with the Green Champions
  - Supporting requests for work experience

- Held internal and external workshops with partners to explore joint working opportunities, and discussed the idea of a Bradford Anchors Network with Bradford Council

- Implemented our Anchor Institution Action Plan, which has included:
  - Promotion of healthcare careers in a range of settings through our Widening Participation programme
  - Developing the Thrive Management Essentials Programme, working with SMEs to support career development for managers
  - Started to develop health equity dashboards for CSUs which will allow for better planning to meet the needs of the population we serve
  - Continued to deliver our sustainability programme to reduce our carbon footprint
  - Opened our library to members of the public for improved internet access and support in job applications across the NHS

Osbourne.Sheridan 22/07/2026 09:58:21

Recommendation/s: (including any decision/approval required)	The Finance and Performance Committee is asked to: 1. **Note** the content of the paper
Link to Strategic Objective:	Partnership - To collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals
Link to Priority Initiatives 2025/26:	Health Equity and Health Inequalities
Implications	
Risk:	This work relates to the Strategic Risk SR07 as set out in the Board Assurance Framework: **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.
Legal/Regulatory:	Social Impact is part of the CQC's well-led assessment framework. There are also contractual requirements in the standard NHS contract about social value.
Quality & Patient Safety:	There are no implications for quality and patient safety
Equality, Diversity and Inclusion and Health Equity:	Health Equity is one of the domains in the Joseph Rowntree Foundation Self-Assessment Framework we have used and so informs the action plan.
Resources:	There is no impact on resources
Environmental sustainability:	This work is closely linked to the Trust's Green Plan, and environmental sustainability is one of the sections of the action plan as well as being part of the Joseph Rowntree Foundation Self-Assessment Framework.
Assurance Route	
Meeting/s where content has been discussed previously:	n/a

Report content

1. Purpose

This paper provides the 6-month update to the Finance and Performance Committee on progress on BTHFT's role as an anchor institution. A paper on this topic was last presented to the Committee in November 2025.

2. Background/context

Anchor institutions are large, typically non-profit or public sector organizations that are "rooted in place" and unlikely to relocate because their long-term sustainability is tied to the wellbeing of the local populations they serve. Examples include hospitals, universities, local authorities, and housing associations. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use.

Through this definition, the Trust is an anchor institution for Bradford. Increasingly the Government is asking anchor institutions, to do more to influence the socioeconomic development of their local communities in line with their ambitions around social mobility – akin to the Corporate Social Responsibility duty for private sector organisations.

Jo Bowers-Sheehan
02/02/2026 09:59:41

It is included in the 10-year Plan for Health as something providers should do 'more' of, and it is part of CQC's well-led framework as well as being a contractual obligation via the NHS Standard Contract.

The paper presented to the Committee in 2025 outlined the findings from the Trust's self-assessment of how well it is carrying out its role as an anchor institution using a framework developed by the Joseph Rowntree Foundation and set out governance arrangements for this work.

The Social Value Oversight Group (SVOG) has been set up to oversee this work. It is chaired by the Director of Strategy and Transformation, and the membership includes representatives from DDAT, Procurement, Education and Training, HR, Estates, and Strategy and Transformation.

Since the last update, the Trust has made progress in implementing the action plan. The Social Value Oversight Group continues to meet every other month, and has begun work to develop a set of metrics which can be used alongside the self-assessment to measure progress. Additionally, the Social Value Oversight Group wanted to see more emphasis on digital skills so we have added actions to support our work in addressing digital poverty through work internally and across the Bradford District and Craven system.

The Social Value Oversight Group held an internal workshop in January 2026 for all leads to talk through their sections of the action plan and their priorities for the year. This resulted in identifying four key priorities for the Trust for 2026:

- Maximising the social impact opportunities offered by the Health on the High Street Programme. This work is to ensure the Health on the High Street project delivers a positive social impact as part of its benefits realisation, not just directly for the Trust and its patients and staff, but also for the wider community
- Connecting with the University of Bradford to develop joint approaches to their work in the community as part of their social mobility and community outreach work. We are particularly looking at their work with teenage white boys who are most at risk of falling out of the education system
- Working with our Green Champions – there are clear synergies between our environmental work and our role as an anchor institution, with some people being interested in all aspects of our work.
- Requests for Work Experience placements – the Trust receives more requests for work experience placements than it is able to offer each year. This priority is to look at whether and how the capacity may be increased to allow more people to come to the Trust for work experience placements, and explore other ways of supporting young people into employment.

3. Action Plan Implementation

The action plan is set out following the structure of the Joseph Rowntree Foundation self-assessment, and is split across five domains: BTHFT as an employer, BTHFT as a procurer, Bricks and Mortar, Service Delivery and BTHFT as a body Corporate and Civic.

BTHFT as an employer

Our Widening Participation team continues to promote careers in healthcare, working with schools, Skills House and others. The team does this through its Career Ambassadors, around 100 members of staff who volunteer their time to go into schools, attending careers days, talking about their work and offering mock interviews to help young people prepare for university interviews, as well as attending careers and jobs fairs to promote the range of careers and opportunities available.

Between September 2025 and May 2026, they attended 60 careers fairs, of which 26 were attended by 44 careers ambassadors. The team also hosted or attended 9 bespoke events and workshops in addition to the careers fairs. Beyond more formal events focussed on jobs and careers, the team attended 12 community engagement events with the aim of encouraging people into careers in healthcare and providing information on alternative routes into healthcare roles. Through this work the Trust is both promoting jobs locally, where they are available, and working to ensure the workforce reflects the make-up of the population of Bradford.

Joshua Sheridan
2026-03-03 09:58:14

Supporting and developing our workforce

To support people with their careers a new careers hub is being developed and will launch later in the year. This hub will provide specific information about development and career paths, with the aim of enabling people to develop to their full potential.

Alongside the careers hub, a management training programme, Thrive Management Essentials, will be launched in July 2026. Working with SMEs, it will deliver bitesize courses on management basics in a wide range of areas, from Essential Skills for Line Managers to Writing Effective Business Cases and an Introduction to Finance.

BTHFT as a procurer

Work is underway to develop a new procurement dashboard which will allow the trust to be able to identify local suppliers and SMEs to baseline our current purchasing patterns. This will then enable to be able to develop approaches to procuring more from local companies, particularly SMEs, where possible.

BTHFT has also taken part in a series of joint workshops with Bradford District Care Trust, Airedale NHSFT, Bradford Council and the NHS North of England Commercial Procurement Collaborative to consider social value in procurement. This work will lead to a clearer picture of shared priorities across Bradford District and Craven, and to explore more opportunities for joint working with the potential for joint procurement where this is more efficient.

Bricks and Mortar

The Trust library has started to provide support to its patients in providing access to a tablet to enable them to access the internet to be able to engage with online services such as registering with health and other services, support with using the NHS App, and searching and applying for jobs with support and advice from library and HR staff. Since it launched in May 2026, members of the community are able to book in with library staff to use the IT resources available. The team are also working with Yorkshire Women's Forum who have a similar community scheme to connect up and ensure that we are maximising the joint capacity that is available to support people in communities.

The Trust continues to implement its Green Plan. This is reported on separately to this Committee with the last report in June 2026, but is important to our work as an anchor institution as it shows we are committed to minimising our impact on the environment.

Service delivery

An A&E health inequalities dashboard has been developed by Business Intelligence. In addition, BI are also supporting the development of a Health Equity Dashboard covering the indicators from the Health Inequalities Statement which is a statutory reporting requirement for the Trust. This will allow teams to access information about their patients to better understand inequalities in access, outcomes and experience and improve health equity.

A travel equity tool has also been developed allowing staff members involved in relocation of services to understand the equity impacts on travel. It was developed initially for the Health on the High Street project but can be used for any move of a BTHFT service between its sites (from BRI to Broadway, from SLH to Westwood Park and so on) and looks at bus changes and car journey routing, allowing the Trust to understand it's wider impact from the "green" perspective as well as from a financial perspective from patients.

The Making Every Contact Count (MECC) service, which acts to connect patients attending outpatient appointments with public health run initiatives in the community (e.g. exercise, diet and social inclusion initiatives) is now well embedded, and hundreds of patients have accessed services as a result.

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22/05/2026 08:38 BST

BTHFT as a body corporate and civic

Much of the focus of this work is working in partnership with neighbouring NHS Trusts – Bradford District Care Trust and Airedale NHSFT. Representatives from all three Trusts have started to meet regularly to share the work being undertaken at each trust, and to talk about opportunities for joint work where appropriate. Bradford Council has recently joined these meetings, and has proposed expanding its

Building Bradford's Supply Chain network of suppliers to incorporate other anchor institutions based in Bradford. The network currently consists of the Council's main suppliers, many of them involved in infrastructure and redevelopment projects across the city. The Council has developed a Social Value Policy which outlines their approach to social value through their tendering and contracting arrangements, monitoring it through their contract management processes and producing an annual report on their social impact at the end of each year.

The University of Bradford is a key stakeholder the trust has been working with and another anchor institution for Bradford. The University has recently been ranked the best University for social mobility in the UK for the sixth time. This is a great achievement, and as such the Trust is looking to partner with the University in some of their work, and to look at potential areas for joint working. This follows a BTHFT Strategic Advisory Forum meeting held in February 2026 which was jointly led by BTHFT and the University and considered both organisation's roles as anchor institutions for Bradford with a specific focus on education and how the two organisations can work with the education system to promote healthcare as a career and enable more young people to access higher education.

4. Next steps

In the next six months, the self-assessment carried out in 2025 will be repeated to see what progress has been made in the intervening period. This will inform an update to the action plan. Additionally, the priorities will be reviewed to ensure they are relevant and achievable.

This work will be reported back to the Committee in six months' time.

Recommendation

The Committee is asked to **note** the Trust's progress.

Osbourne,Sheridan
22/07/2026 09:58:21

Finance & Performance Committee			
Meeting Date:	17/06/2026	**Agenda Reference:**	FC.6.26.16
Report Title:	Green Plan Progress Update		
Presented by:	Robert Dadzie, Head of Sustainability		
Executive Lead:	David Moss, Director of Estates & Facilities		
Author:	Robert Dadzie, Head of Sustainability		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	• The Trust continues to make good progress in delivering the priorities set out within its Green Plan, with several major projects reaching key milestones. • Solar photovoltaic installations have now been completed across Bradford Royal Infirmary and St Luke's Hospital and are expected to generate approximately 1,061 MWh of renewable electricity annually. In addition, the Trust's LED replacement programme has been completed, with 3,984 light fittings upgraded to improve energy efficiency and reduce carbon emissions. • The Trust has continued to progress its fleet decarbonisation programme, replacing existing electric vehicle charging infrastructure and developing proposals for further charging installations to support the transition to a low-emission Estates fleet. In total 12 dual charging points are planned for installation this year, which will cater for 24 parking bays across both hospitals and for Estates vehicles. • Clinical leadership for sustainability has been strengthened through the identification of Dr Kate Wilkinson, Consultant Anaesthetist, as the Trust's proposed Net Zero Clinical Lead. Kate has already supported the development of the successful funding application to remove the Trust's remaining nitrous oxide manifold infrastructure and will help drive the delivery of sustainable clinical practice initiatives across the organisation. • Progress has continued on the Trust's major decarbonisation project. The £11.4m scheme to connect St Luke's Hospital to the Bradford Energy Network has progressed through design development and is now moving towards the appointment of a main contractor. • Following a recalculation of the Trusts annual carbon emissions to include broader range of Scope 3, preparations are now underway to deliver a training workshop that will discuss opportunities to embed sustainability into Procurement operations. • Work is also underway to strengthen the Trust's approach to climate adaptation and resilience. Preparatory work has commenced to review the Trust's Climate Adaptation Plan, undertake a Climate Change Risk Assessment, and assess organisational maturity against the NHS Climate Adaptation Framework.			

Osbourne.Sheridan 22/07/2026 09:58:21

	• Looking ahead, priorities for the year include progressing with the development of the Trust's Green Travel Plan. Following appointment of the Net Zero Clinical Lead, work will also begin developing the Net Zero Clinical Transformation Group. **Appendix 1:** The Green Plan 2025 to 2028 is available in the Committee reading room here. **Assurance provided:** The report provides assurance that delivery of the Green Plan continues to progress, with significant decarbonisation projects advancing, climate adaptation work commencing, and sustainability considerations becoming increasingly embedded within the Trust's operational, clinical and strategic decision-making processes.
Recommendation/s: (including any decision/approval required)	The Finance & Performance Committee is asked to: • receive this report and consider the level of assurance provided; • note plans to appoint Dr Kate Wilkinson, Consultant Anaesthetist, as the Trust's Net Zero Clinical Lead. This appointment is based on an allocated allowance of 1 PA / month, which has been approved by the department's internal management team; and • note the plans to introduce ESR training on Climate Adaptation.
Link to Strategic Objective:	Sustainability - To deliver our financial plan and key performance targets
Link to Priority Initiatives 2025/26:	Green Plan
Implications	
Risk:	N/A
Legal/Regulatory:	N/A
Quality & Patient Safety:	The actions outlined support improved estate resilience, safer clinical infrastructure and greater organisational preparedness for climate-related risks, helping to enhance quality and protect safety of patient care. There are no identified adverse impacts on quality or patient safety.
Equality, Diversity and Inclusion and Health Equity:	The Green Plan supports efforts to reduce health inequalities in Bradford by contributing to improved air quality and reduced travel-related emissions, in line with the Bradford Clean Air Zone. Initiatives such as remote consultations and delivery of care closer to home improve access to services and support more equitable health outcomes for local communities.
Resources:	The following resources will be essential to the success of the Plan: • **Financial investment** – Continued access to capital funding is required to deliver infrastructure and estate improvements, with some reliance on external funding sources. • **Staff capacity** – Delivery depends on sufficient dedicated time across Estates and Facilities, Procurement, Informatics, clinical leadership and the Green Champions network. • **Training** – Ongoing investment is needed to upskill the workforce and embed sustainability and Net Zero principles into routine practice. • **Governance and oversight** – Clear governance arrangements and Exec Board oversight are required to ensure effective delivery of the Green Plan.

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Environmental sustainability:	The Green Plan is expected to deliver a significant positive impact on environmental sustainability by reducing the Trust's carbon footprint, improving air quality, cutting waste, and enhancing biodiversity across the estate. Through targeted actions such as energy efficiency upgrades, fleet decarbonisation, sustainable procurement, and improved waste management, the Trust will reduce both direct and indirect emissions in line with NHS Net Zero targets. The plan also supports climate adaptation by making buildings and services more resilient to extreme weather, while green space enhancements will promote biodiversity and contribute to a healthier environment for patients, staff, and the wider community.
Assurance Route	
Meeting/s where content has been discussed previously:	The Trust's Green Plan was updated and approved by the Board in July 2025. An update was delivered to the Board in January 2026.

Report content

1. Purpose

The purpose of this paper is to provide the Finance & Performance Committee with an update on progress against the Trust's Green Plan, including recent sustainability achievements, secured external funding, and the recalculation of the Trust's greenhouse gas (GHG) assessment to include emissions from revenue and capital purchases. The paper also seeks support for the continued development of climate-related financial disclosures and associated governance arrangements.

2. Background/context

The Green Plan is a strategic requirement aligned with national NHS Net Zero commitments and sets out actions that will have implications for the Trust's operations, finances and clinical activity. Delivery of the Plan requires coordinated action across the organisation, supported by clear governance and sustained Board oversight.

This paper responds to NHS guidance requiring all Trusts to maintain an up-to-date Green Plan and builds on previous sustainability activity, stakeholder engagement and an assessment of the Trust's environmental risks and opportunities.

3. Assessment

The Trust's Green Plan sets out a structured response to the increasing financial, operational and regulatory impacts of climate change on NHS organisations. Key drivers include rising energy costs, exposure of estates and supply chains to climate-related disruption, national NHS Net Zero commitments, and emerging expectations around climate-related financial disclosure.

The recalculation of the Trust's greenhouse gas (GHG) footprint to include emissions from both revenue and capital purchases reflects improved data maturity and alignment with national guidance. This expanded boundary provides a more accurate understanding of the Trust's emissions profile, particularly in relation to procurement and capital investment decisions, which represent a significant proportion of NHS emissions.

Gabrielle Meridan
13/03/2026 09:58:21

Progress against action plan - RAG Status

Green (On Track / Completed)

- **Board sustainability training delivered** in December 2025, improving Board awareness of Net Zero, climate risks and Green Plan priorities.
- **Sustainability communications strategy implemented**, providing a framework for staff engagement and awareness activities.
- **28 Green Champions recruited** across the Trust to support local delivery of Green Plan objectives.
- **Sustainability category introduced into staff awards**, recognising and promoting environmental leadership across the organisation.
- **Staff travel survey completed** and findings are being used to inform development of the Trust Green Travel Plan.
- **Digital menu ordering implemented**, supporting reduction of paper use and enabling future work on seasonal and sustainable food choices.
- **Food waste recycling arrangements established**, with food waste converted into renewable energy and agricultural products.

Amber (Progressing with Revised Timescales)

- **Net Zero Clinical Lead identified** and expected to be formally appointed shortly. Establishment of the Clinical Transformation Group will follow appointment.
- **Energy reporting and sub-metering programme** progressing; external specialist support is being procured to develop business cases.
- **Theatre energy optimisation programme** has identified opportunities for Air Handling Unit (AHU) setbacks through Passive Infrared (PIR) controls. Installation planning is underway, however implementation has been delayed pending Infection Prevention Control (IPC) approval.
- **Green Travel Plan development** has commenced, with proposals received and procurement activity underway.
- **Procurement sustainability training programme** remains in planning and will be aligned with wider procurement transformation activity.
- **Climate adaptation programme progressing**, including commissioning of a Climate Change Risk Assessment and review of the Trust's existing Climate Adaptation Plan ahead of Board approval.
- **Climate adaptation training module** in discussion with the Education Team, subject to approval for ESR deployment.

Proposed Amendments to Green Plan Actions

- Recommend removal of the action **"Assess workforce capacity and skill requirements for delivering the Green Plan"** as it does not currently have a clear measurable outcome.
- Recommend revising delivery dates for:
  - Net Zero Clinical Transformation Group – **Mid 2026**
  - Energy reporting and sub-metering business cases – **Mid 2026**
  - Theatre energy studies and optimisation programme – **Mid 2026**

Key Commentary

- Delivery remains broadly on track, with significant progress in workforce engagement, communications, food sustainability initiatives and governance.
- The main areas requiring revised timescales relate to clinical engagement, technical energy projects and climate adaptation activities, where dependencies on specialist resource, procurement processes and governance approvals have extended delivery programmes.
- No significant concerns are identified regarding overall Green Plan delivery, although several actions will require milestone adjustments to reflect current programme assumptions.

Osbourne Sheridan
22/01/2026 09:59:21

Level of assurance

This paper provides assurance that the Trust is making appropriate progress in delivering its Green Plan, that key sustainability actions and funding have been secured, and that arrangements are being

developed to strengthen climate-related financial risk management and disclosure. Further assurance will be provided as this work matures and is embedded within routine governance and reporting processes.

4. Options analysis/Proposal
N/A

Appendix 1

The Green Plan 2025 to 2028 is available in the Finance and Performance Committee reading room here.

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22/07/2026 09:58:21

Board of Directors			
Meeting Date:	23/07/26	**Agenda Reference:**	Bo.7.26.13
Report Title:	Partnerships – Strategic View		
Presented by:	Mark Hindmarsh, Director of Strategy & Transformation		
Executive Lead:	Mark Hindmarsh, Director of Strategy & Transformation		
Author:	Alison Smith, Head of Strategy & Partnerships		

Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	This paper provides a summary of partnership working that the Trust is currently engaged with in Bradford, across West Yorkshire and more widely. There is a particular focus on how this work connects to our strategic objective "to collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals". The Chief Executive and Executive Directors regularly attend collaboration and Place Provider Partnership meetings and the detail of many of these is reported in the Board report from the Chief Executive.			
Recommendation/s: (including any decision/approval required)	The Board is asked to: • note this strategic view of partnership working and the links to the Strategic Framework, the strategic objectives and the five transformation priorities • note the current opportunities and developments in partnership working			
Link to Strategic Objective:	Partnership - To collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals			
Link to Priority Initiatives 2025/26:	Health Equity and Health Inequalities			

Implications	
Risk:	This paper relates to a strategic risk in the new BAF: **STRATEGIC RISK 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.
Legal/Regulatory:	
Quality & Patient Safety:	
Equality, Diversity and Inclusion and Health Equity:	The Partnerships strategic objective highlights that the main objective of partnership working is to improve health equity and reduce health inequalities
Resources:	None
Environmental sustainability:	Our partnerships work looks at BTHFT's role as an anchor institution in Bradford so there is a link to the Trust's Green Plan and sustainability.

Assurance Route	
Meeting/s where content has been discussed previously:	November 2025 Board of Directors – this is a twice-yearly report Anchor Institution update to Finance & Performance Committee in July 2026

23/07/2026 Board of Directors Agenda Item 13

Report content

1. Purpose

The purpose of this paper is to update the Board on opportunities and developments in partnership working and assure the board of progress towards the Trust's strategic objective *to collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals.*

The paper provides assurance for the partnerships strategic risk (SR07) in the new Board Assurance Framework:

***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.*

We have a statutory duty to collaborate (set out in the Health and Social Care Act 2022) and the CQC Assessment Framework for Well-Led includes this Quality Statement:

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Partnership working is a key ingredient for all three shifts described in the NHS 10-year Plan:

- Shift from hospital to community
- Shift from sickness to prevention
- Shift from analogue to digital

Lead responsibility for building strategic partnerships sits with the Director of Strategy and Transformation, supported by the Head of Strategy and Partnerships.

2. The Strategic Context: Place Provider Partnership

The Place Provider Partnership is taking responsibility for delivery of the Health and Wellbeing Strategy and vision for Bradford District & Craven. The longstanding Strategic Partnering Agreement sets out how Partners have agreed to work together in a collaborative and integrated way and will support this new way of working.

A host provider model is being developed with Bradford District Care Trust as the nominated host provider who will hold contracts with the ICB and be responsible for monitoring outcomes. The Joint Committee (the Act as One Committee) is operating in shadow form during 2026/27.

3. The Strategic Context: New BTHFT Strategic Framework for 2026/27 and 5-year Integrated Delivery Plan

The new BHTFT Strategic Framework for 2026/27 in Appendix A, which is also being considered at the July Board meeting, highlights partnerships and health equity as a key enabler of the four recovery objectives: Quality, People, Finance and Performance.

The Strategic Framework identifies five Transformation Priorities that are designed to deliver the three shifts in the NHS 10-year plan and the targets in our 5-year Integrated Delivery Plan. All require effective partnership working with NHS and wider health and care system partners:

- EXCEL
- Outpatients and Theatre Improvement
- Improving Quality
- Health on the High Street
- Place Collaboration

Osbourne-sinclair
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4. EXCEL

Partnership working within the EXCEL programme has progressed, supporting the core aims of reducing pressure on the Emergency Department (ED), improving patient and staff experience, reducing avoidable demand, improving patient progression through the first 72 hours of care, and strengthening discharge processes. These ambitions can only be achieved through a whole-system approach, so the programme has continued to build and embed collaborative relationships across health, care and community partners.

The programme gained recognition through the National Neighbourhood Health Implementation Programme, where the Trust was spotlighted for actively contributing to neighbourhood health development across the Bradford district and supporting the shift towards preventative, population-based and neighbourhood-centred care.

Engaging Primary Care, Yorkshire Ambulance Service, Bradford District Care NHS Foundation Trust, Local Authority and Public Health teams, the Voluntary, Community and Social Enterprise (VCSE) sector, the Integrated Care Board and community leaders has enabled several collaborative initiatives:

- Working with Primary Care Networks on community-based respiratory and COPD pathways with Primary Care Networks to support earlier intervention, improve self-management and reduce avoidable ED attendances and admissions.
- Collaborating with the Airedale Digital Care Hub and system partners to develop the Bradford and Craven Single Point of Access (Gateway to Care)
- Better links between Primary Care, Elderly Care Services, the Elderly Virtual Ward and the Multi-Agency Integrated Discharge Team to support earlier discharge planning
- Exploring opportunities with Community Pharmacy and Primary Care to reduce discharge delays and enable more care closer to home.
- Developing stronger relationships with community and voluntary sector mental health services to explore alternative pathways for lower-acuity presentations

The programme has also continued to work with local communities, engaging with more than 50 patient and community groups across Bradford District. This has provided valuable insight into barriers experienced by local populations, including inclusion health groups, and ensured that improvement efforts focus on what matters most to patients. It has directly informed patient experience improvements:

- Developing a multi-lingual patient journey video to improve understanding of the Emergency Department process and enhance accessibility.
- Introducing digital patient communication screens that provide real-time information and health promotion information

Collectively, these partnerships are helping to improve understanding of the factors driving avoidable ED attendance, improve access, support timely discharge and strengthen community-based alternatives to hospital care. In doing so, the programme is contributing to easing pressure on the Emergency Department while improving both patient and staff experience across the urgent and emergency care pathway.

For the next 12 months the focus of the EXCEL programme will be on improving the Emergency Department and inpatient pathways – specifically the first 72 hours of care. Even with this more internal focus the EXCEL programme will continue to work with system and community partners and ensure their insights inform improvement work.

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5. Outpatients and Theatre Improvement

Outpatient Transformation

Successful transformation of outpatient and diagnostic care is very dependent on partnership working across the system. Community and neighbourhood services can offer, for example, rapid and early

access to diagnostics prior to referral or discharge from hospital outpatient services to neighbourhood teams.

Key partners will include primary care, the WYICB and Westcliffe Health Innovations (our partner at the Eccleshill Community Diagnostic Centre). Health on the High Street and ABCAS both offer important opportunities to redesign care pathways and offer patients a better experience of outpatient care.

Good progress has been made developing Advice and Guidance options and the award-winning GP Assist decision-support and referral tool. But more recently this has been impacted by the loss of resource at the ICB requiring new approaches to collaboration across the system.

Theatre Improvement
There are three workstreams: Pre-Assessment, Theatre Utilisation and Workforce. Like EXCEL, this programme cannot deliver its objectives without collaboration.

Key work with partners includes:

- Bradford Institute for Health Research: AI-supported triage tool to help identify patients suitable for shorter telephone pre-assessments versus more complex face-to-face assessment pathways. Uses Connected Bradford and linked Primary Care data sources.
- Digital solutions such as DrDoctor to support digital pre-assessment questionnaires, improve patient engagement and increase clinical capacity.
- Community diabetes services to identify and optimise patients earlier, particularly where poorly controlled diabetes contributes to surgical delays or cancellations.
- WYAAT Theatre Network to benchmark performance, share learning and adopt best practice
- Working with Leeds Teaching Hospitals NHS Trust to benchmark workforce models and support safer and more sustainable theatre staffing.

6. Improving Quality

The Trust's Quality Account 2025/26 was published in June 2026 and describes how we have worked in partnership to achieve quality priorities. As a learning organisation, we are proud of our focus on delivering high-quality care and our ambition to provide outstanding healthcare for all our communities. We work closely with partners across the health and care system, listen to feedback from patients and communities, and continue to innovate and improve the services we provide.

One of the five quality priorities for 2026/27 is workforce planning, where partnership with education providers is highlighted as key to creating a sustainable workforce pipeline. This is also key to maximising our impact as an anchor institution and was discussed by the Board and Council of Governors at an event hosted by the University of Bradford in February 2026. The University of Bradford is the best in England for social mobility and its work with schools and colleges to widen local participation in higher education will help create that workforce pipeline.

As well as working closely with the University of Bradford, the Executive team have now established a Joint Partnership Board with the University of Leeds Faculty of Medicine and Health, which met most recently on 3 June 2026. Feedback from medical students on placement is very positive and opportunities are being explored to offer placements to other University of Leeds allied health professional students. Students with positive experience of placements in Bradford are more likely to become our future workforce.

Working with both Universities in this way also creates broader opportunities to work together on topics as diverse as research, support for local entrepreneurs and social mobility. We continue to build partnerships in the field of clinical innovation building relationships with Nexus at Leeds University and the equivalent team at the University of Bradford. There is also a growing partnership with the West Yorkshire Combined Authority, and the Trust has held exploratory meetings with several innovators introduced by WYCA in recent months.

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Working with both Universities in this way also creates broader opportunities to work together on topics as diverse as research, support for local entrepreneurs and social mobility.

7. Health on the High Street

The Health on the High Street programme has worked with partners from the beginning, with the original steering group set up to include Airedale Trust, Bradford District Care Trust, primary care and the Voluntary Care Sector Alliance, Bradford Metropolitan District Council. This approach is important to ensure alignment with ABCAS, Airedale's New Hospital Programme and new community facilities such as the proposed Keighley Health Hub and neighbourhood health centres. It will also maximise opportunities to run services jointly with partners and create new and innovative care pathways.

The draft vision is *"to create an accessible, integrated health and wellbeing destination in the heart of Bradford that reduces health inequalities, transforms how care is delivered, strengthens partnerships and brings services closer to the communities who need them the most."*

A dedicated partners group is now being set up to:

- Look for opportunities to co-locate services that are linked to the BTHFT services planning to move to the Broadway Centre
- Look for opportunities to enable one-stop shop models of care, cross-organisational multi-disciplinary team working or offer drop-in services that patients might access whilst there for another reason.
- Look for opportunities to co-locate other health and well-being services to improve access and reduce health inequalities.

8. Place Collaboration

The Board development session in June 2026 focused on 'working in a complex system' and provided updates on the Place Provider Partnership, the Act as One Committee and the four Strategic Delivery Groups:

- Airedale Bradford Collaboration on Acute Services (ABCAS)
- Integrated Neighbourhood Health
- Corporate Services Review
- Children, Young People and Families

Board members had the opportunity to discuss risks and opportunities for BTHFT and were assured of the Trust's involvement in all these system-wide programmes.

A regular paper will now be provided to Board with updates from the Strategic Delivery Groups and the first will be presented to this meeting.

9. Strategic Partnerships – next steps

- Formally constitute the Health on the High Street Partners Group to support the vision of an integrated health and wellbeing destination in the city centre.
- Regular reports to Board on place collaborations – including ABCAS, neighbourhood health, corporate services review and children, young people & families
- Re-establish regular Board to Board sessions with the University of Bradford when the new Vice-Chancellor starts later this month

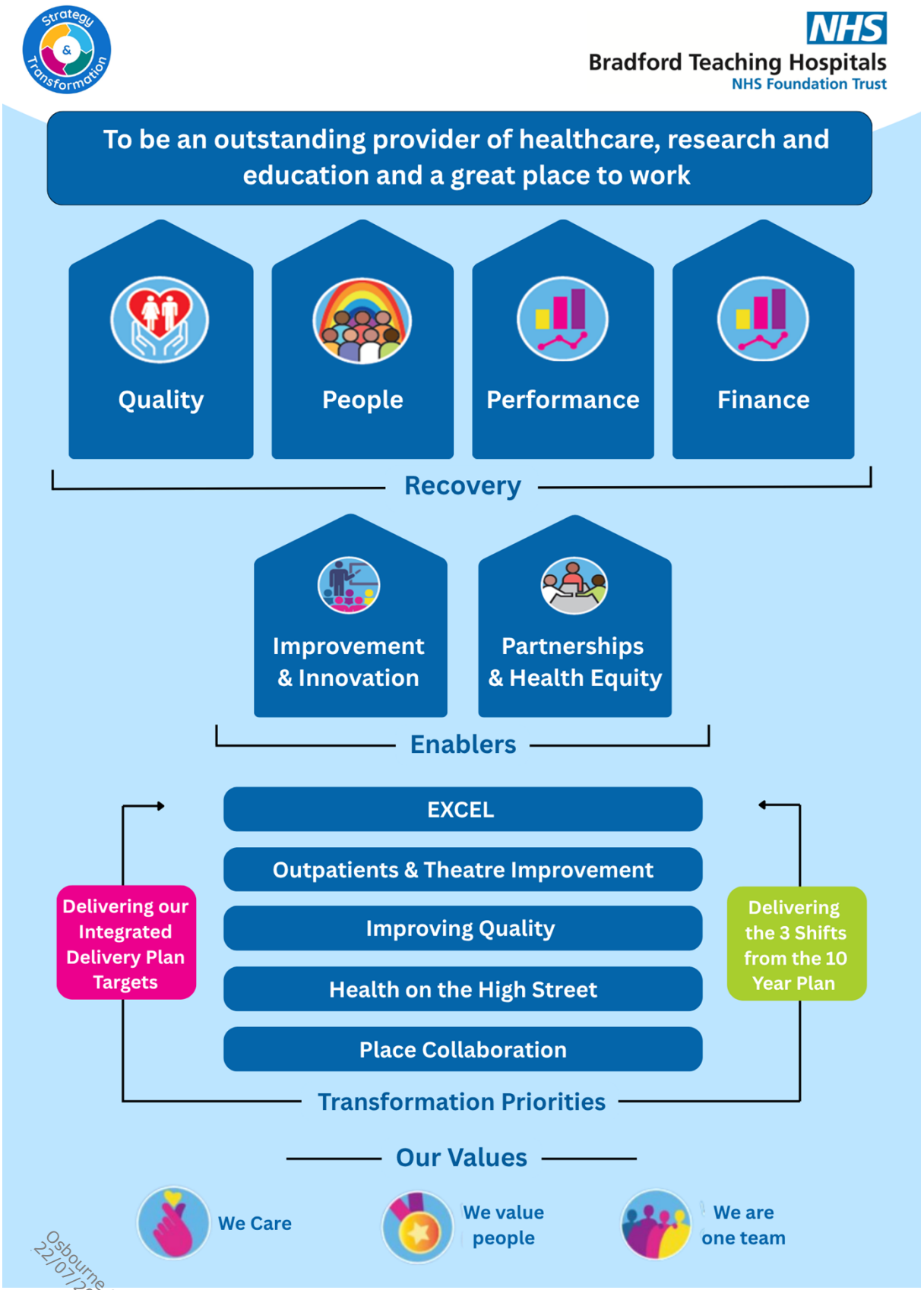
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10. Recommendation

The Board is asked to:

- note this strategic view of partnership working and the links to the Partnerships and Health Equity objective in the Trust's Strategic Framework and the transformation priorities for 2026/27.
- note the current opportunities and developments in partnership working.

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Board of Directors			
Meeting Date:	23/07/26	**Agenda Reference:**	Bo.7.26.13a
Report Title:	Strategic Partnering Agreement		
Presented by:	Mark Hindmarsh, Director of Strategy & Transformation		
Executive Lead:	Mark Hindmarsh, Director of Strategy & Transformation		
Author:	Mark Hindmarsh, Director of Strategy & Transformation		

Report Summary				
Purpose of the paper:	Decision ☒ approve	Assurance ☐	Action ☐	Information ☐
Summary of Key Issues/Highlights:	The current operating context is informed by three areas: firstly, 10-Year Health Plan: Fit for the Future, published in July 2025. Secondly, Bradford District and Craven Health and Care Partnership developed its Health, Care and Wellbeing Strategy in September 2025 and implementation is underway. Thirdly, establishing shadow Partnership Governance arrangements in 2026/27 which acts as a transitional year to support emerging Provider Partnerships as they prepare to sign an NHS / Integrated Health Organisation contract with NHS West Yorkshire ICB for the provision of in-scope services. The Strategic Partnering Agreement (SPA) sets out the key terms that the Partners have agreed to work together on and aims of the Partnership to work in a collaborative and integrated way on a Best for Bradford District and Craven basis. It describes an approach to shared decision making and how resources are committed. The most recent refresh of the SPA was approved in May 2025 by the Bradford District and Craven Health and Care Partnership Board. This SPA refresh sets out arrangements established to enable delivery of the Strategy and takes account of the operating context. This full review of the SPA and Governance Handbook supports arrangements through this 2026/27, and changes include: • alignment of with the Health, Care and Wellbeing Strategy (September 2025) of the vision, objectives and principles, the Health and Wellbeing Strategies and the BMDC District Plan; • refresh of the Governance clauses and schedule to reflect the emergent Provider Partnership Governance arrangements; • inclusion of a new schedule outlining compliance with Health Overview and Scrutiny; • outlined Integrated Neighbourhood Health as a key policy driver for services change; and • Hill Dickinson review of the SPA including boiler plate clauses to enable and support the transitional year 2026/27 and undertook a review of the transitional year Partnership Governance arrangements. Further work underway to draft an updated Information sharing and Conflicts of Interest (clause 13). During 2026/27 decision making will continue to be discharged through ICB delegation from NHS West Yorkshire ICB Board to Bradford district and Craven place via the Bradford District and Craven Health and Care Partnerships Board (a Committee of the ICB). Therefore, the governance arrangements set out in the SPA are aligned to governance framework of the			

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	ICB and should be read alongside the NHS West Yorkshire Integrated Care Board's Constitution and associated documents including the Scheme of Reservation and Delegation (SoRD), the Financial Scheme of Delegation (FSoD), and the Standing Financial Instructions (SFIs). Following agreement of the SPA by partners, the Bradford District and Craven Governance Handbook and finalisation of the ICB staffing structure changes, the Governance Handbook will be refreshed and re-published on the Partnership's Act as One website. The updated SPA is available in the reading room click here
Recommendation/s: (including any decision/approval required)	The Board is asked to: • approve the updated SPA; and • authorise the Chief Executive to sign the SPA as the Trust's representative.
Link to Strategic Objective:	Partnership - To collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals
Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	This paper is relevant to BAF risk SR07 - 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.
Legal/Regulatory:	N/A
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	N/A

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Board of Directors			
Meeting Date:	23/07/26	**Agenda Reference:**	Bo.7.26.14
Report Title:	Trust Strategic Framework – 2026/27 Update		
Presented by:	Mark Hindmarsh, Director of Strategy & Transformation		
Executive Lead:	Mark Hindmarsh, Director of Strategy & Transformation		
Author:	Alison Smith, Head of Strategy & Partnerships		

Report Summary				
Purpose of the paper:	Decision ☒ approve	Assurance ☐	Action ☐	Information ☐
Summary of Key Issues/Highlights:	This paper proposes a refreshed Strategic Framework for 2026/27, informed by an evaluation of the 2025/26 approach and reflecting the evolving national and local strategic context. The updated framework recognises the current focus on Recovery in 2026/27, while also describing the strategic transformation required for sustainability in the longer term.			
Recommendation/s: (including any decision/approval required)	The Board is asked to agree an updated 2026/27 Strategic Framework, that provides a bridge to the development of the new Corporate Strategy for 2027 - 2032 and supports delivery of the Recovery Programme in 2026/27. The framework articulates immediate recovery priorities and longer-term transformation across the Trust, through: • an updated strategic visual/poster • priority trust-wide transformation programmes for 2026/27 • an approach to Board assurance aligned with National Oversight Framework measures			
Link to Strategic Objective:	All			
Link to Priority Initiatives 2025/26:	Health Equity and Health Inequalities			

Implications	
Risk:	Relevant to all risks on the BAF
Legal/Regulatory:	The Corporate Strategy 2022-2027 and the updated Strategic Framework for 2026/27 are required for the Shared Direction and Culture section of CQC's Well Led Framework.
Quality & Patient Safety:	The updated 2026/27 Strategic Framework includes the Quality objective that is defined as 'to provide outstanding care for patients delivered with kindness'.
Equality, Diversity and Inclusion and Health Equity:	The People Objective is 'to be one of the best NHS employers prioritising the health and wellbeing of our people and embracing, equality, diversity and inclusion". The Partnerships objective is 'to collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goal'.
Resources:	None
Environmental sustainability:	None

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Assurance Route

Meeting/s where content has been discussed previously:	ETM on 10/4/26 and 11/5/26

Report content

1. Introduction

In 2026/27, the Trust faces heightened expectations to deliver on its financial plan, improve productivity, deliver a headcount workforce reduction and progress system working. A clear and practical Strategic Framework is essential to articulate these immediate recovery priorities, while also sustaining progress on the strategic transformation required for long-term sustainability.

The current 2025–2027 Strategic Framework (Appendix A) was developed to support delivery of the Trust's five Strategic Objectives during the final two years of the Corporate Strategy (*Our Patients, Our People, Our Place and Our Partners Corporate Strategy 2022-2027*). It introduced ten trust-wide priority initiatives for 2025/26 and a set of composite metrics ("progress dials") to track progress.

A commitment was made to the Board to review the framework, initiatives, and measures after one year. In March 2026, the Board supported the development of a refreshed Strategic Framework for 2026/27, recognising the need for clearer alignment with national strategy, evolving system priorities and a stronger balance between recovery and reform.

2. Changing National & Local Context

Since the original framework was developed, there have been several important national and local strategic developments that impact how the Trust must operate moving forward. Nationally, the NHS 10-Year Plan, published last July, signals three major shifts: moving care from hospitals into communities, prioritising prevention over treatment, and accelerating the transition from analogue to digital services.

Locally, the new Place Strategy looks ahead to 2040, forecasting future health needs and setting out shared district-wide ambitions that reflect these national shifts. It aligns closely with the District Strategy 2025–2035, which envisions Bradford as a place where people can live smart, healthy and happy lives, thriving in vibrant, well-connected communities.

Changes to the NHS Planning Framework have also brought increased scrutiny from NHS England. The Trust now has a 5-Year Integrated Delivery Plan, with ambitious 1-Year and 3-Year finance, performance and workforce plans. These expectations place the organisation in a period of focused Recovery, which was captured in the discussion and outputs from our 'Working Together in 26-27' event held on 25th February 2026.

An up-to-date and well embedded strategic framework is required by CQC for the *Shared Direction and Culture* domain of the Well-Led framework, which emphasises the need for a shared vision and set of strategic goals that staff across the organisation understand and support.

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3. Strategic Framework 2025/26 Evaluation: Posters

An evaluation has been carried out to gather insights from last year's strategy poster exercise and use feedback to strengthen and refine our approach to strategic planning for 2026/27. This involved meeting with leads from across the Trust to capture structured feedback on:

- the strategy posters as a tool for strategic planning and service improvement,
- their experience of the poster development and engagement process,
- the framework's alignment with internal and external priorities.

This feedback has been analysed to identify core themes and improvement opportunities. These insights will also inform the new corporate strategy for 2027 onwards. The key feedback was:

- Now needs to align with the 10-Year Plan – refresh Trust's strategic direction in line with the national agenda, with clearer articulation of what the three strategic shifts mean for BTHFT so teams can confidently align their priorities
- More focused Trust-wide priority programmes - fewer, more targeted initiatives would improve effectiveness; the breadth of ten priorities diluted focus
- Not always clear that 'sustainability' covers financial and performance sustainability
- Value in protected time and clarity - helped senior leaders reflect on their varied workstreams, consolidate activity into one place, useful communication tool with the rest of the Trust
- More post-development embedding was needed – great starting point for strategic thinking, but more to do to prompt and support continuous, active use of posters across the year
- Need flexible, tailored formats – poster format didn't suit all CSUs/corporate teams equally well; value could increase if teams could adapt the format and personalise in line with individual CSU priorities.
- Opportunity for co-design – teams would welcome involvement in developing design and format

4. An Updated Strategic Framework for 2026/27

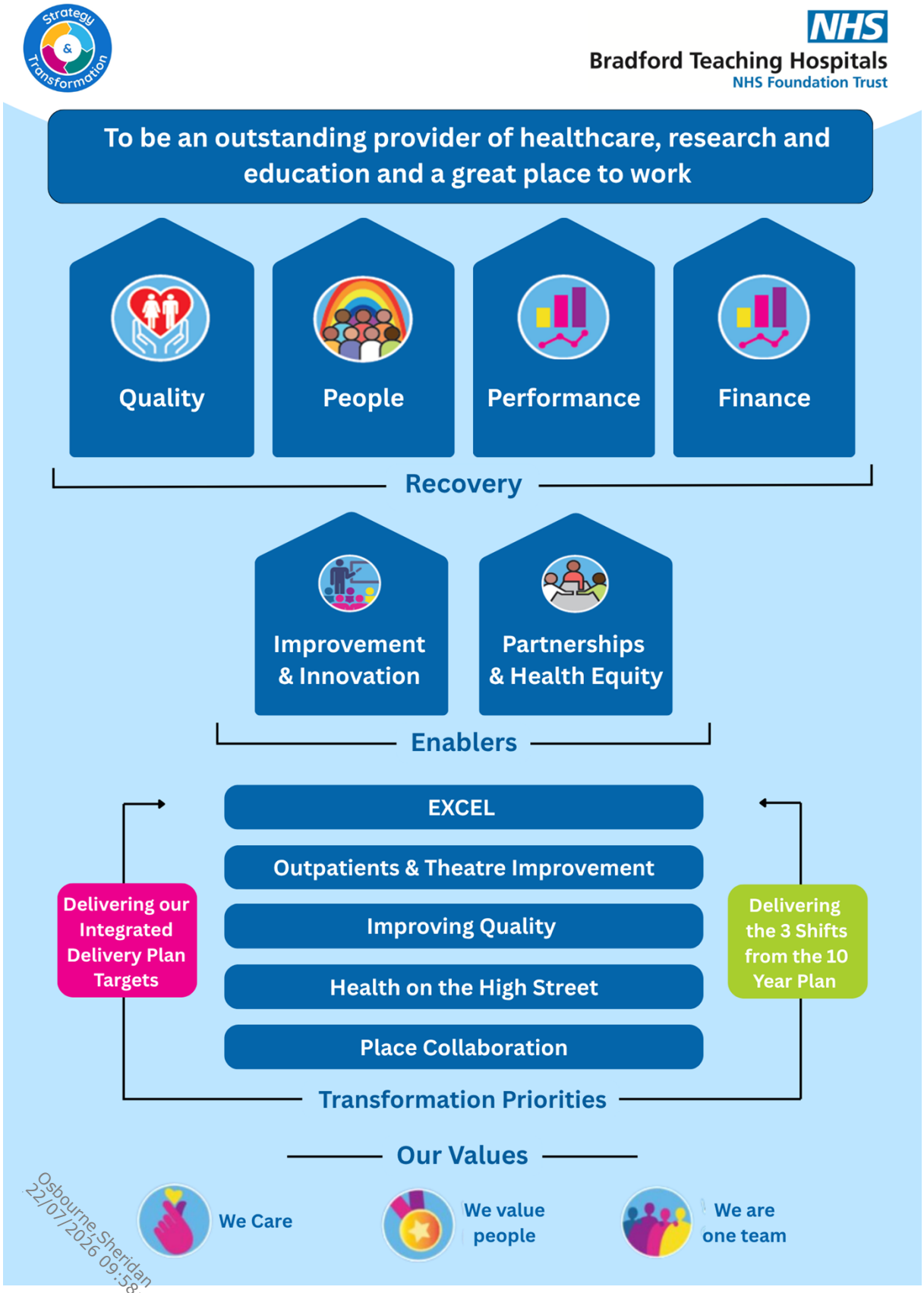
In response to the changing context, and the feedback we received through our evaluation work, an updated Strategic Framework for 2026/27 has been developed to replace the framework developed in 2025 (see Figure 1).

The framework retains a similar structure to its predecessor and includes the same core components: our vision, strategic objectives and trust-wide priority programmes of work.

However, these elements have been reframed and presented in a way that more closely aligns with the focus on Recovery, the commitments made in our 5-Year Integrated Delivery Plan, our shared strategic ambitions with Airedale and BDCT, and the NHS 10-Year Plan.

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Fig 1. 2026/27 Proposed Strategic Framework



5. Strategic Objectives

We have sought to maintain continuity with the strategic objectives outlined in the corporate strategy, and the Vision, Objectives and Values poster (Appendix B).

This structure was shaped by the outputs of the 'Working Together in 26/27' event on 25 February 2026, where financial and workforce sustainability, operational robustness, and care quality were highlighted as our key areas for Recovery in 2026-27. Therefore, we hope this strategic framework provides a clear basis that colleagues across the organisation can readily connect with and put into practice.

The strategic vision is delivered through four primary objectives, that will drive our progress during this period of recovery: ***Quality, People, Performance,*** and ***Finance.*** These are underpinned by two enabling objectives - ***Improvement & Innovation*** and ***Partnerships & Health Equity*** - which provide mechanisms to support delivery across the four areas above.

Responding to feedback from the recent evaluation, we have divided "sustainability" into two separate components - ***Performance*** and ***Finance*** - to improve clarity and ensure alignment with our recovery agenda and the planning targets for 2026/27.

We have also further emphasised the organisation's commitment to reducing health inequalities, consistent with the place strategy and the Joint Strategic Ambition agreed with Airedale and BDCT. Previously captured within the definition of Partnerships objective, as well as through the Health Equity and Health Inequalities programme, this priority is now articulated more explicitly in the revised framework, using the updated objective of ***Partnerships & Health Equity***.

6. Trust-Wide Priority Transformation Programmes

Feedback gathered through the evaluation indicated that the number of Priority Initiatives last year (Appendix A) was too large and the initiatives too diverse. Although this approach supported momentum and engagement last year, it is less well suited for the current period of focused recovery.

In response, this element of the framework has been refined. For 2026/27, the framework has moved from ten Priority Initiatives to five clearly defined Trust-Wide Transformation Programmes. These programmes have been selected on two grounds: they have a material impact on the Trust's ability to deliver the workforce, financial, and performance ambitions set out in our 5-Year Integrated Delivery Plan, and they directly support delivery of the three strategic shifts in the NHS 10-Year Plan.

The proposed priority transformation programmes for 2026/27 are:

- **EXCEL**
- **Outpatients & Theatre Improvement**
- **Improving Quality**
- **Health on the High Street**
- **Place Collaboration** (ABCAS, Integrated Neighbourhoods, Corporate Services, and Children, Young People & Families)

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7. Monitoring progress and board assurance

In 2025, the Board approved the introduction of 'progress dials' to provide assurance of progress towards the Trust's strategic objectives. The progress dials were intended to provide the Board with a balanced, high-level view of performance by drawing together multiple indicators aligned to each objective.

These composite metrics were developed for four of the five objectives - Quality, People, Partnerships, and Sustainability - following engagement with Board Committees and colleagues across the organisation. At the time, it was not possible to develop a composite metric for the Improvement objective.

A commitment was made to review and refine this approach after one year, informed by colleague feedback and the availability of more mature data sources.

In this period of Recovery, and in line with the specific targets described in our 5-Year Integrated Delivery Plan, there is an opportunity to strengthen Board assurance by aligning the Strategic Framework more explicitly with nationally set performance indicators.

Since the progress dials were developed last year, the NHS Outcomes Framework (NOF) has been embedded as the set of measures used for NHS league tables.

It is therefore proposed that progress against the four objectives aligned to Recovery - ***Quality, People, Performance, and Finance*** - is assessed using the relevant National Oversight Framework (NOF) performance domains.

Strategic Objective	National Oversight Framework Domain(s)
Quality	Patient Safety; Effectiveness and Experience
People	People and Workforce
Performance	Access to Services; Productivity
Finance	Finance and Productivity

Progress against the two enabling objectives - ***Improvement and Innovation; Partnerships & Equity*** - will be reported to the Board through existing programme and portfolio governance arrangements.

Aligning the Strategic Framework with the National Oversight Framework provides a coherent approach to Board assurance, bringing assurance in line with how we are now judged externally. It enables oversight of the strategic objectives, the Trust's recovery priorities, and the national Quality standards, simultaneously, using established measures, and avoiding duplication with existing reporting arrangements. It can also be monitored internally via the new PowerBI NOF dashboard.

Subject to agreement, further work will be undertaken to align with ongoing developments in the visualisation and reporting of National Oversight Framework data to Board, ensuring this is explicitly linked to the updated Strategic Framework.

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8. Embedding the Framework

In the Shared Strategic Ambition statement that was presented to Board on 31 March 2026, the Trust has committed to publishing a new Corporate Strategy in 2027 and better aligning strategic priorities with Airedale and BDCT. Work on the new Corporate Strategy will begin in September 2026, with engagement aligning with the 2027/28 update of our 5-Year Integrated Delivery plan. Findings from the recent CQC Well-Led report will also inform the engagement process for the Corporate Strategy refresh.

In the meantime, the updated 2026/27 Strategic Framework is intended to provide clear direction and focus during this period of Recovery. It supports CQC's requirements in the *Shared Direction and Culture* domain of the CQC Well-Led framework, which emphasises the need for a shared vision and set of strategic goals that staff across the organisation understand and support.

The 'Working Together in 26/27' event on 26th February 2026 set out a clear case for change and engaged senior leaders in discussions about the evolving strategic context and how the organisation needs to operate during this period of Recovery.

Building on this engagement, the refreshed Strategic Framework could be formally launched at a Trust-wide staff briefing, and explicitly linked to the delivery of the Recovery programme. The framework will also be used as a reference point for CSUs and Corporate Departments during the engagement and development of the 2027/28 Corporate Strategy.

9. Conclusion

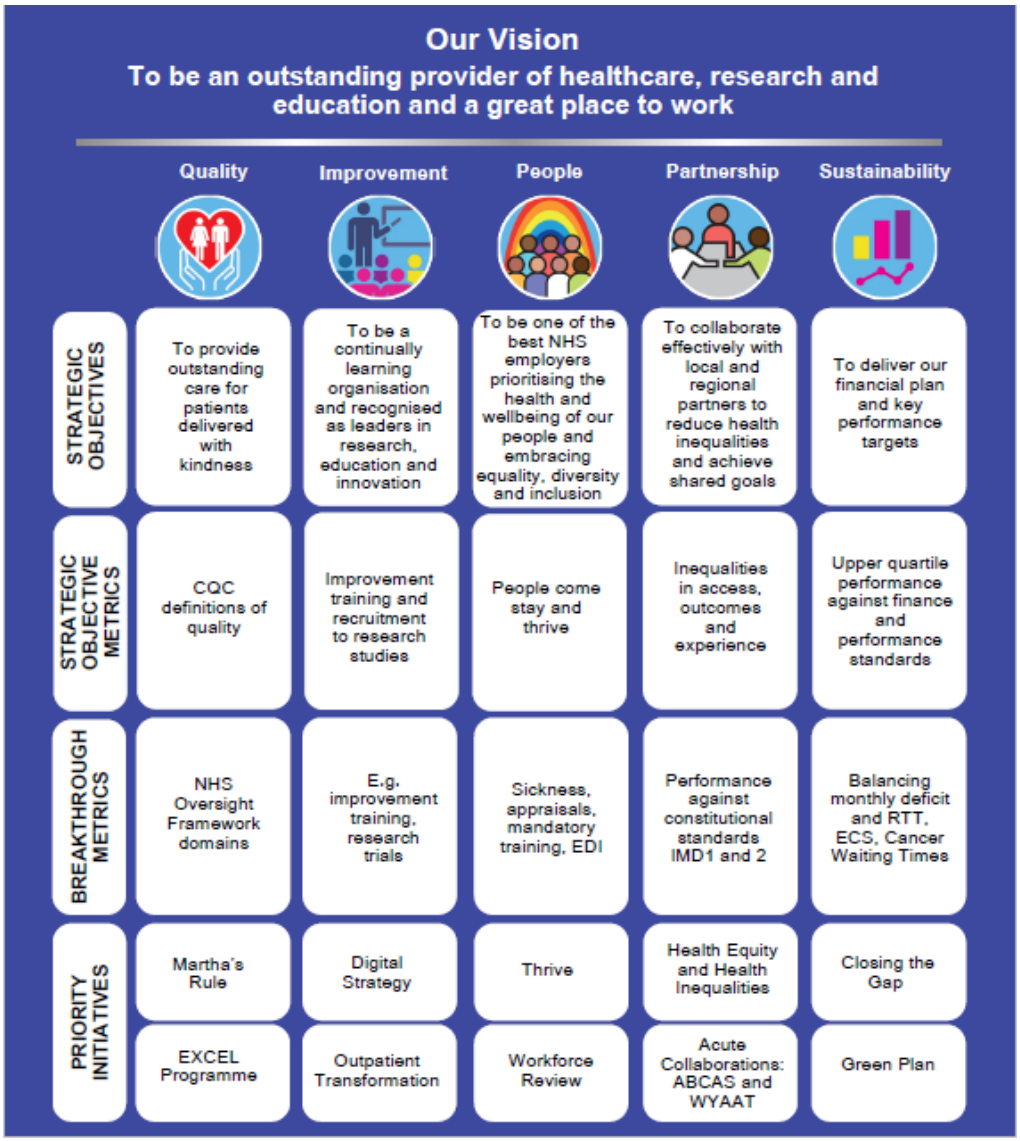
The Board is asked to agree an updated 2026/27 Strategic Framework, that provides a bridge to the development of the new Corporate Strategy for 2027 and supports delivery of the Recovery programme in 2026/27.

The framework balances immediate recovery priorities and longer-term transformation across the Trust, through:

- an updated strategic visual/poster
- five trust-wide transformation priorities for 2026/27
- an approach to Board assurance aligned with National Oversight Framework measures

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Appendix A:



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ACTasONE

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Our Vision, Objectives and Values

Our Vision

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

Our Objectives

Quality

To provide outstanding care for patients, delivered with kindness

Improvement

To be a continually learning organisation and recognised as leaders in research education and innovation

People

To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion

Partnership

To collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals

Sustainability

To deliver our financial plan and key performance targets

Our Values

We Care

We value people

We are one team

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Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	23 July 2026	Agenda item	Bo.7.26.15

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Audit Committee

Date of meeting: 17 June 2026

Key escalation and discussion points from the meeting
Alert:
Internal Audit The Committee received the following list of final reports which had received **Limited** assurance: a. Sepsis Management b. Quality of local investigations c. Space Utilisation It was agreed that these would be deferred to the September committee meeting to allow for in-depth discussion, in particular because of the committees concern of an emerging pattern there that should have been better control in second line assurance to prevent identified issues from occurring.
Advise:
None
Assure:
The Committee was pleased to note: - The Internal Audit Annual Report and Head of Internal Audit Opinion - 2025/26 which concluded that *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 External Audit ISA260 reported an effective working relationship between the Trust and the auditor's and that, subject to minor matters to be clarified, the Accounts would be approved by the Board, signed off by the auditor and submitted to NHS England on time. - The Committee welcomed that the external auditors had removed from this year's ISA260 report the previously reported risk of a significant weakness in respect of governance issues. The Committee was able to recommend to the Board that the Annual Accounts, the Letter of Representation and the Annual Report be approved at the next Board meeting.

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Report completed by:

Zafir Ali, Audit Committee Chair and Non-Executive Director, 17 June 2026

Board of Directors			
Meeting Date:	23 July 2026	**Agenda Reference:**	Bo.7.26.16
Report Title:	Board Assurance Framework Q1 2026/17 and High-Level Risks		
Presented by:	Prof Karen Dawber, Chief Nurse / Laura Parsons, Associate Director of Corporate Governance/Board Secretary		
Executive Lead:	Prof Karen Dawber, Chief Nurse		
Author:	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 (BAF) Quarter 1 2026/27

The Board of Directors requires robust and independent assurances on the effectiveness of the systems and processes in place for meeting its strategic objectives and delivering appropriate outcomes. The Board therefore has overall responsibility for ensuring that the process of risk identification, evaluation and control is effective.

This paper provides the Board with an opportunity to review and comment on the BAF (appendix 1) the BAF has been reviewed by the Risk Committee and Board Committees.

As previously reported, the format of the BAF has been updated to reflect recommendations made in the Audit Yorkshire Internal Audit Report (BTH26/2026) dated 22 April 2026 and following discussion held at the Board Development Session on 29 April 2026.

Following reviews of the BAF by Executive leads changes to strategic risks scores are proposed for Q1 2026/27 and can be seen at section 2.

Risk Appetite Statement (RAS)

Following discussion at the Board Development Session held in April and further discussion by the Risk Committee on 13 July 2026, the RAS is to be further considered by the Executive Team and presented to the September Board Committee meetings for discussion, for final approval by the Board on 24 September 2026.

High Level Risk Register (HLRR)

All **operational** risks scoring 15 and above (high level risks) are presented to the Risk Committee monthly and reviewed by the Board Assurance Committees.

At its meetings on 1 June 2026 and 13 July 2026 the Risk Committee considered the high-level risks, including any new risks, closures, changes in score, and risks beyond review date.

The Board Committees reviewed the high-level risks within their remit at their meetings held in June and July 2026 and at the time of this report there are -

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	• No risks beyond their target mitigation date. • Two new risks (2926 and 2911) with completed risk assessments. • One risk which has reduced in score (2509). • Three risks which have been closed (290, 2773 & 2764). • One risk beyond the review date (70). The high-level risk register showing all high-level risks rated 15+ for July 2026 is attached at Appendix 2.
Recommendation/s: (including any decision/approval required)	The Board is asked to confirm whether it is assured that all risks on the High-Level Risk Register and BAF are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.
Link to Strategic Objective:	N/A
Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	This report details the strategic risks which are reviewed and updated by Executive leads prior to quarterly reporting to ETM, and then to Committees and the Board.
Legal/Regulatory:	N/A
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	**Risk Committee:** 1 June 2026 and 13 July 2026 **People Committee:** 10 June 2026 and 15 July 2026 **Finance and Performance Committee:** 17 June 2026 and 22 July 2026 **Quality Committee:** 18 June 2026 and 22 July 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. Assessment

Board Assurance Framework Q1 2026/27

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

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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.

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).

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.

Q1 2026/27 Opening Score	Q4 2025/26 Risk Score	Exec Director Lead
16 4x4	**12 4x3**	Chief Digital & Information Officer

The Q1 risk score has **increased** from **12 to 16** with the following rationale applied by the Executive Lead:

The increase in risk score is attributable to multiple workforce challenges in domain expertise resulting in missed and partial national submissions that populate numerous external reporting metrics for example, SHMI and Model Hospital information.

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.

Q1 2026/27 Opening Score	Q4 2025/26 Risk Score	Exec Director Lead
12 4x3	**9 3x3**	Director of HR

The Q1 risk score has **increased** from **9 to 12** with the following rationale applied by the Executive Lead: The risk score has increased from 9 to 12 because workforce shortages and staff retention issues could have a greater impact on services than previously assessed. Work is continuing to improve recruitment, retention, apprenticeships and staff wellbeing, but challenges remain, particularly around sickness absence and vacancies in some staff groups. As a result, the overall risk position for Quarter 1 is rated as deteriorating.

<u>High Level Risk Register (HLRR) – Operational Risk</u>

All **operational** risks scoring 15 and above (high level risks) are escalated monthly to the Risk Committee and onward to the relevant Committees and the Board.

At its meetings on 1 June and 13 July 2026 the Risk Committee considered a summary of all high-level risks, including any new risks, closures and changes in score and those risks which had passed their review date. The Committees reviewed the high-level risks within their remit at their meetings held in June and July 2026.

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The HLRR, showing all high-level risks rated 15+ in July 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 July 2026 and shows trends and highlights areas for the Board to consider.

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 the number of changes made to the target mitigation date for each high level risk since it was created.

New risks to the High-Level Risk Register (HLRR)

Two new risks have been accepted onto the HLRR since the last report to the Board.

Risk ID:	Risk Score	Residual Score	Risk Description	Lead Director	Review Date	Committee
2926	**20**	**12**	IF the Trust does not deliver a balanced financial position in year, THEN the Trust will not achieve its agreed financial plan with NHS England resulting in additional sanctions being placed on the Trust by NHS England reducing its ability to invest in services and being unable to maintain liquidity to meet its financial obligations.	Chief Finance Officer	31/08/2026	Finance & Performance Committee
2911	**15**	**9**	The Neonatal service has gaps at consultant level due to retirement and maternity leave. Recent locum appointments only partially cover the gap and availability of suitably qualified individuals is limited. **NB The risk description needs to be updated to the correct format.**	Chief Medical Officer	31/07/2026	Quality Committee & People Committee

Risks which have been removed/closed

Three risks have been closed since the last report.

Risk ID:	Risk Score	Risk Description	Lead Director	Rationale	Committee
290	**20**	If we are unable to renew our ageing estate then there will be operational disruption, patient safety incidents, and failure to meet statutory and regulatory compliance requirements. Resulting in increased service interruptions, reduced estate resilience, inefficient use of clinical space, increased reactive maintenance costs, and a negative impact on patient safety, effectiveness and experience, staff well-being, and delivery of safe and effective healthcare services.	Director of Estates and Facilities	This risk is reflected on the Trust Board Assurance Framework as a Strategic Risk to the organisation, there is no requirement for duplicate risk on the High-Level Risk Register. Risk Closed 6/7/2026.	Finance & Performance Committee / Quality Committee
2773	**16**	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	Chief Nurse	June 26 - risk assessment given extensive update. Decision to close this one and re-open with up-to-	People Committee / Quality Committee

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		untimely medical supervision resulting in substandard care, for all children irrespective of care level needs, reduced flow and possible closure of beds.		date reflection of current risk.	
2764	**15**	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.	Chief Operating Officer	17/6/26 Business case was approved and Consultant appointed. RTT and waiting list improvements and continued upwards trajectory. Standalone risk no longer appropriate and for closure.	Finance & Performance Committee / Quality Committee

Risks which have changed in score

One risk has reduced in score since the last report to the Board.

Risk ID:	Current Score:	Previous Score:	Risk Description:	Lead Director:	Rationale:	Committee:
2509	**12**	**16**	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.	Chief Nurse	29/05/2026 – 400 children on standard assessment pathway and JACC remains at 2 years. Whilst waiting list times and numbers remain high, new pathway implemented and mitigations in place. Score reduced to 12	Quality Committee

Risks beyond their review date

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

Risk ID:	Current Score:	Target Score:	Risk Description:	Lead Director:	Review Date:	Committee:
70	**15**	**6**	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.	Chief Medical Officer	01 July 2026	Finance & Performance Committee / People Committee

3. Recommendation

The Board is asked to confirm whether it is assured that all risks on the High-Level Risk Register and BAF are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.

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BOARD ASSURANCE FRAMEWORK

2026/27

Proposed Q1 Position 2026/27

Q1 2026/27 Position Reporting Timescales:

Risk Committee:	13/07/2026
People Committee:	15/07/2026
Finance & Performance Committee:	22/07/2026
Quality Committee:	22/07/2026
Board of Directors:	23/07/2026

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Board Assurance Framework Key

Trust Risk Management Strategy: Risk Rating Matrix (Consequence x Likelihood)					
Consequence	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
Major 4	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
Moderate 3	3 Low	6 Moderate	9 High	12 High	15 Extreme
Minor 2	2 Low	4 Moderate	6 Moderate	8 High	10 High
Negligible 1	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

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 that the Trust 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

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BOARD ASSURANCE FRAMEWORK DASHBOARD 2026/27

Strategic Risk	Assurance Committee	Exec Lead	Q1	Q2	Q3	Q4	2026/27 Residual Score	Risk Appetite & Tolerance
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**				**10 5x2**	**Open (Score 12-20)**
SR02: If the Trust does not maintain effective quality governance, patient safety and assurance arrangements, **then** quality and safety risks may not be identified, escalated or addressed in a timely manner, **resulting in** avoidable harm, poor patient outcomes and experience, failure to deliver our statutory and regulatory obligations and reduce confidence from our key stakeholders.	**Quality Committee**	**CN**	**15 5x3**				**10 5x2**	**Open (Score 12-20)**
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**	**CDIO**	**16 4x4**				**8 4x2**	**Open (Score 12-20)**
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**	**16 4x4**				**8 4x2**	**Open (Score 12-20)**
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**	**12 4x3**				**8 4x2**	**Seek (Score 16-25)**

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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**	**9 3x3**				**6 3x2**	**Seek (Score 16-25)**
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**	**12 4x3**				**8 4x2**	**Seek (Score 16-25)**
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**	**20 5x4**				**10 5x2**	**Open (Score 12-20)**
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**	**12 3x4**				**9 3x3**	**Open (Score 12-20)**
All Strategic Objectives								
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**	**10 5x2**				**5 5x1**	**Minimal (Score 6-10)**

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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 SO1:	**Quality:** To provide outstanding care for our patients, delivered with kindness.		
						Monitoring	Finance and Performance Committee		
RISK SCORE JOURNEY:									
01.04.26	**Q1**	**Q2**	**Q3**	**Q4**	**2026/27 Residual**	**Risk Appetite:**	**Open**		
20 Extreme	**20 Extreme**				**10 High**	**Risk Appetite Description:** There is a willingness to consider all potential delivery options and choose those which balance acceptable level of reward in terms of improvement and/or value for money.		**Risk Appetite Behaviour:** Balanced approach between opportunity and control.	
5x4	**5x4**				**5x2**	**Acceptable Residual Risk (Tolerance) Score:**		**12-20**	
Quarterly Oversight (risk score): Deteriorating / Static / Improving					**Q1: Static**	**Q2:**	**Q3:**	**Q4:**	**Quarterly summary below:**
Residual Score Rationale:	**10**	To achieve the residual 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 2030 (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. We are developing our Estates Strategy which will be completed by April 2027.

Controls, Processes and Compliance	Assurance	Q1 Assurances						Overall Rating
		First Line		Second Line		Third Line		
Estates & Facilities KPIs	E&F Dashboard reported to Finance & Performance Committee – April, May and June 2026			✓				
Estates Governance Framework	Assurance Map reported to Finance & Performance Committee - May 2026			✓				
	Assurance Map Red rating analysis reported to Finance & Performance Committee - June 2026			✓				
	Estates Operations Compliance Assurance Report reported to Finance & Performance Committee – June 2026			✓				
	Deep Dive: Infrastructure & Capital Risk reported to Finance & Performance Committee – June 2026			✓				

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Estates Capital Projects	Internal Audit Report – Estates Capital Programme (BTH/37/2026) Significant Assurance reported to Finance & Performance Committee – May 2026					✓			
	Internal Audit Report – Estates Invoicing (BH/30/2026) Significant Assurance reported to Finance & Performance Committee – May 2026					✓			
Space Utilisation	Internal Audit Report – Space Utilisation (BH/38/2026) Limited Assurance reported to Finance & Performance Committee – June 2026					✓			
	Biannual car parking update presented to Finance & Performance Committee – April 2026			✓					
Health & Safety /Regulatory Compliance	Health & Safety Annual Report 2025/26 reported to Finance & Performance Committee – June 2026			✓					
	Annual Fire Safety Report reported to Finance & Performance Committee – June 2026			✓					
	Water and Ventilation (Infection Prevention) Biannual report reported to Finance & Performance Committee in April 2026			✓					
	Clinical Engineering Department Annual Report 2025/26 reported to Finance & Performance Committee – April 2026			✓					
Trust Green Plan	Green Plan Biannual Report – F&P Committee June 2026			✓					

Gap in Controls and Assurance	Action identified	Lead	Target completion	Progress
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
	To utilise former Cancer Support Yorkshire building as a hot desking model	Director of Estates	September 2026	In progress
Estate Options	To continue to identify options for the Estate, in line with NHS Property Services	Director of E&F	September 2026	In progress
	To pursue a bid to potentially take over three NHSPs properties (Eccleshill, Eccleshill Intermediate Treatment ITC and Westbourne Green).	Director of E&F	December 2026	In progress
Health on the High Street	To identify space through modern retail space opportunities	Director of E&F	June 2028	In progress

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Q1 High level Risks Scored 15+ Aligned to BAF Risk: SR01							
				Quarter end risk score			
Risk ID	Exec Lead	Risk Description	Committee	Initial Score	Current Score	Trend Analysis	Residual Score
-	-	-	-	-	-	-	-

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BOARD ASSURANCE FRAMEWORK 2026/27

STRATEGIC RISK SR02: **If** the Trust does not maintain effective quality governance, patient safety and assurance arrangements, **then** quality and safety risks may not be identified, escalated or addressed in a timely manner, **resulting in** avoidable harm, poor patient outcomes and experience, failure to deliver our statutory and regulatory obligations and reduce confidence from our key stakeholders.						**Executive Director Lead:**	Chief Nurse		
						Strategic Objective SO1:	**Quality:** To provide outstanding care for our patients, delivered with kindness.		
						Monitoring:	Quality Committee		
RISK SCORE JOURNEY:						**Risk Category:**	**Quality**		
01.04.26	**Q1**	**Q2**	**Q3**	**Q4**	**2026/27 Residual**	**Risk Appetite:**	**Open**	**Area of risk:**	**Regulatory Compliance and Quality & Patient Safety**
N/A New Risk	**15**				**10**	**Risk Appetite Description:** 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.		**Risk Appetite Behaviour:** Conservative decision making.	
-	**5x3**				**5x2**	**Acceptable Residual Risk (Tolerance) Score:**		**12-20**	

Quarterly Oversight (risk score): Deteriorating / Static / Improving	**Q1 N/A**	**Q2:**	**Q3:**	**Q4:**	**Quarterly summary below:**

Residual Score Rationale:	**10**	A significant failure in quality governance, patient safety oversight or assurance arrangements could have a serious impact on patient safety, regulatory compliance and stakeholder confidence therefore the consequence will always remain at a score of 5. Effective governance, assurance and organisational learning arrangements, supported by Board oversight and triangulated quality intelligence, should provide reasonable assurance that emerging risks are identified, escalated and managed appropriately. This risk cannot be eradicated entirely, however with robust arrangements it should be possible to reduce the likelihood to 2 (unlikely).

Quarterly position:

During Quarter 1 the Trust continued to operate established governance arrangements supporting oversight of quality, patient safety and patient experience. This has included scheduled reports to Boards and Committees alongside operational governance and grip and control. Internal Audit has been utilised and a number of reports completed.

To note, limited assurance was given to the Quantity of local investigation reporting highlighting the requirement to further improve.

Operational pressures, including the delivery of the recovery plan, have impacted on the timeliness of some investigations and complaint responses. However, these are monitored on a weekly basis and any urgent issues addressed.

Maternity and neonatal services remain under high levels of scrutiny. In Quarter 4 the Trust was notified of full compliance with the MIS standards and participated as one of the 12 Amos Trusts.

We continue to meet with NHS England as part of the IQIG process and are currently applying to have conditions lifted from the licence.

As part of the CTG programme a robust EQIA process is in place to review any schemes and their impact on quality and quality delivery.

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Controls, Processes and Compliance	Assurance	Q1 Assurance						Overall rating
		First Line		Second Line		Third Line		
Quality Governance Framework	Quality Oversight & Assurance Profile and Patient Safety Incident Investigation (PSII) report – Quality Committee, May 2026	-		✓		-		
	Patient Safety Group Highlight report – Quality Committee, May 2026	-		✓		-		
	Clinical Outcomes Group Highlight report – Quality Committee, April/May 2026	-		✓		-		
	Quarterly Insights Report – Quality Committee, May 2026	-		✓		-		
	Quality Committee Dashboard – Quality Committee, April/May/June 2026	✓		✓		-		
	Quality Account – Quality Committee, June 2026	✓		✓				
	Quality Account Improvement Priorities Quarterly Update – Quality Committee, April 2026	-		✓		-		
Risk Management Framework	High Level Risk Register – Quality Committee, April/May/June 2026	-		✓		-		
Patient Experience	Patient Experience Group Highlight Report	-		✓				
	Patient Engagement and Experience annual report- Quality Committee, May 2026	-		✓		-		
	EXCEL Programme- Quality Committee, April 2026	✓		✓		-		
Safeguarding	Safeguarding Adults Annual report – Quality Committee, June 2026	-		✓		-		
	Safeguarding Children Annual report – Quality Committee, June 2026	-		✓		-		
Assurance and Regulation	CQC Well Led Action Plan – Quality Committee, April 2026 and Board, May 2026	-		✓		-		
	Antimicrobial Resistance – Quality Committee, May 2026	-		✓		-		
	Infection Prevention and Control Quarterly report – Quality Committee, May 2026	-		✓		-		
	Clinical audit annual report and high-priority plan – Quality Committee, May 2026	-		✓		-		
	Ward accreditation – Quality Committee, April 2026	-		✓		-		

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	Progress report on Children's Ward Escalation and Actions	✓		-		-		
Nursing and Midwifery	Maternity & Neonatal Services Update – Quality Committee and Board, April/May/June 2026	✓		✓		✓		
Internal Audit Reports	Quality of Local Incident Reporting – Limited Assurance – Quality Committee, June 2026	-		-		✓		
	Pharmacy Aseptics Unit – Significant Assurance – Quality Committee, May 2026	-		-		✓		
	Sepsis Management – Limited Assurance – Quality Committee, June 2026	-		-		✓		
	PSIRF; Learning Disabilities – Significant Assurance – Quality Committee, April 2026	-		-		✓		

Gap in controls and Assurance	Action Identified	Lead	Target Completion	Progress
Process	Revised approach to QuOC/SEG.	Chief Nurse	September 2026	In progress
CSU Governance	Implement a governance maturity assessment framework to baseline and monitor adoption of Leader Standard Work across CSUs, enabling standardised governance processes, consistent reporting arrangements and improved oversight.	Associate Director of Quality	October 2026	In progress
Children's Ward Improvements	To maintain oversight of actions and ensure executive oversight of required actions following Red Bradford Accreditation Scheme rating.	Chief Nurse	July 2026	In progress
Assurance and Regulation	To review and refresh the Trust wide CQC readiness framework, including evidence repositories, self-assessment processes and service-level action plans, to ensure preparedness for announced and unannounced inspection activity.	Chief Nurse	September 2026	In progress
Risk Management	To implement the varied risk management framework.	Chief Nurse	September 2026	In progress
Maternity and Neonatal	To implement the recommendations from AMOS and Ockenden	Chief Nurse	March 2027	In progress

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Q1 High level Risks Scored 15+ Aligned to BAF Risk: SR02							
				Quarter end risk score			
Risk ID	**Exec Lead**	**Risk Description**	**Committee**	**Initial Score**	**Current Score**	**Q1 Trend Analysis**	**Residual Score**
2787	**Chief Nurse**	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.	Quality Committee F&P Committee	**12 3x4**	**20 4x5**	→	**4 1x4**
979	**Chief Nurse**	If we experience a pandemic this will result in services being impacted due to increased demand and staff absence resulting in potential for loss of life or illness to staff and patients.	Quality Committee People Committee	**20 4x5**	**16 4x4**	→	**16 4x4**
2868	**Chief Nurse**	If we do not have a functioning track and trace system for maternal antibodies, then we will fail to identify the presence of maternal antibodies in pregnancy. Resulting in women not being commenced on the appropriate surveillance pathway harm to mother and baby.	Quality Committee	**15 3x5**	**15 3x5**	→	**5 1x5**
40	**Chief Nurse**	If we cannot demonstrate effective implementation of Personalized Care Plans for all women, then we 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 will result in poor women's experience, risk to effective care and noncompliance with guidance.	Quality Committee	**12 4x3**	**15 5x3**	→	**3 1x3**
30	**Chief Nurse**	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 increased risk of stillbirth.	Quality Committee	**10 5x2**	**15 5x3**	→	**5 5x1**
2879	**Chief Medical Officer**	Middle Grade medical staffing gaps in Obstetrics and Gynaecology.	Quality Committee	**16 4x4**	**16 4x4**	→	**8 2x4**

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BOARD ASSURANCE FRAMEWORK 2026/27

STRATEGIC RISK 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.						**Executive Director Lead:**	Chief Digital and Information Officer	
						Strategic Objective SO2:	**Improvement:** To be a continually learning organisation and recognised as leaders in research, education and innovation.	
RISK SCORE JOURNEY:						**Monitoring:**	Quality Committee	
01.04.26	**Q1**	**Q2**	**Q3**	**Q4**	**2026/27 Residual**	**Risk Appetite:**	**Open**	
12 High	**16 Extreme**				**8 High**	**Risk Appetite Description:** There is a willingness to consider all potential delivery options and choose those which balance acceptable level of reward in terms of improvement and/or value for money.	**Risk Appetite Behaviour:** Balanced approach between opportunity and control.	
4x3	**4x4**				**4x2**	**Acceptable Residual Risk (Tolerance) Score:**	**12-20**	
Quarterly Oversight (risk score): Deteriorating / Static / Improving					**Q1: Deteriorating**	**Q2:**	**Q3:**	**Q4:**	**Quarterly summary below:**
Residual Score Rationale:	**8**	To achieve the residual risk score of 8 and for the likelihood of the risk to be unlikely there will need to be sustained investment in the digital estate and appropriately resourced trained workforce – improved capability and capacity.						

Quarterly position:
The increase in risk score is attributable to multiple workforce challenges in domain expertise resulting in missed and partial national submissions that populate numerous external reporting metrics for example, SHMI and Model Hospital information.

Controls, Processes and Compliance	Assurance	Q1 Assurance						Overall rating
		First Line		Second Line		Third Line		
Data Security and Protection Audits	Data Security and Protection Toolkit – Board, May 2026 and Quality Committee, June 2026			✓				
Information Governance	SIRO Report – Quality Committee, June 2026			✓				
Cyber Governance arrangements	Response to NHSE Cyber Risk Assurance letter (PRN02540) – Closed Board, June 2026			✓				
Digital Strategy	Digital Report – Quality Committee, April 2026			✓				
Internal Audit	Digital Strategy – Significant Assurance – Quality Committee, April 2026					✓		

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Gap in Control	Action Identified	Lead	Target Completion	Progress
Cyber security capacity and specialist resource	• To increase resource to enable full utilisation of new technologies and sustain proactive assurance.	Head of IT and Cyber Security Manager	September 2026	In progress
	• To work with IT and clinical engineering departments and suppliers to ensure medical and IoT devices are patched in a timely manner.	Head of IT and Cyber Security Manager	March 2027	In progress
Digital and Data Transformation	• To progress year 2 digital strategy objectives with a focus on the brilliant basics' objectives.	Chief Digital & Information Officer	March 2027	In progress
Improving analytic capability	• To prepare for the Data Centre due to come online in Q3, building a resilient foundation for a new data warehouse.	Head of IT	December 2026	In progress
Workforce Capacity and domain expertise	• To realign business intelligence and data warehouse functions to meet operational centre of excellence principles.	Director of Performance	September 2026	In progress
	• To work with strategic partners to build a data foundations programme.	Chief Digital & Information Officer	December 2026	In progress

Q1 High level Risks Scored 15+ Aligned to BAF Risk: SR03

Risk ID	Exec Lead	Risk Description	Committee	Initial Score	Current Score	Trend Analysis (Quarter)	Residual Score
901	**Chief Digital & Information Officer**	Due to the increasing scale, sophistication and frequency of cyber threats, there is a risk that a major cyber security incident (including ransomware or DDoS attacks) disrupts critical digital services and infrastructure, resulting in impacts to patient services, regulatory non-compliance, reputational harm, and prolonged recovery activity, which may include data loss.	Quality Committee	**20 5x4**	**16 4x4**	→	**12 4x3**

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BOARD ASSURANCE FRAMEWORK 2026/27

STRATEGIC RISK SR04: If we are unable to attract the resources, skills and experience needed **then** we will be unable to maintain standards and deliver research, education and innovation priorities, **resulting in** an inability to retain our research and teaching status, and a negative impact on patient care.						**Executive Director Lead:**	Chief Medical Officer
						Strategic Objective SO2:	**Improvement:** To be a continually learning organisation and recognised as leaders in research, education and innovation.
RISK SCORE JOURNEY:						**Monitoring:**	Quality Committee
01.04.26	**Q1**	**Q2**	**Q3**	**Q4**	**2026/27 Residual**	**Risk Appetite:**	**Open**
16 Extreme	**16 Extreme**				**8 High**	**Risk Appetite Description:** There is a willingness to consider all potential delivery options and choose those which balance acceptable level of reward in terms of improvement and/or value for money.	**Risk Appetite Behaviour:** Balanced approach between opportunity and control.
4x4	**4x4**				**4x2**	**Acceptable Residual Risk (Tolerance) Score:**	**12-20**

Quarterly Oversight (risk score): Deteriorating / Static / Improving	**Q1: Static**	**Q2:**	**Q3:**	**Q4:**	**Quarterly summary below:**

Residual Score Rationale:	**8**	To achieve the residual score of 8, staffing levels would need to align with future workforce plans.

Quarterly position: As this risk is in two parts (previously two strategic risks) the score remains 16 in relation to staffing pressures and action required to actively reduce headcount. The challenges associated with staffing pressures increases the likelihood of negative impact on standards and patient care. In relation to research and teaching status, there is currently no risk. The teaching status is in a good position, and we are high performing as a research centre.

Controls, Processes and Compliance	**Assurance**	**Q1 Assurance**						**Overall rating**
		First Line		**Second Line**		**Third Line**		
Medical Appraisal and Revalidation Compliance	Medical Appraisal and Revalidation Annual Report presented to People Committee – June 2026			✓				
Guardian of Safe Working Hours	Quarterly Guardian of Safe Working Hours presented to People Committee – May 2026			✓				
National Education & Training Survey (NETS) feedback	Annual NETS assurance report presented to People Committee – June 2026			✓				
First 72 hours standards	Baseline 72 hours standards self-assessment presented to Board of Directors – May 2026			✓				
Education Reporting and Self-Assessment	Education Annual Report presented to People Committee – May 2026			✓				

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Clinical Audit	Clinical Audit Annual Report presented to Quality Committee – May 2026			✓				
	Clinical Audit High Priority Plan presented to Quality Committee – May 2026			✓				
	Clinical Outcomes Group Highlight Report presented to Quality Committee – May, June 2026			✓				

Gap in Control	Action Identified	Lead	Target Completion	Progress
Numbers of resident doctors on rotas	To continue to work with the Deanery to fill vacancies.	Director of Education	March 2027	In progress
Research Dashboard	To improve access to research information / activity through research dashboard.	Director of Research Operations	March 2027	In progress
NIHR Funding	To utilise NIHR Funding to improve research activity.	Director of Research Operations	March 2027	In progress
Trust Research Strategy	To progress action plan associated with the Trust Research Strategy.	Director of Research/Clinical Director	March 2027	In progress
Education Plan	To implement actions identified in the Education Plan.	Head of Education	March 2027	In progress
Executives and Research	To develop meetings with the Research Executive Team and Trust Executive Team.	Chief Medical Officer	March 2026	Complete

Q1 High level Risks Scored 15+ Aligned to BAF Risk: SR04

Risk ID	Exec Lead	Risk Description	Committee	Initial Score	Current Score	Quarter Trend analysis	Residual Score
-	-	-	-	-	-	-	-

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BOARD ASSURANCE FRAMEWORK 2026/27

STRATEGIC RISK 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.	**Executive Director Lead:**	Director of HR
	Strategic Objective SO3:	**People:** To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing quality, diversity and inclusion.
	Monitoring:	People Committee

RISK SCORE JOURNEY:

01.04.26	Q1	Q2	Q3	Q4	2026/27 Residual	Risk Appetite:	Seek
9	12				8	**Risk Appetite Description:** 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: Ther is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.	**Risk Appetite Behaviour:** Innovation and transformation encouraged.
3x3	4x3				4x2	**Acceptable Residual Risk (Tolerance) Score:**	16-25

Quarterly Oversight (risk score): Deteriorating / Static / Improving	Q1: Deteriorating	Q2:	Q3:	Q4:	Quarterly summary below:

Residual Score Rationale:	8	To achieve the residual score of 6, the Trust will need to demonstrate sustained improvement across key workforce indicators, including reduced vacancy and sickness absence rates, improved staff retention, enhanced appraisal compliance. positive workforce engagement measures. Achievement of workforce plan objectives and delivery of targeted recruitment and wellbeing initiatives would reduce the likelihood of the risk materialising to unlikely (2), whilst recognising that workforce challenges would continue to have a moderate impact on service provision.

Quarterly position: The risk score has increased from 9 to 12 because workforce shortages and staff retention issues could have a greater impact on services than previously assessed. Work is continuing to improve recruitment, retention, apprenticeships and staff wellbeing, but challenges remain, particularly around sickness absence and vacancies in some staff groups. As a result, the overall risk position for Quarter 1 is rated as deteriorating. The impact of the risk has changed from a 3 to 4 due to the complex nature and multiple additional risks involved.

Controls, Processes and Compliance	Assurance	Q1 Assurance						Overall rating
		First Line		Second Line		Third Line		
People KPIs / Dashboards	People Dashboard reported to People Committee – April, May and June 2026			✓				
Workforce Planning Submission	Workforce Reduction Plan reported to People Committee – May 2026			✓				
Nursing & Midwifery staffing Data Publication Report	Monthly report reported to People Committee – April, May and June 2026			✓				

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Apprenticeships Strategy	Annual Apprenticeships Report reported to People Committee – April 2026			✓				
Wellbeing and Attendance Management Plan	Update reported to People Committee – May 2026			✓				
Staff Survey and Action Plan	Report and Action Plan reported to People Committee – June 2026			✓				
Freedom to Speak Up	Quarterly FTSU report reported to People Committee – May 2026			✓				
Guardian of Safe Working Hours Review	Quarterly update reported to People Committee – May 2026			✓				
Health and Safety (People Focus)	Assurance Report presented to People Committee – June 2026			✓				

Gap in Control	Action Identified	Lead	Target Completion	Progress
Workforce Reduction Plan	• To include HCA workforce model in the workforce reduction plan for reporting to the Board and NHS England.	Director of HR / Associate Chief Nurse for Quality & Workforce	July 2026	**Complete**
Recruitment of HCAs	• To improve the healthcare assistant vacancy rates and explore alternative recruitment initiatives.	Associate Chief Nurse for Quality & Workforce	September 2026	In progress
Sickness Policy and Action Plans	• To refresh sickness action plans	Associate Director of HR	June 2026	**Complete**
	• To review and consult on Sickness Policy changes.	Associate Director of HR	June 2026	**Complete**
KPI and Dashboard reporting	• To improve and enhance workforce KPI and dashboard reporting to fulfil assurance reporting requirements to the People Committee and the Board.	Director of HR / CDIO	September 2026	In progress
Pay and banding Newly qualified nurses	• To respond to national guidance and pursue any regional work to achieve consistency of the progression improvements for newly qualified nurses including a review of job descriptions.	Associate Chief Nurse for Quality & Workforce	December 2026	In progress
Freedom to Speak Up	• CSU to Exec meetings to consider how CSUs are managing concerns locally and whether themes align to with those identified through FTSU reporting process.	FTSU Guardian and Exec Lead	September 2026	In progress
Timeliness of investigation responses (Grievance / Capability / Disciplinary / Sickness	• Director of HR reviewing resource implications and closer monitoring of timescales	Director of HR	September 2026	In progress

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Q1 High level Risks Scored 15+ Aligned to BAF Risk: SR05							
Risk ID	**Exec Lead**	**Risk Description**	**Committee**	**Initial Score**	**Current Score**	**Trend Analysis**	**Residual Score**
-	-	-	-	-	-	-	-

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BOARD ASSURANCE FRAMEWORK 2026/27

STRATEGIC RISK 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.						**Executive Director Lead:**	Chief Operating Officer		
						Strategic Objective SO3:	**People:** To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing quality, diversity and inclusion.		
RISK SCORE JOURNEY:						**Monitoring:**	People Committee		
01.04.26	**Q1**	**Q2**	**Q3**	**Q4**	**2026/27 Residual**	**Risk Appetite:**	**Seek**		
9 High	**9 High**				**6 Moderate**	**Risk Appetite Description:** 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: Ther is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.		**Risk Appetite Behaviour:** Innovation and transformation encouraged.	
3x3	**3x3**				**3x2**	**Acceptable Residual Risk (Tolerance) Score:**		**16-25**	
Quarterly Oversight (risk score): Deteriorating / Static / Improving					**Q1: Static**	**Q2:**	**Q3:**	**Q4:**	**Quarterly summary below:**
Residual Score Rationale:	**6**	To achieve the residual risk score of 6 we will need to achieve the trust's wider EDI ambitions around EDI, including some of our longer-term targets. Our focus to mitigating this risk will be to work with CSU's/ departments with a data driven approach, ensuring they are aware of the inequalities that exist within their areas of responsibility, and that they can have some focussed effort around our EDI objectives.							

Quarterly position: We have some good foundations in place allowing us to embed EDI as core activity across the Trust (e.g. establishment of the Equality & Diversity Council and our four staff equality networks). Good progress has already been made on our previous strategic EDI objectives, which includes meeting our legal and contractual requirements, and this progress has been reported to People Committee on a regular basis. In terms of business as usual, the mandated frameworks such as WRES, WDES, diversity pay gap reporting and the equality delivery system continue to be part of our core EDI business, and we are making steady progress, but with a number of priority areas of focus that still require improvement. A key priority area for the WRES is to focus on diversifying our senior level representation. A range of work areas are currently being further developed with colleagues around this, including reviewing and refreshing our strategic EDI objectives (2026-2029) which align to our EDI workforce ambitions and will work towards mitigating this strategic risk. Our draft EDI objectives (which have been developed through a range of targeted engagement) were presented to the Trust Equality & Diversity Council in July and include;

- Adopting the NHS Race Observatory 7 anti-racist principles
- Inclusive leadership and culture
- Workforce equity and experience

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Controls, Processes and Compliance	Assurance	Q1 Assurance						Overall rating
		First Line		Second Line		Third Line		
Strategic EDI Objectives	EDI update– reported to Board, May 2026			✓				
Equality Delivery System 22	WRES, WDES Annual Data Report presented to People Committee – May 2026			✓				
	EDS Assurance Report reported to Quality Committee - April 2026			✓				
Equality & Diversity Council and Staff Equality Networks	Quarterly Equality and Diversity Council Updates to the Board – May 2026			✓				
				✓				
People Dashboard	People Dashboard reported to People Committee in April, May and June 2026.			✓				

Gap in Control	Action Identified	Lead	Target Completion	Progress
Equality Impact Assessments	To roll out the Equality Impact Assessment Guidance and Proforma	Head of EDI	September 2026	In progress
Review of EDI Objectives	To support delivery of the EDI objectives and progress of the EDI action plans.	Head of EDI	March 2027	In progress
Policies and Procedures	To review existing bullying and harassment policy moving to Civility, Respect Resolution Policy	Head of EDI	September 2026	In progress
	To review Disability Equality Policy	Head of EDI	September 2026	In progress
Anti Racism Charter	To work with the NHS Race & Health Observatory and adopt and introduce district wide anti racism principles	Head of EDI	March 2027	In progress

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Q1 High level Risks Scored 15+ Aligned to BAF Risk: SR06							
Risk ID	**Exec Lead**	**Risk Description**	**Committee**	**Initial Score**	**Current Score**	**Trend Analysis**	**Residual Score**
-	-	-	-	-	-	-	-

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BOARD ASSURANCE FRAMEWORK 2026/27

STRATEGIC RISK 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.						**Executive Director Lead:**	Director of Strategy and Transformation
						Strategic Objective SO4:	**Partnership:** To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals.
						Monitoring:	Quality Committee
RISK SCORE JOURNEY:							
01.04.26	**Q1**	**Q2**	**Q3**	**Q4**	**2026/27 Residual**	**Risk Appetite:**	**Seek**
12 High	**12 High**				**8 High**	**Risk Appetite Description:** 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: Ther is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.	**Risk Appetite Behaviour:** Innovation and transformation encouraged.
4x3	**4x3**				**4x2**	**Acceptable Residual Risk (Tolerance) Score:**	**16-25**
Quarterly Oversight (risk score): Deteriorating / Static / Improving					**Q1: Static**	**Q2:**	**Q3:** **Q4:** **Quarterly summary below:**
Residual Score Rationale:	**8**	To achieve the residual risk score of 8 there would need to be a fully functional Place Provider Partnership delivering the ambitions of the Place Based Strategy through the effective working of the four Strategic Delivery Groups by 1 April 2027.					

Quarterly position: The four Strategic Delivery Groups have strengthened partnership working. ICB changes are impacting capacity, so the Trust is providing the capacity and expertise to support the working groups of the Place Provider Partnership, which are now established. Trust Executive Directors are key players and an organisation we are leading key aspects of this work. Challenges during the first quarter have included capacity within trust and partners and it has taken some time to reach consensus on the governance arrangements. Board Development Session on system working held in June 2026.

Given the significance of inequalities as a driver for our population health outcomes, the close-down of the Reducing Inequalities Alliance has left a gap in assurance. However, public health are starting to take on this leadership role for BD&C Place. Within the Trust, the Health Equity and Health Inequalities Programme is progressing overseen by the Health Equity Oversight Group. The Health Inequalities Statement was included in the Trust's Annual Report 2025/26 and published on the Trust's website.
During the quarter we have established quarterly reporting to the Board on BTHFT's role as an anchor institution and working with partners to maximise social value.
Partners Group is being established for Health on the High Street.
New Strategic Framework for 2026/27 strengthens the emphasis on partnership working to improve health equity.

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Controls, Processes and Compliance	Assurance	Q1 Assurance						Overall rating
		First Line		Second Line		Third Line		
Collaboration working	Collaboration at Place Update – Board of Directors May 2026			✓				
	Committee in Common monthly report – Board of Directors			✓				
	CEO Report – Board of Directors May 2026			✓				
Partnerships	Update on WYAAT Programmes – Board of Directors May and June 2026			✓				
	Place Provider Partnership – Strategic Update to Board May 2026			✓				
Health Equity and Inequalities Programme	Quarterly EDC report to Board of Directors – May 2026			✓				
	Health Inequalities Statement – Annual Report 2025/26 to Board of Directors - June 2026			✓				

Gaps in Control	Action Identified	Lead	Target Completion	Progress
ABCAS Programme	• To develop speciality working groups for ABCAS.	Director of Collaboration	July 2026	Complete
	• To establish formal governance group across AFT and BTHFT to support the decisions required on collaboration.	Director of Collaboration	September 2026	In progress
Health on the High Street	• To establish a Partners Group.	Head of Strategy and Partnerships	September 2026	In progress
ICB Changes	• To mitigate the impact of changes in WY ICB and the disestablishment of the Reducing Inequalities Alliance.	Head of Strategy and Partnerships	September 2026	In progress
Building skills and capability	• To ensure inequalities training is included in the trust induction programme, the Nursing Preceptorship Training and the Thrive Management Essentials Programme.	Head of Strategy and Partnerships	December 2026	In progress
Access to inequalities data	• To develop a health inequalities dashboard.	Head of Strategy and Partnerships	September 2026	In progress

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Q1 High level Risks Scored 15+ Aligned to BAF Risk: SR07							
Risk ID	**Exec Lead**	**Risk Description**	**Committee**	**Initial Score**	**Current Score**	**Trend Analysis**	**Residual Score**
-	-	-	-	-	-	-	-

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BOARD ASSURANCE FRAMEWORK 2026/27

STRATEGIC RISK 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.	**Executive Director Lead:**	Chief Finance Officer
	Strategic Objective SO5:	**Sustainability:** To deliver our financial plan and key performance targets
	Monitoring:	Finance & Performance Committee

RISK SCORE JOURNEY:

01.04.26	Q1	Q2	Q3	Q4	2026/27 Residual	Risk Appetite:	Open	
20 Extreme	20 Extreme				10 High	**Risk Appetite Description:** There is a willingness to consider all potential delivery options and choose those which balance acceptable level of reward in terms of improvement and/or value for money.		**Risk Appetite Behaviour:** Balanced approach between opportunity and control.
5x4	5x4				5x2	**Acceptable Residual Risk (Tolerance) Score:**		12-20

Quarterly Oversight (risk score): Deteriorating / Static / Improving	Q1: Static	Q2:	Q3:	Q4:	Quarterly summary below:

Residual Score Rationale:	**10**	To achieve the residual risk score of 10, the trust must identify and implement measures to improve the Income & Expenditure forecast by £39m compared to the Month 2 mid case forecast. These measures should include increased CTG delivery £15.5m, recovery of the Elective Recovery Fund position £12m and mitigations to planned MARS savings £11.5m.

Quarterly position:

The risk score in Q1 has remained the same at 20 due to the risks to delivering the required run rate improvements.

At the end of Q1 the Trust reported a position £1.7m adverse to plan. Run rate controls and Closing the Gap (CTG) efficiencies contributed £9.9m to this position. ERF income below plan.

Grip and control measures further embedded in Q1 include:

Tighter recruitment controls via Executive Workforce Control processes, CFO sign off of discretionary non-pay expenditure. Reductions in substantive, bank and agency workforce. Review of business cases approved in 2025/26 and curtailment of recruitment into related posts. Business case controls further strengthened – no significant investments approved in Q1. MARS savings achieved recurrently but below targeted levels – seeking NHSE support.

Improved governance and more rigorous oversight of CTG programme, including:

Appointment of Recovery Director, weekly CEO-led Trust Recovery Board, weekly Executive Recovery Group, named executive director leads for overarching CTG programmes, robust gateway process for CTG plan development and delivery assurance. Service area triumvirate teams increased role of directly supporting CSU delivery.

Sufficient outline schemes identified to deliver full £58.4m formally planned CTG target – translating the schemes into delivery via these structures is the risk that must be mitigated. £19m of schemes at Gateway 3 (delivery / transacted) with a further £45m at Gateway 2 (costed, scoped, yet to be transacted). These are full year values and there are risks to in in year delivery in full in 2026/27. To mitigate this, pipeline schemes at Gateways 0 & 1 total £5m.

Executive-led Outpatients and Theatres productivity programmes providing focus and governance to support improving the Elective Recovery Funding position.

Drivers of the Deficit report commissioned – draft report received to indicate further opportunities to deliver efficiencies.

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Cash risks are being actively managed by more robust Cash Committee, and detailed forecasting. Treasury Management Policy updated April 2026. Revenue cash support application submitted to NHSE in 2025/26 Q4 to provide sufficient cash for 2026/27 Q1 operational cash requirements. Forecasts indicate cash support may be required in Month 6 – will follow appropriate process with Board visibility.

Controls, Processes and Compliance	Assurance	Q1 Assurance						Overall rating
		First Line		Second Line		Third Line		
Medium Term Financial Plan	Medium Term Plan reported to F&P Committee – June 2026			✓				
Clinical Service Unit (CSU) financial management framework	Monthly Finance Report reported to F&P Committee – April, May and June 2026			✓				
Closing the Gap Programme	Financial Recovery Update reported to F&P Committee - May and June 2026			✓				
Efficiency Opportunities	Closing the Gap Reports reported to F&P Committee – April, May and June 2026			✓				
Financial Controls	Monthly Finance Report reported to F&P Committee – April, May and June 2026			✓ ✓				
	National Cost Collection Assurance Report reported to F&P Committee – June 2026			✓				
Procurement	Procurement Update reported to F&P Committee – April 2026			✓				
Cash & Liquidity Monitoring	Monthly Finance Report reported to F&P Committee – April, May and June 2026			✓				
Capital Programme & Plan	Monthly Finance Report reported to F&P Committee – April, May and June 2026			✓				
Pathology Joint Venture	JV Financial and Performance Position reported to F&P Committee – June 2026			✓				
Corporate Services Review	Closing the Gap report reported to F&P Committee – April, May and June 2026			✓				

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Gap in Control	Action Identified	Lead	Target Completion	Progress
Closing the Gap – delivery of identified plans	Executive-led CTG programmes and Service Area triumvirates supporting CSUs with delivery	Executive Recovery Group	March 2027	In progress
	To hold CFO meetings with CSUs via the Accountability Framework.	CFO	March 2027	In progress
	To ensure multi-year planning process and revised budget setting process for 2026/27 is maintained.	CFO	March 2027	In progress
Elective Recovery Fund activity and income reporting and delivery	To improve timeliness and accuracy of reporting on ERF position. To maximise productivity via Theatre and Outpatients CTG improvement programmes	CFO / CDIO Exec leads for CTG programmes	March 2027	In progress
System Partners collaboration	To continue to engage with system partners to collaborate on shared cost improvement plans.	CFO with Exec Leads	March 2027	In progress
Delivery of the Capital Programme	To improve resources are available for the management of the capital programme, with an explicit 5-year plan to enable more effective planning of the capital programme.	CFO with Exec Leads	March 2027	In progress
Grip and Control Recommendations	To implement the 27 Grip and Control recommendations.	CFO with Exec Leads	March 2027	In progress
Capital Programme	To improve monitoring of the ongoing developments of capital programme, reduction of CDEL and cash for future capital programme via the Capital Strategy Group and Capital Operational Group.	CFO with Exec Leads	March 2027	In progress

Q1 High level Risks Scored 15+ Aligned to BAF Risk: SR08							
Risk ID	**Exec Lead**	**Risk Description**	**Committee**	**Initial Score**	**Current Score**	**Q1 Trend Analysis**	**Residual Score**
2926	**Chief Finance Officer**	IF the Trust does not deliver a balanced financial position in year, THEN the Trust will not achieve its agreed financial plan with NHS England RESULTING IN additional sanctions being placed on the Trust by NHS England reducing its ability to invest in services and being unable to maintain liquidity to meet its financial obligations.	**Finance & Performance Committee**	**12 4x3**	**20 5x4**	→	**12 4x3**

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BOARD ASSURANCE FRAMEWORK 2026/27

STRATEGIC RISK 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.						**Executive Director Lead:**	Chief Operating Officer	
						Strategic Objective SO5:	**Sustainability:** To deliver our financial plan and key performance targets	
RISK SCORE JOURNEY:						**Monitoring:**	Finance & Performance Committee	
01.04.26	**Q1**	**Q2**	**Q3**	**Q4**	**2026/27 Residual**	**Risk Appetite:**	**Open**	
12 High	**12 High**				**9 High**	**Risk Appetite Description:** There is a willingness to consider all potential delivery options and choose those which balance acceptable level of reward in terms of improvement and/or value for money.	**Risk Appetite Behaviour:** Balanced approach between opportunity and control.	
3x4	**3x4**				**3x3**	**Acceptable Residual Risk (Tolerance) Score:**	**12-20**	

Quarterly Oversight (risk score): Deteriorating / Static / Improving	**Q1:** Static	**Q2:**	**Q3:**	**Q4:**	**Quarterly summary below:**

Residual Score Rationale:	**9**	To achieve the residual score of 8 and reduce the likelihood of the risk from 4 (likely) to 3 (possible) there would need to be significant financial investment to mitigate financial risk and the issue of balance finance vs performance delivery.

Quarterly position: The Q1 risk score remains at 12.

As at Q4 2025/26 the Trust's National Oversight Framework (NOF) position is ranked 56th out of 134 trusts an improvement on 58th in Q3. Although performance remained strong overall at 1.76 an improved position on the previous quarter, key challenges remain and include -

- Translating closing the gap targets into delivery and balancing difficult decisions – financial balance vs performance delivery.
- Challenges remain in relation to delivery of the objectives and targets identified in the operational Improvement Plan e.g. 7% RTT improvement in Year 1 risk to performance vs delivery of financial plan.
- Theatre Improvement Programme – St Lukes Day Case Unit remains closed therefore potential impact on elective activity plan being mitigated through additional weekend operating.

Controls, Processes and Compliance	**Assurance**	**Q1 Assurance**						**Overall rating**
		First Line		**Second Line**		**Third Line**		
Medium Term Plan	Medium Term Plan reported to F&P Committee – June 2026			✓				
Operational Financial and Workforce Plans	Operational Highlight Report reported to F&P Committee – April, May and June 2026			✓				

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Operational Improvement Plan (RTT)	Operational Improvement Plan (Delivering Operational Excellence) reported to F&P Committee in April, May and June 2026			✓				
Theatre Improvement Programme	Deep Dive Report reported to F&P Committee – June 2026			✓				
65 Week Wait	Operational Highlight Report reported to F&P Committee – April, May and June 2026			✓				
EPRR	Annual EPRR Update and Submission reported to F&P Committee – April 2026			✓				
Closing the Gap Programme	Recovery Update reported to F&P Committee – April, May and June 2026			✓				
Getting it Right First Time (GIRFT)	GIRFT report/routine model hospital KPI reported to F&P Committee – April, May and June 2026			✓				
National Oversight Framework (NOF)	IPR & Operational Performance Report reported to F&P Committee – April, May June 2026			✓				
WYATT Case for Change	WYAAT updates reported to Board – May 2026			✓				
Discharge Management	Internal Audit Report Follow Up Report (BTH/37/2026) Significant Assurance reported to F&P Committee – May 2026					✓		
Utilisation of Resources	Internal Audit Report – Outpatients (BTH/29/2026) Significant Assurance – reported to F&P Committee – May 2026					✓		

Gap in Control	Action Identified	Lead	Target Completion	Progress
Closing the Gap	To address the recommendations identified by Audit Yorkshire findings (21 April 2026)	COO / Deputy CEO Chief Finance Officer	September 2026	In progress
Service Risks	To complete histopathology business case.	Deputy Director of Operations (Cancer and Diagnostics)	September 2026	In progress
	To improve dialysis provision through a long-term strategic plan – business case in progress regarding estate.	Deputy Director of Operations (Cancer and Diagnostics)	December 2029	In progress
	To fill gaps identified in the Non-Surgical Oncology (NSO) Business case acute oncology Outpatient to be submitted	Deputy Director of Operations (Cancer and Diagnostics)	September 2026 December 2026	In progress

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	To ensure existing Vascular and Interventional Radiology (VIR) Consultant is trained and rota gaps are filled.	Deputy Director of Operations (Cancer and Diagnostics)	April 2026	Complete
Skipton Hospital Capacity Renal Dialysis	To expand chair capacity at Skipton Hospital following capital expenditure approval.	Director of Estates & Facilities	April 2027	In progress
Financial & Resource challenges	To escalate issues to WYAAT and specialised commissioning.	Chief Finance Officer	2026/27	In progress
Lack of ring fenced ultra-green elective off-site facility	To implement dedicated day case theatres at St Lukes Hospital.	Director of Estates & Facilities	April 2027	In progress
Independent Sector (IS) lack of funding	To recruit additional histopathologists as per above business case to reduce reliance on SBS Services Histopathology.	Deputy Director of Operations (Cancer and Diagnostics)	September 2026	Partial
SSNAP (Stroke Audit programme) Standards	To make quarterly improvements on performance against the new SSNAP standards/criteria.	Deputy Director of Operations (Unplanned services)	September 2026	In progress
Discharge Management	To maintain oversight of the effectiveness of action taken in response to the recommendations made in the Internal Audit Report (August 2025)	Deputy Director of Operations (Unplanned services) / Deputy Director of Nursing (Ops)	November 2026	In progress

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Q1 High level Risks Scored 15+ Aligned to BAF Risk: SR09							
Risk ID	**Exec Lead**	**Risk Description**	**Committee**	**Initial Score**	**Current Score**	**Q1 Trend Analysis**	**Residual Score**
2604	**Chief Operating Officer**	There is a risk that the number of patients in the emergency department will exceed its design 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.	Quality Committee F&P Committee	**20 4x5**	**20 4x5**	→	**12 4x3**
2756	**Chief Operating Officer**	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	Quality Committee F&P Committee	**20 5x4**	**20 5x4**	→	**12** 4x3
2549	**Chief Operating Officer**	If we cannot agree a workforce model for NSO then we will not be able to continue to support the current/planned NSO model of care within the Trust and region, resulting in delays with cancer treatment causing harm to patients.	People Committee Quality Committee	**16 4x4**	**16 4x4**	→	**8 4x2**
70	**Chief Operating Officer**	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 harm 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.	F&P Committee People Committee	**20 4x5**	**15 3x5**	→	**6 2x3**
2753	**Chief Medical Officer**	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.	Quality Committee F&P Committee	**25 5x5**	**20 5x4**	→	**5 5x1**
2601	**Chief Medical Officer**	If we fail to replace and maintain the cardiac catheter lab then we will prevent optimal numbers of patients being seen, resulting in longer waits for elective PCI and pacing work, and pressure on beds due to acute waits. Resulting in increased patient harm and poor patient experience.	Quality Committee	**15 5x3**	**15 5x3**	→	**9 3x3**
2725	**Chief Medical Officer**	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.	Quality Committee	**15 3x5**	**15 3x5**	→	**3 3x1**
95	**Chief Medical Officer**	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	People Committee Quality Committee	**15 3x5**	**15 3x5**	→	**6 3x2**

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BOARD ASSURANCE FRAMEWORK 2026/27

STRATEGIC 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.						**Executive Director Lead:**	Chief Operating Officer / Chief Nurse		
						Strategic Objective:	All		
						Monitoring:	Board of Directors		
01.04.26	**Q1**	**Q2**	**Q3**	**Q4**	**2026/27 Residual**	**Risk Appetite:**	**Minimal**		
10 High	**10 High**				**5 Moderate**	**Risk Appetite Description:** There is a preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.		**Risk Appetite Behaviour:** Conservative decision making.	
5x2	**5x2**				**5x1**	**Acceptable Residual Risk (Tolerance) Score:**		**6-10**	
Quarterly Oversight (risk score): Deteriorating / Static / Improving					**Q1: Static**	**Q2:**	**Q3:**	**Q4:**	**Quarterly summary below:**
Residual Score Rationale:	**5**	To achieve the residual score of 5 the trust will need to have **fully implemented** and **evaluated the effectiveness** of the actions identified in the April 2026 Well Led Inspection Action Plan and fully implemented and reviewed the effectiveness of an improved Board Assurance Framework, including the implementation of all recommendations from the internal audit reports on risk management and the BAF.							

Quarterly position: Good progress has been made during Q1 to improve governance and risk management arrangements as follows –

The trust received a rating of Good in the recent CQC Well Led Inspection with an Action Plan approved by the Board of Directors in May 2026. Good progress has been made to address and complete several actions.

As a result of recommendations identified in the annual audit of the Board Assurance Framework, a new BAF format has been introduced during 2026/27 with plans to enhance and improve board reporting, agenda templates and work plans to incorporate references to the Trust's strategic risks. This work will be completed in Q2 2026.

The External Audit ISA260 report to the Audit Committee and Board stated that – 'Based on the evidence provided from management, our review of the CQC reports, discussions with NHS England and review of public documentation, the Trust has made progress against the recommendations raised previously. Based on our procedures performed, we are satisfied that this no longer represents a significant weakness.'

Controls, Processes and Compliance	**Assurance**	**Q1 Assurance**						**Overall rating**
		First Line		**Second Line**		**Third Line**		
Annual Governance Statement	Annual Governance Statement 2025/26 – Audit Committee & Board of Directors, June 2026			✓				
Annual Report 2025/26	Annual Report and Accounts Submission – Audit Committee & Board of Directors, June 2026			✓				
External Audit	ISA260 report – Audit Committee & Board of Directors, June 2026					✓		

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Quality Account	Quality Account 2025/26 – Quality Committee & Board of Directors, June 2026			✓				
Annual Review of Compliance against Code of Governance and NHS Provider Licence	Annual Compliance Statement, ETM, Audit Committee & Board of Directors, May 2026			✓				
Annual Review of NED independence	Annual Assurance Report, Board of Directors, May 2026			✓				
Annual Effectiveness Reviews & Terms of Reference	Committee Annual Reports and updated Terms of Reference – Committees & Board of Directors, April/May 2026			✓				
High Level Risk Register	Monthly reports - ETM, Committees & Board of Directors, April/May/June 2026			✓				
Board Assurance Framework	Q4 report – ETM, Committees & Board of Directors, May 2026			✓				
Risk Management Strategy	Risk Management Strategy and Risk Appetite Statement – Audit Committee & Board of Directors, May 2026			✓				
CQC Well Led Inspection	Outcome of CQC Well Led Inspection (Good) and action plan – Board of Directors, May 2026					✓		
Internal Audit Reports	Internal Audit Report – Risk Management (Significant Assurance) – April 2026					✓		
	Internal Audit Report – BAF (Limited Assurance) – April 2026					✓		

Gap in Control	Action Identified	Lead	Target Completion	Progress
CQC Well Led Inspection	To implement the actions identified in the Well Led Inspection Action Plan	Various – see action plan	November 2026	In progress
Board Assurance Framework and risk management Internal Audit recommendations	To implement the actions identified in the Internal Audit Reports on the BAF and risk management.	Associate Directors of Quality and Corporate Governance	September 2026	In Progress
Improvements to technical governance (e.g. Board and Committee arrangements)	To produce and hold information sessions for report authors, to provide board assurance committees with clear and concise reports.	Corporate Governance Team	Sessions to be held quarterly during 2026/27	In Progress

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Improvements to Board Dynamics	To continue to deliver a Board Development Programme during 2026/27.	Chair & Organisational Development Lead	March 2027	In Progress

Q1 High level Risks Scored 15+ Aligned to BAF Risk: SR10							
Risk ID	**Exec Lead**	**Risk Description**	**Committee**	**Initial Score**	**Current Score**	**Trend Analysis**	**Residual Score**
-	-	-	-	-	-	-	-

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All Open Operational Risks with a current scoring of 15 or over (as at 30/06/2026)

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)	Control measures in place at the time of entering the risk on to the Risk Register	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.	01 Aug 2026	25	(5) Catastrophic	(5) Will undoubtedly recur, possibly frequently	5	(5) Catastrophic	(1) Cannot believe that this will ever happen again	Utilise Sunday capacity. Provide twice weekly dialysis (instead of 3 sessions) where it is clinically appropriate. Patients who require urgent care through lack of timely dialysis can be brought to BTHFT and receive dialysis as an acute inpatient through ADU or Ward 15. Patients are encouraged to take up peritoneal dialysis and home dialysis to reduce the demand on in-centre haemodialysis.	25/06/2026 Available slot capacity remains low with 98% of slots occupied. Delay in BRI ADU opening - hopeful for refurbishment completion in July 26, 2 rooms identified at SLH, ward 15 expansion plans shelved due to costs. Home therapies enrolled in national QI project to try and increase uptake.	30 Nov 2026	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
2604	04 Jul 2024	Sajid Azeb	Mayada Elsheikh	Risk Assessment	Quality & Patient Safety Academy 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 2026	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	12	(4) Major	(3) May recur occasionally	05/02/26 - successful bid for relatively small amount of capital means some estates work has begun w/c 2/2/26. SDEC trial has resulted in taking an average of 70 patients per day assisting with the decongestion however this comes to an end in March 2026. Review needed 31.3.26 to assess impact on AECU. Risk score therefore not amended as the SDEC mitigation will end shortly. Regular monitoring of use of TES trolleys, AZ sub-wait and "poorly chairs". Nurse staffing review will help with oversight of temporary escalation spaces. Improvement action plan has an Estates workstream which is looking at use of space. 12/01/2026 - Reviewed at ETM - risk continues, weekly oversight in place, staffing review underway and to be presented to Board in January 2026. Target date for mitigation updated to 31/3/2027 as some of the	21/04/2026 (ME) January update EXCEL programme now at 1 year- looking into this in detail. Pre hospital, in hospital and discharge pathways being looked at. Dedicated team allocated as part of the outstanding programme.	31 Mar 2027	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
2756	16 Jul 2025	Sajid Azeb	Mayada ME Elsheikh	Risk Assessment	Quality Committee Finance and Performance Committee	AED Long Waits	If we are unable to see, treat, and admit or discharge patients within 4 hours then patients will increasingly experience a long length of stay in the A&E department. Consequently, they are more likely to experience increased mortality and morbidity	31 Jul 2026	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	12	(4) Major	(3) May recur occasionally	Clinical Nurse Specialist (CNS) input 24/7 Command Centre provision for operational support System escalation as required. Current SOP for speciality review of patients Ongoing work on acceptance criteria to speciality areas including but not limited to SAU, Plastics, GATU and Max Fax Patient Flow Hub is now in operation. CIC, NIC and SMIC will have situational oversight. AED new standardised plan for the management of the department in periods of extreme pressure (full capacity protocol) Consultant resource, where appropriate is diverted to AED.	21/04/26 (ME) Unchanged Uplift in nursing number, recruitment completed. Clinically ready to proceed SOP completed Consultant uplift, March start nights Pharmacist approved Pharmacist approved, awaiting appointment. Internal professionals standards currently being implemented by CMO. Discussed at multiple hospital management groups 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	31 Jul 2027	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20

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2787	23 Sep 2025	Karen Dawber	Jessica Hodgins	National Guidance	Quality Committee Finance and Performance Committee	Maternity theatres	If maternity theatre staffing and perioperative practice is not delivered in line with national standards there is an increased risk of women experiencing delays in operative procedures and complications resulting in harm. With the current staffing model there is also a risk that care in the intrapartum areas could be compromised due to midwifery staffing not meeting safe staffing standards whilst undertaking theatre staffing roles.	31 Jul 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	The anaesthetist is available in the department should the women deteriorate and this is recognised. The staff will request a 2nd anaesthetist, ODP or recovery practitioner from the general theatres. The labour ward will backfill a 2nd midwife if it is safe to release staff which is dependent on activity and acuity in the labour ward. This cannot be consistently provided and can only be done if it isn't going to impact on the safe delivery of intrapartum care. Recruitment to staffing vacancies Vacant shifts are sent to bank Recruitment to staffing vacancies In the event that a second maternity theatre is required without a 2nd resident ODP the main theatres are contacted and asked to send an ODP as urgent.	1. Task and finish group to explore alternative workforce models 2. Write a paper to ETM to include the workforce modelling required to achieve the GPAS and AfPP standards 3. To seek funding and propose interim measure of bank recovery staff 4. Develop a business case to outline the required staffing model to achieve safe standards of care	30 Sep 2026	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
901	07 Dec 2016	Vikki Lewis	Carl Hanson	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 at risk. Such disruption could expose the Trust to formal enforcement actions from regulatory bodies (e.g. Information Commissioner's Office (ICO) or National Cyber Security Centre (NCSC), erode public and partner confidence, and lead to significant unplanned financial impact of £120 million (estimated) on incident remediation, extended staff downtime, and potential legal settlements ultimately impacting delivery of frontline services and organisational performance targets.	31 Jul 2026	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	12	(4) Major	(3) May recur occasionally	Technical prevention via current firewall. Engagement with NHS Digital Cyber alerts scheme in order to undertake external security assessment and give report and recommendations. Annual security penetration testing undertaken as part of the CAF/DSPT. The Trust has also achieved the ISO27001 accreditation, which ensures the Trust follows best practice in terms of technology, people and process.	June 2026 - DSPT/CAF Submission / Audit March to July 2026 - Phishing Exercises & Awareness Campaigns March to June 2026 - Procurement and installation of Rubrik Backup and Resilience Tool.	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	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	Horizon scanning for any outbreak intelligence Vaccination seasonal flu plan for staff and patients Waste management in place Trust Outbreak Plan Surge and Escalation arrangements (OPEL) Good links with ICBs and NHS E Infection Control procedures	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
2549	05 Apr 2024	Sajid Azeb	Ellie Maciver	Risk Assessment	People Quality Committee	Workforce Constraints within Non-Surgical Oncology (NSO)	If we are not able to agree a workforce model for NSO then we will not be able to continue to support the current/planned NSO model of care within the Trust and region, resulting in delays with cancer treatment causing harm to patients.	30 Sep 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	• Local monitoring of waiting times with adhoc additional sessions where possible • ETM approved locum consultant • Exec sponsored involvement in NSO Programme (WYAAT Programme)	23/6/26 Risk Updated EG Risk assessment updated, no change to score. Work ongoing in collaboration with NSO Programme and ABCAS. Business cases being drafted and will be presented to a joint Exec meeting.	30 Sep 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16

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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 Ward. The Labour Ward is a busy acute area therefore delays in timely reviews as per the BSOTS triage time frame for MAC and patient flow delays occur . This will result in the service not meeting the recommendations of CQC and Ockenden for providing safe care. This presents a significant risk where patients cannot receive safe care based on their level of need and complexity. Adequate middle grade staffing will ensure that regardless of clinical complexity or patient background, every individual receives a consistently high-quality obstetric and gynaecological care and patient experience. If the Women's CSU are not able to recruit suitable middle grade doctors this will also result in some essential sessions not being able to have sufficient cover which for elective gynaecology results in the cancelation of patients, often at short notice which presents a risk to patients quality of life and safety, along with being a very poor experience. 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.	30-Sep-26	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 rota has currently only been expanded to 16 person due to the gaps but even then, there are significant gaps and a reliance on bank and agency shifts to help cover 2-Partial 2 tier rota implemented with a prioritisation for nights and weekend days to provide senior Obstetric cover to MAC & ANDU 3-Currently in a recruitment process for both senior fellows and SAS doctors, therefore this situation might resolve over the coming months once recruitment and orientation/competency assessment has occurred. We continue to work with the flexible workforce team to secure entrustable locums to help with the night gaps. 4-The Women's CSU are trying to make sure learners have appropriate clinical supervision. We are supporting postgraduate doctors in training to develop the professional values, knowledge,	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.	30 Sep 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16
70	29 Mar 2023	John Bolton	Osman Chohan	Risk Assessment	Finance and Performance People	Issue - 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	SOPs are in place to ensure processes are as safe as possible in the current accommodation. Additional accommodation has been sought with two further portakabins provided to house colleagues. Flexible working and home working has been explored and is utilised where possible. Minor works have been undertaken to improve the accommodation including staff rest facilities. Work has been undertaken to relocate the pharmacy aseptic unit which will give opportunities to redevelop the BRI site.	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 Quality Committee	Emergency Department Medical Staff Coverage - weekend and evenings	If we are unable to provide a sufficient number of middle and senior grade doctors that meets the 24 hour capacity and demand of the Emergency Department then there may be a mismatch of patient acuity and demand versus the number and competencies of clinical decision makers on duty at any one time resulting in an increased risk of patient harm, compromised quality and performance and a negative impact on efficiency and patient flow	31 Jul 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	•The Trust has supported the ED with the ability to go to super sessions and agencies to support the workforce model as it stands •New medical staffing model paper in development to be presented at ETM, this will take into account the skill mix of the workforce for a 24 hour period which takes in account volume and acuity •Increase pools of ACP's, physician associates and SAS posts •Temporary winter pressures funding has been approved to cover locums i.e. increased funding for super sessions •Weekly rotas review and day to day management of rotas •Trainees in place to support medical coverage in the emergency department •Consultant cover ED on the weekend and evenings	21/04/2026 Kingsgate review underway Awaiting perfomance daata to complete phase 4 of workforce review	30 Apr 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	If we fail to replace and maintain the cardiac catheter lab then we will prevent optimal numbers of patients being seen, resulting in longer waits for elective PCI and pacing work, and pressure on beds due to acute waits. Resulting in increased patient harm and poor patient experience.	30 Aug 2026	15	(5) Catastrophic	(3) May recur occasionally	9	(3) Moderate	(3) May recur occasionally	Acute waits being prioritised	24/6/26 Risk updated EG. No confirmed output from ABCAS work as yet - ongoing. Issues of overheating reported during periods of hot weather. The system will be End of Support (EOS) on 31.12.2027. Siemans would still offer a service and support contract and will continue to supply spare parts as long as they remain available. However, beyond this date, they can no longer guarantee spare part availability, and we could potentially find ourselves in a scenario where a failed part required for rep	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	Issue - Storage of Pathology slides and blocks	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.	01 Sep 2026	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	3	(3) Moderate	(1) Cannot believe that this will ever happen again	Staff attending the site in pairs to retrieve material. Staff ensure they have a mobile phone, and colleagues are aware of their location and expected return time. Block stores are positioned in lines and to a height which staff can reach. Material is stored in metal drawers and where possible in order within the cabinets Staff attending the site in pairs to retrieve material. Block cabinets are built and positioned where possible at AGH to hold material.	23/06/2026 - Contract awarded awaiting sign off by supplier. Site visit booked for 27 July 2026 to work up plan for uplift of material. Once uplift has occurred the risk can be closed. Provisional date for uplift mid September. TBC once site visit has taken place.	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	If we do not have a functioning track and trace system for maternal antibodies then we will fail to identify the presence of maternal antibodies in pregnancy. Resulting in women not being commenced on the appropriate surveillance pathway harm to mother and baby.	30 Sep 2026	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	5	(1) Negligible	(5) Will undoubtedly recur, possibly frequently	1-Community Midwifery Managers have admin rights create and unlock Sp_ICE accounts for members of staff. 2-Community teams and individuals take responsibility for their own test tracking. 3-Clinical guidance in place to support staff with where to record in EPR. 4-Existing NNA SOP and maternal antibody clinical guideline. 5-Staff who test track should all have access to Sp_ICE and view all reports when an antibody screen is positive. 6-If the test tracking and recording of results is followed in the antenatal period intrapartum and elective theatre staff should have accessible information to follow the newborn care plan. When planning for EL LSCS and intrapartum care the assigned midwife should check ICE to obtain the mother's blood group and	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	30 Sep 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
40	02 Jul 2023	Karen Dawber	Monica Parmar	National Guidance	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 we 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 will result in poor womens experience, risk to effective care and non compliance with guidance.	30 Sep 2026	12	(4) Major	(3) May recur occasionally	3	(1) Negligible	(3) May recur occasionally	A paper based personalised care plan is provided to women at their booking appointment. The discussions which take place to support informed choices and decision making is documented in the EPR narrative at each contact in the majority of contacts at present. Staff at the receiving hospital can contact BTHFT for this information We are developing an LMNS wide document for women to carry detailing their history and risks.	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	30 Sep 2026	(5) Catastrophic	(3) May recur occasionally	15
30	30 Jun 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 Sep 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	Issues with scan capacity are escalated to the Obstetrics Team Manager and service manager USS department are asked to reschedule any routines/non-urgent patients, scope for an additional list or if they can find capacity anywhere else. Capacity availability in the next 7 days is ascertained The clinical records of the patients who will breech the 72 hour timeframe are reviewed by a Consultant to formulate a plan prioritising the patients into the next scan dates available. Some patients are invited to attend MAC/ANDU over the weekend for a well-being check and CCTG prior to the scan appointment which impacts on this areas workload. Referrals are vetted to ensure scans are justified and the correct test for	Radiology;Plans to train 2 sonographers in obstetrics 2023/2024. They will qualify the end of Summer 2024. 3. Scope how USS will be affected with additional scans in light of the new growth chart which has identified new centiles which trigger growth scans 5. Develop a paper which outlines the risks, service gaps and requirements to achieve local and national guidance and a safe standard of care to women and their unborn baby 6. Radiology to complete a risk assessment regards to ultrasound staffing and a business case to Increase headcount of sonographers Simon kirk/Alison burns/K Lomas Complete 7. USS task and finish group to be held monthly with actions to enable achievement of best practice guidance of scanning within the required timeframes Carly	30 Sep 2026	(5) Catastrophic	(3) May recur occasionally	15

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2628	30 Jun 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 Aug 2026	9	(3) Moderate	(3) May recur occasionally	9	(3) Moderate	(3) May recur occasionally	Nurses are trying to assist with admin tasks and staff are being deployed from other depts in the CSU to assist. A paper will be drafted for a clinical fellow to provide capacity.	25/06/26 - TB clinical fellow in place since Feb 26 which has prevented further delays in assessment of TB patients however new latent TB appointments at 40 weeks (national target 2 weeks) and active TB appointments 6 weeks (target 1 week). Business case being submitted to support service and improve waiting times - outcome awaited. 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
2926	01-Jul-26	Ben Roberts	Chris Smith	CIP/Financial Balance	Finance and Performance Committee	Failure to deliver Financial Plan	IF the Trust does not deliver a balanced financial position in year THEN the Trust will not achieve its agreed financial plan with NHS England RESULTING IN additional sanctions being placed on the Trust by NHS England reducing its ability to invest in services and being unable to maintain liquidity to meet its financial obligations.	31-Aug-26	12	(4) Major	(3) May recur occasionally	12	(4) Major	(3) May recur occasionally	Recovery governance and oversight in place, Recovery Director in place and routine reporting.	Additional external support, improved pipeline of CTG and improved gateway 3 performance. Further review of positions and opportunities, with wider communications plan.	31-Aug-26	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
2911	03-Jun-26	John Bolton	Sam Wallis	Risk Assessment	Quality Committee People Committee	Neonatal service gaps at consultant level due to retirement and maternity leave	The Neonatal service in Bradford is a specialised commissioned Neonatal Intensive Care Unit (NICU) providing medical intensive care to infants born in Bradford and across the wider Yorkshire and Humber network. National BAPM (British Association of Perinatal Medicine) standards recommend a minimum of 7 WTE consultants to cover a NICU.	31-Jul-26	15	(5) Catastrophic	(3) May recur occasionally	9	(3) Moderate	(3) May recur occasionally	Some short-term weekend locum shifts using neonatal consultants from other trusts to work as bank or agency locum	Inability to maintain current high level of services if additional mitigation not in place.	03-Aug-26	(5) Catastrophic	(3) May recur occasionally	15

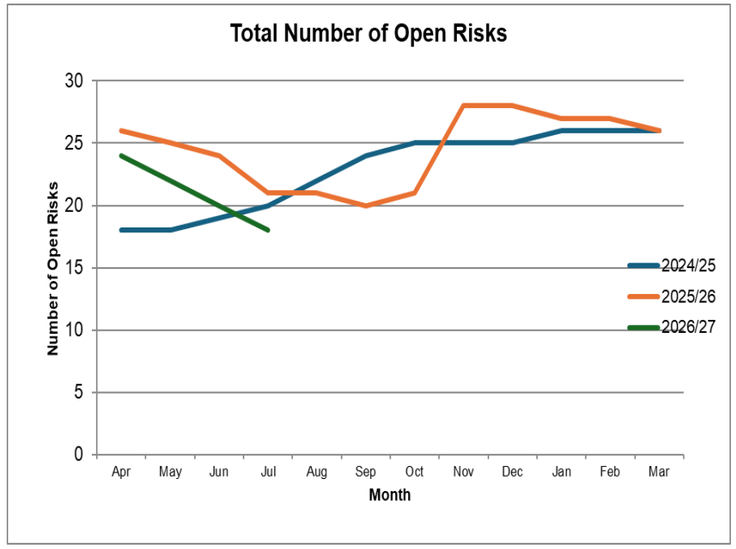
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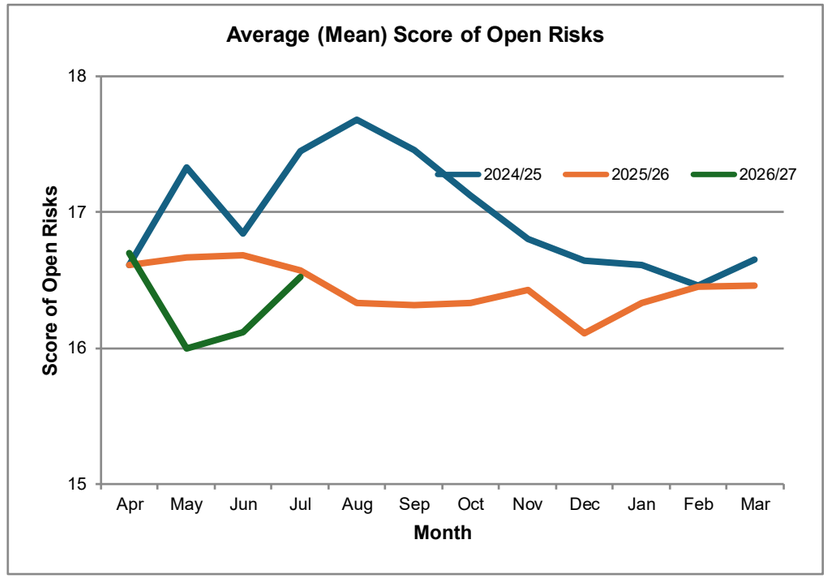
High Level Report on Page – July 2026

Total High-Level Risks	18*
Aligned to F&PC	6
Aligned to QC	16
Aligned to PC	5
Aligned to Board	0

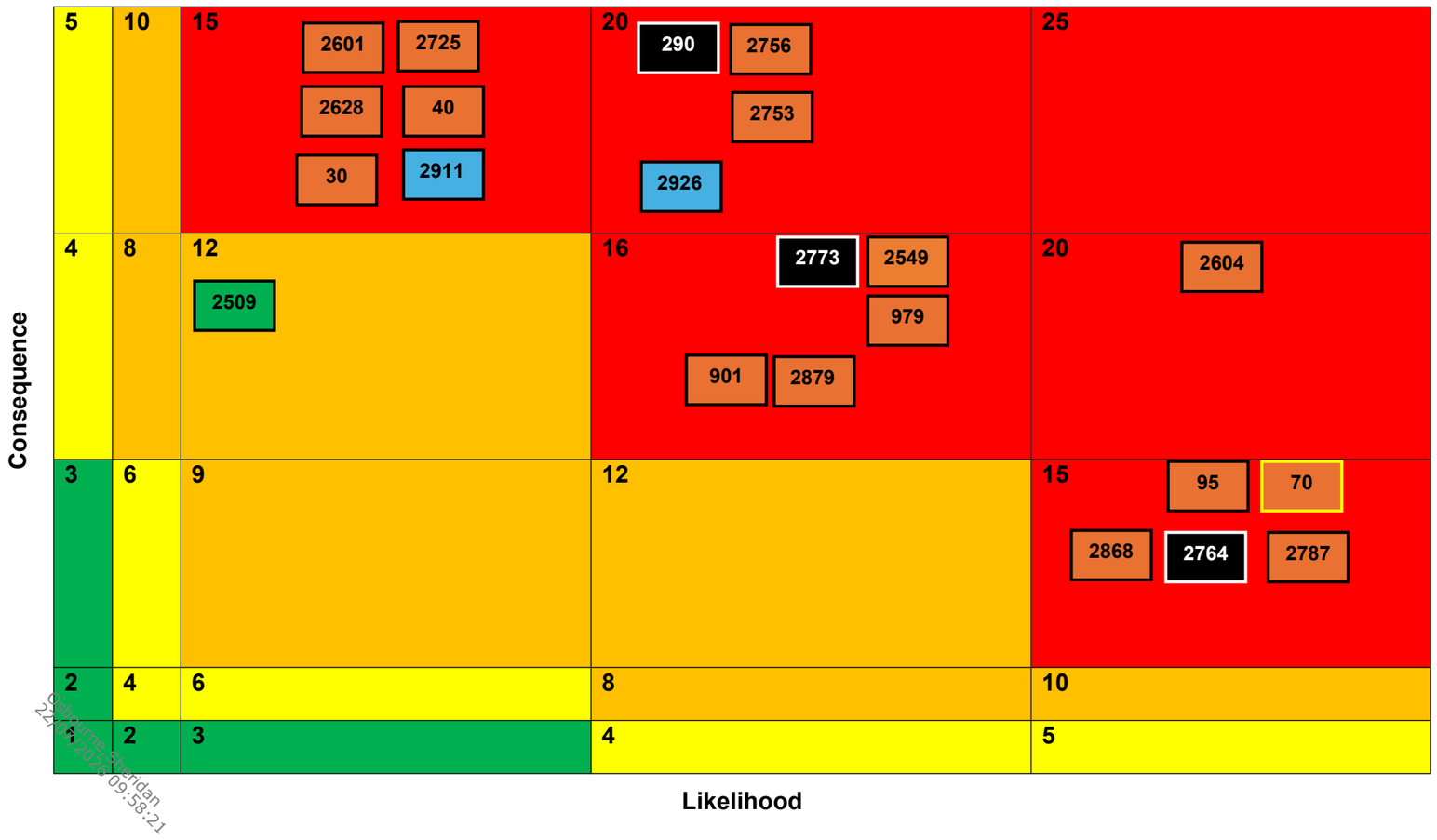
Movement of Risks	
New	2
Marked for closure	3
Risk score increased	0
Risk score static	16
Risk score decreased	1

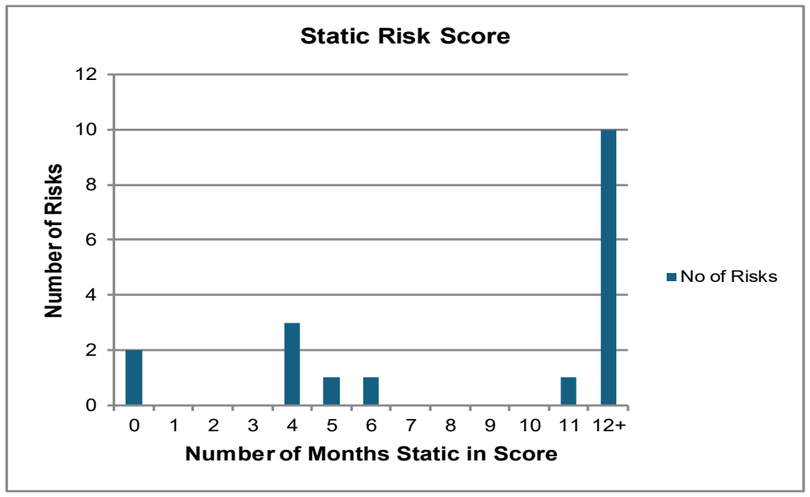
*Note some risks are aligned to more than one Academy/Committee

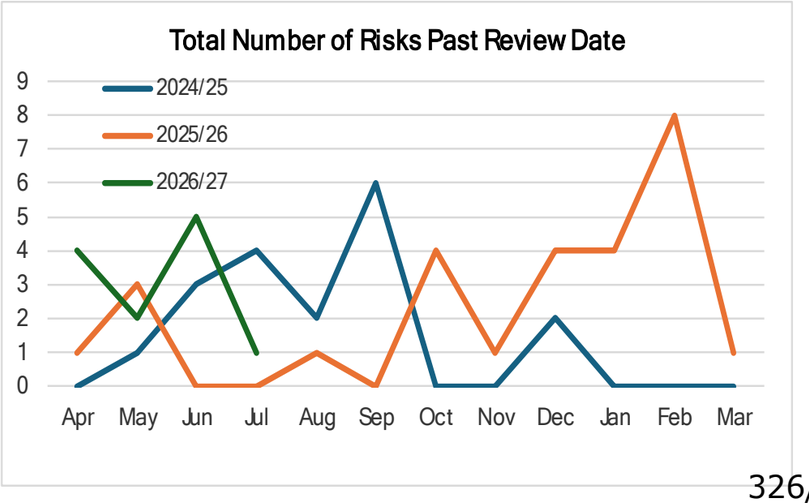




Risk Overview







Key:	New	Closed/Removed	Increase	Decrease	Static	Past Review Date

Changes to Target Mitigation Date of Current High Level Risks - July 2026

IRIS ID	Date of entry	Academy/ Committee	Current Score -July 2026	Target Score	Original	1st Change	2nd Change	3rd Change	4th Change	5th Change	6th Change	7th Change	8th Change	9th Change	10th Change
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	30/09/2026				
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							
2725	26/03/2025	QC	15	3	31/10/2025	31/10/2026									
2628	31/07/2024	QC	15	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	30/11/2026								
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	20	4	31/03/2026	30/06/2026	30/09/2026								
979	29/09/2025	PC & QC	16	16	29/01/2026	28/09/2026									
2879	27/03/2026	QC	16	8	30/09/2026										
40	02/07/2023	QC	15	3	28/08/2026	30/09/2026									
2868	02/03/2026	QC	15	5	31/07/2026	30/09/2026									
2926	01/07/2026	F&P	20	12	31/08/2026										
2911	03/06/2026	QC,PC	15	9	03/08/2026										

Overdue

Change in Target Mitigaton Date

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NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors				
Meeting Date:	23/07/2026		**Agenda Reference:**	Bo.7.26.17
Report Title:	Committee appointments and NED lead roles			
Presented by:	Laura Parsons, Associate Director of Corporate Governance/Board Secretary			
Lead:	Karen Walker, Acting Chair			
Author:	Laura Parsons, Associate Director of Corporate Governance/Board Secretary			
Report Summary				
Purpose of the paper:	Decision ☒ (approve)	Assurance ☐	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	This paper is presented to advise of changes to the NED committee memberships and lead roles. These changes have been discussed with the relevant individuals as part of the appraisal process.			
Recommendation/s: (including any decision/approval required)	The Board is asked to: 1. Approve the proposed changes to committee memberships as outlined above; and 2. Note the assignment of NEDs as champions/leads for specific areas.			
Link to Strategic Objective:	N/A			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	N/A			
Legal/Regulatory:	CQC, well-led framework, Health and Social Care Act			
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:	• NED Appraisals			

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Report content

Committee memberships

The code of governance for NHS provider trusts states that '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'.

The current committee memberships have been reviewed and it is proposed that the following NEDs take on (or in some cases retain for the next year), the roles identified below for each forum.

The proposed memberships are as follows:

	Audit Committee	Quality Committee	People Committee	Finance & Performance Committee	Charitable Funds Committee
Chair	Zafir Ali	Tim Swift	Justine Andrew	Bryan Machin	Altaf Sadique
Members	Bryan Machin	Justine Andrew	Altaf Sadique Tim Swift	Zafir Ali	Tim Swift

All NEDs will also continue to be members of the Board Nomination & Remuneration Committee, and are expected to attend Council of Governor meetings.

As the Board is aware, we are awaiting the nomination of a NED from the University of Leeds. The remaining committee positions will be allocated to the new NED upon appointment, depending on their skillset, experience and preferences.

NED 'champion' roles

In November 2022, the Board was advised of guidance published by NHS England which reduced the number of NED 'champion' roles from 18 to five. NEDs were appointed to the roles and it was agreed that the appointments would be reviewed on an annual basis as part of the NED appraisal process.

In addition to the five roles included in the guidance, NED leads have been assigned to additional areas as outlined below. This ensures that each NED has a lead/champion role.

Area	Lead
Roles included in NHSE guidance	
Wellbeing Guardian	Zafir Ali
Freedom to Speak Up	Justine Andrew
Maternity	Karen Walker
Security Management / Emergency Planning (inc. cyber security)	Altaf Sadique
Doctors Disciplinary	All (appointed by the Chair on a case by case basis)
Additional roles	
Environmental Sustainability	Leeds University NED
Digital and Data	Bryan Machin
Resident Doctors	Altaf Sadique
Research	Tim Swift

Role descriptions for the five roles included in the NHSE guidance and are available in the NED reading room on Admincontrol.

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Board of Directors			
Meeting Date:	23/07/2026	**Agenda Reference:**	Bo.7.26.18
Report Title:	Fit and Proper Person Test annual review		
Presented by:	Laura Parsons, Associate Director of Corporate Governance/Board Secretary		
Lead:	Karen Walker, Acting Chair		
Author:	Laura Parsons, Associate Director of Corporate Governance/Board Secretary		

Report Summary				
Purpose of the paper:	Decision ☐	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐

Summary of Key Issues/Highlights:

NHS England published the Fit and Proper Person (FPP) Framework on 2 August 2023, which is applicable to all board members (executive and non-executive, voting and non-voting). All of the elements of CQC Regulation 5: fit and proper persons: directors are incorporated within the Framework.

Board members are subject to FPP checks on appointment, and on an annual basis thereafter.

The annual checks for each Board member were completed and sent to the NHSE Regional Director by the deadline of 30 June 2026.

The checks are processed by the Recruitment & Resourcing Manager with support from the Deputy Director of HR, and are reviewed by the Director of HR and Board Secretary. The Trust uses the Fit and Proper Person Framework and associated checklist to ensure that all required checks are completed. The Trust commissions an external company to undertake the following checks:

Good Character
Social Media Check: covers content created by the subject on LinkedIn, X (analysis up to 3,200 tweets), Facebook, Instagram, TikTok and YouTube (including video thumbnails and titles), as well as any other profiles identified on the surface web. Checks cover 8 core behavioural risk categories and identify anything adverse that may be of concern in a candidate's profile or associated commentary, such as illegal activity, hate or discriminatory comments, extremism, or content of a sexual or violent nature.

Disqualified Director Check: Check of UK Disqualified Director Register of Companies House including details of directors disqualified by the courts, the Insolvency Service and the Competition and Markets Authority.

Charity Commission's Register: Search for the director's name in the UK Charity Commission Removed Trustees register.

Financial Soundness
Individual Insolvency Register: Check of UK Insolvency databases including current Bankruptcies, Debt Relief Orders, and Individual Voluntary Arrangements.

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	UK Civil Litigation: Covers civil litigation decisions in the UK including employment tribunals, County and High Court judgements, using name and current addresses. **Professional Registration** GMC, NMC or Chartered Accountancy registration checks (where relevant). This ensures that thorough checks are undertaken for areas where the Trust does not have the required capacity/capability in-house, particularly in relation to social media monitoring. The checks have been reviewed and signed off by the Acting Chair and the Senior Independent Director (for the Chair and Acting Chair). All board members in post have been confirmed as fit and proper.
Recommendation/s: (including any decision/approval required)	The Board is asked to receive this report as assurance that the Trust is compliant with the Fit and Proper Person Framework.
Link to Strategic Objective:	N/A
Link to Priority Initiatives 2025/26:	N/A
Implications	
Risk:	N/A
Legal/Regulatory:	NHS Fit and Proper Person Test Framework CQC, well-led framework
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	N/A

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BOARD WORK PLAN 2026/27

Item	Report Author	Executive 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	Mark Hindmarsh / Alison Smith	Director of Strategy & Transformation	x		x	x			x	
Green Plan	David Moss / Robert Dadzie	Director of Estates & Facilities			x			x		
Communications - Annual Update	Shak Rafiq	Chief Executive	x						x	
Digital Strategy	Vikki Lewis	CDIO				x			x	
Improvement Strategy	Mark Hindmarsh / Liz Tomlin	Director of Strategy & Transformation	x				x			
Patient Experience & Engagement Strategy	Ruth Tolley	Chief Nurse			x		x			
EDI Strategy	Kez Hayat	Chief Operating Officer		x			x			
People Strategy	Faeem Lal	Director of HR								Date TBC
Strategy - Emerging Issues	N/A - verbal	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	Karen Dawber	Chief Nurse	x	x						Only when there is relevant information to report
Infection Prevention & Control Q4 Report (Annual Report)	Yaseen Muhammad	Chief Nurse		x						
Maternity and Neonatal Services Update	Sara Hollins	Chief Nurse	x	x	x	x	x	x	x	
Maternity Incentive Scheme	Sara Hollins	Chief Nurse						x		Every January
Inpatient Survey	Sarah Freeman/Ruth Tolley	Chief Nurse					x			
Adults & Children Safeguarding Annual Reports (to include Mental Health Strategy)	Sarah Turner	Chief Nurse			x					
Antimicrobial Resistance (AMR)	Yaseen Muhammad/ Alison Haigh	Chief Medical Officer		x						
First 72 Hours Standards	Amy Illsley/Caroline Varley	Chief Medical Officer		x						
Research Activity in the Trust	Michael McCooe	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)	Kez Hayat	Chief Operating Officer		x						Presentation
Equality & Diversity Council (quarterly reporting - update)	Kez Hayat	Chief Executive	x	x		x	x		x	
Staff Survey Results	Cat Shutt	Chief Executive			x					
Freedom to Speak Up	Sue Franklin	Chief Digital & Iinformation Officer		x			x			
Nursing & Midwifery Staffing Establishment Review	Sarah Freeman/Laura Loveday	Chief Nurse			x			x		
Guardian of Safe Working Hours annual report	Ajay Sud	Chief Medical Officer		x						
Medical Appraisal & Revalidation Annual Report & Statement of Compliance	Remi Akerele	Chief Medical Officer				x				
Diversity Pay Gaps	Kez Hayat	Chief Operating Officer	x				x			Change to title and timings on People Committee work plan
Education Annual Report	Faye Alexander	Chief Medical Officer		x						
Education Self Assessment Report (SAR)	Faye Alexander	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)	Chris Smith	Chief Finance Officer	x	x	x	x	x	x	x	
Performance Report	Carl Stephenson	Chief Operating Officer	x	x	x	x	x	x	x	
Integrated Dashboard	All	All	x	x	x	x	x	x	x	

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BOARD WORK PLAN 2026/27

Item	Report Author	Executive Lead	31 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 Nov 26	28 Jan 27	30 Mar 27	Notes
Operational Plan Submission	Saj Azeb/Ben Roberts/Faeem Lal	Chief Operating Officer / Chief Finance Officer / Director of HR	x						x	Closed Board Feb 2026
Financial Plan	Chris Smith	Chief Finance Officer	x						x	Closed Board Feb 2026
Capital Programme	Michael Quinlan	Chief Finance Officer	x						x	
Budget setting process & timetable	Chris Smith	Chief Finance Officer					x			
Winter Plan	Saj Azeb	Chief Operating Officer					x			
Charity ISA 260, Draft Annual Report & Accounts and draft Letter of Representation	Michael Quinlan	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	Naveed Saddique/ Alison Smith	Director of Strategy & Transformation	x			x			x	
Partnerships - strategic view	Alison Smith	Director of Strategy & Transformation	x		x		x		x	
Anchor Institution	Molly Corner	Director of Strategy & Transformation			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	Laura Parsons	Chief Nurse	x	x	x		x	x		
High Level Risk Register	Laura Parsons	Chief Nurse	x	x	x	x	x	x	x	
Review of Standing Orders/SFIs/Scheme of Delegation	Michael Quinaln	Chief Finance Officer					x			
Constitution review	Laura Parsons	Chief Operating Officer		x	x	x				
Self Certification of Provider Licence	Laura Parsons	Chief Operating Officer		x						
NED Independence Test	Laura Parsons	Chief Operating Officer		x						
Compliance with NHS Code of Governance	Laura Parsons	Chief Operating Officer		x						
Well Led Review & Board Self Assessment	Laura Parsons	Chief Operating Officer								Date TBC
Annual Report from Committees	Laura Parsons	Committee Chairs		x						
Risk Appetite Review	Laura Parsons	Chief Nurse		x	x					
Annual Fire Safety Report	Darren Mitchell	Director of Estates & Facilities			x					
Annual Health & Safety Report	Caroline Nicholson	Director of Estates & Facilities		x	x					
Premises Assurance Model Progress Report	Charlotte Spzara	Director of Estates & Facilities					x			
Annual Security Report	William Hall	Director of Estates & Facilities				x				
Violence Prevention & Reduction Standard	William Hall	Director of Estates & Facilities		x		x				Sept - part of Annual Security Report
Data Security & Protection Toolkit	Jenny Pope/Graeme Holmes	CDIO		x						
DPO Annual Report	Jenny Pope	DPO				x				
SIRO Report	Jenny Pope/Graeme Holmes	CDIO			x		x			
Emergency Preparedness, Resilience & Response & NHSE Core Standards	Steve Amos	Chief Operating Officer				x				
Use of the Trust Seal	Laura Parsons	Chief Operating Officer				x				
NED Champion Roles - annual review	Laura Parsons	Chair		x	x					
Fit and Proper Person Test - annual review	Laura Parsons	Chair		x	x					
Modern Slavery Statement	Laura Parsons	Chief Operating Officer					x			
COG Engagement Policy	Laura Parsons	Chief Operating Officer			x	x				
SID Role & Appointment Process	Laura Parsons	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	Karen Dawber	Chief Nurse	x		x		x		x	
Getting to know the CSUs	Saj Azeb/John Bolton/Karen Dawber	Chief Operating Officer/Chief Medical Officer/Chief Nurse		x		x		x		
Chair's Report	Jacqui Maurice	Chair	x	x	x	x	x	x	x	

BOARD WORK PLAN 2026/27										
Item	Report Author	Executive Lead	31 Mar 26	21 May 26	30 Jul 26	24 Sep 26	25 Nov 26	28 Jan 27	30 Mar 27	Notes
Chief Executive's Report	Debbie Earnshaw / EDs	Chief Executive	x	x	x	x	x	x	x	
Chair's report from Committees	Committee Chairs	Committee Chairs	x	x	x	x	x	x	x	

Key:	
Planned item	
Planned item deferred to future meeting	
Planned item cancelled and not re-planned in / state reason in notes	
Item discussed at the meeting	

Osbourne Sheridan
22/07/2026 09:58:21