

BOARD OF DIRECTORS MEETING IN PUBLIC AGENDA

Date:	Thursday, 24 September 2026	Time:	09:30 – 12:30
Venue:	Conference Room, Field House, BRI	Chair:	Karen Walker, Acting Chair

- 9.45 – 10.00 – Zakir Shariff, Consultant Plastic Surgeon & Tom White, General Manager (MSK & Therapies), Bo.9.26.7 – Skin AI showcase
- 10.10 – 10.40 - Sara Hollins, Director of Midwifery, Bo.9.26.9 - Maternity and neonatal services update
- 10.50 – 11.00 - Michael McCooe, Associate Medical Director, Bo.9.26.11 – Research activity in the Trust
- 12.25 – 12.30 – Zana Bi, Matron & Razwana Bashir, Matron, Bo.9.26.23 - Presentation of Ward 15 exemplar accreditation status

Observers:

- John Waterhouse, Governor
- Alistair Crockford, Internal Audit
- GMTS graduate trainees
- Sarah Waite, OD manager
- Louise Horsley, Senior Quality Governance Lead

No.	Agenda Item	Lead	Outcome	Papers attached
09:30 Section 1: Opening matters				
Bo.9.26.1	Apologies for absence	Chair	For information	Verbal
Bo.9.26.2	- Declarations of interest - Board Code of Conduct	Chair	For information	Bo.9.26.2
Bo.9.26.3	Minutes of the meeting held on 23 July 2026	Chair	For approval	Bo.9.26.3
Bo.9.26.4	Matters arising	Chair	For information	Verbal

09:35 Section 2: Business Reports				
Bo.9.26.5	Report from the Chair	Chair	For assurance	Bo.9.26.5
Bo.9.26.6	Report from the Chief Executive	Chief Executive	For assurance	Bo.9.26.6

09:45 Section 3: Patient Care				
Bo.9.26.7	Getting to know the CSUs – Skin AI showcase	Chief Operating Officer	For information	Presentation
Bo.9.26.8	Report from the Chair of the Quality Committee a. September 2026	Chair of the Quality Committee	For assurance	Bo.9.26.8a
Bo.9.26.9	Maternity and neonatal services update	Chief Nurse	For assurance and approval	Bo.9.26.9
Bo.9.26.10	CQC Action Plan – Urgent & Emergency Care	Chief Operating Officer	For approval	Bo.9.26.10
Bo.9.26.11	Research Activity in the Trust	Chief Medical Officer	For assurance	Presentation

BREAK 11:00 – 11:10

11:10 Section 4: People				
Bo.9.26.12	Report from the Chair of the People Committee a. September 2026 <i>Reports from the People Committee for noting by the Board:</i> b. Medical Appraisal & Revalidation Annual Report & Statement of Compliance c. Violence Prevention & Reduction Standard (included as part of Bo.9.26.14e Annual Security Report)	Chair of the People Committee	For assurance	Bo.9.26.12a Bo.9.26.12b Bo.9.26.14e
Bo.9.26.13	Equality & Diversity Council quarterly reporting update	Chief Executive	For assurance	Bo.9.26.13

11:25 Section 5: Finance & Performance				
Bo.9.26.14	Report from the Chair of the Finance and Performance Committee a. September 2026 <i>Reports from the Finance and Performance Committee for noting by the Board:</i> b. Integrated Dashboard c. Finance Report d. Performance Report e. Annual Security Report f. Emergency Preparedness, Resilience & Response (EPRR) and Core Standards	Chair of the Finance & Performance Committee	For assurance	Bo.9.26.14a Bo.9.26.14b Bo.9.26.14c Bo.9.26.14d Bo.9.26.14e Bo.9.26.14f
Bc.9.26.15	Winter Plan Board Assurance Statement	Chief Operating Officer	For approval	Bo.9.26.15

11:40 Section 6: Strategy & Partnerships				
Bo.9.26.16	Strategy – Emerging issues	All	For assurance	Verbal
Bo.9.26.17	Health Equity	Director of Strategy & Transformation	For approval	Bo.9.26.17

11:55 Section 7: Audit & Assurance				
Bo.9.26.18	Report from the Chair of the Audit Committee – 8 September 2026	Chair of the Audit Committee	For assurance	Bo.9.26.18
Bo.9.26.19	Report from the Chair of the Charitable Funds Committee – 4 August 2026	Chair of the Charitable Funds Committee	For assurance	Bo.9.26.19

12:05 Section 8: Governance				
Bo.9.26.20	High-level risks	Chief Nurse	For assurance	Bo.9.26.20
Bo.9.26.21	Risk Management Strategy and Policy (including Risk Appetite Statement)	Chief Nurse	For approval	Bo.9.26.21
Bo.9.26.22	Governance reports: a. Use of the Trust Seal b. Constitution c. Council of Governors Engagement Policy d. Board NRC Terms of Reference	Associate Director of Corporate Governance/Board Secretary	For approval	Bo.9.26.22

12:25 Section 9: Board Meeting Outcomes				
Bo.9.26.23	Any other business	Chair	For information	Verbal
	a. Presentation of Ward 15 exemplar accreditation status	Chief Nurse		
	b. Thirlwall Inquiry: Immediate Board considerations	Chief Nurse	For approval	Bo.9.26.23b
Bo.9.26.24	Issues to refer to Committees or elsewhere	Chair	For approval	Verbal
Bo.9.26.25	Review of meeting	Chair	For information	Verbal
Bo.9.26.26	Date and time of next meeting:	Chair	For information	Verbal
	• 25 November 2026 – 9.30-12.30			

Annexes for the meeting of the Board of Directors 24 September 2026

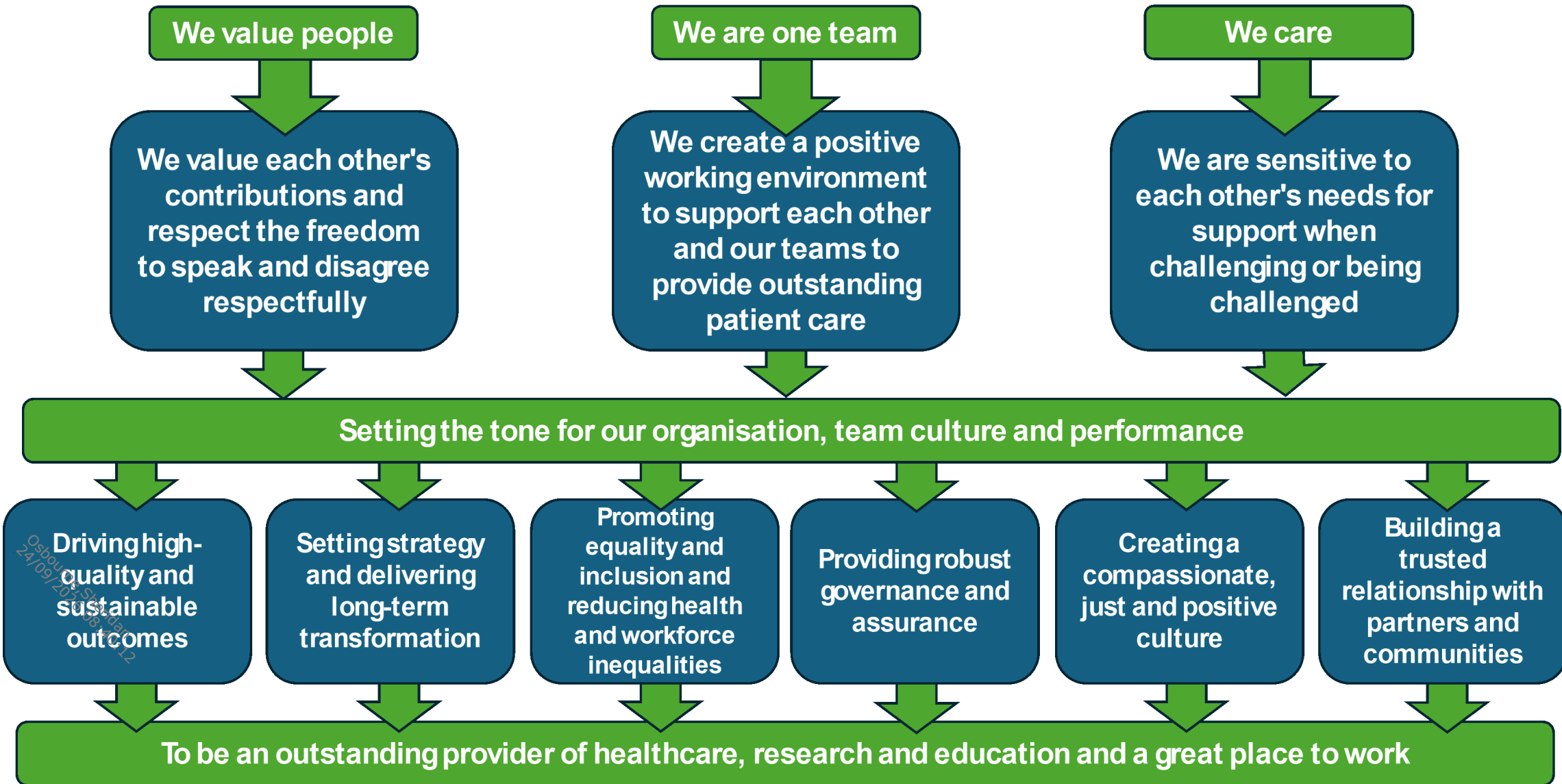
Annex 1: For Information				
Bo.9.26.27	Board of Directors work plan	Associate Director of Corporate Governance/Board Secretary	For information	Bo.9.26.27

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Employee	Role	Date Incurred	Year	Interest Type	Date Ended	Interest Description (Abbreviated)	Provider	Value £'s
Altaf Sadique	Non-Executive Director	01.12.2020	2020/21,2021/	Outside Employment		Industrial member	GS1	0
Altaf Sadique	Non-Executive Director	01.06.2021	2021/22,2022/	Outside Employment		ibox healthcare is working with healthcare providers across the UK and global markets to deliver dashboards & data visualisation solutions help optimise patient flow and operational efficiency.Key customers NG	ibox Healthcare (part of IHG Group Ltd)	0
Altaf Sadique	Non-Executive Director	08.12.2021	2021/22,2022/	Loyalty Interests		Full member GG health institute (EU).	GG Health for Institute (EU)	0
Altaf Sadique	Non-Executive Director	01.09.2022	2022/23,2023/	Loyalty Interests		Known to myself as a personal friend of long standing	Haniif 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 Avande who could be a potential supplier for BTHFT.	ibox Healthcare Avande 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 healthcare and NED at BTHFT could be conflicted in relation to Airedale new build.	ibox Healthcare participant in the NHS New Hospital Progrs	0
Benjamin Roberts	Chief Finance Officer	01.09.2006	2015/16 & befco	Loyalty Interests		Fellow of Chartered Institute of Management Accountants	Chartered Institute of Management Accountants	0
Benjamin Roberts	Chief Finance Officer	01.09.2006	2015/16 & befco	Loyalty Interests		Member of the HfMA (Healthcare Financial Management Association) and Chair the Associations Digital Council	HfMA (Healthcare Financial Management Association)	0
Benjamin Roberts	Chief Finance Officer	22.06.2026	2026/27	Hospitality		PwC Roundtable discussion event discussing the adoption and benefit realisation of innovation in the NHS	PwC	50
Bryan Machin	Non-Executive Director	04.02.2020	2019/20,2020/	Outside Employment	31.05.2026	Trustee (Vice chair)	St Annes Community Services	0
Bryan Machin	Non-Executive Director	01.09.2020	2020/21,2021/	Outside Employment		Member of Disciplinary Committee. Typically hear 2-3 disciplinary cases per year against CIPFA members. Has been voluntary until 2025; now attracts small payment.	Chartered Institute of Public Finance and Accountancy	0
David Moss	Director of Estates	01.12.2022	2022/23,2023/	Loyalty Interests		Chair of Northern and Yorkshire HEFMA	HEFMA	0
David Moss	Director of Estates	01.12.2022	2022/23,2023/	Loyalty Interests		National Chair of HEFMA	HEFMA	0
David Moss	Director of Estates	05.08.2026	2026/27	Loyalty Interests		Local Public Sector director (8 Director) on the Board of Bradford and Airedales Partnership LiftCo's and subsidiary Companies. Role previously held by Robert Madden	Community Health Partnerships	0
Faeem Lal	Director Of Human Resources	18.12.2024	2024/25	Shareholdings and other ownership interests		£1	F&R Group limited	0
Faeem Lal	Director Of Human Resources	01.09.2025	2025/26	Outside Employment		I volunteer at my local mosque, as an unpaid volunteer and unofficial helper in the mosque committee.	JTI Shearbridge	0
Faeem Lal	Director Of Human Resources	01.01.2026	2025/26	Outside Employment		I volunteer with the scouts association and chair the a local scouts group.	Volunteer with the The Scouts Association	0
Helen Lewis	Chief Digital & Information Officer	02.01.2017	2016/17,2017/	Outside Employment		Director of family owned company.	Vikmara Property Development Company	0
Helen Lewis	Chief Digital & Information Officer	02.01.2018	2017/18,2018/	Loyalty Interests		Son is a robotics engineer for Medtronic UK.	Medtronic UK	0
John Bolton	Medical Director	18.04.2019	2019/20,2020/	Loyalty Interests		I hold a commission in the British Army.	British Army	0
John Bolton	Medical Director	13.11.2023	2023/24,2024/	Outside Employment		I am an adult (criminal) court Magistrate sitting on the West Yorkshire bench.	HM Courts & Tribunal Service	0
John Bolton	Medical Director	01.01.2023	2022/23,2023/	Loyalty Interests		My half-sister is a consultant orthopaedic surgeon at Sheffield.	Sheffield Teaching Hospitals NHSFT	0
Justine Andrew	Non-Executive Director	01.10.2024	2024/25	Outside Employment		Trustee of a charitable arts organisation	York Museums Trust	0
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
Justine Andrew	Non-Executive Director	17.08.2026	2026/27	Loyalty Interests		My daughter is a 3rd year integrated Masters psychology student at the University of Oxford, and in the Spring, contacted BIHR regarding potential research / work experience. As a result she undertaking at	Tallulah Andrew	0
Karen Dawber	Chief Nurse	01.09.2022	2022/23	Loyalty Interests		Honorary Professor	University of Bradford	0
Karen Dawber	Chief Nurse	12.11.2022	2022/23	Loyalty Interests		Member of Professional Body, was previously the RCN but changed to MIP	Member of MIP - trade union / professional body	0
Karen Dawber	Chief Nurse	01.11.2021	2021/22	Loyalty Interests		Ellie is my daughter and a volunteer in the Trust	Ellie Dawber	0
Karen Dawber	Chief Nurse	14.03.2024	2023/24	Loyalty Interests		Mind in Bradford is a local mental health charity that provides free mental health support to everyone living in Bradford District and Craven. Trustee post.	MIND in Bradford	0
Karen Dawber	Chief Nurse	01.09.2025	2025/26	Loyalty Interests		Ellie is my daughter and a volunteer in the Trust, during the year Ellie has transitioned, through a competitive process, into an as and when paid role as an Oliver McGowan co facilitator.	Ellie Dawber	0
Karen Walker	Non-Executive Director	01.07.2022	2022/23,2023/	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	2025/26,2026/	Outside Employment		Independent Parliamentary Standards Authority	Chief Executive Officer	0
Laura Parsons	Associate Director of Corporate Governance/Bi	15.08.2025	2025/26	Nil Declaration				0
Mark Hindmarsh	Director of Strategy and Integration	08.04.2025	2025/26	Nil Declaration				0
Melany Pickup	Chief Executive	01.06.2020	2020/21,2021/	Loyalty Interests		Mel is Honorary Professor at the University of Bradford.	University of Bradford	0
Melany Pickup	Chief Executive	18.12.2023	2023/24,2024/	Loyalty Interests		Trustee	Bradford City of Culture 2025	0
Melany Pickup	Chief Executive	28.07.2026	2026/27	Hospitality		Planning meeting with Yassen and Saleem for the Leeds Road festival which are sponsoring our Hospital Charity at the gala dinner and for which over the course of the Two days of the festival BTHFT will ha	Yaseen Yorkshire Property Services / Salmeem Jinnack restu	25
Sajid Azeb	Chief Operating Officer	12.10.2020	2020/21,2021/	Loyalty Interests		Wife own optometry business which hold NHS England Contract	Optometry Business	0
Sajid Azeb	Chief Operating Officer	12.10.2020	2020/21,2021/	Loyalty Interests		Brother a GP and Primary Care Clinical Lead for Calderdale CCG	Calderdale CCG / Calderdale PCN	0
Sajid Azeb	Chief Operating Officer	12.10.2020	2020/21,2021/	Outside Employment		Family Property businesses	Directorship at Greenroyd Ltd and Skircoat Development Ltd	0
Sajid Azeb	Chief Operating Officer	12.10.2020	2020/21,2021/	Outside Employment		MBA Industry Advisory Board Chair	Bradford University	0
Sajid Azeb	Chief Operating Officer	01.12.2025	2025/26	Loyalty Interests		Nephew (initials HM) is a resident doctor currently on rotation to BTHFT as part of his training with the Yorkshire Deanery.	BTHFT Resident Doctor	0
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	15.07.2026	2026/27	Nil Declaration				0
Zafir Ali	Non-Executive Director	01.11.2016	2016/17,2017/	Outside Employment		Various roles including Deputy Head of Internal Audit – Department of Health & Social CareHead of Internal audit for the NHS Counter Fraud AuthorityHead of Internal audit for the NHS Health Research Authori	Government Internal Audit Agency	0
Zafir Ali	Non-Executive Director	20.08.2026	2026/27	Outside Employment		Lay Chair of the Joint Audit Committee for the General Council of the Bar and the Bar Standards Board	The General Council of the Bar of England and Wales	0

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BTHFT Inside Out Board Code of Conduct



UNCONFIRMED - BOARD OF DIRECTORS OPEN MEETING MINUTES

Date:	Thursday 23 July 2026	Time:	09:30 – 12:05
Venue:	Conference Room, Field House, BRI	Chair:	Bryan Machin, Non-Executive Director
Present:	Non-Executive Directors: - Bryan Machin (BM) - Altaf Sadique (AS) - 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) - Laura Parsons, Associate Director of Corporate Governance / Board Secretary (LP) - Sarah Freeman, Deputy Chief Nurse - Shane Embleton, Deputy Director of Estates and Facilities - Julie Pearce, Ward Manager Neonatal Services (JW) for items Bo.7.26.7 and Bo.7.26.9 only - Carly Stott, Head of Midwifery (CS) for items Bo.7.26.7 and Bo.7.26.9 only - Sara Hollins, Director of Midwifery (SH) for items Bo.7.26.7 and Bo.7.26.9 only - Tabitha Lawreniuk, Personal Business Manager as Secretariat		
Observing:	- John Waterhouse, Public Governor - Sarah Smith, Communications Manager		

No.	Agenda Item	Action
Section 1: Opening Matters		
Bo.7.26.1	Apologies for Absence Apologies for absence were noted from: - Karen Walker, Acting Chair - Vikki Lewis, Chief Digital & Information Officer - David Moss, Director of Estates & Facilities	
Bo.7.26.2	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.	

No.	Agenda Item	Action
Bo.7.26.3	Minutes of the Meeting held on 21 May 2026 The minutes of the meeting held on 21 May 2026 were approved as a true and accurate record.	
Bo.7.26.4	Matters Arising The following actions were reviewed, outcomes noted and confirmed as closed: - <u>Bo250016 Strategic Partnering Agreement Refresh 2024/25</u>: A revised document was received on the agenda. <u>Action closed.</u> - <u>Bo26005 Independent Oversight Group (IOG) Update</u>: Presentation shared with the Board. <u>Action closed.</u> - <u>Bo26005 Antimicrobial Resistance</u>: Added to Quality Committee work plan. <u>Action closed.</u> - <u>Bo26006 Baseline report - Self-assessment tool for standards for care of acutely unwell patients in their first 72 hours in hospital</u>: Added to the Quality Committee work plan. <u>Action closed.</u> - <u>Bo26007 CQC well led action plan</u>: 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. <u>Action closed.</u> - <u>Bo26008 Performance report</u>: Dashboards have been updated to include the targets on the cover page. <u>Action closed.</u> - <u>Bo26009 Risk Management Strategy (inc. risk appetite statement)</u>: Terms of reference have been updated to reflect Board comments. <u>Action closed.</u>	
Section 2: Business Reports		
Bo.7.26.5	Report from the Chair BM gave a brief overview of the Chair's report, highlighting that: - Two new governors, Daniel Balaz and Zulfiqar Ahmed, were welcomed to the Trust. The Board also acknowledged and thanked Professor Anne Forster for her service to the Trust. The Board noted the update.	
Bo.7.26.6	Report from the Chief Executive MP introduced the report. She referenced several updates since the publication of the report: - The arrival of a new Prime Minister, Andy Burnham, who had appointed a new Cabinet, including Yvette Cooper (MP for Pontefract, Castleford and Knottingley) as Secretary of State for Health and Social Care. The Trust would await further communication from her as she takes up the role. - MP had held an introductory meeting with Councillor Stephen Place, the new Leader of the Council. The meeting was positive, with Councillor Place sharing key priorities including economic growth and engagement with communities, particularly those without a voice and those outside the city centre. MP also outlined pressures facing the Trust, including increasing demand on A&E and estate constraints, and shared plans for Health on the High Street, which Councillor Place supported. The national independent investigation into maternity and neonatal services was published on 30 June. The Trust had become the first organisation to meet individually with Baroness Amos and a member of the	

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	investigation team. The meeting was positive, and a member of the investigation team would attend the Council of Governors meeting to present further. The report was noted by the Board.	
Section 3: Patient Care		
Bo.7.26.7	Patient Story The Board received a patient story video describing the positive experience of parents of twins who had been born at 24+2 weeks and cared for on the neonatal unit. The parents praised the care and service provided by the neonatal team and highlighted the benefit of being able to stay in a family room close to their babies. JP was asked how such feedback is received by staff in the neonatal unit, and she advised that staff greatly valued receiving positive feedback, particularly as they did not often hear this type of feedback in this format. She noted that sharing the story enabled wider team discussion and helped balance less favourable media coverage. ZA asked why the patient story had featured two parents with NHS backgrounds, noting the potential perception that those working in the NHS may receive a different experience than those without such experience. JP explained that the story had been arranged at short notice and that the family had been selected because they were willing to share their experience and were regularly present on the unit. Their NHS background was not known at the point they were identified and therefore had no influence on the choice to choose them. JA noted that the involvement of the 'Pink Ladies' and the breastfeeding support demonstrated a strong commitment to supporting women with breastfeeding. This helps to enforce and bring to life the data which demonstrates breastfeeding rates. MHi commented that the story helped describe how the 'home from home' model would benefit families. JB asked about morale among nursing staff on the neonatal unit. JP advised that morale could fluctuate depending on acuity, demand and staff absence. Media coverage could also have an impact, although this had become less of a concern recently. SA noted that the full video also referenced the engagement between the clinical team and parents, with parents being involved in discussions and decisions. He suggested this was good practice that should be learned from more widely across the organisation. BM asked whether the practice had developed because of the national focus on maternity and neonatal services, or whether it would have happened regardless. SH advised that the team was very proactive in taking forward initiatives and had been trailblazers in this area, irrespective of the national focus, although this was not sufficiently promoted by the team.	

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	MP noted that, as with patients with dementia and other conditions, it was important to hear from those who know patients best. She referred to previous discussions about a 'caring contract' and asked whether this had progressed. KD advised that the specific term may not be recognised, but that there was now much more ongoing work to hear from experts in the care of patients. She confirmed that the Trust was on the right journey to appropriately working with families and carers of patients. The Board noted the patient story.	
Bo.7.26.8	Report from the Chair of the Quality Committee: June and July 2026 TS gave an overview of the report from the Quality Committee meetings held in June and July 2026. The report alerted the Board to several key issues: - The Committee discussed the increased maternity theatres risk and TS confirmed a paper was included on the private Board agenda to discuss this further. - Two recent internal audits received limited assurance opinions: Sepsis Management and the Quality of Local Incident Investigations. The Committee would receive follow-up updates in six months for Sepsis and through routine reporting for incident investigations. - At the meeting held on 22 July, the key issue for escalation to the Board related to the Amos and Ockenden reviews and the need to ensure appropriate focus on patient experience. SH would provide further detail under the maternity and neonatal services update. MP noted that sepsis management had not been consistently strong during her time at the Trust and asked whether the position had improved or worsened and what action was being taken to better this. JB advised that patient outcomes had improved, although process compliance remained challenging. He noted that changes to sepsis triggers in maternity and paediatrics had shifted the position, and that reporting needed to be aligned with other local hospitals, which used different metrics. Improvement during the year had been slower due to the long-term absence of the sepsis lead nurse, but alternative support was being put in place to ensure the project was not dependent on one individual. ZA noted a pattern of limited assurance reports in patient-facing areas and advised that this would be discussed further at the September Audit Committee meeting. The Board received the report and noted the 'alert' items and the assurance provided. Adults & Children Safeguarding Annual Reports: KD noted that the Trust was entering a period of increased scrutiny following the announcement of grooming gang inquiries. She highlighted the request that records should not be destroyed and noted that Bradford was likely to receive national attention. The report was received and noted by the Board. Improvement Strategy update: MHi advised that the strategy had been added to the internal audit schedule and would be presented to the next Audit Committee. The report was received and noted by the Board.	

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	Patient Experience & Engagement Strategy update: The report was received and noted by the Board. SIRO Report: The report was received and noted by the Board.	
Bo.7.26.9	Maternity and Neonatal services update SH joined the meeting to present the update which sought to assure the Board that a monthly review of maternity and neonatal quality and safety relating to May and June 2026 activity, was presented and key elements discussed at the Quality Committee meetings in June and July. SH provided the following highlights: - The maternity service received a second level 1, Maternity Outcomes Signal System (MOSS) signal trigger on 21 June, triggered by two term neonatal deaths (NND) in addition to the rolling number of term stillbirths reviewed in the April critical safety check. The two NND were discussed and no safety issues relating to intrapartum services were identified. - One NND was the expected death of a baby on the Butterfly palliative care pathway. The second 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 the Maternity and Newborn Safety Investigations (MNSI) programme for investigation. - Maternity Incentive Scheme, Year 8, Training Compliance checkpoint was reached. - The Ockenden Report and Baroness Amos investigation reports had both been published during this period. SH noted the importance of recognising that, while the Trust provides good care for most families, some local families had not received the standard of care expected. Further discussion around each of these reports is detailed as below. Ockenden Report SH advised that the Ockenden Report included a number of recommendations and three key actions: - <u>Roll-out of Martha's Rule to all maternity and neonatal settings in England:</u> SH confirmed that Martha's Rule had been partially rolled out in maternity and neonatal services, although the second opinion process had not yet been used and further work was needed to understand why. - <u>Strengthening candour and cooperation in future reviews:</u> SH advised that the Trust already undertook this work but needed to continue ensuring open and honest conversations. - <u>Human Tissue Authority action requiring all Trusts to review mortuary records:</u> This would be discussed in detail at the private Board. SH advised that these recommendations, together with those from the Amos Investigation, would be reviewed by the National Maternity and Neonatal Taskforce and contribute to a national suite of recommendations. Independent Investigation into Maternity and Neonatal Services in England SH highlighted the following: The investigation had resulted in both a full national report and an individual Trust report. SH noted the value of reading other Trust reports to enable comparison with the BTHFT report.	

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	- The final full report included eight key recommendations. It acknowledged that the scale of action required would take time to implement, but identified some recommendations requiring immediate action. Most were national actions, but two were specific to Trusts. - Trusts were required to complete a Board-level audit within three months of current triage provision, with particular attention to staffing, including appropriate senior medical staffing 24 hours a day, seven days a week. SH advised that BI support would be available to support this, as metrics needed to be developed to enable reporting. - The service would also need to ensure sufficient antenatal bed capacity to admit women requiring support in early labour. SH acknowledged that Bradford continued to receive complaints in this area, as women may not have a medical need to remain in hospital but may feel they need support in early labour. This could create a barrier to women returning once labour had progressed, and so the service needed to consider how to provide more robust support for these women. - In relation to the Trust-specific report, the service had asked the Amos team to contact service users who contributed to the investigation, on the Trust's behalf, to offer an opportunity for the Trust to listen to their experiences first-hand. While the Trust could not undo harm or repair a poor experience, it may be able to share improvements made and use those experiences to further improve services. AS asked whether SH had a "command centre" style structure in mind to enable and support reporting. SH confirmed that this would be useful, particularly in relation to triage and supporting flow through the unit. She noted that the challenge related to timely recording, as staff were often with patients rather than recording contemporaneously, alongside limited information sharing with other organisations when patients accessed care in two separate locations. SH confirmed that this was being actively progressed and was recognised on the risk register. The Board: • confirmed it was assured that Quality Committee had 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; • noted the narrative regarding the Ockenden and Amos reports and the immediate actions required; • noted the completed MOSS Critical Safety Checklist, and the unchanged rating of Green/Amber, with risks monitored via Women's Core Governance Group; and • noted that the second Maternity Incentive Scheme, Year 8, Training Compliance Checkpoint was achieved.	
Section 4: People		
Bo 26.10	Report from the Chair of the People Committee: June and July 2026 JA gave an overview of the report from the People Committee meetings held in June and July 2026. The report alerted the Board to several key issues: - Good progress continued to be made with the workforce reduction plan. - The Committee would, however, need to maintain oversight of the balance	

No.	Agenda Item	Action
	between workforce reduction and cost improvement requirements, workload pressures, and patient outcomes and experience. - The Committee received the Q1 Freedom to Speak Up (FTSU) 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. - The Board was asked to note that the Trust wished to retain a flexible bank model for HCA staff. The flexible bank model had been in operation for some time and was a deliberate part of the Trust's workforce model. Whilst the Trust would continue to make reductions in other areas of bank usage, it was proposed that the HCA bank model was retained. This was different from the overarching request from NHS England (NHSE) to reduce bank staff and therefore needed to be agreed by the Board before reporting back to NHSE. The Board: • received the report and noted the 'alert' items and the assurance provided; and • agreed the proposal to retain the HCA bank model and to report this position to NHSE. Staff survey results and action plan: BM noted that the report did not reference any actions targeted at specific staff groups or services with outlier results in the staff survey. JA confirmed that the Committee had been assured by the staff survey reporting and that targeted work was taking place with Clinical Service Units (CSUs) where outliers had been identified. FL added that localised CSU action plans were in place and fed into the wider Trust action plan. It was also recognised that the Trust should focus on areas of excellence as well as areas requiring improvement. The report was received and noted by the Board. Resident Doctor 10 Point Plan – Board Assurance Framework: The report was received and noted by the Board.	
Bo.7.26.11	Nursing & Midwifery Staffing Establishment Review KD introduced 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. The Chief Nurse's recommendations for nursing were as follows: 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. The Board noted 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 Board was assured by the report and approved the Chief Nurse's recommendations outlined above.	

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	Bi-annual Perinatal Workforce Report – June 2026 KD also presented the bi-annual Perinatal Workforce report which sought to provide 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. KD highlighted that recent national maternity reviews, including the Baroness Amos Investigation and the Ockenden Review, reinforce the importance of ensuring workforce establishments are sufficient to provide safe, responsive 24/7 care across all professional groups. The pressures described within the workforce report align with these national findings, particularly in relation to consultant obstetric, anaesthetic, neonatal and ward workforce capacity. KD advised that an immediate action was in place for the neonatal unit to operate only within its commissioned cot allowance, rather than exceeding it, to enable the unit to remain within safe staffing levels. KD noted that the Trust had historically invested in both capital and staffing for the maternity department. However, the landscape had changed significantly, and current commissioning arrangements for maternity services were not sufficiently robust to cover the cost of service delivery. She emphasised the need for the Trust to be in a strong position should national funding become available, with a credible case ready to support any bid and influence decisions about how funding might be allocated. BR reflected that the Trust had proactively invested in developing a good and outstanding maternity and neonatal service. However, there was a risk that the Trust could be penalised if funding was not made available to support the additional requirements now being placed on services. He highlighted the need to engage with NHSE to ensure this message was understood. BR and KD were clear that the recommendations arising from the Amos and Ockenden reports would carry a cost. It was noted that the Board may not be able to agree additional investment without national income, which may have implications for the Maternity Incentive Scheme Year 8. MP noted that, because of the Trust's investment, it was able to demonstrate an improvement journey during discussions with Baroness Amos. However, she also noted that poorer experiences in other areas, such as A&E, were a consequence of investment decisions. MP advised that Baroness Amos had not yet met with the Secretary of State but that one of the key messages the investigation team wished to convey was the complexity and challenge of operating in a city such as Bradford, with its diversity and population needs. MP noted that it was positive to hear this recognised and that funding for organisations needed to reflect population need. JB commented that the Trust was in a position where addressing one risk could worsen another, and that the Board needed to understand this. JA agreed, noting that risks were often escalated in isolation and needed to be considered collectively to support risk-assessed decision-making.	

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	MP referred to sickness absence and asked whether there was a plan to address this. SH advised that long-term sickness was well managed within maternity, but short-term sickness remained a challenge. She noted that the absence reasons were often linked to home circumstances rather than work-related stress. The service would review flexible working requests and consider how sickness absence could be improved while managing staff expectations. SH hoped that the new sickness absence policy would provide further support. SH also highlighted challenges relating to resident doctors, who were often rotated onto the maternity unit with limited experience, adding further pressure to the service. This risk was reflected on the risk register. SH also noted that recent reports may reduce the number of resident doctors choosing obstetrics and gynaecology as a career. With regards to the recommendations in the paper, the Board was 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. It was noted that the Board was not being asked to approve additional investment at this stage and that proposals would need to progress through the appropriate governance routes. However, the Board was assured that appropriate arrangements were in place to enable the required business cases to progress. BM thanked the maternity team for its approach, which demonstrated clear and considered thinking.	
Section 5: Finance and Performance		
Bo.7.26.12	Report from the Chair of the Finance and Performance Committee: June and July 2026 BM gave an overview of the report from the Finance and Performance Committee meetings held in June and July 2026. The report alerted the Board to several key issues: - The meeting held the previous day discussed the need to ensure that the AAA reports appropriately reflect the assurance provided in relation to both processes and delivery. - The Committee had held increasingly positive and detailed discussions on estates issues, supported by improved papers presented in relation to Estates and Facilities. The Board received the report and noted the 'alert' items and the assurance provided. Integrated Dashboard: The report was received and noted by the Board. Finance Report: The report was received and noted by the Board. Performance Report: The report was received and noted by the Board.	

No.	Agenda Item	Action
	Annual Health & Safety Report: The report was received and noted by the Board. Annual Fire Safety Report: The report was received and noted by the Board. Anchor Institution: The report was received and noted by the Board. Green Plan 2025-2028: The report was received and noted by the Board.	
Section 6: Strategy & Partnerships		
Bo.7.26.13	Partnerships – strategic view MHi provided a summary of partnership working that the Trust is currently engaged with across Bradford, West Yorkshire and more widely. ZA referred to the EXCEL programme and asked whether, without this programme, demand on A&E would be significantly higher. MHi advised that it was difficult to be precise about the factors driving A&E attendance and the specific impact of EXCEL. However, he noted that the preventative work undertaken through EXCEL had been successful previously and had the potential to make a positive impact. AS asked how data was being used to inform this work. SA advised that the integrated neighbourhood health work was driven by public health data, which suggested the need for different responses across different communities. He noted that neighbourhood work was a key enabler of the EXCEL programme, supporting the shift of care out of hospital and reducing front-door demand. In relation to the Trust specifically, SA noted that the absence of an Urgent Treatment Centre meant the community often had no alternative but to attend A&E. While front-door streaming could help divert patients to the most appropriate place, the focus needed to be on reducing attendance in the first instance. He added that there was a need to use Yorkshire Ambulance Service data on community call-outs and map this to understand how alternative service offers could be best used by our community. TS noted the importance of system governance to ensure all elements worked together and asked whether current governance arrangements were adequate. MP advised that the integrated neighbourhood health workstream was in place and that priority areas had been identified using population health management and public health data. She gave the example of high acute admissions for end-of-life care in Bradford, noting the opportunity to invest at scale in services known to be effective, such as REACT, to reduce admissions. Although this would require investment, savings may offset the cost. MP also noted that community services had received a 4.2% uplift and that the neighbourhood health programme had undertaken a process to identify how this funding should be used to help reduce attendances. Investment had also been agreed in a mobile X-ray facility, providing the ability to rule out fractures without the need to bring patients into hospital. KD commented that, while the system was data rich, it remained information poor, and generic information-sharing agreements were difficult to establish. She noted innovative work underway in theatres, particularly around pre-assessment, where cancellations often occurred on the day because patients	

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	were not fit for surgery and were unlikely to become fit, meaning they should not remain on the waiting list. BR advised that 'Connected Bradford' was being expanded to West Yorkshire. However, current patient consent allowed use of the data for research purposes only. A significant programme of work was underway to enable consultation on using the data for service user purposes. This would cover services across the whole Place, including police, fire and rescue, and social care. BR emphasised the need to proceed carefully and ensure all ethical and moral processes were followed, with an appropriate structure in place to support long-term sustainability. The Board noted the update. Strategic Partnering Agreement (SPA): The updated SPA was received and approved by the Board who also authorised the Chief Executive to sign the SPA as the Trust's representative.	
Bo.7.26.14	Trust Strategic Framework 2026/27 update MHi gave an overview of the paper which proposed 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. MHi noted that 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. The revised framework retains a similar structure to its predecessor and includes the same core components: the Trust 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 the Trust's 5-Year Integrated Delivery Plan, the Trust's shared strategic ambitions with Airedale and BDCT, and the NHS 10-Year Plan. BM suggested that, while the immediate focus was on achieving recovery, there may be a case for beginning work on the new strategy now rather than waiting another year. This would support the Board's forward view of where the Trust aimed to be over the next five years. MHi advised that this work had effectively started, with increasing engagement with partners to develop a shared vision. The Trust was beginning to consider this now and would continue engaging partners, staff and stakeholders ahead of developing the strategy. MP noted the need for a document that described the various moving parts and helped the Trust consider what these meant in practice. JA agreed that this would support Board decision-making, particularly around investment. BM added that, as the Trust could not deliver everything asked of it, it would be helpful to have strategic context to inform what the Trust should prioritise. The Board agreed an updated 2026/27 Strategic Framework, providing a bridge to the development of the new Corporate Strategy for 2027 -2032 and supporting the delivery of the Recovery Programme in 2026/27.	

No.	Agenda Item	Action
Section 7: Audit and Assurance		
Bo.7.26.15	Report from the Chair of the Audit Committee – 17 June 2026 ZA gave an overview of the report from the Audit Committee meeting held in June 2026. The Committee had received several final reports which had received Limited assurance were several; these would be deferred to the September committee meeting to allow for in-depth discussion. The Board received the report and noted the 'alert' items and the assurance provided.	
Section 8: Governance		
Bo.7.26.16	Board Assurance Framework (BAF) and high-level risks KD introduced the revised BAF which provided a profile of risks, controls and assurances related to the delivery of the Trust's strategic objectives. The Board confirmed that it was assured that all risks on the High-Level Risk Register and BAF were appropriately recognised and recorded, and that all appropriate actions were being taken within appropriate timescales where risks were not appropriately controlled.	
Bo.7.26.17	NED Champion Roles annual review LP presented the paper, which advised the Board of changes to Non-Executive Director committee memberships and lead roles. LP confirmed that the proposed changes had been discussed with the relevant individuals as part of the appraisal process. The Board approved the proposed changes to committee memberships, as outlined within the paper, and noted the assignment of Non-Executive Directors as champions or leads for specific areas.	
Bo.7.26.17	Fit and Proper Person Test annual review LP presented the paper which sought to provide the Board with assurance that the Trust is compliant with the Fit and Proper Person Framework. The Board was assured that the Trust was compliant with the Fit and Proper Person Framework.	
Section 9: Board Meeting Outcomes		
Bo.5.26.26	Any Other Business There were no other items of business.	
Bo.5.26.27	Issues to refer to Committees 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.	

No.	Agenda Item	Action
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 – 23 JULY 2026

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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	Verbal update to be provided.

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Board of Directors public				
Meeting Date:	24 September 2026	Agenda Reference:	Bo.9.26.5	
Report Title:	Report from the Acting Chair			
Presented by:	Karen Walker, Acting Chair			
Executive Lead:	Karen Walker, Acting Chair			
Author:	Jacqui Maurice, Head of Corporate Governance			
Report Summary				
Purpose of the paper:	Decision ☐ (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 July 2026. The report covers: - Council of Governors session regarding the National Maternity and Neonatal Investigation - Annual Members Meeting - Changes to Council of Governors - NED Appointments process - Strategic Advisory Forum: Voluntary Sector and Communities - Invitation to the 'We are Bradford Awards' - Feedback to the Council following Board of Directors meetings - Key communications			
Recommendation/s: (including any decision/approval required)	The Board of Directors is asked to derive assurance from the report.			
Link to Strategic Objective:	N/A			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	N/A			
Legal/Regulatory:	N/A			
Quality & Patient Safety:	N/A			
Equality, Diversity and Inclusion and Health Equity:	N/A			
Resources:	N/A			
Environmental sustainability:	N/A			
Assurance Route				
Meeting/s where content has been discussed previously:	N/A			

Report content

1. Council of Governors session regarding the National Maternity and Neonatal Investigation (NMNI)

On Thursday 27 August 2026 we welcomed Dr Christine Ekechi, Expert Advisor to the NMNI to a meeting with our Council of Governors to discuss the outcomes of the investigation. Dr Ekechi described the process of the investigation and the key findings overall, and the findings specific to BTHFT. Governors also had the opportunity to raise questions with Dr Ekechi. We were pleased to be able to have this opportunity to discuss the findings directly with a member of the investigation team.

2. Annual Members Meeting

Our Annual Members Meeting (AMM) takes place on Wednesday 30 September 2026 from 5.30pm to 6.30pm, in the Listening for Life Centre, Bradford Royal Infirmary, Smith Lane, BD9 6DA. There will be presentations on the Annual Report from Chief Executive, Professor Mel Pickup and on the Annual Accounts by Chief Finance Officer, Ben Roberts. There will also be an update on the work of our Council of Governors during 2025/26. We have invited questions to be submitted in advance of the event from our members and the public – these need to be submitted by 5pm on Thursday 24 September. Full details are available on our Trust website [here](#) along with the AMM agenda, our Annual Report and Accounts 25/26 and our Quality Account 25/26.

3. Changes to our Council of Governors

Partner Governor Bradford Metropolitan District Council (BMDC)

I am sure you will join me in providing a warm welcome to our newest Governor, [Councillor Dawn Thewlis](#) who has now formally joined our Council as Partner Governor representing BMDC. You will have the opportunity to meet Dawn at our next Council of Governors meeting on 30 September.

4. NED Appointments process

The Governors Nominations and Remuneration Committee (NRC) (with the support of the Trust) is leading on the appointment of two new NEDs to fill the vacancies that will be left by Altaf Sadique and myself following the completion of our second terms in November and December 2026 respectively. The NRC is supported by an executive search agency. The Governors are currently finalising arrangements with regard to the shortlisted candidates, and membership of the interview panel and stakeholder panel.

Following interviews, recommendations regarding the new appointments will first be presented to the full Council of Governors for approval, in line with their statutory duties.

5. Strategic Advisory Forum: Voluntary Sector and Communities held 3 September

Another extremely well received session took place at the Cellar Trust in Shipley attended by key members of our Voluntary sector, BTHFT Board members and Governors and I would particularly like to extend my thanks to Mark Hindmarsh, Director of Strategy and Transformation for organising this (and the previous three sessions) which have all proved informative and enlightening. Once the write-up is completed for the 'Voluntary Sector and Communities' session this will be shared with the Board and Governors. The presentations delivered on the day will also be circulated. I look forward to the Board discussing any follow up actions from these sessions in order for us to progress this engagement.

6. Invitation to the 'We are Bradford Awards'

Just a reminder that our NEDs and Governors are in receipt of an invitation to join Trust staff at our annual 'We Are Bradford Awards 2026' which will be held on Thursday 22 October. *This event follows on from the Trust's Long Service Awards, celebrating colleagues who have worked within the NHS for 30years.* The 'We Are Bradford' celebrations take place from 6.30pm to 10pm. Please would you confirm if you are able to attend, as per the request in the email sent.

7. Feedback to the Council following Board of Directors meetings

The last feedback session from the Board meeting held in July took place on Tuesday 4 August and was very kindly led by Bryan Machin, Senior Independent Director on behalf of myself.

The next feedback session with Governors will take place on Monday 5 October.

8. 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.

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Board of Directors				
Meeting Date:	24 September 2026	Agenda Reference:	Bo.9.26.6	
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 July 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 2026/27 had not been published at time of writing a review of the published position will be undertaken in due course. The prominence of the Referral to Treatment (RTT) 18-week incomplete measure has increased nationally and regionally given the deterioration and the potential winter impact on elective activity and concerns about the national elective waiting list. At BTHFT we have seen a deviation away from plan for RTT performance (matching the national trend) although we have sustained strong delivery of the over 52-weeks RTT position, with the Trust close to upper decile performance amongst Acute providers. Demand has stabilised at increased but predicted levels meaning the pressure is related to clock stopping activity levels rather than new referrals into the organisation. Outpatient activity is delivering in line with plan but not generating the pathway progression expected. This has created an immediate

pressure but also signifies a productivity benefit for future months delivery if focus is applied to waiting list management and streamlining decision making.

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 and combined with improved pathway management can quantifiably deliver the recovery to plan needed. This will of course need to be closed tracked.

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. For the 62-day first treatment standard we have seen some deterioration in performance across several tumour groups relating to complexity, capacity and patient availability. Each theme and tumour group with increased waits have specific recovery plans that are tracked weekly to support improvement. Ongoing transformation work will continue in line with the National Cancer Plan so that recovery is then sustained.

Daily attendances to the Emergency Department (ED) had tracked above expected levels for each month since April, with some of the highest daily numbers on record, but dropped in line with last year during August. Emergency Care Standard (ECS) 4-hour performance and the equivalent measure for paediatric attendances have improved in August. The seasonal drop in attendance may have contributed but there has also been intensive work, monitored daily to improve this position. 12-hour performance has yet to show the same improvement, but process changes are being embedded and admission ward capacity configured in support of this, with gains expected from September which will then be sustained via the winter plan.

Winter Planning

The Winter Plan has been developed and presented through the Executive Team Meeting (ETM) and will be presented at the September Finance & Performance Committee, in addition it will be shared for final sign off and approval at the Board meeting on 24 September 2026.

The plan sets out the Trust's operational response to all requirements contained within the NHS England Winter Planning 2026/27 Expectations and Assurance Framework, which was published on 17 July 2026. The plan has been reviewed against the NHS England Board Assurance Template to ensure compliance with all required planning and assurance standards.

2. People

Equality, Diversity and Inclusion

Belonging & Inclusion Festival

On Tuesday 15 September 2026, as part of the celebrations for National Inclusion Week (14-20 September 2026), we held a "Belonging at Bradford" on the main concourse at BRI. To launch the festival, we were joined by local sporting hero Anthony Cotterill, a two-time Paralympian and elite wheelchair tennis player (who has represented Team GB on the world stage and has won more than 40 international titles, a world championship and global singles ranking of no.5). Colleagues joined Antony in the Sovereign Lecture Theatre where he gave an inspirational presentation, sharing some of his personal experiences of the NHS and healthcare, following a life-changing accident in 2003. Antony spoke about his initial treatment through to the day-to-day challenges of living as a wheelchair user. He gave insight into how small changes can make a big difference in creating a more inclusive experience for our staff, patients and visitor. The celebrations continued on the main concourse at BRI where Antony hosted a meet and greet, photo opportunity with some of his medals and a fun mini assault course using

his sports wheelchair. Colleagues from a range of services/ departments across the Trust (including our four staff equality networks), joined the celebration on the concourse to showcase their work and engage colleagues in conversations about equality, diversity and inclusion. This provided an opportunity for staff to learn more about the support available, celebrate the diversity of our workforce and contribute to ongoing dialogue about how we continue to build an inclusive culture across the Trust, with some fun challenges and the chance to win prizes. Creating an inclusive organisation is everyone's responsibility.

Visit from NHS Race and Health Observatory

On 13 August 2026 we had a visit from the NHS Race & Health Observatory (CEO) Dr Habib Naqvi and Owen Chinembri, Assistant Director for Workforce. A range of engagement sessions took place, including sessions with Trust Board, our four staff equality networks, colleagues from maternity services and representatives from the voluntary and community sector. As part of the closing session, the Trust officially signed up to the 7 anti-racist principles. In addition to this, we have signed up to a 6 month Community of Practice Programme with the NHS Race & Health Observatory to accelerate progress on implementing the 7 principles, to learn from the experts at NHS Race & Health Observatory and to share best practice. Saj Azeb, Chief Operating Officer/ Deputy Chief Executive (and Executive sponsor for the Trust Race Equality Network) has agreed to be executive sponsor for the programme.

3. Place

NHS West Yorkshire ICB

At the time of writing our local ICB had developed a new operating model that came into effect on 1 September 2026, with formal communications due to be shared detailing what this model looks like, what it means for people working for the ICB and what it means for partners. The new operating model reflects the reduced workforce at the ICB which has gone from approximately 1200 people to around 700 people once the final round of appointments has taken place. It is expected that the communications update will include details on how the new operating model will support work that involves wider partners and place-based developments including integrated neighbourhood health and the development of place provider partnerships.

Place provider partnership (PPP) update

It has been confirmed that the formal launch of PPPs is being delayed until April 2028, however work continues at pace to ensure that all PPPs in West Yorkshire are ready in shadow form by April 2027. Bradford District and Craven is one of three PPPs in West Yorkshire the others being Leeds and one for Calderdale, Kirklees and Wakefield. On 1 April 2028, it is now expected that most, if not all, the budget will be devolved to PPPs than previously expected. At this stage, the settlement is being worked through with more details to be provided in due course. The governance work required to get us to where we need to be as a PPP continues, as do organisational development sessions.

Bradford District and Craven Partnership

As part of the ICB change programme, people are now being appointed to roles including those who will be part of the Bradford District and Craven integrator team that will consist of around 35 people. The work of the integrator team will broadly fall in three areas: population health management and clinical leadership; innovation and change; and neighbourhood and primary care development. The aim is to enable Bradford District and Craven to become a population-led, prevention-focused and integrated health and care system. This is to be done by connecting partners, using intelligence to target need, supporting neighbourhood delivery, enabling innovation and change, and providing the system with the insight, infrastructure and assurance needed to deliver better outcomes and reduce inequalities.

The expected objectives are:

- Population insight - build a shared understanding of population need, inequalities, outcomes and unwarranted variation to inform priorities and resource allocation.
- Prevention and population health - Shift the system towards prevention, proactive care and earlier intervention, particularly for populations at greatest risk of poor outcomes.
- Neighbourhood integration- Enable integrated neighbourhood teams and primary care to organise services around defined populations, working across organisational and professional boundaries.

- System transformation - Enable partners to redesign pathways and services around people, moving care closer to home and improving quality, access, experience and productivity.
- Innovation and improvement - Identify, test, evaluate and scale innovative approaches that deliver measurable improvements and ensure successful change becomes embedded.
- System enablement and assurance - Provide the relationships, infrastructure, intelligence, programme support and assurance that enable partners to deliver collectively, while retaining clear organisational accountability.

The integrator team and functions will ultimately transfer across to the host provider for the PPP, with those working in these functions supporting us as we move towards shadow form.

4. Partners

West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common, 28th July 2026

I attended the WYAAT Committee in Common (CiC) meeting on 28th July, the first hour of which was a dedicated session with Regional Chair, Bill McCarthy. We then received an update on operational context and place provider collaboration from each individual place. We reflected on the recent publications relating to maternity, and reviewed the strategy and case for change delivery including programme risks and escalations and a focus on major infrastructure projects.

WYAAT Programme Executive Meeting, 4th August 2026 and 1st September 2026

I attended the WYAAT Programme Executive Meetings on both 4th August and 1st September.

At the August meeting, we received our usual Trust updates and collaborative reports, and reviewed the terms of reference. We also discussed the place provider partnership arrangements, our commissioning approach, and shadow priorities. We discussed maternity and infrastructure which had both been raised at the July Committee in Common. The annual leave project scope was received.

The meeting in September included an update from the Integrated Care Board (ICB) and system, and updates from individual Chief Executive Officers. We received updates around both non-surgical oncology (NSO) and microbiology feasibility. The usual collaborative report was received, and the October programme executive plan was discussed.

WYAAT System Leadership Executive, 4th August 2026 and 1st September 2026

I attended the WYAAT System Leadership Executive on 4th August, which was a focused session on partnerships and strategic commissioning and system development. We discussed progress to date, the case for change, a revised timeline for system changes, the scope of service for place provider partnerships and arrangements for 2027/28. We received an update on system leadership and leading for system change.

At the meeting on 1st September, we discussed progress since the previous meeting, reviewed risks and mitigations, and discussed the 2027/28 planning round.

5. National Reports

NHS West Yorkshire Integrated Care Board (ICB) - Strategic Commissioning and System Development

On 2 September 2026 the trust received a letter from Jonathan Webb, Chief Executive of the NHS West Yorkshire ICB. The letter thanked members of the West Yorkshire System Leadership Executive Group for joining a meeting on 1 September and confirmed the strong support for developing Place Provider Partnerships (PPPs) and a wider move towards integrated neighbourhood health, with Places based on unitary authority footprints and the ICB taking a stronger strategic commissioning role ahead of April 2028. The key risks identified included clarifying the case for change and its benefits for local people,

strengthening strategic commissioning capability, improving provider relationships, managing host-provider implications, securing sufficient capacity, maintaining momentum and balancing future development with current operational pressures. The group agreed that the case for change should focus more clearly on expected outcomes and practical improvements for residents, alongside greater collective leadership, challenge and early problem-solving, potentially supported by readiness or gateway reviews. A clear roadmap of milestones and decisions to April 2028 will also be developed, with the 2027/28 planning process providing an opportunity to test the future approach. The steering group will now progress the case for change, programme roadmap and readiness arrangements, with progress reviewed through future System Leadership Executive meetings.

NHS England Preventing Unlawful Access to Patient Records

Recent national communications concerning staff members' unlawful access to patient records has been positively received locally, regionally and nationally and helps reinforce existing messaging and Information Governance (IG) good practice within Trusts. This has been partly driven by media reports highlighting high-profile incidents. The shift in terminology from 'Inappropriate Access' to 'Unlawful Access' is widely welcomed, as it conveys a stronger and clearer message.

The Trust's current Information Governance (IG) practices concerning **unlawful access** to patient records, include regular staff communications, incident reporting and monitoring, and mandatory annual training. There are auditing facilities available within clinical systems, and this is message is reinforced with colleagues noting that training alone is not always enough to prevent breaches.

Improvements are being planned such as more frequently structured pro-active scheduled all-staff communications, themed global screensavers, and obtaining disciplinary outcome statistics from HR to further strengthen governance and reduce unlawful access incidents. Further information on the publication can be found here - [NHS England » Preventing unlawful access to patient records](#)

NHS England Quality Strategy 2026

A 10-year strategy to make high-quality care the standard across all NHS-funded services was published by NHS England in July was updated on 20 August 2026 to provide detail on three quality domains: Safety, Effectiveness, and Experience. The main aims are to improve outcomes, reduce inequalities, and increase patient satisfaction. Priority areas include patient safety, maternity care, reducing variation in outcomes, improving patient experience, and tackling inequalities. Delivery will focus on stronger leadership, accountability, better use of data and technology, transparency, and continuous improvement. The overarching key message is that Quality improvement is everyone's responsibility and is intended to deliver safer, more effective, and more equitable care across the NHS.

For further information the NHS England publication can be found here - [NHS England » Quality strategy for NHS-funded care in England](#)

Nottingham Maternity Review

In response to the final report of the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust, led by Donna Ockenden in June 2026, the Board continues to receive assurance reports on progress being made against the actions identified for acute NHS trusts. Oversight is led by the Chief Nurse and reported to the Quality Board Committee and onwardly to the Board of Directors.

[NHS England » Nottingham maternity review findings on post-death care and key actions required following the Fuller Inquiry](#)

Maternity and Neonatal 10 Point Plan Assurance Process

In response to systemic failings, NHS England published a Maternity and Neonatal 10 Point Assurance Process in August, to drive accountability, improve safety, governance and enforce national standard across trusts. As above, the Board will receive assurance reporting via the Chief Nurse on the progress being undertaken to implement the requirements of the 10 Point Plan.

Details can be found here - [2026\129. PRN02631 i Letter Maternity and Neonatal 10 Point Plan assurance process 120826-final.pdf](#)

Thirlwall Inquiry

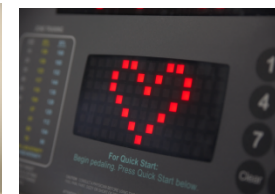
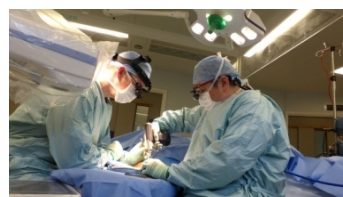
The Trust acknowledges the recommendations made by Lady Justice Thirlwall in her announcement on 15 September 2026 and the findings set out in the report into the failings by those responsible for the safety of babies at the Countess of Chester Hospital. The Trust will carefully consider all aspects of the Inquiry's findings and recommendations and will ensure that these are appropriately addressed, with a particular focus on learning, accountability, and the continued strengthening of arrangements to ensure the safety and wellbeing of babies and their families.

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Board of Directors – Skin AI Showcase

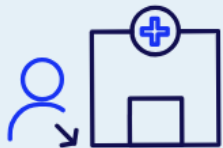
Tom White – Senior General Manager

Mr Zakir Shariff – Consultant Plastic Surgeon and Skin Cancer Lead



Together, putting patients first

What is it?



1. GP referral

GP refers to secondary care on the urgent suspected skin cancer pathway as normal.



2. Image capture

Patients' first appointments are at an imaging clinic, where consent, medical history, context and dermoscopic images are captured.



3. AI assessment

DERM assesses the dermoscopic images of lesions only.



4. Next steps

Based on the outcome of the AI assessment, the case will be directed to the right level of care.

Together, putting patients first

Why was it introduced?



Demand is rising

>11%
annual increase

National urgent referrals for suspected skin cancer are increasing by over 11% each year, placing growing pressure on services.



Workforce is constrained

Consultant shortages

Dermatology services face major workforce pressures, with around 1 in 4 consultant dermatologist posts nationally unfilled, making it difficult to recruit and retain specialists.



Early detection matters

Earlier diagnosis saves lives

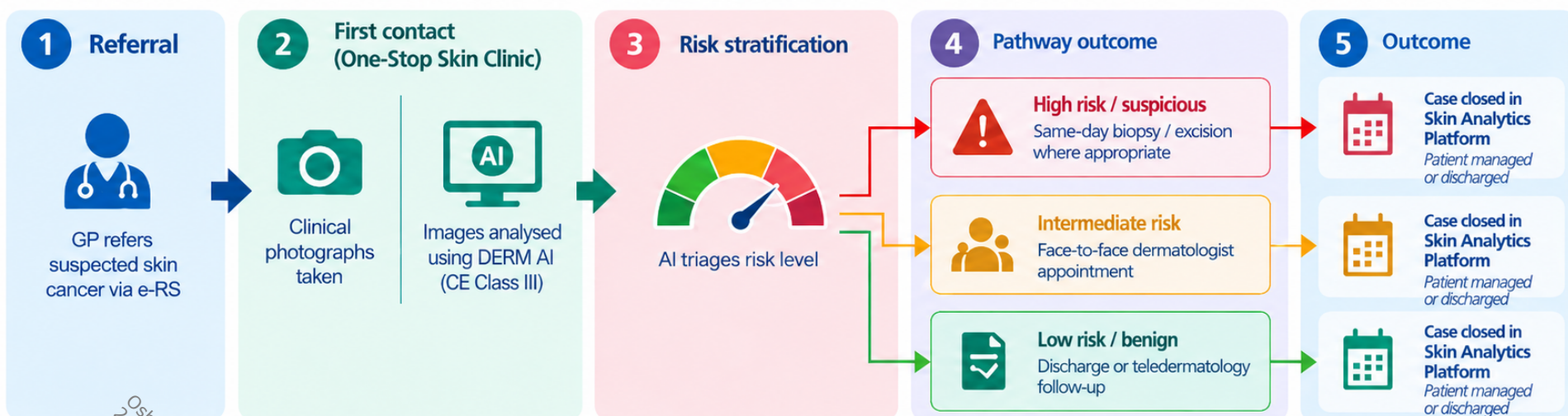
Early skin cancer detection is critical for survival. Around one-third of melanoma cases are identified on routine pathways rather than urgent suspected cancer routes, meaning some patients face longer waits to diagnosis and treatment.

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The Solution

Dermatology One-Stop Pathway (DERM – Skin Analytics)

High-level pathway | Faster diagnosis. Fewer unnecessary appointments. Better outcomes.



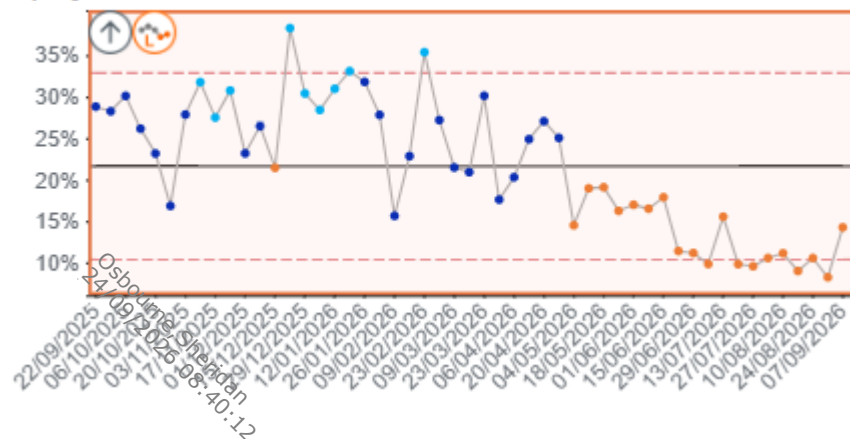
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Together, putting patients first

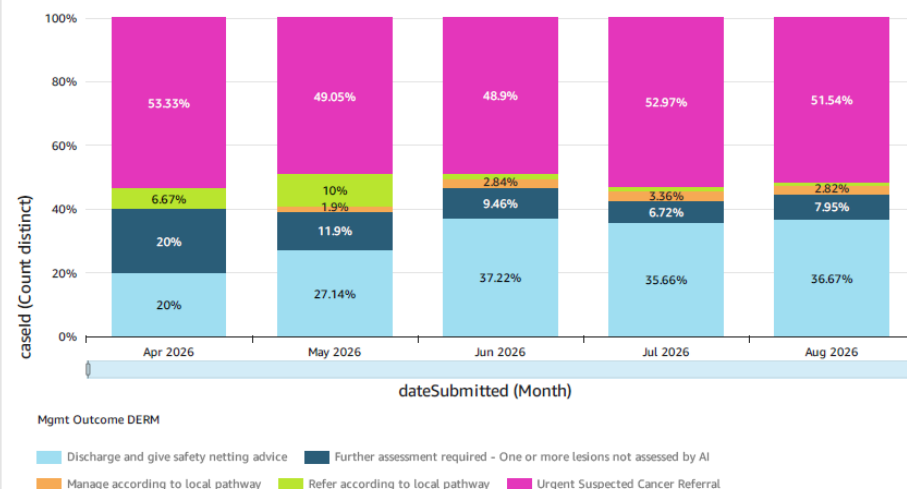
Impact so far

- Over 1,319 patients seen via AI in 4-months
- Stable 36% discharge rate
- Significant reduction (~15%) in biopsies
- Significant positive impact on our summer resilience and future performance

Biopsy Rate (%)



Raw DERM outcomes (monthly)



Together, putting patients first

Meeting Title	Board of Directors		
Date	24 th September 2026	Agenda item	Bo.9.26.8a

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality Committee

Date of meeting: 17th September 2026

Key escalation and discussion points from the meeting

Alert:

- Four new high level risks were reported, three of which I am highlighting for the Board. The first of these is 2913 relating to the growing number of children living with highly complex medical conditions. The committee heard about some of the work taking place to address the risks and particularly those relating to transition from children to adult services.
- Two new high level risks (2605 and 109) relate to haematology and oncology services, where patients have been affected by delays due to workforce pressures, scheduling difficulties and operational constraints. We were informed about immediate mitigation measures that are in place, whilst longer-term workforce and capacity solutions are being developed. The committee will receive a further report on these.

Advise:

- The committee approved those elements of the Risk Appetite Statement relevant to our objectives, and recommend them for approval by the Board, including the proposed change to classify patient safety risk as 'Avoid' rather than 'minimal'.
- The committee considered the action plan proposed following the CQC inspection of the Emergency Department. Whilst we understand the huge logistical pressures affecting the department, we were concerned that existing assurance mechanisms had not highlighted issues around cleanliness, medicines management and wider governance weaknesses before the internal inspection. We were informed of steps that have been taken since the inspection to strengthen governance and audit processes, and agreed that future assurance should not focus only on the existence of audits but on the quality and effectiveness of the governance processes themselves.
- We received a comprehensive update on maternity and neonatal services. Most of this provided good assurance, although we noted there are some areas where further progress is needed to complete the Maternity Care Bundle implementation. The one area of 'advise' for the Board is a continued reference in the report to ongoing workforce pressures, particularly regarding consultant capacity and workforce resilience, where the report wording indicates that safe care may be at risk. Assurance was provided that safe clinical care continues to be prioritised through robust rota management and escalation arrangements. The Committee requested additional clarification regarding how workforce gaps are being mitigated in practice
- The committee received a detailed review of patient engagement and maternity complaints. This identified communication as the most common issue, with many

Meeting Title	Board of Directors		
Date	24 th September 2026	Agenda item	Bo.9.26.8a

complaints related not to clinical care itself, but to how information was conveyed to patients and families or how expectations were managed. Other recurring issues included delays in care, induction processes, documentation, record keeping and consent. The committee heard about extensive improvement work already underway, including enhanced training focused on compassionate and personalised care, quality improvement initiatives surrounding labour ward processes, and continued work to strengthen documentation standards. Members welcomed the reflective nature of the review and encouraged further work to better understand complaints across different population groups.

Assure:

- The Quality dashboard indicates positive improvements in various indicators, including sustained improvements related to E.coli bacteraemia rates following improvement work by clinical teams. There was also discussion regarding mortality rates where reductions in crude mortality rates are not reflected in current SHMI rates, something which we believed is due to historic coding and data submission issues.
- The committee welcomed the newly structured Quality Insights Report which presents themes from incidents, investigations, complaints, claims, coroner activity and learning from deaths. This brings several previous reports into a single structure.

The report showed strong levels of incident reporting, and an analysis of investigations which identifies several recurring organisational themes, including communication failures, delayed diagnosis and treatment, recognition of patient deterioration, follow-up arrangements and governance weaknesses. We have asked that future reports provide greater clarity around the specific actions taken to address these and enable us to demonstrate measurable improvement over time.
- The committee received a highly positive update regarding research activity. Significant external funding had been secured, including investment to expand clinical trials infrastructure. Members heard examples of research activity with international impact in stroke care, patient safety, respiratory medicine, genetics, digital health and population health
- In the light of recent national cases, and correspondence from NHS England, the committee received a report on arrangements to prevent unlawful access to patient records. We were assured that appropriate and robust policies, training arrangements and awareness campaigns were in place, alongside ongoing monitoring and investigation arrangements. Five incidents had been reported during the year, not all of which represented intentional inappropriate access.

Report completed by:

Tim Swift
Committee Chair and Non-Executive Director
18th September 2026

BOARD OF DIRECTORS				
Meeting Date:	24.9.26	Agenda Reference:	Bo.9.26.9	
Report Title:	Maternity and Neonatal (perinatal) update – July 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 ☒	Assurance ☒	Action ☐	Information ☒
Summary of Key Issues/Highlights:	The Director of Midwifery and the Chair of Quality Committee (QC) provide Trust Board with the assurance that a monthly review of maternity and neonatal quality and safety relating to July 2026 activity, was presented and key elements discussed including: • The number of harms occurring in July, 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 July • There was no MOSS triggers received in July • August and September perinatal harms will be shared with October Quality Committee This paper also includes: • Implementation of the Maternal Care Bundle and action plan • National 10-Point Plan Baseline Assessment for Board approval • National Maternity Triage Baseline Assessment for Board approval • Information regarding a MOSS trigger received in August			
Recommendation/s: (including any decision/approval required)	The Board is asked to: • Confirm that they are assured that Quality Committee have reviewed and discussed the contents of the July 2026 Maternity and Neonatal (Perinatal) Services Update Papers, and summary of incidents/harms, as a committee of the Board with delegated authority. Appendices 1 and 2 • To note the baseline assessment/compliance progress with implementation of the Maternal Care Bundle and action plan • Trust Board is asked to agree the governance process for completion and validation of the Trust Board assessment, together with the arrangements for quarterly review and oversight of progress against the agreed action plans • Approve the completed 10-Point Plan, baseline assessment and actions, prior to submitting to NHSE • Approve the National Maternity Triage, baseline assessment and actions/areas of concern prior to submitting to NHSE • Note that the service received a level 1 MOSS trigger in August and submitted the Critical Safety Check within the required timeframe			
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness			

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

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 delegated authority of Trust Board has assurance of an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. A summary of incidents is provided to Closed Trust Board, in addition to any completed Maternity and Neonatal Safety Investigations (MNSI) and internal Patient Safety Incident Investigation (PSII) reports.

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

The monthly paper also serves as the main mechanism for QC, as a delegated authority of Trust 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 July update and associated appendices was discussed at September Quality Committee. To note, Quality Committee was not held in August.

The key elements of the papers discussed included:

- The number of harms occurring in July, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of MNSI and PSSI cases were discussed and are available to Closed Trust Board as appendix 2.
- There were 0 completed MNSI reports and learning/recommendations to share in July.
- September QC reported and recorded that they were assured by the papers, presentation, and discussion. There was nothing identified requiring escalation to Board.

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

Maternal Care Bundle (MCB)– Safety Action E of Maternity Incentive Scheme Year 8

As part of Year 8 of NHS Resolution's Maternity Incentive Scheme (CNST MIS), Safety Action E requires that:

'In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle. Progress with implementation is reviewed quarterly through established governance routes.'

Trust Boards should be seeking assurance that all relevant services providing care in the perinatal period are on track to fully implement the MCB and meeting Safety Action E of CNST MIS (Year 8). Trust Boards should review the evidence through their governance frameworks at least quarterly and validate compliance against each of the standards. This will enable the Trust Board and relevant services to identify common problems and barriers to implementation and develop and share effective solutions.

This report is the first iteration of the services' self-assessment of the current position against the recommendations, together with the action plans required to address areas of non-compliance compliance. Trust Board will be asked to agree the governance process for completion and validation of the Trust Board assessment, together with the arrangements for quarterly review and oversight of progress against the agreed action plans.

As set out in MIS Year 8, the Trust Board should be assured quarterly that providers are meeting, or are on track to meet, the required interventions and elements. Where no process measure is provided for a given intervention, it is for the Trust Board to determine locally what is required to demonstrate compliance in clinical practice.

Current position:

Element 1: Venous Thromboembolism (VTE)

2 elements not implemented.

- Significant prescribing changes impacting on maternity services, accident and emergency department, and gynaecology assessment triage unit
- 1 element partially implemented. A self-assessment tool needs building and integrating into EPR This will require BI and IT support, implementation and data measurement of performance.

Element 2: Pre Hospital and Acute Care

3 elements all partially implemented.

- Trust wide roll out of Maternal Early Warning Score planned to include approval of the agreed care pathways
- Yorkshire Ambulance Service local signage review planned for 22 Sept 2026
- Maternal Medicine Network (MMN) to review local standard operating procedure

Element 3: Epilepsy in Pregnancy

2 elements, both partially implemented.

- Local Epilepsy in Pregnancy guideline needs review and oversight from MMN
- Training confirmation required

Element 4: Maternal Mental Health

3 elements, none implemented.

- Whooley questions self-assessment is not currently available
- Edinburgh Postnatal Depression Score self-assessment not currently used- impacts 2 elements
- Significant IT and BI support required to support implementation and data measurement of performance

Element 5: Postpartum Haemorrhage

3 elements all partially implemented.

- Maternity dashboard amendments required to capture metrics
- Equipment requirement (weighing scales)
- Improved consistency of case reviews for blood loss over 2 1.5 litres and audit of blood loss >1 and <2l
- EPR and dashboard changes required

- Significant IT and BI support required to support implementation and data measurement of performance.

There should be an improved partial compliance position at the quarter 3 review, for elements where local amendments are required.

Element 1 & 4, Maternal Mental Health, is expected to take more time to achieve compliance as it requires the introduction of a screening tool which is not currently used and will require EPR changes and staff training.

10 Point Plan

Following the publication of the Ockenden Nottingham report and Amos National Maternity and Neonatal Investigation report, a 10-point plan of the most urgent actions for maternity and neonatal services to address was issued. An initial baseline assessment with Board level approval is to be submitted to NHSE by 25 September, followed by a Board approved progress update by 31 December. This will be submitted to November Board.

Appendix 4 is the 10-Point Plan, baseline assessment and actions, discussed and agreed with the Chief Nurse and Chief Medical Officer, prior to Board approval.

1. Listening to Women and Families by rolling out Martha's Rule: Compliant
2. Listen to Women and their families using real- time and transparently reported outcomes and experience, and clinical audit that are acted upon at Board level: Area of focus, partial/non-compliance. Clinical audit not currently reported monthly. Patient experience not reported thematically and does not include ethnicity/deprivation.
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care: Compliant. Job descriptions and Board terms of reference need updating to reflect.
4. Addressing inequalities in maternity and neonatal outcomes: Partially compliant. Maternal Care Bundle element can be changed to compliant following Board approval of the plan presented with this report. Perinatal Team members identified and committed to attending the Perinatal Equity and Anti-Discrimination programme due to commence in September. Executive support may be required to facilitate attendance, particularly of obstetric and medical members with clinical responsibilities.
5. Ensuring 24/7 safety and responsiveness of services: Compliant with 1 point partially compliant.
6. Ensuring 24/7 safety and responsiveness of services: Compliant
7. Trust review of homebirth services: Compliant
8. Responding to incidents, complaints and concerns with humanity and candour: Compliant
9. Deliver safe and effective triage in maternity services: non-compliant. Local benchmarking undertaken due to delay in the publication of the national benchmarking tool which is now available and will be completed and presented to November Board. No significant gaps identified in current triage processes; Board level reporting of maternity triage data and performance is not currently in place.
10. Post death care: Compliant. Review of mortuary records completed and returned by 31 July 2026

Board is asked to approve the baseline assessment prior to submission to NHSE.

National Maternity Triage Baseline Assessment

National Maternity Triage guidance was issued in July 2026 with the intention of establishing a high-level framework for safe, consistent and equitable urgent maternity care across England.

The immediate request post Amos publication requires Trusts to submit a Board approved baseline assessment to NHSE alongside the 10-Point Plan.

Appendix 5 is a copy of the baseline assessment audit. Maternity Triage at BTHFT is well established and meets many of the requirements described in the national guidance.

However, there are several points which may require Board level support/escalation:

1. Further information is needed to understand if the proposed new patient experience portal will enable us to add a patient experience triage survey. If this function is not available, we will need to develop one outside of the portal which will require IT/BI support.
2. Significant MNVP input is required to deliver principle 6 particularly of the guidance. Limited MNVP resource, including current long-term sickness, may impact on the progress of this
3. Significant BI support will be required to build the dashboards to pull the extensive data monitoring requirements. This is the current priority for the dedicated maternity BI support. An initial meeting was held on 3.9.26 to discuss.
4. Telecoms team support will be required regarding the reporting of telephone data.
5. There is one element regarding the dedicated telephone person being in an isolated room away from an office, which we are currently non-compliant with. There are varying views on whether we will progress this recommendation as there are many safety positives to them being in the MAC hub including: advice can be sought from colleagues, oversight of CTG's. There will be a financial implication if the decision is to meet this recommendation, including refurbishment and obtaining adequate IT and telecoms into a new location. We are unable to immediately identify an alternative location.
6. Maternity triage is clearly signposted throughout the hospital from all main entrances, emergency departments, outpatient areas and maternity services – this needs a review and there could be financial implication if new signage is required
7. Some of the data matrixes have been graded partial and some noncompliant. Where they are graded partial ad hoc reports from BI are already available on request but needs to be incorporated into a dashboard. Where non complaint (red) this data has never been requested previously

Maternity Outcomes Signal System (MOSS):

- The maternity service received a level 1, MOSS signal trigger on 7 August, triggered by a term neonatal death in addition to the rolling number of term neonatal deaths and stillbirths reviewed in previous critical safety checks.
- The service is also aware of a 2nd neonatal death in the same time period, which has not pulled through to the MOSS trigger system. Following discussions with 'NHS Back Office, and MOSS, it is not possible to change the data at the MOSS end as they do not have access to the birth notification data. This will change once SPEN becomes the data source for MOSS.
- The 2nd baby was included as part of the critical safety check for this response.
- MOSS have confirmed that after looking at our data and the thresholds for Level 1 and 2 signals, an extra event in July 2026 would have raised the data point in the CUSUM chart but this would remain a Level 1 signal, and not a Level 2.
- 1 NND was the expected death of a baby on the Butterfly palliative care pathway. The 2nd baby was an unexpected death following an emergency caesarean section, born in poor condition and did not respond to extensive resuscitation. This case has been referred 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 previously, 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.

• **Assessment**

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

• **Options analysis/Proposal**

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

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

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

• **Appendices stored in Admincontrol**

- Appendix 1- Maternity and Neonatal (Perinatal) Services Update, July 2026 [click here](#)
- Appendix 2- Closed Board Harms July 2026 [click here](#)
- Appendix 3- 10 Point Plan [click here](#)
- Appendix 4- Maternity Triage Benchmarking [click here](#)
- Appendix 5- MOSS Critical Safety Checklist Response [click here](#)

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Board of Directors				
Meeting Date:	24/09/2026	Agenda Reference:	Bo.9.26.10	
Report Title:	Care Quality Commission – Urgent and Emergency Care – Action Plan			
Presented by:	Sajid Azeb, Chief Operating Officer/Deputy Chief Executive			
Executive Lead:	Sajid Azeb, Chief Operating Officer/Deputy Chief Executive			
Author:	Jill Clayton Deputy Director of Nursing Urgent, Emergency, Care of the Elderly and Stroke CSU Edward Holmes, Deputy Director of Operations, Unplanned Care			
Report Summary				
Purpose of the paper:	Decision ☒	Assurance ☒	Action ☐	Information ☐
Summary of Key Issues/Highlights:	The Care Quality Commission (CQC) carried out an inspection of Urgent and Emergency Care 16 to 18 September 2025. The outcome of the inspection was a rating of Requires Improvement. Following the rating an action plan is required to be submitted to the Care Quality Commission by 24 September 2026. The CQC's principal concerns centred on patient flow delays, inconsistent risk assessment and documentation, workforce pressures, environmental safety risks and weaknesses in governance oversight. The Trust has already implemented a recovery programme with notable progress. Remaining work is focused on embedding improvements, demonstrating sustained performance improvement through audit and governance processes, delivering workforce and estates developments and ensuring specialty response times consistently meet expected standards. This ongoing work will be overseen by the EXCEL improvement programme, which will track the trajectory of improvement and the measures associated with each action through to completion.			
Recommendation/s: (including any decision/approval required)	The Board is asked to review and approve the action plan for submission to the CQC.			
Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness			
Link to priority transformation programmes:	EXCEL			
Implications				
Risk	The action plan directly mitigates risks associated with patient safety, overcrowding, delayed speciality reviews, workforce capacity, environmental safety and governance oversight identified through the CQC inspection. Delivery of the plan is monitored through the Emergency Department Recovery Programme, EXCEL programme			

	governance arrangements, risk register monitoring, Quality and Safety meetings and executive oversight processes. Failure to deliver sustained improvement could impact regulatory compliance, patient safety and organisational reputation.
Legal/Regulatory:	This report relates directly to the Trust's response to findings from the Care Quality Commission inspection of Urgent and Emergency Care and demonstrates compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including Regulations 9, 12, 15, 17 and 18. Submission of the action plan forms part of the Trust's regulatory obligations to the Care Quality Commission.
Quality & Patient Safety:	The action plan contains a range of measures designed to improve patient safety and quality of care, including enhanced risk assessment processes, strengthened pain and pressure area management, improved speciality response arrangements, strengthened infection prevention measures, improved medicines and equipment management, environmental safety improvements and enhanced governance oversight. These actions are intended to reduce the risk of patient harm and improve patient outcomes within Urgent and Emergency Care services.
Equality, Diversity and Inclusion and Health Equity:	The action plan includes actions aimed at improving care for vulnerable patients, including patients experiencing mental health crises, children and young people requiring mental health assessment, older people at risk of falls and pressure damage, and patients requiring enhanced observations. The proposed actions support equitable access to safe and person-centred care regardless of age, disability or mental health need.
Resources:	The action plan refers to investment in additional nursing establishment, practice educator support, workforce planning expertise, audit and governance capacity, estates improvements, environmental modifications, EPR development and clinical leadership time. These resources have been prioritised through the Emergency Department Recovery Programme and existing executive governance arrangements
Environmental sustainability:	There are no significant direct environmental sustainability implications arising from this report. Some elements of the estates and environmental improvement programme may contribute to a safer and more efficient care environment, but the primary focus of the action plan is regulatory compliance, patient safety and quality improvement.
Assurance Route	
Meeting/s where content has been discussed previously:	Emergency Department Recovery Programme Board. Emergency Department Quality and Safety Meeting. Clinical Services Unit Governance Meetings. EXCEL Programme governance arrangements. Trust Quality Governance structures. Executive oversight through the Chief Operating Officer Quality Committee

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Report content

1. Purpose

To provide assurance on the improvement action plan developed following the Care Quality Commission (CQC) inspection of the Trust's Urgent and Emergency Care services in September 2025.

2. Background/context

Following the Care Quality Commission (CQC) inspection of the Trust's Urgent and Emergency Care in September 2025, the service was rated overall as Requires Improvement. As a result, an action plan is required to be submitted to the CQC by 24 September 2026.

The CQC's principal concerns centred on patient flow delays, inconsistent risk assessment and documentation, workforce pressures, environmental safety risks, and weaknesses in governance oversight. The Trust has already implemented a substantial Emergency Department Recovery Programme with notable progress in patient safety processes, staffing, governance and environmental risk management. Remaining work is focused on embedding these improvements, demonstrating sustained performance improvement through audit and governance processes, delivering workforce and estates developments, and ensuring specialty response times consistently meet expected standards

3. Assessment

The attached action plan focuses on addressing the CQC concerns across the five key regulatory areas: safe care and treatment, person-centred care, staffing, premises and equipment, and governance.

A number of key concerns were highlighted, and the action plan provides assurance on the progress made to date, setting out both the significant recovery actions already implemented and the work still to be completed.

4. Options analysis/Proposal

The ongoing work will be overseen by the EXCEL improvement programme, which will provide governance for delivery and track the trajectory of improvement and the measures associated with each action through to completion.

The action plan demonstrates substantial progress against the identified CQC concerns, with most workforce, governance and care process actions completed and remaining actions focused on evidencing sustainability and completing environmental improvements.

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Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RAE
Our reference	UEC LAP 02203/AP15548
Location or provider name and ID	Bradford Royal Infirmary RAE01

Regulated activities	Regulation
	Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Regulations for service providers and managers - Care Quality Commission (cqc.org.uk)
	How the regulation was not being met: • Delayed specialist reviews in ED resulting in delayed assessment, treatment, care planning, and prolonged patient waits in overcrowded emergency areas. • Inadequate pain and pressure ulcer management, including inconsistent identification of patients at risk of pressure damage, incomplete pain assessments, delays in administering pain relief, and failure to adequately monitor vulnerable patients. • Unsafe management of equipment and medicines, including expired medications, overdue equipment safety checks (PAT testing), dirty and blood-stained equipment, and insufficient oversight to ensure routine safety checks were completed. • Infection prevention and control (IPC) failings, with fluctuating hand hygiene compliance, incomplete audit processes, and areas of significant non-compliance increasing the risk of healthcare-associated infection. • Lack of documented bed rail risk assessments and reliance on family members to help keep patients safe, placing vulnerable patients at risk of harm. • Failure to provide timely specialist-led care, with RCEM referral standards not being met, leaving ED staff to manage patients awaiting specialty input and increasing the risk of delayed or inappropriate treatment.
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	

Delayed specialist review and timely specialist led care

Action 1a: Redesign and expand our Same Day Emergency Care (SDEC) services to provide a safe and efficient alternative to hospital admission for more patients. (Completed with ongoing oversight via the EXCEL Programme)

Action 1b: Co-design and implement standardised admission processes across all specialities to create a seamless, efficient, and safe patient journey from referral to ward. (In progress with ongoing oversight via the EXCEL Programme)

Action 1c: Rapid Assessment and Treatment (RAT) model has been implemented led by senior clinicians to improve early assessment, identification and management of deteriorating patients, enhanced sepsis screening and education, and strengthened specialty escalation processes. This is in line with model ED national guidance. (Completed with ongoing oversight via the EXCEL Programme)

Action 1d: Implementation of Internal Professional Standards for the referral, review and admission of Specialty patients, including monitoring compliance with the RCEM standard for specialty review within 60 minutes of referral. (In progress, will be monitored via the EXCEL Programme).

Pain, pressure ulcer management and patient risk assessment

Action 1e: Introduction of Standard Operating Procedures for trolley rails use, pressure ulcers, pain assessment, patient observations and mental health care. (Completed with ongoing oversight via CSU governance)

Action 1f: Embed consistent, system-wide patient risk assessments into daily practice, creating a proactive culture of safety and harm reduction. (Completed with ongoing oversight via the EXCEL programme)

Medicines and equipment safety

Action 1g: Enhanced equipment safety and medicines management processes through ED audits. This includes expired medicines, equipment safety checks and equipment cleanliness (Completed with ongoing oversight via the CSU governance)

Infection prevention and control

Action 1h: Enhanced IPC monitoring through introduction of regular ED audits, hand hygiene monitoring, staff education, spot checks and managerial oversight. (Completed with ongoing oversight via CSU governance)

Who is responsible for the action?

Jill Clayton, Deputy Director of Nursing,
Emma Clinton, ED Matron,
Jeremy Till, ED clinical lead
Emergency Department Senior Leadership Team.
Ed Cornick, Deputy Director of Ops Unplanned care/
Command centre/COO team.
Michelle Wilson, Paediatric Matron

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How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• Delivery of measurable improvements across key performance indicators via the EXCEL Programme • Monthly review of delivery through ED Quality and Safety meetings to include: ○ Monthly audit programme covering sepsis, risk assessments, pain assessment, pressure ulcer management, medication management, equipment safety, IPC compliance and patient safety indicators. ○ Ongoing staff education, simulation training and competency assessments. ○ Risk management oversight through risk register monitoring and action tracking. • Monitoring of RCEM standard for specialty review within 60 minutes of referral, monitoring of waits for review and bed admissions for Specialist teams, and all related ISP/72 hours actions will be led through new fortnightly NEL patient waiting meeting with all CSUs • Executive oversight through the Trust-wide recovery programme, CSU governance structure, new Operational Governance and the EXCEL programme. • The Trust wide Quality Team will be undertaking an assurance exercise within 6 months of the date of this action plan	
Who is responsible?	Operational Lead - Jill Clayton, Deputy Director of Nursing Executive Lead – Sajid Azeb, COO
What resources (if any) are needed to implement the change(s) and are these resources available?	
Additional nursing resource, practice educator support, clinical leadership time, EPR development, audit support and established governance processes. These resources have been prioritised through the recovery programme and executive oversight arrangements. Utilisation of safe staffing tool, incorporating professional judgement and acuity.	
Date actions will be completed:	31 December 2026

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Patients may continue to experience risks associated with delays and overcrowding; however, mitigating controls including RAT, enhanced clinical oversight, structured huddles, safety audits and escalation processes are already in place to reduce risk.

Completed by: (please print name(s) in full)	Karen Dawber

Position(s):	Chief Nurse
Date:	21/09/2026

Regulated activities	Regulation
	Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Regulations for service providers and managers - Care Quality Commission (cqc.org.uk)
	How the regulation was not being met: • Care was not consistently person-centred, with incomplete patient assessments and documentation, including missing pain scores, allergy status, pressure area assessments, and poor recording of pain relief, meaning patients' individual needs were not always fully identified or understood. • There were gaps in care planning and risk assessments particularly for patients experiencing mental health crises or prolonged stays, with no documented care plans, limited evidence of ongoing review of personal care needs, and missed assessments for falls, bed rails and pressure ulcer risks, increasing the risk of avoidable harm. •

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Patient Assessments and Care Planning

Action 1a: Standardised patient assessment and risk documentation has been implemented covering pain, allergy status, pressure damage, falls, bed/trolley rail use and other relevant patient risks.

Action 1b: A quality improvement programme has been implemented to improve the assessment, management, documentation and reassessment of pain.

Mental healthcare

Action 1c: SOPs have been developed to support assessment and care planning for patients presenting in mental health crisis, including those experiencing prolonged stays within ED.

Action 1d: Mental health REACT screening and risk management requirements have been standardised, with compliance audited by the Mental Health Lead.

Action 1e: A daily CAMHS huddle is in place to review children and young people attending ED or admitted to hospital, supporting identification of mental health needs, coordinated care planning, escalation and follow-up.

Who is responsible for the action?

Operational Lead - Jill Clayton, Deputy Director of Nursing,

ED Clinical Lead – Jeremy Till, Consultant

Executive Lead - Sajid Azeb, COO

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Monthly review of delivery through the ED Quality and Safety Meetings and the EXCEL programme.
- Daily spot checks and monthly audits of patient assessments and risk assessment documentation.
- Monitoring of pain assessment, management and reassessment through the ED quality improvement programme
- The Trust wide Quality Team will be undertaking an assurance exercise within 6 months of the date of this action plan

Who is responsible?

Operational Lead - Jill Clayton, Deputy Director of Nursing,

ED Clinical Lead – Jeremy Till, Consultant

Executive Lead - Sajid Azeb, COO

What resources (if any) are needed to implement the change(s) and are these resources available?

Practice educator capacity, EPR system development, governance support and dedicated audit time. Resources are available through the recovery programme.

Date actions will be completed:

Completed 31 July 2026. Ongoing compliance and effectiveness will be monitored through the assurance arrangements above.

How will people who use the service(s) be affected by you not meeting this regulation until this date?

The risk of incomplete documentation remains; however, enhanced oversight, audit programmes and staff education have been implemented to mitigate risks and safeguard patients.

Completed by:

(please print name(s) in full)

Karen Dawber

Position(s):	Chief Nurse
Date:	21/09/2026

Regulated activities	Regulation
	Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Regulations for service providers and managers - Care Quality Commission (cqc.org.uk) How the regulation was not being met: • Safeguarding and security staffing concerns: Security staff had not completed required safeguarding training and were frequently left alone with patients, contrary to trust policy requiring clinical staff to remain present. • Insufficient staffing levels: The department did not have enough suitably qualified staff, resulting in chronic nursing shortages, heavy workloads, missed breaks, delays in care and treatment, and staff concerns that patient care was being adversely affected.
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve Safeguarding and Security Action 1a: Safeguarding training is mandated for all staff dependent on their roles and responsibility, this includes security staff within ED. In line with our Trust policy any patient requiring mechanical restraint by security staff will have a registered professional in attendance with clinical oversight. Action 1b: The policy has been reviewed with targeted training that would clarify safeguarding responsibilities and expectations for security staff. Safe Staffing Action 1c: A comprehensive nursing review has been completed and investments made by the Trust Board. Medical workforce review is underway, and the Trust has commissioned external support commencing September 2026. Action 1d: Duty rosters have been reviewed to ensure appropriate skill mix and staffing coverage on all shifts. The Nurse in Charge role is now protected as a supernumerary position	

to provide effective operational oversight, clinical leadership, and support to staff throughout each shift.	
Action 1e: Structured departmental safety huddles have been introduced to improve communication, situational awareness, and proactive risk management.	
Who is responsible for the action?	Operational Lead - Jill Clayton, Deputy Director of Nursing, ED Clinical Lead – Jeremy Till, Consultant Executive Lead - Sajid Azeb, COO Director of Estates and Facilities - David Moss
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
- Monthly review of delivery through the ED Quality and Safety Meetings and EXCEL programme - Six-monthly nursing establishment reviews including SNCT data. - Daily workforce monitoring and escalation processes. - Regular review of staffing performance and workforce metrics. - Ongoing training compliance monitoring. - Monitoring of safeguarding training compliance for security staff through mandatory training arrangements. - Assurance that Trust policy requiring clinical staff to remain present when security staff support patients is being followed - The Trust wide Quality Team will be undertaking an assurance exercise within 6 months of the date of this action plan Executive oversight of workforce plans and recruitment activity.	
Who is responsible?	Operational Lead - Jill Clayton, Deputy Director of Nursing, ED Clinical Lead – Jeremy Till, Consultant Executive Lead - Sajid Azeb, COO Director of Estates and Facilities - David Moss
What resources (if any) are needed to implement the change(s) and are these resources available?	
Additional nursing establishment investment, recruitment support, workforce planning expertise and education resources. Funding and business cases have been progressed through executive governance routes.	
Date actions will be completed:	Completed 21 September 2026, ongoing work continues in relation to medical staffing as part of business as usual. Ongoing compliance and

	effectiveness will be monitored through the assurance arrangements above
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How will people who use the service(s) be affected by you not meeting this regulation until this date? Operational pressures may continue to affect staffing resilience; however, additional temporary staffing, enhanced leadership oversight and escalation arrangements are in place to minimise patient impact.
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Completed by: (please print name(s) in full)	Karen Dawber
Position(s):	Chief Nurse
Date:	21/09/2026

Regulated activities	Regulation
	Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Regulations for service providers and managers - Care Quality Commission (cqc.org.uk)
	How the regulation was not being met: • Unsafe environment for patients experiencing mental health crises: Designated mental health rooms were not fully compliant with safety standards and contained ligature risks, unsecured furniture, and other environmental hazards. There was no suitable mental health assessment room in the paediatric ED. • Premises and equipment safety failures: Patients had access to potentially harmful items, including unsecured consumables and cleaning chemicals, with inconsistent adherence to COSHH requirements. Unsecured oxygen cylinders also posed a safety risk. • Poor environmental cleanliness: Areas used by patients overnight were not consistently cleaned, resulting in litter and concerns about the cleanliness and suitability of the care environment.

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Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Environment and equipment safety

Action 1a: A programme of environmental improvement has been established across the Emergency Department, including mental health environmental reviews, implementation of safety checklists for mental health cubicles, environmental refurbishment plans and strengthened cleaning and safety monitoring processes. Controls have also been implemented to ensure compliance with COSHH and safe storage requirements.

Action 1b: A risk assessment has been completed in recognition of the lack of a dedicated space designed for children presenting in mental health crisis. This supports adapting a standard room to meet the needs of the individual on a case by case basis.

It is acknowledged and has been raised external to the Trust that the AED department is not fit for purpose for the number of attendances. The building was designed for up to 250 people per day, we now see in advance of 500 on a daily basis. To fully address environmental concerns can only be fully mitigated with significant multi-million pound investment to rebuild and redesign the AED.

Who is responsible for the action?

Director of Estates and Facilities - David Moss

Operational Lead - Jill Clayton, Deputy Director of Nursing,

Executive Lead - Sajid Azeb, COO

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Regular environmental safety audits.
- Daily safety checklist compliance monitoring.
- Monitoring of COSHH and safe storage compliance
- Monitoring of overnight cleaning and environmental cleanliness
- Estates governance.
- Quality and Safety Committee review of environmental risks and actions.
- Continued discussions with NHSE in relation to capital investment.
- The Trust wide Quality Team will be undertaking an assurance exercise within 6 months of the date of this action plan
- Ongoing patient and staff feedback.

Who is responsible?

Director of Estates and Facilities - David Moss

Operational Lead - Jill Clayton, Deputy Director of Nursing,

Executive Lead - Sajid Azeb, COO

What resources (if any) are needed to implement the change(s) and are these resources available?

Capital funding, estates redevelopment resources, CCTV improvements, environmental modifications and ongoing facilities support. Business cases are being progressed through Trust governance processes.	
Date actions will be completed:	A number of the minor remedial actions have been completed, however, to fully mitigate these risks would require extensive capital investment beyond the authorisation of the Trust.

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Interim controls, environmental checklists, risk assessments and enhanced monitoring remain in place to minimise risks to patients while longer-term estates improvements are delivered.

Completed by: (please print name(s) in full)	Karen Dawber
Position(s):	Chief Nurse
Date:	21/09/2026

Regulated activities	Regulation
	Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Regulations for service providers and managers - Care Quality Commission (cqc.org.uk)
	How the regulation was not being met: - Audits lacked clear outcome data, evidence of improvement actions, and demonstrated impact on patient care. Key areas of concern, including time-critical medicines, showed little or no progress. - The department did not routinely audit consent or DNACPR documentation, had limited audit activity overall, no medical lead for clinical audit, and did not always participate in required national emergency medicine audits.

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- Risk assessment audits relating to areas such as pressure damage, falls, pain management and documentation did not always take place.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Action 1a: The ED Consultant audit, risk and clinical governance leads are in place and work closely with CSU-level risk and clinical governance leads.

Action 1b: The governance framework includes dedicated workstreams, clear executive accountability, strengthened audit programmes, implementation of quality improvement projects, development of departmental dashboards, risk register oversight, and enhanced monitoring of clinical performance indicators.

Action 1c: The ED Clinical audit programme has been expanded to include:

- patient assessments and documentation
- medication safety
- mental health care
- documentation quality including consent and DNACPR documentation, and
- compliance with national standards, and
- participation in required national audits

Who is responsible for the action?

Operational Lead - Jill Clayton, Deputy Director of Nursing,

ED Clinical Lead – Jeremy Till, Consultant

Executive Lead - Sajid Azeb, COO

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Monthly quality and safety governance meetings.
- Regular audit cycles with identified improvement actions, accountable owners and action tracking, with re-audit where required to demonstrate improvement
- Dashboard reporting of key quality metrics.
- Risk register review and escalation processes.
- The Trust wide Quality Team will be undertaking an assurance exercise within 6 months of the date of this action plan

Executive review through CSU and Trust governance structures.

Who is responsible?

Operational Lead - Jill Clayton, Deputy Director of Nursing,

ED Clinical Lead – Jeremy Till, Consultant

Executive Lead - Sajid Azeb, COO

What resources (if any) are needed to implement the change(s) and are these resources available?

Governance support, audit resource, informatics development, dashboard reporting and clinical leadership capacity. These have been incorporated into the recovery programme.

Date actions will be completed:	Completed 31 July 2026, with ongoing monitoring, trust wide governance/oversight arrangements then embedded as routine business practice.
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How will people who use the service(s) be affected by you not meeting this regulation until this date?

Without full implementation there remains a risk that opportunities for improvement may not be identified as quickly as intended; however, strengthened governance, executive scrutiny and quality surveillance arrangements are already mitigating this risk.

Completed by: (please print name(s) in full)	Karen Dawber
Position(s):	Chief Nurse
Date:	21/09/2026

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QUALITY COMMITTEE				
Meeting Date:	17/09/2026		Agenda Reference:	QC.9.26.12
Report Title:	Research Activity in the Trust			
Presented by:	Dr Michael McCooe (Deputy Director of Research)			
Executive Lead:	Dr John Bolton (Chief Medical Officer)			
Author:	Professor John Wright (Director of Research) & Dr Tracy Watson (Director of Research Operations) & Research Department Heads			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	This report for research describes some of the main areas of work and progress over the last few months; these include: - Applied Health Research Activity - Clinical Research Activity			
Recommendation/s: (including any decision/approval required)	<i>The Quality Committee is asked to:</i> Review this report for information; it highlights how important research activity is for healthcare and treatment improvement.			
Link to Strategic Objective:	Improvement and innovation- To be a continually learning organisation and recognised as leaders in research, education and innovation			
Link to priority transformation programmes:	N/A			
Implications				
Risk:	NA			
Legal/Regulatory:	NA			
Quality & Patient Safety:	NA			
Equality, Diversity and Inclusion and Health Equity:	NA			
Resources:	NA			
Environmental sustainability:	NA			
Assurance Route				
Meeting/s where content has been discussed previously:	NA			
Report content				
This report is for information and highlights how important research activity is for healthcare and treatment improvement. It is available at appendix 2 in the reading room here.				

Meeting Title	Board of Directors		
Date	24 September 2026	Agenda item	Bo.9.26.12a

Committee Escalation and Assurance Report (AAA)

Report from the: People Committee

Date of meeting: 9th September 2026

Key escalation and discussion points from the meeting

Alert:

The Committee highlighted concerns regarding unresolved workforce reduction methodology relating to medical trainees, dashboard data quality, sickness absence performance, training DNA rates, appraisal compliance, vaccine hesitancy and several workforce-related risks requiring clearer ownership and mitigation.

Dashboard Quality

The Committee raised concerns regarding data accuracy; calculation errors; missing metrics and insufficient narrative development. It was noted there were issues with production, however this needs to be resolved if the committee is to use the reliability of the dashboard as an assurance and governance tool.

Workforce Reduction Methodology

There is an ongoing unresolved position regarding medical trainees and workforce reduction calculations. This has potential implications for workforce planning; financial recovery; compliance with NHS England requirements and achievement of reduction targets.

Sickness Absence

The Trust is not yet achieving its target and has not demonstrated sustained improvement despite encouraging early indicators. This remains a significant workforce risk and will continue to be a focus.

Appraisal Compliance

The committee reflected on the internal audit limited assurance finding regarding non-medical appraisals, including how its own oversight can be strengthened. The Committee recognised:

- More than 500 overdue appraisals
- A significant deterioration from previous years
- Weak operational ownership
- Potential consequences for workforce engagement and performance management

The Committee discussed consideration of a defined annual appraisal window and stronger operational ownership to improve compliance and oversight. The committee also discussed enhanced reporting to Committee including Trust wide overdue appraisals. We also discussed a potential CSU deep dive each month across all people related data (sickness; FTSU; appraisals; training etc).

Training DNA Rates

These remain high and are stubbornly not moving over several months. High DNA rates were reported, particularly around cannulation training, risking reduced workforce productivity, increased pressure on medical staff and inefficiency. This will be picked up between nursing and training.

Advise:

The Committee advised on strengthening workforce diversity reporting, embedding anti-racism through a single people strategy, improving the staff survey approach, enhancing flu vaccination engagement, and further developing job planning and appraisal arrangements.

Meeting Title	Board of Directors		
Date	24 September 2026	Agenda item	Bo.9.26.12a

Provider Capability Assessment

The Committee provided constructive challenge regarding the proposed green rating, encouraging a broader consideration of workforce experience, EDI outcomes, speaking-up culture and access to training before ultimately supporting the rating.

Diversity and Representation

The Committee advised that workforce diversity reporting should move beyond headline representation figures and examine:

- Comparison with local population demographics
- Distribution by grade and profession
- Under-representation and over-representation patterns
- Impact of interventions.

The Committee advised maintaining focus on anti-racism as an organisational strategy rather than creating multiple separate equality workstreams and supported the proposed integration through the wider People Plan.

Staff Survey Approach

Advice centred on:

- Closing the feedback loop
- Communicating actions already taken
- Refining existing plans rather than creating new ones
- Ensuring incentive arrangements are transparently explained

Flu Vaccination Programme

The Committee advised strengthening the programme through:

- Addressing vaccine hesitancy directly, including targeted work with demographic groups demonstrating lower uptake.
- Using trusted community voices to encourage uptake and learning from COVID engagement approaches

The Committee highlighted vaccine hesitancy as a strategic workforce issue and challenged whether the proposed interventions were sufficiently robust to improve uptake.

Non-Medical Job Planning

The 75% target remains a stretch and the Committee advised that communications should focus on the benefits of job planning for patient care, workforce deployment, and service effectiveness, rather than presenting it solely as a compliance requirement. This will come back to Committee in January.

Assure:

The Committee received assurance regarding workforce reduction progress, violence prevention, nursing staffing oversight, safe working arrangements, development of the People Priority Action Plan and the emerging benefits of ETOC (Enhanced Therapeutic Observation and Care).

Workforce reduction trajectory

The Trust is delivering a reduction in substantive, bank and agency workforce numbers broadly in line with plan, with approximately 110 WTE reduction achieved by July and reductions in bank and agency usage evident. The Committee was assured that progress is moving in the right direction, although sustainability through winter remains a concern.

Violence Prevention and Reduction

Strong assurance was provided that considerable progress has been made against the national Violence Prevention and Reduction Standard, with red indicators reducing significantly and evidence of strengthened leadership, security provision, training compliance, and management of incidents.

Meeting Title	Board of Directors		
Date	24 September 2026	Agenda item	Bo.9.26.12a

Nursing and Midwifery Staffing

Despite ongoing vacancies and workforce pressures, the Committee was assured that robust oversight arrangements remain in place, including twice-daily staffing reviews, escalation processes, and active recruitment initiatives.

Guardian of Safe Working Hours

The Committee was assured that exception reporting remains within expected ranges and that actions are in place to address workload pressures, rota redesign, and workforce deployment concerns.

People Priority Action Plan

Whilst this remains a work in progress, the revised plan gave the committee greater assurance because it clearly differentiated outcomes, measures, milestones and ownership, enabling more effective scrutiny of both delivery and impact.

ETOC Programme

The committee was updated on the initial feedback from the ETOC trials on three wards. Alongside good examples of patient centred care and stories from staff, the Committee received positive assurance from NHS England feedback, local implementation experience and patient examples that the programme is delivering cultural and workforce improvements alongside improved patient experience.

Report completed by:

Justine Andrew
Committee Chair and Non-Executive Director
15th September 2026

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ANNUAL REPORT ON MEDICAL APPRAISAL AND REVALIDATION				
Meeting Date:	09/09/2026		Agenda Reference:	PC.9.26.10
Report Title:	Medical Appraisal and Revalidation Annual Statement of Compliance			
Presented by:	Mr John Bolton, Chief Medical Officer			
Executive Lead:	Mr John Bolton, Chief Medical Officer			
Author:	Dr Remi Akerele, Associate Medical Director for Professional Medical Standards			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	- All Acute Trusts are required to submit an annual NHSE Statement of Compliance for Medical Appraisal and Revalidation (attached). Key elements have been presented within the Trust Annual Report in June 2026 - All doctors who do not hold a National Training Number are required by the GMC/NHS England to undertake Medical Appraisal on an annual basis. - At close of play on 31st March 2026, 551 doctors had a prescribed Designated Body connection to the Trust - For the appraisal year 2025-2026: 532 doctors (96.55%) achieved a Category 1 appraisal (Completed Appraisal) 19 doctors (3.45%) were allocated a Category 2 (Missed Approved Appraisal) - There were no Category 3 appraisals (Unapproved Missed Appraisal) for the period 2025-2026 - The Medical Appraisal and Revalidation moved to fall under the remit of the Chief Medical Officer's office in April 2025 (previously under the remit of Human Resources) - Work has been done to improve transparency and equity with regards to SPA remuneration for the Medical Appraiser role across CSUs - Formal update training was delivered to established appraisers in 2025-2026 in keeping with the single recommendation by Audit Yorkshire in February 2025. - A further 10 new Medical Appraisers were trained at the end of 2025 in order to maintain our current appraiser:appraisee ratio			
Recommendation/s: (including any decision/approval required)	<i>The People Committee is asked to note that:</i> - The Trust is compliant with the requirements of Responsible Officer Regulations - The Trust is compliant with submission to NHS England of Annex A - Professional Standards Framework for Quality Assurance and Improvement - Comparative data for benchmarking against Acute Trusts has not been available since 2020			

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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:	There are no risks associated with this paper
Legal/Regulatory:	Annex A - Professional Standards Framework for Quality Assurance and Improvement to NHS England Statement of Compliance
Quality & Patient Safety:	The process of Medical Appraisal and Revalidation improves the quality of care provided to patients, patient safety and, by ensuring doctors remain fit to practice, increases public trust and confidence in the medical system
Equality, Diversity and Inclusion and Health Equity:	No impact
Resources:	Required resources: Funding for access to and support for Premier IT appraisal platform (PReP) Funding for access to and support for Edgecumbe Dr360 colleague and patient feedback tool Funding to support new appraiser training Support for mandated CPD refreshers for established appraisers (currently every 3 years as per NHSE guidance) Appraiser SPA remuneration – currently held at CSU level Staffing
Environmental sustainability:	No impact
Assurance Route	
Meeting/s where content has been discussed previously:	Annual Trust Report previously presented at People Committee Meeting June 2026

Report content
1. Purpose Mr John Bolton, Chief Medical Officer took over the role of Responsible Officer (RO) for BTHFT in June 2025 following completion of the pre-requisite training. Attached is the NHSE Statement of Compliance (Annex-A) for Responsible Officer duties for BTHFT for 2025-2026. 2. Background/context All Acute Trusts are required to submit Professional Standards Framework for Quality Assurance and Improvement Statement of Compliance (Annex A) to NHS England in their capacity as GMC Designated Bodies. The Annual Trust Medical Appraisal and Revalidation Report (presented to People academy in June 2026) forms the basis of Section 3 of Annex-A Statement of Compliance. 3. Options analysis/Proposal Annual submission of Annex-A Statement of Compliance is a mandatory requirement for all Acute Trusts. As outlined in Section 3, the sustained increase in the number of doctors connected to BTHFT as a Designated Body has continued such that at 31st March 2026, there were 551 doctors with a prescribed GMC connection. We have achieved a Category 1 (completed appraisal) rate of 96.55% for the period 2025-2026. There were no Category 3 appraisals (Unapproved Missed) for the same period.

As per the Statement of Compliance, it is anticipated that the next steps for Medical Appraisal and Revalidation will include the following:

- Continue the 12-18 month programme of appraiser recruitment in order to maintain/improve current appraiser:appraisee ratios
- Address points for improvement from Appraiser Satisfaction Survey where feasible in order to facilitate and improve appraiser experience
- Continue regular activity including Local Network Meetings/ Committee Meetings and annual Quality Assurance Audit as per NHSE guidance.
- Continue within current Peer Review group with anticipated review of BTHFT processes in 2027-2028.
- Continue to address/monitor the issue of equity amongst appraisers with regards to remuneration including ensuring that appraiser SPAs are 'ring-fenced' within CSU budgets
- Complete the current review/update to our current Medical Appraisal and Revalidation Policy
- Await further guidance from the GMC with regards to registration of Physicians Assistants and their governance from an Appraisal and Revalidation perspective.

Appendices store in Admincontrol [click here](#)

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Board of Directors - Public				
Meeting Date:	24.9.26		Agenda Reference:	Bo.9.26.13
Report Title:	Strategic Equality and Diversity Council September 2026 Update			
Presented by:	Mel Pickup, Chief Executive Officer			
Executive Lead:	Saj Azeb, Chief Operating Officer/ Deputy Chief Executive			
Author:	Ruth Haigh, Equality, Diversity & Inclusion Manager			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☒	Action ☐ (review/discuss/ comment)	Information ☒
Summary of Key Issues/Highlights:	The Trust's Equality and Diversity Council (EDC), chaired by CEO, has a remit for both workforce and wider health inequalities and continues to meet quarterly. This report provides an update on the key highlights from the last EDC meeting, which was held on 9th July 2026, and was chaired by Mel Pickup, Chief Executive. The following key items were discussed at the July EDC meeting: • EXCEL Patient & Workforce Engagement • Refreshed Strategic EDI Objectives • Update on Supreme Court ruling on the definition of Sex in the Equality Act 2010 • Equitable Healthcare for People with Learning Disabilities at BTHFT • Health Equity Digital Tools • Colleague Equality Network Updates			
Recommendation/s: (including any decision/approval required)	<i>The Board is asked to:</i> 1. Note the contents of this update report 2. Support the proposed areas of work identified in section 4			
Link to Strategic Objective:	People - To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion			
Link to Priority Initiatives 2025/26:	Thrive			
Implications				
Risk:	BAF SR06: There is a risk that we are unable to achieve our ambitions on ED&I, including tackling health inequalities due to ingrained attitudes that persist in society and across our health and care organisations. If we are unable to recruit, retain and develop a workforce at all levels that is representative of the population we serve, then we may have low levels of staff engagement and morale, resulting in an adverse impact on patient safety and experience, staff experience and wellbeing, and a failure to attract diverse staff to work for our Trust.			
Legal/Regulatory:	There is a requirement to ensure the Trust is compliant with a whole range of NHS equality frameworks and including the Equality Act 2010 (specifically the Public Sector Equality Duty). Our progress on EDI is a key success measure under the CQC well-led framework.			

Quality & Patient Safety:	Our progress on EDI and Health Equity is a key success measure for providing quality patient care.
Equality, Diversity and Inclusion and Health Equity:	EDC provides leadership and focus for advancing EDI across the Trust, including our progress on Health Equity. It also provides a platform for our four staff equality networks to share their lived experience and to influence the Trust EDI agenda.
Resources:	N/A
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	N/A

Report content
1. Purpose The purpose of this report is to update the Trust Board on the work of the Equality and Diversity Council and provide an overview of the key areas of focus since our last update in May 2026. 2. Background/context EDC has been in place since January 2021 and continues to meet every quarter, providing strategic direction, leadership and support to the Trust EDI agenda, including the Trust's approach in tackling population health inequalities. EDC Membership: All EDC members are encouraged to attend each meeting, and EDC is usually very well attended. Where attendance is not possible members are asked to send a representative on their behalf. Staff Equality Networks: Chairs of each of the Trust's staff equality networks are included as members of EDC with dedicated agenda time at each meeting. This enables staff networks to have a voice where they can actively influence EDI across the Trust. 3. Assessment EDC continues to be well attended and generates lots of useful discussion, with 23 people attending the July meeting, section 4 (below) captures some of the key discussions and actions arising from the meeting which took place on 9th July 2026. Next EDC is due to take place on Wednesday 7th October 2026. 4. Highlights of the EDC meeting – Wednesday 9th July 2026 EXCEL Patient & Workforce Engagement: Vaqass Akhtar, Service Improvement Lead provided an overview of the EXCEL programme in the Emergency Department (ED) and gave an update on how “extensive multi-stakeholder engagement” is helping to shape positive changes across the service with a view to reducing not just the volume of patients attending the ED dept, but also to improve the experience for both patients and our workforce, including informing pathway co-design and ED refurbishment. Some of the connecting themes and learning have included looking at;

- Wait times and demand in ED
- Communication and information vacuum
- Staff behaviours, including empathy and care
- Accessibility of care for patients with additional needs
- System and pathway challenges and environment
- Comfort and cleanliness.

This work is helping to shape a number of areas such as;

- GP pathways and neighbourhood integration
- ED refurbishment
- Digital patient information screens and live operational dashboard
- Staff development
- Improved communication (including e.g. BSL training for nursing teams) and development of multi-lingual patient journey videos.

The team are experiencing a willingness from primary care colleagues to work collaboratively in improving patient pathways and experience, with some pilot schemes already under way to re-direct patients to care that is better suited to their needs.

Refreshed Strategic EDI Objectives: Kez Hayat, Head of Equality, Diversity & Inclusion shared an update on the development of the refreshed EDI strategic objectives for 2026-2029. These have been developed through a range of targeted engagement and aligned to our agreed People Strategy ambitions. The refreshed EDI objectives include:

- Advancing Anti-Racism (Adopting the NHS Race & Health Observatory 7 Principles)
- Inclusive Leadership & Culture
- Workforce Equity and Experience

Each objective will be supported by some key principles, and within each objective there has been identified 4 key areas of focus. The approach will be data led (with insight and accountability), collaborative (providing engagement and voice), involve working closer with system partners, and with more robust governance and assurance.

The proposal was well received by EDC with some discussion around how progress will be measured and monitored by People Committee. It was agreed that a finalised plan would be brought back to the October EDC meeting after the proposal has been taken to Executive Team Meeting to agree next steps. EDC will be kept updated on progress.

There was some discussion about the need to have more focus on LGBT+ equality for patients and staff, and the LGBT+ network will work with the EDI team and other colleagues to improve data collection and experience. Mel suggested a staff app may help to improve data collection from a comms perspective, including staff survey and pulse checks.

Post meeting update: A visit from the NHS Race & Health Observatory took place on 13th August 2026 where it was agreed to formally accept their 7 principles which marks the start of our journey to become an anti-racist organisation.

Update on Supreme Court ruling on the definition of Sex in the Equality Act 2010: Kez Hayat provided an update on the provision of single-sex services following the Supreme Court ruling (for Women Scotland Ltd v Scottish Minister). A 40-day consultation period with

parliament was initiated on 21st May, and a further update on this is still awaited, along with specific NHS Guidance (being developed by NHS England) which will ensure there is consistency in approach to reviewing and refreshing our Trans Equality Policy and will avoid premature interpretation of legal position. Until such time as this guidance is available, we are taking a stance that the current Trans Equality Policy still stands (this is consistent with the position taken by NHS EDI colleagues from across the region). Kez also provided an overview of the potential implications for us as an acute Trust and how we propose to engage with staff and other stakeholders to ensure the most appropriate response to the legislation and guidance (when available).

The update was welcome by EDC and in particular by the LGBT+ staff network who are keen to be involved in any further comms and updates.

Post meeting update: NHSE hosted a webinar on 30th July 2026 around the provision of single sex facilities (for staff), ahead of their published guidance and with guidance for patient facilities also to follow. On the back of this webinar a paper has been taken to ETM on 14th September 2026 providing an update and proposed next steps.

Equitable Healthcare for People with Learning Disabilities at BTHFT: Caroline Carass, Learning Disability Nurse (Accessible Needs Team) led a discussion around Learning Disability, exploring some of the health equity challenges experienced (including lower life expectancy and poorer access to and experience of healthcare) and how we as a Trust can work to change this.

Caroline highlighted the importance of addressing communication barriers, economic disadvantage and other challenges to accessing services. Caroline shared a case study which highlighted the importance of developing a VIP passport to better understand the specific needs of patients with learning disabilities, along with the importance of not only involving carers in this process, but the positive impact of involving senior clinicians to reduce formality, improve communication and build trust.

The Trust is moving towards having a “Reasonable Adjustment Flag” on patient records which will indicate a specific need (and avoid errors or the need for repeat explanations).

Alison Smith invited Caroline to get involved with the Health on the Highstreet project to ensure the needs to patients with learning disabilities are considered.

Health Equity Digital Tools: Naveed Saddique, Health Equity Lead provided an overview of two new digital tools that are being developed by the Health Equity team and will be available for staff as a desktop icon.

Travel Equity Tool: This has been developed specifically for “Health on the Highstreet” to quantify who carries the access burden (travel time, costs, number of bus changes etc. by population group/ IMD). This can be helpful when planning service moves/ reconfiguration, enabling a more thorough equality impact assessment. The tool only covers the Bradford postcodes at present but with plans to develop more widely as needed.

Equity in Practice Scenarios: Builds staff capacity to recognise and respond to inequalities in everyday decisions and provides groups the opportunity to discuss approaches through scenario-based decision making (with branching choices) and learning on best practice approaches (from a health equity perspective).

Karen Dawber suggested the team linking in with Zeph Curwen and other operations colleagues to use the tools to help understand DNA's.

Colleague Equality Network Updates:

It was agreed that each colleague equality network would have a scheduled slot on upcoming team briefs to provide improved reach and coverage and raise the profile of networks across the Trust. All agreed it was important to promote the support available to people, but also the role colleagues can play as ally's in supporting and improving working life for others.

The networks were pleased to have had the opportunity to be involved in the Staff Survey action plan engagement and attend People Committee where next steps were discussed. They also reported on a successful collaborative event that took place on 13th May 2026 to celebrate international staff networks day.

EDC congratulated all networks on the progress they are making, particularly around their efforts in raising their profile, improving access to support, collaborative working and focus on allyship.

Enable Colleague Equality Network: Under the leadership of Simon Kirk, the Enable network is in the process of re-establishing itself. Formal network meetings are taking place on a monthly basis, along with more informal monthly networking and drop-in sessions (removing pressure to attend a formal meeting when support is needed). The network is working hard on communications, raising their profile through regular sessions on the main concourse at BRI. They are improving their intranet pages, have worked with the OD team to incorporate some slides into Trust Induction and with the HR team to incorporate a new process of sending information about the network/ available support to staff who declare a health condition on commencement in post. The network are also taking steps to develop an Enable Subgroup focused specifically on neurodiversity and have shared a questionnaire Trustwide to try to understand why people are not coming forward to join the network and benefit from support mechanisms (unfortunately, the response rate for this was low). The EDI team to link with the network in developing some intranet resources on neurodiversity.

The EDI and HR team have developed a Thrive Management Essentials session to empower managers in understanding their role and responsibility to support colleagues with the provision of Reasonable Adjustments in the workplace.

Gender Equality Network: Shaheen Kauser (network chair) confirmed the network has been focussing on broadening the reach of its membership and on comms and engagement work (including developing a refreshed intranet page, aligned to the other network pages). Shaheen talked through the network work plan to highlight upcoming areas of work, and provided an update on 2 of the network work-streams that have been meeting to progress some key areas of focus, including;

- Development & progression of women (with focus on diverse backgrounds), exploring available mentoring and leadership opportunities.
- Disaggregation of workforce data by protected groups has helped to better understand the reasons behind some of the inequalities (with plans to develop a listening event later in the year to explore key themes such as returning to work after maternity/ adoption leave).

Establishment of a colleague breastfeeding room on the BRI site. Further connections were made at EDC to push this forward.

LGBT+ Staff Equality Network: Membership continues to increase with Amelia Cripps (Network Chair) reporting the largest number of attendees on record at the last meeting (and membership doubled over the last 12 months). In June the network celebrated PRIDE month with comms and engagement including, progress flag flying, new rainbow road crossings at the BRI site, a newly developed screensaver and Let's Talk comms, including an article about the importance of allyship. Amelia shared photos of the PRIDE event which took place on the main concourse on 29th June 2026, which was a great success and featured a quiz, cake and conversation. A community artwork piece was created at the event which is being developed further by the comms team for permanent display on the main concourse. The network continues to forge great links with other local NHS LGBT+ networks.

The network is in discussion with OD colleagues to develop an LGBT+ focussed module for the Thrive Management Essentials programme to raise awareness and promote allyship and better care for LGBT+ patients. The are also making great progress in refreshing their LGBT+ Network Intranet page.

RESIN (Race Equality Staff Inclusion Network): June Thomas (network chair) invited Moses Jameh to demonstrate the refreshed RESIN network intranet pages (which are 90% complete and just need some final review with a comms lens). The new pages will have some dedicated focus on network activity, development opportunities and allyship.

Other updates:

Kez Hayat is working with Bradford Hate Crime Alliance and colleagues in Informatics to establish a Hate Crime reporting app on our intranet which will provide guidance, support and free staff training.

5. Proposal

It is recommended that the Trust Board:

- Note the contents of this report
- Support the proposed areas of work identified in section 4

Osbourne, Sheridan
24/09/2026 08:40:12

Meeting Title	Board of Directors		
Date	24 September 2026	Agenda item	Bo.9.26.14

Committee Escalation and Assurance Report

Report from the: Finance and Performance Committee

Date of meeting: 16 September 2026

Key escalation and discussion points from the meetings

Alert:

Financial position

Two aspects of the monthly Finance Report lead to this **Alert** rating. All aspects of the position will be presented at the Board meeting on 24 September. The **Income and Expenditure** position shows an increased risk of not hitting the plan. The Committee heard of potential mitigations that mean achieving that plan cannot be ruled out, there are some material issues to be resolved before the Committee could conclude that the best case would not be a deficit outturn. The Committee received information about slippage in delivering the **Capital** plan and noted the frequent meetings taking place to accelerate delivery.

Recovery Programme Update

The Chief Executive was in attendance for a discussion of the Recovery Programme Update. The Committee noted the strengthened governance and the input of external capacity to review delivery of some of the Closing the Gap schemes. Whilst the Committee was assured about the processes that have been put in place there remains concern about delivery capacity and pace, hence the **Alert**.

High Level Risks

The Committee noted that the two 'red' risks concerning Emergency Department capacity and length of stay in the Emergency Department were still to be reframed. Two new capacity and demand red risks were noted concerning chemotherapy and haematology and past both their review and mitigation dates. The Committee was assured that these new risks had been recorded on the risk register and actions being undertaken to reduce the risks. Clarity when using 'demand and capacity pressures' in a risk description was requested in future.

Operational Performance

The Committee received updates on the KPI performance exceptions which will be included on the Board agenda on 24 September. One issue is a matter for **Alert**; DM01 6 weeks performance which is the only operational KPI RAG rated red for the year end. The Committee noted that it was only Audiology of the services contributing to DM01 performance that was causing this rating. In noting EMT's decision to invest in the service, the Committee was advised of the poor relative position of Audiology performance on this indicator nationally.

Meeting Title	Board of Directors		
Date	24 September 2026	Agenda item	Bo.9.26.14

Advise:**Operational Performance**

The Committee welcomed the report that the majority of KPIs used to track progress continue to rank above peer average and are trending upwards or exceeding planned targets. On the balance of all year-end forecasts the Trust is likely to meet most of its planning targets and improve its NOF ranking for access to services if current performance trends are sustained.

Attention was drawn to some indicators requiring additional oversight as they are behind trajectory and recovery plans are still being finalised; hence the inclusion in this 'Advise' section regarding forecast year end performance.

- 4-hour Emergency Care Standard (ECS): The average performance required to meet the 2026/27 planning targets is in line with Trust out-turn position from last year. With increased demand and multi-factor challenges across UEC impacting on these metrics this KPI has been escalated to amber. The Trust's 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.
- RTT 18-week performance: Work is underway to quantify the exact challenge for H2 but the increased WL size and current trend are sufficient to flag concern against this target. Recovery remains entirely feasible and improvement plans will be quantified to show this, which may allow a return to a green forecast for this KPI next month.
- Cancer 62-day: Tumour group level recovery plans have been reviewed by the Operational SLT and are being tracked weekly to support the required improvement in capacity and timescales. The YTD position is however below plan and full recovery to year end targets could be at risk, meaning an amber rating whilst improvements are embedded.

The Committee was assured by the quality of the analysis in the report and the actions being taken to maximise KPI performance whilst noting the risks to full delivery of all targets.

The Board will receive the detailed Operational Performance Report at its September meeting and can expect the Finance and Performance Committee to continue to scrutinise whether the reported work to deliver the planned performance is successful.

Q. Bourne, Sheridan
24/09/2026 08:40:12

Meeting Title	Board of Directors		
Date	24 September 2026	Agenda item	Bo.9.26.14

Assure:

Other matters

The Committee was assured by the reports and presentations on a range of important issues:

- Risk Appetite Statement: the Committee focussed on the risk appetite statements under Strategic Objective 5, Sustainability and approved the proposed wording. The Committee noted that the different categorisation of risk appetite across all aspects of the Trust's work helped to provide a context and a framework for the challenging prioritisation decisions taken operationally and strategically.
- Provider Capability Assessment: the Committee was assured by the work presented regarding the ELT's self assessment relating to the Access and delivery of services, Productivity and value for money and Financial performance and oversight domains and supported the proposed ratings, noting that not all were green.
- Contract Update – assured by the information provided
- Procurement Update – assured by the information provided
- Winter Plan and Board Assurance Statement – assured by the depth of analysis provided, the planning being undertaken and the Trust's record in managing its winter response in recent years.
- Emergency Preparedness, Resilience, and Response Update and Submission - assured by the depth of analysis provided, the planning being undertaken and the Trust's record in recent years. The Committee delegated the decision on final submission to the COO.
- Annual Security Report – assured by the annual report which highlighted areas of progress, continued challenges and plans for focussed continued improvement in 2026/27.
- Accommodation Report – assured that the risks in managing the Trust's accommodation were understood and mitigated and welcomed plans for the development of a Trust Accommodation Strategy.
- Medium Term Financial Plan – assured by the approach to the MTFP whilst noting the focus must remain on delivery of the current financial plan as that is one of the fundamental uncertainties of any future financial plan.

Report completed by:

Bryan Machin

Committee Chair and Non-Executive Director

17 September 2026

Osbourne, Sheridan
24/09/2026 08:40:12

Integrated Performance Report

August 2026

Osbourne Sheridan
24/09/2026 08:40:12

Summary Dashboard - August 26

as of month 5 Aug-26

Net Income & Expenditure Position		Total Headcount Reduction		Clock Stopping Activity Delivered		Quality Access Standards Achieved	
Measures the delivery of income and expenditure, which incorporate cost improvement and productivity plans, against financial targets		Tracks progress against the workforce reduction targets (Substantive, Agency & Bank) which underpin our sustainability plans		Monitors delivery against activity targets for New Outpatients, Daycase & Elective Inpatient Spells and Outpatient Procedures.		Assess compliance against agreed targets for the national constitutional standards which are reported in the NHS Oversight Framework	
-£9.92m		7,375.1	-186.9	129,590		5 out of 8	
-68.6%		+0.0%		+12.2%		39 of 123	
Vs Target	Vs Last Month	Vs Target	Vs Last Month	Vs Target	Vs Last Month	National Rank	Vs Last Month
Net I&E position at the end of the reported month and variance to the fiscal year-to-date target		Headcount reported (and change to March 2026) and variance to headcount plan for month end		Volume of activity and variance to planned activity volume for the fiscal year-to-date		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

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

Finance and productivity

Effectiveness and experience

Patient safety

People and workforce

1 - High performing



4 - Low performing



2 - Above average



2 - Above average

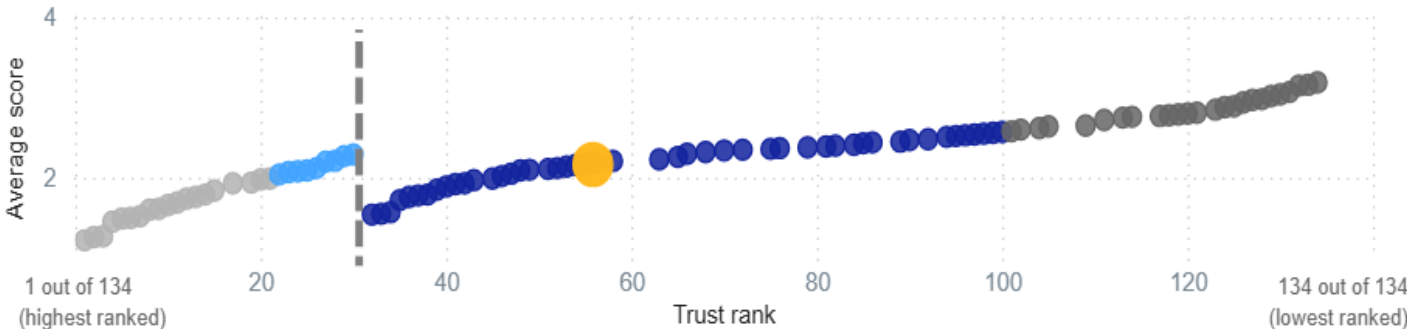


3 - Below average



Average score by trust rank placement

Segment 1 2 3 4 Selected trust





Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

Finance & Performance - August 2026

Osbourne Sheridan
24/09/2026 08:40:12

Finance & Performance

Headline KPI Summary



Headline KPI	Latest Month	BTHFT Plan	Perf.	3-Month Trend	Q4 NOF Rank	Year to Date	YTD Plan	Year End Target	Year End RAG
Average Ambulance Handover	Aug-26	18:00	17:03	↓	N/A	17:22	18:09	18:25	G
Emergency Care Standard	Aug-26	83.10%	82.77%	↑	8 of 123	82.17%	83.10%	83.00%	G
12 Hour LoS in Emergency Department	Aug-26	6.76%	9.61%	↑	36 of 122	9.77%	6.77%	7.31%	G
Length of Stay ≥21days	Aug-26	82	80	↓	N/A	N/A	N/A	82	G
Average Delay Post Discharge Ready Date	Aug-26	3.7	3.2	↓	N/A	3.4	3.7	3.7	G
18 Week RTT Incomplete	Aug-26	68.80%	68.10%	↓	54 of 130	N/A	N/A	73.71%	A
18 Week RTT Incomplete vs Plan	Aug-26		-0.70%		52 of 131				-
52 Week RTT Incomplete	Aug-26	0.21%	0.14%	↓	19 of 130	N/A	N/A	0.22%	G
52 Week Community Waits	Jul-26		0.00%		1 of 78	N/A	N/A		-
New Outpatients (ERF) vs Plan	Aug-26	100.00%	96.34%	↓	N/A	101.72%	100.00%	100.00%	A
Elective Activity vs Plan	Aug-26	100.00%	93.40%	↓	N/A	99.23%	100.00%	100.00%	A
6 Week Diagnostic Standard (DM01)	Jul-26	85.52%	86.26%	↓	N/A	N/A	N/A	94.65%	R
Cancer 28 Day Faster Diagnosis Standard	Jul-26	82.01%	78.19%	↓	53 of 117	80.20%	79.70%	80.03%	G
Cancer 31 Day General Treatment	Jul-26	94.74%	96.88%	↓	N/A	96.58%	94.57%	31.54%	G
Cancer 62 Day General Treatment	Jul-26	78.79%	68.05%	↓	56 of 118	73.20%	76.40%	100.00%	G
Variance to Financial Plan (£m)	Aug-26	£0.00m	£2.06m	↑	108 of 134	£4.00m	£0.00m	£0.0m	R
Planned Surplus/Deficit	Aug-26	£0.33m	- £1.73m	↑	52 of 134	-£9.88m	-£5.89m	£0.0m	R
Delivery of CTG Target	Aug-26	£4.94m	£3.90m	-	N/A	£20.17m	£21.41m	£58.4m	R
Delivery Capital Plan	Aug-26	£1.60m	£0.50m	↓	N/A	£2.60m	£9.70m	£34.38m	
Delivery Cash Plan	Aug-26	£6.50m	- £0.20m	↑	N/A	£15.90m	£17.30m	£4.4m	R

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

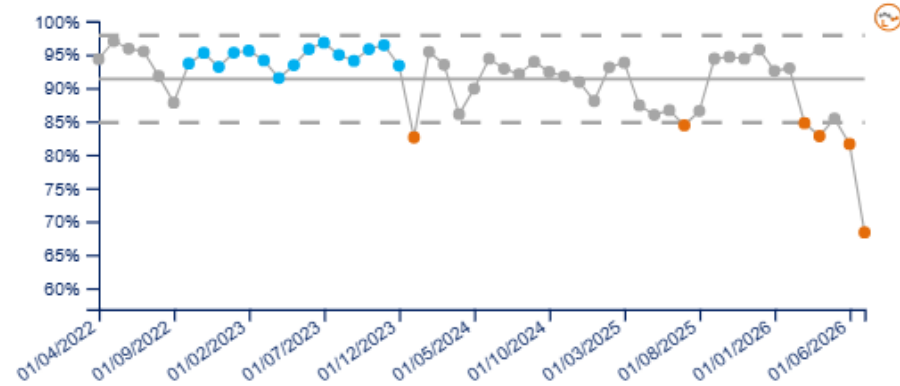
Red = unlikely to meet target

Amber = recovery planned but not certain

Green = expected to meet target

Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	91.4%	68.4%	81.6%	-13.2

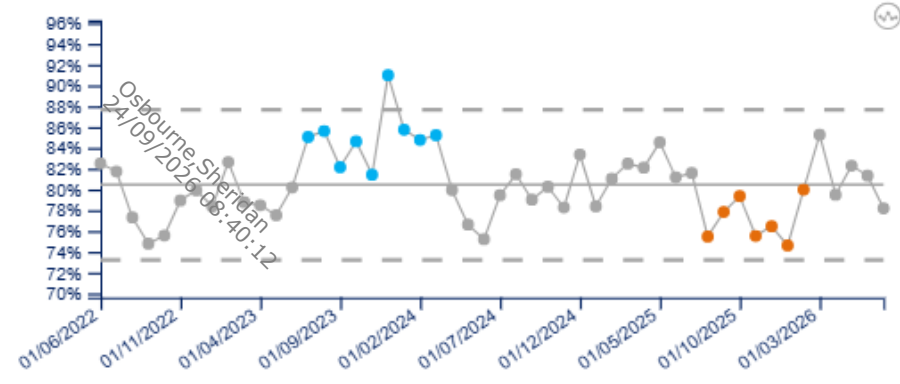
Cancer 2 Week Wait Referrals



Shift Trend: None – performance remains within expected variation

Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	80.5%	78.2%	81.3%	-3.1

Cancer 28 Day Faster Diagnosis



Shift Trend: None – performance remains within expected variation

Latest Commentary

2026-Jul

Cancer - 2 Week Wait Referrals

Analysis

2WW performance dropped significantly in July due to an OMFS consultant vacancy impacting the Head & Neck pathway, alongside temporary triaging delays from the rollout of Skin AI (now resolved).

Risks, Mitigations & Assurance

An agency OMFS consultant is due to start in September with additional clinics planned to bring patients forward, though a permanent staffing solution remains outstanding.

Latest Commentary

2026-Jul

Cancer - 28 Day FDS

Target

Performance was slightly below plan in July but is forecast to recover in August

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. OMFS (impacting H&N performance) currently have a consultant vacancy. An agency consultant has been appointment with clinics commencing this month however a long term solution is still required.

Additional Skin clinics are running on weekends to support the 2WW position however capacity issues have resulted in a biopsy backlog. Bronte Forward Wait is being utilised to clear this backlog however delays in taking the biopsy means that the full benefit of Skin AI cannot yet be realised.

Histology delays continue to impact Skin and Gynaecology for 28 and 62 day performance.

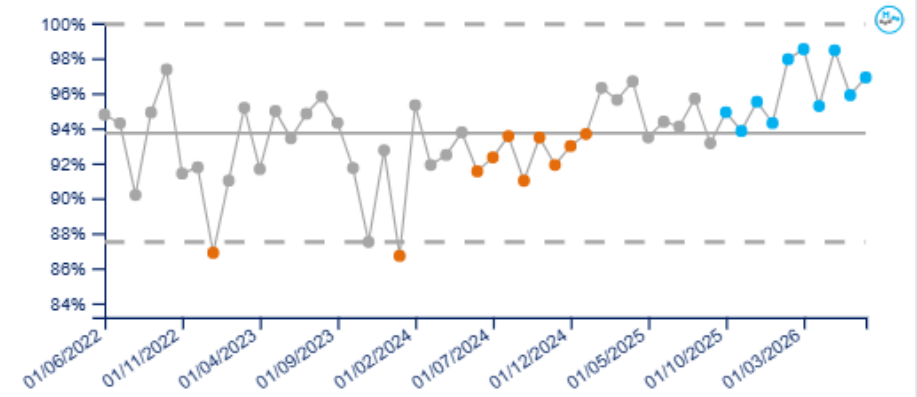
Benchmarking

Overall performance remains above peer average



Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	93.7%	96.9%	95.9%	+1.0

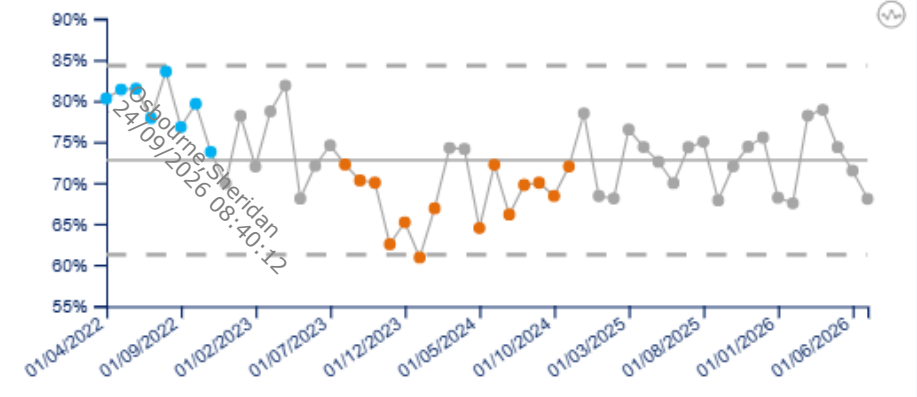
Cancer 31 Day First Treatment



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

Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	72.8%	68.1%	71.5%	-3.4

Cancer 62 Day Standard



Shift Trend: None – performance remains within expected variation

Latest Commentary

2026-Jul
Cancer - 31 Day 1st
Treatment
Analysis
Benchmarking

Performanace remains above plan, target and previous Trust average
The Trust is in the upper quartile for this KPI

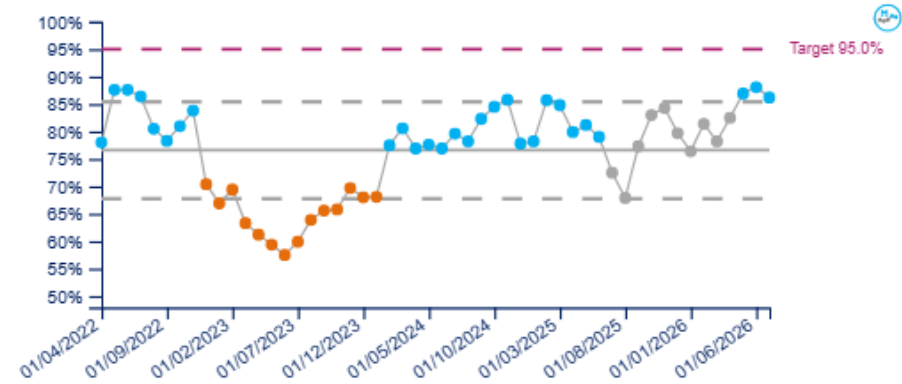
Latest Commentary

2026-Jul
Cancer - 62 Day
Standard
Target
Analysis
Risks, Mitigations &
Assurance
Benchmarking

Performance is below plan
Delay reasons are in line with previous months. Performance has become more challenged across Head & Neck, Skin, and Breast pathways.
Tumour group level recovery plans have been reviewed by the Operational SLT and are being tracked weekly to support the required improvement in capacity and timescales.
MDT optimisation work is due to commence in Lung and Skin from September with a potential roll out in Breast.
Performance is below peer average

Latest Period	Target	Latest Value	vs Target	vs Previous
Jul 2026	95.0%	86.2%	-8.8 ▼	-1.9 ▼

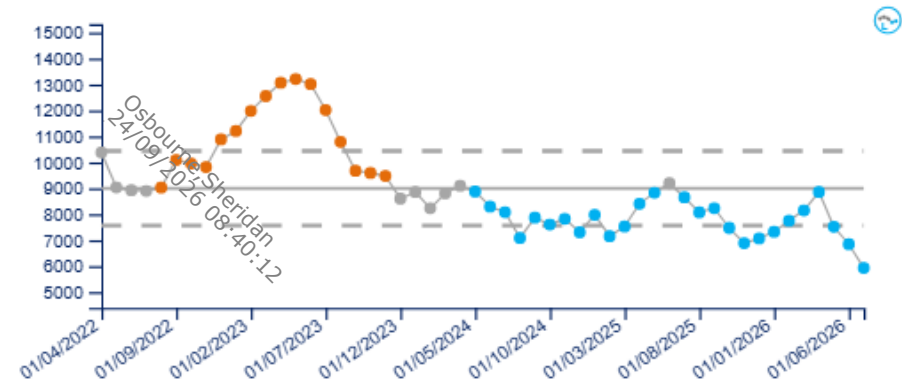
Diagnostic Waiting List % <6 Weeks



Shift Trend: None – performance remains within expected variation

Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	9,002	5,931	6,844	-913 ▼

Diagnostic Waiting List



8/48 Shift Trend: Improvement – performance below average for 7 consecutive periods

Latest Commentary

2026-Jul

Diagnostic - % < 6Wks

Target

Analysis

Risks, Mitigations & Assurance

Performance is ahead of the NHSE agreed planning trajectory. The target is not currently 95%. DM01 performance for August is projected to reduce and continue to do so in September. Breach numbers remain consistent (predominately in Audiology) whilst total waits reduce (further improvement in Non-Obstetric Ultrasound). 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 recover if recruitment is approved for full establishment.

Latest Commentary

2026-Aug

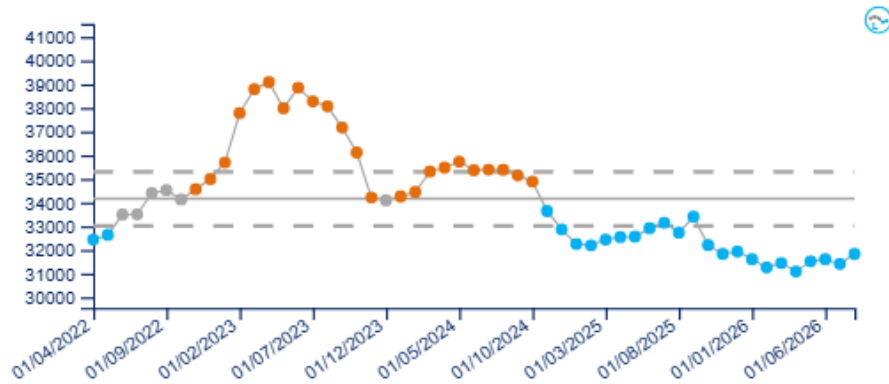
Diagnostic - Waiting List

Target

NOUS waiting list reduction has continued

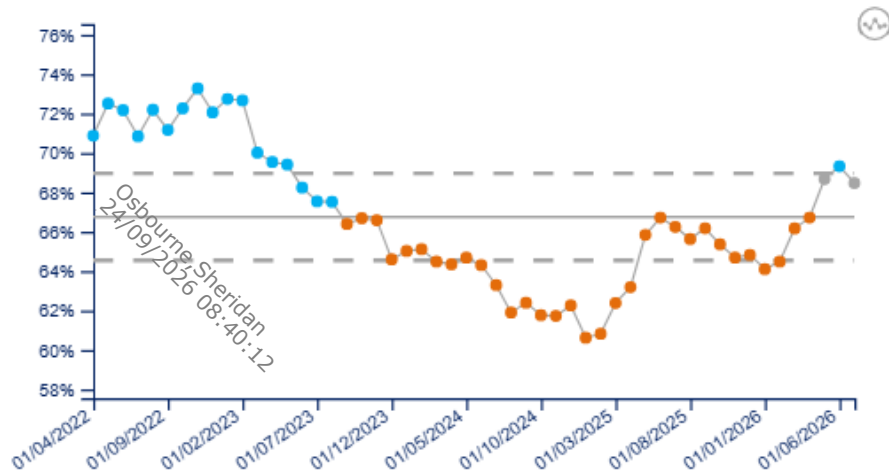
Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	34,165	31,827	31,409	+418 ▲

RTT 18 Weeks Total Pathways



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

RTT 18 Weeks Performance %



Shift Trend: None – performance remains within expected variation

Latest Commentary

2026-Jul

RTT - 18 Wk Total Pathways

Target

Analysis

Risks, Mitigations & Assurance

Benchmarking

Total RTT WL is c.2,800 above plan

Clock starts remain higher than expected. Clock stops slightly below plan with admitted pathway productivity not yet at planned levels.

August submission period extended to support additional validation.

Delivery of plan expected in September. Additional activity and a focus on waiting list management planned in aid of recovery.

In line with national trend.

Latest Commentary

2026-Jul

RTT - % 18 Wks

Target

Analysis

Risks, Mitigations & Assurance

Benchmarking

Performance has dropped to below the agreed planning target

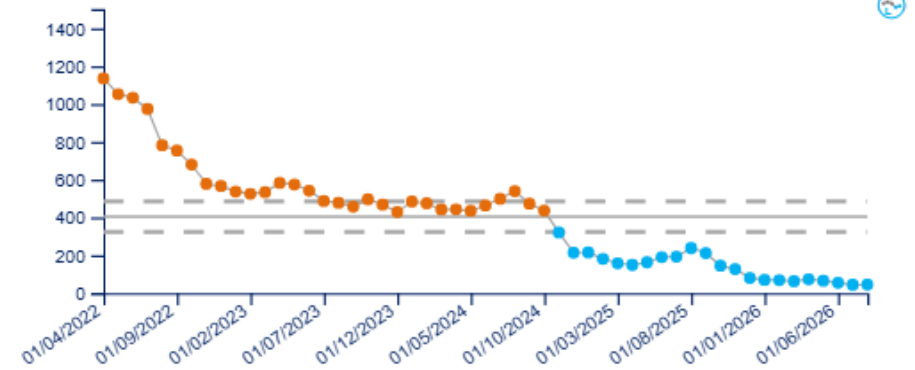
Overall waiting list has not reduced in line with plan. Growth in demand during Q1 is now resulting in additional waits above 18-weeks which reduces performance.

WL validation metrics are positive but it may be possible to derive some benefit from waiting list management initiatives for which support has been offered. Recovery would be achieved if additional activity to meet original planning volumes for clock stops could be achieved. The theatre and outpatient recovery programmes are tasked to support this.

Performance remains above peer average

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	404	45	44	+1

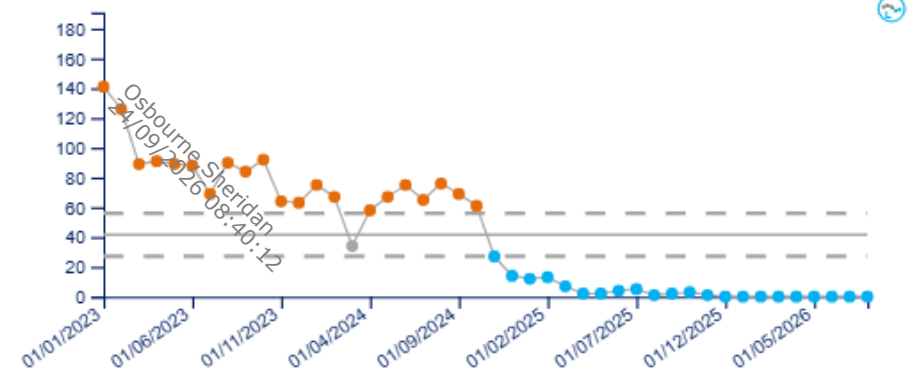
RTT 52 Week Breaches



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

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	42	0	0	0

RTT 65 Week Breaches



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

Latest Commentary

2026-Aug
RTT - 52 Wk
Breaches

Target
Analysis
Risks, Mitigations &
Assurance

Benchmarking

Performance remains better than plan

Long wait management at all levels of operations continues to maintain positive performance against this standard. Challenges are ongoing in Trauma & Orthopaedics however the long wait position is improving, further supported via weekend Medinet theatre lists. Recovery plans are required for potential long wait breaches in Oral Surgery due to a consultant vacancy. An agency locum has been recruited however the clinical priority is to recover the deteriorating Cancer position.

The Trust continues to benchmark just below the upper decile for 52-week RTT.

Latest Commentary

2026-Aug
RTT - 65 Wk
Breaches

Target
Analysis
Risks, Mitigations &
Assurance

Zero reported vs target of zero

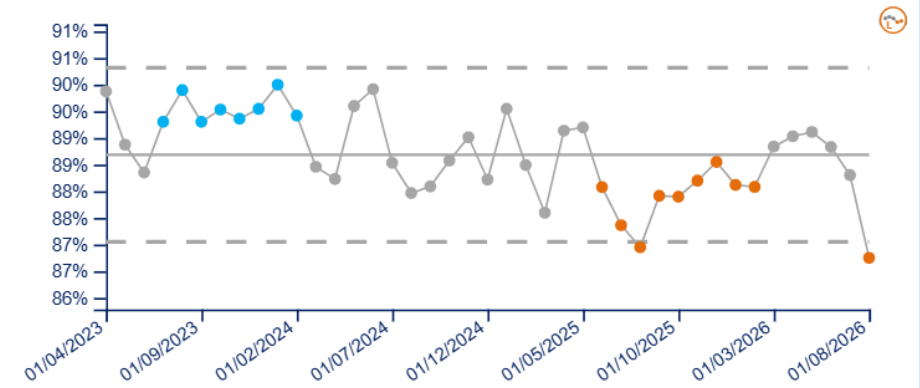
We continue to meet this target

No change to previous narrative



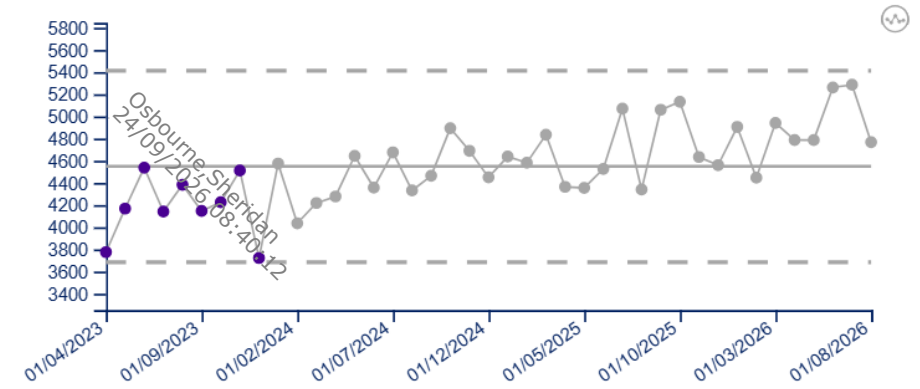
Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	88.7%	86.7%	88.3%	-1.6

Day Case Rate



Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	4,548	4,767	5,285	-518

Elective Ordinary & Day Case



Shift Trend: None – no improvement direction applied

Latest Commentary

2026-Aug
Elective - Day Case
Rate

Analysis

Day cases as reported against our planning target have dropped in August impacting this rate. These are predominately in T&O and general surgery, with the latter relating to diagnostic capacity. Delivery expected to return to previous ratio in September.

Benchmarking

Model hospital data suggests we can improve our DC rate

Latest Commentary

2026-Aug
Elective - Elective
Ordinary & Day
Case

Target

Activity was behind plan for August by in line with plan YTD

Analysis

Productivity (theatres) is behind plan but offset by counting and coding improvements.

Risks, Mitigations &
Assurance

August trend is in line with seasonal expectation.

Productivity increases are required month on month, making targets more difficult to meet.

The theatre improvement programme is fundamental to this process.

Finance & Performance

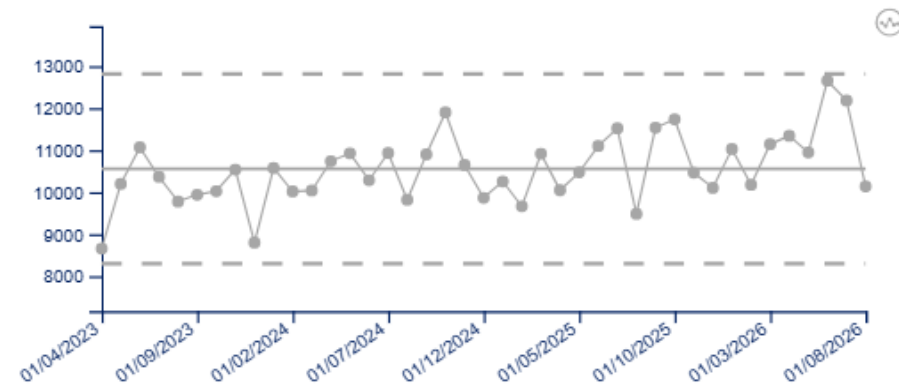
Outpatients



BTHFT
Business
Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	10,560	10,141	12,182	-2,041 ▼

Outpatient Attendances New



Latest Commentary

2026-Aug
Outpatients -
Attendance (New)

Target

Analysis

Risks, Mitigations &
Assurance

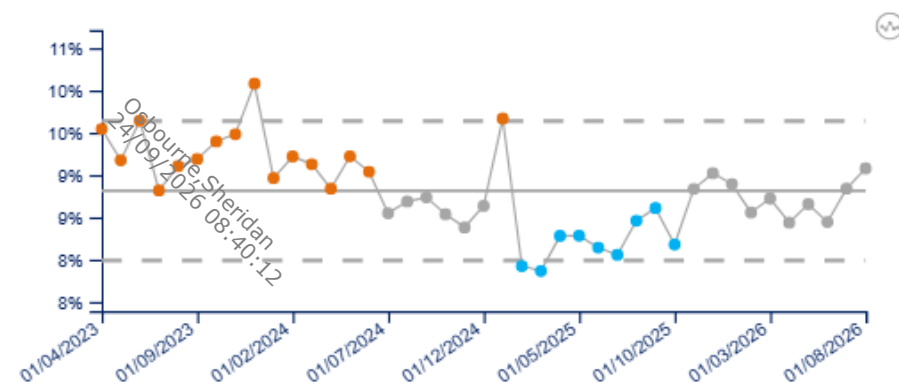
Performance for August was below plan but YTD is above plan

Trend in line with seasonal expectation, although activity levels dropped more than forecast. A/L and TOIL were above previous summer levels.

Optimisation workstream continues and includes work to reduce DNA and follow up rates.

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	8.8%	9.1%	8.8%	+0.2 ▲

DNA Rate All



Latest Commentary

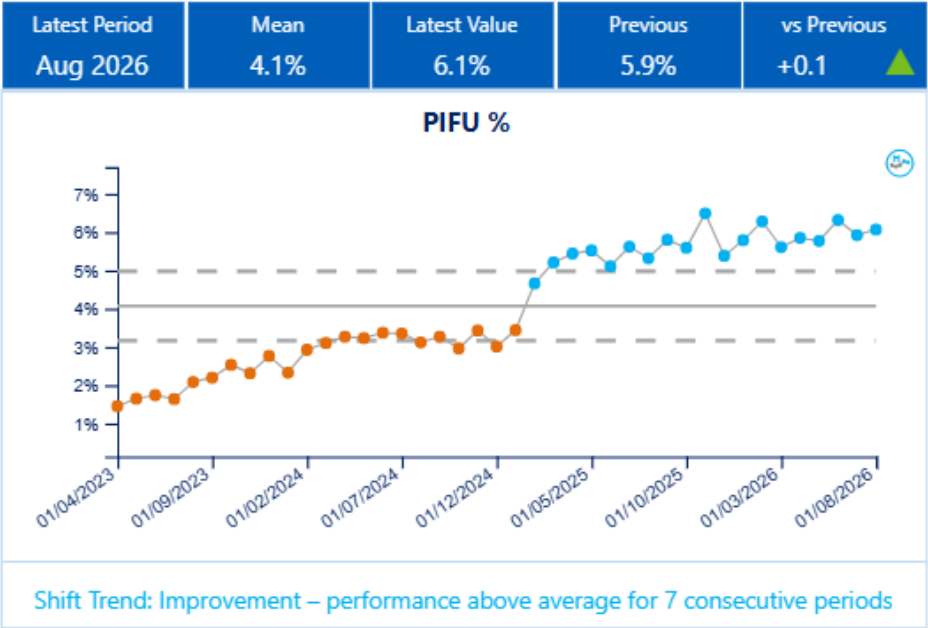
2026-Aug
Outpatients - DNA
Rate (All)

Analysis

Risks, Mitigations &
Assurance

Rates increased slightly

Review of productivity data flows underway to ensure accuracy. Service led transformation plans being tested as part of outpatient optimisation work-stream.



Latest Commentary	
2026-Aug	
Outpatients - PIFU %	
Target	Delivery is above target and in line with plan
Analysis	Adoption is high across key specialties
Benchmarking	Above peer average

Osbourne Sheridan
24/09/2026 08:40:12

Finance & Performance

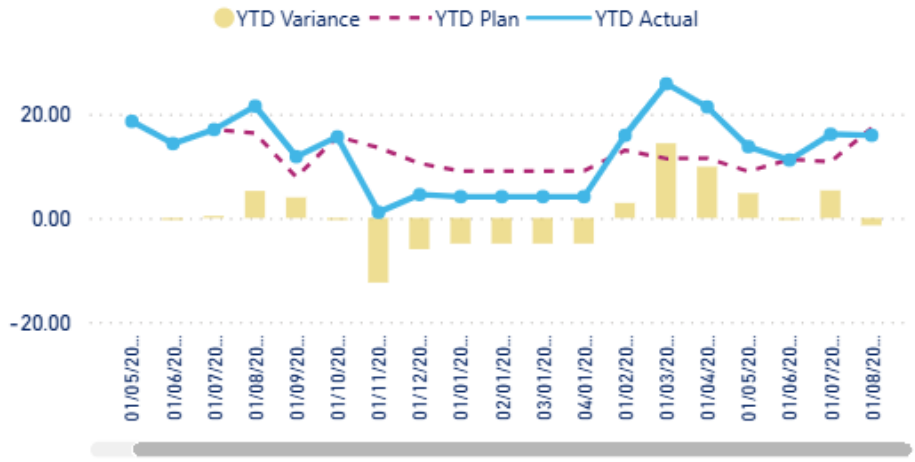
Delivery Cash & Capital Plan



BTHFT
Business
Intelligence

Period	YTD Plan	YTD Actual	YTD Variance	Status
Aug 2026	£17.30	£15.90	(1.40)	Below Plan

Delivery of Cash Plan (YTD)



Latest Commentary

Delivery Cash Plan

Target

£17.3m

Analysis

Total cash balance is £15.9m which is £1.4m less than plan.

Year to date Operational I&E cash is (£4.1m), which is £10.5m below plan. This adverse variance is primarily driven by the Trust's Year to date deficit of £9.9m which is £4.4m worse than plan, together with revenue cash support receipts being £6.6m lower than planned.

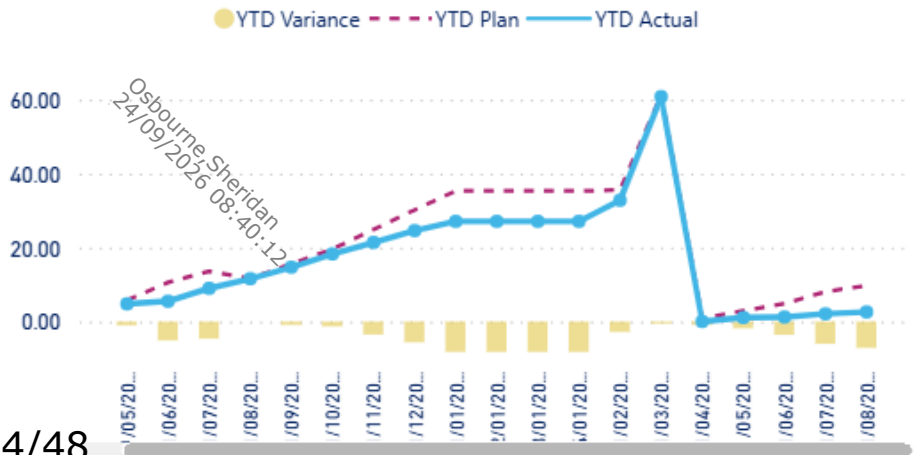
Working capital cash is £11.5m, £5.2m ahead of plan. The favourable position reflects the timing of working capital movements, including £2.7m of planned provision payments that have not yet been made and £2.7m of additional cash held relating to Elective Recovery Fund and Low Volume Activity funding.

Capital cash is £8.5m, £3.9m ahead of plan. This favourable variance is principally due to the slower than planned delivery of the capital programme, resulting in capital expenditure being £7.1m below plan.

This benefit has been partially offset by grants and donations income being £2.7m below plan, reflecting delays in the delivery of capital projects and the associated timing of funding receipts.

Period	YTD Plan	YTD Actual	YTD Variance	Status
Aug 2026	£9.70	£2.60	(7.10)	Below Plan

Delivery of Capital Plan (YTD)



Latest Commentary

2026-Aug

Delivery Capital Plan

Target

£9.7m

Analysis

Capital expenditure was £2.6m year to date, £7.1m below plan, reflecting a slower than anticipated start to the capital programme. This includes the planned £2.5m investment in the SLH DCU, which was expected to complete in Month 4 but has been deferred to a later period. The variance also reflects normal programme phasing, including procurement lead times and project mobilisation activity.

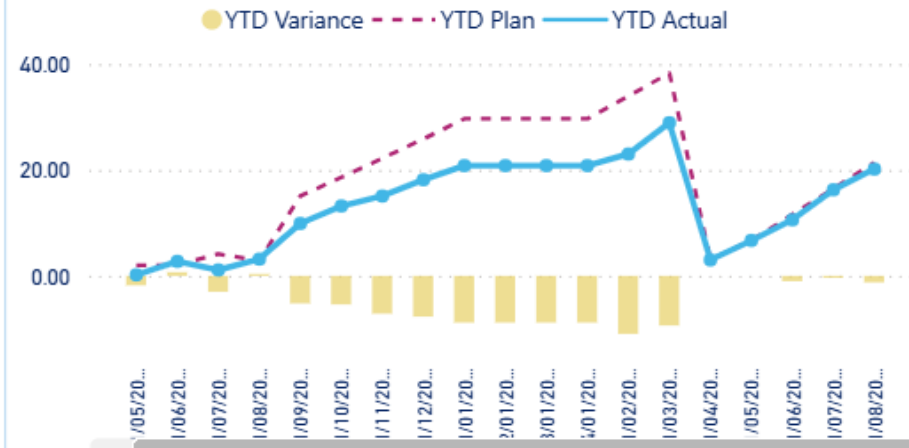
The full year capital forecast has been revised to £0.7m below budget to support the funding of the WYAAT Aseptic Unit at LHT. The Trust remains confident that the overall capital programme can be delivered by the year end, although this will require a significant increase in expenditure during the second half of the year.

There is an emerging risk of a capital underspend against plan.

The Capital Strategy Group is reviewing the reserve schemes programme to identify projects that can be accelerated or brought forward during the year to mitigate this risk and maximise utilisation of available capital resources.

Period	YTD Plan	YTD Actual	YTD Variance	Status
Aug 2026	£21.41	£20.17	(1.24)	Below Plan

Closing the Gap (YTD)



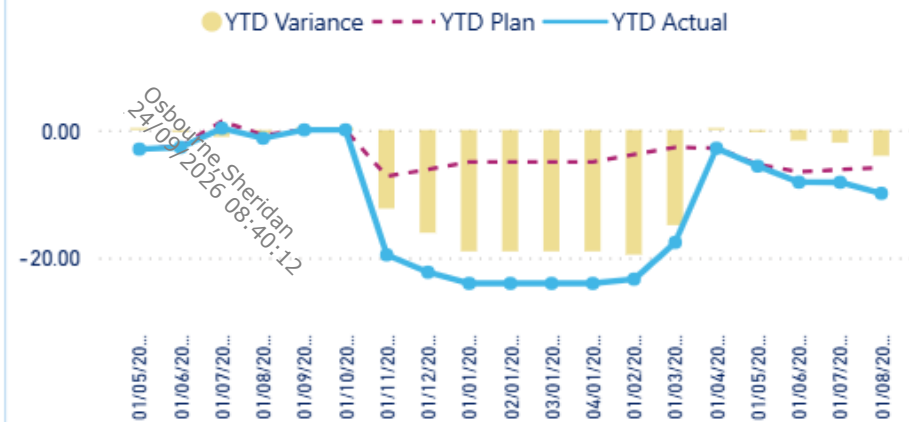
Latest Commentary

2026-Aug
Closing the Gap
Analysis

The Closing the Gap programme is reported as behind plan by £1.2m at Month 5. 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 the plan.

Period	YTD Plan	YTD Actual	YTD Variance	Status
Aug 2026	£-5.89	£-9.92	(4.04)	Below Plan

Delivery of Income & Expenditure Plan (YTD)



Latest Commentary

2026-Aug
Income &
Expenditure Plan
Analysis

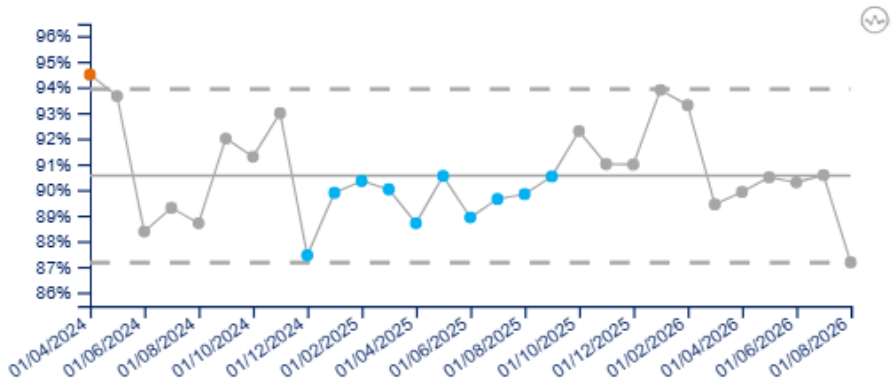
The Trust is reporting a year to date deficit of £9.9m, this is £4.0m worse than plan. The main drivers of variance at Month 5 are the Deficit Support Funding withheld by NHSE (£1.0m), the impact of industrial action (£1m), ERF under-delivery (£0.8m) & the shortfall in CTG delivery (£1.2m).

The in-month position for August was a deficit of £1.7m which is £2m worse than the £0.3m planned surplus for the month.

A number of non-recurrent pressures arose in-month, including a drop in ERF performance and some unexpected expenditure, however the principal reason for the off-plan position is the run rate not improving sufficiently via the Closing the Gap (CTG) programme to meet the planned in-month surplus

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	90.6%	87.2%	90.6%	-3.4

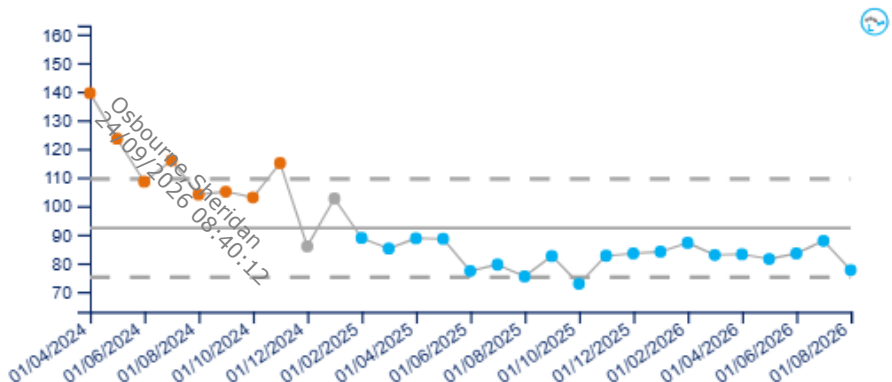
Bed Occupancy %



Shift Trend: None – performance remains within expected variation

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	92	78	88	-10

Average Patients LoS 21+ Days



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

Latest Commentary

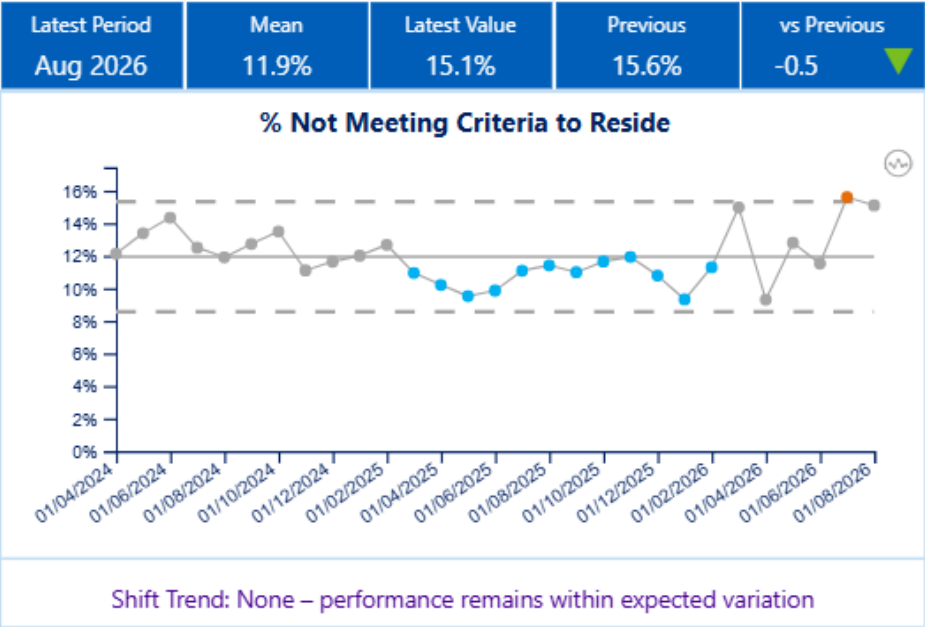
2026-Aug
Bed Occupancy %
Analysis
Risks, Mitigations &
Assurance

Reduced in August to levels below those planned for
Will increase into winter. Winter plan includes additional bed capacity to support this.

Latest Commentary

2026-Aug
LoS - Avg Patients
LoS 21+ Days
Target
Risks, Mitigations &
Assurance

Meeting plan
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.



Latest Commentary	
2026-Aug NMCTR - % Not Meeting Criteria to Reside Analysis	NMCTR performance has improved in August (15.1%) compared with 15.6% in July. September performance expected to improve to 13.9%. Data is currently being reviewed through both OPTICA and EPR to determine whether this reflects a genuine performance change or improved recording and richer data capture.

Osbourne, Sheridan
24/09/2026 08:40:12

Finance & Performance

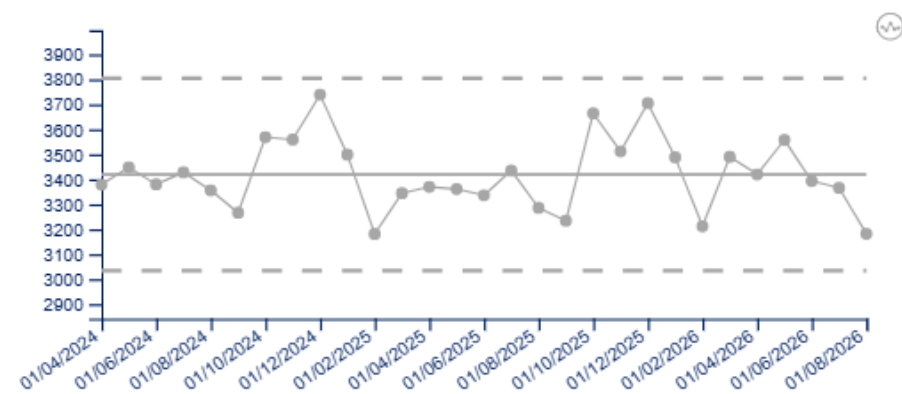
Ambulance Arrivals



BTHFT
Business
Intelligence

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	3,419	3,182	3,366	-184

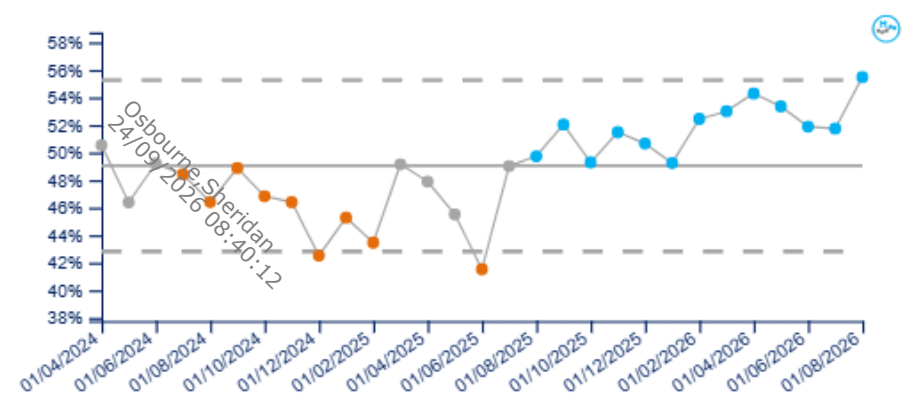
Ambulance Arrivals



Shift Trend: None – no improvement direction applied

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	49.0%	55.5%	51.7%	+3.7

% Ambulance Handover <15 Mins



Latest Commentary

2026-Jun
Ambulance -
Arrivals
Target
Analysis

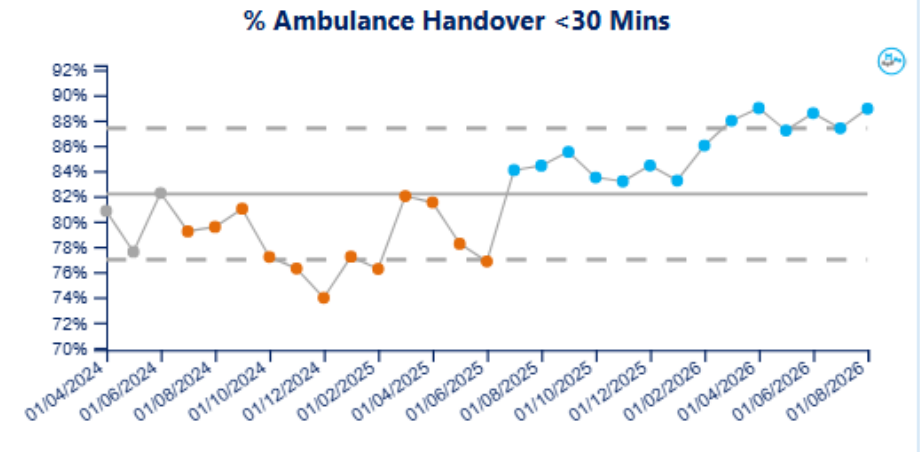
N/A
Within control limits

Latest Commentary

2026-Aug
Ambulance -
Handover <15 min
Analysis

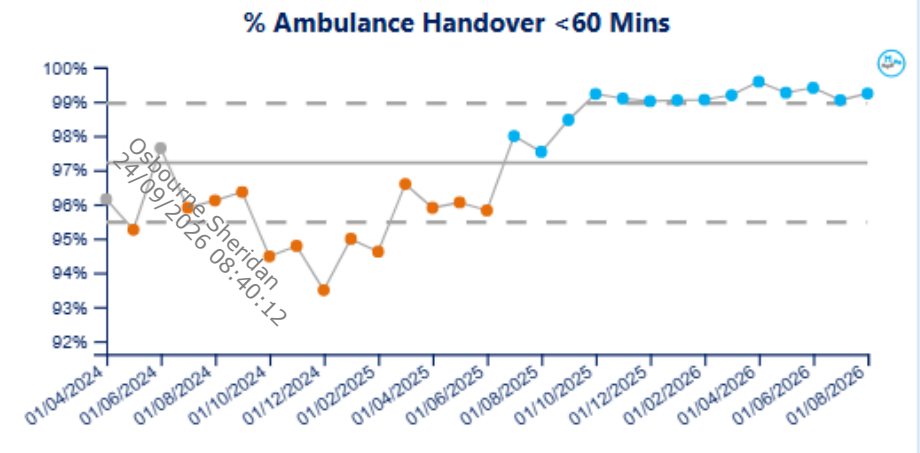
15-minute handover performance improved to 55.4% in August (51.7% July), with reduced bed waits and bed blocks supporting improved patient flow. The CSU continues to prioritise escalation of flow and bed capacity issues. Weekday live validation (Mon–Fri, 09:00–17:00) continues to improve data quality - validated delays reducing to 11 in August, compared to 32 in July. Seven-day validation remains a priority to strengthen oversight, accuracy and timely identification of delays.

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	82.2%	88.9%	87.4%	+1.6 



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

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	97.2%	99.2%	99.0%	+0.2 



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

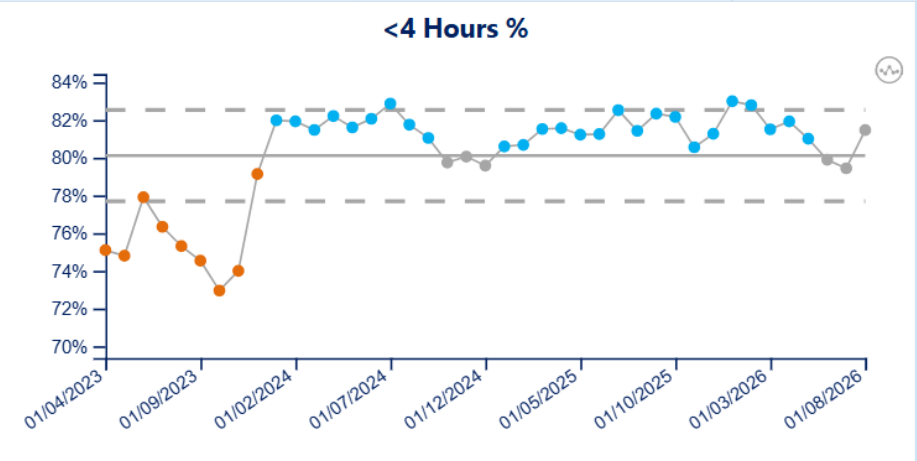
Latest Commentary

2026-Jun	
Ambulance - Handover <30 min	
Target	N/A
Analysis	Performance sustained at improved levels

Latest Commentary

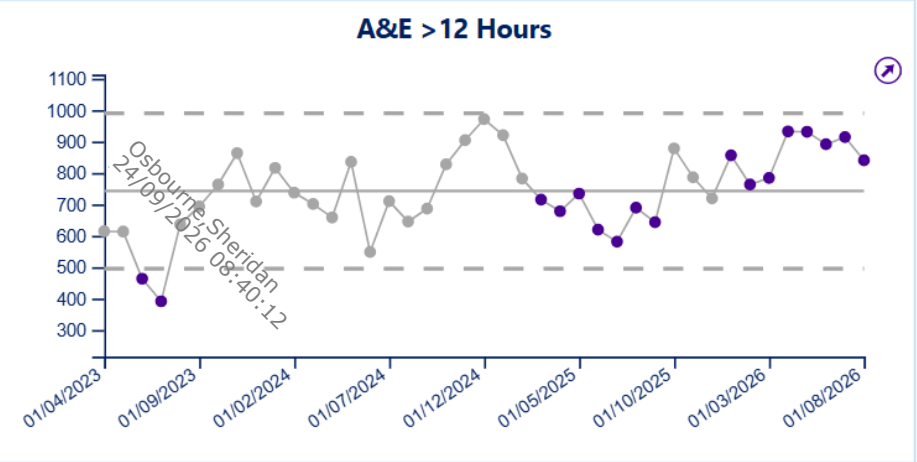
2026-Jun	
Ambulance - Handover <60 min	
Target	N/A
Analysis	Performance sustained at improved levels

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	80.1%	81.5%	79.4%	+2.0



Shift Trend: None – performance remains within expected variation

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	742	840	914	-74



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

Latest Commentary

2026-Aug
ECS - <4 Hours %
Target
Analysis
Risks, Mitigations & Assurance
Benchmarking

Overall ECS performance has improved compared to July from 81.0% to 82.7% in August. However, remains below plan YTD.

Overall ECS performance has benefitted from improved paediatric performance during July and August, reduced attendances throughout August and changes to the current consultant/Senior Decision Maker (SDM) model and improved validation oversight

Work continues to align EXCEL workstreams with national frameworks, including Model ED, Model Discharge, EEMAC, the Model Acute Pathway and the CQC Action Plan. Rapid Assessment & Treatment (RAT) remains in place following ETM approval of the revised consultant model, with roles and responsibilities under review. Work is also underway to align RAT, Amber Zone and EEMAC into a single patient pathway, strengthening senior clinical oversight and ED flow.

Performance is close to upper decile for August

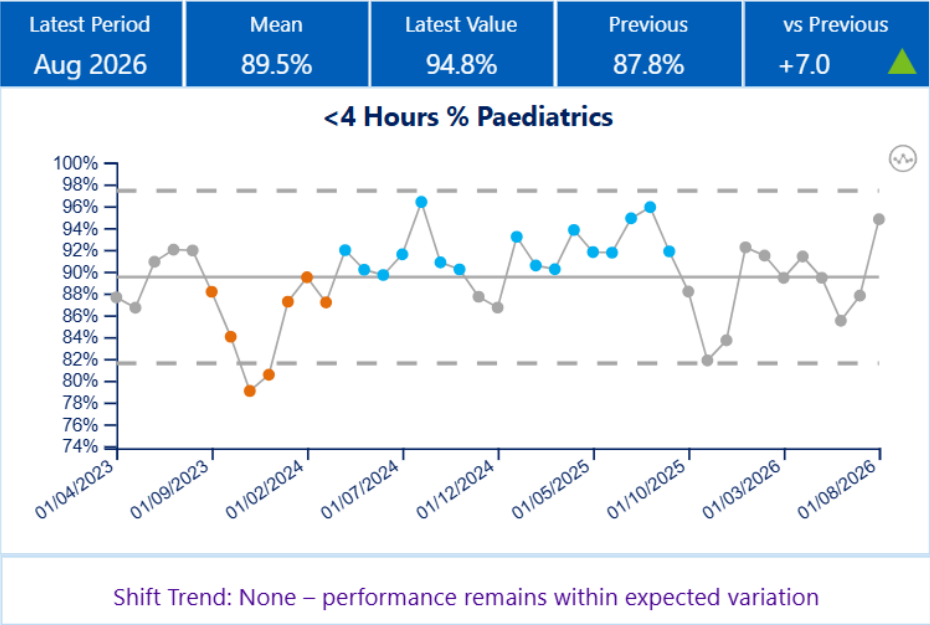
Latest Commentary

2026-Aug
ECS - A&E > 12 Hours
Target
Analysis
Risks, Mitigations & Assurance

Performance remained worse than target

Similar to ECS 4-hour plus challenges with bed waits for key admission areas

Key focus of operational teams and the EXCEL programme. Actions to improve flow into admission areas progressing. SOP reviewed and validation process monitored with feedback to teams to aid improvement through learning.



Latest Commentary	
2026-Aug ECS - <4 Hours % Paediatrics Target Analysis	Performance has improved but is below target T&F group focussed on actions to address drop in performance. Impact visible and if sustained could provide recovery to NHSE planning target in September.

Osbourne Sheridan
24/09/2026 08:40:12



Bradford Teaching Hospitals
NHS Foundation Trust

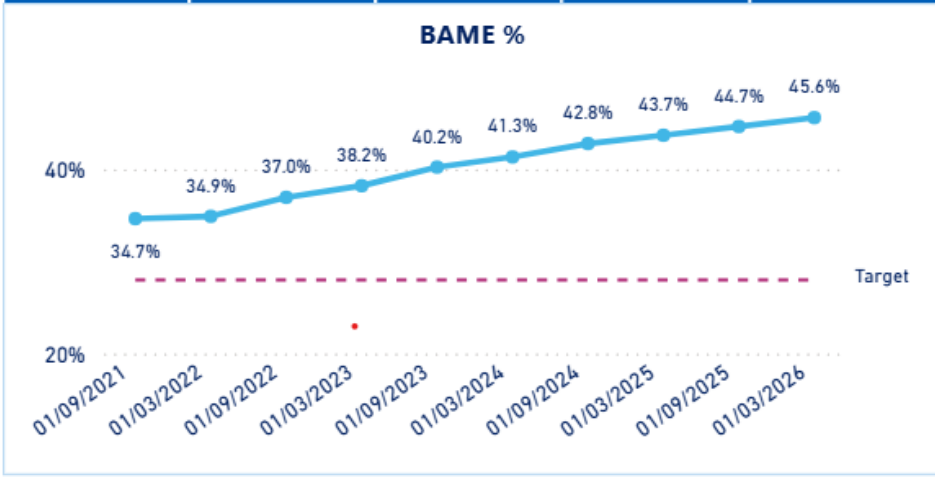
Integrated Performance Report

People - August 2026

Osbourne, Sheridan
24/09/2026 08:40:12

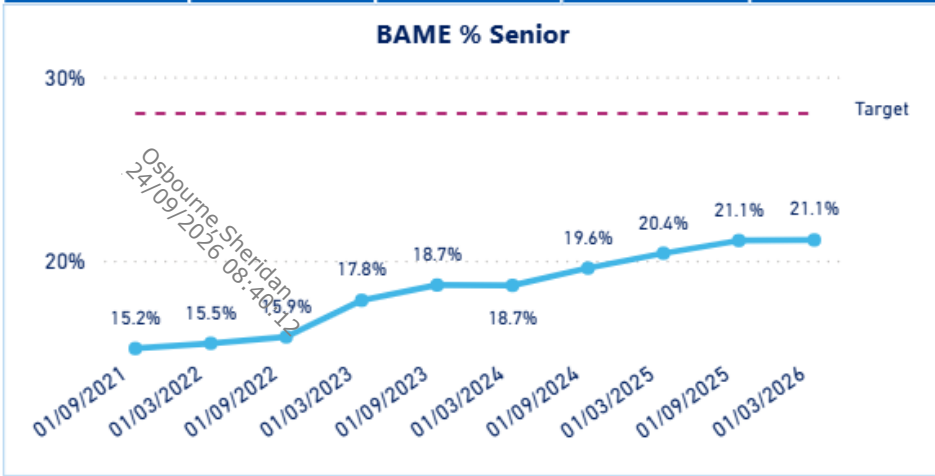


Latest Period	Target	Latest Value	vs Target	vs Previous
Mar 2026	28.0%	45.6%	+17.6 ▲	+1.0 ▲



Neutral Metric - Performance is 5.3% above average

Latest Period	Target	Latest Value	vs Target	vs Previous
Mar 2026	28.0%	21.1%	-6.9 ▼	0.0 ▲



Neutral Metric - Performance is 2.7% above average

Latest Commentary

2026-Mar
BAME - BAME %
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%).

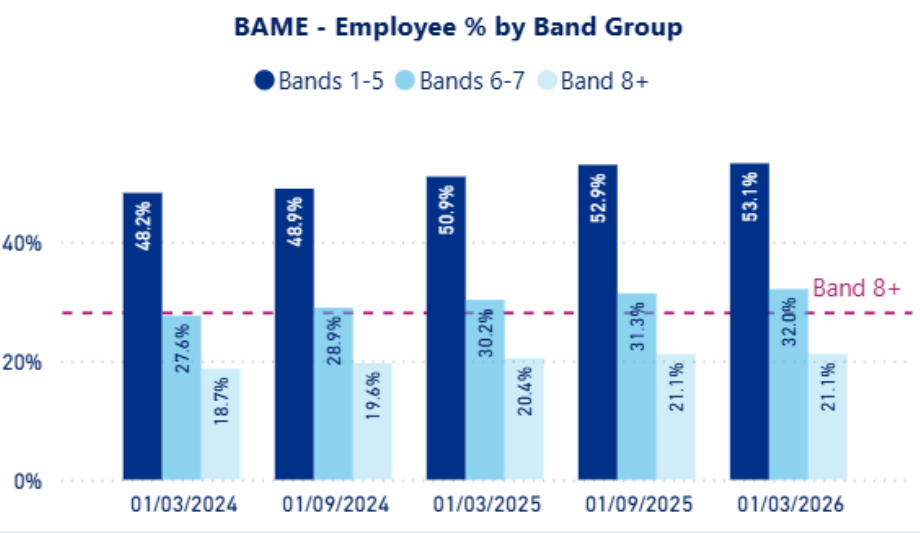
Latest Commentary

2026-Mar
BAME - BAME
Senior %
Analysis

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. We have also seen a 1% decrease (from 72% to 71%) of women represented at more senior levels (Bands 8a+/ VSM).

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.

Latest Period	1-5 vs Prev	6-7 vs Prev	8+ vs Prev	Band Gap
Mar 2026	+0.2	+0.7	0.0	32.0%



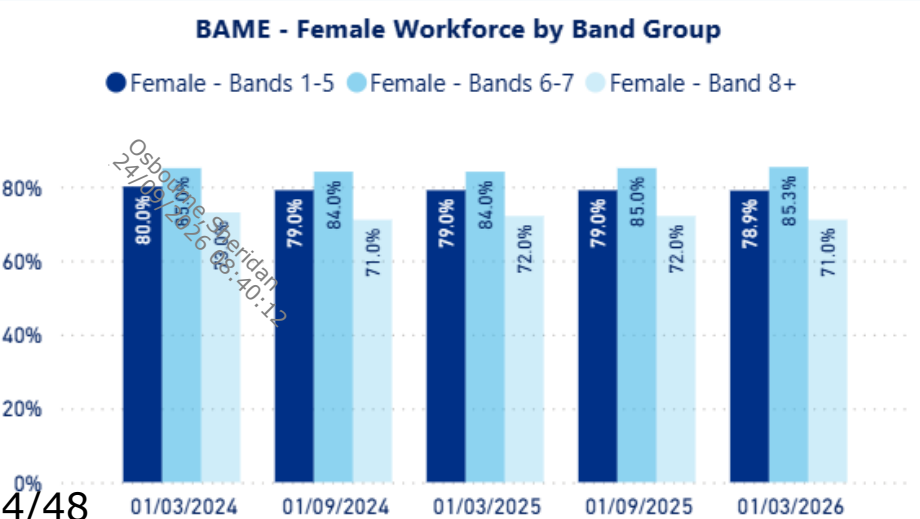
Latest Commentary

2026-Mar
BAME - Employee %
by Band Group
Analysis

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. We have also seen a 1% decrease (from 72% to 71%) of women represented at more senior levels (Bands 8a+/ VSM).

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Latest Period	1-5 vs Prev	6-7 vs Prev	8+ vs Prev	Band Gap
Mar 2026	-0.1	+0.3	-1.0	7.9%



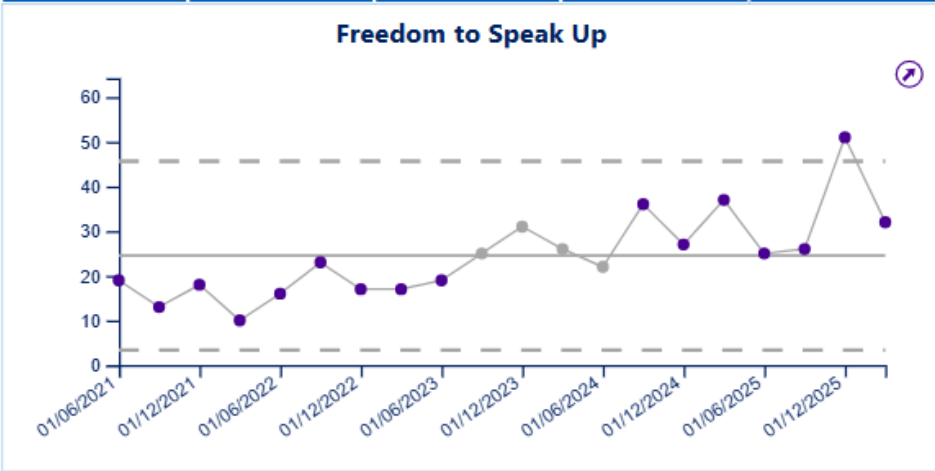
Latest Commentary

2026-Mar
BAME - Female
Workforce by Band
Group
Analysis

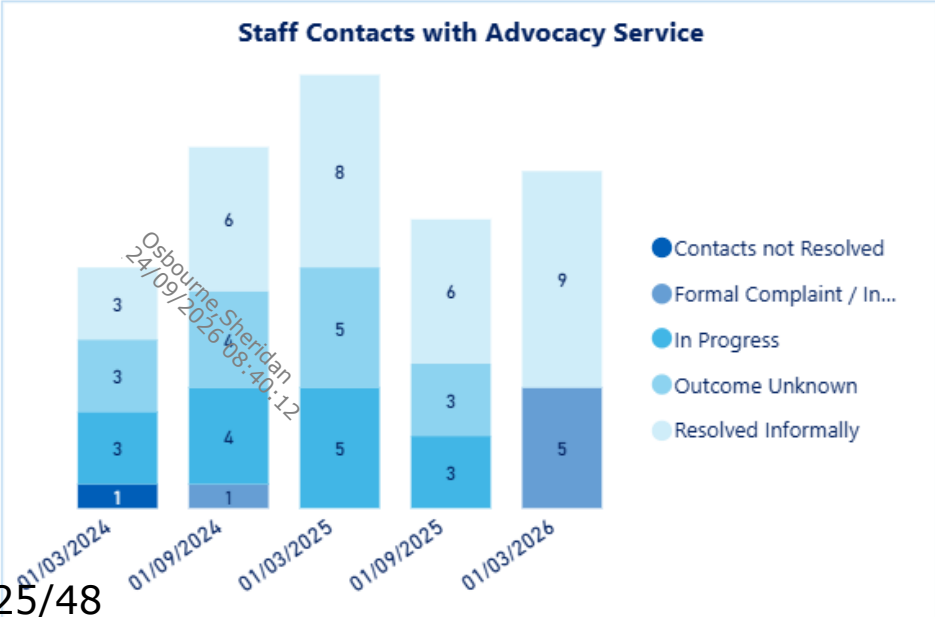
With 77% women in the workforce as a whole; women continue to be over-represented in the lower to middle bands (with no change over the last 6-months)

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.

Latest Period	Mean	Latest Value	Previous	vs Previous
Mar 2026	25	32	51	-19



Shift Trend: None – performance remains within expected variation



Latest Commentary

2026-Mar
FTSU - Freedom to
Speak Up
Analysis

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.

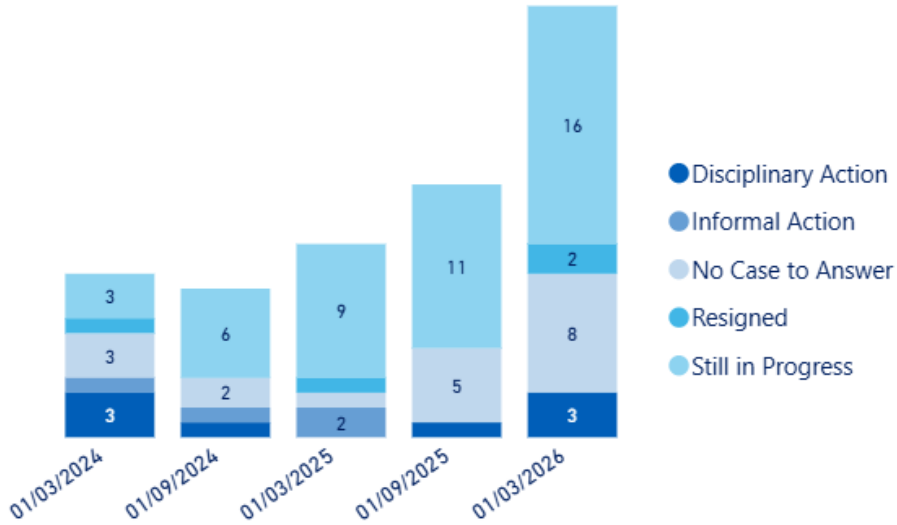
Latest Commentary

2026-Mar
Staff Contacts with
Advocacy Service
Analysis

Risks, Mitigations &
Assurance

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. 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.

Harassment & Bullying



Latest Commentary

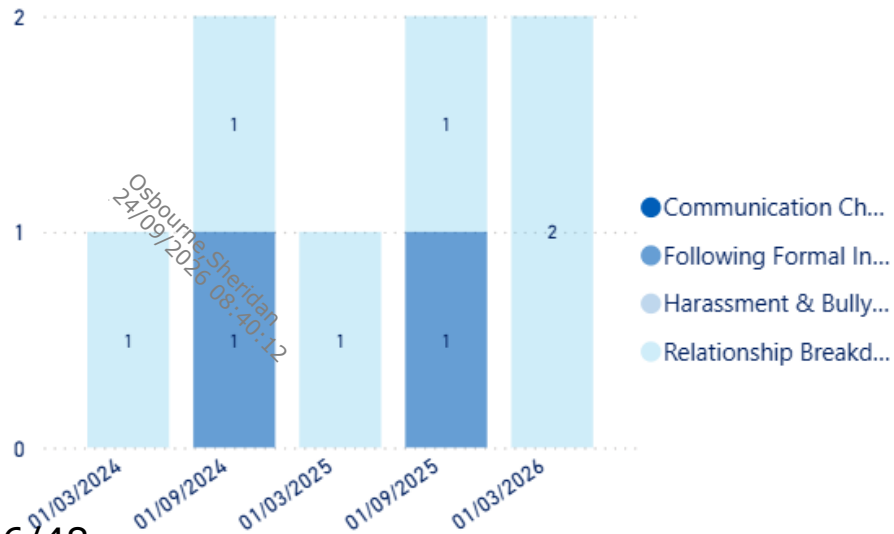
2026-Mar
H&B - Harassment & Bullying
Analysis

Risks, Mitigations & Assurance

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.

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.

Mediation Service Contacts



Latest Commentary

2026-Mar
Mediation - Mediation Service
Contacts
Analysis

Risks, Mitigations & Assurance

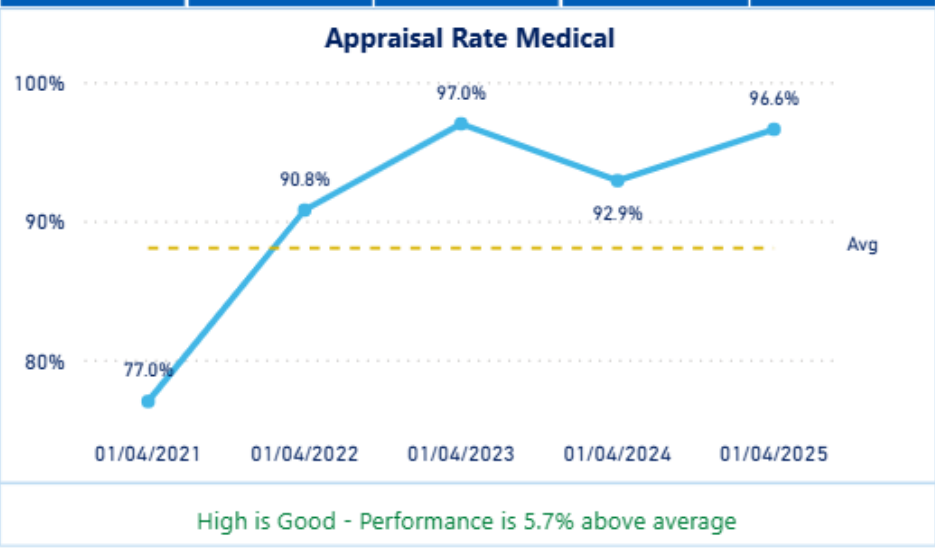
2 mediations have taken place since the last update (with successful outcomes for all parties). 1 further case is still ongoing and there were 2 further cases that did not go to mediation as after initial discussions, they were resolved outside the process.

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.

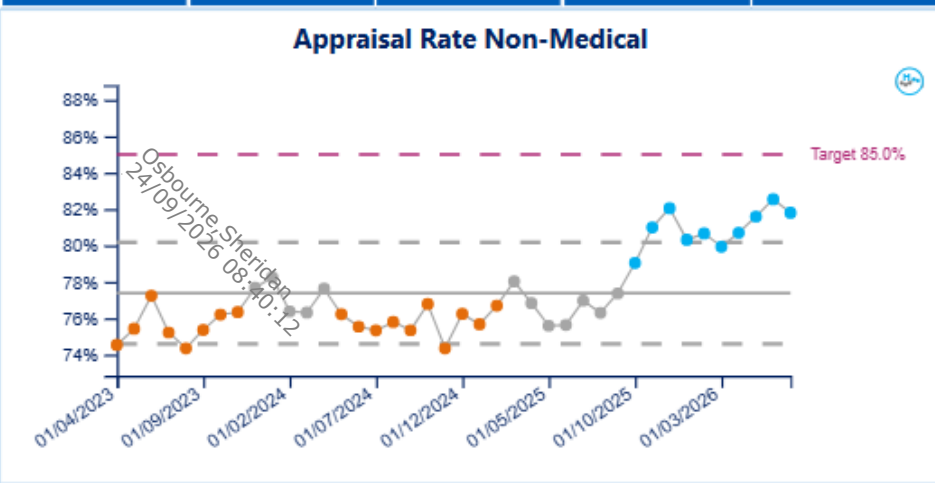
People

Appraisal Rate Medical & Non-Medical

Latest Period	Avg	Latest Value	Previous	vs Previous
Apr 2025	90.9%	96.6%	92.9%	+3.7 ▲



Latest Period	Target	Latest Value	vs Target	vs Previous
Jul 2026	85.0%	81.8%	-3.2 ▼	-0.7 ▼



27/48 Trend: Improvement – performance above average for 7 consecutive periods

Latest Commentary

2026-Apr
Appraisal Rate -
Medical
Analysis

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).

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.

Latest Commentary

2026-Jul
Appraisal Rate -
Non-Medical
Analysis

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.

The OD team have completed an internal audit to ensure consistency and compliance with Dynamic Conversations and Dynamic Conversation Appraisals. Over 100 colleagues participated and bespoke training sessions are being offered in areas where the incorrect process is being used or there is variability in quality. Audit Yorkshire have also commenced their audit of non-medical appraisals and sampling is underway.

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%)

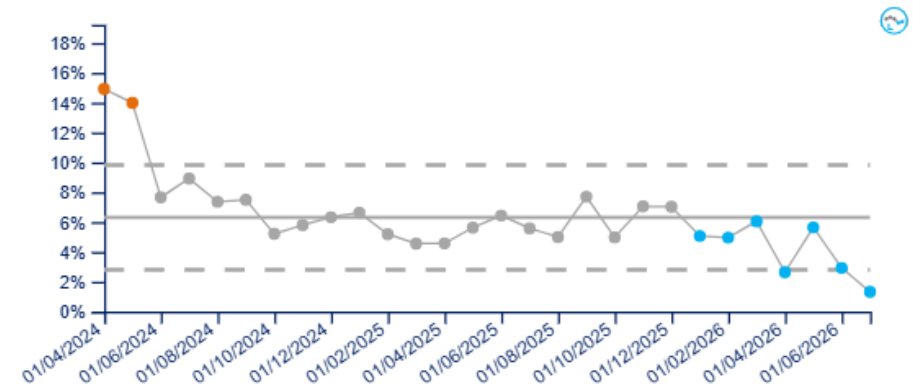
People

Nursing Fill Rates



Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	6.3%	1.3%	2.9%	-1.6

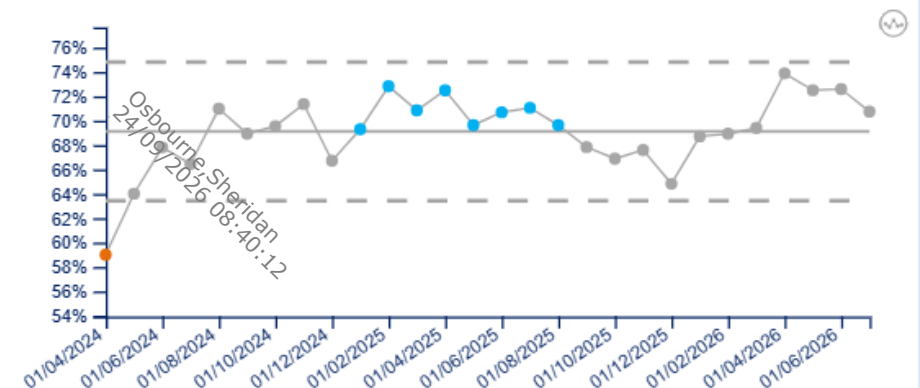
Nursing Agency Fill Rate %



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

Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	69.1%	70.8%	72.6%	-1.8

Nursing Bank Fill Rate %



28/48 Shift Trend: None – performance remains within expected variation

Latest Commentary

2026-Jul

**Nursing Fill Rates -
Nursing Agency Fill
Rate**

Target

0.53

Analysis

Agency shifts filled for July 2026 were 48. This is split 48 registered and 0 unregistered staff. Out of the 48 filled registered shifts, 21 were filled with registered theatre staff. There has been a decrease in Nursing agency from 5.6% in May to 1.3% in July. Unregistered remains at zero agency usage.

Risks, Mitigations &
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 for the Nursing Workforce Lead.

Latest Commentary

2026-Jul

**Nursing Fill Rates -
Nursing Bank Fill
Rate**

Analysis

In July, the total number of requests sent to bank was 8714 compared with May requests of 8842 an increase of 128 requests. This is split for July was 3641 requests for registered staff and 5073 requests for unregistered staff. Of those 3641 registered requests a total of 2576 were filled by bank staff which is 70.8% of requested compared with 72.5% in May a decrease of 1.7%. Out of the 5073 requests for unregistered staff 3691 were filled by bank which is 72.8% compared to May which was 69.2% an increase of 3.6% against requests.

Risks, Mitigations &
Assurance

The high bank usage is in part the result of vacancies. If the 171 HCA and 80 RN vacancies were filled that would equate to around 37,650 hours in bank reduction. This would remove 25,650 hours from unregistered use and 12,000 hours from registered bank use. On average this would be 2,331 shifts for unregistered and 1,090 for registered staff.

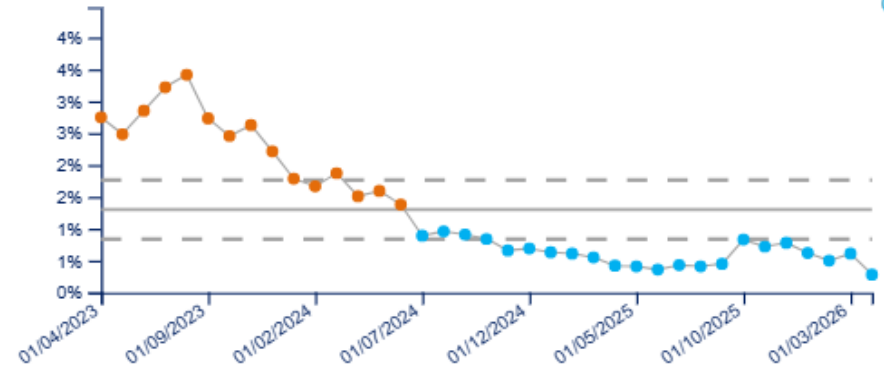
People

Agency & Staff Sickiness



Latest Period	Mean	Latest Value	Previous	vs Previous
Apr 2026	1.3%	0.3%	0.6%	-0.3

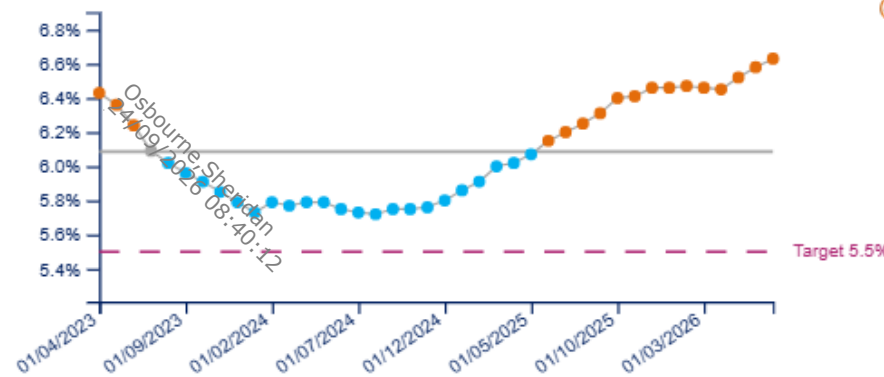
Agency %



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

Latest Period	Target	Latest Value	vs Target	vs Previous
Jul 2026	5.5%	6.6%	+1.1	+0.1

Staff Sickiness



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

Latest Commentary

2026-Jul
Agency - Agency %
Target
Analysis

0.64

Overall, Trust wide there has been a decrease agency use from 29.13 WTE in June to 22.29 WTE in July 2026 . There have been decreases in the following areas:-
Unplanned Services, Planned Services, Estates and Facilities.

With increases in the following area:-
Diagnostic & Corporate Operational Services.

Using no agency are the following areas:-
Research and Corporate Services

Risks, Mitigations & 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.

Latest Commentary

2026-Jul
Staff Sickiness
Analysis

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 year-to-date figure for the Trust as at July 2026 stands at 6.63%, which is slightly higher than in June 2026 at 6.58%. The staff groups with the highest sickness rates at July 2026 are Additional Clinical Services at 11.23%, Estates & Ancillary at 9.46%, Admin & Clerical at 6.91%, Add Prof Scientific & Technic at 6.82%, Nursing and Midwifery at 6.27%. The only staff groups whose sickness remains below target in July 2026 were Allied Health Professionals at 4.45%, Healthcare Scientists and Medical & Dental with rates of 1.24%, 3.76% respectively. The overall YTD sickness % has remained consistently above 5.5%.

Risks, Mitigations & Assurance

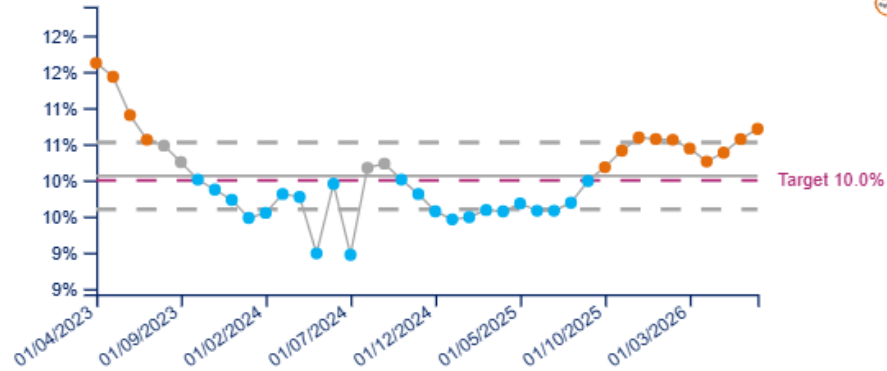
A new Health Wellbeing & Attendance Policy has been introduced as from the 01 July 2026. Sickness action plans have been designed to support CSU's to reduce their sickness rates in line with their overall sickness targets for April 2027, with key strategies and timeframes. As part of the new policy training sessions are being held monthly. Bespoke training will be provided as and when required. Briefing sessions have been undertaken regarding the new policy and 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 trigger points, 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.

People

Staff Turnover & Stability

Latest Period	Target	Latest Value	vs Target	vs Previous
Jul 2026	10.0%	10.7%	+0.7 ▲	+0.1 ▲

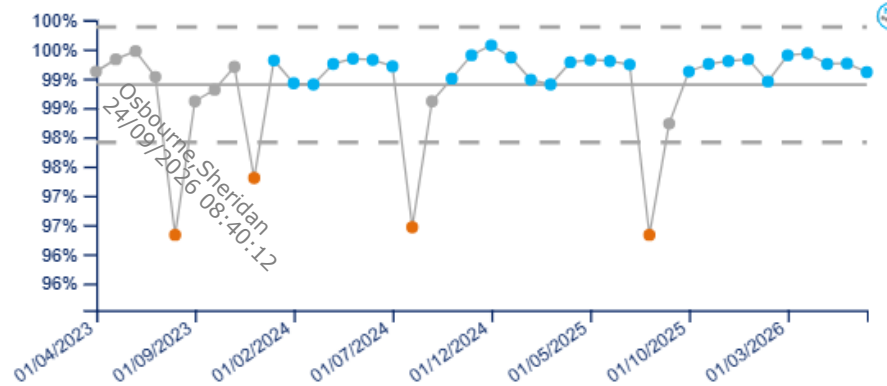
Staff Turnover



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

Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	98.9%	99.1%	99.3%	-0.2 ▼

Staff Stability



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

Latest Commentary

2026-Jul Staff Turnover Analysis

Whilst turnover rates have improved over the last 2 years, we have seen a slight increase in turnover since July 2025. As at July 2026, the Trust turnover rate was at 10.71%, the highest turnover rate was within Estates and Facilities at 13.90%, followed by Research at 12.40%, Diagnostics and Corporate Operational Services at 10.85%, Unplanned Services at 10.46%, and then Planned Care at 10.01%.

Latest Commentary

2026-Jul Staff Stability Analysis

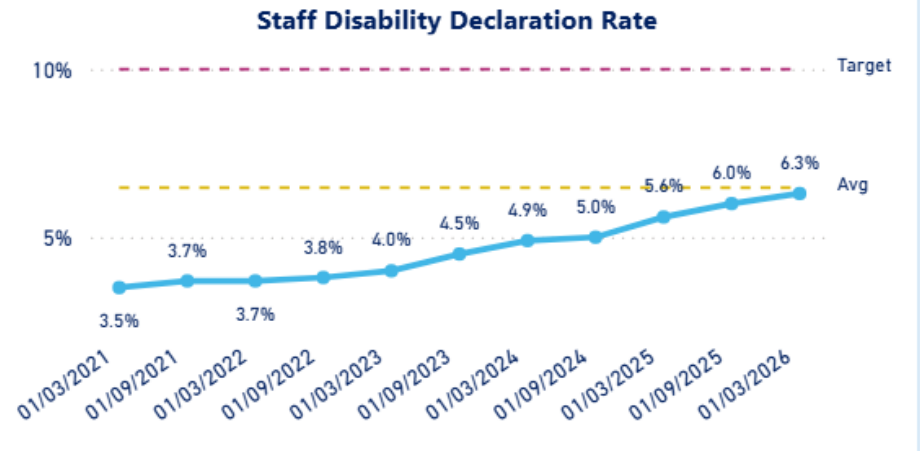
The stability index shows the percentage of all colleagues including rotational doctors and fixed-term appointments who are still in post at the end of the month and who were in post at the start of the month. Following a slight reduction to 99% in February 2026 due to changeover of rotational doctors, the stability index for July 2026 is marginally lower than May but remains above the February low.

People

Disability Declaration & Training

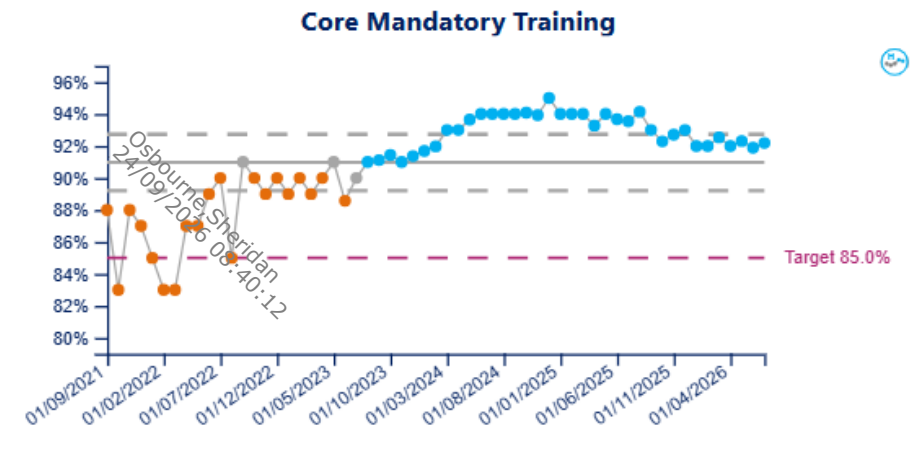


Latest Period	Target	Latest Value	vs Target	vs Previous
Mar 2026	10.0%	6.3%	-3.7 ▼	+0.3 ▲



Neutral Metric - Performance is 1.7% above average

Latest Period	Target	Latest Value	vs Target	vs Previous
Jul 2026	85.0%	92.2%	+7.2 ▲	+0.3 ▲



Latest Commentary

2026-Mar Disability Declaration - Declared Yes

Analysis

Risks, Mitigations &
Assurance

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%.

Disability Declaration: Whilst the 2024 staff 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.

Latest Commentary

2026-Jul Core Mandatory Training

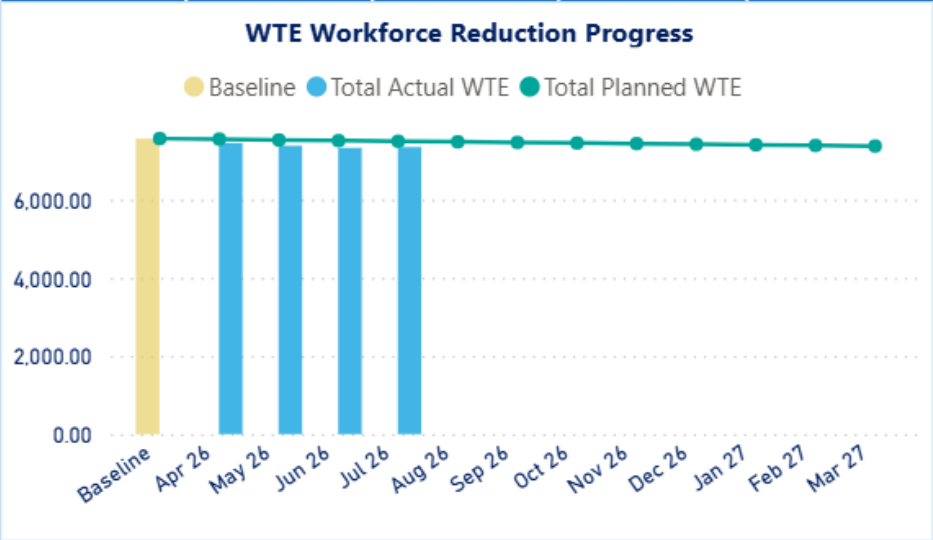
Analysis

Overall compliance for August was 92%, no change from last month. The majority of subjects maintained compliance from last month. Fire Safety saw a 2% decrease and Basic Life Support saw a 1% decrease. Compliance for all subjects over the month of August did not see much improvement due to multiple factors such as planned leave and reduced activity.

Estates & Facilities compliance for core mandatory training has reached 92%, with a 2% improvement from last month.



Latest Period	Baseline	Actual	vs Plan	vs Previous
Jul 2026	7,561.96	7345.26	-149.69 ▼	+19.73 ▲

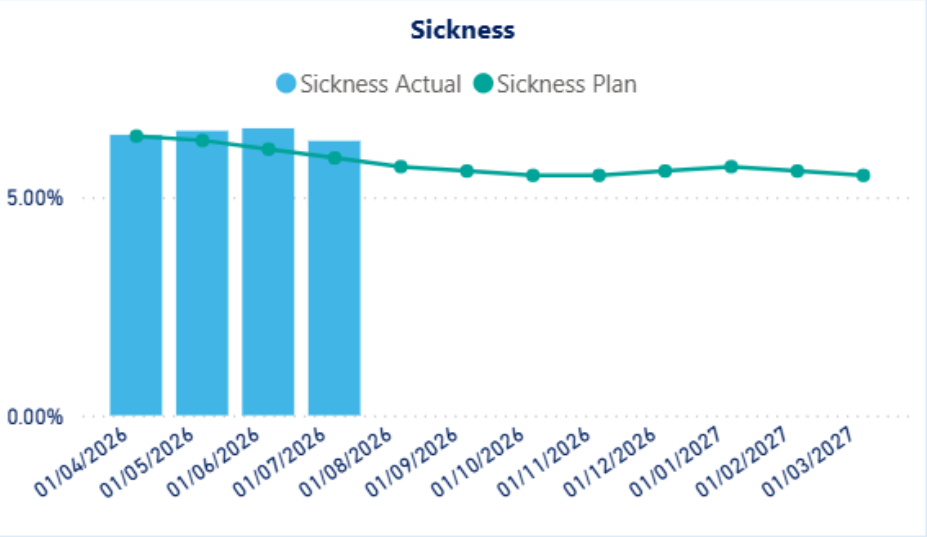


Latest Commentary	
2026-Apr	
WTE - Workforce Reduction Progress	
Target	-
Analysis	-
Risks, Mitigations & Assurance	-
Benchmarking	-

KPI	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)	7,556.63	7,549.38	7,525.79	7,510.37	7,494.95	7,479.53	7,464.11	7,448.69	7,433.27	7,417.85	7,402.43	7,387.01	7,371.59
Substantive WTE (Actual)	6,778.20	6,752.55	6,723.25	6,699.57	6,668.02								
Bank staff WTE (Actual)	748.00	659.95	621.08	596.82	654.95								
Agency staff WTE (Actual)	35.76	38.27	35.31	29.14	22.29								
Total Actual WTE	7,561.96	7,450.77	7,379.64	7,325.53	7,345.26								
Variance	(5.33)	98.61	146.15	184.84	149.69								

People
Sickness (Plan vs Actual)

Latest Period	Actual	Plan	vs Plan	vs Previous
Jul 2026	6.29%	5.90%	-0.39% ▲	-0.29% ▼



Latest Commentary	
2026-Apr	
Sickness - Sickness Plan vs Actual	
Target	-
Analysis	-
Risks, Mitigations & Assurance	-
Benchmarking	-

KPI	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
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 (Actual)	6.43%	6.52%	6.58%	6.29%								
Variance	-0.03%	-0.22%	-0.48%	-0.39%								



Bradford Teaching Hospitals
NHS Foundation Trust

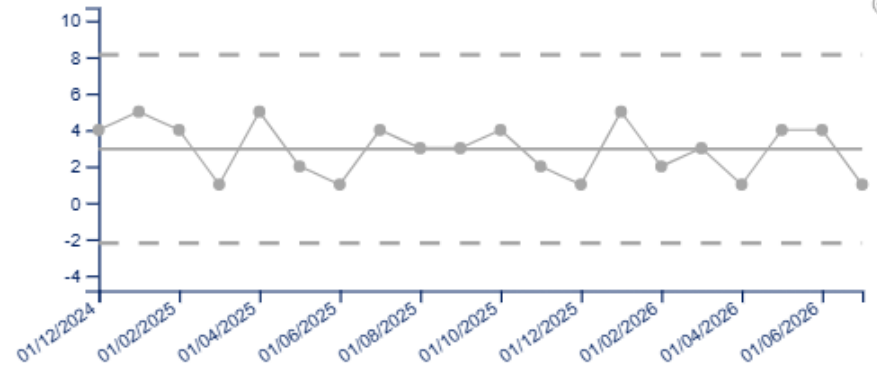
Integrated Performance Report

Quality - August 2026

Osbourne, Sheridan
24/09/2026 08:40:12

Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	3	1	4	-3 ▼

C. Difficile



Shift Trend: None – performance remains within expected variation

Latest Commentary

2026-Jul
IPC - C. Difficile
Analysis

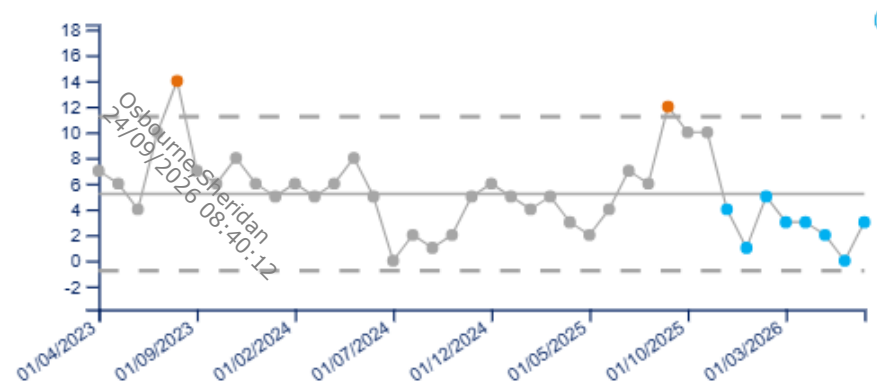
The number of HOHA (Healthcare Onset Healthcare associated) C. diff infections have been consistant since December 2024 with no significant increase in numbers. Only one case of HOHA was idfentified in July 2026. The review of cases was carried out. Different ribotypes have been identified in the recent 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

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

Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	5	3	0	+3 ▲

E. Coli



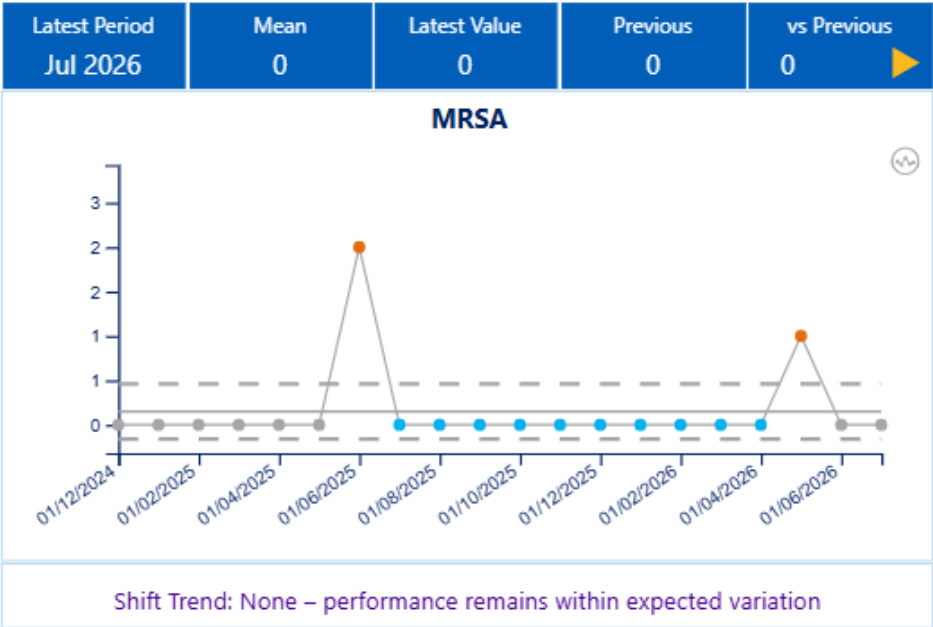
Latest Commentary

2026-Jul
IPC - E. Coli
Analysis

The number of HOHA E. coli has been consistantly low since December 2025 after a task and finisgh group was craeted to review practices.

Risks, Mitigations & Assurance

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



Osbourne, Sheridan
24/09/2026 08:40:12

Latest Commentary	
2026-Jul IPC - MRSA Analysis	Only one case of healthcare Onset- Healthcare associated case of MRSA has been identified in last 12 months. The single case was identified in May 2026.
Risks, Mitigations & Assurance	Bacteraemia Reduction plan A comprehensive improvement plan updated regularly Immediate review of bacteraemia cases for quick learning Triangulation of cases using PSIRF Preparing for ANTT accreditation Updated SOP for Central Venous Access devices (CVAD) Support Gloves off Campaign Hydration improvement project Audits of Octenisan compliance (IRIS on non-compliance) Addition of a tool to ask patients about Octenisan bath

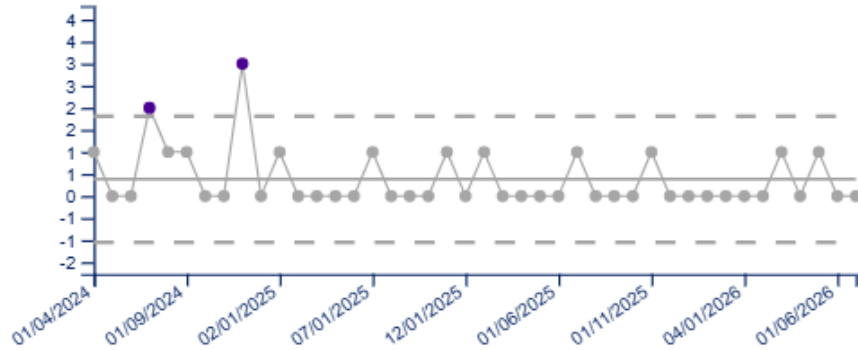
Quality

Cooling Babies & Stillbirths



Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	0	0	0	0

Cooling Babies



Latest Commentary

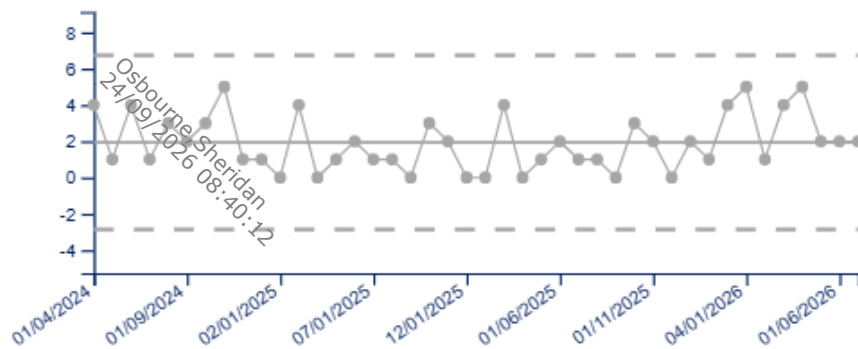
2026-Jul
Cooling Babies
Analysis

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
Jul 2026	2	2	2	0

Stillbirths

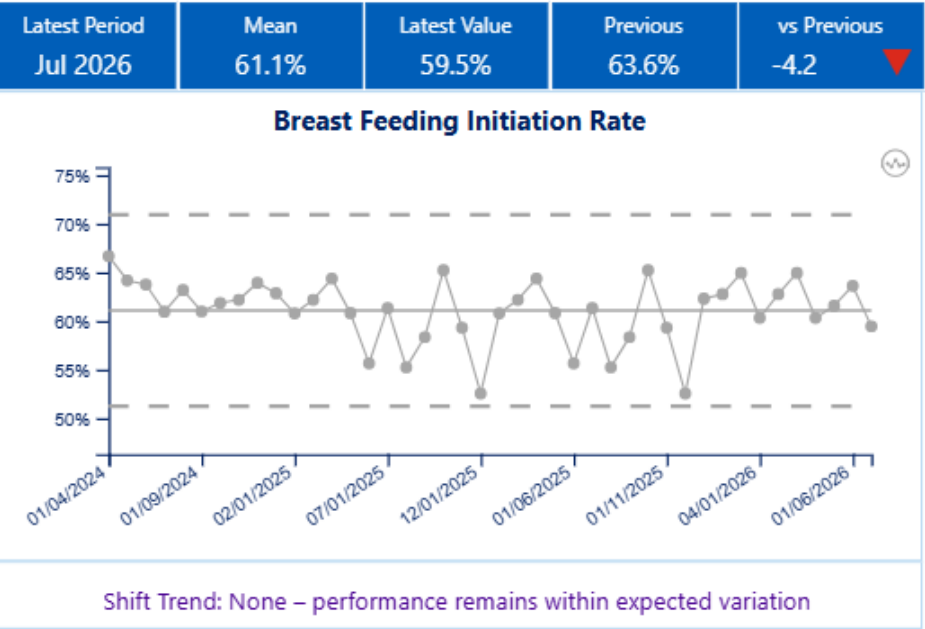


Latest Commentary

2026-Jul
Stillbirths
Analysis

Stillbirths continue to be monitored and reported on a monthly basis. Each baby is subject to a Perinatal Mortality Review Tool (PMRT), local MDT case review, and any intrapartum stillbirth of a term baby is referred to MNSI for independent investigation.

A thematic, MDT, table top review of all stillbirths occurring January to March 2026, was undertaken in April, due to a notable increase in the first quarter of the year. External peer support, service user involvement, Executive and Non-Executive colleagues attended the review and could not determine any significant themes. The group concluded that the 2025 rate was likely the anomaly, and 2026 is in line with 2024 rates. A series of actions/areas of focus were agreed including reissuing of previous messaging around reduced fetal movements, and use of interpreters



Latest Commentary	
2026-Jul Breast Feeding Initiation Rate Analysis	The Specialist Midwife for Infant Feeding leaves the organisation in September. The post has been appointed to, but there will be a brief gap in leadership, and a period of orientation into the new role, which will impact on progress towards reaccreditation. UNICEF BFI are aware, and accreditation has been deferred until 2027. This risk is clearly described on the Women's CSU Risk Register.

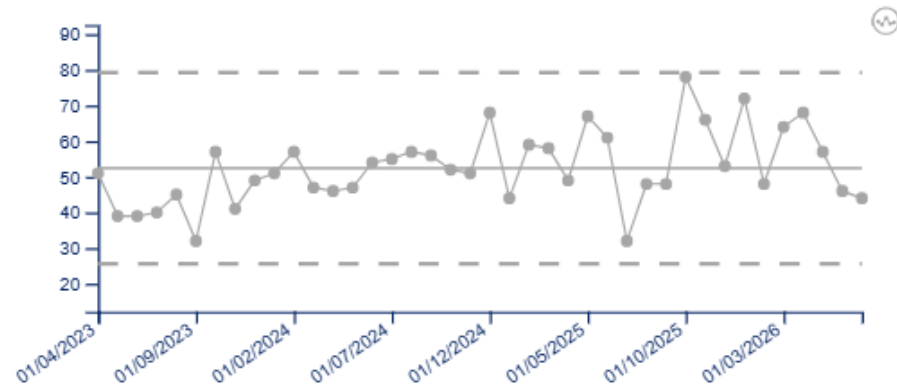
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24/09/2026 08:40:12

Quality Falls with Harm



Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	52	44	46	-2

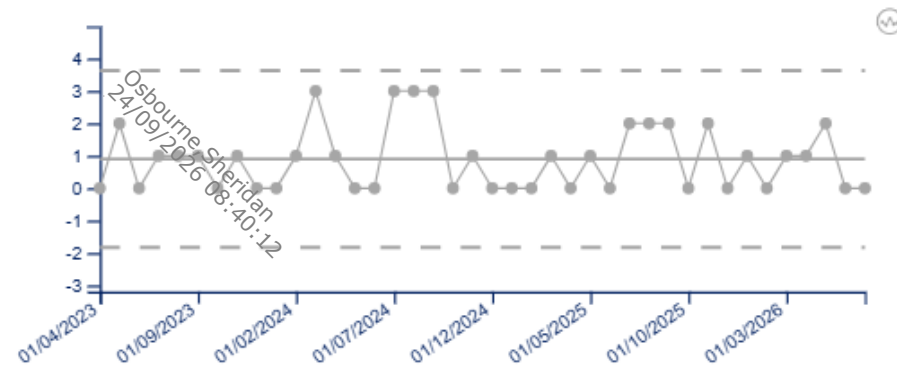
Falls with Harm



Shift Trend: None – performance remains within expected variation

Latest Period	Mean	Latest Value	Previous	vs Previous
Jul 2026	1	0	0	0

Falls with Severe Harm



Latest Commentary

2026-Jul
Falls With Harm
Analysis

Falls with harm remain within the upper and lower control limit and have shown a gradual decrease since April 2026. There were no falls with severe harm in June or July. All falls continue to be reviewed using the Royal College of Physicians hot debrief and after action review processes.

Risks, Mitigations &
Assurance

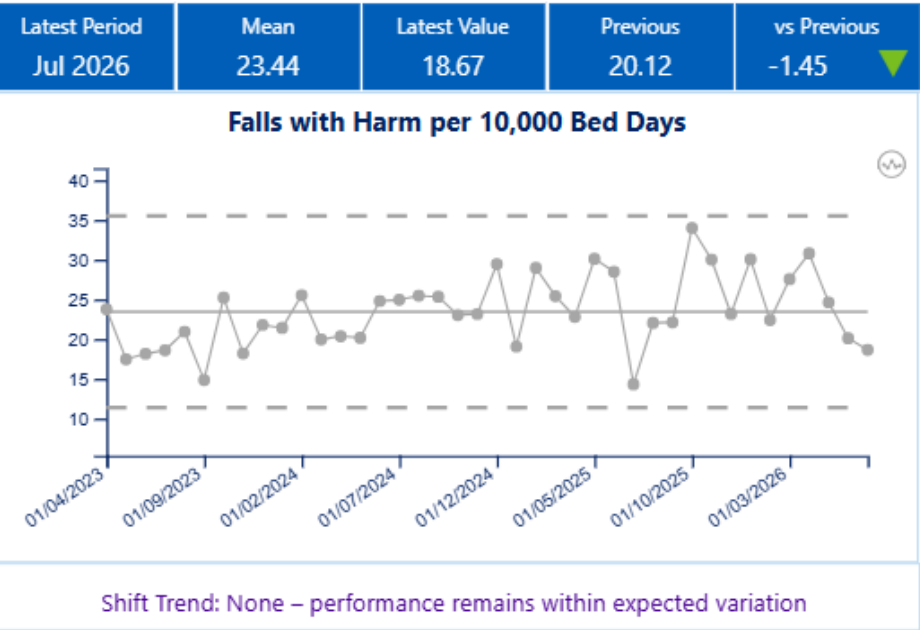
CSUs attend the Falls Improvement Group to discuss ward data and share learning identified.

Quality improvement initiatives ongoing.

Benchmarking

Falls Lead appointed.

National Audit for In Patient Falls monitoring all fractures and head injuries as a result of falls in the Trust.

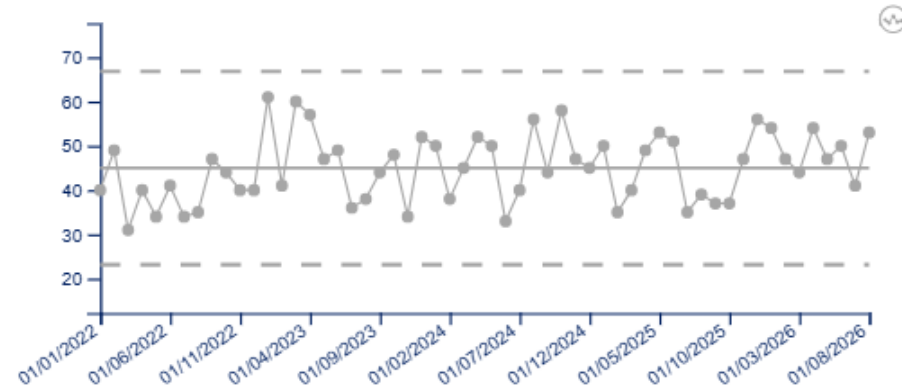


Latest Commentary	
2026-Jul Falls With Harm Analysis	Falls with harm remain within the upper and lower control limit and have shown a gradual decrease since April 2026. There were no falls with severe harm in June or July. All falls continue to be reviewed using the Royal College of Physicians hot debrief and after action review processes.
Risks, Mitigations & Assurance	CSUs attend the Falls Improvement Group to discuss ward data and share learning identified. Quality improvement initiatives ongoing.
Benchmarking	Falls Lead appointed. National Audit for In Patient Falls monitoring all fractures and head injuries as a result of falls in the Trust.

Osbourne Sheridan
24/09/2026 08:40:12

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	45	53	41	+12 ▲

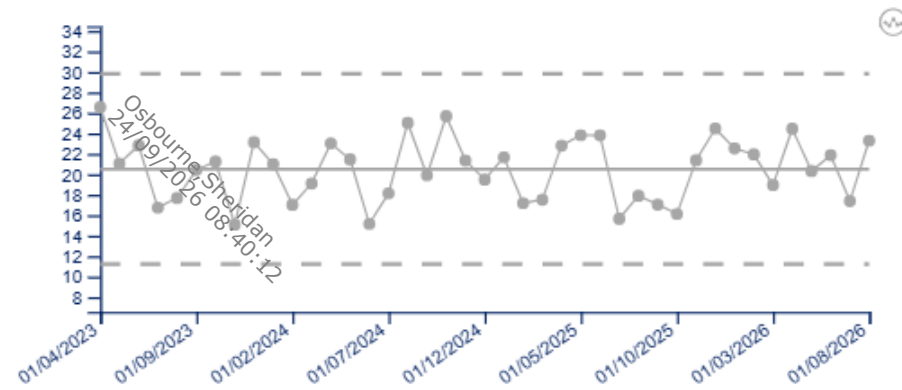
Pressure Ulcers All Categories



Shift Trend: None – performance remains within expected variation

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	20.52	23.29	17.39	+5.90 ▲

Pressure Ulcers All Categories per 10,000 Bed Days



41/48 Shift Trend: None – performance remains within expected variation

Latest Commentary

2026-Aug
Pressure Ulcers - PU
All Categories
Analysis
Risks, Mitigations & Assurance

In August 2026, the number of pressure ulcers in all categories remained within the upper and lower control limits.
Risks: accurate completion of the Trust risk assessment tool on EPR (PURPOSE T).

Mitigations: collaboration with Calderdale and Huddersfield NHS Trust to identify trasferable learning and improve compliance.

Quality Improvement work continues on wards 23, 26, 17 and AED supported by the TVN team.

Monthly pressure ulcer improvement group

Latest Commentary

2026-Aug
Pressure Ulcers - PU
All Categories Bed
Days
Analysis
Risks, Mitigations & Assurance

In August 2026, the number of pressure ulcers per 10,000 bed days remained within the upper and lower control limits.
Risks: accurate completion of the Trust risk assessment tool on EPR (PURPOSE T).

Mitigations: collaboration with Calderdale and Huddersfield NHS Trust to identify trasferable learning and improve compliance.

Quality Improvement work continues on wards 23, 26, 17 and AED supported by the TVN team.

Monthly pressure ulcer improvement group

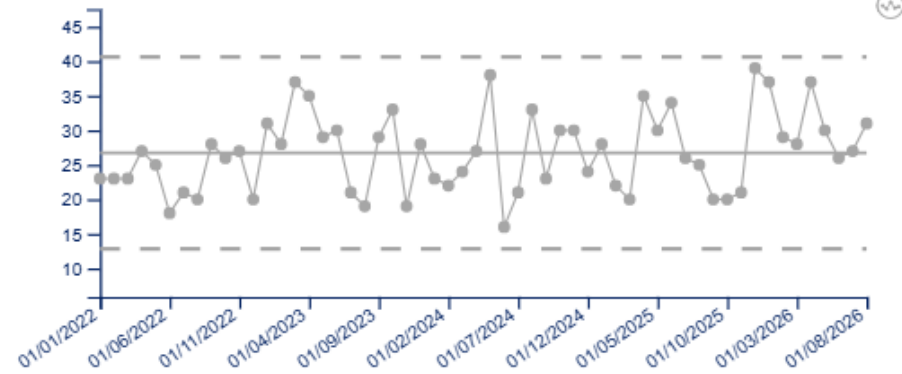
Quality

Pressure Ulcers Cat 2 & 3+



Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	27	31	27	+4

Pressure Ulcers Category 2



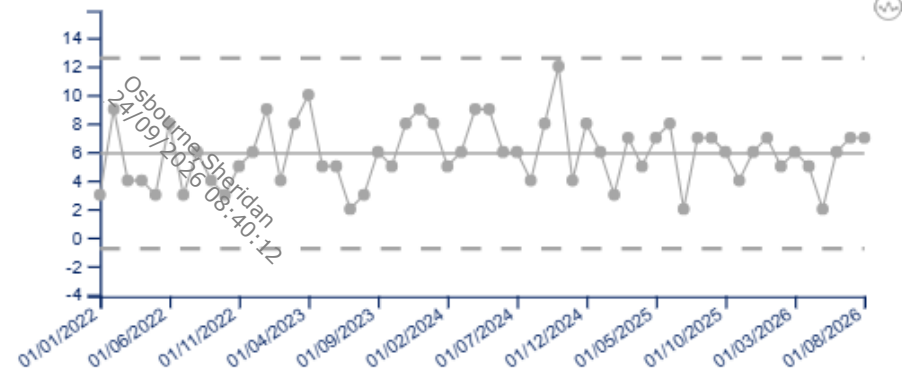
Latest Commentary

2026-Aug
Pressure Ulcers - PU
Category 2
Analysis
Risks, Mitigations &
Assurance

Category 2 pressure ulcers remained within the upper and lower control limits in August 2026. Education and training is being delivered to new and existing staff, for example, HCA bootcamp, e-learning modules and QI support.

Latest Period	Mean	Latest Value	Previous	vs Previous
Aug 2026	6	7	7	0

Pressure Ulcers Category 3+

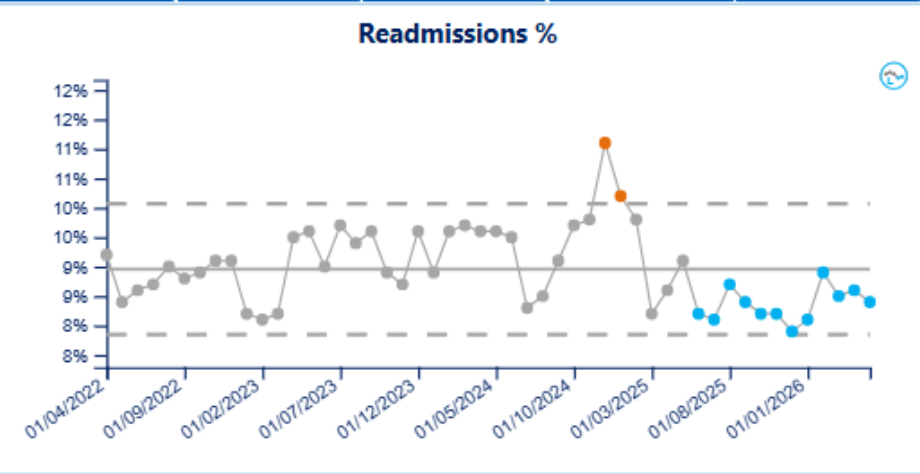


Latest Commentary

2026-Aug
Pressure Ulcers - PU
Category 3+
Analysis
Risks, Mitigations &
Assurance

Pressure ulcers category 3+ remain within the upper and lower control limits. Link nurse session on tissue viability planned for 16th September and 'Stop the pressure day' events on 19th November. Joint working with Calderdale and Huddersfield NHS Trust to improve compliance with PURPOSE T. Quality improvement projects ongoing.

Latest Period	Mean	Latest Value	Previous	vs Previous
May 2026	9.0%	8.4%	8.6%	-0.2



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.

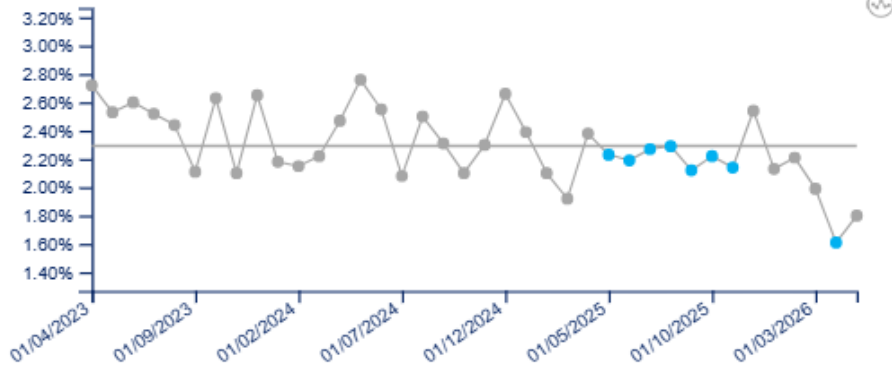
Risks, Mitigations &
Assurance

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.

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Latest Period	Mean	Latest Value	Previous	vs Previous
May 2026	2.29%	1.80%	1.61%	+0.19 ▲

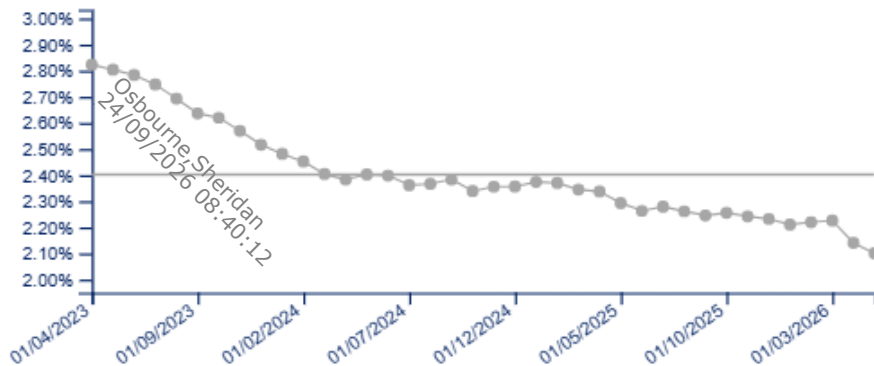
Crude Mortality (Monthly)



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

Latest Period	Mean	Latest Value	Previous	vs Previous
May 2026	2.40%	2.10%	2.14%	-0.04 ▼

Crude Mortality (Rolling 12 Months)



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

Latest Commentary

**2026-Aug
Mortality - Crude
Mortality (Monthly)**
Analysis

Our crude mortality rate increased slightly to 1.80% for the month of May 2026, the latest reported figure (reported in August 2026). This rate is lower than the national figure (2.27%) 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 Commentary

**2026-Aug
Mortality - Crude
Mortality (Rolling
12 months)**
Analysis

As a 12-month rolling average, BTHFT currently has a mortality rate of 2.10%, lower than the national average of 2.27% and well below the average for the rest of the West Yorkshire region, which has an average rate of 2.68%.

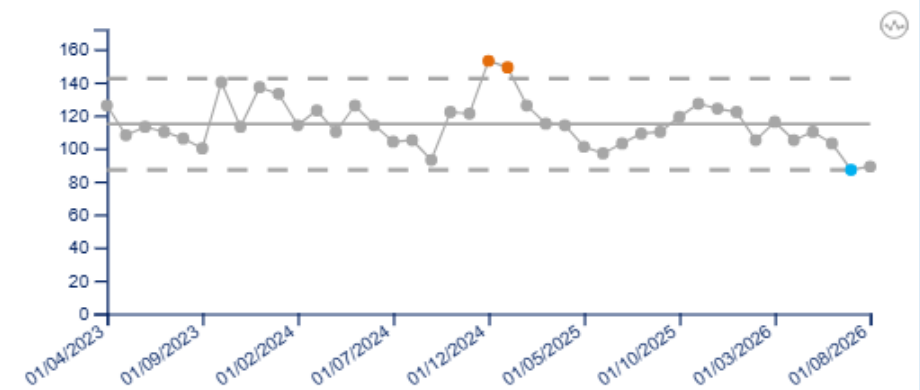
Risks, Mitigations & Assurance

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
Aug 2026	115	89	87	+2

Adult Inpatient Deaths at BTHFT



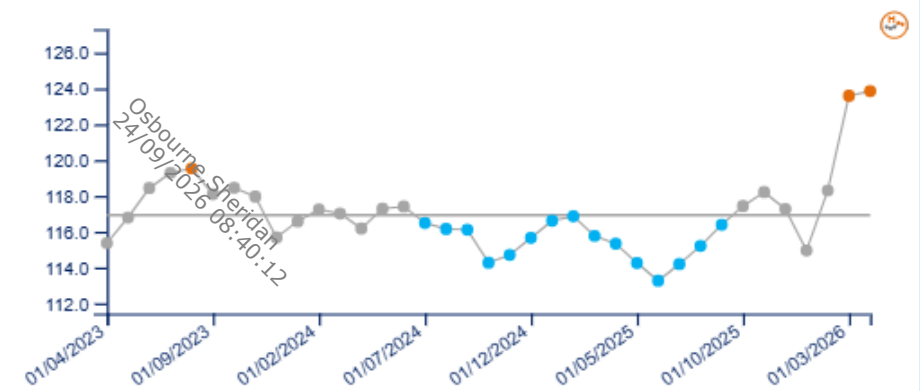
Latest Commentary

2026-Aug
Mortality - Inpatient
Deaths
Analysis

In August 2026, the Trust saw 89 adult inpatient deaths. This is a slight increase on last month but is at a far lower level than what we observe at this time of year.

Latest Period	Mean	Latest Value	Previous	vs Previous
Apr 2026	116.93	123.85	123.60	+0.26

SHMI (Rolling 12 Months)



Latest Commentary

2026-Aug
SHMI (Rolling 12
months)
Target
Analysis

100
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 123.85.

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 in the near future. Based on current analysis, the Trust is assured that this reflects a data quality issue rather than a genuine change in mortality performance.

Key to KPI Variation and Assurance Icons

Variation			Assurance			
Special cause of <u>(H)</u> igher or <u>(L)</u> ower values indicating areas of concern	Special cause of <u>(H)</u> igher or <u>(L)</u> 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

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/>

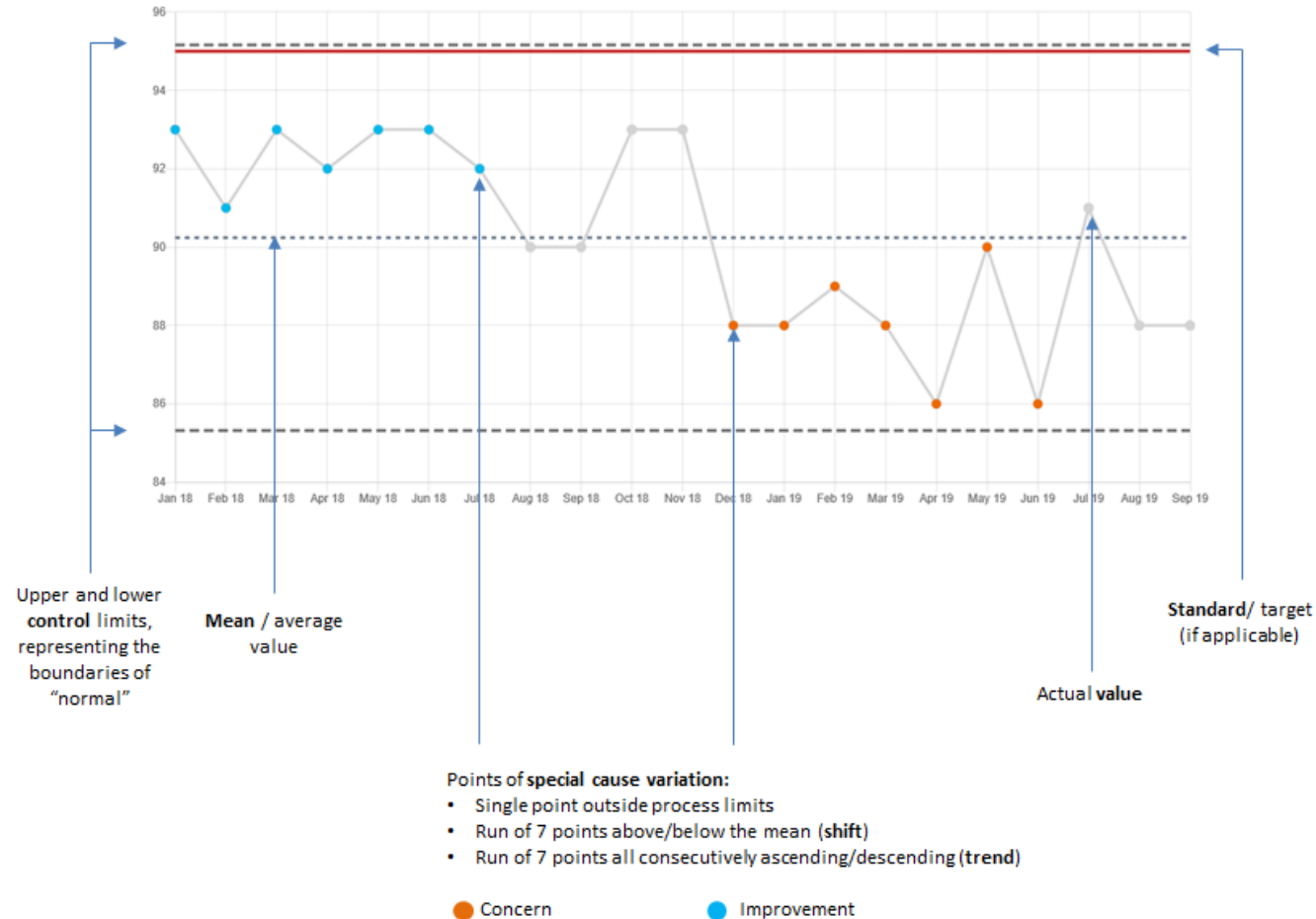
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Interpreting Statistical Process Control Charts

Guidance notes

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

SPC charts



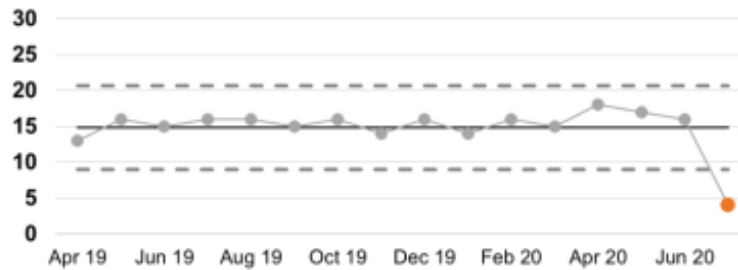
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Interpreting Statistical Process Control Charts

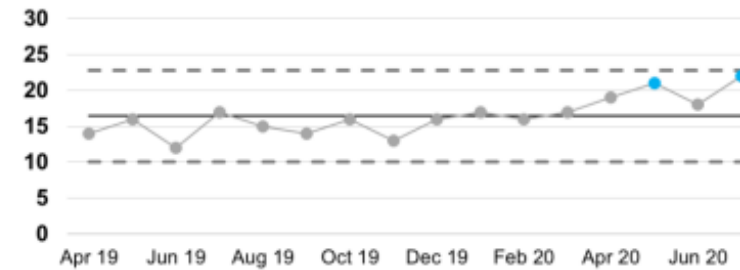
SPC rules : special cause variation



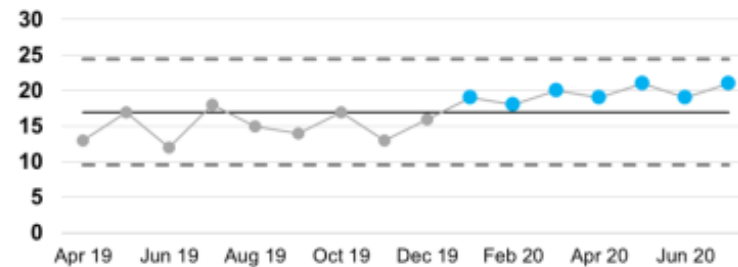
A single point outside the process limits



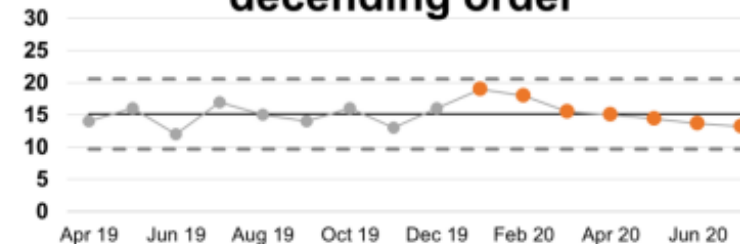
Two out of three points close to a process limit



A shift of points above / below the mean



A run of points in consecutive ascending or descending order



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Board of Directors Public				
Meeting Date:	24/09/2026		Agenda Reference:	Bo.9.26.14c
Report Title:	Month 5 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 year-to-date deficit of £9.9m, this is £4.0m worse than plan. The main drivers of variance at Month 5 are the Deficit Support Funding withheld by NHSE (£1.0m), the impact of industrial action (£1m), ERF under-delivery (£0.8m) & the shortfall in CTG delivery (£1.2m). - The in-month position for August was a deficit of £1.7m which is £2m worse than the £0.3m planned surplus for the month. - A number of non-recurrent pressures arose in-month but the adverse, including a drop in ERF performance and some unexpected expenditure, however the principal reason for the off-plan position is the run rate not improving sufficiently via the Closing the Gap (CTG) programme to meet the planned in-month surplus. - The underlying monthly run rate continues to improve but is not improving at the pace required to align to the profiling of the breakeven annual plan. - The CTG programme is reported as behind plan by £1.2m at Month 5; 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 Trust is formally forecasting delivery of the breakeven plan in its formal submissions to NHSE via the monthly PFR return, but this is contingent on achieving a significant and sustained reduction in the current cost run rate over the coming months. Capital Expenditure - Capital expenditure was £2.6m year to date, £7.1m below plan, reflecting a slower than anticipated start to the capital programme. This includes			

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	the planned £2.5m investment in the SLH DCU, which was expected to complete in Month 4 but has been deferred to a later period. The variance also reflects normal programme phasing, including procurement lead times and project mobilisation activity. Cash - Year to date cash is £15.9m, which is £1.4m below the planned balance of £17.3m. - The lower cash position is primarily driven by the year to date deficit being £4.4m worse than plan. This has been partly offset by the capital programme being £7.0m behind plan, resulting in lower capital expenditure and a corresponding cash benefit.
Recommendation/s: (including any decision/approval required)	Board is asked to: 1. Note the content of this report 2. Support an expected cash application in October for November 2026
Link to Strategic Objective:	Sustainability - To deliver our financial plan and key performance targets
Link to Priority Initiatives 2025/26:	Closing the Gap 2025/26
Implications	
Risk:	Provides an update relevant to Strategic Objective 2 on the Board Assurance Framework, Reference no 6. Strategic Risk: If we and/or our Integrated Care System (ICS) partners in aggregate fail to deliver our financial plan in the short and medium term, including failure to secure an adequate capital funding allocation, then we may fail to maintain financial stability and sustainability, we may have insufficient internal cash and liquidity to support ongoing day to day expenditure and to support the necessary revenue and capital investments required to maintain safe and sustainable services and to support the corporate strategy, resulting in reduced ability to meet demand, develop services and to maintain / improve the safety and quality of care, impaired patient experience, an increased likelihood of system intervention and / or regulatory action including the potential loss of decision making autonomy and a negative impact on the Trust's reputation.
Legal/Regulatory:	Requirement from NHSE to deliver the financial plan
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/a
Assurance Route	
Meeting/s where content has been discussed previously:	F&P Committee September 2026 ETM September 2026

Finance and Performance Committee				
Meeting Date:	16 September 2026		Agenda Reference:	FC.9.26.14
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 (NOF) and our medium-term planning commitments is broadly positive when compared to target, plan and peer benchmarking. The Trust is meeting the majority of selected KPI in this report and has improvement plans in place for delivery of year end targets. The inclusion of the DM01 6-week KPI in the NOF for 2026/27 and the slight deterioration in ECS performance could impact the Trusts overall ranking nationally. 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. Impact from these actions have been visible in August performance. LoS >21 days: The number of long length of stay patients has stabilised with 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. Targets increased from July with delivery remaining on track to achieve year end figures. Cancer 62 Day: Performance has deteriorated and backlogs have increased. Tumour group level recovery plans have been reviewed by the Operational SLT and are being tracked weekly to support the required improvement in capacity and timescales. Year End:			

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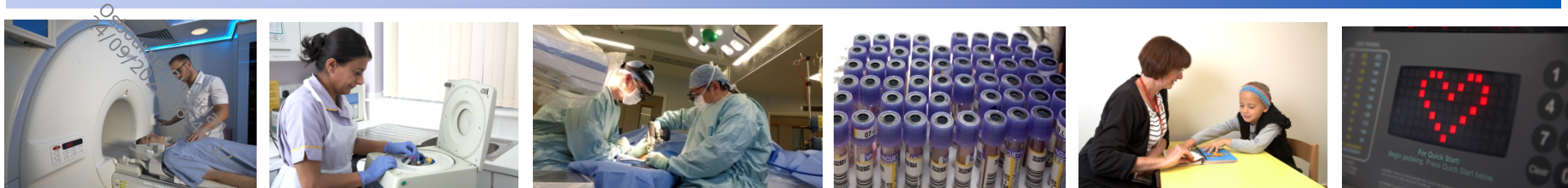
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	The majority of KPI used to track progress continue to rank above peer average and are trending upwards or exceeding planned targets. The following section highlights some indicators requiring additional oversight as they are behind trajectory and 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. 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)	<i>The Committee is asked to:</i> 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
August 2026 Performance



Headline KPI Summary

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	Aug-26	18:00	17:03	↓	N/A	17:22	18:25	G
Emergency Care Standard	Aug-26	83.10%	82.77%	↑	8 of 123	82.17%	83.00%	A
12 Hour LoS in Emergency Department	Aug-26	6.76%	9.61%	↑	36 of 123	9.77%	7.31%	A
Length of Stay ≥21days	Aug-26	82	80	↓	N/A	N/A	82	G
Average Delay Post Discharge Ready Date	Aug-26	3.7	3.2	↓	N/A	3.4	3.7	G
18 Week RTT Incomplete	Aug-26	68.80%	68.10%	↓	54 of 130	N/A	73.71%	A
18 Week RTT Incomplete vs Plan	Aug-26		-0.70%		92 of 130			
52 Week RTT Incomplete	Aug-26	0.21%	0.14%	↓	19 of 130	N/A	0.22%	G
52 Week Community Waits	Aug-26		0.00%		1 of 78	N/A		
New Outpatients (ERF) vs Plan	Aug-26	100.00%	96.34%	↓	N/A	101.72%	100.00%	G
Elective Activity vs Plan	Aug-26	100.00%	93.40%	↓	N/A	99.23%	100.00%	G
6 Week Diagnostic Standard (DM01)	Jul-26	85.52%	86.26%		N/A	N/A	94.65%	R
Cancer 28 Day Faster Diagnosis Standard	Jul-26	82.01%	76.97%	↓	53 of 118	79.84%	80.03%	G
Cancer 31 Day General Treatment	Jul-26	94.74%	97.03%		N/A	96.62%	31.54%	G
Cancer 62 Day General Treatment	Jul-26	78.79%	69.46%	↓	56 of 118	73.37%	77.44%	A

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

Operational Performance Summary

Performance across the Headline KPI which align to the NHS Oversight Framework (NOF) and our medium-term planning commitments is broadly positive when **compared to target, plan and peer benchmarking**. The Trust is meeting the majority selected KPI in this report and has improvement plans in place for delivery of year end targets. The inclusion of the DM01 6-week KPI in the NOF for 2026/27 and the slight deterioration in ECS performance could impact the Trusts overall ranking nationally.

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. Impact from these actions have been visible in August performance.

LoS >21 days: The number of long length of stay patients has stabilised with a multi-disciplinary team reviewing the current processes related to the KPI, which include a focus on NCTR, 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. Targets increased from July with delivery remaining on track to achieve year end figures.

Cancer 62-day: Performance has deteriorated and backlogs have increased. Tumour group level recovery plans have been reviewed by the Operational SLT and are being tracked weekly to support the required improvement in capacity and timescales.

Early Warnings

Paediatric ECS: Attendances had increased in line with seasonal trend and performance 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 focussed on this KPI with improvement noted in August.

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 August our RTT incomplete waiting list was 2,863 greater than plan.

Operational Productivity: Theatres and Outpatient optimisation is being monitored via the Trust Recovery programme and whilst progress is positive the required pace at which these benefits are needed in support of both RTT and CTG benefits suggest we are tracking behind plan in terms of realising these.

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 for this domain if **current performance trends** are sustained.

Headline KPI – Year End Forecast Concerns

DM01 6-weeks (26/27): Performance for July remained above plan but due to the ongoing challenges in Audiology for which the improvement plan has only just been approved through ETM 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 include the number of planned patients who are beyond 6 weeks onto the reportable position which would reduce Trust performance by c.7% when implemented.

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.

RTT 18-week performance: Work is underway to quantify the exact challenge for H2 but the increased WL size and current trend are sufficient to flag concern against this target. Recovery remains entirely feasible and improvement plans will be quantified to show this, which may allow a return to a green forecast for this KPI next month.

Cancer 62-day: Tumour group level recovery plans have been reviewed by the Operational SLT and are being tracked weekly to support the required improvement in capacity and timescales. The YTD position is however below plan and full recovery to year end targets could be at risk, meaning an amber rating whilst we fully embed improvements.

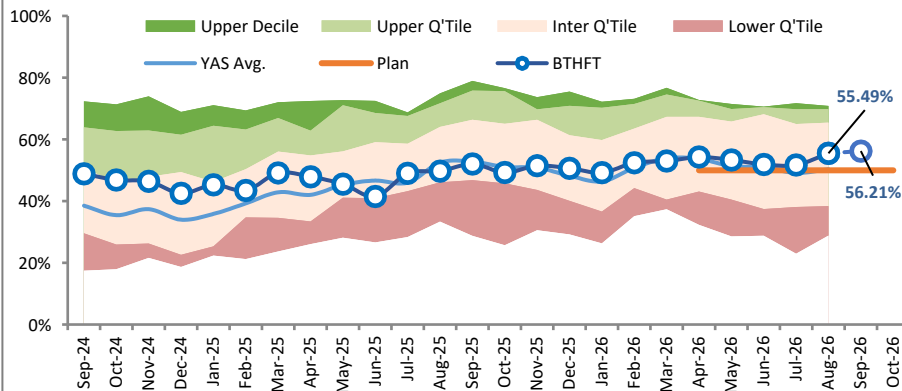
Summaries by overarching objectives

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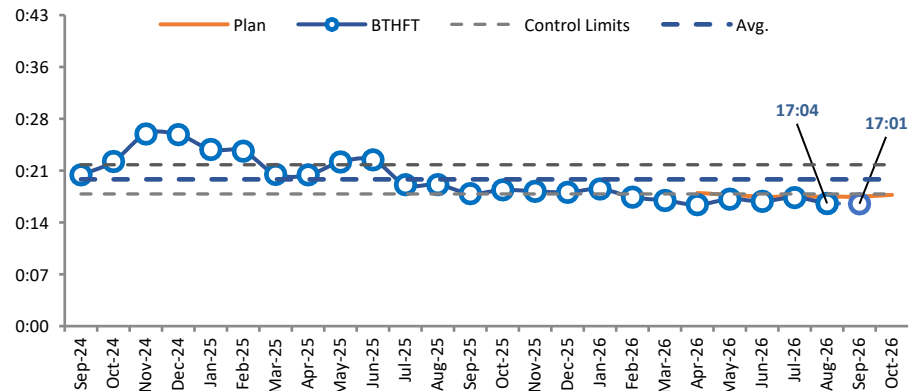
1. Ambulance Handover Performance

Objective: Reduce Ambulance Turnaround Time

1.1 Ambulance Performance Benchmarked (Source: YAS)



1.2 Average Ambulance Handover Time (Source: YAS)



1.3 Additional Ambulance Metrics

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Avg. Daily Arrivals	108	118	117	120	113	115	113	114	115	113	109	103
Avg. Handover Time (MM:SS)	18:25	18:56	18:44	18:36	19:03	17:55	17:28	16:53	17:39	17:21	17:52	17:03
Avg. Crew Clear Time (MM:SS)	26:50	26:36	25:23	24:43	25:00	25:08	26:25	26:42	25:27	26:56	28:05	27:39
Total Turnaround Time (MM:SS)	45:04	45:18	44:07	43:01	43:55	42:53	43:43	43:21	42:57	44:06	45:48	44:30
% <60 mins	98.5%	99.2%	99.1%	99.0%	99.0%	99.1%	99.2%	99.6%	99.3%	99.4%	99.0%	99.2%
% Handover <45 Mins	95.3%	94.9%	94.0%	95.8%	95.2%	96.8%	97.0%	97.9%	96.5%	97.6%	96.7%	96.6%
% Turnaround <45 Mins	54.6%	55.1%	56.7%	60.3%	58.2%	60.6%	58.3%	59.4%	60.5%	56.8%	52.7%	56.4%

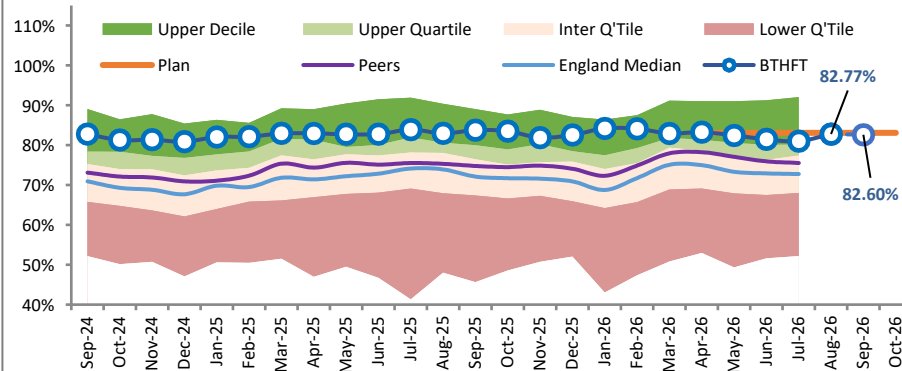
Latest position

- 15-minute handover performance improved to 55.4% in August (51.7% July), with reduced bed waits and bed blocks supporting improved patient flow. The CSU continues to prioritise escalation of flow and bed capacity issues.
- Weekday live validation** (Mon–Fri, 09:00–17:00) continues to improve data quality - validated delays reducing to 11 in August, compared to 32 in July. Seven-day validation remains a priority to strengthen oversight, accuracy and timely identification of delays.
- The Patient Flow Co-Ordinator (**PFC**) **continues proactive engagement with crews** to identify and resolve crew-clear delays. Breaks on the ambulance ramp continue to cause avoidable congestion; the CSU is reinforcing operational expectations around ramp use alongside ongoing PFC oversight.
- 45-minute turnaround performance** increased to 56.4% in August (52.7% July). Crew-clear times remain a key contributor, with sustained high ED attendances also delaying transfers from the handover area despite stable ambulance arrivals. Discussions with **YAS and system partners** are underway to develop a direct pathway into SDEC, supporting patient flow and timely access to care.
- Early engagement with **YAS and the Performance Team** is underway to better understand care home demand across Bradford and West Yorkshire, providing insight into ED demand patterns and potential improvement opportunities.

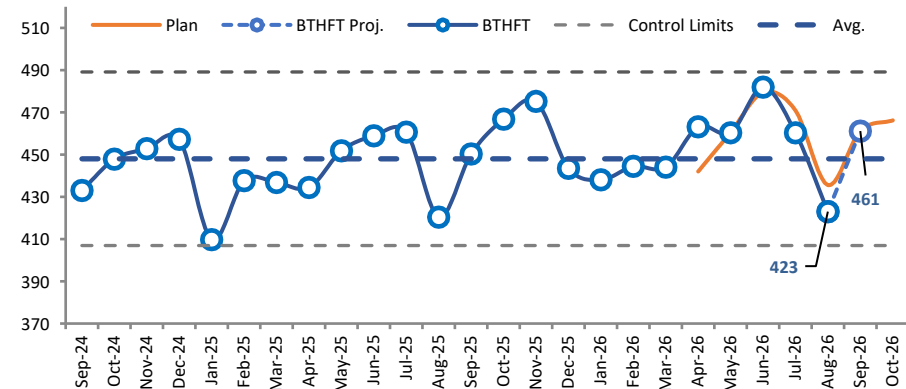
2. Emergency Care Standard (ECS)

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

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Type 1 Performance	75.9%	76.1%	74.0%	75.3%	77.0%	77.1%	75.2%	74.9%	73.2%	71.7%	71.1%	74.1%
Arrival to Assessment	00:17	00:21	00:20	00:18	00:18	00:18	00:17	00:15	00:15	00:16	00:17	00:15
Assessment to Treatment	02:42	03:04	03:03	02:54	03:00	02:57	03:02	02:56	02:42	02:52	03:03	02:50
Treatment Length	01:53	02:35	01:57	01:58	02:03	02:01	01:59	02:01	01:59	01:52	01:58	01:59
% Patients Streamed	47.0%	46.7%	44.4%	45.5%	50.8%	48.4%	47.0%	46.6%	47.9%	49.2%	TBC	TBC

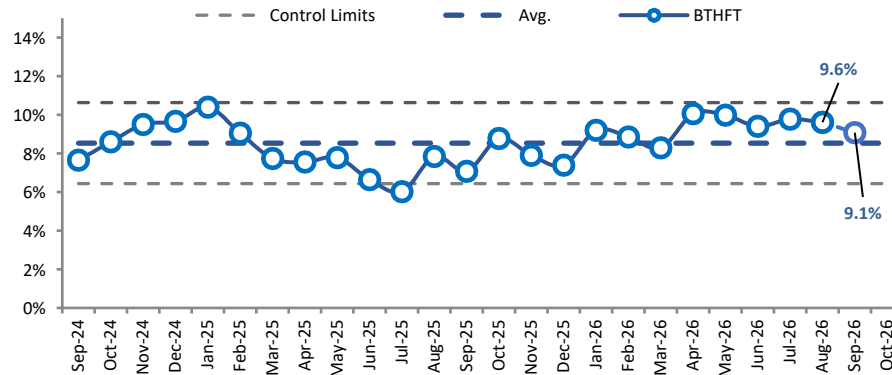
Latest position

- Overall ECS performance has improved compared to July from 81.0% to 82.7% in August. However, remains below plan YTD. Type 1 **ECS performance** also remains a challenge, delivering below plan for July and August, despite lower T1 attendances than expected.
- Overall ECS performance has benefitted from **improved paediatric performance** during July and August, reduced attendances throughout August and changes to the current consultant/Senior Decision Maker (SDM) model and improved validation oversight. A B3 data validation clerk has been approved by WCP to provide standardised ECS performance reviews from the Command Centre.
- Work continues to align EXCEL workstreams with national frameworks, including Model ED, Model Discharge, EEMAC, the Model Acute Pathway and the CQC Action Plan. **Rapid Assessment & Treatment (RAT)** remains in place following ETM approval of the revised consultant model, with roles and responsibilities under review. Work is also underway to align **RAT, Amber Zone and EEMAC** into a single patient pathway, strengthening senior clinical oversight and ED flow.
- Regular improvement meetings led by the COO and operational teams are supporting improved performance, with particularly strong gains in paediatrics since August and overall ECS performance moving closer to plan.
- Model content** went live on the 8th September, with these SDEC patients automatically removed from the ECS clock, reducing reliance on manual validation. Time spent in SDEC will also be available, providing greater insight into the patient pathway and flow.

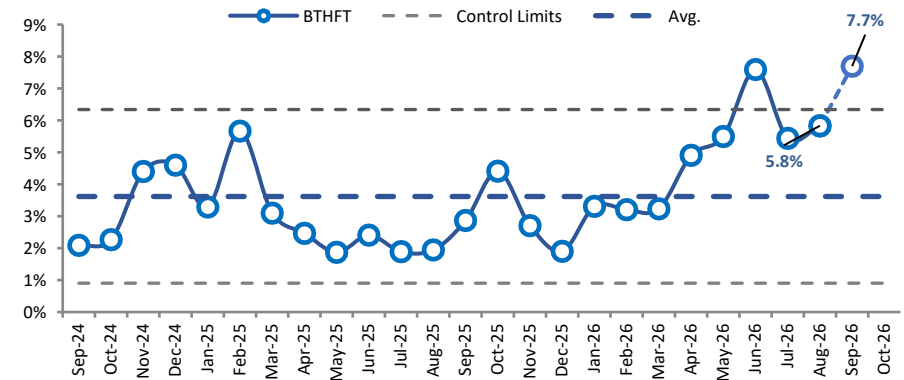
3. Emergency Department (ED) Length of Stay

Objective: Improve Patient Experience in ED

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



3.2 % >12 Hour DTA to Admit



3.3 Additional Admission Metrics

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Avg. # Daily Admissions	88	87	85	84	80	84	85	85	87	86	85	81
Avg. Wait DTA to Admit	05:05	06:21	06:02	05:38	07:02	06:40	05:58	05:47	05:59	06:02	05:31	05:36
LoS (Admitted P'ts)	07:14	08:10	08:19	07:30	08:21	08:08	07:42	07:38	07:41	08:11	07:52	07:35
LoS (Discharged Pts)	02:56	03:08	03:08	03:03	03:00	02:58	02:56	02:59	02:54	02:51	02:52	02:42
LoS (Admitted & Discharged Pts)	03:51	04:09	04:08	03:57	04:03	04:01	03:55	03:54	03:53	03:52	03:52	03:42
% Patients Admitted	21.3%	20.0%	19.3%	20.4%	19.7%	20.4%	20.8%	19.7%	20.5%	19.2%	19.9%	20.7%

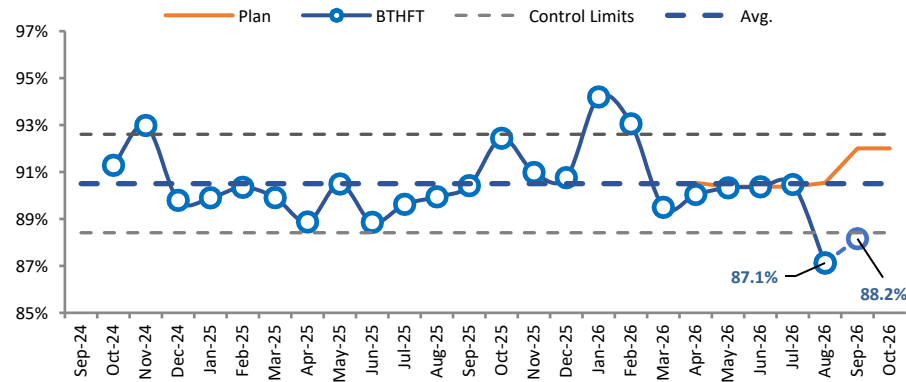
Latest position

- **12-hour DTA:** The Reset Week implemented in June delivered encouraging improvements into July although changes made to the use of Ward 24 (for palliative care patients) in August has **increased pressure** on side room capacity, particularly in AMU, increasing long waits in ED with subsequent impacts also observed in 12-hour DTA performance. 12-hour performance current forecast remains high in September in line with increasing ED demand.
- The CMO, COO and CN has written to clinical teams outlining that side room utilisation will be at the behest of the clinical site matrons, and this may mean that medical and surgical teams need to see these patients on outlying wards more frequently. This change in process is embedding.
- 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.

4. Inpatient Length of Stay (LoS)

Objective: Maintain Hospital capacity for daily admissions

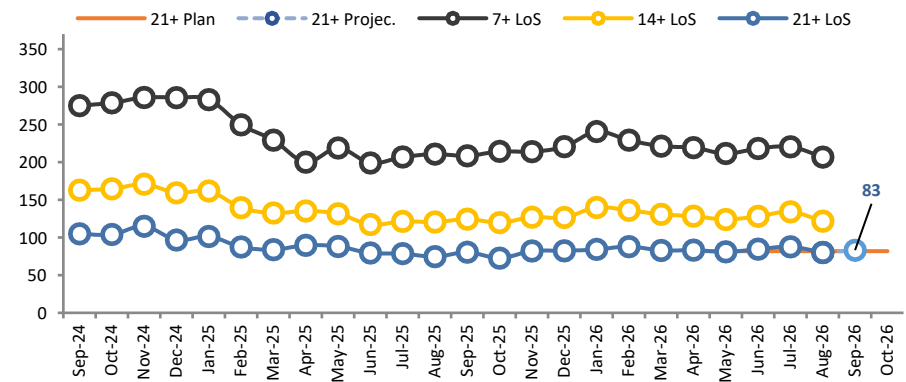
4.1 Bed Occupancy



4.3 Additional Inpatient LoS Metrics

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Avg. Inpatient LoS	4.6	4.5	4.5	4.8	4.7	5.0	4.8	4.6	4.7	4.7	4.9	5.1
% Patients Discharged <4PM	40.6%	38.3%	36.8%	42.2%	40.1%	37.9%	39.9%	40.0%	39.8%	41.7%	40.6%	41.1%
# NEL Admissions	4,175	4,378	4,208	4,372	4,197	3,920	4,348	4,084	4,251	4,134	4,299	3,841
7+ LoS	208	214	214	221	241	229	221	219	212	218	220	207
14+ LoS	124	120	127	127	140	136	131	128	124	128	134	122
21+ LoS	81	73	82	82	84	88	83	83	81	85	88	80

4.2 Patient LoS Profile (Source: EPR)



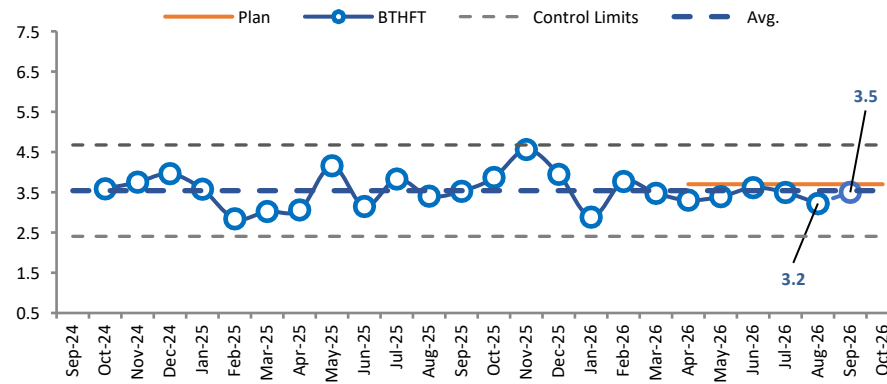
Latest position

- **General & Acute:** Elective and non-elective admissions reduced significantly in August, with reductions across the 7+, 14+ and 21+ day LoS cohorts indicating positive progress in discharging patients with longer stays. This activity is reflected in the increase in average inpatient LoS (at discharge) and reduced bed occupancy.
- **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.

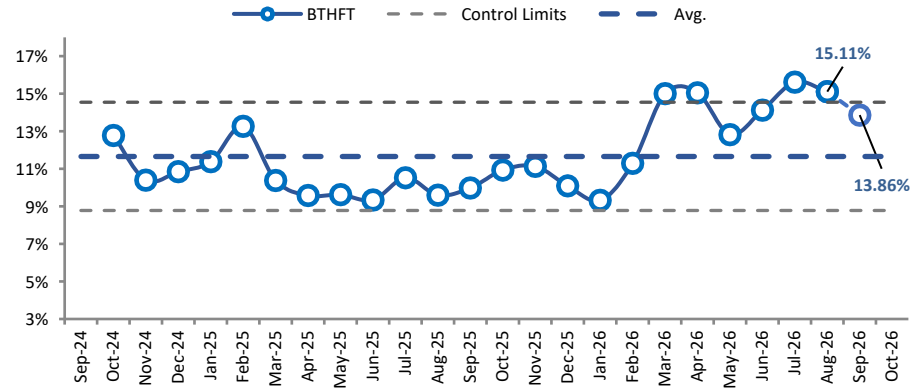
5. Discharge Processes

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

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
% of Pts with Discharge Ready Date	94.9%	95.8%	95.6%	94.9%	95.6%	95.3%	95.5%	95.7%	96.0%	96.1%	95.7%	96.1%
% of Pts Discharged on/before DRD	78.3%	79.4%	80.3%	78.5%	78.1%	80.7%	79.0%	80.1%	78.1%	77.3%	74.6%	73.6%

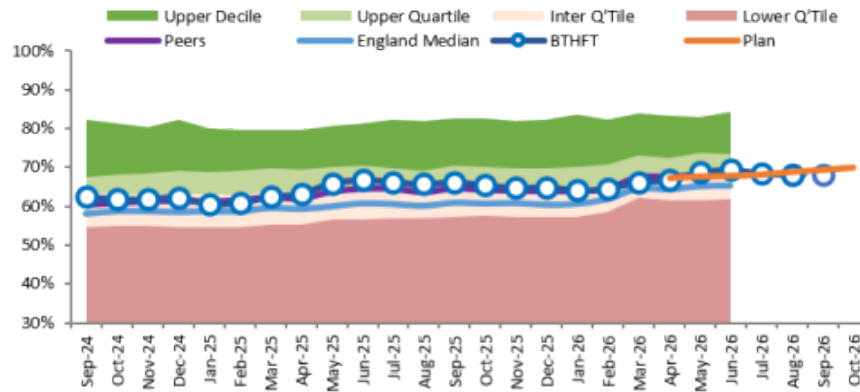
Latest position

- **NMCtr** performance has improved in August (15.1%) compared with 15.6% in July. September performance expected to improve to 13.9%. Data is currently being reviewed through both OPTICA and EPR 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.
- A re-audit of the discharge ready date SOP has highlighted the need to strengthen monitoring and ward-level accountability, with the CSU taking forward actions to improve compliance and consistency.
- **Model Discharge Pathway** gap analysis found early discharge planning is inconsistent, with treatment intent not routinely linked to discharge intent and Criteria Led Discharge not yet embedded in routine ward practice. Delays relating to transport, TTOs, therapy assessments and equipment continue to affect timely discharge, compounded by variable accuracy of EDD/DRD recording across wards.
- Work will begin as part of EXCEL to implement ward-level operational standards aligned to the Model Discharge Pathway, standardising Criteria Led Discharge and improving EDD/DRD accuracy and ward-level understanding of delays.

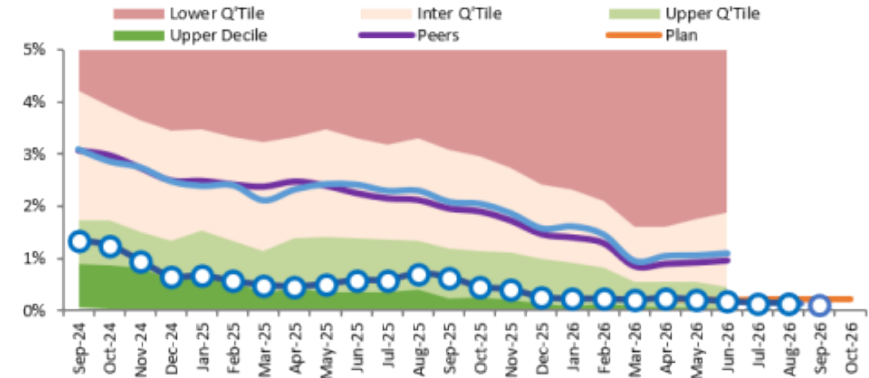
6. Referral to Treatment (RTT)

Objective: Deliver RTT Improvements

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



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



6.3 Additional RTT Metrics

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Waiting List Size	33,406	32,206	31,833	31,932	31,610	31,263	31,444	31,093	31,525	31,606	31,412	31,959
Waiting List Change		-1,200	-373	+99	-322	-347	+181	-351	+432	+81	-194	+547
% New RTT Within 18 Weeks	67.0%	68.1%	67.3%	67.0%	66.7%	67.7%	70.0%	69.7%	72.1%	72.0%	71.7%	70.2%
Incomplete (52+)	212	145	127	80	70	69	63	73	65	55	44	45

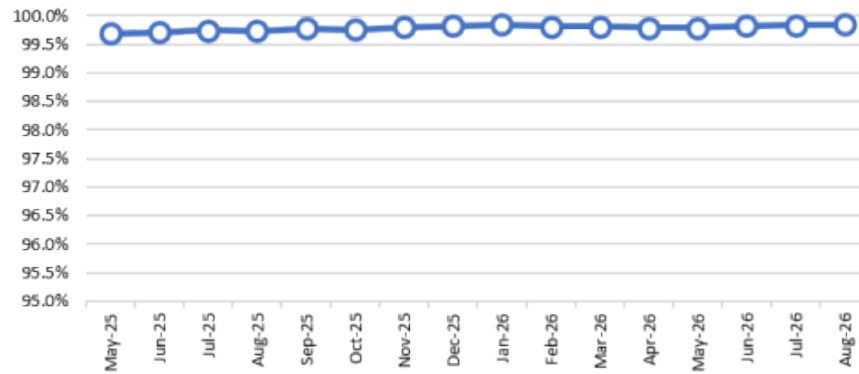
Latest position

- **RTT performance remained stable** in August at 68.1% with the waiting list size increasing as a result of reduced activity levels over the summer holidays.
- **RTT over 52 weeks waits has reduced** in August down to 45. Challenges are ongoing in Trauma & Orthopaedics however the long wait position is improving, further supported via weekend Medinet theatre lists. Recovery plans are required for potential long wait breaches in Oral Surgery due to a consultant vacancy. An agency locum has been recruited however the clinical priority is to recover the deteriorating Cancer position. The Trust continues to benchmark just below the upper decile for 52-week RTT.
- No patient was waiting over 65 weeks at month end.
- Operational concerns are ongoing 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 further in order to match the improvement trajectory set. Outpatient and Inpatient productivity (described on later slides) is being improved via dedicated programmes of work.

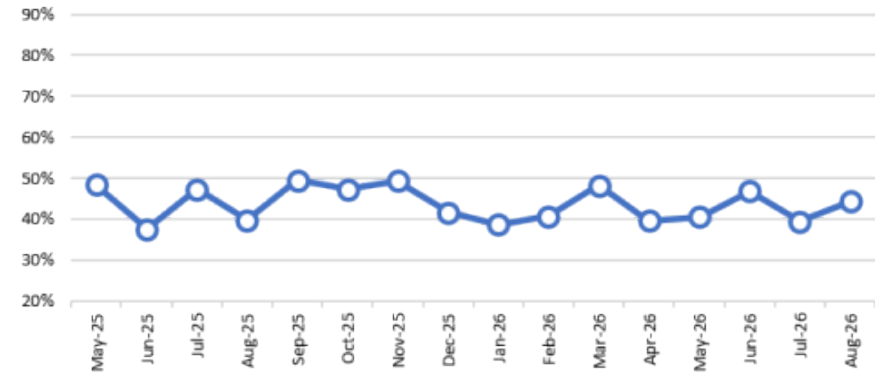
7. Waiting List Management and Validation

Objective: Reduce Errors to Improve Wait Times

7.1 RTT Waiting List Confidence Level



7.2 Correction Rate



7.3 Additional WL Management and Validation Metrics

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
RTT LUNA DQ Metrics	567	647	503	456	425	489	468	533	508	459	445	425
Correction Rate - Non RTT	14.94%	15.28%	20.20%	23.09%	19.21%	14.80%	26.76%	14.42%	15.48%	27.31%	14.85%	29.61%
Non-RTT DQ Process Failures	20,130	19,644	18,922	18,738	19,088	19,019	19,662	19,127	18,304	18,776	19,698	23,552

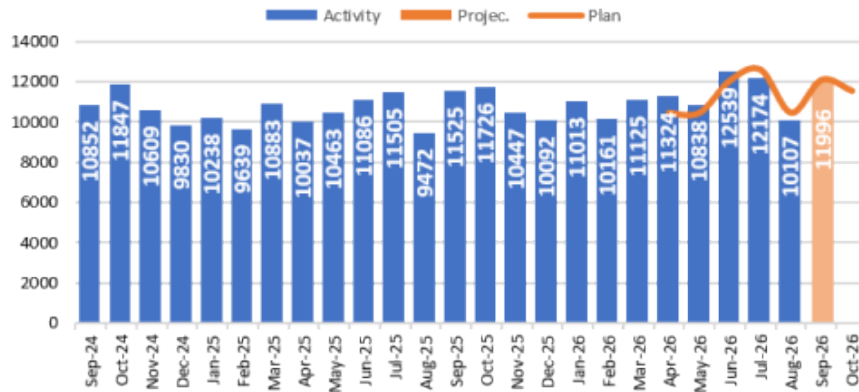
Latest position

- Confidence in the RTT waiting list, as reported nationally via Luna Dashboard, remained high at 99.84% in August 2026. This is highest in the Northeast and Yorkshire region and **third best nationally**. The number of Data Quality (DQ) metrics associated with the RTT waiting list remain low. Percentage of RTT pathways with a DQ issue are lowest in Northeast and Yorkshire region and third lowest in nationally.
- This improvement reflects targeted validation, DQ prevention work with services and increased productivity in validation.
- The use of **Artificial Intelligence** is being tested by the Corporate Access Team to further streamline validation of RTT pathways and increase productivity.
- Technical validation of process failures has been paused to allocate staff on validation of Non-RTT orders. This has contributed to increase in process failure backlog. As soon as validation of Non-RTT is up to date, validation of process failures will recommence in October 2026.
- Correction data is being used to identify hot spots of RTT errors, to direct the DQIS's error prevention support.
- The Data Quality Intervention Specialist (DQIS) team has worked on DQ prevention with admin team and clinical teams of Urology, ENT and Plastics, which has contributed to significant reduction in the number of errors corrected on RTT pathways by these services.
- DQIS team is now working on prevention of RTT errors created by Orthoptics, Endocrinology, Podiatry and Trauma and orthopaedics.

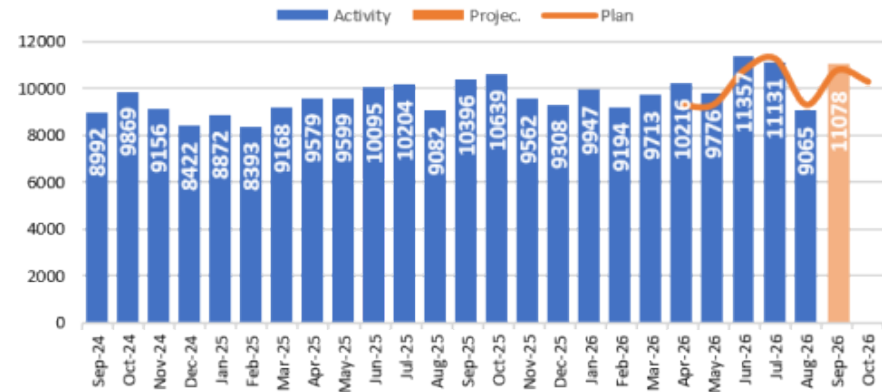
8. Outpatient Productivity

Objective: Improve Non-Admitted Productivity

8.1 New Outpatient Activity (ERF)



8.2 Outpatient with Procedure (ERF)



8.3 Additional Outpatient Metrics

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
% of Clock Stops and DTA per OPA	25.32%	25.26%	24.80%	24.70%	24.88%	25.16%	24.86%	24.82%	24.30%	24.18%	24.96%	24.43%
DNA Rate	7.93%	7.56%	8.12%	8.27%	8.17%	7.88%	8.02%	7.78%	7.97%	7.79%	8.12%	8.32%
Follow Up Orders	29,816	30,505	27,810	27,372	29,526	26,834	28,298	28,578	26,448	31,034	30,407	25,719
PIFU %	4.99%	4.88%	5.85%	4.71%	5.23%	5.78%	5.09%	4.59%	5.23%	5.79%	5.21%	5.95%
PIFU % (including Therapies)	5.16%	5.63%	6.50%	5.34%	5.35%	6.29%	5.60%	5.08%	5.76%	6.32%	5.93%	6.11%
First to Follow Up Ratio	2.68	2.73	2.74	2.83	2.80	2.79	2.70	2.67	2.65	2.65	2.69	2.72

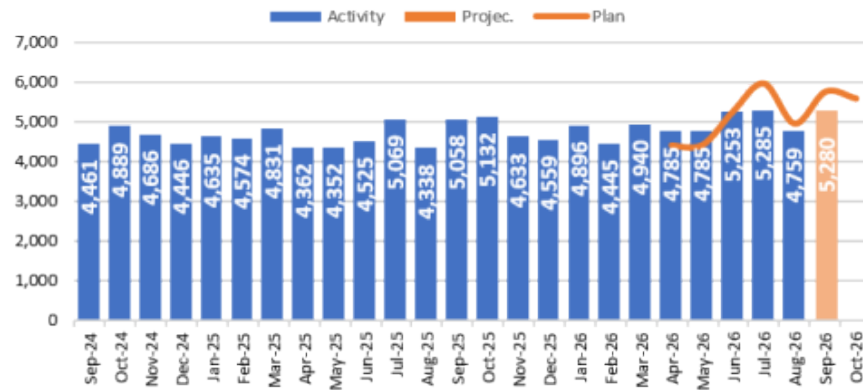
Latest position

- New outpatient activity (ERF)** has reduced over summer due to annual leave. The Trust remains above plan YTD however services currently behind are working on plans to recover their activity before the end of the FY.
- Robotic Process Automation (RPA)** is being rolled out in Interventional Radiology to support activity recording. RPA coding is being explored in Audiology which will further increase activity above plan.
- The straight to A&G process continues to be rolled out with several areas already showing promising reduction in referrals. Optimising referrals and organising diagnostic capacity so patients present with all available information will continue as a focus.
- 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.
- 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.

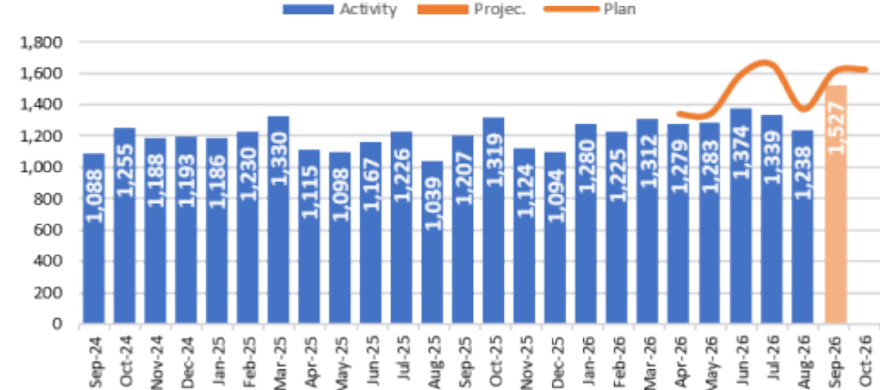
9. Inpatient Productivity

Objective: Increase Elective Ordinary and Day Case Volumes

9.1 Elective Activity



9.2 Elective Activity in Theatres



9.3 Elective Activity

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Admitted Clock Stops	1,315	1,391	1,245	1,226	1,421	1,284	1,449	1,332	1,363	1,519	1,438	1,385
Daycase Rate	88.3%	87.9%	87.7%	88.5%	88.3%	87.9%	89.3%	89.2%	88.6%	89.2%	88.8%	86.4%
Number of Lists Run	645	695	585	573	667	621	640	615	589	660	668	609
Patients Per List	1.9	1.9	1.9	1.9	1.9	2.0	2.1	2.1	2.2	2.1	2.0	2.0
Reportable Cancellations	45	56	44	28	58	57	62	42	36	58	58	51
28-day Rebooking Breaches	17	7	4	8	7	2	12	12	6	12	13	11

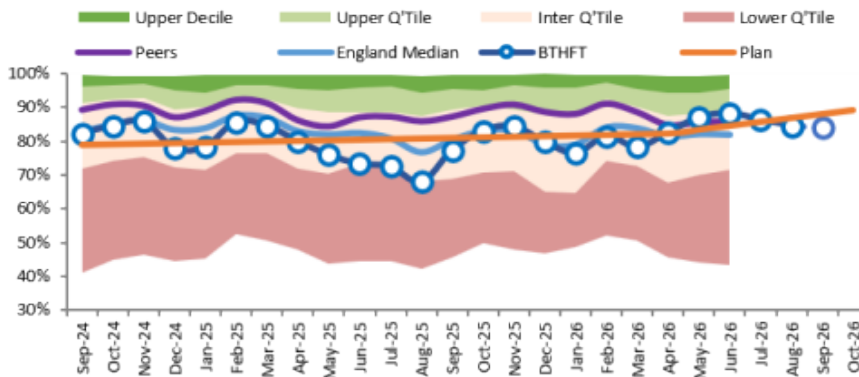
Latest position

- Activity achieved slightly below plan in August due to the summer holidays. 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 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 in coming weeks.
- Plastics are utilising the Bronte Forward Wait area to increase theatre activity whilst supporting the biopsy backlog in Skin. Long term plans are required to increase Plastic activity once the seasonal demand in Skin reduces.

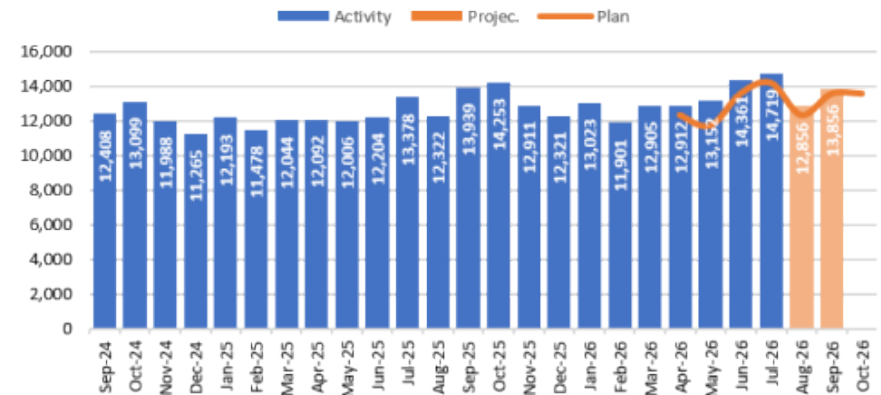
10. Diagnostic Waiting Times

Objective: Increase Activity to Reduce Delays for Diagnostic Tests

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



10.2 Diagnostic Activity vs Plan



10.3 Additional Diagnostic Metrics

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
(Phys. M'ment) Activity	1,862	2,035	1,740	1,539	1,734	1,450	1,544	1,692	1,620	1,987	2,020	1,947
(Phys. M'ment) Performance	70.2%	70.8%	69.1%	58.3%	55.5%	63.9%	63.1%	61.8%	70.0%	70.0%	63.8%	64.1%
(Imaging) Activity	10,270	10,536	9,577	9,262	9,716	9,145	9,876	9,726	9,965	10,693	10,913	11,437
(Imaging) Performance	77.7%	85.2%	87.7%	84.5%	80.9%	85.1%	82.1%	90.2%	93.5%	96.7%	98.4%	98.9%
(Endoscopy) Activity	1,807	1,682	1,594	1,520	1,573	1,306	1,485	1,494	1,567	1,681	1,786	1,735
(Endoscopy) Performance	92.8%	92.4%	92.6%	89.5%	86.7%	90.8%	88.3%	84.0%	89.5%	89.0%	87.9%	85.0%

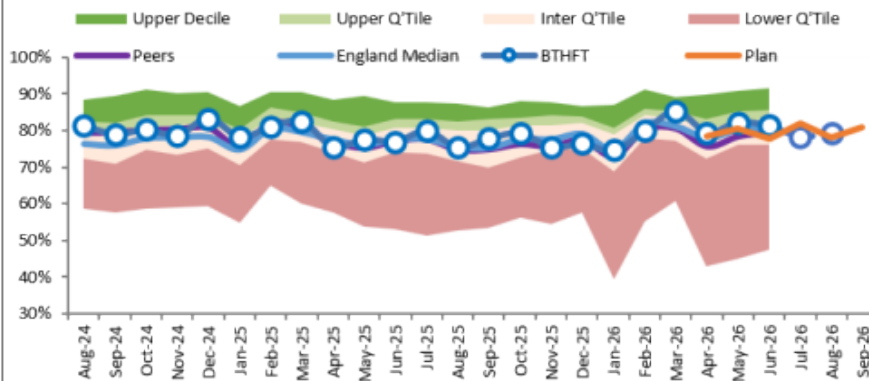
Latest position

- DM01 performance for August is projected to reduce and continue to do so in September. Breach numbers remain consistent (predominately in Audiology) whilst total waits reduce (further improvement in Non-Obstetric Ultrasound).
- 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.
- Additional Cardiology Stress Echo lists in September will significantly reduce breaches with a view to recover in Q3.
- 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. Due to reduced capacity over summer the full impact of 8 rooms has not yet been realised however activity is expected to increase from September.

11. Cancer Diagnostic Phase

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)

	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Trust	80.0%	85.3%	79.5%	82.3%	81.3%	78.2%	79.2%
Breast	97.5%	98.3%	96.0%	97.7%	97.5%	96.9%	95.1%
Gynaecology	81.9%	73.0%	77.2%	79.2%	79.0%	68.6%	69.5%
Haematology	50.0%	61.5%	47.6%	40.0%	17.4%	60.0%	50.0%
Head & Neck	75.3%	85.0%	82.1%	72.0%	66.0%	69.5%	71.6%
Lower GI	75.4%	78.1%	75.4%	83.2%	79.4%	75.3%	81.3%
Lung	85.7%	98.1%	92.6%	92.3%	95.3%	93.9%	90.2%
NSS	93.3%	100.0%	93.3%	90.0%	100.0%	100.0%	77.8%
Upper GI	88.9%	87.3%	81.2%	93.7%	87.9%	89.4%	92.1%
Skin	66.5%	77.4%	64.9%	68.3%	77.8%	70.5%	70.7%
Urology	79.5%	87.2%	75.2%	79.5%	79.4%	74.5%	76.5%

11.3 Additional Cancer Diagnostics

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
# 2WW Refs	1,736	2,123	1,976	1,822	1,739	2,000	1,825	2,028	1,853	1,819	2,117	2,159	1,730
% 2WW Performance	83.8%	94.0%	94.9%	94.8%	95.7%	92.6%	92.9%	84.8%	81.8%	85.5%	81.6%	69.4%	
# Total Patients Seen FDS	1,982	2,080	2,020	1,872	1,742	1,879	1,889	1,798	1,848	1,722	1,949	2,210	1,813
# Undiag, unbooked >28 days	264	317	358	282	307	275	172	231	245	254	320	315	355

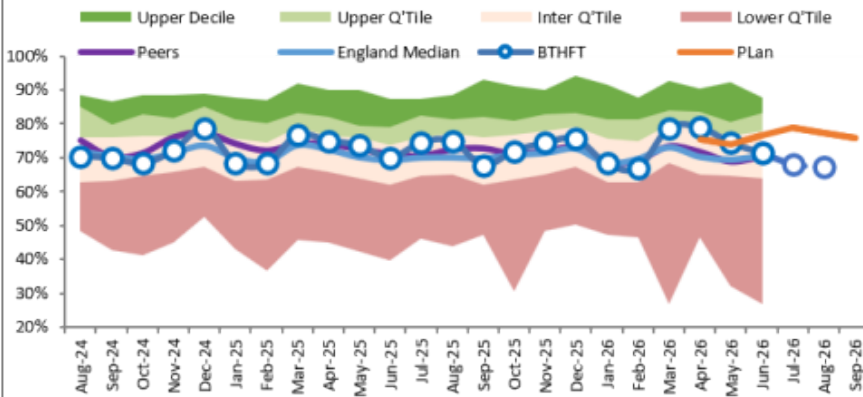
Latest position

- Overall performance has reduced below plan YTD. 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. An agency consultant has been appointment with clinics commencing this month however a long term solution is still required.
- Additional Skin clinics are running on weekends to support the 2WW position however capacity issues have resulted in a biopsy backlog. Bronte Forward Wait is being utilised to clear this backlog however delays in taking the biopsy means that the full benefit of Skin AI cannot yet be realised.
- Histology delays continue to impact Skin and Gynaecology for 28 and 62 day performance.

12. Cancer Treatment

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)

	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Trust	67.3%	78.7%	78.9%	74.3%	71.5%	68.1%	67.2%
Breast	72.1%	93.7%	76.9%	64.0%	68.9%	69.0%	66.7%
Gynaecology	33.3%	93.3%	70.0%	50.0%	50.0%	66.7%	80.0%
Haematology	69.0%	71.4%	92.9%	89.5%	91.3%	69.2%	81.8%
Head & Neck	42.1%	61.5%	87.0%	63.0%	42.3%	55.2%	53.3%
Lower GI	35.0%	65.2%	80.8%	57.9%	64.3%	34.5%	63.6%
Lung	44.8%	48.3%	26.7%	37.1%	46.2%	34.6%	37.5%
Upper GI	85.7%	71.4%	81.5%	100.0%	69.2%	62.9%	69.2%
Skin	84.8%	84.6%	87.5%	87.2%	80.0%	88.9%	73.0%
Urology	76.8%	74.5%	77.6%	83.1%	88.1%	88.7%	73.2%

12.3 Additional Cancer Treatment Metrics

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
# 31 Day Treatments	232	277	295	260	245	263	243	271	275	259	291	256	273
31 Day Performance	95.7%	93.1%	94.9%	93.8%	95.5%	94.3%	97.9%	98.5%	95.3%	98.5%	95.9%	96.9%	96.7%
62 Day Backlog	89	87	63	50	70	84	44	47	50	62	49	67	72

Latest position

- July performance against the 62 Day standard remains below plan and continues to deteriorate in August as the backlog is cleared.
- MDT optimisation work is due to commence in Lung and Skin from September with a potential roll out in Breast.
- Head & Neck and Skin 62 day performance continues to be impacted by capacity issues at the start of the pathway plus ongoing histology delays.
- Breast Screening pathways continues to cause delays. The service are managing the patients closely however limited visibility of these patients before diagnosis makes it hard to save breaches.
- Theatre capacity is an ongoing concern for Breast and Urology with 31 day performance at risk in September. Services are closely monitoring patient pathways to save potential breaches where possible however delays will continue to increase the 62 day backlog.
- Civica go live in planned for November 2026. Benefits include Personalised Stratified Follow Up (PSFU) and digital remote monitoring system (RMS) for patients after cancer treatment, which will reduce unnecessary follow-ups.

Finance and Performance Committee				
Meeting Date:	09/09/2026		Agenda Reference:	FC.9.26.18
Report Title:	Annual Security Report April 2025 – March 2026			
Presented by:	David Moss, Director of Estates and Facilities			
Executive Lead:	David Moss, Director of Estates and Facilities			
Author:	William Hall – Violence Prevention & Reduction Lead / Local Security Management Specialist			
Report Summary				
Purpose of the paper:	Decision ☐	Assurance ☒	Action ☐	Information ☐
Summary of Key Issues/Highlights:	• Scope and assurance. This report covers security management, violence prevention and reduction, policing partnership, operational demand and strategic security risks across Bradford Royal Infirmary and St Luke's Hospital during 2025/26. • Operational demand. The year end Security Highlight Report records 667 security category IRIS reports, including 515 violence and aggression reports, and 2,491 security calls for service across the BRI site. The Emergency Department was the highest demand area, with 1,057 calls. • Violence and aggression. The report's IRIS table contains 515 recorded incidents, an increase of 115 from 400 in 2024/25. The report also records 187 physical assaults, of which 168 involved medical factors. • Targeted controls. Dedicated Emergency Department security provision, body-worn video, specialist risk assessments, focused engagement, enhanced training pilots, repeat offender management, unacceptable behaviour measures and joint work with West Yorkshire Police continued. Evaluation of sustained impact remains a priority. • Police partnership and crime prevention. West Yorkshire Police recorded 584 calls for service in the 2026 reporting period, compared with 1,130 in the previous report period. The reason for the full reduction is not established and is not attributed solely to Trust action. The Trust vehicle and cycle crime table reduced from 19 offences in 2024/25 to 13 in 2025/26. • Governance and VPR assurance. The VPR Sub-Committee, action plan, revised terms of reference, audit actions and cross functional workstreams strengthened oversight. The July 2026 assessment is presented separately as post period assurance and not as 2025/26-year end performance. • DBS assurance. A Trust-wide concern was raised during the reporting period that some long serving staff may not have received a historic CRB or DBS check. A corporate, legally proportionate, role-based assurance review is recommended, led by People and Human Resources with appropriate specialist input. • Protective security. The Terrorism (Protection of Premises) Act 2025 received Royal Assent during the reporting period. Detailed Trust mobilisation, workstream delivery and assurance activity after 31 March 2026 are identified as post period evidence.			
Recommendation/s: (including any decision/approval required)	<i>The Finance & Performance Committee is asked to note the content of the report, specifically:</i> 1. Note the report and the sustained volume and complexity of security demand during 2025/26, particularly in the Emergency Department and in relation to clinically related challenging behaviour, physical assault, verbal abuse and anti-social behaviour. 2. Take reasonable assurance from verified annual activity data, dedicated Emergency Department security provision, the West Yorkshire Police			

	partnership, targeted violence prevention activity, crime prevention measures and strengthened VPR governance. - Endorse continued delivery of the VPR action plan, prioritising remaining Red and Amber indicators, intervention evaluation, dashboard validation, staff support, reporting confidence and evidential support for appropriate criminal justice action. - Support completion of the Trust-wide training needs analysis, a risk-based training and competency plan, evaluation of enhanced conflict resolution and breakaway pilots, and continued deployment and evaluation of body-worn video where justified by risk and approved governance. - Support continued review of security workforce resilience, demand, technology and protective-security priorities. Material revenue or capital requirements should return through the appropriate business-case and governance route. - Approve commissioning of a Trust-wide DBS assurance review led by People and Human Resources, with Recruitment, Safeguarding, Information Governance, Equality, staff-side, Security and VPR input. The review should establish the baseline, identify historic gaps, confirm legal eligibility and proportionate check levels by role, review self-disclosure and rechecking arrangements, consider the DBS Update Service, and produce a costed risk based options appraisal and implementation plan. - Note that the DBS review must not assume that the same level or frequency of check can lawfully be applied to every role. Any recommendations must be based on role eligibility, proportionality, equality, data protection, safeguarding risk and operational feasibility. - Support continued readiness work under the Terrorism (Protection of Premises) Act 2025, including auditable governance, premises assessments, protective-security plans, training, exercising and resource proposals. - Require progress to be monitored through the Health and Safety Committee, with material risks, decisions and exceptions escalated through the agreed governance route.
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:	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

Annual Security Board Report: 1 April 2025 – 31 March 2026

1. EXECUTIVE SUMMARY

- 1.1 This Annual Security Board Report provides assurance regarding the management of security, violence prevention and reduction, policing partnership, operational demand and strategic security risks across Bradford Teaching Hospitals NHS Foundation Trust during the period 1 April 2025 to 31 March 2026.
- 1.2 Throughout 2025/26, the Trust continued to strengthen its approach through partnership working with West Yorkshire Police, targeted violence prevention initiatives, Body Worn Video deployment, focused support in high-risk clinical environments, and governance aligned to the NHS Violence Prevention and Reduction Standard.
- 1.3 Verified 2025/26 security evidence records 667 security category IRIS reports, of which 515 were violence and aggression category IRIS reports, and 2,491 security calls for service across the BRI site. The Emergency Department remained the highest-demand area, with 1,057 calls for service.
- 1.4 The Trust's dedicated Police Community Support Officer partnership continued to provide a consistent policing presence at Bradford Royal Infirmary. West Yorkshire Police reporting records a reduction in police calls for service from 1,130 in the 2025 report period to 584 in the 2026 reporting period.
- 1.5 The report also identifies evidence and assurance gaps that require continued management, including validation of physical assault classifications, Conflict Resolution Training compliance data, intervention evaluation and wider workforce assurance.

2. PURPOSE / AIM

- 2.1 The purpose of this Annual Security Board Report is to provide assurance to the People Committee and Trust Board regarding security services across Bradford Royal Infirmary and St Luke's Hospital during 2025/26. It covers operational demand, violence prevention, physical assault, police partnership, crime prevention, anti-social behaviour, missing persons, workforce capability, technology, infrastructure, governance, evidence gaps and forward risks.
- 2.2 The report outlines strategic direction and operational performance, demonstrates progress in managing security-related risks, presents analysis of incident and crime trends, provides assurance regarding compliance with the NHS Violence Prevention and Reduction Standard, and highlights priorities for future investment and service development.
 - Security incident management and operational demand.
 - Violence prevention and reduction activity.
 - Police partnership and crime prevention.
 - High-risk areas and repeat demand themes.
 - Workforce, training and service resilience.
 - Technology, infrastructure and Designing Out Crime.
 - Evidence gaps, caveats and forward risks.

3. PROPOSAL

- 3.1. The report provides assurance regarding the effective management of security across Bradford Teaching Hospitals NHS Foundation Trust and summarises work undertaken during 2025/26 across the following workstreams:
 - Violence Prevention and Reduction.
 - Physical assault and violence reduction.
 - Crime prevention and anti-social behaviour.
 - Missing persons management.
 - West Yorkshire Police partnership working.

- Workforce development and risk management.
- Technology and infrastructure.
- Security governance and assurance

4. APPENDICES

- 4.1. Appendix 1: West Yorkshire Police Annual Report
4.2. Appendix 2: VPR Action Plan

5. NHS VIOLENCE PREVENTION AND REDUCTION (VPR) STANDARD – 2026 UPDATE AND ASSURANCE

- 5.1 The Trust has continued to strengthen its approach to violence prevention and reduction in line with NHS England requirements. A comprehensive Violence Prevention and Reduction action plan remains in place and is monitored through the VPR Sub-Committee and wider governance routes.
- 5.2 The July 2026 assessment demonstrates continued improvement in organisational maturity against the Violence Prevention and Reduction (VPR) Standards, building on the progress reported in January and April 2026.
- 5.3 Of the 43 indicators, Red ratings have reduced from 10 in January to 5 in April and 3 in July, representing a 70% reduction in Red indicators since January. Green indicators have increased from 22 in January to 23 in April and 26 in July, meaning 60% of all VPR indicators are now rated Green.
- 5.4 The most significant improvement since April is within Leadership & Accountability, where the remaining Red indicator has been eliminated and 8 of 10 indicators are now Green. Collaboration has also achieved full Green maturity, with both indicators now rated Green.
- 5.5 Governance & Assurance has demonstrated further improvement, with one Red indicator progressing to Amber. However, two Red indicators remain and further development is required to strengthen governance and assurance arrangements.
- 5.6 Data and Workforce continue to demonstrate sustained strong assurance, with no Red indicators across either domain. Evaluation also remains free of Red indicators, although further work is required to fully embed evaluation arrangements and demonstrate the impact and effectiveness of VPR activity.
- 5.7 The Interventions domain remains the principal residual area of risk. While the significant improvement achieved between January and April has been sustained, the July position remains unchanged at 1 Red, 6 Amber and 1 Green. Continued focus is therefore required to embed interventions consistently and strengthen evidence of their effectiveness and outcomes.

6. VPR STANDARDS – COMPARATIVE POSITION:

- 6.1. See Appendix 2 – VPR action plan. This was presented at Performance Committee in the update report in May 2026.

Domain	Jan 2026 (R/A/G)	Apr 2026 (R/A/G)	Jul 2026 (R/A/G)	Movement Apr → Jul	Interpretation
Leadership & Accountability	1/2/7	1/2/7	0/2/8	↓ Red, ↑ Green	Further improvement – Red eliminated and Green increased, demonstrating strengthened leadership, accountability and organisational ownership.
Governance & Assurance	3/3/2	3/3/2	2/4/2	↓ Red, ↑ Amber	Improving – one Red indicator has progressed to Amber, demonstrating reduced risk, although further development is

Domain	Jan 2026 (R/A/G)	Apr 2026 (R/A/G)	Jul 2026 (R/A/G)	Movement Apr → Jul	Interpretation
					required to strengthen governance and assurance maturity.
Collaboration	0/1/1	0/1/1	0/0/2	↓ Amber, ↑ Green	Full Green maturity achieved, demonstrating strengthened collaborative arrangements and effective partnership working.
Data	1/1/6	0/1/7	0/1/7	No change	Sustained strong assurance – no Red indicators and 7 of 8 indicators remain Green.
Workforce	0/1/4	0/1/4	0/1/4	No change	Sustained strong assurance – no Red indicators and 4 of 5 indicators remain Green, demonstrating maintained workforce capability.
Interventions	5/2/1	1/6/1	1/6/1	No change	Stable but remains the principal residual risk, with continued focus required on embedding and evidencing intervention effectiveness.
Evaluation	0/1/1	0/1/1	0/1/1	No change	Stable – no Red indicators, with further development required to fully embed evaluation and demonstrate impact.
TOTAL	10/11/22	5/15/23	3/14/26	↓ 2 Red, ↓ 1 Amber, ↑ 3 Green	Continued positive trajectory with further reduction in residual risk and increasing organisational maturity.

6.2 The July assessment provides evidence of a continued positive trajectory, with no domain demonstrating deterioration and further movement from Red and Amber towards Green. Since January, the overall position has moved from 10 Red / 11 Amber / 22 Green to 3 Red / 14 Amber / 26 Green.

6.3 The remaining three Red indicators are concentrated within Governance & Assurance (2) and Interventions (1), providing a clear focus for ongoing improvement activity.

6.4 On this basis, the overall position continues to support Substantial Assurance, with residual risk clearly identified, increasingly contained and subject to targeted improvement activity. The priority for the next reporting period should be to maintain the gains achieved while progressing the remaining Red indicators and converting established Amber controls to demonstrably effective and sustainable Green arrangements.

7. VIOLENCE AND AGGRESSION – OPERATIONAL RESPONSE AND INNOVATIONS

7.1 Violence and aggression towards staff remains one of the most significant operational risks facing the Trust. During 2025/26, 515 violence and aggression category IRIS reports were recorded, and Security Services attended a wide range of calls involving aggression, verbal abuse, assaults, violence and safeguarding related behavioural risk.

7.2 The Trust continued to respond through clinical engagement, enhanced incident review, Body Worn Video, environmental risk assessments, training pilots, repeat offender management and partnership working with West Yorkshire Police.

- 7.3 These arrangements improve staff confidence and strengthen organisational capability to respond to incidents, but further work is required to evaluate the impact of individual interventions and to evidence sustained outcomes.

8. BODY-WORN VIDEO (BWV)

- 8.1. Body Worn Video remains a key element of the Trust's Violence Prevention and Reduction strategy. The 2025/26 security highlight evidence states that Body Worn Video in clinical areas has improved staff morale and sense of safety and appears to be reducing incidents of violence and aggression towards staff and others.
- 8.2. Eccleshill Community Diagnostic Centre and M4 were identified as recent trial areas, with Ward 5 identified as the next area for deployment. Body Worn Video continues to support de-escalation, evidence capture, incident investigation and criminal justice outcomes where appropriate.

9. ENHANCED SECURITY PRESENCE IN EMERGENCY DEPARTMENT

- 9.1. Following a successful pilot, the Trust has permanently embedded dedicated Security Officers within the Emergency Department as part of the core staffing model. Security Officers now work alongside clinical colleagues on a daily basis, providing an immediate response capability, supporting staff and patient safety, and contributing to the management of violence, aggression and disruptive behaviour. Feedback from clinical teams, as reported previously to the Executive Team, has remained consistently positive, with staff highlighting improved perceptions of safety, enhanced partnership working, and a timelier and coordinated response to security incidents.

10. VPR ENGAGEMENT

- 10.1. In support of the NHS Violence Prevention and Reduction Standard, the Security Team has continued to lead and support a broad programme of violence prevention, awareness, training and engagement activity across the Trust. This has included delivery of violence prevention awareness sessions, support for conflict management and personal safety initiatives, engagement with clinical and operational teams, promotion of incident reporting and lessons learned, and collaboration with key partners to strengthen the Trust's approach to preventing and responding to violence and aggression. These activities aim to promote a safer working environment for staff, patients and visitors, while embedding a proactive culture of violence prevention across the organisation.
- 10.2. We hosted a series of violence prevention awareness stalls across multiple clinical and public areas of the hospital sites, including main entrances, emergency departments, and high-footfall ward corridors. These stalls aimed to raise awareness of staff protection measures, reporting procedures, and to engage with staff, patients, and visitors on the importance of respectful behaviour in healthcare settings.

11. CONFLICT RESOLUTION TRAINING (CRT) DELIVERY AND COMPLIANCE

Training Delivery Model

- 11.1. The Education and Training Department continues to deliver e-learning *Conflict Resolution Training (CRT)* in accordance with national guidance. Sessions are delivered during Trust Induction, ensuring all new starters receive the appropriate training on managing conflict and promoting safer working environments. Refresher training is mandated every three years and is delivered via an eLearning platform.

Compliance Performance

- 11.2. As of the reporting period:
Total staff compliant: 4,742

- 11.3. **Compliance rate: 94.99%**
Staff not compliant (never completed training): 11

- 11.4. These figures reflect a high level of organisational compliance with mandatory CRT requirements.

- 11.5. **eLearning Refresher Access:** All CRT refresher training is accessible through the Trust's eLearning system, enabling staff to complete this requirement flexibly and efficiently within the three-year revalidation cycle.
- 11.6. During 2025/26, the Security Management Team worked with Education and Training colleagues to strengthen capability in areas experiencing higher levels of violence and aggression. Enhanced Conflict Resolution Training was booked for ED, AMU1 and AMU4 staff as part of a pilot.
- 11.7. A Trust-wide Training Needs Analysis remains central to future workforce development planning and should support a risk-based training programme aligned to incident trends and local operational risks.

12. RISK ASSESSMENTS

- 12.1. During the reporting period, 23 specialist security-related risk assessments were undertaken by the Security Management Team at the request of departments.

13. INCIDENT REPORTING AND CULTURAL IMPROVEMENTS

- 13.1. Accurate and timely reporting of security related incidents remains fundamental to the Trust's Violence Prevention and Reduction programme. During 2025/26, continued emphasis was placed on improving reporting culture, strengthening incident investigation and increasing staff confidence in both internal reporting and criminal justice outcomes.
- 13.2. The Trust recorded 667 security related IRIS reports, including 515 violence and aggression-category reports. Security Services also attended 2,491 calls for service. These figures demonstrate significant operational demand and provide intelligence to inform targeted interventions.
- 13.3. Despite progress, under reporting remains a recognised challenge, particularly where staff do not submit incident reports, decline to provide witness statements, or are reluctant to engage in criminal investigations. This can limit opportunities to pursue criminal sanctions and reduce the effectiveness of preventative interventions.
- Enhanced trend analysis and repeat offender identification.
 - Improved targeting of violence prevention interventions.
 - More effective deployment of security resources.
 - Improved partnership working with West Yorkshire Police.
 - Stronger evidential support for investigations and prosecutions.

14. TRUST WIDE REPORTING: VIOLENCE PREVENTION AND REDUCTION

- 14.1. The table below details IRIS-reported physical assaults on NHS staff by patients, visitors and members of the public during the period 1 April 2025 to 31 March 2026, compared with the previous five years. Reported assaults increased from 174 in 2024/25 to 187 in 2025/26. This may in part reflect increased reporting confidence and targeted engagement activity; however, continued monitoring is required to distinguish changes in reporting behaviour from changes in underlying incidence

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15. CLINICALLY RELATED VS. INTENTIONAL PHYSICAL ASSAULTS

15.1. A significant proportion of physical assaults reported during the 2025/26 period continue to be associated with medical or clinical factors. These are incidents where the perpetrator lacked awareness of their actions or their consequences due to factors such as:

- Acute or chronic medical conditions
- Mental ill health
- Severe learning disabilities
- Effects of medication or treatment

15.2. Such assaults are categorised as *clinically related challenging behaviour*, recognising that the individuals involved may not have had criminal intent. These cases present unique challenges in terms of risk mitigation, staff training, and the implementation of supportive interventions that balance patient care with staff safety.

15.3. In contrast, 19 physical assaults were recorded as not involving identified medical factors. These incidents were considered for appropriate criminal, civil or administrative action according to the circumstances of each case and the available evidence. Outcomes during the reporting period included:

- Adult cautions
- Community resolutions
- Custodial sentences
- Community service orders
- Financial penalties, including fines and court costs
- Compensation awards to victims

15.4. This demonstrates the Trust's commitment to pursuing appropriate legal consequences where thresholds are met and where the victim supports prosecution.

16. VIOLENCE AND AGGRESSION REPORTING TRENDS (IRIS DATA)

16.1. The following table presents data on violence and aggression incidents (including threatening behaviour and verbal abuse) as recorded on the IRIS Incident Reporting System for the period 1 April 2025 to 31 March 2026, compared with previous years.

16.2. **Key Trend:** Recorded incidents increased by 115 during 2025/26. This increase is considered to provide a more representative picture of the incidents experienced by staff, patients and visitors. In particular, reports of verbal abuse have increased in an area historically recognised as under-reported..

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A significant contributing factor to this higher-than-average reporting of incidents has been the targeted engagement and awareness work undertaken by the Security Management Team, aimed at encouraging accurate and timely reporting of incidents.

16.3. **Targeted Interventions in High-Risk Areas:** Following trend analysis and individual incident reviews, the Security Services team has engaged directly with several high-risk clinical areas to provide additional support and intervention. These areas include:

- Accident and Emergency Department (AED)
- Ward 4
- Ward 17
- NICU
- M4
- Ward 27
- Ward 28

16.4. This proactive engagement has included awareness sessions, environmental risk assessments, liaison with ward leadership teams, and collaboration with the VPR Sub-Committee to ensure appropriate mitigation measures are in place.

V&A	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Total	298	273	280	494	400	515

16.5. The table below highlights the 5 highest reporting areas for violence and aggression during the reporting period:

Area 2025/26	Combined incidents of Physical assault, threatening behaviour & verbal abuse
Emergency Department	140
AMU 4	46
AMU 1	36
Ward 27	36
Ambulatory Care Unit	16
Total	274

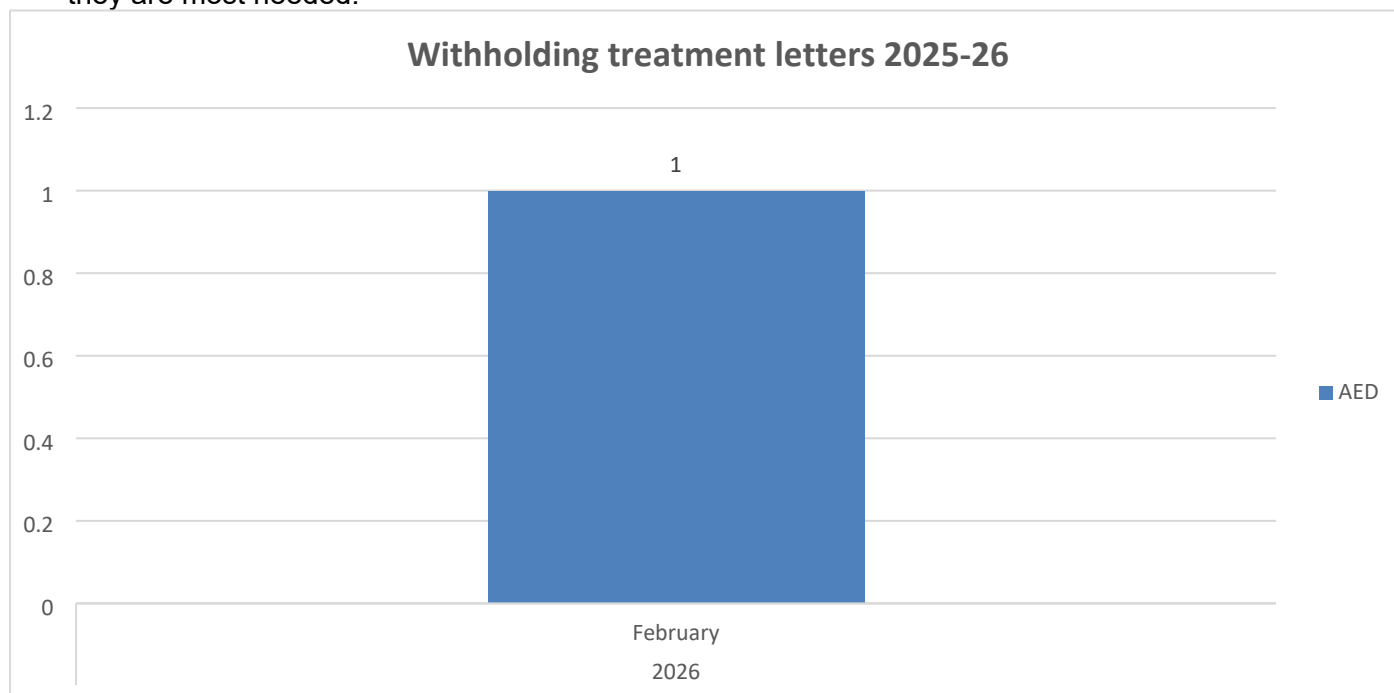
16.6. The Security Management Team are working with the AED Leadership Team to ensure that 'warning' letters are issued to patients attending and being verbally abusive to staff to reduce the numbers of verbal abuse, threatening behaviour, and physical assaults, as a result of this several unacceptable behaviour warning letters have been issued to patients.

16.7. Work with the AED leadership team has been undertaken within the 2025/26 year, with observation within ED taking place of patient and clinical interactions, a proactive review of incidents taking place and the information flow of incident reporting and follow-ups which formed input into the EXCEL programme.

16.8. This included additional patrols within AED by the Security team and on-site PCSO that saw a reduction in incidents and calls during their presence at peak times.

16.9. The data highlights several priority areas requiring continued focus and also suggests that incidents of violence, aggression and abuse may remain under-reported in some areas. The Security Management Team will continue to work with service leads to promote reporting, improve data quality, ensure appropriate follow-up of incidents, and identify local training and support requirements. This approach

will help strengthen organisational intelligence and ensure targeted violence prevention and reduction interventions are directed where they are most needed.



17. MANAGEMENT OF ANTI-SOCIAL BEHAVIOUR AND HIGH-RISK PATIENTS

17.1. The Security Management Team continues to work in close partnership with the Accident and Emergency Department (AED) to support the management of frequent and regular attenders who display abusive, violent, or anti-social behaviour. One of the key tools used in this process is the completion of Anti-Social Behaviour (ASB) Diaries, which enable staff to record and collate relevant incidents for appropriate review and escalation.

17.2. Where justified, the Trust considers a range of formal interventions, including:

- Withdrawal of treatment, in line with Trust policy and ethical review
- Access bans from the Trust premises
- Application for Criminal Behaviour Orders (CBOs) in collaboration with West Yorkshire Police (WYP)

17.3. Currently, several individuals are subject to WYP anti-social behaviour measures, including yellow and red warning letters. Notably, one high-risk individual, who threatened to kill a member of staff is subject to a CBO application and due in Crown Court in September 2026.

17.4. Another high-risk individual has been issued with a restraining order prohibiting attendance at BRI, except in the case of a genuine medical emergency or a pre-booked, evidenced appointment. The order remains in force until 7 July 2031.

18. CHALLENGES IN REPORTING AND STAFF CONFIDENCE

18.1. Analysis of recent data trends highlights ongoing barriers to effective incident reporting and prosecution, particularly regarding violence and aggression. Key challenges include:

- Reluctance to Report or Provide Statements: Some staff continue to withhold formal incident reports or victim statements, which significantly limits the Trust's and Police's ability to take enforcement action.
- Underlying Causes:
 - Fear of retaliation or re-attendance by perpetrators

- Cultural or community-based sensitivities (e.g., shared community groups)
- Staff being victims of domestic abuse, leading to underreporting due to complex personal dynamics
- A perceived lack of follow-up or faith in the outcomes of reporting

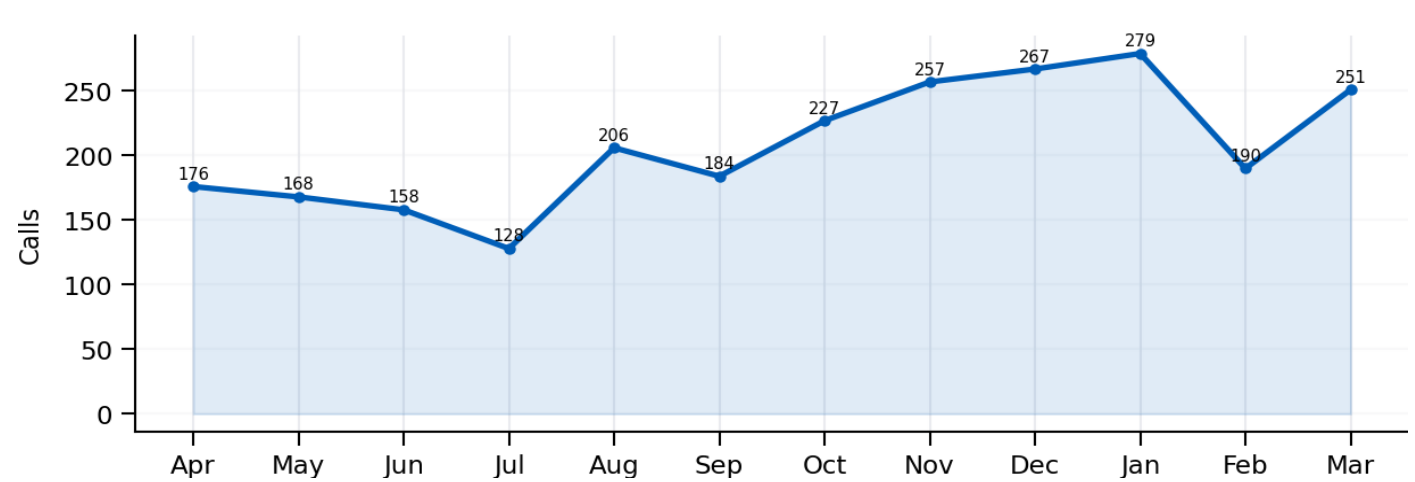
To address these issues, the Trust is:

- Engaging directly with departments where underreporting is most prevalent
- Working in partnership with West Yorkshire Police to reassure staff and clarify the legal support available
- Delivering educational inputs to raise awareness of reporting pathways and victim support mechanisms

19 NUMBER OF CALLS FOR SERVICE PER MONTH – SECURITY 2025/26

- 19.1. Security Services continue to provide a 24-hour response capability across Trust sites. Analysis of calls for service provides insight into operational demand, emerging risks, resource requirements and opportunities for preventative intervention.
- 19.2. During 2025/26, Security Services attended 2,491 calls for service. The highest monthly demand was recorded in January 2026 with 279 calls.

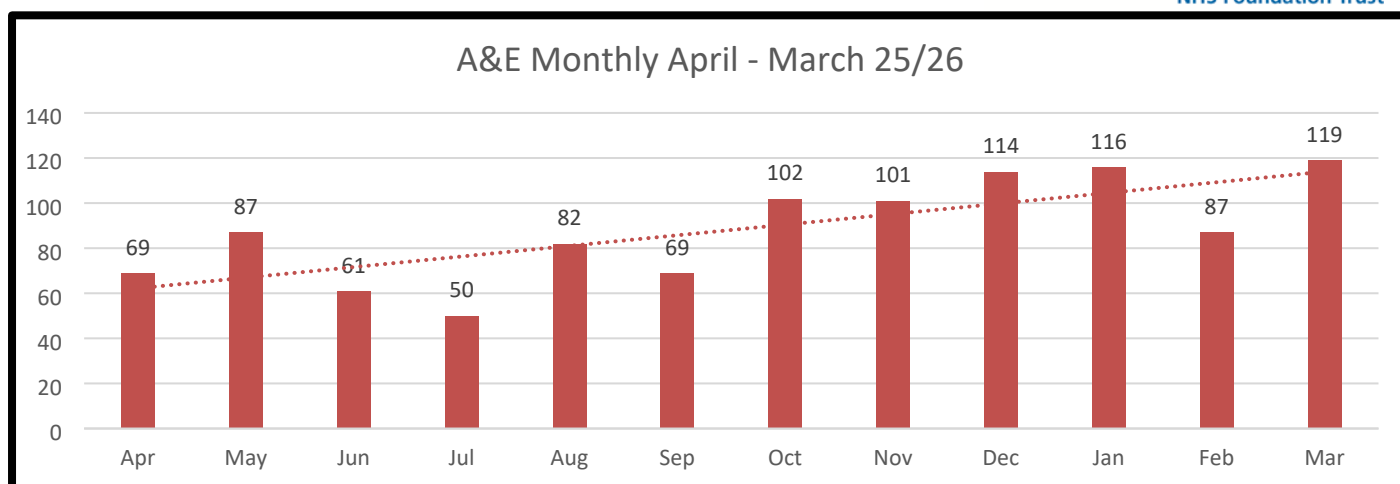
Security calls for service by month, 2025/26



- 19.3. The data supports continued focus on demand planning, targeted support in pressure months, and further investment in training and prevention across all Clinical and Non-Clinical settings.

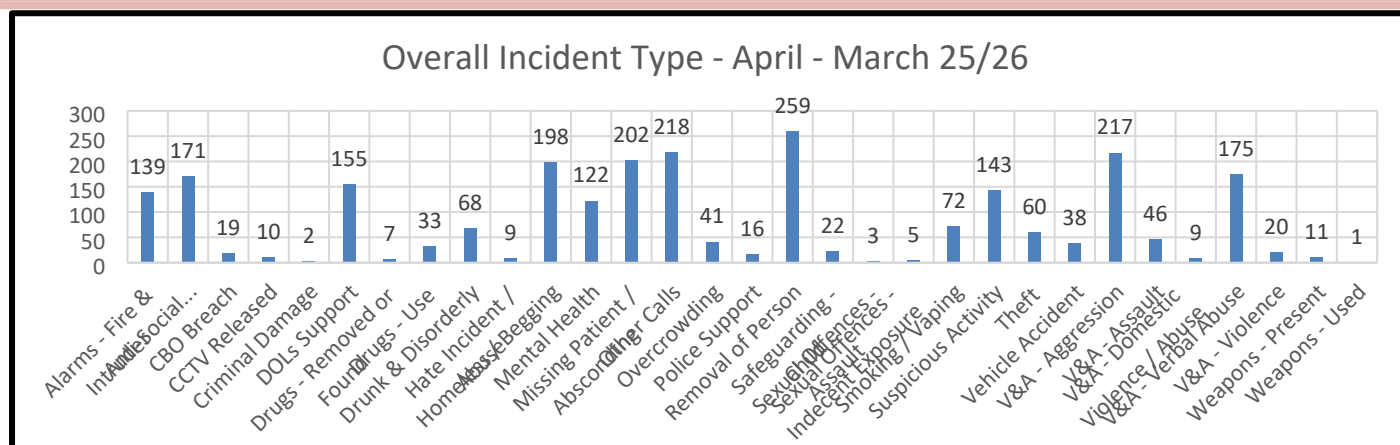
20. NUMBER OF CALLS FOR ACCIDENT AND EMERGENCY ONLY EACH MONTH: 2025/26

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20.1. The data reflects monthly incident volumes within the Emergency Department, highlighting a peak in March (119 incidents) and a noticeable dip in July (50 incidents). The overall monthly average is approximately 88 incidents which equates to an increase of 3 per month compared with last year's figures. The trend supports the continued need for sustained security presence and proactive violence prevention measures within this high-demand area.

21. OVERALL INCIDENT TYPE – SECURITY RESPONSE 2025/26



21.1. The data highlights the range and frequency of security-related demand across the Trust. Violence and Aggression, comprising 467 recorded incidents across the relevant V&A categories, represents the largest combined area of demand, followed by Removal of Person (259), Other Calls (218), Missing Patient/Absconding (202), Homeless/Begging (198), Anti-Social Behaviour (171) and DoLS Support (155). This demonstrates the broad operational scope managed by Security Services and reinforces the continued need for violence prevention, staff training and effective response protocols.

22. VEHICLE & CYCLE CRIME

22.1. During the reporting period (April 2025 to March 2026), the Trust recorded a continued reduction in reported car crime, while no crimes were noted in motorbike and cycle-related thefts. These figures remain low in the context of overall Trust footfall, car park usage, and the broader local crime environment.

Reported Theft Data

Year	Theft of Vehicle	Sat-Nav / Media	Catalytic Converter	Number Plate	Tools	Wing Mirror	Cycle	Cycle Tyre	Motorbike	Total
2024/25	1	1	1	1	1	1	1	1	1	10
2025/26	1	1	1	1	1	1	1	1	1	10

2021/ 22	0	9	7	1	1	0	0	0	1	19
2022/ 23	4	15	2	4	0	1	2	1	3	32
2023/ 24	1	12	0	0	0	0	2	0	1	16
2024/ 25	0	15	0	3	0	1	0	0	0	19
2025/ 26	1	11	0	0	0	1	0	0	0	13

Source: West Yorkshire Police and Trust Security Data

22.2. **Crime Prevention Initiatives:** The decrease in car crime is attributed to a sustained and collaborative approach with West Yorkshire Police (WYP), including:

- Joint security assessments of car parks with the WYP Crime Reduction Officer.
- Routine high-visibility patrols by PCSOs and Security Officers.
- Targeted presence during national theft trends (e.g., satellite navigation systems, catalytic converters).
- Strategic police vehicle patrols across the Trust car parks.
- Assessment for dedicated car park enforcement roles to reduce crime and increase revenue.
- In December 2025, the Trust retained the Park Mark Safer Parking Award across multiple sites (C Block, Horton Wing, Smith Lane, BRI Main), highlighting excellence in crime prevention, safety, and environmental management of car parking facilities. Due to the number of thefts from vehicles within the maternity car park, the award was deferred for maternity and will be reviewed in December 2026.
- Car parking barriers have been installed throughout the sites, including staff car parking areas, which has aided in the reduction of vehicle crime.

22.3. **Motorbike and Cycle Crime:** There have been no reported incidents involving theft of cycles and motorbikes in the reporting period, and the security improvements to the cycle hubs appear to have been a sufficient deterrent. The Security Management Team continues to monitor this closely in partnership with WYP.

Interventions include:

- Daily monitoring and patrol of cycle storage and car park areas by PCSOs and security staff.
- Targeted communications to staff regarding secure locking practices and storage use.
- WYP bike marking days of action
- Engagement with individuals exhibiting suspicious or anti-social behaviour on Trust premises.

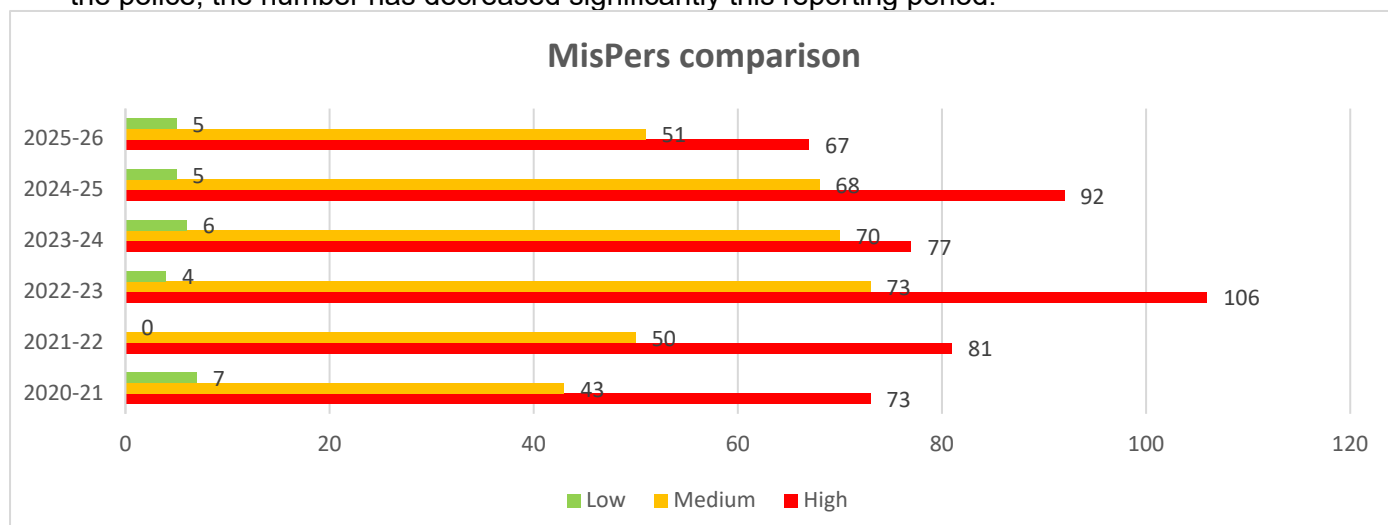
The majority of offences are believed to be committed by individuals with substance misuse issues, and crime spikes are often linked to specific repeat offenders. The Trust remains comparatively low in reported crime rates relative to the wider West Yorkshire area.

22.4. **Wider Theft and Security Concerns:** Environmental Factors: Incidents often result from avoidable security lapses, such as unsecured windows, wedged doors, and tailgating.

- Theft of Patient Property: Continues to feature in incident reports. Patients are encouraged to leave valuables at home, and PCSO patrols target known 'hot spot' wards.
- Storage Issues: Lack of secure ward level storage for personal electronic devices contributes to opportunistic thefts.
- Procedural Compliance: Inconsistent adherence to the Trust's *Patient Property and Valuables Procedure* hampers investigations and increases compensation costs.

23. MISSING PERSONS

- 23.1. Working with WYP to reduce the number of patients reported inappropriately as 'missing' (123 in the reporting period compared to 165 in the previous year). The Security Management Team works with specific ward staff identified as inappropriately reporting/not following the protocol to re-educate and reduce inappropriate reporting to the police; the number has decreased significantly this reporting period.



24. DESIGNING OUT CRIME

- 24.1. **Women's and Children's Unit – Abduction Lockdown System Enhancements:** Following lockdown testing and subsequent reviews, the Security Management Specialist supported improvements to the Women's and Children's Unit abduction lockdown arrangements. Issues identified during exercises were reviewed with Estates and contractors, resulting in modifications to door access arrangements and system functionality. Further enhancements, including improved alarm indication and enhanced staff awareness measures, continue to be progressed through governance processes.
- 24.2. **Security Design Input on Capital Projects:** The Security Management Specialist continued to provide specialist security design advice across refurbishment and capital projects, ensuring security considerations were incorporated at the design stage. This included recommendations relating to access control, CCTV, alarm systems, police room facilities and compliance with Secured by Design principles to reduce opportunities for crime, anti-social behaviour and unauthorised access.
- 24.3. **Maternity Car Park CCTV and Crime Reduction Measures:** Following a significant increase in thefts from vehicles, particularly thefts of vehicle infotainment systems, additional CCTV coverage was specified and subsequently implemented within the maternity car park. The enhanced surveillance arrangements were introduced to improve deterrence, support police investigations and strengthen public confidence in site security. Further car park security improvements, including controlled vehicle access arrangements, have complemented these measures.
- 24.4. **Car Park Access Control and ANPR Implementation:** Automatic Number Plate Recognition (ANPR) technology and vehicle barrier systems were introduced across staff parking areas at Bradford Royal Infirmary and St Luke's Hospital. The project has improved control of vehicle access, strengthened parking security and provided a more effective platform for managing unauthorised use of Trust car parking facilities. Supporting operating procedures were also developed for CCTV monitoring, patrols and fault response arrangements.
- 24.5. **Endoscopy Development Security Enhancements:** The Security Management Specialist provided design and commissioning support to the new Endoscopy development, including access control arrangements, CCTV considerations and intruder alarm provision. Security requirements were incorporated into the snagging and commissioning process to ensure the new facility opened with suitable physical security measures and departmental alarm arrangements in place.

- 24.6. **Emergency Department Refurbishment Security Design:** The Security Management Specialist provided specialist input into Emergency Department refurbishment proposals to ensure that security and policing requirements were considered within the design process. This included engagement with West Yorkshire Police and capital project teams regarding police accommodation, operational requirements and compliance with crime prevention design standards.
- 24.7. **CCTV Infrastructure and Security Technology Improvements:** Work was undertaken to improve the resilience and performance of the Trust's CCTV infrastructure, addressing technical issues impacting image quality, recording capability and incident investigation. The Trust also commenced implementation of advanced AI-enabled CCTV technology and Smart Wall integration to improve incident tracking, searching and future integration with access control systems.
- 24.8. **Ongoing Car Park Security Enhancements:** The Trust continued to strengthen security within its car parks through the identification and closure of remaining CCTV coverage gaps, installation of additional cameras and ongoing development of ANPR and barrier technology. These improvements support the Trust's wider commitment to reducing vehicle crime, improving safety and providing a more secure environment for staff, patients and visitors.
- 24.9. **Martyn's Law and Protective Security Programme:** The Trust has undertaken a significant programme of work to prepare for the forthcoming Martyn's Law legislation and strengthen protective security arrangements across its estate. A multidisciplinary working group was established to oversee compliance planning, undertake gap analysis against emerging requirements, review site-specific vulnerabilities, and develop a phased implementation plan. Workstreams have included the review of access control measures, hostile vehicle mitigation, lockdown arrangements, emergency response procedures, staff awareness training, communications, governance arrangements and integration of protective security considerations into capital developments and refurbishment projects. This programme has enhanced organisational preparedness, improved understanding of terrorism-related risks and strengthened the Trust's ability to protect staff, patients and visitors from a range of security threats.

25. STRATEGIC ALIGNMENT AND ASSURANCE

- 25.1. Effective security management is integral to safe, high-quality healthcare. Security Services support patient safety, staff wellbeing, operational resilience and regulatory compliance.
- 25.2. Security Services align to the Trust strategic objective for People by supporting staff safety, workforce wellbeing, violence prevention, training, partnership working and environmental safety improvements.
- 25.3. Governance arrangements operate through the VPR Sub-Committee, Health and Safety Committee, People Academy, Executive Management Team, Finance and Performance Committee and Trust Board. These arrangements provide oversight of security risks, VPR performance, incident trends, audit recommendations, legislative compliance and workforce safety initiatives.

26. EQUALITY, DIVERSITY AND INCLUSION (EDI)

- 26.1. The Trust is committed to creating a safe, inclusive and respectful environment for all staff, patients, visitors and partner organisations. Security Services support this commitment through fair, proportionate and person-centred security management practices.
- 26.2. Security Services support the Trust's zero tolerance approach to violence, aggression and discrimination, including incidents involving racist abuse, religious discrimination, disability-related harassment, homophobic or transphobic abuse, sexist behaviour and other forms of targeted hostility.
- 26.3. The Trust continues to improve equality monitoring, demographic analysis and reporting transparency to better understand how incidents affect different groups and to ensure interventions are equitable and proportionate.

26.4. Security has supported Trust-wide EDI objectives through:

- Engagement with the Women's Network and RESIN Forum
- Addressing and investigating incidents involving hate-based aggression
- Participation in SPaRC community outreach initiatives, enhancing visibility and support
- EDI community and staff engagement sessions
- Demographic information added to the IRIS and VPR dashboards
- Hate Crime awareness days

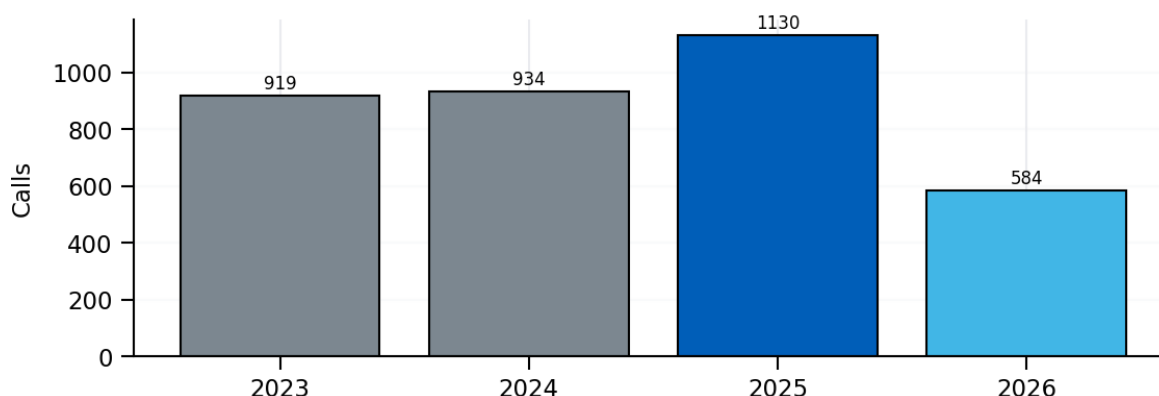
27. WEST YORKSHIRE POLICE PARTNERSHIP WORKING

27.1. The strategic partnership between Bradford Teaching Hospitals NHS Foundation Trust and West Yorkshire Police remains a critical component of security management, violence prevention, crime prevention and community safety.

27.2. The Trust funds 50 percent of the equivalent of 2.45 full-time PCSO posts, providing a dedicated and consistent policing presence at Bradford Royal Infirmary. The PCSOs are integrated within the Bradford West Neighbourhood Policing Team and provide visible reassurance across the hospital site.

27.3. West Yorkshire Police data demonstrates a significant reduction in BRI police calls for service, from 1,130 in the 2025 report period to 584 in the 2026 reporting period. Peak demand is reported between 14:00 and 18:00.

BRI police calls for service by reporting year



- High-visibility patrols and reassurance.
- Crime prevention and intelligence gathering.
- Missing person enquiries and CCTV review.
- Anti-social behaviour management.
- Support for victims of crime.
- Problem-solving initiatives with clinical and security teams.

27.4. **Role and Value of PCSOs within the Hospital Environment:** PCSOs play a vital role in addressing shared NHS and policing priorities, providing visible and approachable reassurance to staff, patients, and visitors. Their presence enables real-time intelligence sharing, proactive intervention, and a consistent link between local policing and healthcare operations.

27.5. **Operational Delivery and Cost-Effectiveness:** The PCSO team operates on a three-team rota, enabling strategic coverage during peak demand periods. This operational model supports crime prevention, public confidence, and value for money for both the NHS and West Yorkshire Police.

27.6. **Crime Prevention and Measurable Impact:** Although preventative work is difficult to quantify, the continued low levels of recorded thefts on hospital wards highlight the impact of combined police action in prior years and ongoing enforcement supported by a robust Trust policy framework.

27.7. **Enhancing Staff Confidence in Reporting:** There remains a need to increase reporting confidence among staff—particularly agency and temporary staff—regarding violence and abuse. Joint efforts are

underway, led by the Neighbourhood Policing Team (NPT) and the Trust's Security Management Team, to deliver bespoke PCSO tasking and tailored training inputs to improve engagement and awareness.

- 27.8. **Sustained Demand Reduction:** A three-year incident and call data analysis demonstrates consistently low levels of crime and call volumes at BRI. Even when accounting for fluctuations due to COVID-19, these figures reflect the ongoing success and maturity of the policing and NHS partnership model.
- 27.9. **Partnership Continuity and Long-Term Commitment:** The PCSO contract has been successfully renewed for a further three years, ensuring sustained visible policing presence on-site and reinforcing the strength of the strategic partnership with West Yorkshire Police.
- 27.10. **Local Police Engagement:** Police teams have actively participated in staff forums, supporting the Trust's violence prevention strategy. Regular liaison has strengthened joint risk assessments and care for vulnerable individuals on site.
- 27.11. **Support for Women's Group:** PCSOs have supported the Trust's Women's Group, attending sessions to share personal safety advice, enhance awareness of reporting mechanisms, and provide community reassurance, particularly for female staff.
- 27.12. **Joint Working with West Yorkshire Police – Anti-Social Behaviour:**
The Security Team continues to work closely with West Yorkshire Police's Anti-Social Behaviour (ASB) Unit to identify, monitor and reduce the number of patients exhibiting repeat ASB on Trust premises. This joint approach ensures a coordinated response to behavioural risks and strengthens community safety within the hospital environment.
- 27.13. **Management of Homeless Individuals on Site:** Partnership working with the Trust's Homeless Health Team has focused on reducing the inappropriate use of hospital facilities by individuals seeking refuge. Where behaviours escalate into persistent anti-social activity, cases are now routinely escalated to the police, and individuals are removed from the site where appropriate.
- 27.14. **Mental Health Partnership – Right Place, Right Care:** The Trust continues to play an active role in the *Right Place, Right Care* mental health initiative, in collaboration with WYP and YAS. The LSMS/VPR Lead contributed to partnership workshops by delivering training on role clarity, expectations, inter-agency procedures, and coordinated crisis response, ensuring individuals in mental health distress receive timely and appropriate care.
- 27.15. **Hate Crime Awareness and Inclusion Initiatives:** As part of the Trust's commitment to inclusion and zero tolerance for hate crime, PCSO-led engagement sessions were delivered on-site. These events educated staff, patients, and visitors on recognising, reporting, and responding to hate crime, further strengthening links between the Trust and local policing teams.
- 27.16. For the full Policing report, please see Appendix 1

28. WEST YORKSHIRE POLICE: 2026/27 SECURITY WORKPLAN

- 28.1. The Trust continues to work in partnership with West Yorkshire Police, and the security management team will work with them to develop a 2026/2027 hospital policing plan based on the crime trends of 2025/2026 as identified in the tables within the report.
 - Addressing the proactive element of security in the year, specifically working with the Police to reduce violence and aggression and theft.
 - Working with the WYP ASB team to actively monitor and target individuals exhibiting anti-social behaviour
 - Undertaking risk assessments in the 5 high reporting areas of violence and aggression

- Ad hoc input in relation to security recommendations for new build and refurbishment projects throughout the organisation
- Ad hoc input at MDT meetings for complex patients exhibiting signs of violence and aggression
- Baby Abduction Testing (Women's and Children's Unit)
- Child/infant Abduction Testing (Children & Young Persons' wards)
- Quarterly seasonal security awareness tabletop advice sessions, supported by WYP
- Continue to deliver reporting confidence sessions in collaboration with WYP and witness care from the courts to high reporting areas within the Trust
- Violence Prevention and Reduction (VPR) Task and Delivery Group

28.2. Continual review (twice annually) of the Trust status against the Violence Prevention and Reduction Standard

29. TECHNOLOGY AND INFRASTRUCTURE

- 29.1. Technology plays a critical role in preventing and detecting crime, supporting investigations, improving staff safety and strengthening organisational resilience. During 2025/26, the Trust continued to review CCTV, access control, Body Worn Video, digital reporting and personal safety technology
- 29.2. CCTV supports investigation of violence and aggression, missing patient enquiries, vehicle crime, anti-social behaviour, safeguarding incidents, evidence gathering and site security monitoring. Areas of focus
- 29.3. include Emergency Department entrances, public access areas, car parks and high-risk clinical environments.
- 29.4. Work continued to strengthen VPR reporting capability through dashboard development. The intended benefits include improved visibility of incident trends, better performance monitoring, identification of high-risk areas and stronger compliance evidence.

30. MARTYN'S LAW READINESS AND PROTECTIVE SECURITY

- 30.1. Martyn's Law, the Terrorism (Protection of Premises) Act 2025, creates new protective security expectations for qualifying premises. Health and Safety Committee reporting identifies that BTHFT is expected to fall within the Enhanced Tier due to estate size, function and footfall.
- 30.2. The Trust has commenced preparedness work through Health and Safety Committee reporting and a Martyn's Law Working Group (MLWG) programme. Evidence identifies principal risk areas including Enhanced Tier compliance, role clarity, grey space complexity and regulatory enforcement risk.
- 30.3. Post-period evidence identifies movement from initial programme set up into active workstream mobilisation through governance, physical security and estates, public protection procedures, and training and exercising workstreams.
- Develop a Trust-wide Counter-Terrorism Security Plan.
 - Confirm accountable roles and governance arrangements.
 - Complete training needs analysis and competence framework.
 - Undertake protective security assessments and risk treatment planning.
 - Convert planning activity into auditable evidence and prioritised action.

31. DISCLOSURE AND BARRING SERVICE ASSURANCE

- 31.1. During 2025/26, a Trust-wide workforce assurance issue was raised concerning the frequency and coverage of Criminal Records Bureau and Disclosure and Barring Service checks. Enterprise correspondence records concern that some long-serving staff may not have received either check because they remained in the same role, and that current practice may rely mainly on a check at appointment or when applying for a different role.

- 31.2. The issue is not confined to Security Services and should be addressed through a corporate workforce and safeguarding review. People and Human Resources should lead the review with Recruitment, Safeguarding, Information Governance, Equality, staff-side, Security and VPR input.

The review should establish the assurance baseline, identify historic gaps, confirm role eligibility and the proportionate level of check, and assess self-disclosure, rechecking, role-change and continuous-update arrangements.

32. FORWARD-LOOKING RISKS AND RECOMMENDATIONS

	Why it matters	Recommended action
Violence and aggression	Continues to affect staff safety, wellbeing and operational delivery.	Maintain targeted VPR programme, intervention evaluation and staff support.
Workforce resilience	Security response depends on resilient, trained and available staff.	Validate workforce data and review staffing model, sickness and training requirements.
Training and competency	High-risk teams require skills matched to local risk.	Complete TNA, options appraisal and training evaluation.
Data quality and dashboards	Board assurance depends on reliable intelligence.	Validate dashboard data and create an intervention outcome framework.
Technology and infrastructure	CCTV, access control and BWC underpin prevention and evidence capture.	Develop integrated security technology plan with Estates and Digital Services.
Martyn's Law	New duties create regulatory and operational readiness requirements.	Progress workstreams and produce auditable compliance evidence.
Police partnership	Visible policing and ASB response remain key controls.	Maintain PCSO model and joint demand reduction work.
DBS assurance	Historic gaps may affect workforce and safeguarding assurance.	Commission a lawful, proportionate, role-based corporate review.

33. RECOMMENDATIONS TO THE BOARD:

- Note the contents of this Annual Security Board Report and the progress made during 2025/26.
- Take assurance from verified annual security activity data, policing partnership evidence and VPR governance progress.
- Support continued development of the Violence Prevention and Reduction programme and action plan.
- Support completion of a comprehensive Training Needs Analysis and enhanced training plan.
- Support continued deployment and evaluation of Body Worn Video where operationally justified.
- Support further development of security performance reporting and dashboard capability.
- Support Martyn's Law readiness work, including governance, protective security, public protection procedures and training workstreams.
- Note the increasing demands on the service and implications for strategic workforce planning

34. CONCLUSION

- 34.1. This Annual Security Board Report provides assurance regarding the management of security, violence prevention and reduction, policing partnership, operational demand and strategic security risks across the Trust during the period 1 April 2025 to 31 March 2026.

- 34.2. Security Services continued to play a vital role in supporting safe healthcare delivery. The volume and complexity of incidents attended by Security Officers demonstrates the evolving role of healthcare security and the importance of maintaining a professional, skilled and resilient service.
- 34.3. The Trust has continued to strengthen its VPR arrangements through governance, action planning, staff engagement, Body Worn Video, targeted intervention and partnership working. Operational demand remains significant, with the Emergency Department continuing as the highest-demand area.
- 34.4. Based on the evidence available, there is reasonable assurance that effective arrangements are in place for managing security across Bradford Teaching Hospitals NHS Foundation Trust. Opportunities for improvement remain in workforce assurance, intervention evaluation, data maturity and evidence closure, but the overall direction of travel is positive.

Appendices store in Admincontrol [click here](#)

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Finance and Performance Committee				
Meeting Date:	16.09.2026	Agenda Reference:	FC.9.26.17	
Report Title:	EPRR Update and Submission			
Presented by:	Steve Amos, Emergency Planning Manager			
Executive Lead:	Sajid Azeb, Chief Operating Officer / Deputy Chief Executive / Accountable Emergency Officer			
Author:	Steve Amos, Emergency Planning Manager			
Report Summary				
Purpose of the paper:	Decision ☒ approve	Assurance ☐	Action ☐	Information ☐
Summary of Key Issues/Highlights:	This paper is to update the Finance & Performance Committee on: The current position of the NHSE Core Standards and associated evidence			
Recommendation/s: (including any decision/approval required)	The Finance & Performance Committee is asked to: - Note the NHSE Core Standards current position - Note the Principles of Health Command % training - Note the Lessons identified tracker - Approve the Fuel Emergency Plan - Note the update on EPRR resource			
Link to Strategic Objective:	N/A			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	N/A			
Legal/Regulatory:	The Civil Contingencies Act 2004, (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England.			
Quality & Patient Safety:	No known impact			
Equality, Diversity and Inclusion and Health Equity:	No known impact			
Resources:	No known impact			
Environmental sustainability:	No known impact			
Assurance Route				
Meeting/s where content has been discussed previously:	The Fuel Emergency Plan has been to Trust Resilience group , H&SC and ETM.			

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Report content

1. Purpose

This report provides the Finance & Performance Committee with a position update in relation to our compliance with our compliance against the EPRR NHSE core standards. In specific it provides details of:

- The NHSE Core Standards current position
- Principles of Health Commander % training compliance
- An updated Lessons identified tracker
- Trust Fuel Emergency Plan
- An update on EPRR resource capacity

2. Assessment

a. NHSE Core Standards position

The same 62 core standards remain subject to review this year, although the assurance process has been revised.

West Yorkshire ICB has identified the five highest-priority risks from the NHS England North East and Yorkshire EPRR Risk Register and is focusing its assurance activity on the core standards most closely aligned to these risks. Organisations are not required to resubmit evidence where the ICB has already undertaken a review of a specific core standard during 2025 or 2026.

The Trust has continued to submit evidence against the requested core standards and all submissions reviewed to date have been assessed as compliant. In addition, the NHS North East and Yorkshire Regional Team will undertake a dip-sample review during this full assessment year, examining one identified core standard from each of the ten EPRR domains. This review is scheduled to take place during the week commencing 19 October 2026.

An evidence folder for all 62 core standards is being compiled to support the 'dip sample' request. Audit Yorkshire will also undertake an internal audit of our compliance and evidence later this year. As things currently stand, it is anticipated that the trust will report on being Substantially compliant by the deadline of 30th October. Substantial compliance is a minimum of 56 standards compliant out of 62, the remaining ones will be classed as partially compliant with none at non-compliant. As work is still progressing for another 6 weeks, the exact number cannot currently be confirmed. The main reason that some standards have not increased as hoped from last year from partial to substantial was the reduction of the EPRR team from 2 to 1 for 9 months, the team is now fully staffed, see section e.

b. Principles of Health Commander (PHC) Training update

The Trust is required to report on the % compliance with the EPRR PHC training figures for strategic and tactical levels on quarterly basis at the Local Health Resilience Partnership.

We are currently reporting compliance of Tactical 90%, Strategic 77%, EPRR 90%. The Strategic training compliance level will improve by December due to training already booked being completed and the availability of NHSE further training dates. It is not possible to have training compliance at 100% due to new starters joining the rota, but 85% is a baseline figure which we are normally working at.

- c. Lessons identified tracker
 All learning from incidents, exercises and training is logged on the tracker, this is shared with the Trust Resilience Group and Health & Safety Committee. The Committee is asked to note the progress made (Appendix 1).
- d. Fuel Emergency Plan
 The Fuel Emergency Plan has been produced to support the Trust should there be a national shortage of fuel and the Government enacts their National Emergency Plan in the event of a fuel crisis (NEP-F). This plan has been out for consultation to the Trust Resilience Group, Health & Safety Committee and ETM and is now for final approval. Appendix 2.
- e. EPRR Resource
 As part of the EPRR Core Standards, organisations are required to assess workforce capacity and capability to ensure they can fully discharge their statutory EPRR responsibilities. In April, the Finance and Performance Committee was advised that, due to staff turnover, the Trust's EPRR function was operating with only one substantive team member in post. Following a successful recruitment process, the previously vacant Emergency Planning Advisor position has now been filled. The successful applicant has commenced in post, and the Trust can therefore demonstrate that the EPRR team is fully established and appropriately resourced to meet its EPRR obligations and discharge its duties effectively

3. Options analysis/Proposal

The Finance & Performance Committee is asked to:

- Delegate authority to the Chief Operating Officer, in their capacity as Accountable Emergency Officer, to provide final approval and sign-off of the Trust's Statement of Compliance against the EPRR Core Standards, which is anticipated to achieve a Substantial Assurance rating and will be submitted to West Yorkshire ICB by 30 October 2026 (Appendix 3).
- Note and approve the Fuel Emergency Plan in accordance with the Trust's EPRR governance arrangements.
- Note the progress against actions recorded within the lessons identified tracker and the current compliance position for PHC training.

Appendices store in Admincontrol [click here](#)

Appendix 1. Lessons Identified Tracker

Appendix 2. Fuel Emergency Plan

Appendix 3. Core Standards sign off sheet

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Board of Directors public				
Meeting Date:	24/09/2026		Agenda Reference:	Bo.9.26.15
Report Title:	Bradford Teaching Hospitals NHS Foundation Trust's (BTHFT) Draft Winter Operational Response Plan for 2026–27 and Board Assurance Statement			
Presented by:	Edward Cornick, Deputy Director of Operations, Unplanned Care			
Executive Lead:	Sajid Azeb, Chief Operating Officer & Deputy CEO			
Author:	Edward Cornick, Deputy Director of Operations, Unplanned Care			
Report Summary				
Purpose of the paper:	Decision ☒ Approve	Assurance ☐	Action ☐	Information ☐
Summary of Key Issues/Highlights:	• Predicted demand for adult acute beds this winter is 490–515, peaking January–February, consistent with last winter's pattern and analysis. • The plan provides 18–30 additional adult beds: Ward 17 (+4), Ward 9 (+2), and Ward 8 (+12 delivered as the 24/7 Enhanced SDEC trolley/mobile bed model), with a further beds gained via Ward 10 (+4) and Ward 23 (+8) subject to Business Case approval outside of the winter process. • There are a number of resilience schemes to be approved for mobilisation, some of which were submitted by CSUs via the winter 'Dragons Den' process, some are central schemes they include: Specialist Medicine discharge lounge, Enhanced SDEC, Therapy Front Door Rapid Assessment & Rehabilitation, Point of Care Testing, an additional winter Patient Transport vehicle, the staff flu and COVID-19 vaccination programme, and Hospital at Night weekend/bank holiday cover. • Total forecast cost of the approved schemes is £648,964, funded entirely from the System Resilience budget (full breakdown in the appended Winter Plan Financials workbook). • Respiratory bed capacity remains under significant pressure (28 beds available against 36–38 required). The preferred mitigation is opening Ward 10, subject to Business Case approval; the fallback, as used last winter, is to flex the Ward:HDU staffing ratio at additional cost. • Flu vaccination for staff launches 1 October 2026, targeting 60% uptake (2025/26 achieved 46%, up from 34% the previous year). • Full Capacity Protocol, OPEL escalation, Command Centre operational meetings and system Surge and Escalation governance have all been refreshed for 2026/27, including a pre-Christmas Multi-Agency Discharge Event. • Key risks being tracked include workforce capacity and wellbeing, ability to flex to surges, side-room pressure from flu/RSV, staff flu vaccine uptake, timely mobilisation of schemes, protecting elective capacity, and the ICB's evolving role as system convener. • The draft winter plan has been checked against the Board Assurance Statement (see Appendix 1) and there is assurance that the plan meets all the criteria set within with Board Assurance Framework. • The Board of Directors is asked to approve the draft winter plan and Board Assurance Statement.			
Recommendation/s: (including any decision/approval required)	<i>The Board is asked to:</i> • Approve the draft winter plan and Board Assurance Statement.			

Link to Strategic Objective:	Performance- To deliver our key performance targets				
Link to priority transformation programmes:	EXCEL				
Implications					
Risks:	Related Corporate Risks <table border="1"> <tr> <td>2604</td><td>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.</td></tr> <tr> <td>2756</td><td>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</td></tr> </table>	2604	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.	2756	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
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2756	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				
Legal/Regulatory:	Requirement from NHSE and ICB as part of winter planning				
Quality & Patient Safety:	Providing additional schemes over winter, including increasing bed capacity, will provide additional mitigation for predicted winter pressures and help ensure that patient quality and safety is maintained.				
Equality, Diversity and Inclusion and Health Equity:	n/a				
Resources:	The report outlines the proposed spending of the winter resilience budget				
Environmental sustainability:	N/A				
Assurance Route					
Meeting/s where content has been discussed previously:	Finance & Performance Committee – 17.9.26				

Report content
1. Purpose This paper sets out Bradford Teaching Hospitals NHS Foundation Trust's (BTHFT) draft Winter Operational Response Plan for 2026–27. It summarises the national and regional context for winter planning, the Trust's assessment of predicted demand and capacity, the resilience schemes proposed to maintain patient flow and the Emergency Care Standard, and the associated financial implications. The Board of Directors is asked to approve the draft plan, including the schemes and non-recurrent funding set out in the Assessment and Summary and Costs sections, and to note the two areas where further approval is still required outside of the winter process (opening Ward 10 and expanding Ward 23). 2. Background/context Winter planning for 2026–27 has been developed against the backdrop of performance last winter. Overall Emergency Care Standard (ECS) performance across Type 1, 2 and 3 attendances was sustained in early winter, dropped in November/December, and recovered in January/February – in line with previous winters and the expected position. Paediatric attendances followed a similar

pattern, with a significant rise in November attendances driving a change in paediatric ECS performance.

Nationally, NHS England's Winter Planning 2026/27 – Expectations and Assurance guidance requires Trusts to eliminate corridor care as a patient safety priority, maintain elective capacity, protect delivery of agreed 2026/27 trajectories, assure tested arrangements for escalation, infection prevention and control (IPC), on-call leadership and staff welfare, and implement the model Emergency Department, model acute pathway and model discharge pathway. Plans are required to be assured through Trust Board governance. BTHFT's plan has already been tested through internal desktop analysis of last year's plan and performance, the Trust's contribution to the system ICB winter plan submitted in August, the winter checklist returned to NHSE in August, and a regional winter planning test event on 17 September in York, with lessons fed back into further planning.

Locally, public health intelligence points to a predictable seasonal pattern: a back-to-school rise in infections every September, a seasonal rise in RSV peaking at the end of November, flu typically peaking in January, and the busiest period coinciding with the peak in RSV, the rise in flu and the Christmas holidays – with the possibility of a new COVID variant or rise in known pathogens adding further pressure. This, together with last winter's demand of 490–515 adult acute beds (peaking January–February) and the Trust's longstanding respiratory capacity pressures, is the precursor for the schemes and actions set out in this plan.

3. Assessment

Predicted demand: analysis of last winter indicates 490–515 adult acute beds were required, peaking in January–February. This demonstrates a continued need to improve capacity in key areas (Same Day Emergency Care), improve flow (discharge lounges) and strengthen admission avoidance (therapies), alongside a longstanding requirement for additional respiratory beds.

For winter 2026–27 the Trust plans to make available 18–30 additional adult beds compared with core bed base: 4 beds on Ward 17, 2 beds on Ward 9 and 12 overnight trolley beds on Ward 8 (consistent with 2025–26), plus a further 4 beds on Ward 10 and 8 beds on Ward 23, both subject to Business Case approval outside of this process. The 12 additional beds on Ward 8 will be delivered as SDEC trolley/mobile bed spaces for AMU and Care of the Elderly patients awaiting admission. This extends the current Same Day Emergency Care model from a Monday–Friday, 8am–8pm service to a 24/7, seven-day model, with additional AIM consultant, nursing and HCA cover. This is judged a proportionate expansion: last winter's plan allowed for up to 20 SDEC trolleys, but demand did not require this, and there is a desire not to over-expand SDEC capacity beyond what activity supports.

Respiratory capacity remains a significant risk area. Current capacity is 28 beds (22 ward beds plus 6 HDU beds), against a demand assessment of 36–38 beds. Without additional capacity there is a risk of insufficient NIV bed capacity (worsening AED HDU waits and crowding), inappropriate use of ICU beds for respiratory NIV (leading to cancelled elective activity), and respiratory patients outlying onto AMU and other wards (further affecting ED crowding). The preferred mitigation is to open Ward 10 in line with the previously approved ETM strategic review, creating additional respiratory capacity and improving downstream flow; this requires Business Case approval. If this is not approved, the fallback mitigation used last winter is to flex the ward:HDU staffing ratio from 22:6 to 18:10 (with exceptional use of ICU), funded through the winter resilience budget at increased nursing and therapy cost.

A CSU-led 'Dragons Den' process was used to identify further resilience schemes funded from non-recurrent winter resilience funding. CSUs submitted proposals using a standard template; submissions were received in addition to the existing central winter schemes, and were assessed against winter planning expectations and available funding. The schemes approved for mobilisation are: a Specialist Medicine discharge lounge (Band 5 RN-led, increasing early ward discharges and

freeing up bed capacity); the enhanced 24/7 SDEC model described above; a Therapy Front Door Rapid Assessment and Rehabilitation service (5-day, senior OT/Physio-led) to increase same/next-day discharges and reduce length of stay; continuation of Point of Care Testing for rapid 4-in-1 virology testing across five key admission areas (AED, Paediatric Wards, AMU 1, AMU 4 and the Respiratory ward); an additional winter Patient Transport Service vehicle (via Transcare) to support timely discharge; the staff flu and COVID-19 vaccination programme delivered by Rimmington's Pharmacy; and continuation of the Hospital at Night Health Care Support Worker service, extended to long days on weekends and bank holidays. Full financial detail is set out in the Summary and Costs section of the plan and the appended Winter Plan Financials workbook, which totals £648,964, funded entirely through the System Resilience budget.

A number of further schemes were identified but are not currently funded, including a TTO doctor based in the Command Centre, embedding of the 72-hour standard and model ED through operational and medical leadership, additional deep cleaning and portering capacity, extended weekend pharmacy opening to facilitate discharges, additional beds on Wards 18 and 19, and improved Command Centre operational meetings; these represent further potential improvement opportunities should additional funding become available.

Alongside bed and scheme capacity, the plan sets out a range of flow and operational actions: a zero-tolerance approach to avoidable internal delayed discharges, a 30-minute maximum for ward transfers, an agreed outlier Standard Operating Procedure, side-room allocation governance led by clinical site matrons, and ring-fencing of elective beds (Wards 11, 14, 20 and 21, and the ENT Day Case Unit) to protect planned care. System escalation arrangements have been strengthened, including weekly tactical Surge and Escalation meetings (chaired by system providers rather than the ICB for 2026–27) and a pre-Christmas Multi-Agency Discharge Event ('Ho Ho Home for Christmas') to support safe, timely discharge over the holiday period. Paediatric surge and escalation arrangements have also been reviewed, with an OPEL-aligned escalation framework covering AED, CCDA and inpatient wards, and continued investment in medical and nursing establishment.

Performance will be tracked through a winter metrics dashboard covering the Emergency Care Standard (adult and paediatric), 12-hour length of stay in AED, waits over 24 hours for mental health patients, 45-minute ambulance handover times, harm and mortality associated with crowding and corridor care (using the established RCEM methodology also adopted by NHSE), and patient complaints relating to AED waits.

Key risks to successful delivery of the plan, and to be monitored by ETM through winter, are: staff wellbeing and sufficient workforce capacity; increasing reliance on bank and agency staff; the Trust's ability to flex capacity to respond to surges; potentially high rates of flu and/or RSV driving increased need for side rooms; flu vaccine uptake among colleagues; timely mobilisation of the winter schemes described above; protecting elective care capacity under pressure; and the ICB's evolving role as system convener. As this is a decision paper rather than an assurance paper, a formal assurance rating has not been applied; the plan has, however, been tested through internal review, the system ICB submission and the NHSE winter checklist process, and will continue to be monitored and refreshed through winter via the governance route set out below.

4. Options analysis/Proposal

Short term (immediately following approval): the Trust will mobilise the funded winter schemes – the Specialist Medicine discharge lounge, enhanced SDEC model, Therapy Front Door Rapid Assessment and Rehabilitation team, Point of Care Testing and additional Patient Transport vehicle – with the enhanced SDEC model and additional ward beds (Wards 17, 9 and 8) opening from October 2026, alongside the flu vaccination programme, which also commences 1 October 2026.

Medium term (November 2026 to February 2027, the peak demand period): the plan will be monitored via the Command Centre Operational Meeting, the weekly system Surge and Escalation meeting, and the OPEL escalation framework, with a Multi-Agency Discharge Event ahead of Christmas to support safe, timely discharge over the holiday period. A dashboard of winter metrics will be reviewed regularly, with corrective action taken where performance diverges from trajectory. This is a live document and will continue to be updated and refreshed as winter progresses.

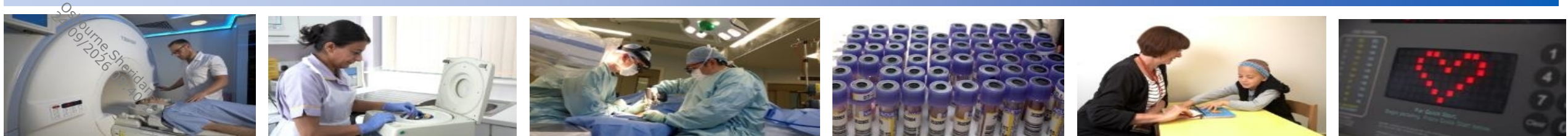
Longer term: decisions are required on opening Ward 10 (in line with the previously approved ETM strategic review, requiring Business Case approval)

The Board of Directors is asked to approve the draft winter plan set out in this paper and the Board Assurance Statement as attached at Appendix 1.

Osbourne, Sheridan
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WINTER OPERATIONAL RESPONSE PLAN 2026-27

This is a live document and will be updated leading up to and throughout the winter period



- | | | | |
|-----------|---------------------------------------|-----------|-----------------------|
| 01 | Reflection on Last Winter | 05 | Paediatrics |
| 02 | National / Regional Agenda | 06 | Summary and Costs |
| 03 | Infection Prevention & Vaccination | 07 | Metrics and key risks |
| 04 | Demand and Capacity & Resilience Plan | 08 | Appendices |

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SECTION 1

REFLECTION ON LAST WINTER

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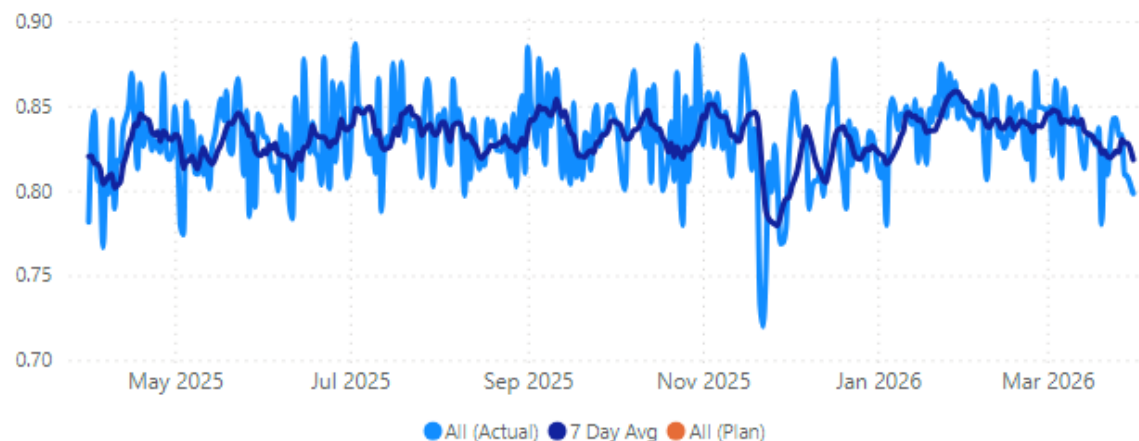
National Reflection on Last Winter

Nationally, last winter was the best in 3 years for fewer delays to care and ambulance response and handover times, but patient experience varied across sites and systems.

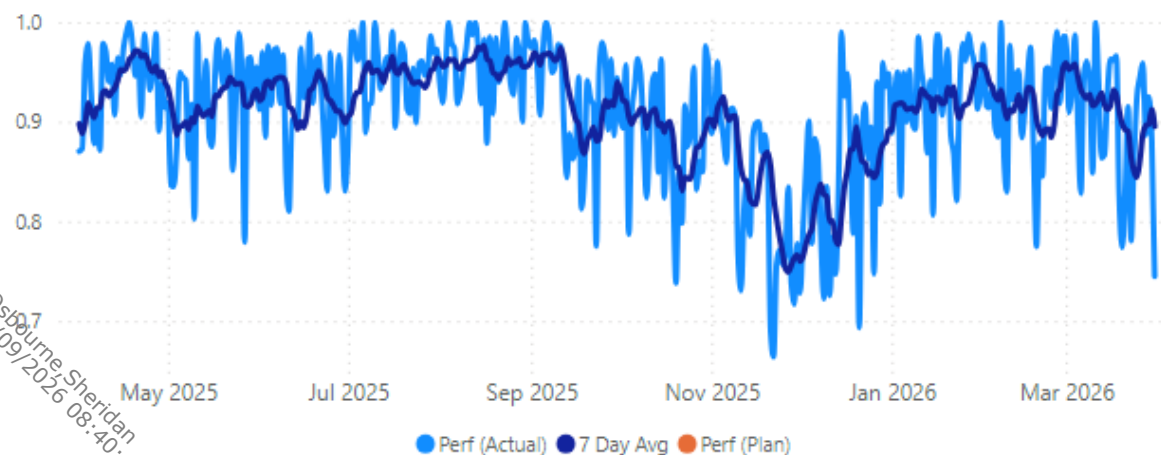
In the UK we had an early flu season from Oct, peaking in early Dec, with the lowest number of admissions related since 23/24.

It was the lowest COVID year we have had since 2019 and RSV was also lower than previous years. We had a January norovirus peak.

Performance last winter at BTHFT



Overall ECS, type 1,2,3. Sustained in early winter, dropping Nov/December before recovery in Jan/Feb (in line with previous winters and expected position)



Paeds following a similar pattern. significantly more paed's attendances over November period last year driving change in paed's ECS performance

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SECTION 2

NATIONAL / REGIONAL AGENDA

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National

For operational delivery through winter, NHS Trusts must plan to:

- Eliminate corridor care as a patient safety priority
- Maintain elective capacity
- Protect delivery of agreed 26/27 trajectories
- Assure tested arrangements for escalation, IPC, on call leadership and staff welfare
- Implement model emergency department, model acute pathway and model discharge pathway
- Full guidance [NHS England » Winter planning 2026/27 – expectations and assurance](#)

Plan assured through Trust Board governance

Regional



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National Operating Models

- **Emergency Departments (EDs):** improving patient flow, rapid assessment, timely decision-making and reducing delays in emergency care.
- **Acute pathways:** ensuring patients admitted to hospital move efficiently through assessment, treatment and inpatient care.
- **Discharge pathways:** making sure patients leave hospital promptly and safely when they no longer need acute care, with community, social care or other support arranged where required.
- **Whole-system planning,** including increased community capacity, urgent community response services and integrated discharge arrangements to help people receive care closer to home and avoid unnecessary hospital stays.

Response to Model ED, Acute Pathway & Discharge



Reviews have been carried out against these national requirements and findings included into our EXCEL programme



To improve oversight and leadership of the model acute pathway & discharge pathway a UEC access "patients waiting" meeting will be in place from Sept using new BI dashboard (appendix)



New Long LoS meeting for all patients over 21 days from September – patient by patient review by CSU matrons



Discharge pathway review reviewed via ETM (see appendix).



72 hours/ IPS action plan being led by MDO and Dep Dir of Ops (appendix)

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Full Capacity Protocol

Corridor care is a significant patient safety and experience issue; the NHS is committed to reducing this activity in hospitals across England in both emergency departments and inpatient wards.

Corridor care is care that is delivered in a clinically inappropriate environment that does not meet key standards for safety, privacy and dignity, sleep, infection prevention and access to essential facilities. Unmanaged risk.

A Temporary Escalation Space (TES) is a clinical area that is not normally used for inpatient care but is opened temporarily to accommodate patients when demand exceeds available bed capacity. Managed risk.

BTHFT full capacity protocol being updated. Current version - in the appendices for reference

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C. Sheridan

Our TES spaces

GREEN

- Fully risk assessed
- Appropriate staffing
- Clinically safe environment
- Used infrequently
- Closed once pressure reduces

AMBER

- Some environmental limitations
- Short-term staffing mitigations required
- Opened regularly during peak pressure

RED

- No privacy/dignity
- Poor visibility
- Unsafe staffing
- IPC concerns
- Used continuously
- Patients receiving corridor care

The TES spaces in BTHFT are in the emergency department, rated as amber. The use of these spaces will be monitored daily through the sit rep and operational meetings. A BI dashboard tracking usage over winter (and beyond) will be reviewed as part of the new ECS access meeting with corrective actions allocated as required.

Testing of Plans

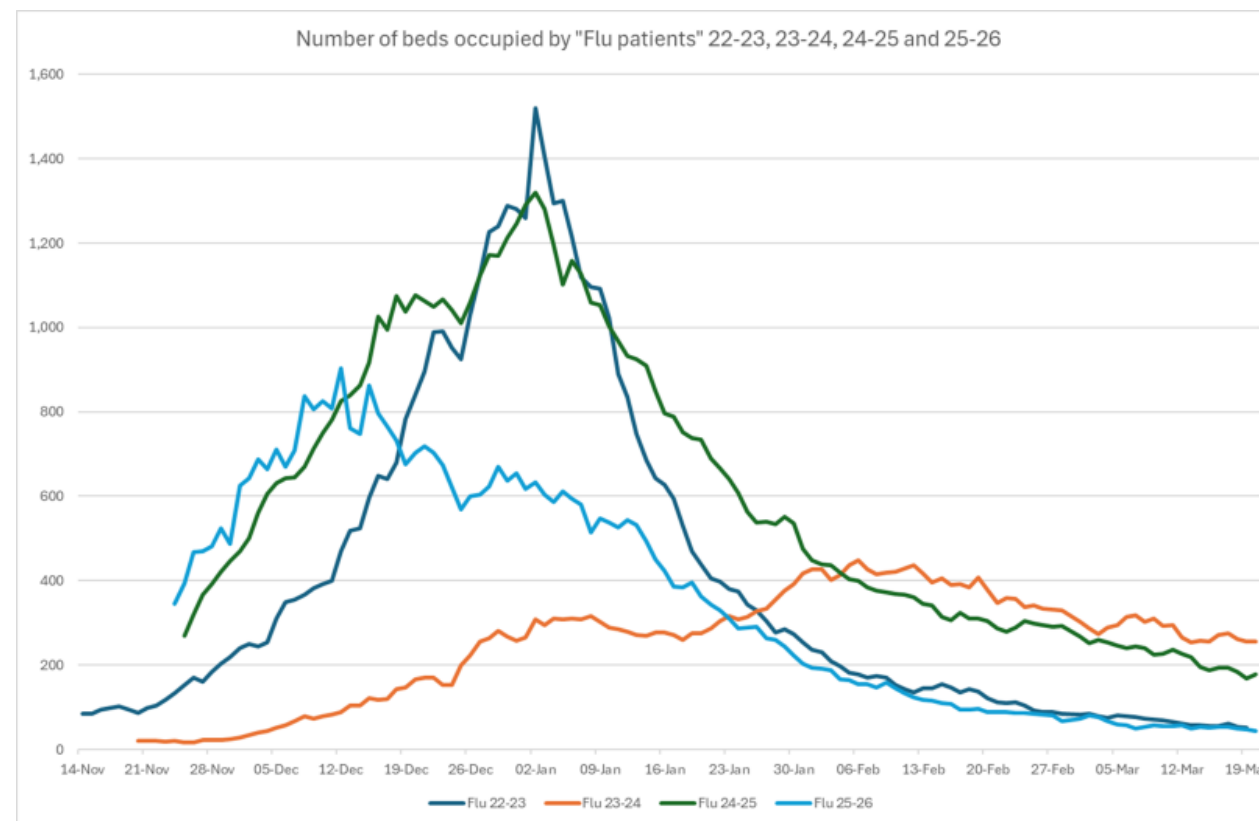
- Internal desktop analysis of last year's plan and performance
- Our contribution to system ICB winter plan submitted in August ([appendix](#))
- Winter checklist returned to NHSE in August
- Regional winter planning test event 17th Sept in York. Senior Ops team attending, with any lessons fed back into further winter planning actions

SECTION 3

INFECTION PREVENTION & VACCINATION

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- There is a back to school rise in infections every September – ED pressures, but fewer admissions.
- There is a seasonal rise in RSV peaking at the end of November – impact on NIC.
- Flu cases usually peak in January.
- The busy time comes with the peak in RSV and the rise in flu alongside Christmas holidays.
- Plan for a rising demand in infectious diseases through autumn, peaking in January.
- A new COVID variant or a rise in known bugs could lead to services being put under additional pressure.



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- 2025-2026 vaccination rates were 46% for the trust. This was a significant improvement compared the 34% in 2024/25.
- The vaccination programme will start from 1st October 2026. This start date is based on evidence of the waning of flu vaccine's effectiveness in adults which means that it is preferable to vaccinate individuals closer to the time when the flu virus is likely to circulate. As flu typically peaks in December or January, this will provide optimal protection during the highest risk period, even in early seasons such as we saw in 2025 to 2026 season.
- This year the target set by NHS England is 60% for healthcare workers.
- We will deliver a coordinated communications and engagement programme, to support operational delivery, encourage positive behaviour change and enable informed decisions about vaccination. Programme has 3 principle's, Make It Easy, Make It Visible, Make It Local.
- COVID vaccine will not be offered this year.
- IPC team link with Health Protection Team and Outbreak Control Group multi agency
- POCT 4 in 1 virology will be carried out in key service areas.
- Additional cleaning capacity funded via non recurrent winter funding.

SECTION 4

DEMAND AND CAPACITY

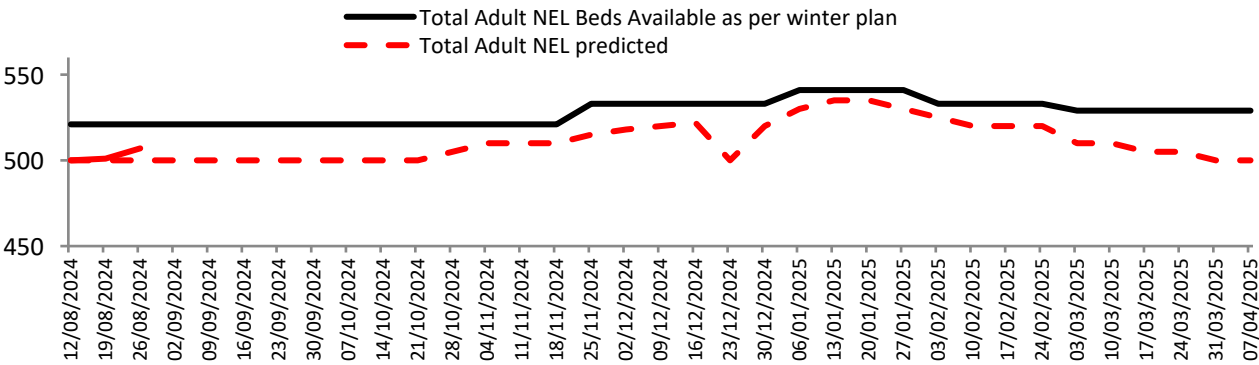
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Predicted Demand

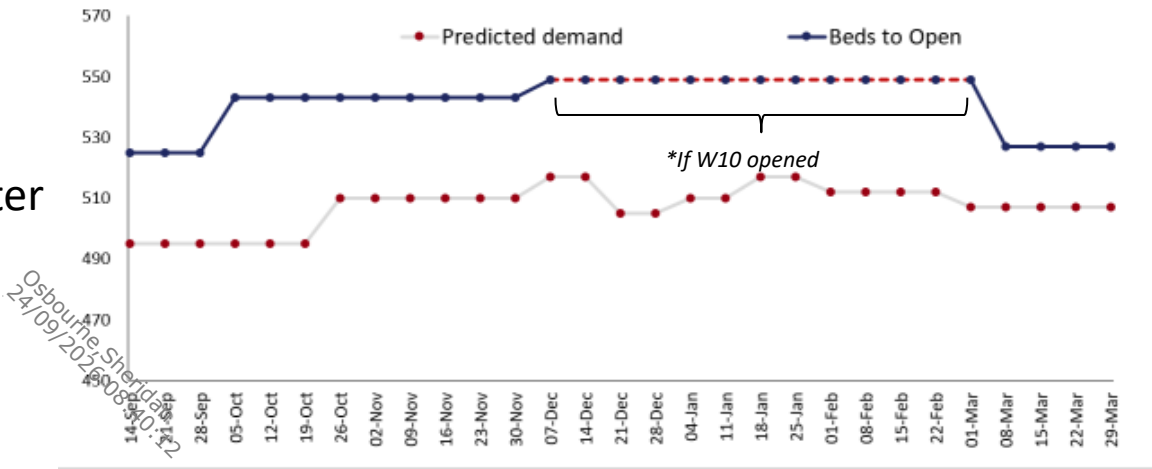


Bradford Teaching Hospitals NHS Foundation Trust

Last
winter
plan



This
winter
plan



- Analysis of previous winter indicates c490-515 adult acute beds required over winter period, peaking Jan-Feb.
- Demonstrates need to improve capacity in key areas (SDEC) and flow (discharge lounges) and admission avoidance (therapies)
- Also a longstanding requirement for more respiratory beds (see resilience schemes slides, if BC approved, further 8 beds opened mid winter).
- There will also be 12 SDEC trolleys added to the bed stock, four beds on W17 and two beds on W9, in addition to the respiratory beds (see resilience schemes slides). Opened in October (see plan left)
- Plan last winter was up to 20 SDEC trolleys, but demand did not require this. There is a strong desire to ensure the current SDEC model this winter is not adversely impacted by over exceeding capacity on the unit.

25/26 Winter

Ward 17	4 beds
Ward 9	2 beds
Ward 8	12 – 20
Total	18 – 26

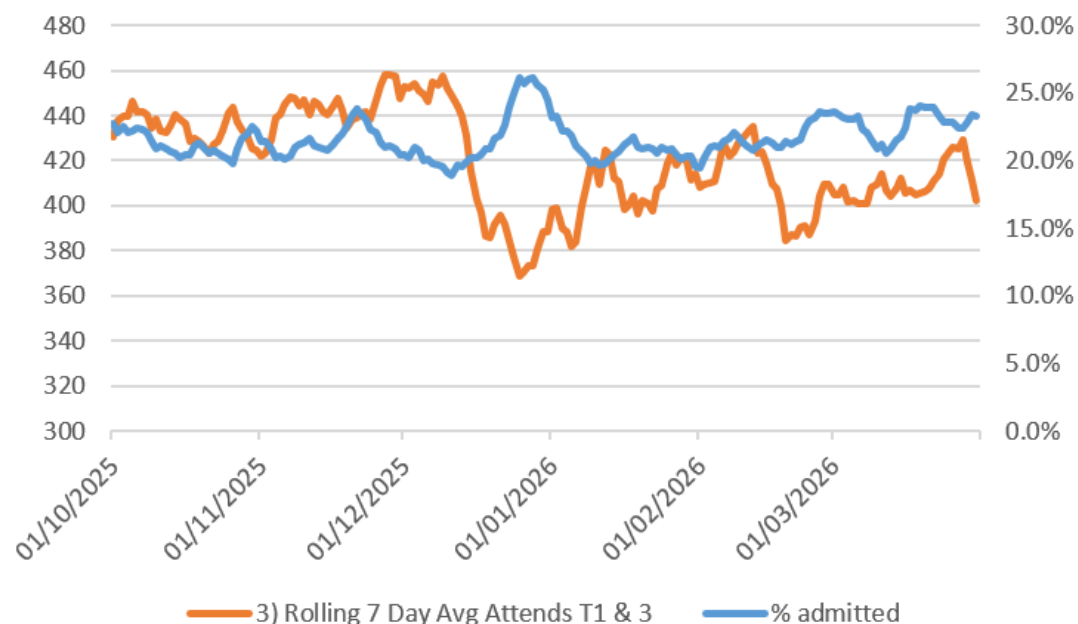
26/27 winter

Ward 17	4 beds
Ward 9	2 beds
Ward 8	12 beds
Ward 10	+4 beds (pending approval at ETM/Board)
Ward 23	+8 beds (pending approval at ETM/Board)
Total	18-30 beds

Together, putting patients first

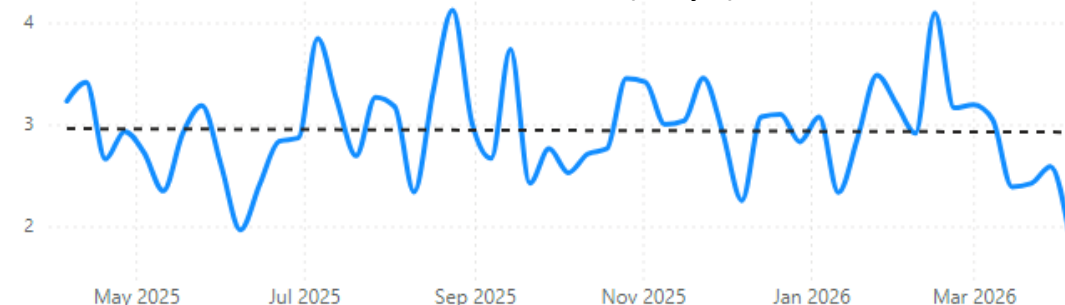
Predicted Demand

Attendances and conversion rate

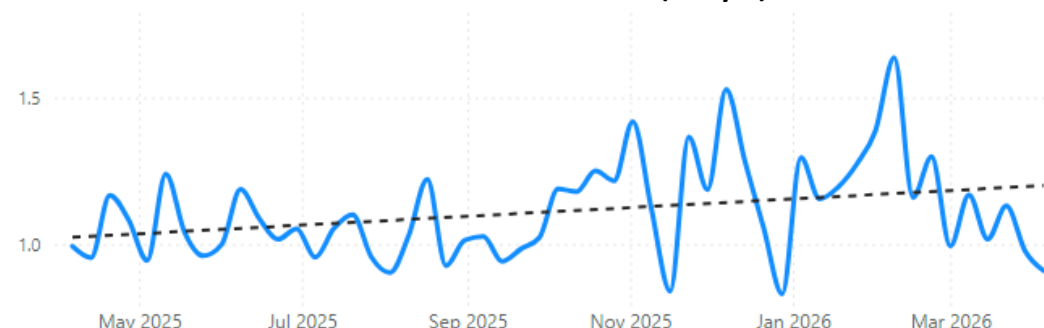


- Conversion rate picks up in January, as does LoS on assessment units in line with acuity
- Acute/Assessment units taking LoS burden/pressure in winter, need for better downstream outflow from assessment units. Full access to all data in [appendix](#)

Downstream Wards av LoS (days)



Acute/Assessment units av LoS (days)



SECTION 4 – DEMAND AND CAPACITY

Resilience Plan

Osbourne Sheridan
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Dragons Den

- As part of winter planning we have engaged with the CSU's and asked them for suggestions for schemes that would positively contribute to maintaining hospital flow utilising non recurrent funding.
- CSUs completed a template detailing their ideas which were reviewed.
- We received 6 submissions (over and above the existing winter central schemes), which were reviewed against winter planning expectations and funding available. The existing schemes and new CSU schemes approved for mobilisation for additional resilience are detailed below.
- Full plans CSU submitted plans in [appendix](#)

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- Provider: Lakeside Taxis Ltd, t/a Transcare – an existing NHS transport provider delivering renal dialysis, physiotherapy, hydrotherapy, oncology, A&E discharge and other discharge transport for BTHFT
- Additional stretcher ambulance with electric tail lift and on-board oxygen for 2 patients (plus capacity for 3 further passengers), crewed by 2 staff trained in First Aid, CPR and moving & handling
- Operates Monday to Friday, 08:00–18:00, from 3 November 2025 to 2 April 2026 (106 working days), Supports timely discharge and eases pressure on patient flow and bed availability over winter

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Specialist Medicine Discharge Lounge

- A dedicated, clinically supervised space for patients who are medically fit for discharge but awaiting medication completion, transport, family collection or community arrangements (proposed for Outpatients West, former Acute Oncology area, or Cardiology DSU)
- Aim: improve patient flow across Specialist Medicine by supporting earlier ward discharges and increasing bed capacity for emergency and elective admissions
- Key objectives: increase discharges before midday, reduce delayed discharges, and strengthen multidisciplinary discharge planning
- Staffing: Band 5 RN
- Risk if not delivered: continued avoidable discharge delays, reduced bed capacity and poorer patient flow

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TESTING

Point of care testing in admission areas is essential in to ensure rapid decision making. As previous two years, 4 in 1 POCT virology testing will be carried in five key areas including:

1. AED (both adult and paediatric)
2. Paediatric Wards
3. AMU 1
4. AMU 4
5. Respiratory ward (Currently ward 23)

As from previous years, the cost will be funded by the winter resilience budget

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Enhanced SDEC Model

- Same model as last winter. Extends Same Day Emergency Care from Monday–Friday, 8am–8pm to a 24/7, seven-day model
- Creates up to 12 trolley/mobile bed spaces on Ward 8 for AMU and Care of the Elderly patients awaiting admission, managed under agreed clinical criteria with SDEC consultant oversight
- Staffing: additional AIM consultant cover at weekends; 2x Band 5 nurses and 2x HCA overnight Mon–Fri, and 2x Band 5 and 2x HCA for 24-hour weekend cover
- Expected outcomes: reduced A&E bed waits and corridor care, improved ambulance handover performance, reduced length of stay
- Risk if not delivered: worsening ED crowding, increased 4-hour and 12-hour breaches, ambulance handover delays, and greater workforce and financial pressure
- Requirement for right admissions from ED, joint working required across CSU. Clinical criteria developed so AIM oversight of admissions.
- *UEIC will also provide expansion of Ward 17 bed base by x4 beds, and expansion of Ward 9 bed base by x2 beds, both at no additional cost other than consumables*

- A dedicated Rapid Assessment Team and Intensive Rehabilitation Team spanning ED, AMU, SDEC, assessment areas and downstream wards
- Moves senior OT/Physio decision-makers to the front door to identify patients suitable for same- or next-day discharge, and to set rehabilitation goals early for those requiring admission
- 5-day service each using seconded Band 6 OT/Physio, Band 5 backfill and Band 4 assistant practitioners
- Expected outcomes: more same/next-day discharges, reduced hospital-acquired deconditioning, shorter length of stay, improved rehabilitation outcomes
- Key risk: recruiting Band 6 therapists to temporary contracts

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- Staff flu (and COVID-19) vaccination delivered on-site by Rimmington's Pharmacy via ward-based and roving clinics, under the national NHSE Community Pharmacy Seasonal Vaccination Service
- A cost to the Trust now applies: extended vaccination delivery beyond the core campaign period and any incentive scheme will need to be drawn from winter funding
- Core campaign period itself remains funded via the NHSE Item of Service fee, claimed directly by Rimmington's from NHSBSA, with no direct cost to the Trust for that period
- Supported by a "Make it Easy, Visible, Local" communications and engagement plan targeting lower-uptake staff groups to maximise winter uptake
- Risk if not delivered: lower staff vaccination uptake, increased winter sickness absence and greater workforce and patient safety risk

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Hospital at night

- Recruit substantive Band 3 HCSWs to work long days (07:30–20:00) on weekends and bank holidays, using a permanent staff group
- Combined with the existing overnight H@N service (2x HCSW, 19:30–08:00, 7 days/week), this closes the gap in cover across the full 24-hour period
- Replaces the Medical Student Assistant pilot (ended July 2025), which faced onboarding and availability gaps around exams, annual and study leave
- HCSWs undertake phlebotomy, cannulation, ECGs and cardiac arrest team support, freeing resident doctors for clerking, ward rounds and discharge summaries
- Expected outcomes: reduced resident doctor OOH workload, improved patient flow and timeliness of care, reduced risk of NHS England withdrawing training doctors
- Risk if not delivered: continued high out-of-hours workload (63% of residents report this as heavy/extremely heavy), sustained poor GMC workload ranking (224th of 226 Trusts) and reputational/training risk

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Mitigation schemes for respiratory capacity

Current capacity: total 28 beds

Respiratory ward beds = 22

Respiratory HDU = 6 beds

Demand indicates a requirement for total beds 36-38

Risks

- Insufficient NIV bed capacity – leads to long waits for admission in A&E HDU (exacerbating crowding).
- Inappropriate use of ICU beds for respiratory NIV – leading to cancellation of elective cases.
- Insufficient respiratory ward beds – leads to respiratory patients outlying on AMU, other wards, at home awaiting GP admission, further impacting on ED crowding
- Risk associated with current environment - does not have HTM 03-01 compliant ventilation to provide an Airborne Protective Facility (see approved ETM strategic review in appendix)

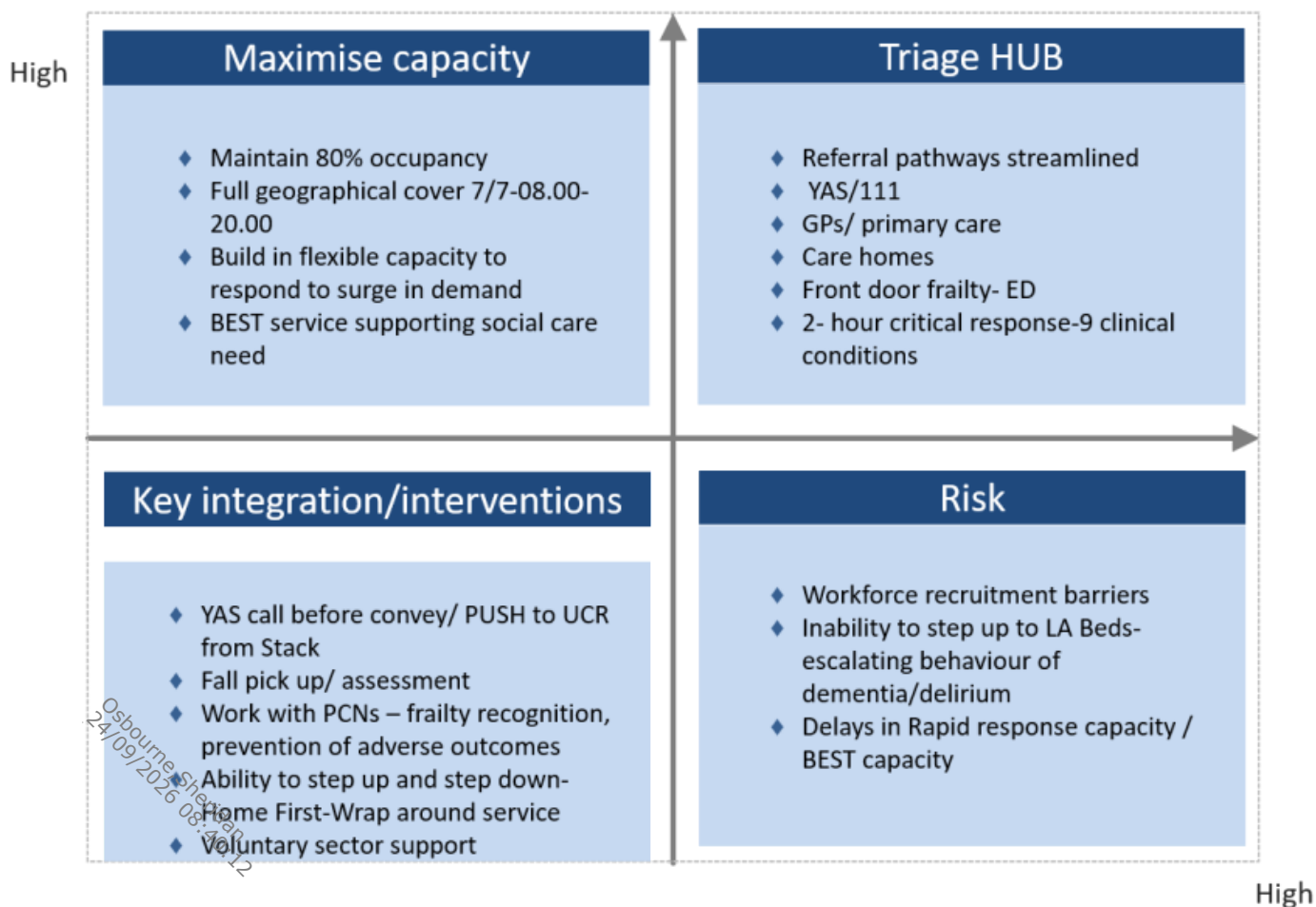
Schemes

- Open W10 in line with approved ETM strategic review. Ensures the W10 environment starts to be used for it's intended purpose and will create greater downstream flow out of acute/assessment units. Requires BC approval.

OR

If this is not possible, the mitigation is the same as previous winter previous winter we have flexed the existing ratio of Ward: HDU 22:6 to 18:10 (plus utilisation of ICU in exceptional circumstances). This leads to an associated increased costs of nursing and therapy to meet the NIV demand – this would have to be funded through the winter resilience budget

UCR Resilience for Winter



- **Senior-led triage:** UCR triage delivered by senior clinical decision-makers, giving patients advanced practice assessment, consultant-level support and rapid diagnostics/treatment — enabling sick patients to stay safely at home, backed by clear governance and clinical responsibility protocols
- **Smart pathway routing:** Lower-acuity patients are redirected to alternative pathways (primary care unplanned care, GP, care navigation, community services), ensuring the sickest adults needing to remain at home get prioritised, wrap-around support and a face-to-face response within 2 hours of referral

SECTION 4 – DEMAND AND CAPACITY

Other Actions

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- Zero avoidable internal delayed discharges (TTOs, transport and ward processes)
- Maximum 30 min cut off for ward transfers
- Patients from acute/assessment units who are not being discharged will be identified to transfer to available downstream beds in line with agreed SoPs
- Increased use of all Virtual models, hot clinics and safety netting
- Rapid Assessment and Treatment (RAT) embedded within ED
- Vetting of all bed requests by consultant/senior AED as standard part of roles
- Criteria to admit SOP in use by senior decision maker in AED as standard part of roles
- Better bed utilisation in downstream medical and surgical beds via utilisation of agreed outlier SOP.

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Workforce

- Colleague wellbeing will remain a key area of focus, with the Thrive portal supporting and encouraging wellbeing conversations.
- Sickness absence levels are under close monitoring which will continue. The new policy has been launched and a task force group set up as part of workforce recovery.
- Flu vaccination commences from 1st October and last years area's of low uptake will be a focus.
- Bank & Agency use is under close monitoring and existing grip and control will continue through winter.
- In response to high levels of operational pressures, workforce deployment will be considered.
- Annual leave planning and rota management will be undertaken well in advance of the key holiday period to ensure sufficient levels of cover.
- Mutual aid between organisations will be explored in line with existing agreements.

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Flow and downstream beds – further downstream actions/increased accountabilities

- In specialities that adopt a consultant of the week model the expectation of those specialties is to deliver the GIRFT Clinical Operational Standards.
- Continue to embed learning from Reset week which led to reduction in 12 hour + DTAs (see appendix) and wider work programme of EXCEL workstream 3.
- New medical operational forum created to facilitate move to the interprofessional standards and 72 hours guidance and greater medical engagement in operational flow
- Improved model on W27 – twice weekly review by reprofiled rehab consultant PAs to act as co-ordinating function for rehab patients who are on W27, with an explicit KPI to reduce this cohort LoS
- Creation of new "non elective patients waits" meeting - holding downstream specialities to account for their parts of the ECS pathway and 72 hours standards with the same principles/rigour applied to RTT access.
- Beds identified on wards 18 and 19 for additional capacity – work with surgical CSU to open as surge capacity. W17 and W9 winter bed opened as standard as part of usual winter planning.

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Side Room Utilisation and ownership of outliers

- Side rooms have become more pressured across the site following the changes to the acute oncology pathway and the creation of the palliative care ward on w24.
- Suspected and confirmed patient cases will be either isolated in single rooms or cohorted in bays if single rooms are not available.
- Clinical site matrons hold overall responsibility for side room allocation across the trust, balancing IPC risk and patient flow
- Oncology/haematology patients or any SR patients on the non-elective pathway (NEWS ≤ 3) may be placed in side rooms outside their specialty ward where clinically safe
- After AMU, patients are admitted under the most appropriate specialty as determined by the AIM consultant
- Medical outliers stay within the medical bed base; surgical outliers stay within the surgical bed base
- Compliance monitored on an ongoing basis

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Command Centre Operations meetings

The Command Centre Operational Meeting is a meeting to ensure key stakeholders are aware of the daily position in terms of ED traffic, bed availability, expected admissions from routes other than ED and staffing.

The meeting is also a vehicle to cascade important messages from support departments which will directly impact on the site or patient flow with actions linked to the OPEL document

The aim of the meeting is to facilitate meeting the Emergency Care Standard on a daily basis, by encouraging appropriate and timely decision making relating to admissions and discharges.

Seniority of chairing and frequency of the meeting will be increased in line with OPEL scoring

New agenda and ToR in Appendices

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System escalation meetings

- Bradford District and Craven health system have created a surge and escalation plan (see appendix) xxx setting out escalation triggers (in line with OPEL levels) and a system governance/command structure, to manage coordinated actions across hospital, community, and ambulance partners to manage patient surges and protect flow/safety when demand outstrips capacity.
- For 2026/27, the weekly tactical Surge and Escalation meetings will be chaired by system providers rather than the ICB, with meeting frequency increasing in line with system pressures.

MADE event and Ho Ho Home for Christmas

- BTHFT will has a Multi Agency Discharge Event in the run up to the Christmas period. This will bring together staff from a range of backgrounds in acute, community, mental health, local authority, primary care and voluntary sectors together for 2/3 days. These "expert patients" join ward rounds and other internal processes, reviewing patients' care pathways to highlight and unblock delays, capture escalation issues, and ensure safe, timely discharges. This will be supported by a central BTHFT coordinating team.
- Ho Ho Home for Christmas will be a campaign to focus on safely discharging medically fit patients so they can be home for the holiday period.

Maintaining Elective / Planned Care Capacity

- All available NEL beds are ring fenced and will not be used for any DC or EL cases
- The following are Elective Ring-Fenced Beds and will not be used for NEL patients.
 - **W11:** 16 beds (Elective Surgery)
 - **W14:** 17 beds (Elective Orthopaedics)
 - **W21:** 23 beds inc mon beds (Elective Surgery)
 - **W20:** 27 trolleys (Elective Daycases)
 - **ENT DCU:** 10 trolleys & 6 Chairs (ENT & Ophthalmology)
- Without protected capacity, elective beds are likely to be absorbed by emergency pressures during periods of high demand, resulting in increased theatre cancellations, longer waiting times, reduced theatre utilisation

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SECTION 5

PAEDIATRICS

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Surge and Escalation model

A CYP specific Escalation process and OPEL scoring that covers Childrens AED, CCDA and in-patient ward is established and forms part of the Trust overall sitrep

Triggers detailed below:

Location	All	All	AED	AED	AED	AED	CCDA	CCDA	CCDA	CCDA	Ward	Ward	Ward	Ward	Ward
Escalation Status	Appropriate nurse staffing levels in all areas	Number of children requiring admission (ED, CDA, repats etc.)	Longest time to Triage	Number children in HDU/resus	Number of children in department	Longest time to 1st medical review	Number of children in CCDA	Number of GP & Direct access referred due to arrive	Longest time to Triage	Longest time to 1st medical review	Bed capacity	Number red patients	Number blue patients	Number of patients in Stabilisation	Patients to be transferred to other hospitals due to bed capacity

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Surge and escalations plans

Actions dependant on OPEL score

Bed capacity outside of parameters.	Staffing establishment outside of normal parameters	Acuity
Check regional bed state, Transfer patients more clinically stable Identify with IPC cohorting bays Explore Expansion to full bed base (38), Identify with IPC chortling bays Transfer patients more clinically stable Use of cubicles and transfusion bay ward 12, with support of suitable trained staff Expansion to full bed base (38) Expand use of surgical area 1st and 2nd bay (5+4 beds) (5+4 beds)	Explore support from surgical area, ACE, Community, Neonates and agency Extend consultant hours, CCDA cover until 2100. Middle grade staff approached for additional support Review nurse and medical staffing numbers next 12-24hours support flow Support from surgical area, ACE, Neonates, On call consultant to be present on the unit Volunteer cover until 2100. Enhanced pay rates for Middle grade staff Explore support from surgical area, ACE, Community, Neonates, CNS, Reinstate Children’s emergency rota	Transfer patients more clinically stable. All level 2 referred to embrace Ensure external service provide requested cover i.e. CAMHS Escalation of children not appropriate

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Surge and escalations plans

Staffing model

The medical and nursing establishment has had significant investment to provide cover at times of peak activity.

Medical

Provide resident consultant cover at times of peak activity

Mon - Fri 08:30-17.30	2 resident consultants
Mon - Fri 17.00-22.00	1 resident consultant
Mon – Fri night 22.00-08:45	1 on call consultant
Sat - Sun 08:30-14:30	1 consultant
Sat - Sun 08:30-17:30	1 consultant and on call
Sat - Sun night 22.00-08:45	1 on call consultant

Nursing

Children’s ED and CYPU Collaboration

- The CSU undertook a successful Children’s ED and CYPU Collaboration between the nursing teams in children’s ED and the Children and Young People’s Unit.
- The areas now work in conjunction and flex staff according to the greatest clinical acuity/need

Nursing establishment

- The CSU are in Year 2 of a 4 year plan to increase the nursing establishment

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SECTION 6

SUMMARY AND COSTS

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Summary winter schemes

Funded through existing winter resilience and

- Nursing for 12 surge beds on SDEC (medical staffing existing CSU run rate)
- Point of Care testing
- Additional winter PTS discharge vehicle
- Rapid therapies assessment team
- Spec med discharge lounge
- Vaccination
- Hospital at night

Not funded but further potential improvement schemes

- TTO Dr based in the command centre
- ISP/72 hours/model ED embedded through operational and medical leadership (NEL patients waiting meeting)
- Additional deep cleaning teams/Additional porters
- Extended pharmacy opening times at weekends to facilitate discharges
- Additional beds identified on W18 and W19
- Improved CC operational meetings

Forecast cost and run rate implications

Scheme	Scheme type	Grade	Total (£)	CSU
Discharge Lounge – Specialist Medicine (Option 1, on the ward)	CSU dragons den	Band 5	£55,992	Spec Med
Enhanced SDEC Model for Winter	CSU dragons den	Band 5, HCA & Consultant	£293,948	UEC
Therapy Front Door Rapid Assessment & Rehab – Option 1 (5-day)	CSU dragons den	Multi-disciplinary	£126,505	Therapies
Patient Transport	Central scheme	-	£43,345	UEC
POCT	Central scheme	-	£18,000	UEC
Hospital at Night	Central scheme	Band 3	£44,220	-
Vaccination	Central scheme	-	£66,954	-
Total			£648,964	

Full summary and all considered schemes below and in appendices
[Winter Plan Financials 2026-27 200826 \(version 1\).xlsb.xlsx](#)

SECTION 7

METRICS AND MEASUREMENT

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A suite/dashboard of metrics will be established to measure the following against an expected trajectory

1. The Emergency Care Standard (adult and paed)s)
2. 12h LoS in AED
3. >24 h waits for MH patients
4. 45 min ambulance handover times
5. Harm and mortality (based on the established RCEM methodology also adopted by NHSE)

Link

https://rcem.ac.uk/wp-content/uploads/2023/03/Excess_deaths_associated_with_crowding_and_corridor_care.pdf

6. Patient complaints, especially relating to waits to be seen in AED

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Key Risks



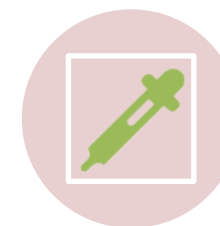
STAFF WELLBEING AND
ENSURING SUFFICIENT
WORKFORCE CAPACITY



INCREASING BANK AND
AGENCY RELIANCE



INABILITY TO FLEX TO
RESPOND TO SURGES



POTENTIAL HIGH RATES OF
FLU AND/OR RSV AND
NEED FOR SIDE ROOMS



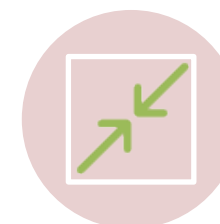
FLU VACCINE UPTAKE IN
COLLEAGUES



MOBILISATION OF WINTER
SCHEMES



PROTECTING ELECTIVE
CARE CAPACITY



ICB NO LONGER A ROLE AS
SYSTEM CONVENER

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SECTION 9

APPENDICES

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- New NEL access meeting dashboard [New Ward Flow - Power BI](#)
- ETM Review of model discharge [ETM Paper Model Discharge Pathways 31.07.26 v.2.docx](#)
- 72 hours action tracker [Action Tracker- 72 Hour Standards & Measures.xlsx](#)
- Submission to ICB as part of system winter planning [Winter Checklist NHSE July 2026 v1 BTHFT.xlsx](#)
- Full winter plan financials [Winter Plan Financials 2026-27 200826 \(version 1\).xlsb.xlsx](#)
- NHSE winter guidance [NHS England » Winter planning 2026/27 – expectations and assurance](#)
- Existing BTHFT full capacity protocol [S54.1 FULL CAPACITY PROTOCOL.pptx](#)
- Dragon's Den Submissions [Winter_Planning_Dragons_Den_Combined_Submissions.docx](#)
- Reset week - reducing 12 hour DTAs [DTA_Reset_ETM_Cover_Sheet_and_full_write_up v1.docx](#)
- ERM approved resp bed base review [Respiratory AMU bed base options appraisal.pptx](#)

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Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.

This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



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Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):

Bradford Teaching Hospitals Foundation Trust

If Other, write Provider/Trust Name:

Contact details (email, phone number):

Saj Azeb,

Date:

07/09/2026

Please complete these sections					
Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes		
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes		
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	Attened system winter planning meeting and completed our element of system plan.	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Team attending event on 17th Sept.	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Saj Azeb, Chief Operating Officer & Deputy CEO	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Via command centre established escalation processes.	

Winter Planning 26/27

Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans. Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Section B: 26/27 Winter Plan checklist			Please complete these sections		
Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	The Trust has a vaccination plan which will commence on the 1st October. A communications and engagement plan has been developed to increase the uptake of the vaccine amongst colleagues. It will aim to improve uptake through a behaviour change approach based on core principles of Make it Easy, Make it Visible, Make it Local. Previous year uptake data will be utilised to target groups requiring a focus	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	All services will be supported with their staff vaccination plans and IPC actions to reduce the risk of staff sickness.	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	The vaccination will be offered individually to eligible patients and based on clinical decision by the medical team.	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	We have demographic analysis of our population and know we have severe population health inequalities and are ethnically diverse with vaccine hesitancy. Vaccination of visitors to the hospital will be available as a way to encourage uptake for our communities who may be at higher risk and less likely to access vaccination in their community. Our Health Equity team work on embedding health promoting conversations into routine care and make every contact count.	
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	HFAST pathway is in place and D2A and IMC. One limitation currently is inability to step patients from the community with escalating behaviour due to dementia/delirium who require a permeant care placement into short term ASC beds rather than via hospital admission.	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: •coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	A desktop review was carried out in August, against national discharge requirements across acute, community and social care. This confirmed established discharge pathways 1-3, shared digital working for discharge via OPTICA, Home First as default model. Weekly long LOS reviews are being put in place. UEC access & performance meetings will review LLOS, EDD, DRD. Discharge performance is already monitored at Board level. Named Exec Lead in place and oversight is enabled via the command centre meetings and hourly reports and escalations. Full capacity protocol will include rapid discharge protocol.	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Planned Ho Ho Home for Christmas campaign and a Multi Agency Discharge Event.	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	Well established medical SDEC in place, with expansion of operating hours and weekends tested in winter last year, planned to continue through this winter.	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Frailty team inreach to ED and assessment area's with flow to care of the elderly wards working well.	
Capacity					
	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Staffing levels reviewed daily and any areas of pressure managed via command centre.	

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3	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Rota sign off processes in place.	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	The annual delivery plan has been signed off with seasonality expectations built in based on previous years seasonal delivery.	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Delivery against trajectory is monitored constantly and published data weekly, and as part of Trust Recovery through a recovery dashboard.	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	UCR triage provided by senior clinical decision makers and 2 hour face to face response required at home prioritised. Service provides advanced clinical practice, consultant level support and rapid diagnostics and treatment. Streaming in place for patients with lower acuity to other services.	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	We are strengthening our Full Capacity Protocol to include clear and explicit limits on corridor care and required escalations and review of breaches.	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	We have RAT and streaming in place and our Full Capacity Protocol aims to protect ambulance handover timeliness.	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	The command centre are they key point of liaison with system partners and are responsible for our multi agency integrated discharge team.	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	Plans in place for both. Colocated UTC in place, minor injury and minor illness streams. ED RAT trials completed and EEMAC in design. Medical SDEC and frailty stream in place. Review taken place against model discharge, plan in place.	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	IPC policies and protocols are in place along and are coordinated by the command centre team	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	Lead for IPC engaged in production of the plan.	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	A dedicated team carries out fit testing. Records are maintained in ESR system. For PPE, each clinical area have materials manager who manage supplies including PPE. In case of emergency increased demand in PPE, additional supply is arranged by procurement team with WYATT. Procurement team have SOP on that.	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	Source isolation policy explains all infectious conditions with patient placement and required precautions.	
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	Rotas and on call guidance packs in place. On call training provided.	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	The command centre provide hourly updates of OPEL scores. We have an early morning organisation wide safety huddle and site huddles throughout the day.	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	Reviewed and discussed at regional COO meetings including escalation of repatriation patients.	

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	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	Each service area has a BC lead. Action cards are available on intranet and in command centre for all key business continuity incidents. Generic business continuity ward plans available.	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	adverse weather plan in place, regularly updated with learning or new guidance. Adverse weather debriefs held.	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	Previous IA learning has been reviewed to inform any future IA.	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	Any concerns or incidents discussed as part of daily safety huddle.	
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.			
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.			
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.			

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name:

Provider CEO name:

Date reviewed:

Provider Chair name:

Date reviewed:

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Please confirm date reviewed

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



Section B

Prevention
Flow, occupancy and discharge
Capacity and community
UEC Flow
Infection Prevention and Control (IPC)
Leadership and operational grip
Specific actions for Mental Health Trusts

Rating

5 - Full assurance
5 - Full assurance
5 - Full assurance
5 - Full assurance
5 - Full assurance
5 - Full assurance

Awaiting assessment

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Board of Directors public			
Meeting Date:	24/09/2026	Agenda Reference:	Bo.9.26.17
Report Title:	Health Equity		
Presented by:	Mark Hindmarsh, Director of Strategy and Transformation		
Executive Lead:	Mark Hindmarsh, Director of Strategy and Transformation		
Author:	Naveed Saddique, Health Equity Lead		
Report Summary			
Purpose of the paper:	Decision ☒ (approve)	Assurance ☐	Action ☐ (review/discuss/ comment)
Summary of Key Issues/Highlights:	Health equity means everyone has a fair opportunity to achieve the best possible health. This requires recognising and addressing the different needs, circumstances and barriers that affect people's health and their access to, experience of and outcomes from healthcare. BTHFT is committed to advancing health equity by providing care that responds to differing needs and working with partners to address unfair and avoidable differences in health across the communities it serves. This paper provides assurance on progress since the previous Board of Directors update in March 2026 and asks the Board to approve revised Health Equity Objectives for 2026-28 and endorse the proposed delivery framework. Progress includes: - Health Inequalities Statement for 2025/26 published and used to inform priorities for 2026/27 - Improved scores on NHS Providers self-assessment - New A&E Inequalities Dashboard - Digital tool for calculating the health equity impact of service moves (measures the impact on travel distances and public transport journeys) has been used to assess impact of Health on the High Street - New health equity module for preceptorship training delivered to 70 nurses and AHPs so far. Uses new digital tool for testing health equity scenarios. - Digital Access Hub – the library is now open for public access to the internet to help address digital exclusion - Over 700 new starters introduced to population health and health equity during induction. Presentation at every induction session this year. - Health Equity Village event at BRI - Patient engagement work started with renal team to address inequalities in Did Not Attend rates		
Recommendation/s: (including any decision/approval required)	The Board of Directors is asked to: 1. Approve the five revised Health Equity Objectives for 2026-28; 2. Endorse the continuing work plan for 2026/27 (Appendix 1) 3. Note progress since March 2026		
Link to Strategic Objective:	Partnerships and health equity - To collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals		
Link to priority transformation programmes:	Health on the High Street		
Implications			

Risk:	Strategic Risk: If the trust fails to collaborate effectively with its partners, then there will be a fragmented approach to healthcare across Bradford District and Craven and West Yorkshire, resulting in missed opportunities to address health inequalities and improve patient and staff experience and outcomes.
Legal/Regulatory:	This report supports the Trust's health inequalities duties and annual reporting requirements. The NHS Foundation Trust Annual Reporting Manual requires foundation trusts to take account of NHS England's Statement on Information on Health Inequalities and to reflect relevant health inequalities information in their annual reporting. The 2025/26 Health Inequalities Statement forms part of the Trust's response to these requirements and may also inform NHS England contractual reporting. The Care Quality Commission assessment framework also looks for equity in experiences and outcomes and how the Trust proactively engages with underserved populations.
Quality & Patient Safety:	The programme supports the Trust's quality responsibilities by seeking to reduce avoidable differences in access, outcomes and experience between population groups.
Equality, Diversity and Inclusion and Health Equity:	The programme complements the Trust's equality, diversity and inclusion responsibilities by applying an equity lens to patient access, experience and outcomes.
Resources:	Delivery will be managed through the existing 2 WTE Health Equity team and depends on contributions from Business Intelligence, clinical specialties, corporate teams and partner organisations. It will continue to be overseen by the Health Equity Oversight Group (HEOG).
Environmental sustainability:	Development of health equity projects may have positive effects on the Trust's role as an anchor organisation and delivery of the Green Plan.
Assurance Route	
Meeting/s where content has been discussed previously:	• Health Equity Oversight Group reviewed the draft objectives and work plan and provided feedback. • This report provides the six-monthly update to Quality Committee and Board. • The Quality Committee on 17th September 2026 endorsed and approved the proposals contained within this paper.

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Report content

This paper is divided into two sections:

- 1 - Health Equity Objectives 2026-28** – this section requests approval of the revised objectives
- 2 - Progress and assurance** - summarises delivery and next development priorities

1 – Health Equity Objectives 2026-28

1.1 Why new objectives are needed

The Trust's health inequalities objectives were previously contained within the health equity chapter of the EDI Strategy, which expired in December 2025. The objectives were carried to March 2026 to allow for a managed transition. A revised set of objectives is now required to provide a clear framework for the Trust's health equity work for 2026-28.

New workforce strategic equality objectives are also being developed and will be considered by the People Committee in September 2026.

1.2 The changing healthcare landscape

Several national and local developments have shaped the revised objectives.

- The [NHS 10 Year Health Plan](#) (July 2025) embeds action on inequalities across its three shifts, retains a focus on Core20PLUS5 and sets the NHS a target of a 2% year-on-year productivity gain for the next three years. This is reflected in the Trust's 5-year Integrated Delivery Plan for 2026-2031 and the strategic framework for 2026/27 which highlights partnerships and health equity as key enablers of the Trust's overall vision.
- The [NHS Oversight Framework 2026/27](#) (NOF) includes provider domains covering population health and inequalities, access, effectiveness, experience, patient safety, finance, productivity and innovation, and people. For trusts, the population health and inequalities domain includes the percentage of inpatients making a supported quit attempt through an in-house tobacco dependence treatment service; access, outcomes and experience are also explicitly reflected across the provider framework.
- The national [Quality Strategy](#) for NHS-funded care identifies leadership and management capability as an enabler and defines high-quality care through safety, effectiveness and experience with reducing health inequalities as a core aim.
- [The Bradford District & Craven Health and Care Partnership's 2025 strategy](#) which places reducing health and healthcare inequalities at the heart of achieving the 'Happy, Healthy, at Home' vision. It recognises the need for prevention and community approaches and the opportunities to address inequalities in the development of neighbourhood health.

Additionally, the Trust has committed to becoming an actively anti-racist organisation that addresses racial inequalities and has adopted the NHS Race and Health Observatory Anti-Racism Principles.

Back in October 2024, the Board also set three requirements that are still relevant now: (1) focus positively on improving health equity (2) implement small, scalable improvement projects (3) build health equity knowledge and capability across the Trust.

1.3 NHS Providers Health Inequalities Self-Assessment

Method and context: The [NHS Providers Health Inequalities Self-Assessment](#) helps trusts assess the current status of health equity/inequalities work. This was used to assess progress in 2024 and 2025.

For 2026, a survey was developed using the questions from the self-assessment for members of the Health Equity Oversight Group (HEOG) to complete. It was completed by 18 HEOG members with scores averaged across four domains. The maturity ratings scale is as below in ascending order –

- Not started
- Emerging
- Developing
- Maturing
- Thriving

Domain	Self-Assessment Score			
	2025	2026	Maturity rating	More to do
Strategic Leadership	56%	76%	Improved from maturing to thriving	Further embed CORE20+5 framework; embed equity lens in strategic planning
Data, Insight and Evaluation	57%	76%	Maturing	Dashboard for CSUs, reporting to Board and annual Health Inequalities Statement
Building Public Health Capacity	38%	59%	Improved from developing to maturing	Expand training to all staff groups
System Partnerships	50%	85%	Maturing	Engage with new system-wide and ICB structures

Scores have improved under all headings because the health equity work plan for 2025/26 was designed to respond to the self-assessment carried out last year, and included actions under all four headings.

This year was the first full year with a formal health equity work plan, and the first year of formal oversight by the Health Equity Oversight Group. Having taken the input from panel members into consideration, we have improved two of the domains (strategic Leadership from Maturing to thriving, and Building Public Health Capacity from Developing to Maturing) and maintained the other two domains (Data, insight and evaluation and system partnerships) at Maturing overall. The actions highlighted are built into the work plan for 2026/27.

1.4 Revised Objectives for Health Equity

The previous EDI Strategy contained five health inequalities objectives. The revised framework retains five objectives but consolidates and revises them in response to the changes described above, the Board's directives, the self-assessment and learning from delivery to date.

The table compares the previous objectives to the revised objectives -

	Previous objective		New objectives for 2026–28
1	Embedding health equity	1	Build organisational capability to identify and act on healthcare inequalities
2	Data analysis and utilisation	2	Develop a sustainable health equity intelligence function
3	Strengthen our role as an anchor organisation	-	Folded into Objectives 1 and 5
4	Providing care based on population profiles	3	Deliver targeted improvement projects with measurable equity outcomes
		4	Align health equity within the Trust's recovery priorities (new)
5	Collaborating with partners	5	Strengthen system and community partnerships to co-design and deliver measurable health equity improvements

The key changes are:

- **Objective 1** carries forward the embedding work but focuses it on building the capability of staff and specialties to identify and act on healthcare inequalities. This responds directly to the Board directive and the self-assessment gap on building capability. Delivery includes the preceptorship programme, a lunch-and-learn series, the health equity champions network, corporate induction and HEOG governance. Measures will aim to increase reach, confidence and application in practice rather than training activity alone.
- **Objective 2** develops data analysis into a sustainable health equity intelligence capability. At its core will be a health equity dashboard, developed with BI, to support the Health Inequalities Statement, HEOG reporting and specialty-level analysis. The objective also includes improving ethnicity data completeness and supporting specialties to interpret and act on variation.
- **Objective 3** refocuses the broad ambition of providing care based on population profiles into targeted improvement projects with measurable equity outcomes. Current examples include the renal DNA project and Making Every Contact Count. The [CVD Modern Service Framework](#) aims to reduce inequalities by providing joined up cardiovascular, renal and metabolic prevention and care.
- **Objective 4** is new. It intends to embed and support health equity within the Trust's recovery programme focusing on quality, access, productivity, planning and transformation priorities. DNA financial impact analysis and honing services' impacts on health equity provide examples of how unequal access can be addressed while improving quality and use optimising resource usage.
- **Objective 5** carries forward partnership working with a clearer focus on outcomes and is key to our role as an anchor institution. It covers VCSE and community engagement, Health Equity Village events and work with partners including BIHR and community organisations. Partnership activity will be expected to lead to jointly owned actions or measurable improvements.

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1.5 Work Plan

Progress: A draft work plan has been produced to deliver the proposed objectives. It draws directly on the self-assessment findings and maps each project to the NHS Providers self-assessment objectives. The plan contains 16 projects/workstreams and provides the basis for moving from individual activities to a coordinated programme of improvement, intelligence, capability and partnership work using the IHI Model for Improvement to effect sustainable change. **Appendix 1** details the intended projects, workstreams and timescales.

Next development: Following approval, the work plan will be confirmed with named ownership, baselines, measures, milestones and reporting routes. HEOG will oversee delivery and Quality Committee and Board will receive six-monthly assurance on progress and impact.

1.6 Recommendation

The Board is asked to approve the five revised objectives and endorse the continuing work plan in Appendix 1, with detailed oversight undertaken by the Health Equity Oversight Group.

2 - Progress and assurance

The following sections summarise work completed since the last update to Board of Directors in March 2026, the evidence currently available and the next development priority. Where outcome or evaluation data are not yet available, this is identified explicitly.

2.1 Development of health equity digital tools

Progress: Two digital tools have been developed and deployed.

Equity in Practice provides interactive clinical scenarios across 12 specialties, each with three branching decision points that surface health equity considerations at the point of care. The tool is hosted on the Trust intranet and has been incorporated into the nursing and AHP preceptorship programme as a core learning resource.

The Bradford Travel Equity Tool models travel time and access burden for a defined patient cohort to any service location, disaggregated by deprivation. The tool supported the Health on the High Street equity assessment, providing evidence-based travel analysis across five clinical services: Audiology, Breast Screening, Dermatology, Gynaecology and Ophthalmology.

Evidence and next development: Both tools were developed in-house without external licence expenditure, with maintenance managed within existing resources. The equity scenarios have supported the facilitation of the preceptorship training triggering discussion and debate around inequalities and will be a core part of the preceptorship training offer. It's intended this training tool will be promoted to a wider audience within the trust.

For the Health on the High Street Programme the Travel Equity Tool has analysed the impact of the potential moves from BRI and SLH to Broadway. Utilising patient postcodes, it's helped to understand the impact of the potential moves on patient journeys and who is affected. It showed that people from the Core20 more deprived postcodes would benefit most from shorter car journeys and easier public transport routes. Similarly, the tool has also been used to analyse a potential macular service move from SLH to Windhill Green – the tool identified this would be disadvantageous to the most deprived. The tool can be accessed via a desktop icon once access has been approved.

2.2 Digital Access Hub at BRI Library

The high prevalence of digital exclusion and low health literacy within the Bradford population means that many residents face difficulties accessing digital healthcare services, applying for roles using NHS jobs and engaging with systems such as the NHS App. Low health literacy is known to be associated with poorer health outcomes¹.

The team at the BRI library have opened the library to the public to offer personalised digital support, and worked with partners (BMDC Digital Inclusion Programme, Yorkshire Women's Forum) to design and promote the offer to members of the public.

Aim: The aim is to provide a safe and supportive environment for members of the public to receive one-to-one personalised assistance to access digital support, access reliable health information, use the NHS App, and receive assistance with NHS job applications and gain confidence with online recruitment. There is no budget, so it has to be delivered with existing resources.

Test of change: Create a digital access hub with public internet access at the BRI library.

Results of trial: During the initial trial, feedback was very positive from people using the service. Having approached the trial asking people to book an appointment to meet the team, this did lead to lower utilisation than anticipated and some did not arrive for appointments they had booked. However for those attending, sessions lasted over an hour and a half on average and the feedback was universally positive.

In summary:

- the library team were able to support people with access to the internet, finding information about a medical condition, the NHS App, and NHS Jobs applications
- feedback demonstrated high levels of satisfaction and the importance of personalised digital support
- those that did not attend said they found it difficult to get to the hospital site or to find and access Field House
- Information Governance considerations required use of a stand-alone tablet computer. Users would have preferred access to a PC (especially for job applications).

Learning: The project has demonstrated that there is a genuine need for this type of support within the community. However, the combination of challenges travelling to and parking at the hospital, restrictions on IT access due to IG considerations, appointment-only provision, and the inherent challenges of reaching digitally excluded populations limited the number of people who engaged with the service.

Next Steps: Work in partnership with community groups and other local services such as GPs, pharmacies and schools to overcome the barriers to access and connect with other teams working to address digital exclusion.

2.3 Health Inequalities Statement

Progress and assurance: The [2025/26 Health Inequalities Statement](#) was published online as part of the Trust's 2025/26 Annual Report. It is more comprehensive than in previous years following NHS England's November 2025 revision, which introduced Key Lines of Enquiry, a measurement framework, expanded patient group requirements and ethnicity coding standards. Data is disaggregated throughout by deprivation, ethnicity, age and sex. Delivery required coordinated input from Patient Experience,

¹ **The Updated Systematic Review on Health Outcomes:**

Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2011). [Low health literacy and health outcomes: an updated systematic review](#). *Annals of Internal Medicine*, 155(2), 97–107.

Business Intelligence and Performance alongside external partners such as the Reducing Inequalities Alliance and Bradford Council.

Key Findings: There are gaps in the Trust's ethnicity coding data. 72% of patients have an ethnicity recorded, 5% have not stated their ethnicity, and 23% are coded as unknown. The data also shows that recent efforts to focus on improving access for patients with Learning Disabilities have been successful – between 2024/25 and 2025/26 there was a bigger increase in the % of patients seen within 18 weeks for patients with a Learning Disability. But there are also issues to address – for example, the DNA rate remains higher for CORE20 patients from more deprived populations.

Next development: A health equity dashboard is in development with the Business Intelligence team – a prototype has already been developed for emergency care. Once fully developed and validated, it is intended to automate the data extraction currently undertaken manually for the health inequalities statement and make inequalities data routinely available to CSUs and specialties. This will support data-informed conversations about equity throughout the year. A project is starting to improve ethnicity coding and the renal project is targeting DNA rates.

2.4 Health Equity Village

Progress: A Health Equity Village event was held at BRI in June 2026, bringing together local partners to provide a health equity perspective on services available to the community. Partners who hosted stalls at the event included Yorkshire Women's Forum, Bradford Council's Digital Inclusion Services and the Trust's library service. Activities included diabetes risk checks, guidance on accessing free mobile phone and data packages, and information on library services.

Evidence and next development: The event attracted approximately 80 to 100 visitors. A short-form social media video was produced with a local community advocate, extending reach beyond those who attended in person. Attendee and partner feedback was positive including requests to be involved in future events. Similar events are being planned at community sites across the district; learning from the first event will inform the format and partner mix.

2.5 Renal missed appointment reduction and health equity

Data: Analysis of the impact of deprivation on attendance rates has shown that Core20 patients (from the 20% most deprived populations) are more likely to miss their appointments, which affects timely access to health care and can lengthen waiting times. Renal services have the largest gap between new appointment DNA rates for Core20 and non-Core20 patients (18.5% compared to 7.5%).

Progress: The renal service is participating in a regional wide health equity programme focused on reducing missed appointments with a focus on health equity. The aim is to reduce DNAs/missed appointments for the Transplant Assessment Clinic, with a specific focus on Core20 patients living in IMD deciles 1 and 2. To date, workshops have been facilitated (including attendance from a patient champion), data analysed and PDSA cycles developed. Reducing the number of missed appointments will improve access to care, reduce waiting times for patients, and also increase clinic efficiency.

Evidence and next development: Data has shown that patients who are Pakistani, from the Core20 postcodes (predominantly IMD 1), aged 50-59 and male are more likely to miss their appointment than other groups. The first PDSA cycle has started with investigative phone calls to patients who have missed appointments on multiple occasions to understand the reasons. Interventions will then be developed and tested to target this cohort such as:

- Facilitating digital access for those unable to afford or use a device or internet access (connecting to digital inclusion offers from the library, BMDC and community groups)
- Changes to appointment booking processes
- Developing a pre transplant checklist/passport
- Providing patients with videos in multiple languages
- Exploring opportunities to redeploy existing staff roles
- Reframing the patient directed renal transplant assessment letter

3 - Conclusion and next steps

The Board of Directors are asked to:

1. Approve the five revised Health Equity Objectives for 2026-28;
2. Endorse the continuing work plan for 2026/27 (Appendix 1)
3. Note progress since March 2026

The programme has moved from establishing governance and individual projects towards a more structured delivery model built around capability, intelligence, measurable improvement, Trust priorities and partnerships. Current assurance includes completion of annual reporting, deployment of practical tools, development of the work plan and improvement across all four self-assessment domains.

The next phase is to demonstrate that this activity produces measurable and sustainable improvements in access, outcomes and experience. Priorities are to finalise the work plan, strengthen ownership and measures, complete the health equity dashboard, improve organisational capability and deliver and evaluate the impact of projects and partnership activity.

Osbourne, Sheridan
24/09/2026 08:40:12

Appendix 1 – work plan

Summary timeline a high-level view of project phasing across the four quarters of 2026/27. All timelines are proposed and subject to agreement through HEOG.

Ref	Project/workstream	Q1	Q2	Q3	Q4
Build organisational capability to identify and act on healthcare inequalities					
1.1	Preceptorship programme training	•	•	•	
1.2	Lunch and learn webinars/COP	•	•	•	•
1.3	Health equity champions		•	•	•
1.4	Corporate induction	•	•	•	•
1.5	HEOG governance and reporting	•	•	•	•
Develop a sustainable health equity intelligence function					
2.1	Health equity dashboard	•	•	•	•
2.2	Ethnicity recording improvement		•	•	•
2.3	HI Statement delivery	•			•
Deliver targeted improvement projects with measurable equity outcomes					
3.1	Renal DNA project (MISSME)	•	•	•	•
3.2	Making Every Contact Count	•	•	•	•
3.3	CVD rehab and secondary prevention equity (TBC)				
Align health equity within the Trust's recovery priorities (new)					
4.1	DNA financial impact calculation	•	•		
4.2	Equity gateway for business cases		•	•	•
4.3	Waiting List Equity Analysis (TBC)				
Strengthen system and community partnerships to co-design and deliver measurable health equity improvements					
5.1	VCSE and community engagement	•	•	•	•
5.2	Enhancing partnerships with an equity focus (research, education etc)		•	•	•

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Meeting Title	Board of Directors		
Date	24 September 2026	Agenda item	Bo.9.26.18

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Audit Committee

Date of meeting: 8 September 2026

Key escalation and discussion points from the meeting

Alert:

Internal Audit

The Committee received the following final reports which had received **Limited** assurance: a) Sepsis Management; b) Space Utilisation and c) Non-clinical / non-medical staff appraisals. The Committee was concerned of an emerging pattern that there should have been better control in second line assurance to prevent identified issues from occurring.

a) Sepsis Management – the audit concluded that arrangements for sepsis reporting and oversight are not sufficiently resilient. Updated screening arrangements following the NICE guidance had been fully operationalised and monitoring activity was predominantly retrospective. The Chief Medical Officer provided assurance and explained that the concern appeared to relate more to oversight, resilience and reporting than to evidence of poor patient outcomes. A review had been undertaken to examine sepsis management and outcomes, including mortality, length of stay and diagnostic coding. The review suggested that outcomes for patients with sepsis were broadly consistent with other groups and with regional comparators. It was also noted that the Trust may report sepsis screening rates using a different denominator from neighbouring organisations, which may partly explain comparative performance. The Committee was assured that sepsis management would be incorporated into the clinical outcomes and effectiveness governance structure, with reporting strengthened through the relevant committee routes.

b) Space Utilisation – The limited rating was driven by several factors, including the lack of a fully embedded strategic approach to space utilisation, missed utilisation surveys, weaknesses in policy and data access, reliance on key individuals, loss of historical data following staff changes, and inconsistent operation of the space utilisation group. The Deputy Director for Estates & Facilities attended and explained that the relevant group had stood down during COVID and was later restarted. It was proposed that the space utilisation group be combined into a wider estates operational and strategic group to bring together the same key stakeholders, including capital and clinical representatives, and to improve strategic oversight. Work was underway to improve data and measurement. The Committee took assurance from the direction of travel and the work underway.

c) Non-clinical / non-medical staff appraisals - While arrangements are in place to monitor and report appraisal performance, there remains issues with both quantity and quality of appraisals at the Trust. Appraisal compliance was below the 85% target, at 81% as of 31 March 2026. Although this does represent an improvement from 76.8% in March 2025. Issues were identified with inconsistency in documentation, including managers overwriting previous appraisal records rather than creating new documentation. The HR Director explained that options being considered included introducing an appraisal window, rather than having appraisals take place across the

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full year. The matter was to be considered further by People Committee, with further updates expected on improvement actions and backlog reduction.

Advise:

The Committee revisited the previous **Limited** assurance **Discharge Management** audit. Although previous recommendations had been implemented and a follow-up report had provided **Significant** assurance, the Committee remained concerned that compliance had only improved from around 10% to 14%, against a much higher expected target (in terms of Discharge Ready Dates and accuracy of information recorded on EPR). It was explained that the issue remains challenging nationally and locally, but there had been targeted improvement on Ward 27, where use of a discharge coordinator and Optica had improved compliance from 31% to 94%.

The Committee discussed the patient safety and quality risks associated with delayed discharge, including prolonged exposure to hospital risks and the need to assess whether harm has occurred for patients staying longer than necessary. Discharge management is being picked up through the Excel programme under patient flow work, and regular audit and spot checks will be used to monitor progress. The Committee requested a further update in approximately six months.

Assure:

Internal Audit

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

Report No	Report	Final	Draft	Opinion
BH/35/2026	Sepsis Management	✓		Limited
BH/36/2026	IRIS Investigations	✓		Limited
BH/37/2026	Discharge Management Follow-up	✓		Significant
BH/38/2026	Space Utilisation	✓		Limited
BH/01/2027	Waste Reduction and Cost Improvement Plans Benchmarking			N/A
BH/02/2027	Sustainability and Green Plan Benchmarking			N/A
BH/03/2027	Data Security and Protection Toolkit Benchmarking			N/A
BH/04/2027	Root Cause Analysis Benchmarking			N/A
BH/05/2027	Budgetary Accounting Framework	✓		High
BH/06/2027	Clinical Stock Management Benchmarking			N/A
BH/07/2027	Programme Management	✓		Significant
BH/08/2027	Non Clinical/ Non-Medical Staff Appraisals	✓		Limited
BH/09/2027	Implementation of the Improvement strategy	✓		Significant
BH/10/2027	Overall response to CQC/Well Led – Phase 1	✓		Significant
BH/11/2027	Data Quality	✓		Significant
BH/12/2027	Safeguarding – Safeguarding conversations in the Emergency pathway	✓		Significant

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Note: IRIS Investigations audit report was deferred to the November audit committee meeting for detailed discussion.

Other matters

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

- Internal Audit progress report 2026/27.
- External Auditors Annual Report 2025-26.
- Annual statement to council of Governors regarding external audit.
- Follow up of internal audit recommendations.
- Assurance regarding compliance with risk management strategy.
- Counter fraud progress report.
- Draft Charitable Funds Annual Report.

Report completed by:

Zafir Ali, Audit Committee Chair and Non-Executive Director, 14 September 2026

Osbourne, Sheridan
24/09/2026 08:40:12

Meeting Title	Board of Directors		
Date	24 September 2026	Agenda item	Bo.9.26.19

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: CHARITABLE FUNDS COMMITTEE

Date of meeting: 4 August 2026

Key escalation and discussion points from the meeting
Alert:
Finance Report - The report highlighted a VAT issue relating to Home from Home. Advice had been received indicating there was a likely pathway for VAT recovery, but written confirmation was still required. The Committee noted that obtaining written advice would provide assurance in the event of future HMRC challenge. - A capital drawdown from investments (around January/February 2027) will be needed for the build.
Advise:
Independence Committee: The independence roadmap remains on track. Trustee recruitment launches in September following a skills audit, with a shadow board forming late 2026. Financial Sustainability: Cash decreased by ~£100,000 since the previous meeting. Day-to-day fundraising is not currently covering operating costs, and the Charity may need to liquidate ~£130,000 in investments by year-end for liquidity if the trajectory continues.
Assure:
Neonatal Unit & Fundraising. Fundraising Performance (Home from Home Campaign) Secure/forecasted funding sits at ~£3.4M against the total build requirement, leaving ~£166,000 unallocated. Project completion is targeted for 4 June 2027 following a slight 3-week delay. The Big Give: An application has been submitted hoping to secure match funding that could generate up to £100,000. Yorkshire Charity Clay Day: Generated £75,000, with an invitation to pitch again for the 2027 event for a similar potential return. British Police Symphony Orchestra Event: Scheduled for 10 October, targeting approximately £30,000 gross income and £10,000 net income. Major Grants/Pledges: Secured £2.375 million in pledges/received funds as of late June, backed by a secondary pipeline of ~£500,000 and ongoing support from the Harry and Mary Foundation.

Report completed by: Altaf Sadique

Charitable Funds Committee Chair and Non-Executive Director

04/08/2026

Board of Directors Open				
Meeting Date:	24 September 2026	Agenda Reference:	Bo.9.26.20	
Report Title:	High-Level Risk Register			
Presented by:	Prof Karen Dawber, Chief Nurse			
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:	All operational risks scoring 15 and above (high level risks) are presented to the Risk Committee monthly and are 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 September 2026 and at the time of this report there are - • Two risks beyond their target mitigation date. • Four new risks (2913, 2903, 109 and 2605) with completed risk assessments. • One risk which as reduced in score (95). • No risks have been closed. • Three risks beyond their review date (2756, 2604 and 2753). The high-level risk register showing all high-level risks rated 15+ for September 2026 is attached at Appendix 1.			
Recommendation/s: (including any decision/approval required)	The Board is asked to confirm whether it is assured that all risks on the High-Level Risk Register are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.			
Link to Strategic Objective:	N/A			
Link to Priority Initiatives 2025/26:	N/A			
Implications				
Risk:	This report details the high level risks which are reviewed and updated by Executive leads prior to monthly reporting to the Risk Committee, 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:	ETM: 7 September 2026 People Committee: 9 September 2026 Finance and Performance Committee: 16 September 2026 Quality Committee: 17 September 2026

Report content

1. Purpose

This paper provides a profile of high level risks in the form of the High-Level Risk Register (HLRR) see Appendix 1.

2. Assessment

High Level Risk Register (HLRR) – Operational Risk

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 meeting on 7 September 2026, ETM considered a summary of all high-level risks, including any new risks, closures and changes in score and those risks which had passed their review date (due to availability issues, this month’s Risk Committee was cancelled, and the high level risk report was considered by ETM). The Committees reviewed the high-level risks within their remit at their meetings held in September 2026.

The HLRR, showing all high-level risks rated 15+ in September 2026, is attached at Appendix 1.

High Level Risks Report on a Page

The document at Appendix 2 provides a visual overview of all high-level risks at BTHFT as at September 2026 and shows trends and highlights areas for the Board to consider.

Target Mitigation Dates

There are two risks beyond their target mitigation date.

Risk ID:	Current Score	Risk Title	Target Mitigation Date	Lead Director	Committee:
2911	15	Neonatal service gaps at consultant level due to retirement and maternity leave	03/08/2026	Chief Medical Officer	Quality Committee / People Committee
2926	20	Failure to deliver Financial Plan	31/08/2026	Chief Finance Officer	F&P Committee

Changes to target mitigation dates

The document at Appendix 3 provides a detailed overview of all current high-level risks and the number of changes made to the target mitigation date for each risk since it was created.

New risks to the High-Level Risk Register (HLRR)

Four 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
2913	16	6	If the needs of and resource (commissioning) for Children with Medical Complexity (CMC), in particular staffing resource and adequate care locations are not provided, then our high risk population will suffer the consequences of our system challenges, i.e. low quality care, adverse events such as medication errors, long care waits and deterioration, fragmented care, inefficient care models and inadequate nurse to patient ratios, this will also result in poor family experience, complaints and distrust of clinical staff.	Chief Nurse	Kay Rushforth	Quality Committee
2903	15	4	If Community Midwives experience increased issues with IT connectivity in the community, then they will be unable to access records or document contemporaneously, resulting in a risk of transcribing errors, that information is lost or tasks are unactioned.	Chief Digital and Information Officer	30 September 2026	Quality Committee
109	16	8	IF the current capacity and demand pressures within Haematology is not urgently addressed, THEN the service will be unable to reliably deliver timely inpatient and outpatient care across the full range of Haematology activity, including acute and complex patient management, cancer follow-up, specialist Haemophilia care, CNS and registrar clinics, surgical activity and transfusion in-reach. RESULTING IN a high and increasing risk to patient safety, timely access to care and service delivery, with growing waiting times and backlogs, delayed cancer follow-up, increasing escalation requirements, and reduced resilience across the Haematology service.	Chief Medical Officer	1 October 2026	Quality Committee / People Committee/ F&P Committee
2605	15	8	IF we are unable to increase treatment space and ensure a safe skill mix of nurses and deliver chemotherapy to the day unit on time, THEN we are unable to provide chemotherapy and immunotherapy in line with a patients scheduled treatment plan to provide lifesaving treatments; RESULTING IN, delays to planned treatment such as neo-adjuvant, curative, and palliative chemotherapy, poor outcomes, disease progression, and deaths sooner than predicted.	Chief Operating Officer / Deputy CEO	1 December 2026	F&P Committee / Quality Committee

Risks which have been removed/closed

No risks have been closed since the last report.

Risks which have changed in score

One risk has reduced in score since the last report to the Board.

Risk ID:	Previous Score	Current Score	Risk Description	Lead Director	Rationale for closure	Committee
95	15	12	If we are unable to provide a sufficient number of middle and senior grade doctors that meets the 24 hour capacity and demand of the Emergency Department then there may be a mismatch of patient acuity and demand versus the number and competencies of clinical decision makers on duty at any one time resulting in an increased risk of patient harm, compromised quality and performance and a negative impact on efficiency and patient flow	Chief Medical Officer	19/08/2026 - Paper approved at ETM approving recruitment to 4 middle grade posts to facilitate consultants coming off nights and to maintain 4 SDMs overnight. Recruitment is in progress and the residual risk will reduce to 9 once all staff are in post.	People Committee / Quality Committee

Risks beyond their review date

There are three high-level risk beyond the review date.

Note: Risks 2604 and 2756 are currently undergoing review and pending closure, with one new high level risk to be created to effectively reflect the current ED risk/s.

Risk ID:	Current Score:	Target Score:	Risk Title:	Lead Director:	Review Date:	Committee:
2756	20	12	AED Long Waits	Chief Operating Officer	31/07/2026	Quality Committee / F&P Committee
2604	20	12	Emergency Department Overcrowding	Chief Operating Officer	31/07/2026	Quality Committee / F&P Committee
2753	20	5	Renal Dialysis Capacity	Chief Medical Officer	01/08/2026	Quality Committee / F&P Committee

Risks which have been the same score for 12 months or more

11 risks have had a static score for 12 months or more.

Risk ID:	Current Score:	Target Score:	Risk Title:	Lead Director:
2601	15	9	Cath Lab Equipment Failure	John Bolton, Chief Medical Officer
2549	16	8	Workforce Constraints within Non-Surgical Oncology (NSO)	John Bolton, Chief Medical Officer
901	16	9	Risk of Cyber Security Threats	Vikki Lewis, Chief Digital and Information Officer
70	15	6	Pharmacy Accommodation - Cramped and not fit for purpose	Sajid Azeb, Chief Operating Officer
2604	20	12	Overcrowding of AED	Sajid Azeb, Chief Operating Officer

2725	15	3	The physical condition of the environment where pathology slides and blocks are stored at St Luke's Hospital.	John Bolton, Chief Medical Officer
40	15	3	The CSU is unable to effectively demonstrate that Personalised Care Plans are in place	Karen Dawber, Chief Nurse
2879	16	8	Middle grade medical staffing gaps in Obstetrics and Gynaecology	John Bolton, Chief Medical Officer
2868	15	5	Maternal Antibody Test Tracking and identification in Pregnancy and at Birth.	Chief Nurse
2879	16	8	Middle Grade Medical Staffing Gaps in Obstetrics and Gynaecology	Chief Medical Officer
2756	20	12	AED Long Waits	Chief Operating Officer

3. Recommendation

The Board is asked to confirm whether it is assured that all risks on the High-Level Risk Register are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.

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All Open Operational Risks with a current scoring of 15 or over (as at 02/09/2026)																					
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																			
BAF Risk Ref	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)
SR02	2753	11 Jul 2025	John Bolton	Rebecca McNally	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 QJ project to try and increase uptake.	30 Nov 2026	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
SR09	2604	04 Jul 2024	Sajid Azeb	Mayada Elsheikh	Risk Assessment	Quality Committee Finance and Performance Committee	Emergency Department Overcrowding	There is a risk that the number of patients in the emergency department will exceed its designed capacity and available resources meaning providing safe, timely, and efficient care to current and incoming patients becomes challenging resulting in a potential for unsafe care delivery and increased stress on staff.	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 solutions are around wider plans and delivery	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. -OPEL Score run by command centre and escalation to execs communicated daily. Full escalation protocol created in Nov 2024, not always actioned but needs review. (point 2 in treatment plan) -Internal professionals standards currently being implemented by CMO. Discussed at multiple hospital management groups (point 3 in treatment plan) -5 consultants (6 approved) appointed, starting nights in March. (point 4 in treatment plan). -Workforce review underway (see risk 0095) awaiting Kingsgate review also.	31 Mar 2027	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
SR09	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	31 Jul 2027	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20

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SR02	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.	30 Oct 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.	17.07.26; Discussed in core governance. Business case being included on the Finance and Performance Committee agenda and Trust Board meeting for consideration.	30 Oct 2026	(4) Major	(5) Will undoubtedly recur, possibly frequently	20
SR08	2926	01 Jul 2026	Ben Roberts	Chris Smith	Cost Improvement Programme/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 2026	12	(3) Moderate	(4) Will probably recur, but is not a persistent issue	12	(3) Moderate	(4) Will probably recur, but is not a persistent issue	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 2026	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	20
SR03	901	07 Dec 2016	Vikki Lewis	Carl Hanson	Business Continuity	Quality Committee	Cyber Exploitation and Incidents	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.	30 Nov 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.	August 2026: After an unsuccessful recruitment campaign, the Cyber Manager post now out for a second time, shortlisting ongoing. July 2026: MFA now fully deployed to all staff with remote access to 365 services.	01 Apr 2027	(4) Major	(4) Will probably recur, but is not a persistent issue	16
SR02	979	02 Jul 2018	Karen Dawber	Yaseen Muhammad	Business Continuity	Quality Committee People Committee	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 mitigate. October 2024 Risk has been re-reviewed and approved at IPCC. As this risk is based on a national risk and regional risk from the North East & Yorkshire risk register GR1, the Trust score will stay the same.	28 Sep 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16

SR02	109	14 Oct 2022	John Bolton	Jen Green	Risk Assessment	Quality Committee Finance & Performance Committee People Committee	Haematology Consultant Team & Haemophilia Service Delivery	IF the current capacity and demand pressures within Haematology is not urgently addressed, THEN the service will be unable to reliably deliver timely inpatient and outpatient care across the full range of Haematology activity, including acute and complex patient management, cancer follow-up, specialist Haemophilia care, CNS and registrar clinics, surgical activity and transfusion in-reach. RESULTING IN a high and increasing risk to patient safety, timely access to care and service delivery, with growing waiting times and backlogs, delayed cancer follow-up, increasing escalation requirements, and reduced resilience across the Haematology service.	01 Oct 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	Escalation list of malignant patients sent to team manager weekly monitored by pathway navigator. Clinic slots converted to accommodate escalation patients. In depth capacity and demand outcomes show to amend capacity in some areas to cover the deficit – work with consultants to action this. Capacity and demand work showing opportunities for conversion of sub specialities. Recruitment to non malignant CNS team to expand capacity. Pathway navigator monitoring. Job planning review.	Risk updated 10.08.2026 EG Updated risk assessment Erica Graves and Ruth Tolley in line with recent escalations and records of moderate harm. Risk rating increased to 16.	01 Jan 2027	(4) Major	(4) Will probably recur, but is not a persistent issue	16
SR09	2549	05 Apr 2024	Sajid Azeb	Ellie MacIver	Risk Assessment	People Committee 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
SR02	2879	27 Mar 2026	John Bolton	Hannah Ackroyd	Risk Assessment	f2913	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 and there will be times where there is only one registrar at nights, and where this doctor is not entrustable 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).	30 Sep 2026	16	(4) Major	(4) Will probably recur, but is not a persistent issue	8	(2) Minor	(4) Will probably recur, but is not a persistent issue	1-The 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, skills	1-The recruitment of specialty doctors and clinical fellows to fill the gaps of both the Trust grade doctors that are required for our establishment, as well as clinical fellows and MTIs to fill the gaps created by the deanery short fall. 2-To follow the Royal College Obstetricians Gynaecologists (RCOG) workforce guidance as to how to future proof the speciality for individual Trusts; promote, recruit and retain locally employed doctors and to consider recruitment through the RCOG MTI scheme. A full summary of this is available from: O&G Workforce Report 2022 RCOG 3-The service has escalated their safety position to both the deanery and the RCOG. There are plans to support the unit with 2 MTI's which should be in post in 2026. There has also been a formal complaint to the Deanery due to the inequity of the rotation (this skill mix and shortfall is	30 Sep 2026	(4) Major	(4) Will probably recur, but is not a persistent issue	16
SR02	2913	04 Jun 2026	Karen Dawber	Kay Rushforth	Risk Assessment	Quality Committee	Children and Young People with Medical Complexity	If the needs of and resource (commissioning) for CMC, in particular staffing resource and adequate care locations are not provided, then our high risk population will suffer the consequences of our system challenges, i.e. low quality care, adverse events such as medication errors, long care waits and deterioration, fragmented care, inefficient care models and inadequate nurse to patient ratios, this will also result in poor family experience, complaints and distrust of clinical staff.	12 Jul 2027	16	(4) Major	(4) Will probably recur, but is not a persistent issue	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	Presentations provided to explain situation and definition. Linking with commissioners, SEND collaborators, adult services. Data collection begun to determine CMC population Working with BI to look to the future to count code and work with AI Some complex care is provided on the children's ward by paediatricians at the discretion of the Consultant Regional Paediatric Critical Care Operational Delivery Network (PCCODN) in existence Adult ICU at BRI admit children at 16 years Sheffield model of care for admission to ICU at 16+ managed by children's MTA staff with adult and critical care team Some inpatient care is provided when child admitted to hospital by child's home care team where deterioration is not too great and care team able	1. Appoint RD Nurse and support into work 2. Secure and open HDC facilities 3. Develop frailty index and test and place template into EPR 4. Use definition of RD complexity and place template into EPR 5. Develop parents forum 6. Liaise with all collaborators, adult teams, PCCODN, Commissioners, rehab consultant 7. Develop/share policy and procedure for CMC 8. Exhibit/advertise work 9. Purchase beds	09 Jul 2027	(4) Major	(4) Will probably recur, but is not a persistent issue	16

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SR09	2605	08 Jul 2024	Sajid Azeb	Erica Graves	Risk Assessment	Quality Committee Finance and Performance Committee	The Meadows - Chemotherapy Day Unit Capacity	IF we are unable to increase treatment space and ensure a safe skill mix of nurses and deliver chemotherapy to the the day unit on time, THEN we are unable to provide chemotherapy and immunotherapy in line with a patients scheduled treatment plan to provide lifesaving treatments; RESULTING IN, delays to planned treatment such as neo-adjuvant, curative, and palliative chemotherapy, poor outcomes, disease progression, and deaths sooner than predicted.	01 Dec 2026	25	(5) Catastrophic	(5) Will undoubtedly recur, possibly frequently	8	(2) Minor	(4) Will probably recur, but is not a persistent issue	Escalation list to manage patient prioritisation. During clinic meetings and grand rounds patients are identified who are at risk of not receiving outpatient treatment as scheduled and are treated as ward attenders or admitted to the inpatient service at BRI to provide urgent chemotherapy to save lives. Escalation patients and capacity discussed at twice weekly scheduling meetings with attendance from operational team, nursing team, aseptics and pharmacy. Increased skilled nursing capacity. Admitted to the inpatient service to try and treat with urgent chemotherapy to save lives. Patients admitted on to the acute ward to receive the treatment indicated on their scheduled	26.08.26 Risk assessment updated EG/NT Risk score increased to 15 based on recent number of moderate harm iris escalations as a response to capacity challenges in both day unit and aseptic delivery	31-Mar-27	(5) Catastrophic	(3) May recur occasionally	15
SR01	70	29 Mar 2023	John Bolton	Osman Chohan	Risk Assessment	Finance and Performance Committee People Committee	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, resulting in increased risk to patient care, staff wellbeing and trust finance through loss of drugs due to inadequate storage space. Note - The pharmacy aseptic unit is listed as a separate risk - risk 3696.	30 Sep 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.	19.08.2026 Entry by Osman Chohan, Chief Pharmacist - Pharmacy accommodation remains inadequate for the demand across various services in Pharmacy, chiefly Dispensary, Pharmacy Stores, Clinical Pharmacy, Aseptics, Radiopharmacy and Homecare team. A separate Risk in regards the Aseptic Unit describes the aseptics challenges in greater detail. - Incidents in regards to dispensing errors are frequently reported and the dispensing error rate is higher than national average (current 12 month rolling rate is 0.030% against a national benchmark level of 0.020%, i.e. 30 errors per 100,000 items dispensed, which is 50% higher than national average). - Pharmacy need a new robot which can hold majority of packs of oral medicines and dispense faster and more accurately without the need for manual loading or picking. The current estate cannot accommodate	30 Sep 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
	2601	28 Jun 2024	John Bolton	Rebecca McNally	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 Oct 2026	15	(5) Catastrophic	(3) May recur occasionally	10	(5) Catastrophic	(2) Do not expect it to happen again but it is possible	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. Siemens 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 repair is no longer available.	31 Mar 2027	(5) Catastrophic	(3) May recur occasionally	15
SR04	2725	26 Mar 2025	John Bolton	Leah Richardson	Risk Assessment	Quality Committee	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

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SR02	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 antibody status. If any queries are	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 to	30 Sep 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
	2903	17 May 2026	Vikki Lewis	Joanne Beer	Escalated from Division	Quality Committee	IT connectivity in community	If Community Midwives experience increased issues with IT connectivity in the community then they will be unable to access records or document contemporaneously, resulting in a risk of transcribing errors, that information is lost or tasks are unactioned.	30 Sep 2026	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	4	(2) Minor	(2) Do not expect it to happen again but it is possible	Business continuity plan; recording on paper and then transcribing later is the midwives only option. This is however time consuming and there is a transcribing error risk and a risk that information is lost or tasks unactioned. Midwives have the same SIM card in their mobile phones as their laptops. Verbal communication of histories is provided when a referral to another service/department is made. An uncontrolled hazard exists as the financial cost to staff is not being measured. The co-op card is heavily relied upon, being used as a business-as-usual paper documentation tool, rather than a business continuity document, in view of the challenges with access to the electronic patient record	1. Reporting connectivity issues via the Trust incident reporting mechanism to be completed 2. Digital midwife and IT manager, John Greenaway looking at alternative SIMS with more than one network coverage 3. Desktop PC access for community staff in GP surgery's to be reviewed 4. Exploration of an offline mode for EPR records to be explored in line with other maternity EPR systems 5. Exploration of Trust mobile phones and Trust PC's being from different providers to give staff a second connection option by tethering to their Trust phone.	30 Sep 2026	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15
SR02	2911	03 Jun 2026	John Bolton	Sam Wallis	Risk Assessment	Quality Committee People Committee	Neonatal service gaps at consultant level due to retirement and maternity leave	IF the Neonatal Intensive Care Unit (NICU) continues to have a consultant workforce shortfall due to retirement, maternity leave and difficulties recruiting suitably qualified locum or substantive consultants, THEN the remaining consultant workforce will have insufficient capacity and resilience to sustainably deliver both acute clinical services and essential non-acute activities, RESULTING IN an increased risk of staff burnout and sickness absence, reduced service resilience, cancellation of outpatient clinics and increased waiting times, non-compliance with national service specifications and NICE guidance, failure to meet Maternity Incentive Scheme requirements (including potential loss of CNST premium recovery), reduced delivery of consultant-led training, mortality reviews, quality improvement and family engagement activities, and diminished clinical governance and leadership, with consequent risks to patient safety, service quality and organisational performance.	01 Oct 2026	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 Non-consultant delivery of outpatient and non-acute care: Resident doctors conduct supervised general clinics Speciality doctor runs a hydronephrosis clinic ACP/Nursing/Midwifery colleagues contribute to QI, governance and PMRT work Further controls required - Additional consultant level cover - readvertise for 1 year locum consultant to meet gap - may be limited by lack of suitable candidates Expand non training grade medical workforce to provide additional resilience (see below) Additional consultant level cover - readvertise for 1 year locum consultant to meet gap Expand non training grade medical	Inability to maintain current high level of services if additional mitigation not in place. Risk to acute service if further gaps/sickness given lack of resilience Risk to patients, family experience, trainee experience, unit reputation. Actions : Readvertise 1 year consultant locum • May be limited by lack of suitable candidates. When previously advertised the 2 locums were the only 2 who were appointable. Leeds Neonatal service has recently appointed 4 consultants so available pool of individuals with necessary skills, training and experience is very limited. Expand non-training grade medical workforce • Upgrade speciality doctor role to specialist. Individual in current speciality role has necessary experience and skills, and is keen to progress. This will allow greater autonomous practice to support	03 Aug 2026	(5) Catastrophic	(3) May recur occasionally	15

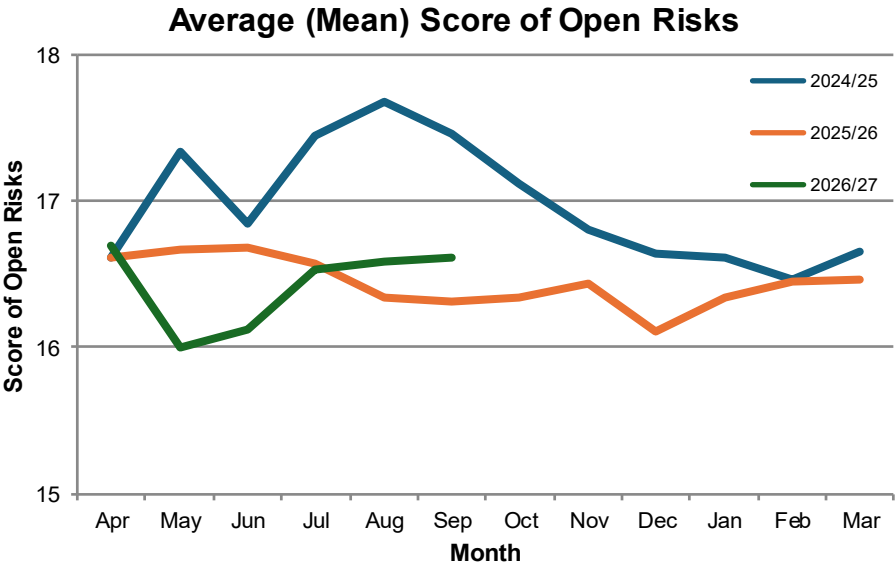
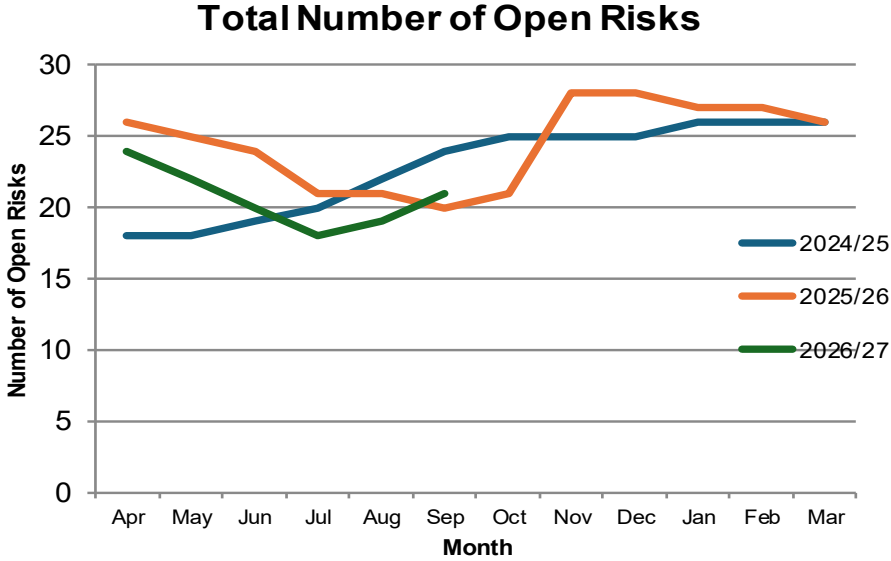
SR02	40	02 Jul 2023	Karen Dawber	Monica Parmar	National Guidance	Quality Committee	The CSU is unable to effectively demonstrate that Personalised Care Plans are in place	If we are not able to demonstrate effective implementation of Personalised Care Plans for all women then we will not be able to demonstrate 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.	21/05/2026 Procurement process for a trust wide patient portal has begun with meetings weekly to agree specification and requirements. These meetings include procurement and Ddat colleagues. There is a plan to go out to tender once final sign off has been completed. There will then be the opportunity to watch the Presentations of the providers whose Bids are successful. There is currently a high level plan for delivery of the patient portal this year.	30 Sep 2026	(5) Catastrophic	(3) May recur occasionally	15
SR02	30	30 Aug 2023	Karen Dawber	Hannah Ackroyd	Risk Assessment	Quality Committee	USS capacity	If we are unable to perform a fetal ultrasound scan within the required time frames as per guidelines there is a risk of poor fetal outcomes and an increase risk of stillbirth.	30 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 breach 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
SR03	2628	30 Jun 2024	John Bolton	Matt Davies	National Target	Quality Committee	TB Backlog	IF we are unable to see TB referrals within the required 1-2 weeks due to clinical capacity and expertise, THEN there will be delayed assessment, investigation and treatment for active or latent TB RESULTIN 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.	28 Feb 2027	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.	19/08/26 - updated risk assessment completed. TB business case for extra resource has been approved at ETM and the trust are now negotiating with the ICB to secure funding for the additional resource levels of clinical admin.	28 Feb 2027	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	15

High Level Risks Report on Page – September 2026

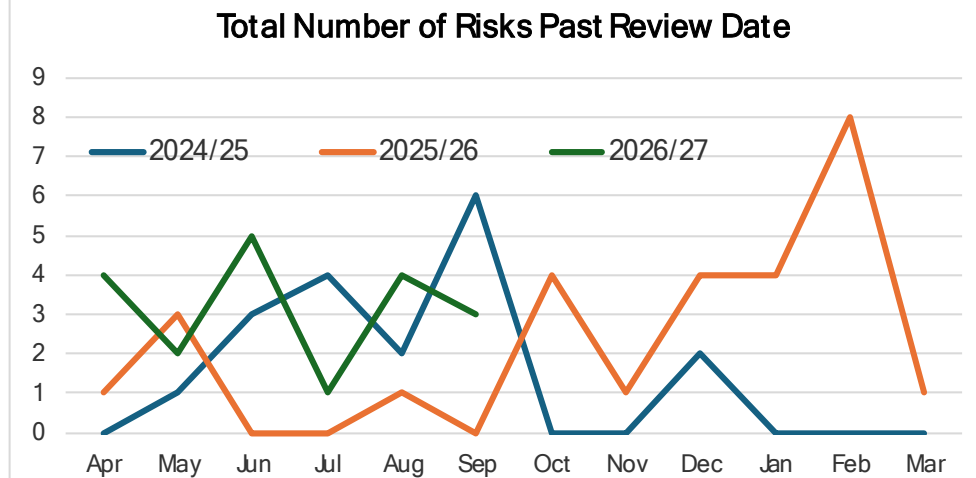
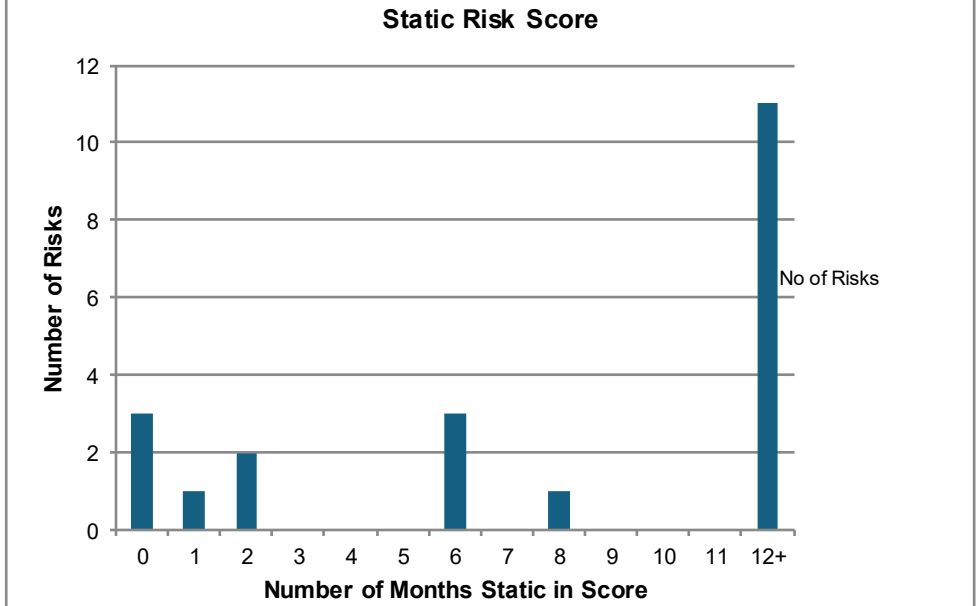
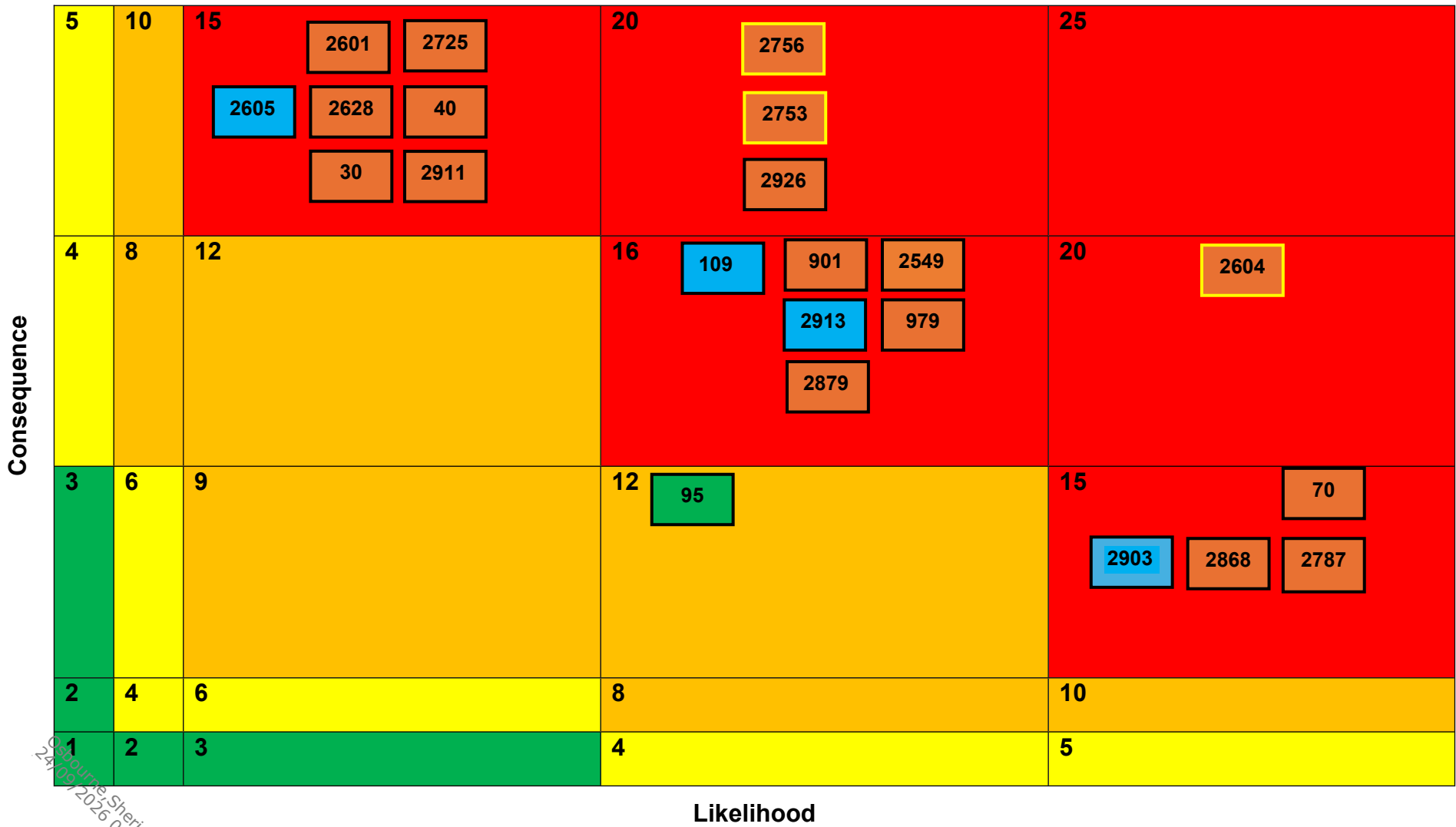
Total High-Level Risks	21*
Aligned to F&PC	9
Aligned to QC	21
Aligned to PC	5
Aligned to Board	0

*Note some risks are aligned to more than one Committee

Movement of Risks	
New	4
Marked for closure	0
Risk score increased	0
Risk score static	17
Risk score decreased	1



Risk Overview



Key:	New	Closed/Removed	Increase	Decrease	Static	Past Review Date
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Changes to Target Mitigation Date of Current High Level Risks - September 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				
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	30/09/2026						
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	30/10/2026							
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										
2913	04/06/2026	QC	16	6	09/07/2027										
2903	31/08/2026	QC	15	4	30/09/2026										
109	31/08/2026	PC, FPC, QC	16	8	01/01/2027										
2605	31/08/2026	QC, FPC	15	8	31/03/2027										

Overdue

Change in Target Mitigaton Date

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Board of Directors Open				
Meeting Date:	24 September 2026		Agenda Reference:	Bo.9.26.21
Report Title:	Risk Management Strategy and Policy including Risk Appetite Statement			
Presented by:	Prof Karen Dawber, Chief Nurse			
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:	The Risk Appetite Statement (Appendix 1) has been reviewed following the Board Development Session held on 29 April 2026 and refined in response to Board feedback. The revised statement is aligned with the Trust's Risk Management Strategy and Policy to ensure a consistent approach to strategic decision making and risk management. The revised Risk Appetite Statement reflects the Board feedback and refinements made by the Executive Team on 17 August 2026 and has been reviewed by the Board Assurance Committees at the meetings held in September 2026. Risk Appetite is defined as 'the level and type of risk the Trust is willing to accept or pursue in achieving its strategic objectives, as determined by the Board.' It reflects the balance between the opportunity presented by innovation, improvement and transformation, and the threats that arise from uncertainty and organisational change. The Board agrees the Risk Appetite Statement for the Trust, and it is reviewed on an annual basis. The Risk Appetite Statement is designed to: • Set the appetite levels against each strategic objective; • Define the Trust's attitude towards different domains of risk; and • Provide guidance for decision makers across the Trust. The Board are asked to note and approve the following updates to the Risk Appetite Statement attached at Appendix 1 – • In relation to Strategic Objective 3 (SO3) (People), there is a proposed reduction to the risk appetite level from 'Seek' to 'Open', to better reflect the Trust's approach to workforce transformation, innovation and organisational development considering current financial challenges. • A proposed reduction to the appetite for Patient Safety risk from 'Minimal' to 'Avoid'. ETM agreed there would not be an appetite for any level of risk to patient safety and this was supported by the committees. • A proposed change to the SO5a (Finance) risk appetite from 'Open' to 'Cautious', reflecting the current financial environment. • A proposed change to the SO5b (Performance) risk appetite from 'Open' to 'Cautious' to reflect a consistent approach to achieving financial and performance targets.			

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	The Risk Management Strategy and Policy was approved by the Board in May 2026 and has been amended to reflect the changes to the risk appetite statement. A designed version has been produced and is available in the reading room click here
Recommendation/s: (including any decision/approval required)	The Board is asked to approve the Risk Appetite Statement at Appendix 1 and approve the consequential amendments to the Risk Management Strategy and Policy.
Link to Strategic Objective:	N/A
Link to priority transformation programmes:	N/A
Implications	
Risk:	This report sets out the content of the Trust Risk Management Policy and Strategy for approval by the Board of Directors and includes the updated Trust Risk Appetite Statement for review and approval by the Board of Directors.
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:	ETM: 17 August 2026 People Committee: 9 September 2026 Finance and Performance Committee: 16 September 2026 Quality Committee: 17 September 2026

Report content
1. Purpose The purpose of this paper is to present the updated Trust Risk Management Strategy and Policy and revised Trust Risk Appetite Statement for approval by the Board of Directors. 2. Background/Context The Trust's Risk Management Strategy and Policy establishes the framework for the effective identification, assessment and management of risk across the Trust. As part of this framework, the Trust Risk Appetite Statement has been developed to articulate the Board's agreed level of willingness to accept risk in pursuit of the Trust's strategic objectives. The Risk Appetite Statement has been developed to strengthen its role as a practical decision-making framework rather than solely describing the Board's attitude towards risk. It is intended to support strategic decision making by providing the Board, Executive Team and senior leaders with a consistent framework for determining whether proposed opportunities, investments, and other significant strategic decisions align with the Trust's agreed appetite for risk. It complements the Risk Management Strategy and Policy by helping ensure that decisions are informed by an agreed understanding of the level of risk

the Trust is prepared to accept whilst continuing to protect patients, staff, resources and statutory obligations.

A draft Risk Appetite Statement was considered during the Board Development Session held on 29 April 2026. Board members were supportive of the overall approach and recognised the value of establishing a clear statement of the Trust's risk appetite. Feedback highlighted opportunities to strengthen the document by simplifying the language, improving consistency and demonstrating more clearly how the statement should be applied in practice to support strategic decision making.

3. Assessment

Following the Board Development Session, the Risk Appetite Statement (Appendix 1) has been reviewed and refined to reflect the feedback received. The Risk Appetite Statement was discussed in detail by ETM at the meeting held on 17 August 2026 and has been reviewed by the trust's Board Assurance Committees for recommendation to the Board of Directors at the meetings held in September.

The Board is asked to note and approve the following updates to the Risk Appetite Statement –

- In relation to SO3 (People), there is a proposed reduction to the risk appetite level from 'Seek' to 'Open', to better reflect the Trust's approach to workforce transformation, innovation and organisational development considering current financial challenges.
- A proposed change to the Patient Safety domain from 'Minimal' to 'Avoid'. ETM agreed there would not be an appetite for any level of risk to patient safety and this was supported by the committees.
- A proposed change to the SO5a (Finance) risk appetite from 'Open' to 'Cautious', reflecting the current financial environment.
- A proposed change to the SO5b (Performance) risk appetite from 'Open' to 'Cautious' to reflect a consistent approach to achieving financial and performance targets.

The revised Statement represents an important milestone in implementing the Trust's Risk Management Strategy and Policy. As part of the Trust's three-year ambition, risk appetite and risk tolerance will continue to be embedded into service redesign, workforce planning, investment decisions and other significant strategic decisions, supporting leaders at all levels to make informed, proportionate and consistent risk-based decisions.

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Bradford Teaching Hospitals NHS Foundation Trust's Board of Directors Risk Appetite Statement - DRAFT

The Board of Directors recognises that delivering the Trust's strategic objectives requires informed decisions about risk. While some risks must be avoided or minimised, others must be accepted where they support innovation, service improvement and long-term sustainability of services.

The Board of Directors believes that our risk appetite appropriately reflects the progress that the Trust has made in implementing and assuring its Corporate Strategy 2022-2027 and its associated strategies and plans and is fully aligned to our ambition. This Risk Appetite Statement sets out the Board's agreed level of willingness to accept risk in pursuit of the Trust's strategic objectives. It provides a framework to support consistent, transparent and evidence informed decision making, helping the Board, Executive Team and managers balance opportunities for improvement against the potential impact on patients, staff, finances, regulatory compliance and the Trust's reputation. This statement should be considered alongside the Trust's Risk Management Strategy and Policy when making strategic, operational and investment decisions. It is intended to support, rather than replace, professional judgement and should be applied proportionately according to the nature of the decision being made.

The risk appetite levels and descriptions can be seen below -

Appetite Level	Description	Typical Behaviour
Avoid	There is a requirement to avoid risk and uncertainty to deliver an agreed organisational objective	Risk exposure is avoided wherever reasonably practicable. Activity will not proceed where it would knowingly create an unacceptable level of risk
Minimal	There is a preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.	Conservative decision making
Cautious	There is a preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for reward.	Risk must be actively managed and monitored
Open	There is a willingness to consider all potential delivery options and choose those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement and/or value for money.	Balanced approach between opportunity and control
Seek	There is a preference to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk and there is evidence that the organisation is mature: There is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.	Innovation and transformation encouraged

The Board recognises that risk appetite is not uniform across all areas of the Trust. Different strategic objectives require different approaches to risk in order to achieve the Trust's ambitions. However, without exception, the Trust maintains an **Avoid** appetite for risks that may adversely affect:

- Patient Safety

And a **Minimal** appetite for risks that may adversely affect:

- Staff safety and wellbeing
- Regulatory and statutory compliance

These principles apply across all strategic objectives.

SO1: Quality**Strategic Objective:** To provide outstanding care for our patients, delivered with kindness**Risk Appetite: Open** - We are willing 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.

The Board recognises that achieving outstanding care requires continuous improvement, innovation and the willingness to adopt new approaches where there is clear evidence that they will improve patient outcomes, quality of care and patient experience. The Trust therefore has an **Open** appetite for opportunities that support the delivery of this strategic objective, provided risks are appropriately assessed, managed and monitored.

The Board maintains an **Avoid** appetite for patient safety risk and will not knowingly accept decisions that increase the risk of avoidable patient harm. Staff safety and wellbeing, or compliance with statutory and regulatory requirements remain subject to the Trust's **Minimal** risk appetite

Risk Appetite by Domain

Quality of Care	Open
Innovation	Open
Patient Safety	Avoid
Staff Safety and Wellbeing	Minimal
Regulatory Compliance	Minimal

Typical Board Decisions:

This statement should be considered when making decisions relating to:

- Service redesign
- New clinical models of care
- Service Improvement/Quality improvement programmes
- Clinical innovation
- Investment that improves patient outcomes

Associated Strategic Risks: SR01, SR02**SO2: Improvement & Innovation****Strategic Objective:** To be a continually learning organisation and recognised as leaders in research, education and innovation**Risk Appetite: Open** - We are willing to consider all potential delivery options and choose those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement and/or value for money.

The Board recognises that continuous improvement requires the Trust to embrace learning, research, education, innovation and new technologies. Achieving this strategic objective requires the Trust to be willing to test new approaches, evaluate emerging opportunities and support change where there is clear evidence of benefit for patients, staff and the Trust. The Trust therefore has an **Open** appetite for opportunities that support research, education, innovation and continuous improvement, provided risks are appropriately assessed, managed and monitored.

The Board maintains an **Avoid** appetite for patient safety risk and will not knowingly accept decisions that increase the risk of avoidable patient harm. Staff safety and wellbeing, or compliance with statutory and regulatory requirements remain subject to the Trust's **Minimal** risk appetite.

Risk Appetite by Domain

Research, Education and Innovation	Open
Workforce and Culture	Open
Patient Safety	Avoid

Staff Safety and Wellbeing	Minimal
Regulatory Compliance	Minimal
Typical Board Decisions This statement should be considered when making decisions relating to: • Research and innovation programmes • Digital transformation and technology adoption • Education and workforce development initiatives • Quality improvement and organisational learning programmes • Investment in new models of care, research or innovation	
Associated Strategic Risks: SR03, SR04	

SO3: People

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

Risk Appetite: Open - We are willing 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.

The Board recognises that attracting, developing and retaining a skilled, engaged and inclusive workforce is fundamental to delivering safe, high quality care. Achieving this strategic objective requires the Trust to embrace new ways of working, workforce transformation and innovative approaches to recruitment, retention and staff development. The Trust therefore has an **Open** appetite for considered workforce transformation and opportunities that strengthen its workforce, improve organisational culture and support continuous improvement, where the anticipated benefits justify the associated risks and appropriate controls are in place.

The Board is clear that it has no appetite for decisions that knowingly expose staff to significant harm or unlawful treatment. This includes, but is not limited to, bullying or harassment, discrimination, unsafe working environments, or the use of equipment or systems that present a known and avoidable risk to staff health, safety or wellbeing. The Board therefore maintains a **Minimal** risk appetite for risks that could adversely affect staff safety and wellbeing, or compliance with statutory and regulatory requirements. The Board maintains an **Avoid** appetite for patient safety risk and will not knowingly accept decisions that increase the risk of avoidable patient harm

Risk Appetite by Domain

Workforce and Culture	Open
Patient Safety	Avoid
Staff Safety and Wellbeing	Minimal
Regulatory Compliance	Minimal

Typical Board Decisions

This statement should be considered when making decisions relating to:

- Workforce redesign and organisational change
- Recruitment, retention and workforce planning
- Leadership development and organisational culture
- Equality, diversity and inclusion initiatives
- Staff health, safety and wellbeing programmes

Associated Strategic Risks: SR05, SR06

SO4: Partnerships & Health Equity

Strategic Objective: To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals

Risk Appetite: Seek - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk). There is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.

The Board recognises that strong partnerships are fundamental to delivering high quality, sustainable healthcare and improving outcomes for the populations we serve. Achieving this strategic objective requires the Trust to actively pursue opportunities to work collaboratively with local, regional and national partners, embracing new models of care, shared delivery arrangements and system wide transformation. The Trust therefore has a **Seek** appetite for opportunities that strengthen partnerships, improve integration and deliver benefits for patients, communities and the wider health and care system. The Board supports ambitious and innovative approaches to partnership working where there is confidence that appropriate governance, accountability and oversight arrangements are in place, recognising that these opportunities may involve a greater degree of uncertainty than traditional ways of working. The Board therefore maintains a **Minimal** risk appetite for risks that could adversely affect staff safety and wellbeing, or compliance with statutory and regulatory requirements. The Board maintains an **Avoid** appetite for patient safety risk and will not knowingly accept decisions that increase the risk of avoidable patient harm

Risk Appetite by Domain

Partnerships and System Working	Seek
Patient Safety	Avoid
Staff Safety and Wellbeing	Minimal
Regulatory Compliance	Minimal

Typical Board Decisions

This statement should be considered when making decisions relating to:

- Provider collaborative and system partnership arrangements
- Joint service delivery and integrated care initiatives
- Collaborative commissioning and shared service opportunities
- Programmes to reduce health inequalities
- Strategic partnerships with NHS, local authority, voluntary and academic organisations

Associated Strategic Risks: SR07

SO5a: Finance

Strategic objective: To deliver our financial plan

Risk Appetite: Cautious - There is a preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for reward.

The Board recognises that long term financial sustainability is essential to delivering high quality healthcare and maintaining the Trust's ability to invest in services, people and infrastructure. Achieving this strategic objective requires informed financial decision making, prudent stewardship of public resources and a balanced approach to investment, efficiency and transformation. The Trust therefore has a **Cautious** appetite for opportunities that improve financial sustainability and deliver value for money. The Board supports investment and transformation where there is a robust business case, appropriate assurance and a clear understanding of the risks and anticipated benefits.

The Board maintains a **Minimal** risk appetite for decisions that could adversely affect staff safety and wellbeing or compliance with statutory and regulatory requirements. The Board maintains an **Avoid** appetite for patient safety risk and will not knowingly accept decisions that increase the risk of avoidable patient harm. Financial considerations alone should not compromise the delivery of safe, effective and high quality care.

Risk Appetite by Domain	
Finance and Value	Cautious
Patient Safety	Avoid
Staff Safety and Wellbeing	Minimal
Regulatory Compliance	Minimal
Typical Board Decisions This statement should be considered when making decisions relating to: • Annual budgets and financial planning • Cost improvement and efficiency programmes • Capital investment and major business cases • Resource allocation and prioritisation • Financial recovery and transformation programmes	
Associated Strategic Risks: SR08, SR09	

SO5b: Performance	
Strategic objective: To deliver our key performance targets	
Risk Appetite: Cautious - There is a preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for reward.	
The Board recognises that delivering high quality, responsive and sustainable services requires consistent delivery of key performance standards. In the current operational environment, the Trust has a Cautious appetite for performance risk. The Board's priority is to achieve agreed performance targets and therefore favours delivery options where operational risks are understood, controlled and closely monitored. The Trust will pursue improvement, recovery and transformation opportunities where there is appropriate assurance that these will improve performance without creating unacceptable risks elsewhere The Board maintains a Minimal risk appetite for risks that could adversely affect staff safety and wellbeing or compliance with statutory and regulatory requirements. The Board maintains an Avoid appetite for patient safety risk and will not knowingly accept decisions that increase the risk of avoidable patient harm. The Board expects improvements in performance to be achieved without compromising the quality and safety of patient care.	
Risk Appetite by Domain	
Operational Delivery and Performance	Cautious
Patient Safety	Avoid
Staff Safety and Wellbeing	Minimal
Regulatory Compliance	Minimal
Typical Board Decisions This statement should be considered when making decisions relating to: • Operational improvement and recovery programmes • Performance improvement initiatives • Productivity and efficiency programmes • Service redesign and pathway optimisation • Capacity, demand and flow initiatives	
Associated Strategic Risks: SR08, SR09	

BOARD OF DIRECTORS PUBLIC				
Meeting Date:	24.9.26	Agenda Reference:	Bo.9.26.22a	
Report Title:	Report on the use of the Foundation Trust's Seal			
Presented by:	Laura Parsons, Associate Director of Corporate Governance/Board Secretary			
Executive Lead:	Saj Azeb, Chief Operating Officer			
Author:	Sheridan Osbourne, Corporate Governance Officer			
Report Summary				
Purpose of the paper:	Decision ☐	Assurance ☒	Action ☐	Information ☐
Summary of Key Issues/Highlights:	In accordance with the Trust's Board of Directors Standing Orders (Section 8.4) 'A report of all sealings and signatures of documents as a deed shall be made to the Board by the Secretary to the Foundation Trust as and when required. The report shall contain details of the seal number, the description of the document and the date of sealing or signature.' The last report was presented to the Board of Directors on 25 September 2025. The report details the use of the Trust seal between 26 September 2025 -16 September 2026. This includes entry numbers 394-403.			
Recommendation/s: (including any decision/approval required)	The Board of Directors is asked to receive and note this information.			
Link to Strategic Objective:	N/A			
Link to Priority transformation programmes:	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

Report on the Use of the Foundation Trust's Seal

Set out in the table below is a summary of the capital schemes and other documents that have been sealed during 26 September 2025 – 16 September 2026. This includes entry numbers 394 to 403.

Entry Number	Item/Scheme	Date
394	Outstanding Maternity Services (OMS) sub contractor collateral warranty for the employer. Sub contractor – T Clarke Contracting Ltd Main Contractor – Morgan Sindall Construction & Infrastructure Ltd	16.2.26
395	OMS – sub contractor collateral warranty for the employer Sub contractor – The Manser Practice Main contractor - Morgan Sindall Construction & Infrastructure Ltd	16.2.26
396	OMS – sub contractor collateral warranty for the employer Sub contractor – Protech Roofing Main contractor - Morgan Sindall Construction & Infrastructure Ltd	16.2.26
397	OMS – sub contractor collateral warranty for the employer Sub contractor – G&S Engineering (Hull) Ltd Main contractor - Morgan Sindall Construction & Infrastructure Ltd	16.2.26
398	OMS – sub contractor collateral warranty for the employer Sub contractor –Morgan Sindall Construction & Infrastructure Ltd Main contractor – Rhino Precast Ltd	16.2.26
399	Construction contract with Sewell Construction Ltd relating to the demolition of existing fire escape and installation of a new fire escape at St Lukes Hospital	27.4.26
400	Contract with Robertson Construction Yorkshire East Midlands Ltd for the reconfiguration of the existing renal ADU to the new 6 bed unit at Bradford Royal Infirmary	27.4.26
401	Lease of part at Whetley Health Centre, Manningham, Bradford, DB8 9DQ with NHS Property Services Ltd	8.5.26
402	EE/H3G aerial on the rooftop of the maternity block, Bradford Royal Infirmary – Telecoms lease	1.7.26
403	Lease of part ground floor at Whetley Health Centre, Manningham, Bradford, BD8 9DW	1.7.26

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BOARD OF DIRECTORS - PUBLIC				
Meeting Date:	24 September 2026		Agenda Reference:	Bo.9.26.22b
Report Title:	Constitution			
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 ☐	Information ☐
Summary of Key Issues/Highlights:	The Trust's Constitution was last updated in November 2024 and is therefore due for review. The proposed amendments are presented for review and approval by the Board prior to being presented for final approval at the Council of Governors meeting on 30 September 2026. The following amendments have been made: - Amendments to disqualification criteria for Governors and NEDs to include previously being removed from the COG / Board, and failure to confirm their acceptance of the NEDs and Governors Code of Conduct within 14 days of their election/appointment. - Updated references to the NEDs and Governors Code of Conduct and the Process for Managing Concerns in relation to the Chair, another NED or a Governor. - Removal of paragraph 6.14.9 relating to the declaration of interests at Council of Governors meetings, which contradicts paragraph 6.14.2. - Minor typographical amendments. Due to the length of the document, Annex 4 (Model Election Rules) is not attached and is available on request from the Corporate Governance team. No amendments are proposed to this Annex. The Board is asked to note that the Constitution will be subject to further review and amendment subject to the progression of the Health Bill, which is expected to receive Royal Assent by April 2027.			
Recommendation/s: (including any decision/approval required)	The Board of Directors is asked to review and approve the proposed amendments to the Constitution prior to being submitted to the Council of Governors for final approval on 30 September 2026.			
Link to Strategic Objective:	N/A			
Link to priority transformation programmes:	N/A			
Implications				
Risk:	N/A			
Legal/Regulatory:	The Trust is required to have a constitution in line with the NHS Act 2006 (as amended).			

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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Bradford Teaching Hospitals
NHS Foundation Trust

Constitution

DRAFT

Approved by Council of Governors: ~~17 October 2024~~
Approved by the Board of Directors: ~~28 November 2024~~

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BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

CONSTITUTION

Unless the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the National Health Service Act 2006 (as amended).

References in this Constitution to legislation include all amendments, replacements, or re-enactments made.

1. DEFINITIONS

In this Constitution:-

"the 2006 Act"	means the NHS Act 2006 (as amended) ;
"Annual Members Meeting"	means the Annual Meeting of Members open to members of the public;
"Area of the Foundation Trust"	means the area, consisting of all the areas, specified in Annex 1, as an area for a public constituency;
"Board of Directors"	means the Board of Directors as constituted in accordance with this Constitution;
"Council of Governors"	means the Council of Governors as constituted in accordance with this Constitution;
"Director"	means a member of the Board of Directors;
"Financial year"	means- (a) the period beginning with the date on which the Foundation Trust is authorised and ending with the next 31st March; and (b) each successive period of twelve months beginning with 1st April;
"Governor"	means a member of the Council of Governors;
"Lead Governor"	means a Governor elected by the Council of Governors to fulfil the statutory role originally set out by Monitor (now NHS England);
"Local Authority Governor"	means a member of the Council of Governors

	appointed by one or more local authorities whose area includes the whole or part of the area of the Foundation Trust;
"Member"	means a member of the Foundation Trust;
"Non-Executive Director"	means the Non-Executive Directors of the Board of Directors including the Chair;
"Patient"	means an individual who has attended any of the Foundation Trust's hospitals or clinics, whether NHS or private, at any time;
"Carer"	means an individual who has attended any of the Foundation Trust's hospitals or clinics as a carer of a patient other than an individual providing care in pursuance of a contract (including a contract of employment), or as a volunteer for a voluntary organization;
"Partner Governor"	means a member of the Council of Governors appointed by a Partner Organisation specified in Annex 3;
"Patient Governor"	means a member of the Council of Governors elected by the members of the Patient Constituency;
"Public Governor"	means a member of the Council of Governors elected by the members of the Public Constituency;
"Secretary"	means the Secretary of the Foundation Trust or any other person appointed to perform the duties of the Secretary of the Foundation Trust;
"Staff Governor"	means a member of the Council of Governors elected by the members of a Staff Class;
"Standing Orders"	means the Standing Orders of the Foundation Trust;
"the Foundation Trust"	means Bradford Teaching Hospitals NHS Foundation Trust;
"University Governor"	means a member of the Council of Governors appointed by a University providing medical or dental hospital or professional training to the Foundation Trust.

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2 NAME

- 2.1 The name of the Foundation Trust is "Bradford Teaching Hospitals NHS Foundation Trust".

3 PRINCIPAL PURPOSE

- 3.1 The principal purpose of the Foundation Trust is the provision of goods and services for the purposes of the health service in England.
- 3.2 The Foundation Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.
- 3.3 The Foundation Trust may provide goods and services for any purposes related to –
- 3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
 - 3.3.2 the promotion and protection of public health.
- 3.4 Subject to paragraph 15 the Foundation Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order to better carry on its principal purpose.

4 POWERS

- 4.1 The powers of the trust are set out in the 2006 Act.
- 4.2 All the powers of the trust shall be exercised by the Board of Directors on behalf of the trust.
- 4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5 MEMBERS

5.1 Constituencies

The Foundation Trust is to have members, each of whom shall be a member of one of the membership Constituencies, namely -

- (a) The "Public Constituencies",
- (b) a "Staff Constituency" and,

- (c) a “Patients’ Constituency”.

5.2 Public Constituency

5.2.1 The Public Constituencies are to be known by the names listed in column 1 of Annex 1.

5.2.2 Members of the Foundation Trust who are members of the Public Constituency listed in column 1 of Annex 1 are to be individuals:

- (a) who are at least 16 years old and live in the area specified for that Constituency in the corresponding entry in column 2 of that Annex; and
- (b) who are not eligible to become a member of the Staff Constituency and are not members of any other constituency or are otherwise disqualified from membership under paragraph 5.5; and
- (c) who have made an application for membership to the Foundation Trust. Membership is potentially available to all these individuals, and the Foundation Trust is to use its best endeavours to ensure that, taken as a whole, the actual membership of the Foundation Trust’s Public Constituencies that fall within the Bradford Metropolitan District Council area is representative of those eligible for membership.

5.2.3 The minimum number of members required for each Public Constituency is to be the number given in column three of Annex 1.

5.3 Staff Constituency

5.3.1 The staff constituency shall be divided into four classes of individuals as follows:

- a) Medical and Dental practitioners staff class;
- b) Nurses and Midwives staff class
- c) Allied Health Professionals and Scientists class
- d) All Other Staff Class

The minimum number of members in each class of the staff constituencies is specified in Annex 2.

5.3.2 The members of the Medical and Dental Staff Class are individuals who are members of the Staff Constituency who are fully registered within the meaning of the Medicines Act 1956.

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- 5.3.3 The members of the Nurses and Midwives Staff Class are individuals who are members of the Staff Constituency who are registered Nurses or registered Midwives.
- 5.3.4 The members of the Allied Health Professionals and Scientists Staff Class are members of the Staff Constituency whose regulatory body falls within the remit of the Council for the Regulation of Health Care Professionals established by section 25 of the NHS Reform and Health Care Professionals Act 2002, except that they are not registered Nurses or Midwives
- 5.3.5 The members of the All Other Staff Class are members of the Staff Constituency who do not come within paragraphs 5.3.2 to 5.3.4 above.
- 5.3.6 Members of the Foundation Trust who are members of the Staff Constituency are to be individuals who:
- a) are employed under a permanent contract of employment by the Foundation Trust; or
 - b) are individuals who are not so employed but who nevertheless exercise functions for the purposes of the Foundation Trust; and
 - c) who satisfy the minimum duration requirements set out in paragraph 3 of Schedule 7 to the 2006 Act; and
 - d) have made an application for membership of the Foundation Trust; or
 - e) on appointment shall become a member of the appropriate class within the Staff Constituency without an application being made, unless they inform the Foundation Trust that they do not wish to become a member.
- 5.3.7 The minimum number of members of each Staff class is to be 100.
- 5.3.8 A person who is eligible to be a member of the Staff Constituency may not become or continue to be a member of any Constituency other than the Staff Constituency and may not become or continue to be a member of more than one Staff class.

5.4 Patients Constituency

- 5.4.1 The members of the Foundation Trust who are members of the Patient Constituency are individuals:
- a) who are at least 16 years old and have attended any of the

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Foundation Trust's hospitals or clinics as a patient (as defined within this Constitution), or

- b) the carer of a Patient as identified in 5.4.1 a);
- c) is not eligible to become a member of the Staff Constituency and are not members of any other Constituency and are not otherwise disqualified from membership, and has a postcode outside of the BMDC area; and
- d) has made an application for membership of the Foundation Trust.

5.4.2 The minimum number of members required for the Patients' Constituency is to be 100.

5.5 Disqualification for Membership

5.5.1 A person may not be a member of the Foundation Trust-;

- (a) Unless they are of 16 years of age or over.
- (b) If they have demonstrated aggressive or violent behaviour towards Foundation Trust staff, that is, if a Warning Letter has been issued to them under Stage 3 of the Foundation Trust's Policy for Withholding Treatment from Violent and Abusive Patients, a final Written Warning has been issued under Stage 4, or, they have been asked to leave, have been removed or excluded from the Foundation Trust's premises under the Policy.

5.5.2 It is the responsibility of the member to ensure their eligibility and not the Foundation Trust, but where the Foundation Trust is on notice that a member may be disqualified from membership, the Secretary shall carry out all reasonable enquiries to establish if this is the case.

5.6 Termination of Membership

5.6.1 A member shall cease to be a member if they:-

- (a) Resign by notice to the Secretary
- (b) Cease to fulfil the requirements of paragraphs 5.2, 5.3 or 5.4
- (c) Become disqualified from membership by reason of paragraph 5.5.1(b)

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5.7 Voting at Governor Elections

- 5.7.1 A person may not vote at an election for a Public or Patient Governor unless within the specified period they have made a declaration in the specified form stating the particulars of their qualification to vote as a member of the Constituency for which an election is being held. It is an offence knowingly or recklessly to make such a declaration which is false in any material particular.

5.8 Annual Members' Meeting

- 5.8.1 The Foundation Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

- 5.8.2 The following documents shall be presented to the members of the Foundation Trust at the Annual Members Meeting by at least one member of the Board of Directors:

- a) the Annual Accounts;
- b) any report of the External Auditor on the Annual Accounts; and
- c) the Annual Report

The Foundation Trust may combine a meeting of the Council of Governors convened for the purposes of being presented with the above documents with the Annual Members' Meeting.

- 5.8.3 In accordance with paragraph 18 of this Constitution where an amendment has been made to the Constitution in relation to the powers or duties of the Council of Governors, members must be given the opportunity to vote at the Annual Members' Meeting on whether they approve the amendment.

6 COUNCIL OF GOVERNORS

6.1 Composition of the Council of Governors

- 6.1.1 The Foundation Trust shall have a Council of Governors. It shall consist of Public Governors, Staff Governors, Patient Governors, University Governors, Local Authority Governors and other Partner Governors.

- 6.1.2 The Council of Governors shall include:

- (a) 11 Public Governors

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- (b) 2 Patient Governors
- (c) 6 Staff Governors
 - (i) 1 being elected by the Medical and Dental Practitioners Class
 - (ii) 2 being elected by the registered Nurses and Midwives Class
 - (iii) 1 being elected by the Allied Health Professionals and Scientists Class
 - (iv) 2 being elected by the All Other Staff Class
- (d) 1 Local Authority Governor
- (e) 2 University Governors
- (f) 2 Partner Governors

6.1.3 The aggregate number of members of Public Governors and Patient Governors is to be more than half the total membership of the Council of Governors.

6.2 Public Governors

6.2.1 Members of a Public Constituency may elect any of their number to be a Public Governor from within their constituency according to the Election Scheme.

6.2.2 If contested, the election will be by secret ballot.

6.2.3 The Election Scheme, including the process for ratifying Governors if the election is uncontested, is set out in Annex 4.

6.2.4 A person may not stand for election to the Council of Governors as a Public Governor unless they have made a declaration in the form specified in Annex 4 of their qualification to vote as a member for the Public Constituency for which the election is being held and is not prevented from being a member of the Council of Governors by paragraph 8 to Schedule 7 of the 2006 Act or paragraph 6.11 below. It is an offence to knowingly or recklessly make a declaration under paragraph 60 of the 2006 Act which is false in a material particular.

6.2.5 Paragraph 5.7.1 (voting at Governor elections) applies.

6.3 Patient Governors

6.3.1 Members of the Patient Constituency may elect any of their number to be a Patient Governor.

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- 6.3.2 If contested the election must be by secret ballot.
- 6.3.3 The election scheme is set out in Annex 4
- 6.3.4 A person may not stand for election to the Council of Governors as a Patient Governor unless within the period specified in Annex 4 they have made a declaration in the form specified in Annex 4 of the particulars of their qualification to vote as a member of the Patients' Constituency and is not prevented from being a member of the Council of Governors by paragraph 8 to Schedule 7 of the 2006 Act or paragraph 7.10 below. It is an offence to knowingly or recklessly make a declaration under paragraph 60 of the 2006 Act which is false in a material particular.
- 6.3.5 Paragraph 5.7.1 (voting at Governor elections) applies.

6.4 **Staff Governors**

- 6.4.1 Members of a Class of the Staff Constituency may elect any of their number to be a Staff Governor from within that Class.
- 6.4.2 If contested, the election will be by secret ballot.
- 6.4.3 The Election Scheme is set out in Annex 4

6.5 **Role of Local Authority, University and Partner Governors**

- 6.5.1 Subject to the overriding principle that the Governors' first responsibility is to the Council of Governors and the Trust the role of Governors appointed as Local Authority Governors, University Governors and other Partner Governors shall in addition to their general responsibilities as Governors be:
 - a) to speak with authority for the organisation they represent and be able to explain its policies;
 - b) to support the role of the Council of Governors as set out in paragraph 6.13;
 - c) to represent the Foundation Trust to the organisation they represent.
- 6.5.2 The appointment of Local Authority Governors, University Governors and other Partner Governors shall be in accordance with a process agreed with the Secretary of the Foundation Trust.

6.6 **University Governors**

- 6.6.1 The University of Leeds and the University of Bradford shall each

appoint a University Governor.

6.7 Local Authority Governors

6.7.1 The Bradford Metropolitan District Council shall appoint one Local Authority Governor.

6.8 Partner Governors

6.8.1 Healthwatch Bradford and District and a Mental Health, Learning Disabilities and Autism representative organisation (to be determined by the Trust) shall each appoint one Partner Governor.

6.9 Terms of Office

6.9.1 Public Governors, Staff Governors and Patient Governors;

- (a) may hold office for a period of three years
- (b) are eligible for re-election at the end of that period; and
- (c) may not hold office for longer than nine consecutive years.

6.9.2 Local Authority Governors;

- (a) may hold office for a period of three years
- (b) are eligible for reappointment at the end of that period; and
- (c) may not hold office for longer than nine consecutive years.

6.9.3 University Governors;

- (a) may hold office for a period of three years;
- (b) are eligible for reappointment at the end of that period; and
- (c) may not hold office for longer than nine consecutive years.

6.9.4 Other Partner Governors;

- (a) may hold office for a period of three years;
- (b) are eligible for reappointment at the end of that period; and
- (c) may not hold office for longer than nine consecutive years.

6.10 Termination of tenure

6.10.1 A Governor may resign from that office at any time during the term

of that office by giving notice in writing to the Secretary.

6.10.2 If the Governor fails to attend two consecutive meetings of the Council of Governors their tenure of office is to be terminated one month following the second meeting unless in the meantime they have satisfied the Chair that:

- a) the absence was due to a reasonable cause; and
- b) they will be able to start attending meetings of the Council of Governors again within such a period as the Chair considers reasonable.

6.10.3 If the Governor fails to attend a training session for Governors as recommended by the Secretary and approved by the Council of Governors by a date six months from the date of the Governor's election or appointment then their tenure in office is to be terminated six weeks from the said date unless in the meantime they have satisfied the Chair that:

- a) the absence was due to a reasonable cause; and
- b) they will be able to attend a training session within such a period as the Chair considers reasonable.

6.11 Disqualification and Removal of a Governor

6.11.1 A person may not become or continue as a Governor of the Foundation Trust if:

- a) ~~I~~in the case of a Patient Governor, Staff Governor or Public Governor, they cease to be a member of the Constituency they represent;
- b) in the case of a University Governor, Local Authority Governor or other Partner Governor, the appointing organisation withdraws their appointment of them;
- c) they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;
- d) they are a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
- e) they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;

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- f) they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;
- g) they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
- h) they are a person whose tenure of office as the Chair or as a member or Director of a Health Service body has been terminated on the grounds that their appointment is not in the interests of the Health Service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- i) they are an Executive or Non-Executive Director of the Foundation Trust, or a Governor, Non-Executive Director, Chair, Chief Executive Officer of another NHS Foundation Trust;
- j) they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs; ~~or~~
- k) they have failed to declare an interest as required by this Constitution or Standing Orders or, have spoken or voted at a meeting on a matter in which they have an interest contrary to this Constitution or Standing Orders, and in this Paragraph interest includes a pecuniary and a non- pecuniary interest in either case whether direct or indirect.
- l) they have previously been removed from the Council of Governors; or
- k)m) they have failed to confirm their acceptance of the Non-Executive Directors' and Governors' Code of Conduct within 14 calendar days of their election or appointment to the Council of Governors.

6.11.2 Where a person has been elected or appointed to be a Governor and they become disqualified under paragraph 6.11.1 to hold that office, they shall immediately notify the Secretary in writing of such disqualification and upon giving such notice that Governor's term of office, if any, shall terminate and they shall cease to act as a Governor.

6.11.3 If it comes to the notice of the Secretary that a person elected or appointed to be a Governor may be disqualified under Paragraph 6.11.1 to hold that office and the Secretary has not received a

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notice under Paragraph 6.11.2 from that person, the Secretary shall make such enquiries as they think fit and, if satisfied that the person may be so disqualified, the Secretary shall give notice in writing to that person that the Foundation Trust proposes to declare the person disqualified as a Governor. In this notice, the Secretary shall specify the grounds on which it appears to them that the person is disqualified and give that person a period of at least 14 but no more than 28 days in which to make representations, orally or in writing, on the proposed disqualification. Any representations shall be to, and considered by, a committee of the Directors which in this case shall determine the proposal. If no representations are received within the specified time or the committee of Directors upholds the proposal to disqualify having heard representations, the Secretary shall immediately declare that the person in question is disqualified and notify them in writing to that effect. On such declaration the person's tenure of office shall be terminated and they shall cease to act as a Governor.

- 6.11.4 At the commencement of their term of office a Governor shall sign the 'Non-Executive Directors' and Governor's Code of Conduct' ('Code of Conduct') as agreed by the Council of Governors. A Governor may be subject to removal from office for non-compliance with the 'Governor's Code of Conduct'. The process to be undertaken is specified with the Process for managing concerns in relation to the Chair, another NED or a Governor.- 'Governor's Code of Conduct'.

6.12 Vacancies

- 6.12.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.
- 6.12.2 Where the vacancy arises amongst appointed Governors, the Secretary shall request that the appointing organisation appoint a replacement to hold office for the remainder of the term of office.
- 6.12.3 Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty either:
- a) to call an election within three months, provided that the period of the vacancy exceeds three months; or
 - b) to invite the next highest polling Candidate for that seat at the most recent election, who is willing to take office to fill the seat until the next scheduled election, at which time the seat will become vacant and subject to election.
 - c) If no-one is available under 6.12.3 (b) and the vacancy is for

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three months or less the seat will remain vacant until the next scheduled election.

6.13 Duties and Responsibilities of Governors

6.13.1 The general duties of the Council of Governors are to:

- a) Hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors; and
- b) Represent the interests of the members of the Foundation Trust as a whole and the interests of the public.

6.13.2 The roles and responsibilities of the Council of Governors are to:

- a) Represent the views of their respective members and organisations to the Trust, in order that the Foundation Trust may undertake its business in ways consistent with the needs of its members and the wider community, and to represent the views of the Foundation Trust to their members and organisations in a reciprocal manner.
- b) Appoint or dismiss the Chair and the other Non-Executive Directors and to decide their remuneration, allowances and other Terms and Conditions of their offices. The removal of the Chair or a Non-Executive Director requires a motion in accordance with Standing Orders approved by three-quarters of the Governors.
- c) Approve (by a majority vote) the appointment (by the Non-Executive Directors) of the Chief Executive.
- d) Appoint or remove the Foundation Trust's External Auditor.
- e) Give the views of the Council of Governors to the Board of Directors for the purposes of their preparation by the Board of Directors of the document containing the information as to the Foundation Trust's forward planning in respect of each financial year to be given to the Integrated Care Board (ICB) and NHS England (NHSE).
- f) Respond appropriately when consulted by the Board of Directors in accordance with this Constitution.
- g) Consider and receive the Annual Accounts, any report by the External Auditor on them and the Annual Report.
- h) Receive and consider the views of the members on matters of significance to the future plans of the Foundation Trust.

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- 6.13.3 The Foundation Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

6.14 Declaration of Interests

- 6.14.1 A Governor must declare to the Secretary:

- a) any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Foundation Trust;
- b) any interests which are relevant and material to the business of the Foundation Trust;
- c) any other interest as set out in the Standing Orders; and
- d) any other interest as set out in the 'Conflicts of Interest Policy for Bradford Teaching Hospitals NHS Foundation Trust'.

- 6.14.2 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time, setting out any interests required to be declared in accordance with this Constitution or Standing Orders and delivering it to the Secretary within 28 days of a Governor's election or appointment or otherwise within 28 days of becoming aware of the existence of an interest. In addition, if a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if they have declared a pecuniary interest, they shall not take part in the consideration or discussion of the matter. This Paragraph applies to any Committee or Sub-Committee of the Council of Governors as it applies to the Council of Governors and applies to any member of any such Committee or Sub-Committee (whether or not they are also a Governor) as it applies to a Governor. The provisions of this Paragraph are subject to Paragraph 6.14.7.

- 6.14.3 "relevant and material" interests are:

- a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);
- b) Ownership or part-ownership or Directorships of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- c) Majority or controlling share holdings in organisations likely

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or possibly seeking to do business with the NHS;

- d) A position of authority in a charity or voluntary organisation in the field of Health and Social Care;
- e) Any connection with a voluntary or other organisation contracting for or commissioning NHS services; and
- f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Foundation Trust, including but not limited to, lenders or banks.

6.14.4 Any travelling or other expenses or allowances payable to a Governor in accordance with this Constitution shall not be treated as a pecuniary interest.

6.14.5 Subject to any other provision of this Constitution, a Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- a) they, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
- b) they are a partner of, or are in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

6.14.6 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- a) of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;
- b) of an interest in any company, body or person with which they are connected as mentioned in paragraphs 6.14.3 and 6.14.5 which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

6.14.7 Where a Governor:

- a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

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- b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and
- c) if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

The Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

6.14.8 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of this Constitution to be also an interest of the other.

~~6.14.9 If, during the course of a meeting of the Council of Governors, a conflict of interest is established, the Governor concerned shall withdraw from the meeting and play no part in the relevant discussion or decision. If there is a dispute as to whether a conflict of interest exists, the majority of the Governors present at the meeting shall resolve the issue, with the Chair having a casting vote.~~

6.15 Expenses

6.15.1 The Foundation Trust may pay travelling and other expenses to Governors at such rates as it decides. These are to be published in the Annual Report.

6.16 Remuneration

6.16.1 Governors are not to receive remuneration.

6.17 Meetings

6.17.1 The Chair of the Foundation Trust or, in their absence, the Deputy Chair of the Board is to preside at meetings of the Council of Governors.

6.17.2 Meetings of the Council of Governors are to be open to members of the public except in the following circumstances:

- a) The Council of Governors may, by resolution, exclude the public from a meeting (whether during the whole or part of

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the proceedings) whenever publicity would be prejudicial to the public interest or the interest of the Foundation Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or the proceedings.

- b) Without prejudice to the generality of (a) above, the Council of Governors may treat the need to consider the following matters as of a confidential nature:
- approval of the appointment or dismissal of the Chief Executive;
 - any disciplinary or other matter arising from a contract of employment with the Foundation Trust;
 - any matter which involves the consideration of information held by the Foundation Trust in confidence, whether that confidentiality covers clinical, commercial or other information;
 - commercial matters where publication may be to the detriment of the Foundation Trust;
 - legal advice; and
 - litigation actual or anticipated, including any arbitration or dispute resolution process or any matter of a litigious nature whether in a Court, Tribunal or Inquiry.
- c) Without prejudice to the generality of (a) above and without regard to the subject or purport of the recommendation or advice, the Council of Governors may treat as a special reason the need to receive or consider recommendations or advice from sources other than a Director, or the Board of Directors, or the Council of Governors Nominations and Remuneration Committee in accordance with paragraph 7.1.4 to 7.1.7 of this Constitution.

6.17.3 The Council of Governors will meet at least 5 times per year inclusive of the Annual General Meeting.

6.17.4 At a general meeting in September of each year or on such other date approved by the Chair, the Council of Governors are to receive and consider the Annual Accounts, any report of the Auditor on them, and the Annual Report. These documents shall be presented by at least one member of the Board of Directors. This meeting may be combined with the Annual Members' Meeting as set out in paragraph 5.8.

6.17.5 The Council of Governors shall adopt its own Standing Orders for its practice and procedure.

6.17.6 The proceedings of a Meeting of the Governors shall not be

invalidated by any vacancy in its membership.

6.17.7 A Governor elected to the Council of Governors by a Public Constituency, the Patients' Constituency or a Class of the Staff Constituency may not vote at a meeting of the Council unless, immediately prior to the commencement of each meeting, they have made a declaration in a form as determined by the Secretary stating which Constituency or Class they are a member of and is not prevented from being a member of the Council of Governors by paragraph 9 of Schedule 7 to the 2006 Act or under this Constitution.

6.17.8 The Council of Governors may require one or more of the Directors to attend a meeting for the purposes of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or Directors' performance).

7 BOARD OF DIRECTORS

7.1 Composition of the Board of Directors

7.1.1 The Foundation Trust is to have a Board of Directors. It is to consist of Executive and Non-Executive Directors

7.1.2 The Board is to include—

(a) The following Non-Executive Directors-

- (i) a Chair
- (ii) a Non-Executive Director appointed by the Leeds Medical School, and may include a Non-Executive Director appointed by the University of Bradford, such appointments being subject to approval of the Council of Governors at a general meeting,
- (iii) at least 5 other Non-Executive Directors

(b) The following Executive Directors –

- (i) a Chief Executive (and Accounting Officer),
- (ii) a Finance Director,
- (iii) a Medical Leader, who must be a registered Medical or Dental practitioner (within the meaning of the Dentists Act 1984),
- (iv) a Chief Nurse, who must be a registered Nurse or registered Midwife,
- v) a Chief Operating Officer, and
- vi) a Director of Strategy and Transformation.

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- 7.1.3 Only a member of the Public or the Patients' Constituency, or an individual exercising functions for the Leeds Medical School, or the University of Bradford, is eligible for appointment as a Non-Executive Director.
- 7.1.4 All current Directors and future appointments must clearly satisfy and continue to meet the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including all future amendments to the regulation.
- 7.1.5 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Foundation Trust and the other Non-Executive Directors in accordance with the Governors Standing Orders.
- 7.1.6 Further provisions for the appointment of the Chair and the other Non-Executive Directors and the role of the Council of Governors in the said appointments are set out in the Terms of Reference of the Council of Governors Nominations and Remuneration Committee.
- 7.1.7 The Council of Governors will not consider nominations for membership of the Board of Directors other than the recommendations of the Council of Governors Nominations and Remuneration Committee.

7.2 Terms of office

- 7.2.1 The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the Terms and Conditions of office decided by the Council of Governors at a general meeting.
- 7.2.2 The Chief Executive (and Accounting Officer) shall hold office for a period in accordance with the Terms and Conditions of office decided by the relevant committee of Non-Executive Directors.
- 7.2.3 The Executive Directors other than the Chief Executive shall hold office for a period in accordance with the Terms and Conditions decided by the relevant committee of Non-Executive Directors advised by the Chief Executive.
- 7.2.4 On termination of their contract of employment an Executive Director shall cease to be a member of the Board of Directors.
- 7.2.5 If an Executive Director is suspended from their contract of employment or on long term sick leave, the Non-Executive Directors in the case of the Chief Executive and the Non-Executive Directors and the Chief Executive in the case of the other Executive Directors may appoint another person as an Executive

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Director in an acting capacity in their place.

7.3 Disqualification

7.3.1 A person may not be a Director of the Foundation Trust if–

- (a) they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;
- (b) they are a person in relation to whom a moratorium period under a debt relief order applies (under Part7A of the Insolvency Act 1986);
- (c) they have made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;
- (d) they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;
- (e) they are a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- (f) they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
- (g) in the case of a Non-Executive Director, they no longer satisfy paragraph 7.1.3;
- (h) they have failed to declare an interest as required by this Constitution or Standing Orders or, any other interest as set out in the 'Conflicts of Interest Policy for Bradford Teaching Hospitals NHS Foundation Trust'; ~~or~~

(i) have spoken or voted at a meeting on a matter in which they have an interest contrary to this Constitution or Standing Orders, and in this Paragraph interest includes a pecuniary and a non- pecuniary interest in either case whether direct or indirect;

(j) they have previously been removed from the Board of Directors; or

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- (k) they have failed to confirm their acceptance of the Non-Executive Directors' and Governors' Code of Conduct within 14 calendar days of their election or appointment to the Council of Governors.

(i)

7.4 Duties, Roles and Responsibilities

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Foundation Trust so as to maximise the benefits for the members of the Foundation Trust as a whole and for the public.

- 7.4.1 The powers of the Foundation Trust are to be exercisable by the Board of Directors on its behalf.
- 7.4.2 Any of those powers may be delegated to a Committee of Directors or to an Executive Director.
- 7.4.3 A Committee of Non-Executive Directors established as an Audit Committee is to monitor, review and carry out such other functions in relation to the External Auditor as appropriate.
- 7.4.4 It is for the Non-Executive Directors to appoint (subject to the approval of the Council of Governors) or remove the Chief Executive.
- 7.4.5 It is for a Committee of the Chair, Chief Executive and the other Non-Executive Directors to appoint or remove the Executive Directors.
- 7.4.6 The process for removal of the Executive Directors will be for the Chief Executive to make such a recommendation to the Board of Directors in writing setting out the case for removal and for the Board to dispose of the recommendation by way of a resolution in accordance with Standing Orders.
- 7.4.7 The Foundation Trust is to establish a Committee of all Non-Executive Directors to decide the remuneration and allowances, and the other Terms and Conditions of office, of the Chief Executive.
- 7.4.8 The Foundation Trust is to establish a Committee of Non-Executive Directors advised by the Chief Executive to decide the remuneration and allowances, and the other Terms and Conditions of office, of the Executive Directors.
- 7.4.9 The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Foundation

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Trust's forward planning in respect of each financial year to be given to the ICB and NHSE.

7.4.10 The Directors are to present to the Council of Governors at a general meeting the Annual Accounts, any report of the External Auditor on them, and the Annual Report.

7.4.11 The functions of the Foundation Trust under subparagraphs (a) and (b) of paragraph 13.6 below are delegated to the Chief Executive as Accounting Officer.

8 MEETINGS OF THE BOARD OF DIRECTORS

8.1 The Board of Directors, in consultation with the Council of Governors, is to adopt Standing Orders covering the proceedings and business of its meetings and such other matters relating to the conduct of the Foundation Trust's business and functions as it considers appropriate. These are to include setting a quorum for meetings, both of Executive and Non-Executive Directors. The proceedings of the Board of Directors shall not however be invalidated by any vacancy of its membership, or defect in a Director's appointment.

8.2 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

a) The Board of Directors may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest or the interest of the Foundation Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or the proceedings.

b) Without prejudice to the generality of (a) above, the Board of Directors may treat the need to consider the following matters as of a confidential nature:

- approval of the appointment or dismissal of the Chief Executive;
- any disciplinary or other matter arising from a contract of employment with the Foundation Trust;
- any matter which involves the consideration of information held by the Foundation Trust in confidence, whether that confidentiality covers clinical, commercial or other information;
- commercial matters where publication may be to the detriment of the Foundation Trust;
- legal advice; and,
- litigation actual or anticipated, including any arbitration or

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dispute resolution process or any matter of a litigious nature whether in a Court, Tribunal or Inquiry.

- 8.3 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

9. CONFLICTS OF INTERESTS DIRECTORS

- 9.1 The duties that a Director of the Foundation Trust has by virtue of being a Director include in particular:
- 9.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust.
 - 9.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.
- 9.2 The duty referred to in sub-paragraph 9.1.1 is not infringed if:
- 9.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or
 - 9.2.2 The matter has been authorised in accordance with the Constitution.
- 9.3 The duty referred to in sub-paragraph 9.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.
- 9.4 In sub-paragraph 10.1.2, “third party” means a person other than:
- 9.4.1 The Foundation Trust, or
 - 9.4.2 A person acting on its behalf.
- 9.5 If a Director of the Foundation Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Foundation Trust, the Director must declare the nature and extent of that interest to the other Directors.
- 9.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.
- 9.7 Any declaration required by this paragraph must be made before the Foundation Trust enters into the transaction or arrangement.
- 9.8 This paragraph does not require a declaration of an interest of which the

Director is not aware or where the Director is not aware of the transaction or arrangement in question.

9.9 A Director need not declare an interest:

9.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

9.9.2 if, or to the extent that, the Directors are already aware of it;

9.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered –

9.9.3.1 By a meeting of the Board of Directors, or

9.9.3.2 By a Committee of the Directors appointed for the purpose under the Constitution.

9.10 If, during the course of a meeting of the Board of Directors, a conflict of interest is established, the Director concerned shall withdraw from the meeting and play no part in the relevant discussion or decision. If there is a dispute as to whether a conflict of interest exists, the majority of the Directors present at the meeting shall resolve the issue, with the Chair having a casting vote.

10 REGISTERS

10.1 The Foundation Trust shall have:

10.1.1 a register of Members showing, in respect of each Member, the Constituency or class to which they belong;

10.1.2 a Register of Members of the Council of Governors;

10.1.3 a Register of interests of Governors;

10.1.4 a Register of Directors; and

10.1.5 a Register of interests of Directors.

10.2 The Secretary shall be responsible for compiling and maintaining the Registers. Removal from any Register shall be in accordance with the provisions of this Constitution.

a) Register of Members

Members must complete and sign an application in the form prescribed by the Secretary.

b) Register of Governors

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The Register shall list the names of Governors, their category of membership of the Council (Public, Staff or organisation represented) and an address through which they may be contacted which may be that of the Secretary.

c) Register of Interests of the Governors

The Register shall contain the names of each Governor, whether they have declared any interests and, if so, the interests declared in accordance with this Constitution or Standing Orders.

d) Register of Directors

The Register shall list the names of Directors, their capacity on the Board and an address through which they may be contacted which may be the address of the Secretary.

e) Register of interests of Directors

The Register shall contain the names of each Director, whether they have declared any interests and, if so, the interests declared in accordance with this Constitution or Standing Orders.

11 PUBLIC DOCUMENTS

11.1 The following documents of the Foundation Trust are to be available at the Foundation Trust's Headquarters for inspection by members of the public free of charge at all reasonable times:

- a) a copy of the current Constitution;
- b) a copy of the latest Annual Accounts and of any report of the Auditor on them; and
- c) a copy of the latest Annual Report.

11.2 The Foundation Trust shall also make the following documents relating to a special administration of the Foundation Trust available for inspection by members of the public free of charge at all reasonable times:

- a) a copy of any order made under section 65D (appointment of Foundation Trust Special Administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(Foundation Trusts coming out of administration) or 65LA (Foundation Trusts to be dissolved) of the 2006 Act.
- b) a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

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- c) a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.
 - d) a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.
 - e) a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.
 - f) a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(NHSE/I's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.
 - g) a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.
 - h) a copy of any final report published under section 65I (administrator's final report).
 - i) a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.
 - j) a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.
- 11.3 Any person who requests it is to be provided with a copy or extract from any of the above documents.
- 11.4 The Registers mentioned in the paragraph 10.1 above are also available for inspection by members of the public, except in circumstances prescribed by regulations made under the 2006 Act; and insofar as those Registers are required to be available:
- a) they are to be provided free of charge at all reasonable times
 - b) a person who requests it is to be provided with a copy of or extract from them
- 11.5 If the person requesting a copy or extract is not a Member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for providing the copy or extract.

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12 EXTERNAL AUDITOR

- 12.1 The Foundation Trust is to have an External Auditor and is to provide the External Auditor with every facility and all information which they may reasonably require for the purposes of their functions under Chapter 5 of Part 2 of the 2006 Act.
- 12.2 A person may only be appointed as the External Auditor if they (or in the case of a firm each of its members) are a member of one or more of the bodies referred to in paragraph 23(4) of Schedule 7 to the 2006 Act.
- 12.3 Appointment of the External Auditor by the Council of Governors is covered in paragraph 6.13.2, and monitoring of the External Auditor's functions by a Committee of Non-Executive Directors is covered in paragraph 7.4.3.
- 12.4 The External Auditor is to carry out their duties in accordance with Schedule 10 to the 2006 Act and comply with any directions from NHSE on standards, procedures and techniques.

13 ACCOUNTS

- 13.1 The Foundation Trust must keep proper Accounts and proper records in relation to the Accounts.
- 13.2 The Foundation Trust is to keep Accounts in such form as NHSE may with the approval of the Secretary of State direct.
- 13.3 The Accounts are to be audited by the Foundation Trust's External Auditor.
- 13.4 The following documents will be made available to the Comptroller and Auditor General for examination at their request—
 - (a) The Accounts;
 - (b) any records relating to them; and
 - (c) any report of the External Auditor on them.
- 13.5 The Foundation Trust is to prepare in respect of each financial year Annual accounts in such form as NHSE may with the approval of the Secretary of State direct.
- 13.6 In preparing its Annual Accounts, the Foundation Trust is to comply with any directions given by NHSE with the approval of the Secretary of State as to –
 - (a) the methods and principles according to which the Accounts are to be prepared; and

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- (b) the information to be given in the Accounts.

13.7 The Foundation Trust must –

- (a) lay a copy of the Annual Accounts, and any report of the External Auditor on them, before Parliament; and
- (b) once it has done so, send copies of those documents to NHSE.

13.8 The functions of the Foundation Trust with respect to the preparation of the Annual Accounts shall be delegated to the Accounting Officer.

14 ANNUAL REPORTS, FORWARD PLANS AND NON-NHS WORK

14.1 The Foundation Trust is to prepare Annual Reports and send them to NHSE.

14.2 The Reports are to give:

- a) information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual Membership of its Public Constituency is representative of those eligible for such membership; and
- b) information on any occasion in the period to which the report relates on which the Council of Governors exercised its power under paragraph 6.17.9;
- c) information on the Foundation Trust's policy on pay and on the work of the Committee established under paragraph 7.4.7 and such other procedures as the Foundation Trust has on pay;
- d) information on the remuneration of the Directors and on the expenses of the Governors and the Directors; and
- e) any other information NHSE requires.

14.3 The Foundation Trust is to comply with any decision NHSE makes as to -

- a) the form of the Reports;
- b) when the Reports are to be sent to it; and
- c) the periods to which the Reports are to relate.

14.4 The Foundation Trust is to give information as to its Forward Planning in respect of each financial year to the ICB and NHSE. This information is to be prepared by the Board of Directors, having regard to the views of the Council of Governors.

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- 14.5 Each Forward Plan must contain information about-
- 14.5.1 the activities other than the provision of goods and services for the provision of the health service in England that the Foundation Trust proposes to carry on, and
 - 14.5.2 the income it expects to receive from doing so.
- 14.6 Where a Forward Plan contains a proposal that the Foundation Trust carry on an activity of the kind mentioned in sub-paragraph 14.5.1 the Council of Governors must –
- 14.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Foundation Trust of its principal purpose or the performance of its functions, and
 - 14.6.2 notify the Directors of the Foundation Trust of its determination.
- 14.7 If the Foundation Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the Health Service in England, it may implement the proposal only if more than half of the Members of the Council of Governors of the Foundation Trust voting approve its implementation.

15 INDEMNITY

- 15.1 Governors and Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Foundation Trust functions, save where they have acted recklessly. Any costs arising in this way will be met by the Foundation Trust.

16 INSTRUMENTS

- 16.1 A document purporting to be duly executed under the Foundation Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.
- 16.2 The Foundation Trust has a seal, but this is not to be affixed except in accordance with Standing Orders (adopted under Paragraph 8.1 of this Constitution).

17 DISPUTE RESOLUTIONS PROCEDURES

- 17.1 The Foundation Trust will establish appropriate dispute resolution procedures with its contractors ~~and Members~~.

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- 17.2 In the case of a dispute between the Board of Directors and the Council of Governors both parties shall first use their best endeavours to resolve the dispute through a joint meeting of the Council and the Board. Should such a joint meeting fail to resolve the dispute the parties shall seek mediation through the appointment of mutually agreed mediators, who shall not be members of the Foundation Trust. Should such mediation fail the dispute will be determined through reference to arbitration under the terms of the Arbitration Act 1996.

18 AMENDMENT OF THE CONSTITUTION

- 18.1 The Foundation Trust may make amendments of its Constitution only if –
- 18.1.1 More than half of the members of the Council of Governors of the Foundation Trust voting approve the amendments, and
 - 18.1.2 More than half of the members of the Board of Directors of the Foundation Trust voting approve the amendments.
- 18.2 Amendments made under paragraph 18.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.
- 18.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –
- 18.3.1 at least one member of the Council of Governors must attend the next Annual Members Meeting and present the amendment, and
 - 18.3.2 the Foundation Trust must give the members an opportunity to vote on whether they approve the amendment.
- 18.4 If more than half of the members voting under paragraph 18.3.2 approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Foundation Trust must take such steps as are necessary as a result.
- 18.5 Amendments by the Foundation Trust of its Constitution are to be notified to NHSE. For the avoidance of doubt, NHSE's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

19 MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

- 19.1 The Foundation Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

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- 19.2 The Foundation Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors voting approve entering into the transaction.
- 19.3 “Significant Transaction” means:
- 19.3.1 the acquisition of, or an agreement to acquire, assets the value of which is more than 25% of the value of the Foundation Trust's gross assets before the acquisition; or
 - 19.3.2 the disposal of, or an agreement to dispose of, assets of the Foundation Trust the value of which is more than 25% of the value of the Foundation Trust's gross assets before the disposal; or
 - 19.3.3 a transaction that has or is likely to have the effect of the Foundation Trust acquiring rights or interests or incurring obligations or liabilities, the value of which is more than 25% of the value of the Foundation Trust's gross assets before the transaction.
- 19.4 For the purpose of this paragraph "gross assets" means the total of the Foundation Trust's fixed assets and current assets
- 19.5 Where the Foundation Trust has a single requirement for goods, services or works, and a number of transactions are to be entered into to fulfil that requirement, the value of the transaction for the purpose of paragraph 19.3 is the aggregate of the value of each of those transactions.

ANNEX 1: PUBLIC CONSTITUENCIES OF THE FOUNDATION TRUST

Name of Constituency	Area	Minimum number of members	Number of Governors
Keighley	Craven, Ilkley, Keighley Central, Keighley East, Keighley West, Worth Valley	100	2
Shipley	Baildon, Bingley, Bingley Rural, Shipley, Wharfedale, Windhill and Wrose	100	2
Bradford East	Bolton and Undercliffe, Bowling and Barkerend, Bradford Moor, Eccleshill, Idle and Thackley Little Horton,	100	2
Bradford South	Great Horton, Queensbury, Royds, Tong, Wibsey, Wyke	100	2
Bradford West	City, Clayton and Fairweather, Heaton, Manningham, Thornton and Allerton, Toller	100	2
Rest of England and Wales	Remaining electoral wards that do not form part the BMDC area	100	1

Area means the electoral wards as listed.

ANNEX 2: STAFF CONSTITUENCIES OF THE FOUNDATION TRUST

Name of Constituency	Minimum Number of Members	Number of Governors
Medical and Dental Practitioners class	100	1
Nurses and Midwives class	100	2
Allied Health Professionals and Scientists class	100	1
All Other Staff class	100	2

ANNEX 3: LOCAL AUTHORITY, UNIVERSITY AND PARTNER GOVERNORS OF THE FOUNDATION TRUST

Organisation	Number of Governors
Bradford Metropolitan District Council	1
University of Bradford	1
University of Leeds	1
Healthwatch Bradford and District	1
Mental Health, Learning Disabilities and Autism representative organisation (to be determined by the Trust)	1

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BOARD OF DIRECTORS - PUBLIC				
Meeting Date:	24 September 2026		Agenda Reference:	Bo.9.26.22c
Report Title:	Council of Governors Engagement Policy			
Presented by:	Laura Parsons, Associate Director of Corporate Governance / Board Secretary			
Lead:	Karen Walker, Acting Chair			
Author:	Jacqui Maurice, Head of Corporate Governance			
Report Summary				
Purpose of the paper:	Decision ☐ (approve/recommend/ support/ratify)	Assurance ☐	Action ☐ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	The Code of Governance for NHS Provider Trusts, 'Appendix B: Council of governors and role of the nominated lead governor' states under Section 2.6; <i>The council of governors should establish a policy for engagement with the board of directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners. The council of governors should input to the board's appointment of a senior independent director.</i> and states under Section 2.7; <i>The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.</i> The Council of Governors Engagement Policy (Appendix 1) has been reviewed and is now presented for review and approval by the Board prior to its presentation for final approval at the Council of Governors meeting on 30 September 2026. The following amendments have been made: - Updated references throughout the document from 'NHS England/Improvement' to 'NHS England'. - Updated references from 'Chairman' to 'Chair' and; 'Trust Secretary' to 'Board Secretary' and; 'Foundation Trust' to 'Trust' - Alignment of the policy with the Council of Governors Standing Orders with regard to escalating concerns under section 7.4. - Update to the Equality Impact Assessment under section 8. - Hyperlinks have been updated and added to reference documents where available.			
Recommendation/s: (including any decision/approval required)	The Board of Directors is asked to review and approve the amendments to the Council of Governors Engagement Policy prior to the document being submitted to the Council of Governors for final approval on 30 September 2026.			
Link to Strategic Objective:	N/A			

Link to priority transformation programmes:	N/A
Implications	
Risk:	Non-compliance with the Code of Governance for NHS Provider Trusts
Legal/Regulatory:	Requirements of NHS England Code of Governance for NHS Provider Trusts
Quality & Patient Safety:	N/A
Equality, Diversity and Inclusion and Health Equity:	N/A
Resources:	N/A
Environmental sustainability:	N/A
Assurance Route	
Meeting/s where content has been discussed previously:	N/A

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Bradford Teaching Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS ENGAGEMENT POLICY

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Document Control

Policy reference	CG05
Category	Corporate Governance
Strategic objective	~~To be a continually learning organisation~~ <u>N/A</u>

Author	Associate Director of Corporate Governance / Board Secretary
Version	~~67~~
Status	Draft
Supersedes	Version ~~65~~
Executive Lead	Chief Operating Officer
Approval Committees	Board of Directors and Council of Governors
Ratified by	Board of Directors
Date ratified	~~24~~ 3 September 202 ~~64~~
Ratified by	Council of Governors
Date ratified	~~21 October 2024~~ <u>30 September 2026</u>
Date issued	~~22 October 2024~~ <u>1 October 2026</u>
Review date	~~30~~ <u>1st September July 2026</u> <u>2028</u>

Target audience	Board of Directors and Council of Governors
Summary	The purpose of this document is to establish a policy for engagement with the Board of Directors for those circumstances when the Council of Governors have concerns about the performance of the Board of Directors, compliance with the provider licence, or other matters related to the ~~general overall~~ wellbeing of the ~~NHS Foundation Trust~~ <u>and- its collaboration with system partners</u> .
Changes since last revision	Minor changes:~~to~~ - Updated references throughout the document ~~to from~~ 'NHS England/Improvement' to 'NHS England'. - Updated references from 'Chairman' to 'Chair', 'Trust Secretary' to 'Board Secretary', and 'Foundation Trust' to 'Trust' - Alignment of the policy with the Council of Governors Standing Orders with regard to escalating concerns under section 7.4. - Update to the Equality Impact Assessment under section 8. - Hyperlinks have been <u>updated and</u> - added to reference documents where available. -

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Monitoring arrangements	The policy will be kept under review, compared with the provisions developed by other ~~Foundation~~ Trusts and revised in accordance with emerging best practice
Training requirements	None
Equality Impact Assessment	This Policy was assessed in ~~February 2016~~ September 2026 to determine whether there is a possible impact on any of the nine protected characteristics as defined in the Equality Act 2010.

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1. Introduction

This policy has been written in response to the recommendations contained in [The Code of Governance for NHS Provider Trusts 'Appendix B: Council of governors and role of the nominated lead governor'](#) whereby sections 2.6 and 2.7 state; paragraphs

~~A.5.6 and A.5.7 of The NHS Foundation Trust Code of Governance (Monitor, updated 2014) whereby:~~

- ~~(2.6)~~ The Council of Governors should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the provider licence, or other matters related to the [overall wellbeing of the NHS foundation trust and its collaboration with system partners.](#) ~~general wellbeing of the NHS Foundation Trust.~~ The Council of Governors should input into the Board's appointment of a Senior Independent Director ~~(see A.4.1);~~

~~(2.7)~~ The Council of Governors should ensure its interaction and relationship with the Board of Directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and ~~use~~, where possible, ~~of using~~ clear, unambiguous language.

2. Purpose and Scope

2.1 This policy should not be invoked for minor issues raised by an individual Governor. A concern, in the meaning of this policy, should be directly related to the:

- The performance of the Trust and subsequent response of the Board of Directors.
- The Trust's compliance with the conditions of NHS England/~~Improvement~~'s Provider Licence.
- The welfare of the ~~Foundation~~ Trust [and its collaboration with system partners.](#)

2.2 Similarly, the resolution of disputes between the Council of Governors and the Board of Directors is covered in the [Governors' Standing Orders](#) and in paragraph ~~18-217~~ of the [Constitution](#).

Governors should acknowledge the overall responsibility of the Board of Directors for the strategic and operational running of the ~~Foundation~~ Trust and should not use the powers of the Council of Governors, or the provisions of this policy, to challenge unnecessarily the decisions of the Board of Directors.

3. Definitions

- NHS England/~~Improvement~~ - The organisation responsible for overseeing NHS foundation trusts, NHS trusts and independent providers.
- Petitioner/s – A Governor or Governors raising concerns under this policy.
- SID – Senior Independent Director, one of the Non-Executive Directors appointed by

the Board of Directors to provide an alternative to the Chair~~man~~ as source of advice to Governors.

- Lead Governor – The Governor elected from within the Council of Governors and has a communication link with NHS England/~~Improvement~~ to raise formal concerns on behalf of the full Council of Governors. NHS England/~~Improvement~~ may choose to communicate directly with the Lead Governor where they deem it necessary.
- ~~Trust Board~~ Secretary – The person designated to act in the capacity of ~~Trust Board~~ Secretary.

4. Roles and Responsibilities

4.1 Chair

The ~~Foundation~~-Trust Chair acts as the link between the Council of Governors and the Board of Directors. He or she will, therefore, have the principal role in dealing with any issues raised by Governors and will involve the Chief Executive and/or other Executive Directors and Non-Executive Directors, as necessary.

4.2 Senior Independent Director

The Senior Independent Director (SID) acts as an alternative source of advice to Governors. His or her function is to deal with concerns which would be inappropriate to take to the Chair, or where engagement with the Chair has not resolved the matter.

4.3 Governors

Individual Governors have a responsibility to raise concerns (as defined in this policy) and to assure themselves that issues have been resolved. In addition, the Council of Governors as a body has a duty to inform NHS England/~~Improvement~~ (via the ~~Lead Governor~~) if the ~~Foundation~~-Trust is at risk of breaching the conditions of its provider licence.

4.4 Lead Governor

The Council of Governors appoints ~~from within~~ one Governor to act as the Lead Governor to communicate directly with NHS England/~~Improvement~~ in the event that the ~~Foundation~~-Trust is at risk of breaching the conditions of its provider licence.

The ~~Trust Board~~ Secretary ensures that NHS England/~~Improvement~~ is kept updated with the contact details of the Lead Governor.

5. Evidence Requirements

5.1 Governors should not raise concerns that are not supported by evidence. That evidence must satisfy the following criteria:

- Any written statement must be from an identifiable person or persons who must sign the statement and indicate that they are willing to be interviewed about its contents.

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- Other documentation must originate from a bona fide organisation and the source must be clearly identifiable.

5.2 Newspaper or other media articles will not be accepted as prima facie evidence, but may be accepted as supporting evidence.

6. Raising Concerns

6.1 Notwithstanding the central role of the Chair~~man~~ in providing the link between the Council of Governors and the Board of Directors, it is recommended that any Governor or group of Governors who have concerns covered by this policy (the petitioner/s) should, in the first instance, consult the Trust Board Secretary.

6.2 He or she might be able to resolve the matter informally and will certainly be able to advise the petitioner/s on the acceptability of the evidence offered and so whether it is appropriate to take their concerns to the Chair~~man~~.

6.3 The advice of the Trust Board Secretary is not, however, binding upon the petitioner/s and they retain at all times the right to raise the matter with the Chair~~man~~.

6.4 For concerns which it would be inappropriate to raise with the Chair~~man~~, for example, regarding his or her own performance, the role of the Chair~~man~~ as described in this section will be undertaken by the SID.

6.5 The Chair~~man~~ shall investigate all concerns brought to him/her by governors and will involve the Chief Executive and/or the Executive Management Team or Non-Executive Directors at his/her discretion.

6.6 The investigation shall include a review of the evidence offered and discussions with Trust officers as appropriate.

6.7 As soon as practicable after the conclusion of the investigation the Chair~~man~~ shall meet with the petitioner/s to discuss the findings. This meeting has three possible outcomes:

- The petitioner/s are satisfied that their concerns were unjustified and withdraw them unreservedly. In this case no further action is required.
- The petitioner/s are satisfied that their concerns have been resolved during the course of the investigation. The Chair~~man~~ shall write a report on the concerns and the actions taken and present this at a closed section of the next scheduled meeting of the Council of Governors. If the Council of Governors agrees that the matter is resolved then no further action is required. However, should a majority of the Council of Governors voting disagree, then the process for escalation described in section 7 of this engagement policy shall be invoked.
- The matter is not resolved to the satisfaction of the petitioner/s. The Chair~~man~~ shall call a closed extraordinary meeting of the Council of Governors as soon as possible in accordance with 6.17.2(a)7.16.3 (a) of the Foundation Trust Constitution to consider the matter further. That meeting may choose either to take no further action or, if a majority of the Governors present agree, to invoke the escalation process described in section 7 of this engagement policy.

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7. Escalating Concerns

7.1 At this stage of the process the SID will take the lead role for liaising with the petitioner/s. Should the SID be unavailable, or be prevented from participating because of a conflict of interests, then the Council of Governors may choose any other Non- Executive Director to fulfil the role.

7.2 The first duty of the SID is to establish the facts of the matter. This will be accomplished by reviewing the evidence offered by the petitioner/s, the process of the investigation and any documentation produced and also by meetings / interviews with the petitioner/s and any Trust officers involved. In carrying out this process the SID shall seek the agreement of all interested parties and shall have the authority to commission whatever legal or other advice is required.

7.3 Once the facts are established to his or her satisfaction, the SID shall make a decision on the course of action to be followed in the best interests of the Trust and shall describe the reasons for that decision in a written report. The decision of the SID shall be binding upon the Trust. In the first instance, the SID shall present the decision and the report to the petitioner/s and to interested parties within the organisation.

7.4 The SID shall then require the Chairman to call a closed extraordinary meeting of the Council of Governors, as soon as possible, in accordance with [7.16-36.17.2\(a\)](#) of the [Foundation Trust's Constitution](#). The purpose of this meeting, and the sole item on the agenda, will be for the SID to present his or her report and findings and for the Council of Governors to give its response. Then the following outcomes should be considered:

- More than half the members of the Council of Governors voting accept the findings of the SID and no further action is necessary: [1.7](#) or [1.7](#)
- More than half the members of the Council of Governors voting do not accept the findings of the SID but choose not to escalate the matter further. No further action is prescribed by this policy but the Council of Governors may choose to keep the matter under review at future meetings: [1.7](#) or [1.7](#)
- ~~More than half the members of the Council of Governors voting do not agree with the findings of the SID. At this point the [dispute resolution procedure described in section 9 of the Standing Orders of the Council of Governors shall apply. Council of Governors shall seek mediation through the appointment of mutually agreed mediators, who shall not be members of the Foundation Trust. Should such mediation fail the dispute will be determined through reference to arbitration under the terms of the \[Arbitration Act 1996\]\(#\).](#)~~

8. Equality Impact Assessment

8.1 [This policy has been screened for equality impact in accordance with the Equality Act 2010. The assessment has not identified any adverse impact on individuals or groups with protected characteristics. The policy relates to governance and engagement arrangements and does not affect access to services, employment opportunities or eligibility criteria.](#)

8.2 [Information relating to this policy will be made available in accessible formats where required, and reasonable adjustments, communication support or interpretation services will be provided where appropriate to support participation and engagement. The policy supports](#)

transparent, fair and inclusive governance arrangements across the Trust.

8.3 The assessment concludes that the policy presents a low risk of adverse equality impact and does not require a full Equality Impact Assessment. The screening decision will be reviewed as part of future policy reviews or sooner if significant changes are made to the policy.

8.3 This Policy was assessed in February 2016 to determine whether there is a possible impact on any of the nine protected characteristics as defined in the Equality Act 2010.

8.2 It has potential impact on:

• Disability:

It is recognised that some staff and members (public, patients and staff as defined within the Constitution) and the general public may require support, have specific needs or be unable to understand or read the text of this policy. In such instance it will be explained on a one-to-one basis by the Department responsible for this policy or the manager of the member of staff. Any support will be provided in confidence.

• Race and ethnicity:

It is recognised that some members (public, patients and staff as defined within the constitution) and the general public may require support, or be unable to understand or read the text of this policy. In such instance it will be explained on a one-to-one basis by members of the Governance Team.

8.3 It has been found not to have impact on:

- Age
- Gender
- Gender reassignment
- Marriage and civil partnership
- Maternity/pregnancy
- Religion and belief
- Sexual orientation.

8.4 It has also been assessed to determine whether it impacts on human rights against the FRED A principles (Fairness, Respect, Equality, Dignity, Autonomy) and it is considered that it does not have impact. This assessment will be reviewed when the policy is next updated or sooner if evidence of further impact emerges.

9. Privacy Impact Assessment

9.1 The Privacy Impact Screening Tool was completed for this policy and no privacy implications were identified.

10. Financial Implications

10.1 This policy has no financial impact.

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11. Duty of Candour which includes the Being Open Framework

- 11.1** There are no implications associated with the Duty of Candour policy or Being Open framework in relation to this policy.

12. Patient and Public Involvement

- 12.1** Patients and the public were not involved in writing this policy.

13. Training Requirements

- 13.1** Training is not required.

14. Review

- 14.1** This policy will be reviewed by the Board of Directors and the Council in line with the review date and formally recorded in the minutes of their respective meetings.

15. Monitoring Compliance and Effectiveness

- 15.1** The policy will be kept under review, compared with the provisions developed by other [Foundation](#) Trusts and revised in accordance with emerging best practice.

16. Dissemination

- 16.1** This policy will be distributed to all [Governors, and Governors and](#) will be made available to Trust staff via the document library on the intranet and, will be made available to members and the public via the Trust internet site.

17. Document Management

- 17.1** The document management system and archiving processes for the policy will be maintained by the Health Library and Information Service.

18. References

- [Monitor \(updated 2014\) The NHS Foundation Trust Code of Governance](#) [NHSE Code of Governance for NHS Provider Trusts](#)
- Bradford Teaching Hospitals NHS Foundation Trust Constitution
- National Health Service Act 2006 [\(as amended\)](#)
- Health and Social Care Act 2012
- Monitor: Model Core Constitution for NHS Foundation Trusts (April 2013)
- [Standing Orders of the Council of Governors](#)
- [Standing Orders of the Board of Directors](#)

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Board of Directors				
Meeting Date:	24/09/26	Agenda Reference:	Bo.9.26.22d	
Report Title:	Board Nomination and Remuneration Committee (NRC) Terms of Reference			
Presented by:	Laura Parsons, Board Secretary			
Lead:	Karen Walker, Acting Chair			
Author:	Laura Parsons, Board Secretary			
Report Summary				
Purpose of the paper:	Decision ☒ (approve)	Assurance ☐	Action ☐	Information ☐
Summary of Key Issues/Highlights:	The NRC's terms of reference were last approved in September 2025 and are therefore due for review. A review has been undertaken and there are no proposed amendments to the terms of reference which are attached at Appendix 1.			
Recommendation/s: (including any decision/approval required)	The Board is asked to approve the NRC terms of reference.			
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 transformation programmes:	N/A			
Implications				
Risk:	N/A			
Legal/Regulatory:	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:	Board NRC – 3 September 2026			

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**Board Nominations and Remuneration Committee
Terms of Reference**

Purpose	The Committee is responsible for identifying and appointing candidates to fill all the executive director positions on the board and for determining their remuneration and other conditions of service.
Responsible to	Board of Directors
Delegated authority	The Nominations and Remuneration Committee is established under the Trust's Standing Order – Arrangements for the Exercise of Functions by delegation and is constituted as a standing committee of the Board of Directors. The Nominations and Remuneration Committee is authorised by the Board of Directors to act within its terms of reference.
Duties	• To regularly review the structure, size and composition (including skills, knowledge and experience) required of the Board of Directors and make recommendations to the Board with regard to any changes. • To give full consideration to and make plans for succession planning for the Chief Executive and other Executive Director posts. • To agree the Non-Executive membership of an Appointments Panel to appoint any Executive Director. The panel will normally include the Chair and Chief Executive. The panel will have delegated authority to appoint an Executive Director. • To be responsible for agreeing an Appointments Panel to include the Chair which will then have delegated authority to identify and recommend a suitable candidate for approval by the Council of Governors to fill the position of Chief Executive. • To agree the job description for any Executive Director taking into account the role and capabilities required. • To determine on behalf of the Board of Directors the terms and conditions of employment and salary levels of Executive Directors in the Trust and any other Senior Managers not covered by Agenda for Change terms and conditions. The remuneration of the Chief Executive will be proposed by the Chair. The remuneration of Executive Directors will be proposed by the Chief Executive. • In undertaking this function it will:- a) Observe all statutory and contractual obligations as they affect individual postholders. b) Act in accordance with the Foundation Trust's standing orders.

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- c) Have regard to any directions made by the Secretary of State in so far as they apply to Bradford Teaching Hospitals as a Foundation Trust.
- d) Have regard to the guidance in any directives on pay and conditions of employment in respect of very senior managers so far as they apply to Bradford Teaching Hospitals as a Foundation Trust.
- e) Ensure that regulation 5 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 is complied with in respect of any new or continued appointment.
- f) Ensure that in considering any salary over £170,000 or above the agreed pay thresholds as set out in the NHS very senior managers (VSM) pay framework, there is a clear and documented rationale for the level of salary awarded and that a pay case is submitted to NHS England in line with the VSM pay framework.
- g) Consider the pension consequences and associated costs to the Foundation Trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.
- h) Take into account the financial state of the Foundation Trust.
- i) Have regard to legislation on discrimination and the gender pay gap when considering levels of pay/terms and conditions.
- j) Ensure that remuneration is sufficient to recruit, retain and motivate Executive Directors at the level of skills appropriate to the role.
- k) Consider the relationship between the remuneration of these posts and that of other grades of staff employed in Bradford Teaching Hospitals, in particular the layer below Board level. This may include reference to the level of pay awards granted under national pay systems e.g. Agenda for Change.
- l) Consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service.
- m) Consider any proposal for a severance payment to be made to a Senior Manager. A 'Senior Manager' is defined as the Chief Executive or any Director who reports to the Chief Executive, whether or not they are an executive member of the Board. The

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	Remuneration Committee will either reject the proposal or approve a business case to be sent to NHS England if they propose/approve a payment to be made. n) Approve the running of any MARS or Voluntary Redundancy Scheme. o) Make recommendations on any local pay arrangements not covered by national terms. p) Recommend the scope and detail to be included in the annual report concerning basic salary and elements relating to performance including an explanation of the criteria on which performance is based where necessary. q) Review appraisal outcomes for Executive Directors where there is a performance related pay element. r) Be satisfied that a risk assessment has been carried out when it is agreed that an Executive Director can leave the Foundation Trust without serving their full contractual notice. s) Work within the principles contained in the HM Treasury guidance on how to manage public funds in respect of 'special payments' and the Code of Governance for NHS Provider Trusts.
Sub-Groups	The Committee does not have any sub-groups.
Chairing arrangements	The Committee will be chaired by the Trust's Chair. In their absence the Deputy Chair, if present, will preside. If both the Chair and Deputy Chair are absent, or are disqualified from participating, such Non-Executive Director as the Non-Executive Directors present shall choose, shall preside over the meeting.
Membership	The Nominations and Remuneration Committee will consist of the Trust Chair and all Non-Executive Directors.
In attendance	The Chief Executive, Director of HR and the Associate Director of Corporate Governance/Board Secretary will attend in an advisory capacity. The Committee may invite other staff or external advisors to attend as required.
Conflicts of interest	The Chair, any Non-Executive Director present or Executive Director in attendance at a committee meeting will withdraw from discussions concerning their own appointment, remuneration or terms and

	conditions of service.
Support	The Director of HR and Associate Director of Corporate Governance/Board Secretary will service the Committee and provide specialist advice and information as necessary.
Quorum	This will be the Chair and three other Non-Executive Directors.
Frequency of meetings	For the purpose of the Annual Review of Executive Directors pay the Nominations and Remuneration Committee will meet within the first four months following the 1 April each year. The Nominations and Remuneration Committee will meet at other times for the following purposes as determined by the Chair of the Nominations and Remuneration Committee: - • To keep up to date with relevant developments. • To review remuneration policies. • To consider proposals for changes in terms and conditions of employment. • To consider any in-year variation of salaries and terms and conditions of employment of Executive Directors. • To agree process and salaries for new appointments.
Circulation of papers	Papers will be distributed a minimum of three clear working days in advance of the meeting.
Reporting	The Nominations and Remuneration Committee will meet in private and record the reasons for all decisions and report these decisions to the Board of Directors as required. Communicating Decisions The responsibility is vested in the Director of HR to communicate the decision of the Nominations and Remuneration Committee in writing to each postholder where it affects their pay or terms and conditions of service.
Date agreed by the Committee:	3 September 2026
Date approved by the Board:	TBC
Review date:	September 2027

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BOARD OF DIRECTORS - PUBLIC				
Meeting Date:	24/09/2026	Agenda Reference:	Bo.9.26.23b	
Report Title:	Thirlwall Inquiry: Immediate Board considerations			
Presented by:	Professor Karen Dawber, Chief Nurse			
Executive Lead:	Professor Karen Dawber, Chief Nurse			
Author:	Professor Karen Dawber, Chief Nurse			
Report Summary				
Purpose of the paper:	Decision ☒ (approve/recommend/ support/ratify)	Assurance ☒	Action ☒ (review/discuss/ comment)	Information ☐
Summary of Key Issues/Highlights:	On 21 September 2026, NHS England issued a national communication following publication of the Thirlwall Inquiry report into the failures surrounding neonatal care at the Countess of Chester Hospital. NHS England has stated that every NHS Trust and ICB Board reviews the Inquiry findings at its next available public Board meeting and considers whether similar events could occur within their own organisation. The Thirlwall Inquiry Examining the events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital.			
Recommendation/s: (including any decision/approval required)	<i>The Board is asked to:</i> - Note the publication of the Thirlwall Inquiry report and the NHS England response. - Incorporate reviews within the Maternity and Neonatal 10 point plan to include issues highlighted within the report: - Patient safety - Safeguarding - Freedom to Speak Up - Clinical governance - Culture and leadership - Neonatal service assurance. - Seek assurance that: - Appropriate safeguarding, escalation and speaking up arrangements are in place. - SUDIC requirements are communicated and embedded within neonatal services. - A review of insulin storage and security arrangements is completed against NHS England expectations. - Request a further assurance report to a future Board meeting setting out: - Self-assessment against relevant Thirlwall recommendations. - Existing areas of compliance. - Identified gaps and risks. - Action plan, timescales and executive oversight arrangements.			

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Link to Strategic Objective:	Quality - To provide outstanding care for patients, delivered with kindness
Link to priority transformation programmes:	N/A
Implications	
Risk:	Direct link to Quality and patient safety
Legal/Regulatory:	CQC regulations and compliance, provider licence compliance
Quality & Patient Safety:	See main body of report
Equality, Diversity and Inclusion and Health Equity:	
Resources:	There will be cost implications in relation to the recommendations, awaiting further information and guidance from NHSE
Environmental sustainability:	
Assurance Route	
Meeting/s where content has been discussed previously:	Maternity and Neonatal governance reporting to Quality Committee and Board

Report content
1. Background The Thirlwall Inquiry concluded that serious failures in culture, governance, escalation, professional curiosity and organisational response contributed to preventable harm to babies and their families. The report highlights the importance of creating cultures where concerns are actively listened to, challenged and acted upon without fear of reprisal. NHS England has stated that this is not solely an issue for organisations providing neonatal services but is relevant to all Trusts and ICBs. Boards are expected to consider whether they have sufficient safeguards, governance arrangements and speaking up cultures to identify and respond to concerns at an early stage. 2. Assessment The Board is asked to consider the implications of the Inquiry for BTHFT and seek assurance in the following key areas: 2.1 Organisational Culture and Speaking Up • Staff feel empowered and supported to raise concerns. • Freedom to Speak Up arrangements are effective and accessible. • Professional curiosity, challenge and escalation are encouraged at all organisational levels. • Board oversight provides assurance that concerns are acted upon appropriately. 2.2 Safeguarding Assurance • Board members and staff are compliant with safeguarding training requirements appropriate to their role. • Staff understand escalation routes and safeguarding responsibilities. • Safeguarding of babies, children and young people is given appropriate prominence within governance arrangements.

2.3 Neonatal and Paediatric Safety

- Compliance with Sudden and Unexpected Death in Childhood (SUDIC) requirements.
- Assurance that relevant clinical staff understand that SUDIC processes apply to unexpected deaths within neonatal settings.
- Confirmation that local reporting arrangements operate alongside SUDIC requirements. NHS England requires communication of these requirements by 28 September 2026.

2.4 Medicines Security

- Review of current arrangements for storage, access control and monitoring of insulin within neonatal services.
- Assessment of compliance with GIRFT guidance and NHS England requirements for CCTV monitoring of neonatal insulin storage areas by 30 November 2026 and full insulin security requirements by 31 March 2027.

5. Bereavement Care

- Assurance regarding implementation of the National Bereavement Care Pathway and support for families experiencing neonatal loss.

6. Staff Wellbeing

- Consideration of psychological support arrangements available to staff working in neonatal and paediatric services.

3. Recommendation

The Board is recommended to:

3.1 Note the publication of the Thirlwall Inquiry report and the NHS England response.

3.2 Incorporate reviews within the Maternity and Neonatal 10 point plan to include issues highlighted within the report:

- Patient safety
- Safeguarding
- Freedom to Speak Up
- Clinical governance
- Culture and leadership
- Neonatal service assurance.

3.3 Seek assurance that:

- Appropriate safeguarding, escalation and speaking up arrangements are in place.
- SUDIC requirements are communicated and embedded within neonatal services.
- A review of insulin storage and security arrangements is completed against NHS England expectations.

3.4 Request a further assurance report to a future Board meeting setting out:

- Self-assessment against relevant Thirlwall recommendations.
- Existing areas of compliance.
- Identified gaps and risks.
- Action plan, timescales and executive oversight arrangements.

4. Board Discussion Questions

The Board may wish to reflect on the following NHS England questions:

4.1 Could similar circumstances occur within our organisation today?

- 4.2 How confident are we that staff can raise concerns and be heard?
- 4.3 Do our governance systems identify concerning patterns quickly enough?
- 4.4 Are we receiving sufficient intelligence relating to neonatal, paediatric and safeguarding risks?
- 4.5 What further actions are required to strengthen organisational culture, leadership and accountability?
- 4.6 Does the Board need to constitute a standalone committee of the Board to deal with the increasing assurance requirements in relation to maternity and neonatal services.

Osbourne, Sheridan
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To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors

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

21 September 2026

Thirlwall Inquiry report and recommendations

Dear colleagues,

Lady Justice Thirlwall's [report](#) is a sobering moment for all of us working in the NHS. From the devastating failure, both of individuals and the system, to act quickly enough to safeguard babies, to the questions it poses about the NHS culture that prevented this – the need for change goes beyond the walls of a single hospital ward. We must address these together now.

Our thoughts remain very much with the families affected who have experienced unimaginable loss and pain, and the NHS repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.

Recommendations

On Tuesday, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full.

Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this;
- Go further on [new guidance](#) on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death;
- Undertake a review of the 'Working Together to Safeguard Children' (April 2026) and safeguarding training nationally;
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities;
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting:** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children (SUDIC):** The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The [SUDIC protocol](#) is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably

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expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within neonatal units. **All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026.** It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

- **National Bereavement Care Pathway for stillbirth and neonatal death:** ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the [NHS Medium Term Planning Framework](#) (October 2025).
- **Insulin:** By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the [GIRFT neonatology Guide to safe insulin use](#). Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.
- **Safeguarding:** Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts are reminded that the [Insightful Provider Board guide](#) is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Health and wellbeing

We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.

We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

Next steps

The report firmly underlines why the urgent work we are doing through the Maternity and Neonatal Care 10-Point Plan must be a top priority for the NHS. As the Secretary of State has clearly set out, the safety, safeguarding and wellbeing of mothers and babies must never be treated as a side issue and must be a central priority for NHS boards.

The findings of this crucial report will be a key focus of our next CEO leadership event tomorrow. It is important that we challenge each other when we meet on whether we are all doing enough to ensure that babies and children are protected, no staff member is ignored when they raise concerns, and that we are consistently acting to the highest standards of governance and leadership.

Yours sincerely,



Duncan Burton

Chief Nursing Officer for England



Sarah-Jane Marsh

NHS England Chief Operating Officer

Osbourne, Sheridan
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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		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										
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
CQC Adult Inpatient Survey	Sarah Freeman/Ruth Tolley	Chief Nurse				x	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		x	x	x		
First 72 Hours Standards	Amy Iilsley/Caroline Varley	Chief Medical Officer		x				x		
Research Activity in the Trust	Michael McCooe	Chief Medical Officer	x			x*			x	*Presentation from Research Team
PEOPLE										
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 & Information 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			
Education Annual Report	Faye Alexander	Chief Medical Officer		x						
Education Self Assessment Report (SAR)	Faye Alexander	Chief Medical Officer				x	x			
FINANCE & PERFORMANCE										
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	
Operational Plan Submission	Saj Azeb/Ben Roberts/Faeem Lal	Chief Operating Officer / Chief Finance Officer / Director of HR	x						x	Closed Board Feb 2026

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
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	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	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	x			
SIRO Report	Jenny Pope/Graeme Holmes	CDIO			x		x			
Emergency Preparedness, Resilience & Response & NHSE Core Standards	Steve Amos	Chief Operating Officer				x	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	
Chief Executive's Report	Debbie Earnshaw / EDs	Chief Executive	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
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										