Board of Directors Meeting Held in Public

To be held on Wednesday, 26th March 2025 at 1.00pm – 3.45pm

Venue: Boardroom, HDFT, Strayside Wing, Harrogate District Hospital

Lancaster Park Road, Harrogate, HG2 7SX.

AGENDA

All items listed in blue text (throughout the agenda), are to be received for information/ assurance and no discussion time has been allocated within the agenda. These papers can be found in the supplementary pack.

Item No.	Item	Lead	Action	Paper
SECTION 1: Opening Remarks and Matters Arising				
1.1	**Welcome and Apologies for Absence**	Chair	Note	Verbal
1.2	**Patient Story**	Interim Director of Nursing, Midwifery and AHPs/ Medical Director	Discuss	Verbal
1.3	**Register of Interests and Declarations of Conflicts of Interest**	Chair	Note	Attached
1.4	**Minutes of the meeting held on 29th January 2025**	Chair	**Approve**	Attached
1.5	**Matters Arising and Action Log**	Chair	Note	Attached
1.6	**Overview by the Chair**	Chair	Note	Verbal
1.7	**Chief Executive's Report**	Chief Executive	Note	Attached
1.8	**Board Assurance Framework:** Summary	Chief Executive	**Approve**	Attached
1.9	Corporate Risk Register	-	Note	Supp. Pack
SECTION 2: Ambition: Best Quality, Safest Care				
2.1	**Board Assurance Framework:** Best Quality, Safest Care	Interim Director of Nursing, Midwifery and AHPs & Quality Committee Chair	**Approve**	Attached
2.2	Learning from Deaths Quarterly Report	-	Note	Supp. Pack
SECTION 3: Ambition: Great Start in Life				
3.1	**Board Assurance Framework:** Great Start in Life	Interim Director of Nursing, Midwifery and AHPs & Quality Committee Chair	**Approve**	Attached

Item No.	Item	Lead	Action	Paper
3.2	**Strengthening Maternity and Neo-Natal Safety**	Interim Director of Nursing, Midwifery and AHPs / Associate Director of Midwifery	Note	Attached
SECTION 4: Ambition: Person Centred; Integrated Care; Strong Partnerships				
4.1	**Board Assurance Framework:** Person Centred; Integrated Care; Strong Partnerships	Chief Operating Officer / Resource Committee Chair	**Approve**	Attached
4.2	**Board Assurance Framework:** Finance	Finance Director / Resource Committee Chair	**Approve**	Attached
4.3	**HDFT Planning**	Chief Operating Officer / Finance Director / Director of Strategy / Director of People & Culture	**Approve**	Attached
SECTION 5: Ambition: At Our Best: Making HDFT the Best Place to Work				
5.1	**Board Assurance Framework:** At Our Best: Making HDFT the Best Place to Work	Director of People & Culture / People & Culture Committee Chair	**Approve**	Attached
SECTION 6: Ambition: Enabling Ambitions				
6.1	**Board Assurance Framework:** Digital Transformation to Integrate Care and Improve Patient, Child and Staff Experience	Medical Director & Innovation Committee Chair	**Approve**	Attached
6.2	**Board Assurance Framework:** Healthcare Innovation to Improve Quality and Safety	Medical Director & Innovation Committee Chair	**Approve**	Attached
6.3	**Board Assurance Framework:** An Environment that Promotes Wellbeing	Director of Strategy / Resources Committee Chair	**Approve**	Attached
SECTION 7: Escalation from Committees				
7.1	**Escalation from Sub-Committees of the Board**	All Executive and Non-Executive Directors	Discuss	Verbal
SECTION 8: Governance Arrangements				
8.1	**Audit Committee Update**	Committee Chair	Note	Verbal
8.2	**Going Concern**	Director of Finance	**Approve**	Attached
8.3	**Board Appointed Non-executive Roles:** Enhancing Board Oversight	Chair	**Approve**	Attached
8.4	**Risk Management Policy**	Interim Director of Nursing, Midwifery and AHPs	**Approve**	Attached

Item No.	Item	Lead	Action	Paper
9.0	**Any Other Business** *By permission of the Chair*	Chair	Discuss/ Note/ Approve	Verbal
10.0	**Board Evaluation**	Chair	Discuss	Verbal
11.0	**Date and Time of next Board Meeting to be held in public:** Wednesday 28 May 2025 at 1.00 – 3.45pm Venue: Boardroom, Trust Headquarters, Harrogate District Hospital			

Confidential Motion – the Chair to move:
Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.

NOTE: The agenda and papers for this meeting will be made available our website. Minutes of this meeting will also be published in due course on our website.

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Board of Directors – Register of Interests

As at 19 March 2025

Board Member	Position	Relevant Dates From	To	Declaration Details
Jacqueline Andrews	Executive Medical Director	June 2020 June 2020 December 2023 April 2024 May 2024	April 2024 Current Current Current Current	1. Familial relationship with managing partner of Priory Medical Group, York 2. Lead for Research, Innovation and Improvement for Humber and North Yorkshire Integrated Care Board 3. Member, Leeds Hospitals Charity Scientific Advisory Board 4. Familial relationship with Director of GPMx Ltd (healthcare consultancy) 5. Member, Independent Advisory Group for the National Medical and Surgical Clinical Outcomes Review Programme (hosted by HQIP on behalf of NHSE)
Sarah Armstrong	Non-executive Director until 31 March 2022 Chair from 1 April 2022	October 2018 September 2024	Date Date	1. Company director for the flat management company of current residence 2. Chief Executive, The Ewing Foundation, Ovingdean Hall Foundation and Burwood Park Foundation 3. Director of Coffee Porter (family business) 4. Member of West Yorkshire Chairs & Leaders Forum 5. Member HNY Provider Chairs 6. Member HNY CAP Board 7. Member Trustee – NHS Charities Together
Azlina Bulmer	Associate Non-executive Director	November 2022 November 2022 February 2024	February 2024 Date Date	1. Executive Director, Chartered Insurance Institute 2. Familial relationship, Health Education England 3. Chief Operating Officer, Institute of the Motor Industry
Denise Chong	Insight Programme: Non-executive Director	January 2024	Date	1. Trustee, Learning Partnerships Leeds (Feb 2023) 2. Member, Kaleidoscope Learning Trust (KLT) (Dec 2023)
Jonathan Coulter	Finance Director Chief Executive from March 2022	March 2022		No interests declared
Jeremy Cross	Non-executive Director	January 2020	Date	1. Chairman, Tipton Building Society 3. Director and Shareholder, Cross Consulting Ltd (dormant) 4. Chairman, Forget Me Not Children's hospice, Huddersfield

Board Member	Position	Relevant Dates From	To	Declaration Details
				5. Governor, Grammar School at Leeds 6. Director, GSAL Transport Ltd 7. Member, Kirby Overblow Parish Council 8. Stakeholder Non-executive Director, Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Chiara De Biase	Non-executive Director	November 2022 November 2022 May 2024	May 2024 Date Date	1. Director of Support and Influencing, Prostate Cancer UK 2. Clinical Trustee, Candlelighters (Children's Cancer Charity) 3. Director of Health Services, Equity & Improvement, Prostate Cancer UK
Matt Graham	Director of Strategy	September 2021 April 2022	Date Date	1. Member: Local Governing Body, Malton School (part of Pathfinder Multi-Academy Trust) 2. Stakeholder Non-executive Director, Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Jordan McKie	Director of Finance (from July 2023)	August 2022	Date	1. Chair, Internal Audit Provider Audit Yorkshire
Kama Melly	Associate Non-executive Director	November 2022	Date	1. Kings Counsel, Park Square Barristers 2. Bencher, The Honourable Society of the Middle Temple 3. Director and Deputy Head of Chambers, Park Square Barristers 4. Governor, Inns of Court College of Advocacy
Russell Nightingale	Chief Operating Officer	April 2021	Date	1. Director of ILS and IPS Pathology Joint Venture
Emma Nunez	Director of Nursing Deputy Chief Executive from March 2022	No interests declared.		
Andrew Papworth	Non-executive Director	March 2020	Date	1. Chief Finance Officer, Insight222 2. Ambassador for Action for Sport
Laura Robson	Non-executive Director	No interests declared		

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Board Member	Position	Relevant Dates From	To	Declaration Details
Wallace Sampson OBE	Non-executive Director	March 2020 July 2023 August 2023 September 2023 October 2023 August 2024	Current	1. Member of Society of Local Authority Chief Executives 2. Advisory Board Consultant – Commercial Service Kent Ltd. 3. Commissioner – Local Government Boundary Commission for England 4. Chair – Middlesbrough Independent Improvement Advisory Board. 5. Director and Shareholder – Sampson Management Services Ltd. 6. Member – Council of Governors, Leeds University
Alison Smith	Interim Director of Nursing, Midwifery & AHPs	24 March 2025	Current	No interests declared
Julia Weldon	Non-executive Director	November 2022 May 2024	Date	1. Director of Public Health / Deputy Chief Executive, Hull City Council 2. Co-chair of the Population Health Committee, Humber & North Yorkshire Integrated Care Board 3. Voluntary role as Honorary Board Member of the National ADPH.
Angela Wilkinson	Director of People & Culture	October 2019	Date	1. Director of ILS and IPS Pathology Joint Venture

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Clinical Directors, Deputy Directors and Others Attendees (providing advice and support to the Board)

Name	Position	Declaration Details
Emma Anderson	Interim Clinical Director (Children and Young People's Public Health)	No interests declared
Dr Dave Earl	Deputy Medical Director	1. Director, Earlmed Ltd, provider of private anaesthetic services 2. Treasurer, Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice
Emma Edgar	Clinical Director (Long term & Unscheduled Care)	No interests declared
Dr Katherine Johnson	Clinical Director (Planned and Surgical Care)	No interests declared
Dr Natalie Lyth	Clinical Director (Children's and County Wide Community Care)	1. Member, North Yorkshire Local Safeguarding Children's Board and sub-committees. 2. Chair, Safeguarding Practice Review Group. 3. Chair, North Yorkshire and York Looked After Children Health Professionals Network. 4. Member, North Yorkshire and York Safeguarding Health Professionals Network. 5. Member, national network of Designated Health Professionals. 6. Member, Royal College of Paediatrics and Child Health Certificate of Eligibility of Specialist Registration (CESR) Committee and assessor of applications for CESR 7. Familial relationship within Harrogate & District NHS Foundation Trust 8. Member, NHS Safeguarding Strategic Community of Practice for ICBs (Regional).
Dr Matthew Shepherd	Clinical Director (Long Term & Unscheduled Care) Deputy COO	1. Director, Shepherd Property Ltd (March 2019-March 2022)
Shirley Silvester	Deputy Director of Workforce and Organisational Development	No interests declared
Kate Southgate	Associate Director, Quality & Corporate Affairs	1. Familial relationship with Director in NHS England

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Directors and Attendees
Previously recorded Interests – For the 12 months period pre July 2024

Board Member	Position	Relevant Dates From	To	Declaration Details
Sarah Armstrong	Non-executive Director until 31 March 2022 Chair from 1 April 2022	October 2018	31 March 2022	1. Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Jonathan Coulter	Finance Director Chief Executive from March 2022	November 2017	31 March 2022	1. (Interim Chief Executive) Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Richard Stiff	Non-Executive Director (resigned July 2023)		December 2021 February 2022 February 2022 July 2023	1. Director and Trustee of TCV (The Conservation Volunteers) – ceased December 2021 2. Local Government Information Unit (Scotland) Associate – LGIU has now fully merged with LGIU listed as current interest 3. Chair of the Corporation of Selby College – dissolved 28 February 2022 when it became part of the Heart of Yorkshire Group. 4. Director (and 50% owner), Richard Stiff Consulting Limited 5. Director, NCER CIC (Chair of the Board from April 2019) 6. Member, Association of Directors of Children's Services 7. Member, Society of Local Authority Chief Executives 8. Local Government Information Unit Associate 9. Fellow, Royal Society of Arts 10. Member of the Corporation of the Heart of Yorkshire Education Group 11. Stakeholder Non-Executive Director, of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Wallace Sampson OBE	Non-executive Director	March 2020	31 March 2023	1. Chief Executive of Harrogate Borough Council 2. Director of Bracewell Homes – wholly owned Harrogate Borough Council housing company. 3. Chair of Harrogate Public Services Leadership Board

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Board Member	Position	Relevant Dates From	To	Declaration Details
		November 2021	March 2023	4. Member of North Yorkshire Safeguarding Children Partnership Executive 5. Member of Society of Local Authority Chief Executives 6. Director of Brimhams Active - wholly owned Harrogate Borough Council leisure company. 7. Member of Challenge Board for Northumberland County Council. 8. Trustee for the Harrogate District Climate Change Coalition CIO (effective November 2021)

BOARD OF DIRECTORS MEETING – PUBLIC (DRAFT)

Wednesday, 29 January 2025

Held at Trust HQ, Harrogate District Hospital, Harrogate, HS2 7SA

Present:	
Sarah Armstrong	Trust Chair
Jonathan Coulter	Chief Executive
Jeremy Cross (JC)	Non-executive Director, Chair of Resource Committee
Chiara DeBiase (CD)	Non-executive Director, Chair of Audit Committee
Andy Papworth (AP)	Non-executive Director, Chair of People & Culture Committee
Laura Robson (LR)	Non-executive Director, Chair of Quality Committee
Azlina Bulmer (AB)	Associate Non-executive Director
Sarah Shaw (SS)	Non-executive Director (Insight Programme)
Jacqueline Andrews	Executive Medical Director
Jordan McKie	Director of Finance
Russell Nightingale	Chief Operating Officer
Emma Nunez	Executive Director of Nursing, Midwifery and Allied Health Professionals and Deputy Chief Executive
Angela Wilkinson	Director of People & Culture

In Attendance:	
Leanne Likaj	Associate Director of Midwifery
Jimmy Parvin	Deputy Director of Strategy & Improvement
Alison Smith	Deputy Director of Nursing (Safeguarding and Children & Young People)
Kate Southgate	Associate Director of Quality and Corporate Affairs
Lesley Danby	Matron *for item 2 – Patient Story*
Lesley Cullerton	*In attendance for Item 2 – Patient Story*

Apologies:	
Matthew Graham	Director of Strategy
Wallace Sampson OBE (WS)	Non-executive Director
Julia Weldon (JW)	Non-executive Director
Kama Melly (KM)	Associate Non-executive Director

Observers:	
Governors	• Jackie Lincoln (Lead Governor) • Jonathan Allen (Staff Governor) • Andrew Clark (Public Governor) • Mike Fisher (Public Governor) • Rick Sweeney (Public Governor)
Member of the public / press	No members of the public / press

Item No.	**Item**
BD/01/29/1 **1.1**	**Welcome and Apologies for Absence** The Chair welcomed everyone to the meeting. A warm welcome was expressed to Alison Smith, Deputy Director of Nursing (Safeguarding and Children & Young People) and Jimmy Parvin (Deputy Director of Strategy) to their first meeting of the Board.

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1.2	The Chair noted that this would be the last Public Board meeting for the Executive Director of Nursing, Midwifery and AHPs. Thanks were expressed on behalf of the Board for her commitment and dedication to the Trust during her tenure.
1.3	Thanks were also expressed to those attending to observe the meeting as well as a warm welcome to the Trust's new public governors.
1.4	Apologies for absence were noted as above.
	The agenda was taken out of order at this point due to availability of presenters.
BD/01/29/2 **2.1**	**Declarations of Conflicts of Interest and Register of Interests** The register of interests was received and noted.
2.2	**Resolved:** The declarations were noted.
BD/01/29/3 **3.1**	**Minutes of the Previous Board of Directors meeting held on 27 November 2024**
3.2	The following amendment was noted: 14.6 to read *…He noted the risk around Neonatal Care being added to the Maternity Voice Partner and highlighted that this had been discussed with the ICB.*
3.3	**Resolved:** The minutes of the meeting on the 27 November 2024 were approved as an accurate record of the meeting noting the amendment.
BD/01/29/4 **4.1**	**Matters Arising and Action Log** The actions were noted as follows:
4.2	• BD/3/29/36.2 – Board Effectiveness Survey – it was confirmed that the changes to the governance structure continued to embed. In due course a full review will take place. • BD/11/27/13.8 – Assurance from Section 11of Children's Act compliance = action Closed.
4.3	No further matters arising were raised which were not already noted on the agenda.
4.4	**Resolved:** All actions were agreed as above.
BD/01/29/5 **5.1**	**Overview by the Chair** The Chair noted a range of activities that had taken place since the last meeting of the Board.
5.2	The Chair highlighted the following points: • It had been a busy start to the New Year with pressures felt within the organisation and the wider system. This had been exacerbated by the recent cold weather. The Chair on behalf of the Board expressed thanks to colleagues for their continued hard work and dedication. • It was highlighted that it had been two years since HDFT became a registered Domiciliary Care provider. This had played an important role in supporting our patients. • It was noted that two new 0-19 services were joining HDFT - Cumberland, and Westmorland and Furness in April.
5.3	**Resolved:** The Chair's report was noted.

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BD/01/29/6 **6.1** **6.2**	**Chief Executive Report** The Chief Executive presented his report as read. The following points were highlighted: • The annual planning guidance was due to be received by the end of January 2025. • The internal planning process had commenced and a Board workshop session would be held in February 2025 for formal sign off in March 2025. • An update on local systems was provided. In HNY the focus continued on improving urgent care and managing the financial risk in the system, In WYAAT a service review was taking place with the aim of strengthening the delivery of high quality care through our West Yorkshire collaborative. • The Elective Hub at Wharfedale Hospital had been officially opened. • 0 - 19 services for Cumberland, Westmorland and Furness would commence in April 2025 in line with our Great Start in Life ambition. • 0 – 19 services continued to deliver strong performance across the majority of the geographical footprint. • The Urgent Care Pathway remains an area of risk with the ED 4 hour performance in December standing at 67%. • The new stroke pathway between HDFT, York and Leeds facilitated by the West Yorkshire stroke network continued to develop, with the aim to go live as soon as possible. • The month 9 financial position was noted as a deficit of £12.5m which was consistent with previous months' forecasts. • The Corporate Risk Register was noted. It was confirmed that a full review was being undertaken for the new 2025-26 register to be reviewed at the March 2025 meeting of the Board in line with the annual planning process.
6.3	The Chief Executive expressed his thanks to the Executive Director of Nursing, Midwifery and AHPs at her last Public Board meeting, for her contribution to HDFT over the last four years and wished her well for the future.
6.4	The Non-executive Director (LR) noted that some organisations had declared major incidents due to ED pressures. It was queried if any regional organisations had declared such an incident. It was also queried if a local trust did declared such an incident, would it impact on HDFT service delivery. The Chief Executive confirmed that no major incidents had been called by the Trust or locally. The Chief Operating Officer updated the Board on the local system pressures. The Chief Operating Officer highlighted the use of the Opal Escalation Framework as well as the full capacity protocol. A discussion was held on the requirements prescribed by the region of the Trust and wider system should a major incident be declared.
6.5	**Resolved:** The Chief Executive's Report was noted.
BD/01/29/7 **7.1**	**Board Assurance Framework – Summary** The Chief Executive provided an overview on the Board Assurance Framework (BAF). It was confirmed that the BAF focused on assurance regarding the delivery of the Trust Strategy.
7.2	**Resolved:** The Board Assurance Framework Summary was approved.
BD/01/29/8 **8.1**	**Corporate Risk Register** **Resolved:** The Corporate Risk Register was noted.

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BD/01/29/9 **9.1**	**Board Assurance Framework – Best Quality, Safest Care** The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Best Quality, Safest Care.
9.2	This Strategic Ambition had two True North metrics. The first metric was a reduction in moderate and above harm. The second metric was an improved positive patient experience, which had a corporate project linked to it: Patient Experience. Achievement in line with trajectory continues with both metrics.
9.3	The Ambition had one Breakthrough Objective associated with it: Pressure Ulcers. It was noted that there had been a steady decline in hospital and community Grade 3 and above pressure damage since the commencement of the project. As such the threshold had been met to close the project. Moderate and above harm data had further been stratified and the category with the greatest number of incidents was now Diagnostic, Treatment and Procedure. This category encompassed a wide range of issues and an in depth review was required to ascertain clear themes and trends. It was noted that in 2025-26 a breakthrough objective will not be defined and directorates will have their own workstreams to focus on bringing moderate and above incidents down.
9.4	The Corporate Projects associated with this ambition were: • Patient Engagement; • Patient Safety Incident Response Framework – recommended to close, and • Accreditation.
9.5	Both True North metrics were within the Trust's risk appetite (tolerance). There were no corporate risks associated with this ambition.
9.6	The Chair of the Quality Committee confirmed that this element of the BAF had been discussed in detail at the Committee. It was noted that the category for Diagnostic, Treatment and Procedures was wide and that there were no specific areas of concern.
9.7	The Chair of the Quality Committee noted that the PSIRF Project had now closed in the BAF as a corporate project. They queried the patient satisfaction and evaluation of the new process. The Executive Director of Nursing, Midwifery and AHPs noted that this project was to implement PSIRF and as part of the embedding it would be evaluated. The Non-executive Director (CD) noted that PSIRF implementation was also on the internal audit programme.
9.8	**Resolved:** i. The update on the BAF: Strategic Ambition - Best Quality, Safest Care was approved. ii. The Breakthrough Objective: Pressure Ulcers was closed. iii. The Corporate Project: Patient Safety Incident Response Framework was closed.
BD/01/29/10 **10.1**	**Visitors' Charter** The Executive Director of Nursing, Midwifery and AHPs presented the Visitors' Charter. It was confirmed that it had been developed in collaboration with visitors and patients. It was noted that the Quality Committee had reviewed it in detail and had recommended it for approval to the Board.
10.2	The Non-executive Director (AP) noted that the section that highlighted "what you can expect from visitors" noted a zero tolerance approach to violence and aggression. It also noted that visitors *may* be asked to leave if they displayed

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	violence or aggression, rather than *they would be asked to leave.* The Executive Director of Nursing, Midwifery and AHPs confirmed that the Trust operated a zero tolerance approach.
10.3	The Non-executive Director (CD) queried where the Charter would be displayed. The Executive Director of Nursing, Midwifery and AHPs confirmed there would be a full communication plan that included display on the HDFT website as well as screens throughout the hospital.
10.4	**Resolved:** The Visitors' Charter was approved.
BD/01/29/11	**Board Assurance Framework – Great Start in Life**
11.1	The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on this element of the BAF.
11.2	This Strategic Ambition had three True North metrics.
11.3	The first metric was children at risk of vulnerabilities. It was highlighted that this workstream was linked to a future research programme. It was noted that interim measures for monitoring outcomes were in place and reviewed via performance meetings.
11.4	The second metric was an improved positive patient experience. This is linked to the Patient Experience Corporate Project. The designated counter measures for this metric have been recommended to be closed.
11.5	The third metric was maternity harm events. Further details of this metric were noted in the: Strengthening Maternity and Neonatal Safety and Maternity Incentive Scheme as part of the Board agenda.
11.6	All True North metrics were within the Trust's risk tolerance.
11.7	There was one corporate risk associated with this ambition: CRR34: Autism Assessment currently rated at 15.
11.8	The Chair of the Quality Committee had nothing further to note on this Ambition.
11.9	**Resolved:** i. The update on the BAF: Strategic Ambition - Great Start in Life was approved. ii. The True North Metric: Children's Patient Experience was closed.
BD/01/29/12	**Strengthening Maternity and Neonatal Safety**
12.1	The Executive Director of Nursing, Midwifery and AHPs and the Associate Director of Midwifery presented the November and December 2024 Strengthening Maternity and Neonatal Safety Reports to the Board.
12.2	The reports provided a summary and update on the board level safety measures for the months of November and December 2024 as set out in the Perinatal Quality Surveillance Model (Ockenden 2020).
12.3	The report provided details on: • Perinatal Culture and Leadership Programme Overview, • Maternity Unit Diverts,

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	• Avoiding Term Admissions in Neonatal Units (ATAIN), • Saving Babies Lives Care Bundle, • Perinatal Mortality Review Tool (PMRT), • Maternity Incentive Scheme submission, • Maternity Strategy had been published, and • LMNS assurance visit – initial positive feedback provided and awaiting formal report.
12.4	The Associate Director of Midwifery noted that there were no new concerns to raise with Board.
12.5	The CQC Maternity Survey was also reported. Of the 57 questions asked Harrogate performed about the same as all other Trusts for 47 questions, somewhat better than expected in four questions, better than expected in six questions, and significantly better in two questions in comparison with last year. No questions scored somewhat worse, worse or much worse than expected. In relation to the Triage: Assessment and Evaluation section of the survey Harrogate maternity services scored as the fifth highest performing Trust in England with a score of 9.1 in comparison to a National average score of 8.4.
12.6 **12.7**	The Board expressed their thanks to the Associate Director of Midwifery for her leadership
12.8	The Chief Executive reminded the Board that the only *must* do action following the CQC Inspection into Maternity in 2023 was in relation to triage. It was encouraging to note that this area of the service had scored top 5 in the country in the CQC's survey.
12.9	The Associate Director of Midwifery noted that the Maternity Voices Partnership Chair had stepped down from the role with immediate effect. The Partnership had commenced a recruitment process. **Resolved:** The Strengthening Maternity and Neonatal Safety report was noted.
BD/01/29/13 **13.1**	**Maternity Incentive Scheme** The Executive Director of Nursing, Midwifery and AHPs and the Associate Director of Midwifery took the report and associated documentation as read.
13.2	The report detailed the standards required to demonstrate full compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year six.
13.3	Year six of the Maternity Incentive Scheme was launched on 2nd April 2024. The Maternity Incentive Scheme (MIS) is a financial incentive program designed to enhance maternity safety within NHS Trusts. It rewards Trusts that can demonstrate they have implemented a set of core safety actions, ultimately aiming to improve the quality of care for women, families and newborns. The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not achieve all safety actions must develop an action plan for safety improvements and can apply for discretionary funding to support this. ICBs must ensure that any discretionary funding awarded is utilised to support the action plan. The report provided details of the position and progress with compliance with the ten maternity safety actions.

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13.4	All ten maternity safety actions were rated as Green, i.e. all standards met. A full evidence set was available for review.
13.5	It was noted that the MIS report had been discussed by the Quality Committee. A recommendation had been made from the Quality Committee to the Board to approve the MIS submission, declaring compliance with MIS Year Six standards.
13.6	**Resolved:** (i) ATAIN Action Plan approved. (ii) Medical Staffing Guideline Action Plan approved. (iii) Neonatal Medical & Nursing Workforce Action Plan approved. (iv) Training Plan and Training Action Plan approved. (v) The Trust Board were satisfied that the evidence provided demonstrated achievement of the NHSR Maternity Incentive Scheme ten maternity safety actions and safety actions' sub-requirements as set out in the safety actions and technical guidance document. (vi) The Trust Board granted authority to the Chief Executive to sign the Maternity Incentive Scheme Board declaration form prior to submission to NHS Resolution.
BD/01/29/14 **14.1**	**Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships** The Chief Operating Officer provided the Board with an update on the Strategic Ambition: Person Centred, Integrated Care, Strong Partnerships.
14.2	This Strategic Ambition had four True North metrics.
14.3	Metric 1: 4 Hour ED standards – it was noted that by March 25 a target of 78% was set. In the December 2024 compliance was at 69% which was 12th regionally. The stretch target was noted as 85% compliance by March 2026 and 95% compliance by March 27.
14.4	Following stratification of data, the greatest contributor to the delivery of this metric was the time to inpatient beds. The target time was set at 120 minutes. This was not currently being achieved, with the exception of paediatrics. It was noted that there has been significant bed and flow pressures linking to rising acuity and respiratory viruses in Quarter 3. This had led to a deterioration in performance. Winter planning measures were highlighted to mitigate the increased pressures. A Corporate project on Discharge had been commissioned to support the workstream further.
14.5	This metric was currently outside of the risk appetite.
14.6	Metric 2: Length of stay for frailty patients – the target was to be within the top quartile for length of stay. The current position was noted as in the middle of the table. It was highlighted that the Discharge Project would impact on delivery.
14.7	Metric 3: Elective Recovery Standard (RTT) – the target is for no patients to be waiting over 52 weeks for treatment by March 2026. This was currently on track to deliver. By March 2027 there was a national stretch target of performance to be back to RTT standard of 92%. The Trust was currently on track to deliver this with current compliance of 68%.

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14.8	Metric 4: Cancer 62 day treatment standard – the target was for less than 40 patients over 62 days by 1st April 2025. This was currently being achieved.
14.9	The Chief Executive noted the encouraging trajectory for both RTT and Cancer targets.
14.10	**Resolved:** The update on the BAF: Strategic Ambition - person centred, integrated care, strong partnerships was approved.
BD/01/29/15 15.1	**Board Assurance Framework – Finance** The Director of Finance provided the Board with an update on the Enabling Ambition: Finance.
15.2	This Ambition had one True North Metric: Financial Sustainability. There were no breakthrough objectives linked to this area. There was a wide range of corporate projects in place which had direct and in-direct positive implications for the financial position.
15.3	The risk rating was now at 16 and this was outside of the Trust's risk appetite.
15.4	At month 9 the Trust was reporting a deficit of £12.5m against the system plan of £3.6m.
15.5	It was noted that the elective recovery comes with positive income which impacts the Trust bottom line. The control environment was benchmarked as positive.
15.6	There were two corporate risks associated with this Ambition. The risk in relation to local authority funding was noted as anticipated to decrease in risk level following discussions with partners.
15.7	The Director of Finance highlighted that there may be a need for cash support in Month 12.
15.8	The Non-executive Director (JC) noted that in early iterations of planning guidance it include productivity guidance. It was encouraging to note that Harrogate had an estimated improvement opportunity of 3.2% which was lower than the peer group.
18.9	The Non-executive Director (LR) requested clarity on local authority contracts and if the risk was anticipated to reduce by the next Board meeting - did that indicate that the money would be transferred to us. The Director of Finance noted that the discussions were moving in a positive direction, but full confirmation had not been reached.
15.10	**Resolved:** The update on the BAF: Strategic Ambition – Finance was approved.
BD/01/29/16 16.1	**Board Assurance Framework – At Our Best: Making HDFT the Best Place to Work** The Director of People and Culture provided the Board with an update on the Strategic Ambition: At Out Best: Making HDFT the Best Place to Work.
16.2	This Strategic Ambition had two True North metrics.
16.3	Metric 1: Staff Engagement with a focus on continually improving the Employee Engagement Score.

Item No.	Item
16.4	Metric 2: Staff Availability. It was noted that when the programme had commenced the greatest impact on this metric related to vacancies. A Breakthrough objective had been developed to support this. Due to the progress made, it was recommended that the Breakthrough Objective would close. The greatest impact on this metric was now noted as sickness absence. It was highlighted that the People and Culture Committee had discussed this in detail. The Staff Survey results would be released from embargo next month and this would support in reviewing this indicator.
16.5	Both True North metrics were below the Trust's risk tolerance.
16.6	There were no Corporate Risks linked to this element of the BAF at this time.
16.7	The Chair of the People and Culture Committee noted that following a previous concern raised by the Guardian of Safe Working a Gemba to the Surgical Assessment Unit has taken place in the Committee. The positive changes were noted. In addition the Committee had reviewed the action plans from the Guardian of Safe Working. The Chair of the Committee confirmed that the action plans were being reviewed appropriately by directorates and assurance was provided. In addition, it was confirmed that a new Guardian of Safe Working had been appointed and that they would join Committee in March.
16.8	The Chair of the Committee noted that internal audit reports were an item on the agenda for all sub -committees but no relevant reports had been received.
16.9	**Action –** relevant Internal Audit Reports to be submitted to the overseeing Committee.
16.10	The Non-executive Director (LP) noted that a meeting had taken place with internal audit to discuss next year's plan.
16.11	**Resolved:** i. The update on the BAF: Strategic Ambition - At Our Best, making HDFT the best place to work was approved. ii. The Breakthrough Objective: Vacancy Whole Time Equivalent (WTE) closed.
BD/01/29/17 **17.1**	**Board Assurance Framework – Enabling Ambition: Digital Transformation to Integrate Care and Improve Patient, Child and Staff Experience** The Executive Medical Director provided the Board with an update on the Enabling Ambition: Digital Transformation.
17.2	The Enabling Ambition had one true north metrics: Metric 1: Quality & Safety – systems which enable staff to improve quality and safety of care.
17.3	It was noted that the BAF circulated was not fully updated. The Executive Medical Director therefore gave an overview of the programmes of work that had taken place in 2024-25. It was noted that the programme for 2024-25 had completed and that revised goals for 2025-26 were in development.
17.4	**Resolved:** The update on the BAF: Enabling Ambition: Digital Transformation was approved and the programme closed for 2024-25.
BD/01/29/18 **18.1**	**Board Assurance Framework – Enabling Ambition: Healthcare Innovation to Improve Quality & Safety**

Item No.	Item
	The Executive Medical Director and the Deputy Director of Strategy provided the Board with an update on the Enabling Ambition: Healthcare Innovation.
18.2	This Enabling Ambition had four True North metrics: Healthcare Innovation, HDFT Impact, Children's Public Health and Clinical Trials. All workstreams were on track and remained below the Trust's risk appetite.
18.3	There are no Breakthrough Objectives or Corporate Projects linked to this Ambition. There was however, a Strategic Programme: HDFT Impact linked.
18.4	The Executive Medical Director confirmed that the 2025-26 True North metrics were in development. The Deputy Director of Strategy provided an overview of HDFT Impact.
18.5	**Resolved:** The update on the BAF: Enabling Ambition: Healthcare Innovation was approved.
BD/01/29/19	**Board Assurance Framework – Enabling Ambitions: An Environment that Promotes Wellbeing**
19.1	The Deputy Director of Strategy provided the Board with an update on the Enabling Ambition: Environment.
19.2	The Enabling Ambition had three True North Metrics: A patient environment that promotes wellbeing; An environment and equipment that promotes best quality, safest care; Minimise our impact on the environment.
19.3	All True North metrics remained below the Trust's risk appetite.
19.4	There were no Breakthrough Objectives or Corporate Projects linked to this ambition.
19.5	The Non-executive Director (LP) queried if the Corporate Risks in relation to Fire Safety were on track to reduce in risk. It was confirmed that this was the case.
19.6	**Resolved:** The update on the BAF: Enabling Ambition: An Environment that Promotes Wellbeing was approved.
BD/01/29/20	**Patient Story**
20.1	Lesley Cullerton, supported by Lesley Danby (Matron) attended the Board to share the story of her husband. Lesley shared with the Board the details of the life she shared with her husband Steve. She discussed how they had met, their hobbies and interests, their families and the life they had planned.
20.2	Lesley shared that Steve had sadly died from bowel cancer. She explained to the Board the difficulties that they had faced with a late diagnosis and subsequent treatment.
20.3	The Matron explained to the Board that following review and investigation a number of changes in process had been implemented to prevent others experiencing a similar situation.
20.4	The Board were extremely moved by Lesley's story. Lesley spoke with clarity and dignity. The Board noted how important it was to hear from Lesley and that her and her husband's experience would stay with them and be a focus of their decision making moving forward.

Item No.	Item
20.5 **20.6**	The Board expressed their sincere thanks to Lesley for her bravery in sharing her story. **Resolved:** The patient story was noted.
BD/01/29/21 **21.1** **21.2** **21.3**	**Escalations from Sub-Committees of the Board** The Chair welcomed Committee Chairs to raise any areas that they wished to escalate from the Committees that had taken place earlier in the day. The Chair of the Quality noted that a discussion had been held on the 0 – 19 services and complexity of safeguarding children. The Chair of the Committee also noted the risk in relation to Autism waiting times. **Resolved:** The escalations were noted.
BD/01/29/22 **22.1** **22.2** **22.3** **22.4** **22.5** **22.6** **22.7**	**Audit Committee Update** The Chair of the Audit Committee provided an overview of the discussions held at the Audit Committee. The last meeting had been held on the 4th December and a wide range of topics had been discussed including a single tender item on professional development. An internal audit update had been received and noted the progress made. It was highlighted that some audits were on a slight lag but the plan would be delivered on time. It was noted that 60% of the plan had been concluded at the time of the meeting. Non-executive Directors had met with internal audit on proposed plans for 2025-26. A recommended plan would be discussed at the March 2025 Committee, prior to which it would be circulate to all Non-executive Directors for review. Two Limited Assurance reports were received and the two relevant executive directors had attended to discuss them. The Director of Strategy attended for the Capital Programme report and the Managing Director of HIF for catering provision. The Committee had full assurance on both plans for commensurate improvements at pace. The fraud and bribery policy was approved. **Resolved:** The Chair's update was noted.
BD/01/29/23 **23.1** **23.2**	**Use of the Trust Seal** The Company Secretary (Associate Director of Quality & Corporate Affairs) presented the report as read. **Resolved:** The details of the use of the Trust Seal were approved by the Board.
BD/01/29/24 **24.1**	**Any Other Business** No further business was received

Item No.	Item
BD/01/29/25 **25.1**	**Board Evaluation** It was noted that a wide range of business had been discussed and the powerful impact the patient story had on the Board.
BD/01/29/26 **26.1**	**Date and Time of the Next Meeting** The next meeting will be held on Wednesday, 26 March 2025.
BD/01/29/27 **27.1** **27.2**	**Confidential Motion** **Resolved:** to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7, Section 18 (E), (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

Signed: ----------

Dated: ----------

Board of Directors (held in Public) Action Log for March 2025 Board Meeting							
Minute Number	**Date of Meeting**	**Subject**	**Action Description**	**Responsible Officer**	**Due Date**	**Comments**	**Status - completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.**
BD/3/29/36.2	29 March 2023	Board Effectiveness Survey	Discussions to be held at the August 2023 Board workshop regarding further developments as a result of the survey.	Associate Director of Quality and Corporate Affairs	Ongoing	Noted that significant work has been completed with regards to the Corporate Framework. Revised agendas, membership and timings are being put in place in Autumn 2024 for Sub-Committees and the Trust Board in Public. This item will remain open as part of the ongoing review.	Ongoing
BD/01/29/16.9	29 January 2025	Board Assurance Framework – At Our Best: Making HDFT the Best Place to Work	Relevant Internal Audit Reports to be submitted to the overseeing Committee.	Associate Director of Quality and Corporate Affairs	March 2025	Actioned	Closed

BOARD OF DIRECTORS (PUBLIC)
26th March 2025

Title:	Chief Executive's report
Responsible Director:	Chief Executive
Author:	Chief Executive

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting. The report highlights key challenges, activity and programmes currently impacting on the organisation.	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	x
	Person Centred, Integrated Care; Strong Partnerships	x
	Great Start in Life	x
	At Our Best: Making HDFT the best place to work	x
	An environment that promotes wellbeing	x
	Digital transformation to integrate care and improve patient, child and staff experience	x
	Healthcare innovation to improve quality	x
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
MARCH 2025

CHIEF EXECUTIVE'S REPORT

National and system issues

1. As the Board will no doubt have seen through various channels, there have been a number of key national announcements made over the last few weeks. These have included how the operating model of the NHS will change in the future, significant NHS leadership changes, and a response to the current position in relation to plans for 2025/26.

2. Since the last Board meeting, Amanda Pritchard has announced that she is stepping down as Chief Executive of NHS England, to be replaced by Jim Mackey in an interim capacity. Other members of the NHSE leadership team have also announced their departure, and a new team has recently been appointed to work for Jim Mackey.

3. This new team are a transition team, because the other significant announcement was the fact that NHSE will be abolished and be folded into the DHSC.

4. At this point I would just like to place my thanks to Amanda and her team for all that they have done to lead the NHS over the last few years, which have been years like no other, with the CoVid pandemic and the recovery from what was a generational event.

5. The announcement in respect of NHSE came within a context of planning for the immediate new year, and also putting the foundations in place in advance of the launch of the NHS 10 year plan, due in a few months.

6. In respect of 2025/26 plans, the Board will know that the key priorities are improving urgent care, reducing waiting lists/times, improving access to primary care, improving access for children and young people to mental health services, and living within the financial allocation available. The financial context is that the approach is much more about determining what can be delivered within the money available rather than determining what needs to be done and then work out how much money is required.

7. The first draft NHS plans submitted at the end of February highlighted a £7bn initial funding gap. This triggered a financial reset session in early March. The key messages were to complete planning as soon as possible, to get all of the funding transparently on the table, and to focus on managing risk.

8. This was complimented by the need to reduce the cost of the NHS operating model, with a 50% reduction in DHSC/NHSE costs by October, a 50% reduction of ICB costs by October, and also a 50% reduction in the growth in corporate costs since the pandemic.

9. These series of announcements have been received in a number of ways. There is general support for the direction of travel that reduces the current duplication, improves the clarity of accountability and aligns this with autonomy to act at local level and deliver better services. There is also a recognition though that this will be extremely unsettling for many

colleagues who work in NHSE/ICBs, with the completely understandable distraction that this will cause.

10. From our perspective we clearly need to respond to the context within which we work, rather than simply react to these changes.

11. Our approach will be to acknowledge the uncertainty and understandable distraction, but get on with delivering our plans for 25/26 that meet the improvement priorities and improves outcomes and productivity. Specifically in relation to corporate services, we have a waste reduction requirement to deliver internally, and we have begun discussions across WYAAT as part of our WYAAT service review that we went through at our Board workshop last month that covers both clinical services and corporate services. Potentially, we (with WYAAT partners) will need to expedite some of these discussions more quickly, but there is nothing in the national thinking that is counter to improvements in quality, sustainability, and productivity that we were thinking through locally.

12. In relation to our ongoing work within HNY ICB, we are currently working through the plans for next year, given the context I have outlined above. As I write this report, our operational, financial and workforce plans are triangulated and deliver the key improvement priorities. There remains though a financial gap of £20m between the resource we need to deliver the services we provide – and provide productively – and the indication from the ICB about the level of funding available. I will update the Board at the meeting about further developments, but the focus is on agreeing a risk share approach across the system to effectively manage financial risk and ensure that there is alignment between financial flows and the accountability for delivery.

13. For 2024/25, as the Board will be aware, the main risk to the HNY system was the forecast financial deficit of c£35m. Non-recurrent funding has been secured that mitigates that risk and will ensure that all organisations achieve financial balance this year.

14. In respect of West Yorkshire and WYAAT in particular, we had an all-executives meeting in early March to go through the initial outputs of the service review that we had collectively undertaken. This will now be taken forward in the new year. As part of this, we are organising a HDFT/LTHT executive meeting to specifically focus on where we can work together. This will initially focus on how we utilise Wharfedale Hospital to best effect. We have also agreed to put in a structured governance arrangement to oversee the developing partnership between the two Trusts.

15. I am pleased to say that the new stroke pathway has now been implemented between ourselves, LTHT, YSFT, and YAS. We will review the impact of this agreed pathway which we are confident will improve the resilience and quality of service received by our population.

16. At a North Yorkshire partnership level, we have a NY Place Board in early April to agree a way forward in terms of using a Joint health committee to deliver improved integrated services across health and care. A workshop is planned for a few months' time, to develop a programme of work that will no doubt also cover the approach to neighbourhood health and the community services offer within that.

17. As part of developing integrated services in the Harrogate and District area, we are in productive discussions with a GP practice in Ripon, supported by the NY Place, to support the provision of primary care. I will be able to update more fully at the meeting next week.

18. As the Board is aware, we work in partnership with Local Authority colleagues across nine areas in relation to the provision of our 0-19 services. From April, we will be working across eleven areas, as we take on the 0-19 services for Cumberland and Westmoreland & Furness councils. Myself and other HDFT colleagues attended welcome events last week to meet with our new staff, which was a very positive experience. We are looking forward to integrating teams into HDFT, learning what they do well, providing support to improve, and working alongside Local Authority commissioners to develop the model of care that will improve outcomes for children and families in this area.

HDFT issues

Introduction

19. The first part of this report has focused significantly on the changes that are happening at national and regional level, whilst also outlining the range of engagement we have with partners across a number of systems to deliver high quality care. Given the raft of announcements, this has necessarily been more extensive than usual.

20. These external changes are really important to understand and respond to, but as I regularly say, health and care services are services delivered to people by people, and without colleagues who are not just talented but reflect our values, we wouldn't be able to deliver the services we deliver across our hospital and communities. It is vitally important to ensure that we continue with our approach to delivering improvement, that supports colleagues and creates an environment in which they can deliver of their best. Whilst there is significant distraction externally, we always need to recognise the care and support delivered every day to thousands of people in many communities, by those who make up HDFT. It is important to always remember this as we work through some of the challenges that we inevitably have to deal with.

Our people

21. We continue to have good staffing levels across most parts of the Trust. In particular, our ward staffing levels remain positive, and this continues to translate into a reduction in the use of agency staff. We remain focused on staff availability as a key indicator within the HDFT Impact programme, with a revised emphasis on staff retention.

22. The national staff survey results have been publically released. These show that we continue to get good feedback from our colleagues and compare favourably across regional and national comparators. We rank around the top quartile in terms of these results, and we will be working on areas to improve. These are the most important indicators for me personally, and we will remain ambitious to truly be a great place to work.

23. As described above, the strategic developments in relation to both the 0-19 expansion and Ripon primary care, mean that we are currently undertaking TUPE processes. These are going very well and will be concluded shortly.

Our Quality

24. As I mention in most reports, there continues to be considerable pressure across the country in respect of urgent care demand. We are now through the winter period and this has enabled us to reduce the bed capacity on the hospital site by closing our escalation beds. Throughout the winter we have been focussed on maintaining the quality and safety of our services, and this has largely been delivered. I do recognise though, that the urgent care pathway does not always deliver the quality of service that we would want, and it remains a key improvement objective for 2025/26.

25. We have undertaken a thematic review of the 12 never events that have occurred over the last four years.

26. This review has shown that there are themes evident throughout the never events which have occurred at HDFT in the last 4 years. The review has shown that learning from never events has not always been embedded trust-wide, meaning similar never events have taken place in subsequent years. This has led to the need for safety recommendations/actions to be repeated on multiple occasions.

27. A near miss never event was reported earlier this month. This occurred within the endoscopy pathway, which is an area where we have experienced these issues previously. An urgent safety review has taken place, and this will be discussed at Quality Committee this month. This reinforces the work we need to do following the thematic review that we have undertaken.

28. We had no maternity diverts within the month of February. This is an Impact priority for the Directorate.

29. Our moderate and above harm incidents have reduced over the last twelve months by around 20%. This is a real success story and demonstrates a tangible benefit of our Impact programme, which has focused on this throughout the year. We are working through the priorities for 2025/26 as part of our planning process.

Our Services

30. Our 0-19 services continue to deliver strong performance across the majority of our geographic footprint and across the vast majority of the KPIs that we measure ourselves against. Of the 45 key mandatory indicators across our nine services, we are delivering against 43.This is very positive and we are engaging some 0-19 teams now in the roll out of HDFT Impact, as we look to improve and deliver strong outcomes.

31. As I have mentioned above, we are in the process of mobilising two new services, with the Directorate and corporate teams working effectively to ensure a safe transition. We know that the performance of the services we are taking on does not match our existing services, so a focus for the next 12 months will be to deliver the standards we consistently deliver across our footprint into our new areas.

32. Our urgent care pathway remains an area of concern in terms of delivering the quality of service we would like to our population. Our ED 4 hour performance has improved in January and February when compared with October – December, and the position in March to date is further improved. The challenge we face and will need to resolve in 2025/26, is to reduce the variability of performance and consistently sustain some of the improvements that we make. This remains a high priority. As part of the fact that the HNY ICB is now in Tier 1 for urgent care, we meet with the national and regional teams in respect of support to improve the delivery of urgent care in Harrogate. Whilst we perform to a standard that compares favourably with a number of Trusts we are welcoming any support that external bodies can provide. The initial support offer includes help with Internal Professional Standards, which will be well received.

33. In relation to cancer, as mentioned last time, this continues to be a real success story for this year in terms of the improvements that have been made in relation to both our FDS standard and 62 day standard. These are important improvements for the patients we serve.

34. We continue to deliver our elective recovery plan, and we have significantly reduced the number of over 52 week waiters. There will be a number of patients that will still have waited over 52 weeks at the end of March. This is due to the need to undertake capital works within the theatre complex, and the subsequent difficulty in providing alternative slots for patients. The catch up will take place in Q1 2025/26, when we will eliminate all over 52 week wait patients. This is significantly ahead of the elective milestones nationally, but is slightly disappointing that we will not quite be able to deliver this within this financial year.

35. I have referenced the commissioning of dental services previously, and I am pleased to say that following constructive system discussions, that we will be appropriately funded to deliver the community dental service for 2025/26. This is a temporary solution whilst the ICB looks to commission an alternative provider in future years.

Our money

36. Our forecast outturn continues to be a deficit of £16.4m. However, as noted earlier, through positive discussions across the system, we will receive additional funding to eliminate this deficit and deliver a breakeven position at the end of the year. This contribution is recognising the grip and management of our finances by our teams through this year and the confidence that the external system has in us to continue to deliver our services as productively as possible.

Corporate Risk Register

37. Since the last meeting of the Board in January, no new risks have been added to the Corporate Risk Register. I can confirm that all risks on the Corporate Risk Register have been reviewed in month by the relevant Directorates, Corporate Services, and the Executive Team. As an Executive Team, we have reviewed the risks and the potential impact on the Trust strategy. Any corporate risks impacting on the Trust strategy are detailed in the relevant sections of the Board Assurance Framework. I can confirm that

one risk has changed in rating on the Corporate Risk Register –*Managing the risk of injury from fire* – this has now met its target rating of 10. Once noted at the Board this will be removed from the Corporate Risk Register to manage at operational level.

Other

38. Our capital programme continues to be delivered. Contractors are on site as part of the construction of our new theatre and imaging building, and we remain on track with our EPR programme.

39. The PLACE results have been published (the environmental assessment of some of our services) and I am pleased to say that our ward food provision is now in the top quartile nationally. The Board will remember the more concerning outcome two years ago, and it is positive to recognise the improvement made.

40. Our digital exemplar ward (Wensleydale) has been shortlisted for a HSJ digital award. We will know the outcome later in the summer, but congratulations are due to all involved.

41. As the Board is aware, Emma is leaving us officially at the end of March. We have undertaken two recruitment processes recently, to appoint a Director of Nursing, Midwifery, and AHPS, and also to appoint from within the Executive Team a Deputy Chief Executive.

42. I am pleased to report that we have appointed Breeda Columb from LTHT as our new Director of Nursing, Midwifery and AHPs. Breeda will start in a couple of months, and in the meantime, I'd like to thank Alison for taking on the interim role until Breeda commences her time here at HDFT.

43. I am also pleased to report that I have appointed Russell Nightingale as Deputy Chief Executive, in addition to his Chief Operating Officer role.

44. Finally, it was great to attend our annual KITE awards event in Durham earlier this month. This was such a positive and uplifting experience, as we celebrated the contribution of many colleagues to the work that we do across HDFT. This was a real reminder of the collective talent that we have at HDFT, and that if we focus on supporting and empowering all of our colleagues we will get great outcomes for our population.

Jonathan Coulter
Chief Executive
March 2025

HDFT – BOARD ASSURANCE FRAMEWORK 2025-2026

HDFT has set its Strategy with an overall purpose of improving the health and wellbeing of our patients, children and communities. To do this we have set our True North Ambitions: to deliver the best quality, safest care; to provide person centred, integrated services through strong partnerships; to give our children and young people a great start in life and to be a great place to work with the right people with the right skills, in the right roles. These will be supported by a strong financial foundation and by our three enabling ambitions to provide care and working environment that promotes wellbeing; to use digital transformation to integrate care and improve patient, children and staff experience; and to be innovative to improve quality and safety.

To support our Strategy, HDFT have set our risk appetite within 6 domains:

Domain	Appetite	
Clinical	Minimal *Threshold – 10*	Appetite for **taking very limited clinical risks** if essential to patient care and outcomes, aiming to optimise patient experience. We will ensure that capacity is planned at a level to meet demand within both our acute setting and our community framework, our appetite for capacity planning is *Cautious.* The Trust is supportive of innovation and has an *open* (high) risk appetite in pursuing innovation and challenging current working practices without compromising the quality of patient care.
Operational	Cautious *Threshold - 12*	Meaning that we have an **ongoing commitment to meeting minimum good practice standards.** We will seek to priorities upgrades and business cases based on our desire to meet these standards. We will not accept operational risks that could directly affect upon the safe delivery of care. Where the operational risk is to Health and Safety, the trust holds a *minimal* appetite and aims to protect the health and wellbeing of our patients and colleagues by delivering services and environments in line with health and safety laws and guidelines

Domain	Appetite	
Financial	Cautious *Threshold - 12*	Value for money and patient care and outcomes being a key factor in our decision-making. We will accept risks that have **limited financial impact or losses** on the basis that there may be upside opportunities with the safe and effective delivery of patient care, but we will not accept risks that may lead to material variances to forecast, reporting misstatements or unplanned overspend against our agreed revenue control target. The trusts recognises supply chain management requires fluidity and has an *Open* appetite for managing suppliers in a manner that protects our interests and service to our patients and service users. We have a zero-tolerance *(Averse)* approach to fraud.
Workforce	Cautious *Threshold - 12*	We will only **accept limited risks if by taking them we could yield improvements** to our patient and service user outcomes and experience. We will not accept risks if this is not the case.

Domain	Appetite	
Reputational	Minimal *Threshold – 10*	We endeavour to have systems and processes in place that **inspire confidence in our patients and the public**. HDFTs appetite overall for reputational risk is *minimal.*
Regulation	Averse *Threshold – 5*	Meaning that we **have zero appetite** for any management decisions that present risks to HDFT maintain its CQC registration or compliance with the law. We will deliver our strategic ambitions as outlined in our Trust Strategy and hold a *Cautious* approach to strategic planning.

Summary of Risk

Summary of Activity since last report:

The Board Assurance Framework for 2024-25 is due to be closed down at the March 2025 Trust Board in Public.

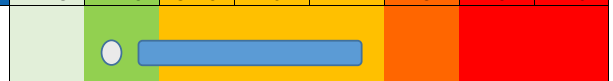
This is the summary of the Board Assuramce Framework March 2025. Of note:

- The Risk Appetite ratings have been amended in line with the Risk Management Policy. The threasholds have been altered as follows. Minimal has a threshold of 10, reduced from 12. Cautious has a threshold of 12, reduced from 16. Adverse has a threshold of 5, reduced from 8. This is inline with national best practice.
- Both Financial True North Metrics and the Person Centred – ED Four Hour Wait are above our Risk Appetite.

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Best Quality, Safest Care	**Ever Safer Care**	**Moderate & Above Harm**	**Clinical: Minimal**								
	Excellent Outcomes										
	A positive experience	**Patient Experience**	**Clinical: Minimal**								

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Person Centred, Integrated Care, Strong Partnerships	The best place for person centred , integrated care	4 hour ED standard	Operational: Cautious	
	An exemplar system for the care of the elderly	Admissions of People with frailty	Operational: Cautious	
	Equitable, Timely Access to Best Quality Planned Care	18 Week RTT	Operational: Cautious	
		Cancer – 62 day Treatment Standard	Operational: Cautious	
Great Start in Life	National Leader for Children & Young People's Public Health Services	Children at Risk of Vulnerability	Clinical: Minimal	
	Hopes for Healthcare	Children's Patient Experience	Clinical: Minimal	
	High Quality Maternity Services	Maternity Harm Events	Clinical: Minimal	
At Our Best – Making HDFT the Best Place to Work	Looking After our people	Staff Engagement	Workforce: Cautious	
	Belonging			
	Growing for the future	Staff Availability	Workforce: Cautious	
	New ways of working			
Finance	Financial Sustainability	Annual Breakeven	Financial: Cautious	
		System Oversight Framework Rating	Financial: Cautious	

Ambition	Workstream	True North Metric	Ambition Metric	Risk Appetite
An Environment that promotes wellbeing	Wellbeing	All	Capital Programme Delivery (Spend vs Budget)	Operational: Cautious
	Quality & Safety		PAM >moderate improvement	Operational: Cautious
	Environmental Impact		Natural gas consumption	Operational: Cautious
Digital Transformation	Well Led		Achieve a score of 5/5 across all seven What Good Looks like (WGLL) pillars	Operational: Cautious
	Ensuring Smart Foundations			Operational: Cautious
	Safe Practice			Operational: Cautious
	Support People			Operational: Cautious
	Empower Citizens			Operational: Cautious
	Improving Care			Operational: Cautious
	Healthy Populations			Operational: Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Healthcare Innovation	**Healthcare Innovation**	**Adopt / develop health innovations that improve the health and care of our patients and CY&P**	**Operational: Cautious**	
	Children's Public Health Research	**To be a leading trust for 0-19 research and undertake research and evidence based around our CYP populations needs.**	**Operational: Cautious**	
	Research Studies	**To be a self funding department , providing opportunities for all potential participants to have access to research.**	**Operational Cautious**	

Key:
Risk Appetite threshold

Current Risk Level

STRATEGIC AMBITION: BEST QUALITY, SAFEST CARE 2024-2025

Our ambition is to provide the best quality, safest care, where quality is defined by safety, effectiveness and patient experience. Through continuous learning and improvement we will make our processes and systems ever safer – we will never stop seeking improvement. We want excellent outcomes for our patients and the children and young people we support which improve their health, wellbeing and quality of life – we will do this by providing effective care based on best practice standards. We want every patient, child and young person to have a positive experience of our care – we will do this by listening and acting on their feedback to continuously improve.

GOALS:

Safety

Ever safer care through continuous learning and improvement

Effectiveness

Excellent outcomes through effective, best practice care

Patient Experience

A positive experience for every patient by listening and acting on their feedback

GOVERNANCE:

Quality Framework

- Board Assurance: Quality Committe
- Programme Board: Quality Governance Management Group (QGMG)
- SRO: Executive Director of Nursing, Midiwfery & AHPs and Executive Medical Director
- Operational Lead: Associate Director of Quality & Corporate Affairs

True North Metrics (Executive Lead: 10-15 Year deliverable)

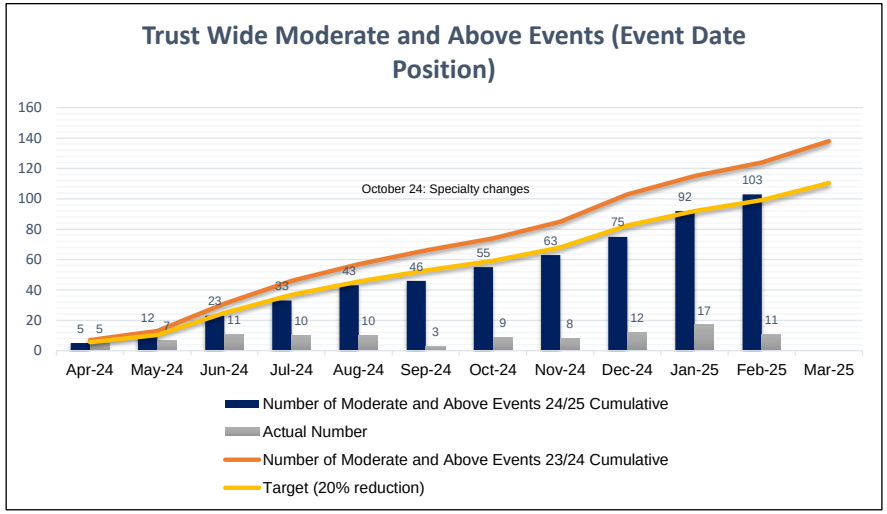
1. • **Eliminating Moderate & Above Harm**
2. • **Patient Experience Positive Response Rates**

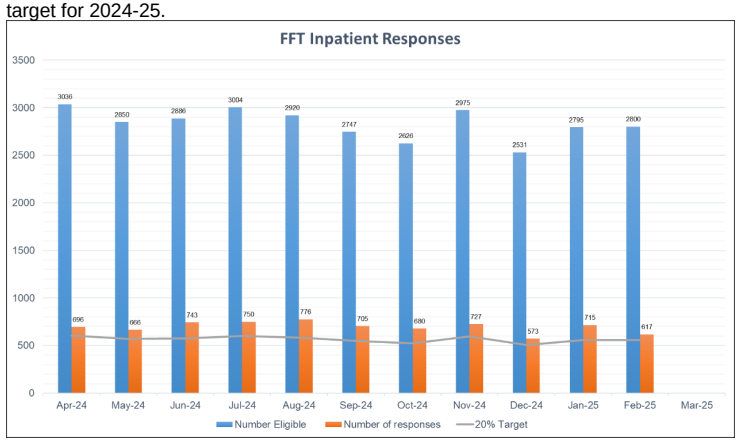
Breakthrough Objective:	Pressure Ulcers
Corporate Project:	Patient Experience Accreditation
Overarching Risk Appetite:	Clinical - Minimal

Overarching Risk Summary:

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Best Quality, Safest Care	**Ever Safer Care**	**Moderate & Above Harm**	**Clinical: Minimal**								
	Excellent Outcomes										
	A positive experience	**Patient Experience**	**Clinical: Minimal**								

True North Summary:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current State	Level of Risk To Achieving in year goal	Level of Risk for progressing actions
Ever Safer Care  Excellent Outcomes 	Eliminate Moderate & Above Harm **Breakthrough Objective**	Decrease the total number of moderate & above harm incidents while increasing reporting of low or no harm	Long term: Eliminate moderate & above harm Short term: 20% reduction each year for 3 years Baseline: 170 per annum Year 1: 136 now 110 Year 2: 109 Year 3: 87	The target for Year 1 (2024-25) is 110 or less moderate and above incidents (approximately 9 per month). This will be tracked from April 2024. Falls Improvement Plan Pressure Ulcers Improvement Plan Quality Governance Framework in place PSIRF Implementation Plan	**Break through Objective: Pressure Ulcers – noted below** April 2024 **–** 5 Moderate and above Safety Events May 2024 – 7 Moderate and above Safety Events June 2024 – 11 Moderate and above Safety Events July 2024 – 10 Moderate and above Safety Events August 2024 – 10 Moderate and above Safety Events September 2024 – 3 Moderate and above Safety October 2024 – 9 Moderate and above Safety Events November 2024 – 8 Moderate and above Safety Events (December 2024 – 12 Moderate and above Safety Events (data being validated and expected to reduce) January 2025 – 17 Moderate and above Safety Events (data being validated and expected to reduce) February 2025 – 11 Moderate and above Safety Events (data being validated and expected to reduce)  Strong progress continues to be made with the January cumulative position below trajectory and the February just above trajectory. The data for January and February 2025 remains unvalidated. It is anticipated that once reviewed the data will remain below trajectory. T No PSIIs were declared in January and February 2025. Including No Never Events declared. A new Thematic Review into deteriorating patient has been launched.		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current State	Level of Risk To Achieving in year goal	Level of Risk for progressing actions
A Positive Experience	Patient Experience Response Rates **Corporate Project**	For every patient to recommend our services	Long term: Development of a real time engagement tool Short term: Increase the response to FFT by 20% over the next 12 months for inpatient (baseline 447) By March 2025: 539 responses per month By December 2025: 801 responses per month	Corporate Project on social value in development Project on increasing engagement led by the Quality Team in development	Corporate Project on the development of a real time patient feedback is detailed in the Corporate Project section below. In January 2025 **715** inpatient FFT responses have been inputted at the time of the report being generated. In February 2025 **617** inpatient FFT responses have been inputted at the time of the report being generated. Currently above trajectory (positive trend) with responses above baseline (2023-24 data) and above target for 2024-25.  Plan in development of increased engagement in development with a focus on: • Public engagement events • Review of feedback systems (Datix, FFT, Surveys etc) Watch Metrics: Complaints compliance at **78%** for January 2025. With 18 Response due a response and 14 meeting time scales.		

Breakthrough Objective: No Current Breakthrough Objective in place for this Ambition

Workstream	True North Metric	Vision	Countermeasures	Current State	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions

Corporate Project: Patient Experience

Workstream	True North Metric	Vision	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
A Positive Experience	Patient Experience Response Rates	Development of real time engagement tool	Corporate Project Continuing to monitor FFT rates and response whilst project in development	Four key workstreams have been implemented: **Friends and Family Test Improvements:** Working group continues to progress with good engagement and a business proposal is being drafted to present a number of options to improve collection methods and reporting. Working ongoing to review the cost benefit analysis of systems for real time feedback. **Real-time listening event**: trial real-time listening event with focus on KITE values took place on the 28th of November 2024. The evaluation of the real-time listening event is guiding HDFT's Patient Experience Corporate Project. Work is ongoing with other NHS Providers to review their approaches. **Patient Experience Team (PET) Visibility event**: The listening event provide an opportunity to consider future events. Placement at the front of the hospital to gather feedback was less successful than anticipated. **Feedback systems improvement:** to seek improvements in the wider feedback and reporting systems available. Such as looking at trialling kiosks and other digital feedback methods, scoping exercise to see what feedback non-NHS organisation utilise to inform improvements and heighten customer experience, and to develop robust processes for sharing non-complaint feedback (FFT, surveys etc) with services and departments to inform change and improvements. This is included as part of the business proposal to update FFT/survey software that would provide a more centralised approach, more accessible reporting and thematic analysis and review of feedback weekly/monthly.		

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related Corporate Risks at this time					

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related External Risks impacted on the above ambition currently.					

STRATEGIC AMBITION: BEST QUALITY, SAFEST CARE 2025-2026

Our ambition is to provide the best quality, safest care, where quality is defined by safety, effectiveness and patient experience. Through continuous learning and improvement we will make our processes and systems ever safer – we will never stop seeking improvement. We want excellent outcomes for our patients and the children and young people we support which improve their health, wellbeing and quality of life – we will do this by providing effective care based on best practice standards. We want every patient, child and young person to have a positive experience of our care – we will do this by listening and acting on their feedback to continuously improve.

GOALS:

Safety

Ever safer care through continuous learning and improvement

Effectiveness

Excellent outcomes through effective, best practice care

Patient Experience

A positive experience for every patient by listening and acting on their feedback

GOVERNANCE:

Quality Framework

- Board Assurance: Quality Committe
- Programme Board: Quality Governance Management Group (QGMG)
- SRO: Executive Director of Nursing, Midiwfery & AHPs and Executive Medical Director
- Operational Lead: Associate Director of Quality & Corporate Affairs

True North Metrics (Executive Lead: 10-15 Year deliverable)

1. • **Eliminating Moderate & Above Harm**
2. • **Patient Experience Positive Response Rates**

Breakthrough Objective:	Safeguarding
Corporate Project:	Patient Experience
Overarching Risk Appetite:	Clinical - Minimal

Overarching Risk Summary:

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Best Quality, Safest Care	**Ever Safer Care**	**Moderate & Above Harm**	**Clinical: Minimal**								
	Excellent Outcomes										
	A positive experience	**Patient Experience**	**Clinical: Minimal**								

True North Summary:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current State	Level of Risk To Achieving in year goal	Level of Risk for progres sing actions
Ever Safer Care  Excellent Outcomes 	Eliminate Moderate & Above Harm	Decrease the total number of moderate & above harm incidents while increasing reporting of low or no harm	Long term: Eliminate moderate & above harm Short term: 20% reduction each year for 3 years Baseline: 140 per annum Year 1: 110 **(achieved)** **Year 2: 88** (approximately 7 per month) Year 3: 71	Falls Improvement Plan Pressure Ulcers Improvement Plan Quality Governance Framework in place PSIRF Plan Thematic Review – Diagnosis, Treatment and Procedures Directorate Countermeasures	The True North Metric of eliminating moderate and above harm continues into its second year (2025-26). The target of a 20% reduction in harm was achieved in 2024-25. 2025-26 sees a step change of a further 20% reduction. This is a target of less than 88 moderate and above incidents for the year, which equates to approximately 7 per month. Countermeasures are noted. Watch Metrics: • Number of Never Events • Number of PSIIs • Level of low and no harm events reported		
A Positive Experience 	Patient Experience Response Rates **Corporate Project**	For every patient to recommend our services	Long term: Development of a real time engagement tool Short term: Increase the response to FFT by 20% over the next 12 months for inpatient (baseline 447) By March 2025: 539 responses per month **(achieved)** By March 2026: 801 responses per month	Corporate Project Increased FFT distribution and collection.	The focus for this True North Ambition is the development of a real time patient feedback mechanism. This programme of work is being developed through a Corporate Project which is detailed below. In parallel to the Corporate Project, as an interim measure, the focus is on increasing the number of Friends and Family Test (FFT) responses. The target was achieved in 2024-25 and therefore a further step change is being implemented. The target to achieve by March 2026 is for 801 responses to be received in month. Countermeasures are noted. Watch Metrics: • Number of Complaints • Percentage compliance with Complaint Response Times		

Breakthrough Objective: Safeguarding

Workstream	True North Metric	Vision	Countermeasures	Current State	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Ever Safer Care	Eliminate Moderate & Above Harm			**In development, further information to be included in May 2025 update.**		

Corporate Project: Patient Experience

Workstream	True North Metric	Vision	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
A Positive Experience	Patient Experience Response Rates	Development of real time engagement tool	Corporate Project Continuing to monitor FFT rates and response whilst project in development	Four key workstreams have been implemented: **Friends and Family Test Improvements:** Working group continues to progress with good engagement and a business proposal is being drafted to present a number of options to improve collection methods and reporting. Working ongoing to review the cost benefit analysis of systems for real time feedback. **Real-time listening event**: trial real-time listening event with focus on KITE values took place on the 28th of November 2024. The evaluation of the real-time listening event is guiding HDFT's Patient Experience Corporate Project. Work is ongoing with other NHS Providers to review their approaches. **Patient Experience Team (PET) Visibility event**: The listening event provide an opportunity to consider future events. Placement at the front of the hospital to gather feedback was less successful than anticipated. **Feedback systems improvement:** to seek improvements in the wider feedback and reporting systems available. Such as looking at trialling kiosks and other digital feedback methods, scoping exercise to see what feedback non-NHS organisation utilise to inform improvements and heighten customer experience, and to develop robust processes for sharing non-complaint feedback (FFT, surveys etc) with services and departments to inform change and improvements. This is included as part of the business proposal to update FFT/survey software that would provide a more centralised approach, more accessible reporting and thematic analysis and review of feedback weekly/monthly.		

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related Corporate Risks at this time					

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related External Risks impacted on the above ambition currently.					

STRATEGIC AMBITION: GREAT START IN LIFE 2024-2025

HDFT is the largest provider of public health services for children and young people in England supporting over 500,000 children and young people to have a great start in life. We have the opportunity to lead the development of children and young people's public health services, sharing our expertise to benefit children nationally. As a district general hospital we often care for children and young people in our adult services so we will ensure that every service meets the needs of children and young people by implementing the 'Hopes for Healthcare' principles co-designed with our Youth Forum. Providing high quality, safe care and a great patient experience for mothers and their babies, and ensuring they and their families have confidence in that care, is the beginning of a great start in life.

GOALS:

Public Health

The national leader for children & young people's public health services

Hopes for Healthcare

Services which meet the needs of children & young people

Maternity Services

High quality maternity services with teh confidence of women and families

GOVERNANCE:

Great Start in Life

- Board Assurance: Quality Committe
- Programme Board: Great Start in Life Programme Board & Quality Governance Management Group (QGMG)
- SRO: Executive Director of Nursing, Midiwfery & AHPs and Director of Strategy
- Operational Lead:Clinical Director for Children & Community & the Associate Director of Midwifery

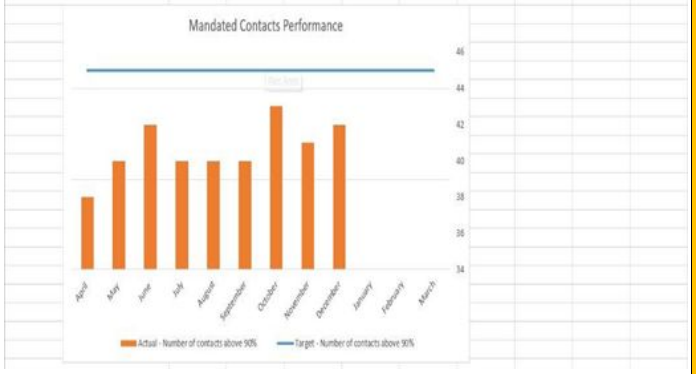
True Metrics (Executive Lead: 10-15 Year deliverable)

1. Early Intervention & Prevention
2. Child Patient Experience
3. Maternity Harm Events

Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Clinical - Minimal

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Great Start In Life	National Leader for Children & Young People's Public Health Services	Children at Risk of Vulnerability	Clinical: Minimal								
	Hopes for Healthcare	Children's Patient Experience	Clinical: Minimal								
	High Quality Maternity Services	Maternity Harm Events	Clinical: Minimal								

True North Metrics Summary:

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
Public Health	Great Start in Life: Early intervention & prevention – Children at Risk of Vulnerability	As an organisation we wish to recognise all children at risk of vulnerabilities in the ante natal period so that by the age of 30 months the child can be graduated into universal services by 10%	Revised Goals in November 2024 Goal 1: To achieve 90% or above on the performance of all mandated health child programme contacts – June 2025 Goal 2: To deliver the Great Start in Life pathway to all eligible children in Darlington and increase outcomes of agreed KPIs linked to Public Health high impact areas – from January 2026 Goal 3: Baseline for Darlington children graduating into universal services established – January 2025	Process mapped and actions agreed. These are being progressed with named leads. Key action relates to S1, slot times and diary management which is being supported by the S1 team. Wakefield team have identified Health Visitor recruitment as a driver metric and are working up the counter measures. Band 5's have moved into trainee SCPHN meaning newly recruited Band 5's need to be trained to pick up appropriate visits. Head of Public Health Nursing – Wakefield is working through training plans / dates to assess when capacity will be available to work to health child program Antenatal visit timescale. There is full recruitment to Band 5's across Co Durham, plan is to move to a model of this staff group being used as an Co Durham resource rather than just locality.	The areas where we are currently not meeting delivery of the mandated healthy child program within national timescales consecutively for four months are; Co Durham 6-8wks and 2.5year reviews (due to pressures in the South of the county) and Wakefield new antenatal and new birth visits. Countermeasures for CYPD Exec PRM now updated to reflect the countermeasures required to support improvement. Performance vs Mandated Contract for BAF |	April	May	June	July	August	September	October	November	December
---	---	---	---	---	---	---	---	---	---
Target - Number of contacts above 90%	45	45	45	45	45	45	45	45	45
Actual - Number of contacts above 90%	38	40	42	40	40	40	43	41	42	 		

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
				Recent successful recruitment to HV in South and following up on start dates. Still 4.7wte vacancies but picture more positive in teams of recruitment to external adverts.			
Hope for Healthcare 	Children's Patient Experience	Improve experience of care by considering elements that matter most to children & young people so we can measure their experience of care and shape services according to their specific needs	Engage with children and young people with lived experience across HDFT geography to re-establish their Hopes for Healthcare. Develop an HDFT CYP Patient Experience Test which will provide outputs that will translate into themes, trends and areas for improvement. This data set will be visible and accessible across Trust governance frameworks. Develop a CYP Shadow Board with representation from HDFTs geography who will provide consultancy to HDFT Board and Services	To embed the "Hopes for Healthcare" principles in all HDFT services	We have engaged with children and young people with lived experience across HDFT geography to re-establish their Hopes for Healthcare. We have Great Start in Life Young Advisors and committees across the full geography of the Trust. We have developed an HDFT CYP Patient Experience Test which will provide outputs that will translate into themes, trends and areas for improvement. This data set will be visible and accessible across Trust governance frameworks. *Noted that National Institute of Health Visiting would like to publish HDFT's CYP 12 month project.* Our Great Start in Life Committees will provide consultancy when required to the Trust and act as a CYP Shadow Board **11.11.24** CYP Patient Experience Tool designed and built into Survey Monkey and MS Forms linked to a QR Code for each Directorate. Directorates are currently working together and with our GSIL Young Advisors to design Posters for Clinical Areas to display the QR Codes and strategies to increase uptake of Surveys. Data will be accessible by the central Patient Experience Team. The CYP PH Directorate will share a monthly Report including 'You Said We Did' Action which will be consulted by our GSIL Committees and Advisors. **Next Steps:** countermeasures to be developed by Directorates. Further input into wider Corporate Project: Patient Experience.	Goal Achieved	Goal Achieved
Maternity Services	Maternity Services	The aim of our maternity services is to work in	To ensure the service is available for service users at all	Ensure staffing in the right place at the right time with the right skills.	No maternity diverts occurred in February.		

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
		partnership to provide a safe, friendly and effective service, aiming to deliver the highest standard of care throughout pregnancy, birth and postnatal period.	times, reducing diverts to zero		Midwifery staffing establishment business case was discussed and agreed at Business Case Review Group due to staffing issues being identified to be main contributor to divert. Paediatric nurse staffing review ongoing – reviewing impact of Children's Admission Unit on requirements. Qualified In Speciality (QIS) nurse provision will be improve once current employees complete one year training package. Further details can be found in the Maternity Strengthening report.		

Breakthrough Objective:

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
None							

Corporate Project:

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
None							

Strategic Project:

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
None							

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR34	Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition. There is a need to reduce the backlog of referrals back to the NICE standard of three months (reduce the waiting list to approximately 120)	3 x 5 = 15	3 x 3 = 9 March 25	Clinical: Patient Safety	Minimal

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related external risks					

STRATEGIC AMBITION: GREAT START IN LIFE 2025-26

HDFT is the largest provider of public health services for children and young people in England supporting over 500,000 children and young people to have a great start in life. We have the opportunity to lead the development of children and young people's public health services, sharing our expertise to benefit children nationally. As a district general hospital we often care for children and young people in our adult services so we will ensure that every service meets the needs of children and young people by implementing the 'Hopes for Healthcare' principles co-designed with our Youth Forum. Providing high quality, safe care and a great patient experience for mothers and their babies, and ensuring they and their families have confidence in that care, is the beginning of a great start in life.

GOALS:

Public Health

The national leader for children & young people's public health services

Hopes for Healthcare

Services which meet the needs of children & young people

GOVERNANCE:

Great Start in Life

- Board Assurance: Quality Committe
- Programme Board: Great Start in Life Programme Board & Quality Governance Management Group (QGMG)
- SRO: Executive Director of Nursing, Midiwfery
- Operational Lead: Triumvirate for CYP Public Health Directorate

True Metrics (Executive Lead: 10-15 Year deliverable)

1. Early Intervention & Prevention
2. Child Patient Experience

Breakthrough Objective:	None
Corporate Project:	CYP Public Health Mobilisation
Overarching Risk Appetite:	Clinical - Minimal

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Great Start In Life	National Leader for Children & Young People's Public Health Services	Children at Risk of Vulnerability	Clinical: Minimal	
	Hopes for Healthcare	Children's Patient Experience	Clinical: Minimal	

True North Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
Public Health 	Great Start in Life: Early intervention & prevention – Children at Risk of Vulnerability	'As an organisation we aim to reduce the number of children who are vulnerable to poor health and wellbeing and to take action to mitigate risks of poor outcomes'.	Goal 1: To achieve 90% delivery of mandated Healthy Child Program Contacts within national timescales. Goal 2: To deliver the HDFT Great Start in Life pathway launching April 25 to all eligible children in Darlington and report outcomes linked to Public Health high impact areas.	*ESR – developing build to report compliance that all practitioners in 0-19 are receiving monthly quality and performance management supervision.* *Local PRMs will address where teams are underperforming and agree Countermeasures to improve compliance.* • There is full recruitment to Band 5's across Co Durham, plan is to move to a model of this staff group being used as an Co Durham resource rather than just locality. • New Locality Manager appointed in South Durham and commenced in post. • Wakefield team have identified Health Visitor recruitment / Grow Your Own as a driver metric and are working up the counter measures which will be reviewed in Wakefield PRM in March 25. • Band 5's have moved into trainee SCPHN meaning newly recruited Band 5's need to be trained to pick up appropriate visits. Head of Public Health Nursing – Wakefield is working through training plans / Preceptorship to identify dates to assess when capacity will be available to work to health child program Antenatal visit timescale.	The Trust North Metric of Early Intervention and Prevention continues into its second year (2025-26). Metrics remain as per revision of year end 24/25 with the addition of QPMS Compliance reporting once build compete. Current performance for February 25: 43/45 HCP Mandated Contacts delivered within timescales, overall, 95%. Wakefield Antenatal and Durham 6-8week are the two areas below 90% in Feb 25. Durham 6-8 week review was at 89.4%.  Watch Metrics: Goal 2: Watch Metrics will report and include the outcomes of the GSIL Pathway linked to High Impact Areas.		

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
Hope for Healthcare 	Children's Patient Experience	Improve experience of care by considering elements that matter most to children & young people so we can measure their experience of care and shape services according to their specific needs	Goal 1: Engage with children and young people with lived experience across HDFT geography to consult with on our CYP Strategy which will for part of the Clinical Strategy Goal 2: CYP Patient Experience Tool Developed-Return rate significantly low - distribution, engagement, and accesses to the tool to be developed with CYP and approach embedded with teams and professionals working with CYP.	CYP Patient Experience Tool 'engagement methods' to increase uptake and return being developed with involvement of CYP representatives. • Focus Groups held with GSIL Young Advisor Committees and individual advisors. • Poster design to be finalised, digitised and circulated to school's W/C 7th April 25. • Standardise paper version of survey for use. • Hopes for Health presentation to increase staff awareness and importance of gathering feedback (at all team huddles) • Assurance Survey for completion by staff to review awareness - this will inform future promotion and target support. • Meeting with S1 & IG scheduled 13th March to explore use of S1 to send survey link and push notification. • Application to charity for adaptable devises to support completion of survey by CYP	The Trust North Metric of improving Children's Patient Experience continues into its second year (2025-26). Increase in number of CYP surveys returned by 10% on previous months numbers. Countermeasures are noted. Watch Metrics: • Directorate CYP Patient Experience Champions to produces a monthly report with themes, trends and areas for improvement. This will be shared with the central patient experience team and reported into MEC Forum. We will review after 6 months data to identify key themes which will inform future counter measures and metrics.		

Breakthrough Objective:

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
None							

Corporate Project:

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
Early Intervention & Prevention - Children and Young People Public Health Mobilisation	Project in development						

Strategic Project:

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
None							

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR34	Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition. There is a need to reduce the backlog of referrals back to the NICE standard of three months (reduce the waiting list to approximately 120)	3 x 5 = 15	3 x 3 = 9 March 25	Clinical: Patient Safety	Minimal

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related external risks					

Harrogate and District NHS Foundation Trust

3.2

Strengthening Maternity and Neonatal Safety Report

February 2025

Title:	**Strengthening Midwifery and Neonatal Safety Report**
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHP's
Author:	Leanne Likaj (Associate Director of Midwifery), Andy Brown (Lead Midwife for Safety, Quality & Clinical Governance)

Purpose of the report and summary of key issues:	The purpose of this report is to provide a summary and update on the board level safety measures for the month of February as set out in the Perinatal Quality Surveillance model (Ockenden, 2020).	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	√
	Person Centred, Integrated Care; Strong Partnerships	√
	Great Start in Life	√
	At Our Best: Making HDFT the best place to work	√
	An environment that promotes wellbeing	√
	Digital transformation to integrate care and improve patient, child and staff experience	√
	Healthcare innovation to improve quality	√
Corporate Risks	No new risks	
Report History:	Maternity Risk Management Group Maternity Quality Assurance Meeting Maternity Safety Champions	
Recommendation:	Board is asked to note the updated information provided in the report and for further discussion.	

STRENGTHENING MATERNITY AND NEONATAL SAFETY REPORT

1.0 Summary

This paper provides a summary and update of the detail on the board level measures for the month of February 2025 as set out in the Perinatal Quality Surveillance model.

1.0 Introduction

The quality surveillance model seeks to provide consistent and methodical oversight of all services, including maternity. Strengthening trust-level oversight for quality and safety includes a focus on leadership, strong governance processes and pathways for information and escalation from floor to Board. The model includes five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. There are local, regional and national elements of this model.

At local level, the model includes a monthly review of maternity and neonatal safety and quality reported to the Trust board.

2.0 Proposal

The report covers the provider Board level measures required as part of the perinatal surveillance model. The report also includes additional neonatal measures.

The Board is asked to note the information provided in the report that provides a local update on progress.

3.0 Quality Implications and Clinical Input

The report provides an update on the key measures set out in the Perinatal Quality Surveillance model and has been analysed and presented by members of the maternity midwifery, neonatal and obstetric teams.

4.0 Equality Analysis

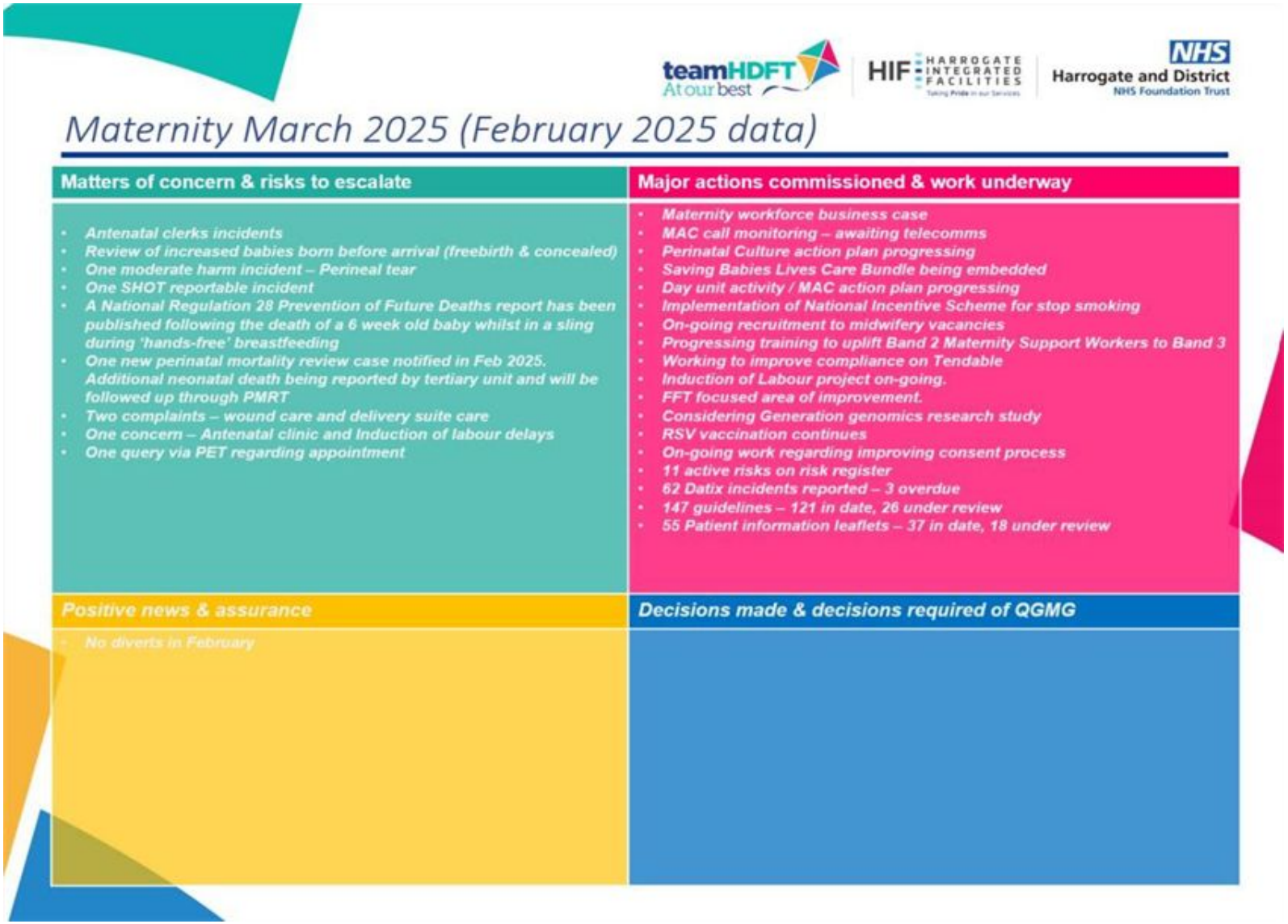
Not applicable.

5.0 Risks and Mitigating Actions

No new risks.

6.0 Recommendation

The Board is asked to note the updated information provided in the report and for further discussion.


teamHDFT
At our best
HIF
HARROGATE INTEGRATED FACILITIES
NHS
Harrogate and District
NHS Foundation Trust
Maternity March 2025 (February 2025 data)
Matters of concern & risks to escalate
Antenatal clerks incidents
Review of increased babies born before arrival (freebirth & concealed)
One moderate harm incident – Perineal tear
One SHOT reportable incident
A National Regulation 28 Prevention of Future Deaths report has been published following the death of a 6 week old baby whilst in a sling during 'hands-free' breastfeeding
One new perinatal mortality review case notified in Feb 2025. Additional neonatal death being reported by tertiary unit and will be followed up through PMRT
Two complaints – wound care and delivery suite care
One concern – Antenatal clinic and Induction of labour delays
One query via PET regarding appointment
Major actions commissioned & work underway
Maternity workforce business case
MAC call monitoring – awaiting telecomms
Perinatal Culture action plan progressing
Saving Babies Lives Care Bundle being embedded
Day unit activity / MAC action plan progressing
Implementation of National Incentive Scheme for stop smoking
On-going recruitment to midwifery vacancies
Progressing training to uplift Band 2 Maternity Support Workers to Band 3
Working to improve compliance on Tendable
Induction of Labour project on-going.
FFT focused area of improvement.
Considering Generation genomics research study
RSV vaccination continues
On-going work regarding improving consent process
11 active risks on risk register
62 Datix incidents reported – 3 overdue
147 guidelines – 121 in date, 26 under review
55 Patient information leaflets – 37 in date, 18 under review
Positive news & assurance
No diverts in February
Decisions made & decisions required of QGMG

Narrative in support of the Provider Board Level Measures – February 2025 data

1. Introduction

The revised perinatal surveillance model sets out six requirements to strengthen and optimise board level oversight for maternity and neonatal safety. Requirements include

a. A monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board,
b. All maternity Patient Safety Incident Investigations (PSIIs) are shared with Trust Boards (in addition to reporting as required to Maternity and Newborn Safety Investigations (MNSI)),
c. To use a locally agreed dashboard to include a minimum set of measures drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings. The minimum measures to be included are:
- Findings of review of all perinatal deaths
- Findings of review of all cases eligible for referral to MNSI
- The number of incidents logged as moderate or above and actions taken
- Training compliance related to the Core Competency Framework and job essential training
- Minimum safe staffing
- Service User Voice feedback
- Staff feedback from Safety champions and walk-about
- MNSI/NHSR/CQC concerns
- Coroner Regulation 28
- Progress in achievement of Maternity Incentive Scheme

Explanatory notes are available in Appendix A.

2. Obstetric cover on Delivery Suite, gaps in rota

Appropriate cover has been provided to Delivery Suite during the month of February 2025. Consultant rota cover has improved during February due to the return from sickness leave. Additionally a Locum Consultant will be in post from March to cover maternity leave.

3. Midwifery safe staffing, vacancies and recruitment update

The Birthrate plus establishment setting report was completed in August 2024. The recent completion recommends the total clinical, specialist and management midwifery staffing should be 80.56 WTE using a 24% uplift for annual, sick and study leave. Birthrate plus states increasingly more Trusts are building in 24% uplift to provide sufficient cover for study leave requirements. The current funded establishment is 74.97 WTE (plus 6.03 WTE on maternity leave). A business case has been submitted to request to increase the establishment of midwifery staffing by 5.48WTE Band 7 midwives. This increase will improve the senior support available out of working hours whilst also increasing staffing at night.

Birthrate plus calculations don't include calculations for support staffing required in the clinical areas and this requires professional judgement. Currently there is a funded establishment for support staff of 13.6 WTE. An additional business case is being written to request to increase the establishment by 6.47WTE Band 3 maternity support workers.

a. Absence position

Total sickness in February was 3.63 WTE midwifery and 0.38 WTE maternity support workers absence. 6.23 WTE midwives are on maternity leave at present.

b. Vacancy position

There remains a vacancy of 2.22 WTE midwives and 1.33 WTE maternity support workers. Both roles are out to advert.

c. NHSP provision

Midwives – Demand this month has remained consistent with January despite an improved sickness absence rate. This is due to a higher level of annual leave in this month.

Support workers – There has been no significant change in the NHSP usage of support workers since last month.

4. Homebirth provision

Home birth provision is covered by community midwives working clinically in the day and a first and second on-call midwife every night between 17:00 – 08:00.

Three homebirths were booked for the month of February 2025. One woman free birthed, one woman had a successful homebirth and one woman transferred to hospital by choice.

In the period 01/02/25 – 28/02/25, the home birth on call provision was unavailable on four occasions due to unexpected sickness and no volunteers to cover.

5. **Neonatal services Special Care Baby Unit (SCBU) staffing, vacancies and recruitment update**
    a. **Neonatal absence position**

1.12 WTE nurse currently on maternity leave. 0.61 WTE non-QIS nurse long term sickness absence.

b. Neonatal Vacancy

There remains a 0.93 WTE vacancy for QIS nurse and a 0.92 WTE QIS nurse is planned to commence April.

c. Qualified in Speciality (QIS) Nurses

SCBU is budgeted for 11.82 WTE overall. To meet British Association Perinatal Medicine (BAPM) standards 70% of this is required to be QIS nurses. This equates to 8.274 WTE. The Operational Delivery Network (ODN) have clarified that the QIS compliance is based on staff in post excluding any vacancy. January QIS compliance was 17%.

There are plans in place to improve compliance with QIS staffing. All nurses working on SCBU are to be QIS qualified and the banding has been adjusted to Band 6 to reflect this. This will enable additional resilience in the event of short notice sickness. Recruitment to Band 6 QIS posts has taken place and staff already in post are undergoing training to become QIS qualified however the training can take up to two years. QIS compliance remains on the risk register for the department.

6. **Birthrate Plus Acuity Staffing Data**
    a. **Delivery Suite Staffing and impact on clinical workload**

A supernumerary delivery suite co-ordinator was rostered and available at the start of every shift. During the month of February the following was noted from Birthrate Plus-

Staffing factors

Breakdown of Factors	Times occurred	Percentage
Short term sickness	33	45%
Lack of beds	0	0%
Unable to fill vacant shifts	20	27%
Staff redeployed to another area	4	5%
No maternity support worker	16	22%
Total	**73**	

Clinical Actions

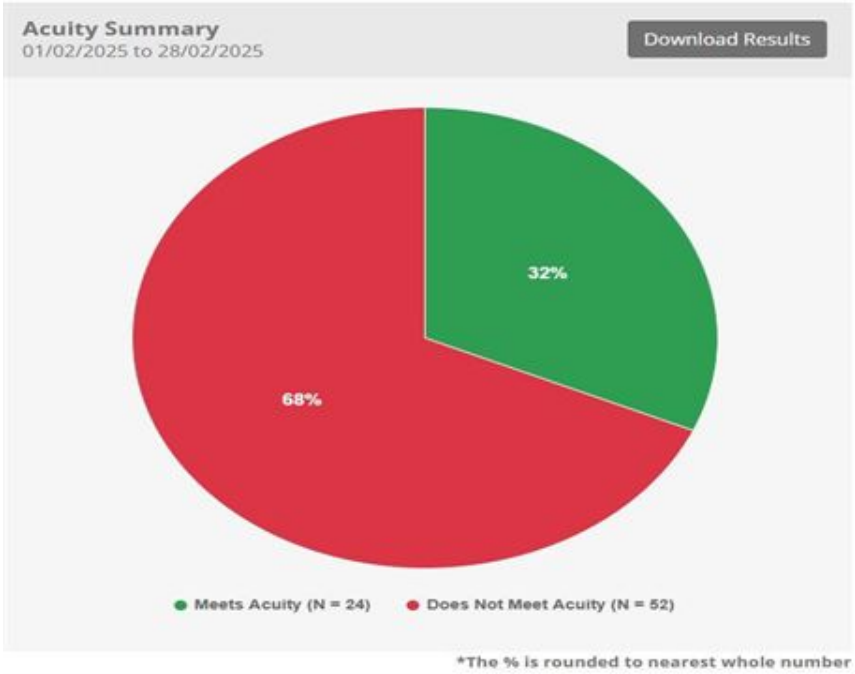
Breakdown of Actions	Times occurred	Percentage
Delay in commencing Induction of Labour (IOL) (Inpatient)	6	14%
Delay in continuing IOL	23	55%
Delay in EL LSCS (delivery suite)	0	0%
Postponed IOL (at home)	9	21%
Delivery Suite coordinator not supernumerary	4	10%
	42	

Management actions taken to mitigate the above issues –

Breakdown of Actions	Times occurred	Percentage
Redeploy staff from Pannal	9	45%
Staff unable to take breaks	8	40%
Review of staff on management time	1	5%
Use of Specialist Midwife	0	0%
Use of staff on training days	0	0%
Use of ward/department managers	0	0%
Staff sourced from wider Trust (theatre & CSW's)	0	0%
Use of hospital MW on call	1	5%
Use of community MW	1	5%
Unit on Divert	0	0%
Patient diverted	0	0%
Total	**20**	

b. Pannal Ward Staffing and impact on clinical workload

During February, according to Birthrate Plus acuity tool, 68% of shifts have been at least one staff member short over the course of the month, with staffing meeting acuity only 32% of the time. This has improved since January.



Staff have been redeployed where possible to support the ward with the clinical activity.

There were 11 elective section lists with 27 women in total on these lists. There was one elective caesarean section completed in Delivery Suite theatre during February.

There were twenty babies who received Transitional Care (TC) provision on Pannal Ward.

7. Red Flag Events Recorded on Birthrate Plus

a. Delivery Suite Red Flags

Delivery Suite record when the following Red Flag events occur, sometimes numerous Red Flags can occur at the same time. There was one Red Flag recorded on Birthrate Plus during February 2025 due to 'delayed or cancelled time critical activity'. Appropriate actions were taken to manage the situation.

b. Pannal Ward Red Flags

There was two occasions where there was a Red Flag identified from the Birth Rate plus Data due to a delay in providing pain relief.

During February there was five delays in induction of labour of over 24 hours which is significantly better position than the previous month.

8. Training Compliance For All Staff Groups in Maternity Related to Core Competency Framework And Wider Job Essential Training

a. Mandatory training (as at 01/03/25)

Department		Assignment Count	Percentage Compliant
421 Level 4 Ante Natal Clinic		10	80%
421 Level 4 Obs & Gynae - Medical Staffing		27	83%
421 Level 4 Maternity Staffing		51	87%
421 Level 4 Pannal Ward		26	88%
421 Level 4 Community Midwifery		24	90%
421 Level 4 Early Pregnancy Assessment Unit		4	95%
421 Level 4 Admin Services - Obs & Gynae		5	96%
421 Level 4 Women's Unit		14	99%
421 Level 4 Medical Records - CG1		8	100%

b. Maternity Incentive Scheme and Core Competency version 2 Training Compliance

Steps are being taken to improve compliance in all areas currently reporting below 90%.

Course Name	Midwives	Obs& Gynae Consultants	Obs& Gynae (Other Staff)	Anaesthetics Consultants	Anaesthetics (Other Staff)	Paediatric Consultants	Paediatric (Other Staff)	Maternity Support Worker
Adult Basic Life Support with paediatric modifications	65/75 (87%)	5/7 (71%)	13/18 (72%)			6/9 (67%)	36/53 (68%)	13/15 (87%)
Harrogate Immediate Life Support (HILS)	8/14 (57%)							
Harrogate Advanced Life Support (HALS)				13/18 (72%)	19/23 (83%)			

Harrogate Newborn Intermediate Life Support (HNILS)	85/87 (98%)						5/5 (100 %)	
Harrogate Newborn Advanced Life Support (HNALS)						7/9 (78%)	20/24 (84%)	
RCUK Newborn Life Support	12/13 (92%)					10/10 (100%)	16/20 (80%)	
MAT - Growth Assessment Protocol (GAP)	71/89 (80%)	5/7 (71%)	8/10 (80%)					
LMNS Fetal Wellbeing Competency Assessment	74/87 (85%)	4/7 (57%)	10/10 (100%)					
MAT – Maternity Training Day 2	85/87 (98%)	7/7 (100 %)	10/10 (100%)					
MAT - Prompt	79/89 (89%)	5/7 (71%)	14/18 (78%)	9/9 (100%)	8/9 (89%)			12/15 (80%)
MAT - Saving Babies Lives	76/89 (85%)	5/7 (71%)	9/10 (90%)					
Safeguarding Adults	72/89 (81%)	6/7 (86%)	16/18 (89%)	14/19 (74%)	21/23 (91%)	8/9 (89%)	39/53 (74%)	15/15 (100%)
Safeguarding Children	88/90 (98%)	5/7 (71%)	12/18 (67%)	17/19 (89%)	23/23 (100%)	10/10 (100%)	39/53 (74%)	15/15 (100%)

9. Risk and Safety

a. Maternity unit divert

There has been no events of divert of the unit in February 2025.

b. Maternity Accepted Diverts

A daily (Monday – Friday) regional meeting is in place, supported by the Local Maternity and Neonatal Systems, to review staffing, activity and the number of women awaiting induction of labour across the regions. During the month of February one woman was captured in local paper records as being transferred to Harrogate maternity service from elsewhere in the region for artificial rupture of membranes, on-going induction process and labour care.

c. SCBU Incidents

No moderate harm incidents. Recent incidents reported regarding off pathway admission, documentation and allergy status not being recorded.

d. SCBU Risk Register

Vacancy of QIS staff remains on risk register.

e. Maternity Risk register summary

Risk Register formally reviewed 04/03/2025. Next review 22/05/25. Eleven active risks. One risk has been archived.

- Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 10).
- Risk to patient experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 8). Series of videos planned regarding different risks and choice.
- Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 8).
- Risk to patient experience and breach of triage timescales due to insufficient midwifery staffing in Maternity Assessment Centre (Score 8).
- Risk of breaching NIPE-SO4 standard and key performance indicator for review and clinical assessment by orthopaedic specialist (Score 6).
- Risk to staff burnout and patient pathways due to challenges to Consultant rota (Score 6).
- Risk due to inability to meet gold standard requirements for clinical documentation (Score 5).
- Risk to patient experience due to delays in scheduling process for elective caesarean section (Score 4).
- Risk to reputation and patient satisfaction for failing to meet national target and provide evidence based care in relation to Continuity of Carer (Score 4).
- Risk to patient safety due to lack of robust sharing of safeguarding information (Score 3).
- Risk to patient safety and experience due to increasing requirement for elective caesarean section list (Score 2).

10. Maternity Incidents

In February 2025 there were 62 total incidents reported through DCIQ.

One Moderate Harm incident was reported relating to a fourth degree tear. Review confirmed that appropriate action taken at delivery and early episiotomy was completed. Duty of Candour letter has been sent.

One RROSE review completed of a pre-term baby born unexpectedly at home. Baby deteriorated following birth during transfer to hospital. Subsequently transferred to tertiary unit but sadly neonatal death was confirmed the following day. PMRT planned. No care issues identified.

Additional incidents of note include:

- Five incidents of Incorrect Treatment/Tests/Procedure. Includes missed opportunity to commence a neonatal feeding plan in community, management of phototherapy, missed antibiotics, and two incidents on SCBU relating to incorrect assessment of baby's age affecting fluid volumes and neonatal IV antibiotic plan

- Five incidents of baby being born before arrival of midwife

- Four incidents relating to Incorrect Patient Appointment information resulting from ANC Clerical issues

Further details regarding the types and number of incidents reported during February can be found on the Power BI dashboard –

https://app.powerbi.com/groups/1e44fd58-1b56-4af1-9c97-003e92cd51b3/reports/d8178f25-948e-49f9-a8a7-98684cb0207b/854c5fe77200b430484d?action=OpenReport&pbi_source=ChatInTeams&bookmarkGuid=a1cd8e03-bc78-41bd-a709-6a98fe7b2ca6

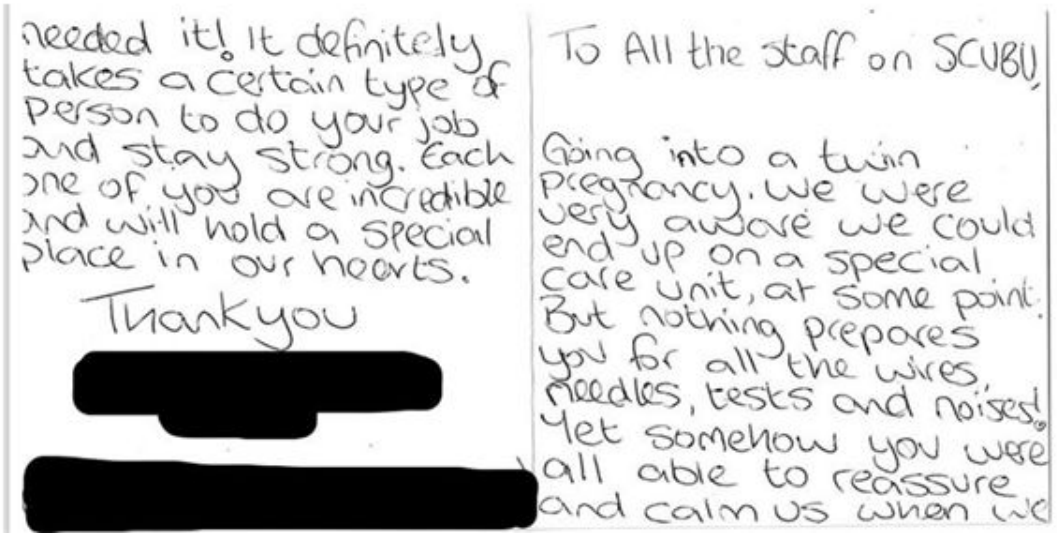
11. Perinatal Mortality Review Tool (PMRT)

a. HDFT PMRT Information

One case notified in February 2025. Additional case reported via Leeds Teaching Hospital following pre-term birth detailed above.

12. Feedback

a. SCBU Feedback



b. Maternity Service User feedback – via Maternity and Neonatal Voices Partnership

Date feedback collected	Date of care	What was good about your experience with maternity services in Harrogate within the last 5 years?	What would you have liked to have been different about your experience with maternity services?	Do you have any ideas and suggestions?
06/02/25	Baby in 24	Had good continuity of carer at Ripon	My placenta had to be removed which after a vaginal birth was a shock.	Prefer paper notes. I read printed patient information leaflets but didn't read any on BadgerNotes.
06/02/25	Baby born in Oct 24	Had good pregnancy care in Harrogate / Ripon	Had my care in Ripon but ended up having to go to Leeds to have the baby as	

			Harrogate was full. We spoke to them a few times and eventually they admitted they were full. This was a shock. Not something we'd prepared for.	
10/02/25	Currently pregnant	Good service. We have always left an appointment feeling well advised and supported.	More support/appointments during the earlier stages of pregnancy as this time is a nervous period.	Preferably more scans so that we feel constant support. More communication and care during a scan with the sonographer. Had the same one each time and haven't found them very empathetic. They haven't said much which is challenging in a pregnancy after loss.
10/02/25	Currently pregnant. Previous birth at Harrogate in March 23	Really quick to offer support, arrange scans and schedule appointments. Excellent 24/7 support Really good community care Helpful and friendly staff	Parking at Harrogate Hospital is really difficult and has meant I've missed appointments. At times they are very protocol rather than individualised.	More parking or street parking nearby
10/02/25	Currently pregnant. Previous birth at Harrogate in 2018	I am a high risk pregnancy and feel the unit is thorough with my care. In particular Mr Altanis is fantastic and goes above and beyond for his patients.	Waiting times are extremely poor compared to 2018 with my first child. We have waited up to 2 hours past our appointment time. Also not ideal or child friendly service to families who struggle to find childcare for scans.	
10/02/25	Currently pregnant	The team at Antenatal clinic are very accommodating, professional and efficient. Midwives are helpful and re-assuring. Thank you!	Midwife availability out of working hours via phone. Sometimes difficult to reach after 5pm	
10/02/25	Had baby Dec 24	Parking Calm and quiet environment Friendly and helpful staff	More breastfeeding support – would have been beneficial to have someone from infant feeding team visit us in hospital before discharge – more support on pannal may have avoided feeding plan we later had to go on.	Comfy chairs for dads Male toilets on ward (or unisex) More breastfeeding support on ward

			There are no comfy chairs/beds for dads who chose to stay with mum and baby on ward.	

10. Complaints, concerns, compliments

- Two formal maternity complaints received in February
  - FEE2540 – complaint relating to concerns about management of caesarean section wound
  - FEE2562 – complaint relating to concerns about care on Delivery Suite

- Additional concerns/feedback:
  - FEE2638/FEE2616 – Feedback relating to concerns about experience in ANC and about lack of capacity to induce labour

- One general enquiry (FEE2730), relating to appointment query with ANC.

11. Coroner 28 made directly to Trust

A National Regulation 28 Prevention of Future Deaths report has been published following the death of a 6 week old baby whilst in a sling during 'hands-free' breastfeeding.

12. Request for action from external bodies – NHS Resolution, MNSI, CQC

No new requests for action have been received from NHS Resolution, or MNSI.

13. Maternity and Newborn Safety Investigation (MNSI)

No new MNSI incidents have been reported in February 2025.

14. Maternity Incentive Scheme (MIS) – year six (NHS Resolution)

The compliance period for MIS ended on 30 November 2024 and compliance was approved at Trust Board in January 2025. The Trust Board gave their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Submission to NHS Resolution has been confirmed. Maternity Incentive Scheme year seven details are expected to be released in April 2025.

15. National priorities

a) Three Year Delivery Plan For Maternity And Neonatal Services

An action plan is in place that documents the steps required and completed to meet the requirements of this document. The remaining actions relate to saving babies lives compliance and continuity of carer. A Local Maternity and Neonatal System assurance visit took place in January to assess the service in relation to the Three Year Delivery Plan. Positive feedback was received on the day and a formal report is being finalised.

16. Local HDFT Maternity Services Dashboard

Maternity Dashboard

No concerns have been highlighted from this month's dashboard. Work is ongoing to ensure benchmarking is included in all data fields captured in the dashboard since the move to Power BI for the reports.

17. Neonatal admissions

a. Avoiding Term Admissions in Neonatal Units (ATAIN)

One incidents of Unexpected Term Admission to SCBU in February. All cases are reviewed by the ATAIN MDT panel.

18. Saving Babies Lives' v3 (released 31 May 2023)

An action plan is in place, work is on-going, and compliance is reassessed by the LMNS quarterly. At the last review Harrogate Maternity Services were 83% compliant.

Small-for-gestational age detection rate [AN detection of SGA user reported or EFW <10th: Proportion of babies SGA (<10th) at birth that were reported by users to be suspected antenatally as SGA <10th or detected by EFW <10th] Fetal growth restriction detection rate [AN detection of SGA <3rd by EFW <3rd: Proportion of babies with birthweight<3rd centile who were detected as <3rd centile from one or more AN EFW]	SGA – Q4 (calendar): 52.4% detection (<10th centile; 22 cases)(National average 49.5%) FGR – Q4 (calendar): 20.0% detection (<3rd centile; 3 cases) (National average 36.8%)	
	Oct-Dec 2024	February 2025
Percentage of babies <3rd centile >37+6 weeks' gestation	1.9% (8/423)	1.6% (2/125 babies born) as % of all babies born
Percentage of babies <10th centile >39+6 weeks' gestation	2.6% (11/423)	4.0% (5/125) as % of all babies born
SBLv3 Element 2 report: Percentage of babies <3rd centile who were born >37+6 weeks	50.0% (8/16) i.e. babies <3rd centile AND >37+6 as proportion of all babies <3rd centile	66.7% (2/3) i.e. babies <3rd centile AND >37+6 as proportion of all babies <3rd centile
Percentage of babies <10th centile who were born >39+6 weeks (% of all babies <10th centile)	25.6% (11/43) i.e. babies <10th centile AND >39+6 as proportion of all babies <10th centile	45.5% (5/11) i.e. babies <10th centile AND >39+6 as proportion of all babies <10th centile
Incidence of women with singleton pregnancy (as % of all singleton births) giving birth (liveborn and stillborn):		
• In late second trimester (16+0-23+6 weeks)	0.96% (fetal loss, 4/417) 0.24% (live 1/417)	4 fetal loss born 16-23+6 weeks (3.3%, 4/123)
• Preterm (24+0-36+6 weeks)	5.04% (live, 21/417) 0.24% (stillborn [TOP], 1/417)	2.4% (live, 3/123)

19. Maternity Safety Champions

Bi-monthly Safety Champion executive and non-executive director walk around and meetings continue. The last meeting and staff engagement occurred in January.

20. Conclusion and recommendation

Please see the grid attached for concerns/risks to escalate and positive news and assurance.

Appendix A - Explanatory notes

1. Birthrate Plus Acuity Staffing Data

The Birthrate Plus acuity score system is based upon indicators of normality in the progress and outcome of labour and the health of the baby at birth, together with other indicators which identify changes from normality. Using the Birthrate Plus classification system the tool provides an assessment of women's needs during their episode of care in the delivery suite and on Pannal Ward, recorded in real time on a four hourly basis to enable managers to ensure safety for women and babies during this period. The score sheet provides a research-based method to enable the midwife to assess the midwifery workload required to care for a woman at any time in the intrapartum and immediate post delivery period. Due to recording the acuity four hourly there can be numerous occurrences of one event, for example the unit being placed on divert. The unit may be on divert for 12 hours which could be captured three times in this data. Workload is based on

- A minimum standard of one to one care for all women in labour
- Increases in this standard for women with higher care needs (Categories III to V)

2. Red Flag Events Recorded on Birthrate Plus

According to NICE (2017), *a midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.*

3. Perinatal Mortality Review Tool (PMRT)

Principles for the conduct of local perinatal mortality reviews:

- There should be comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth*; excluding termination of pregnancy and those with a birth weight <500g if the gestation at birth is not known;
- Such reviews should be conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes
- A multidisciplinary group should review each case at a meeting where time is set aside for doing the work
- There should be scope for parental input into the process from the beginning
- An action plan should be generated from each review, implemented and monitored
- The review should result in a written report that should be shared with families in a sensitive and timely manner
- Reporting to the Trust/Health Board executive should occur regularly and result in organisational learning and service improvements
- Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results, and thereby ensure national learning

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6;
- All antepartum and intrapartum stillbirths;
- All neonatal deaths from birth at 22+0 to 28 days after birth;
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

The PMRT is not designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation;
- Babies who die in the community 28 days after birth or later who have not received neonatal care;
- Babies with brain injury who survive.

4. Avoiding Term Admissions in Neonatal Units (ATAIN)

There is overwhelming evidence that separation of mother and baby at or soon after birth can affect the positive development of the mother–child attachment process. Mothers may find it harder to establish and maintain breastfeeding and it may affect their mental health. Preventing separation, except for compelling medical indications, is an essential part of providing safe maternity services and an ethical responsibility for healthcare professionals. There are five main reasons for admitting babies to SCBU and thereby separating mother and baby; infection, respiratory problems, observation, hypoglycaemia and jaundice. There is a lot of cross over between all of the reasons for admission. An ATAIN Audit tool is completed for every baby admitted to SCBU with a birth gestation over 37 weeks to review if the reason for separation was appropriate and if there is any learning to prevent future incidences of separation.

5. Saving Babies Lives' v3 (released 31 May 2023)

The Saving Babies' Lives Care Bundle (SBLCBv3) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.

Building on the achievements of previous iterations, Version 3 includes a refresh of all existing elements, drawing on national guidance such as from NICE and RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. There are six elements of care:

1. Reducing Smoking in Pregnancy
2. Fetal Growth: Risk Assessment, Surveillance and Management
3. Raising Awareness of Reduced Fetal Movement
4. Effective Fetal Monitoring During Labour
5. Reducing Preterm Birth
6. Management of Pre-existing Diabetes in Pregnancy

STRATEGIC AMBITION: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS 2024-2025

For Harrogate and District, our ambition is to support person centred, integrated care through strong local partnerships. Our goal is for Harrogate and District to be recognised as an exemplar for person centred, integrated care to ensure that patients get the right care, from the right staff, in the right place. With an increasingly elderly and frail population we will prioritise providing the highest quality care and best outcomes for this group, while ensuring that all our patients also benefit from the services and approaches for the elderly and frail. By increasing our capacity and productivity, we will reduce waiting times for planned care and ensure that there is equitable access for all.

GOALS:

Best Place

The best place for person centred, integrated care

Exemplar System

An exemplar system for the care of the elderly and people living with frailty

Equitable & Timely

Equitable, timely access to best quality planned care

GOVERNANCE:

Person-centred Framework

- Board Assurance: Resource Committe
- Programme Board: Elective Programme Board, UEC Programme Board
- SRO: Chief Operating Officer
- Operational Lead: Deputy Chief Operating Officer

True North Metrics

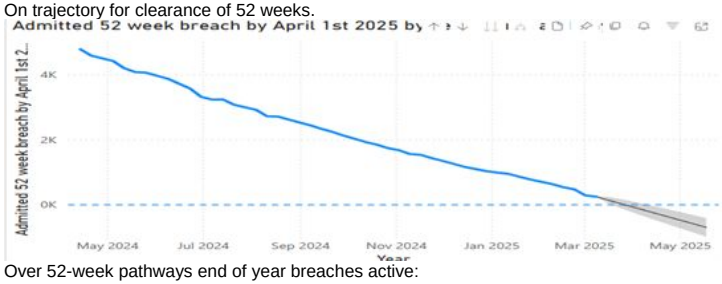
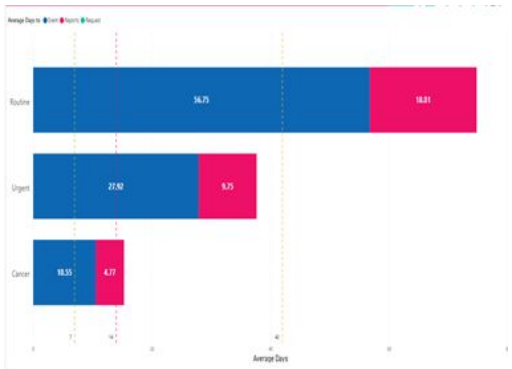
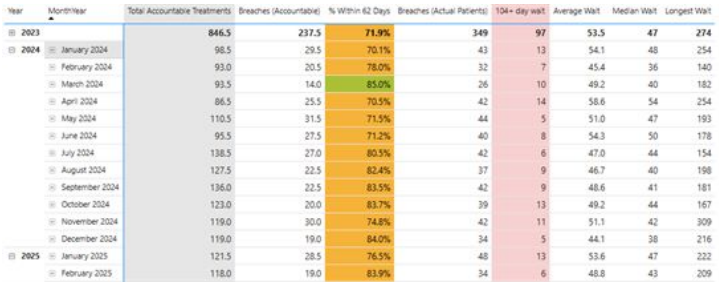
1. **ED 4hr Standard - 95% of patients admitted or dishcharged within 4 hours**
2. **Length of Stay - Top quartile nationally for patients with frailty**
3. **Elective Recovery RTT - 92% of patients waiting under 18 weeks for treatment**
4. **Cancer 62 Day Standard - 85% of patients seen and treated within 62 days on a cancer pathway**

Breakthrough Objective:	Time to move to medical bed from decision to admit in Emergency Department
Corporate Project:	Discharge, Bed Configuration
Overarching Risk Appetite:	Operational - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite (1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20)
Strategic Metrics Summary:				
Person Centred, Integrated Care, Strong Partnerships	**The best place for person centred , integrated care**	**4 hour ED standard**	**Operational: Cautious**	
	An exemplar system for the care of the elderly	**Admissions of People with frailty**	**Operational: Cautious**	
	Equitable, Timely Access to Best Quality Planned Care	**18 Week RTT**	**Operational: Cautious**	
		Cancer – 62 day Treatment Standard	**Operational: Cautious**	

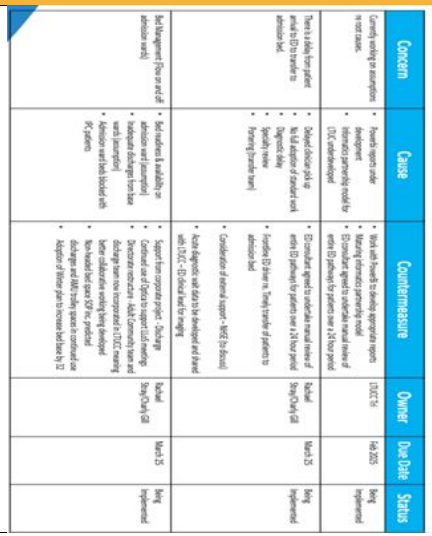
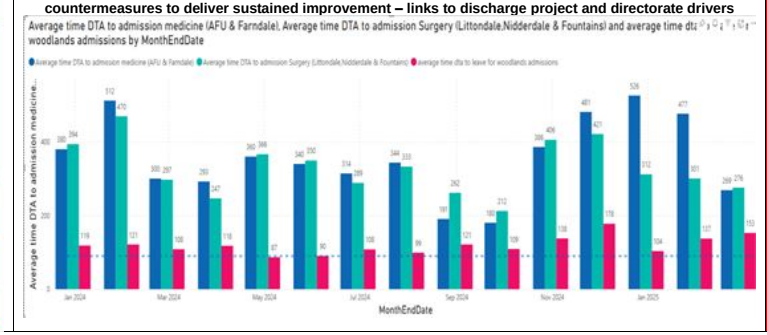
Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care	ED 4-hour standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated and discharged with 4 hours. 95% of admitted patients to be moved to required department within 60 minutes of medical decision.	By March 2026, we want to be at 85% of patients having their care completed within 4 hours. By March 2027, we want to be at 95% of patients having their care completed within 4 hours. **Breakthrough Objective** All patients will move to a ward within 120mins of the decision to admit being made Goal:10% Reduction in number of medical bed delays by June 2025 (missed November 2024 target)	**Concern** Currently working on assumptions re root causes. Lack of flow onto admission ward: Bed Management (Flow off admission wards) **Cause** Powerbi reports under development Informatics partnership model for LTUC underdeveloped Delay to requesting bed in ED Inadequate admission beds Admission ward beds predominantly made up of side rooms blocked with IPC patients esp. over winter months Inadequate discharges from base wards (assumption) **Countermeasure** Work with Powerbi to develop appropriate reports Maturing informatics partnership model ED consultant agreed to undertake manual review of entire ED pathways for patients over a 24 hour period Manual audit – committed use of ASCOM across all specialties to provide audit trail Mini catchball with ED tri – revised driver to address team dynamic and performance focus Consideration of external support – introductory meeting taken place Corporate project – ward configuration Corporate project - Discharge See LOS frailty **Owner** LTUCC Tri Rachael Stray/Charly Gill Rachael Stray/Charly Gill **Due Date** March 2025 March 25 March 25	**Significant bed and flow pressures linked to rising acuity and respiratory viruses through October, November, December leading to deterioration in performance. Winter Planning measures coming online to mitigate acuity/demand/system pressures. Early opening of winter escalation enacted. Optica now fully rolled out** **Winter recovery measures in January have improved performance. Focus now back onto aligning countermeasures to drive sustained improvement and step change back to 78%** Performance Including Ripon / Year / Month / Non Admitted Breaches / Admitted Breaches / Attendances Including Ripon 62.31% 2022 March 1226 889 5611 66.84% 2022 April 830 789 4885 68.46% 2022 May 957 793 5549 71.87% 2022 June 772 793 5564 71.54% 2022 July 786 802 5580 66.86% 2022 August 964 803 5332 64.17% 2022 September 1075 825 5303 68.22% 2022 October 857 814 5258 66.22% 2022 November 875 857 5128 63.65% 2022 December 943 959 5235 78.49% 2023 January 385 643 4649 80.79% 2023 February 329 551 4580 78.45% 2023 March 461 688 5337 83.48% 2023 April 360 501 5219 81.56% 2023 May 461 610 5815 80.54% 2023 June 536 617 5926 81.95% 2023 July 522 532 5838 72.89% 2023 August 784 736 5607 65.56% 2023 September 1157 840 5799 69.87% 2023 October 809 890 5656 68.91% 2023 November 854 838 5443 67.10% 2023 December 920 931 5626 72.04% 2024 January 767 889 5772 71.97% 2024 February 778 713 5320 78.15% 2024 March 576 670 5702 72.51% 2024 April 725 815 5606 73.40% 2024 May 864 790 6219 72.88% 2024 June 873 787 6121 74.25% 2024 July 816 772 6168 79.23% 2024 August 636 592 5912 75.44% 2024 September 831 668 6103 72.23% 2024 October 837 824 5981 68.99% 2024 November 986 863 5965 66.93% 2024 December 1067 929 6035 73.15% 2025 January 703 844 5634 73.66% 2025 February 718 668 5266 		

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Care of the elderly 	Length of Stay with frailty	Top quartile LOS nationally for patients with frailty by March 2026	1st Goal: To identify all patients with frailty by developing a suitable platform for recording and accessing Clinical Frailty Scores, and undertake more detailed evaluation of assessment admission pathways based on CFS data 2nd Goal: to reduce the overall number of patients with frailty who are admitted by improving access for all appropriate patients to early specialist review and intervention 3rd Goal: For those patients with frailty who do require inpatient care, to reduce the average length of stay through early specialist review and intervention	**Concern** Limited accurate data regarding discharge Delayed discharges from all frailty wards Disproportionate number of Leeds council patients on the discharge caseload (21% of all open TAFs) **Cause** Multiple systems used across the Trust The current number of patient discharges per week from AFU, Byland, and Jervaulx at HDFT is not meeting the required target Poor engagement from Leeds services; Limited understanding of Leeds process by HDFT colleagues **Countermeasure** • Dedicated SM resource from 13/01/25 to focus on performance and data • Further Optica tailoring to ensure that it is fit for purpose and includes accurate live data • Corporate discharge project • IMPACT rollout to frailty inc. Collect data escalate transport delays; Develop standard work for MDTs • H@H – GIRFT recommendations – awaiting report – workforce review • Escalated to Programme Director for Intermediate Care at the ICB with subsequent excellent engagement from Leeds Community Healthcare and Leeds city council • From w/c 10 Feb - revamped Monday meeting with requested that broader range of colleagues in attendance • From 11/2 Lead social worker for Leeds city council working onsite at HDFT	Delay due to timescales for EPR. Bed capacity issues have made it difficult to progress the Transformation of the admission process at present. Weekly discharge achievement by ward - Power BI Frailty – percentage of patients over 6 LOS day has further reduced after peaking in December Year, Month / Percentage of frailty emergency admits that stay longer than 7 days / Sum of over 7 LOS 2024, January 46% 58 2024, February 48% 99 2024, March 52% 107 2024, April 51% 116 2024, May 49% 106 2024, June 47% 92 2024, July 50% 112 2024, August 53% 112 2024, September 44% 99 2024, October 51% 116 2024, November 45% 92 2024, December 59% 101 2025, January 49% 94 2025, February 46% 93 Average Frailty LOS also reduced in February Year, Month / Average of LOS days 2024, March 13.50 2024, April 15.02 2024, May 15.15 2024, June 17.12 2024, July 16.21 2024, August 19.67 2024, September 13.17 2024, October 16.33 2024, November 18.72 2024, December 17.24 2025, January 17.70 2025, February 14.39		

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Equitable & Timely	Elective Recovery (RTT) standard	No patients waiting 18 weeks	By March 2025, no patients waiting over 52 weeks for treatment By March 2025, 18-52 weeks pathways reduced to 6,000 By March 2026, back to RTT 92% standard	Wharfedale Theatres (TIF1) gone live in September 2024, staffing in place HDH Additional Theatres (TIF2) build on track for 2026 delivery Outpatient Transformation, rollout of further faster programme and track 6 key metrics Theatres Productivity (80%)	On trajectory for clearance of 52 weeks.  Over 52-week pathways end of year breaches active: 247(800) down from 23,217(1st April 2024) Current pathways over 18 weeks = 6950 (7123) 18 week percentage = 68.9% (67.8%) ON TRACK - Theatre Shutdown in March does present some additional risks to complete clearance of 52 week waiters		
	62 Day Cancer standard	No patient would wait longer than 62 days and 85% of our patients will commence treatment within 62 days of referral	Less than 40 patients over 62 days by 1st April 2025 No patient would wait longer than 62 days and 85% of our patients will commence treatment within 62 days of referral	Developing workforce capability and expertise to better guide analyst time in creation of stratified data dashboard for cancer waiting times Ensure capacity to deliver first appointments within 19 days Stratify impact of complex imaging waits on cancer performance - data now available (August 2024): Imaging - Power BI 	February 83.9 % patients (provisional) treated by 62 days (Jan 76.5%) Cancer Performance Report - Power BI  ON TRACK		

Year	Month/Year	Total Accountable Treatments	Breaches (Accountable)	% Within 62 Days	Breaches (Actual Patients)	104+ day wait	Average Wait	Median Wait	Longest Wait
2023		846.5	237.5	71.9%	349	97	53.5	47	274
2024	January 2024	98.5	29.5	70.1%	43	13	54.1	48	254
	February 2024	93.0	20.5	78.0%	32	7	45.4	36	140
	March 2024	93.5	14.0	85.0%	26	10	49.2	40	182
	April 2024	86.5	25.5	70.5%	42	14	58.6	54	254
	May 2024	110.5	31.5	71.5%	44	5	51.0	47	193
	June 2024	95.5	27.5	71.2%	40	8	54.3	50	178
	July 2024	138.5	27.0	80.5%	42	6	47.0	44	154
	August 2024	127.5	22.5	82.4%	37	9	46.7	40	198
	September 2024	136.0	22.5	83.5%	42	9	48.6	41	181
	October 2024	123.0	20.0	83.7%	39	13	49.2	44	167
	November 2024	119.0	30.0	74.8%	42	11	51.1	42	309
	December 2024	119.0	19.0	84.0%	34	5	44.1	38	216
2025	January 2025	121.5	28.5	76.5%	48	13	53.6	47	222
	February 2025	118.0	19.0	83.9%	34	6	48.8	43	209

Breakthrough Objective:

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Time to move to medical bed from decision to admit in Emergency Department	ED 4-hour standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated and discharged with 4 hours. 95% of admitted patients to be moved to required department within 60 minutes of medical decision.	BO Goal is to reduce time to inpatient bed to under 120mins across all directorate admitting streams. Paediatrics Surgical Medical		**Breakthrough Objective**: **Time to inpatient bed less than 120mins from DTA** **Significant bed and flow pressures linked to rising acuity and respiratory viruses through October, November, December leading to deterioration in performance. Winter Planning measures coming online to mitigate acuity/demand/system pressures. Early opening of winter escalation enacted. Optica now fully rolled out** **Some recovery with winter recovery measures. Significant work to understand and develop the appropriate countermeasures to deliver sustained improvement – links to discharge project and directorate drivers** 		

Corporate Project:

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Discharge	ED 4 hours	No patient will remain in hospital after they no longer meet the criteria to reside	NCTR <10% Virtual Ward Occupancy >90% 'Outliers' on wards <1% Internal delays minimised	In development	**In development**		

Strategic Programme:

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
None							

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR61	Emergency Department (ED) 4 Hour Standard	Risk of increased morbidity/ mortality for patients due to a failure to meet the 4-hour standard. See the A3 & Breakthrough Objectives pertaining to this.	4 x 3 = 12	4 x 2 = 8	Clinical: Patient Safety	Minimal
CRR87	Community Dental	Risk to patient safety due to correlation of long waiting times and increased risk of pain and infection, which may affect quality of life and treatment required. Secondary risk to Trust performance standards by failing to meet NHS annual planning target of no RTT waiters beyond 78weeks currently, 65 weeks by end March 2024 and 52wks by end March 2025.	3 x 4 = 12	3 x 2 = 6 Aug 25	Clinical: Patient Safety	Minimal
CRR105	Cardiology: Risk to providing DGH urgent and emergency care services due to lack of 24/7 cover	Risk to HDFT being able to deliver acute DGH services due to the fragility of the cardiology service.	3 x 4 = 12	3 x 1 = 3	Clinical: Patient Safety	Minimal
CRR96	Stroke: Provision at HDFT for Stroke	Risk to patient care and safety due to delayed treatment caused by: - Lack of HASU Capacity at LTHT and YTHFT and aspects of the regional stroke pathway not being followed; - Potential delays in assessment of patients self-presenting with stroke at HDFT ED. Variation of access to HASU for patients suffering an inpatient stroke at HDFT.	4 x 4 = 16	2 x 2 = 4	Clinical: Patient Safety	Minimal
CRR106	Imaging for ED patients	Risk to patient safety due to potential delays to diagnostic imaging	4 x 3 = 12	4 x 1	Clinical: Patient Safety	Minimal

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	System (HNY) Urgent Care Pressure	Risk that Pressure across HNY providers will increase demand at HDFT, extend patient waiting times and numbers of patients exceeding 6 hours in the emergency department requiring admission leading to increased harm.	4 x 3 = 12	2 x 3 = 6	Clinical: Patient Safety	Minimal

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

STRATEGIC AMBITION: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS 2025-26

For Harrogate and District, our ambition is to support person centred, integrated care through strong local partnerships. Our goal is for Harrogate and District to be recognised as an exemplar for person centred, integrated care to ensure that patients get the right care, from the right staff, in the right place. With an increasingly elderly and frail population we will prioritise providing the highest quality care and best outcomes for this group, while ensuring that all our patients also benefit from the services and approaches for the elderly and frail. By increasing our capacity and productivity, we will reduce waiting times for planned care and ensure that there is equitable access for all.

GOALS:

Urgent & Emergency Care

The best place for person centred urgent and emergency care

Exemplar System

An exemplar system for the care of the elderly and people living with frailty

Equitable & Timely

Equitable, Timely access to best quality planned care

GOVERNANCE:

Person-centred Framework

- Board Assurance: Resource Committe
- Programme Board: Elective Programme Board, UEC Programme Board
- SRO: Chief Operating Officer
- Operational Lead: Deputy Chief Operating Officer

True North Metrics

1. ED 4hr Standard - 95% of patients admitted or dishcharged within 4 hours
2. Length of Stay - Top quartile nationally for patients with frailty
3. Elective Recovery RTT - 92% of patients waiting under 18 weeks for treatment
4. Cancer 62 Day Standard - 85% of patients seen and treated within 62 days on a cancer pathway

Breakthrough Objective:	Time to Inpatient Bed TBC – new Elective Care
Corporate Projects:	1. Bed Capacity 2. Patient Discharge 3. Ripon Primary Care 4. Outpatient Transformation
Overarching Risk Appetite:	Operational - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite 1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Person Centred, Integrated Care, Strong Partnerships	The best place for person centred urgent and emergency care	4 hour ED standard	Operational: Cautious	
	An exemplar system for the care of the elderly	Length of Stay - Patients with frailty	Operational: Cautious	
	Equitable, Timely Access to Best Quality Planned Care	18 Week RTT	Operational: Cautious	
		Cancer – 62 day Treatment Standard	Operational: Cautious	

Strategic Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care 	ED 4-hour standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated and discharged with 4 hours. 95% of admitted patients to be moved to required department within 60 minutes of medical decision.	By March 2026, we want to be at 85% of patients having their care completed within 4 hours. By March 2027, we want to be at 95% of patients having their care completed within 4 hours.	Development of Power BI Maturing Informatics Partnership Model ED pathways Auditing arrangements Corporate Projects	The True North Metric of ED 4 Hour Standard continues into its second year (2025-26). The target of a 78% compliance is to be achieved by end of March 2025. 2025-26 sees a step change with the goal of 85% compliance by March 2026. Countermeasures are noted. Breakthrough Objective: Time to Inpatient Bed (see below) Watch Metrics: • **12 hour breach numbers** • **Sepsis screening in ED** • **Ambulance Handovers** • **ED Attendances vs Plan** **Integrated Board Report - Power BI**		
An exemplar system for the care of the elderly and people living with frailty 	Length of Stay with frailty	Top quartile LOS nationally for patients with frailty by March 2026	1st Goal: To identify all patients with frailty by developing a suitable platform for recording and accessing Clinical Frailty Scores, and undertake more detailed evaluation of assessment admission pathways based on CFS data 2nd Goal: to reduce the overall number of patients with frailty who are admitted by improving access for all appropriate patients to early specialist review and intervention 3rd Goal: For those patients with frailty who do require inpatient care, to reduce the average length of stay through early specialist review and intervention	Development of Data for stratification with advent of new EPR Optica Corporate Project	The True North Metric of Length of Stay continues into its second year (2025-26). Three key goals remain: • Identifying all patients with frailty by developing a suitable platform for monitoring and review. • Reduce the overall number of patients with frailty admitted. • Reduce the length of stay for patients with frailty. With the implementation of the EPR a richer data source is anticipated to support stratification and the development of improved countermeasures Do these goals remain or change for 2025-26? Countermeasures are noted. Watch Metrics: • *Frailty LOS* • *Proportion of LLOS Frailty patients*		

Equitable & Timely 	Elective Recovery (RTT) standard	No patients waiting 18 weeks	By March 2026, back to RTT 92% standard	HDH Additional Theatres (TIF2) build on track for 2026 delivery Outpatient Transformation, rollout of further faster programme and track 6 key metrics Theatres Productivity (80%)	The True North Metric of Elective Recovery (RTT) Standard continues into its second year (2025-26). The goal is to meet 0 patients over 52 weeks by end of March 2025 (Currently there are 247 to be treated). The goal was met for the 18-52 weeks pathway was reduced to 6,000 by end of March – significant reductions have occurred – it is likely that we will have 6500 patients in this time band. The Metric seems a step change for 2025-26 for RTT to meet constitutional standard of 92%. Countermeasures are noted.		
	62 Day Cancer standard	No patient would wait longer than 62 days and 85% of our patients will commence treatment within 62 days of referral	No patient would wait longer than 62 days and 85% of our patients will commence treatment within 62 days of referral	Developing workforce capability and expertise to better guide analyst time in creation of stratified data dashboard for cancer waiting times Ensure capacity to deliver first appointments within 19 days Stratify impact of complex imaging waits on cancer performance - data now available (August 2024): Imaging - Power BI	The True North Metric of 62 Day Cancer Standard continues into its second year (2025-26). The goal was met by the 1st April 2025 for there to be less than 40 patients over 62 days. A further step change for 2025-26 has been implemented. The goal that no patient will wait longer than 62 days and 85% of patients will commence treatment within 62 days of referral.		

Breakthrough Objective:

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Time to move to medical bed from decision to admit in Emergency Department	ED 4-hour standard	95% of admitted patients to be moved to required department within 60 minutes of medical decision.	Reduce time to inpatient bed to under 120mins from Decision to Admit - across all directorate admitting streams –Paediatrics, Surgical, Medical	*Development of Power BI* *Maturing Informatics Partnership Model* *ED pathways* *Auditing arrangements* *Corporate Projects*	This Breakthrough Objective, continues into 2025-26. Significant bed and flow pressures impacted on the ability to progress with this Breakthrough Objective in 2024-25. Significant improvement in January and February however short of the target. Work on discharge and flow as well as right sizing our beds is fundamental to supporting this - see corporate project on Discharge/Bed Capacity		
ELECTIVE CARE	Elective Recovery (RTT) standard	No patients waiting 18 weeks	In development	In development	In development		

Corporate Project:

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Bed Capacity Project	ED 4 Hour Standard	In development	In development	In development	In development		

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
	Length of Stay with frailty Elective Recovery (RTT) standard						
Patient Discharge	ED 4 hours	No patient will remain in hospital after they no longer meet the criteria to reside	NCTR <10% Virtual Ward Occupancy >90% 'Outliers' on wards <1% Internal delays minimised	In development	In development		
Ripon Primary Care	Length of Stay with frailty	In development	In development	In development	In development		
Outpatient Transformation Project	Elective Recovery (RTT) standard	In development	In development	In development	In development		

Strategic Programme:

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
None							

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR61	Emergency Department (ED) 4 Hour Standard	Risk of increased morbidity/ mortality for patients due to a failure to meet the 4-hour standard. See the A3 & Breakthrough Objectives pertaining to this.	4 x 3 = 12	4 x 2 = 8 March 25	Clinical: Patient Safety	Minimal
CRR87	Community Dental	Risk to patient safety due to correlation of long waiting times and increased risk of pain and infection, which may affect quality of life and treatment required. Secondary risk to Trust performance standards by failing to meet NHS annual planning target of no RTT waiters beyond 78weeks currently, 65 weeks by end March 2024 and 52wks by end March 2025.	3 x 4 = 12	3 x 2 = 6 Aug 25	Clinical: Patient Safety	Minimal

CRR96	Stroke: Provision at HDFT for Stroke	Risk to patient care and safety due to delayed treatment caused by: - Lack of HASU Capacity at LTHT and YTHFT and aspects of the regional stroke pathway not being followed; - Potential delays in assessment of patients self-presenting with stroke at HDFT ED. Variation of access to HASU for patients suffering an inpatient stroke at HDFT.	4 x 4 = 16	2 x 4 = 8 January 25	Clinical: Patient Safety	Minimal
CRR106	Imaging for ED patients	Risk to patient safety due to potential delays to diagnostic imaging	4 x 3 = 12	4 x 1 = 4 July 23	Clinical: Patient Safety	Minimal

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	System (HNY) Urgent Care Pressure	Risk that Pressure across HNY providers will increase demand at HDFT, extend patient waiting times and numbers of patients exceeding 6 hours in the emergency department requiring admission leading to increased harm.	4 x 3 = 12	2 x 3 = 6	Clinical: Patient Safety	Minimal

STRATEGIC AMBITION: OVERARCHING FINANCE 2024-2025

GOALS:

Financial Sustainability

HDFT To be a financial sustainably organisation

GOVERNANCE:

Financial Framework

- Board Assurance: Resource Committee
- Performance Review Meetings and Strategy Deployment Room
- SRO: Director of Finance
- Operational Lead: Deputy Director of Finance

True North Metrics (Executive Lead: 10-15 Year deliverable)

1

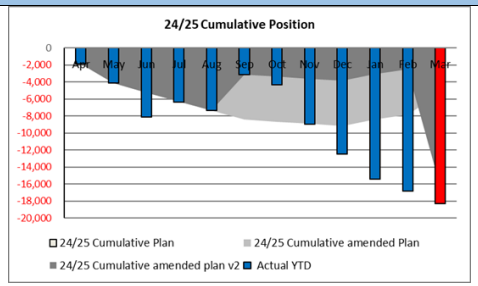
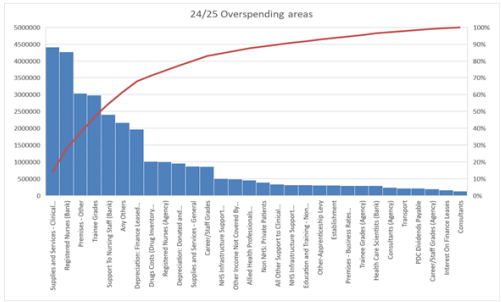
- **Financial Sustainability**

Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Financial - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
Finance	Financial Sustainability	Annual Breakeven	Financial: Cautious	1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
		System Oversight Rating		

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
Financial Sustainability	HDFT to be a financially sustainable organisation	In 2024/25 the Trust, and therefore directorates, should live within the financial resources available to us.	In relation to the operational position the current countermeasures are in place – 1. Delivery of coding optimisation schemes 2. Activity delivery schemes 3. Wider Waste Reduction and Productivity (WRAP) Schemes	As at month 11 the Trust is reporting a deficit of £16.9m against a planned deficit of £2.5m. The majority of Council have finalised the pay award funding, 1 contract remains outstanding and 1 contract has been excluded due to the clawback clause in the contract. Current forecast is from £16.4m (Best) £18m (likely) to £20m (worse) deficit.		

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
		Where this is not possible there is a need to develop wider mitigating actions. The Trust will return to segment 2 of the National Oversight Framework.	4. Review of "unfunded" posts 5. Controls and actions regarding Medical and Dental/Agency 6. Approach to Clinical Supplies and Services 7. PRM focus – move from budget change to run rate impact To support delivery there is also wider Monthly Financial reporting, REACH reporting (financial reporting system) has been rolled out to increase visibility and accessibility of spend information. Discretionary Spend controls and monitoring in place. Additional approval for spend over £10k introduced. NHS Supply Chain restrictions. Introduction WRAP Champions being developed. There is a formal plan in relation to the Price Waterhouse Cooper review commissioned by the West Yorkshire Association of Acute Trusts for the Trust, however, a number of countermeasures are responding to the findings. The Trust is currently participating in the Grant Thornton review of the financial grip and control in Humber and North Yorkshire Integrated Care System. Following the change in Trust segmentation work is being undertaken to establish the exit criteria associated with finance.	 Key areas of overspend are summarised below, the top 4 areas include Clinical Supplies, Bank registered nurses, Premises and Trainee Grades.  Although winter costs commenced early than anticipated the winter ward and escalation beds shut during February, winter costs YTD £268k. The deficit position is impacting the Trust cash position and cash support has been requested for March, £18.6m which is due to be reviewed at NHSE/DHSC panel. An emergency cash control protocol is being developed due to cash concerns forecast for 25/26. Further detail is contained within the finance A3 and regular finance report shared at Resource Committee. The Trust has been moved into Segmentation 3+ following our current financial performance.		

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
				To note there are already a number of controls in place however more unpalatable decisions may need to be considered to deliver affordable plans for 25/26 this is also being discussed with the ICB.		

Breakthrough Objective:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions

Corporate Project:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions

Strategic Project:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR94	Delivery of Financial Plan	The trust position has continued to deteriorate through the year and the forecast protocol will be enacted as the likely forecast for 24/25 is a £16.4m deficit. The Trust has been moved into segment 3+ due to the financial performance to date.	4 x 4 = 16	3 x 4 = 12 March 2025	Financial: revenue, funding and liquidity	Cautious
CRR95	Local Authority funding for the impact of NHS pay award	Complexity with the approach to funding and competing guidance result in pay award funding for 2023/24 and 2024/25 pay awards being slow to agree. Potential for revenue pressure, as well as cashflow whilst	2 x 2 = 4	4 x 1 = 8 March 2025	Financial: revenue, funding and liquidity	Cautious

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
		discussions are ongoing. £2m financial pressure if no funding is forthcoming. Local Authorities have received an uplift to their public health grants in quarter 4, ongoing conversations continue on the transfer of these funds.				
	Group Cash Position	Cash support required for March 25 and concerns for 25/26 have been flagged. An emergency cash protocol are being developed.	4 x 4 = 16	4 x 2 = 8 July 2025	Financial: revenue, funding and liquidity	Cautious

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	Annual Planning 25/26	Although guidance has been issued, the Trust is still awaiting confirmation on agreed funding and activity levels from the ICB. Council Contracts are being contacted to agree opening positions and payments from 1st April.	3 x 3 = 9	4 x 1 = 4 May 2025	Financial: revenue, funding and liquidity	Cautious

STRATEGIC AMBITION: OVERARCHING FINANCE 2025-2026

Our ambition is to provide the best quality, safest care whilst being a financially sustainable organisation.

GOALS:

Financial Sustainability

HDFT To be a financial sustainably organisation

GOVERNANCE:

Financial Framework

- Board Assurance: Resource Committee
- Performance Review Meetings and Strategy Deployment Room
- SRO: Director of Finance
- Operational Lead: Deputy Director of Finance

True North Metrics (Executive Lead: 10-15 Year deliverable)

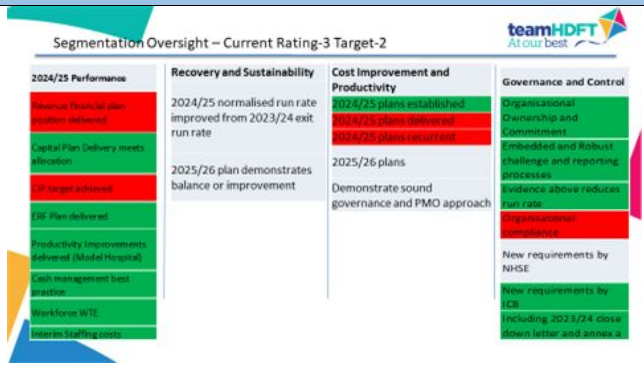
1. • **Annual Breakeven**
2. • **System Oversight Framework Rating**

Breakthrough Objective:	NEW - In Development
Corporate Project:	Whole Trust WRAP Schemes
Overarching Risk Appetite:	Financial - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Finance	Financial Sustainability	Annual Breakeven	Financial: Cautious								
		System Oversight Framework Rating									

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
Financial Sustainability	HDFT to be a financially sustainable organisation	In 2025/26 the Trust, and therefore directorates, should live within the financial	In relation to the operational position the current countermeasures will be in place 1. Controls implemented in 24/25 maintained. 2.	The True North Metric of Financial Sustainability continues into its second year (2025-26). The goal was delivered March 2025 with a Trust breakeven forecast to year end. The Trust also ended 2024-25 in Segment 3 in the Oversight Framework due to the in year financial position.		

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
		resources available to us. The Trust will return to segment 2 of the National Oversight Framework.	 3. Delivery of activity plans resulting in ERF allocation. 4. Waste Reduction and Productivity schemes delivered against the Trust target. 5. Continued focus on reducing agency and bank costs. Maintain/Reduce WTE.	 Countermeasures are noted. Watch Metrics: • *WRAP delivery against Trust target* • *Activity delivery against plan* *Number of CC's managing within allocated budgets*		

Breakthrough Objective:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
NEW			**In Development – further information to be included for the May 2025 update.**			

Corporate Project:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
NEW			**In Development – further information to be included for the May 2025 update.**			

Strategic Project:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
None						

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR94	Delivery of Financial Plan	The trust position has continued to deteriorate through the year and the forecast protocol will be enacted as the likely forecast for 24/25 is a £18m deficit. The Trust has been moved into segment 3+ due to the financial performance to date.	4 x 4 = 16	4 x 2 = 8 March 2025	Financial: revenue, funding and liquidity	Cautious
CRR95	Local Authority funding for the impact of NHS pay award	Complexity with the approach to funding and competing guidance result in pay award funding for 2023/24 and 2024/25 pay awards being slow to agree. Potential for revenue pressure, as well as cashflow whilst discussions are ongoing. £2m financial pressure if no funding is forthcoming. Local Authorities have received an uplift to their public health grants in quarter 4, ongoing conversations continue on the transfer of these funds.	3 x 2 = 6	4 x 1 = 8 March 2025	Financial: revenue, funding and liquidity	Cautious
NEW	New risk - Group Cash Position	Cash support required for March 25 and concerns for 25/26 have been flagged. An emergency cash protocol are being developed.	4 x 4 = 16	4 x 2 = 8 July 2025	Financial: revenue, funding and liquidity	Cautious

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	Annual Planning 25/26	Although guidance has been issued, the Trust is still awaiting confirmation on agreed funding and activity levels from the ICB. Council Contracts are being contacted to agree opening positions and payments from 1st April.	3 x 3 = 9	4 x 1 = 4 May 2025	Financial: revenue, funding and liquidity	Cautious

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

Board of Directors
March 2025

4.3

Title:	Annual Planning 2025/26
Responsible Director:	Executive Director of Finance
Author:	Executive Director of Finance

Purpose of the report and summary of key issues:	This report has been developed to outline progress with the 2025/26 financial plan, as well as support the Board in approving operational plans, financial plans and submissions to NHS England.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	x
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	x
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	x
	BAF4.4 To be financially stable to provide outstanding quality of care	x
Corporate Risks	Risks are to be updated on the Corporate risk register related to this report. Risks are being managed within local risk registers, and will be escalated when appropriate.	
Report History:	Information within the reported is supported by Directorate Board discussions, and the monthly Resource Review sessions. The paper was reviewed at the Extra Ordinary Board held on the 19th March 2025.	
Recommendation:	The Committee is asked to note the contents of the report, recommend the approval of the 2025/26 financial plan and the subsequent submissions to NHS England as described within the report.	

Annual Plan and Budget Sign Off
Board of Directors – Harrogate and District NHS Foundation Trust
March 2025

Summary

This paper has been developed to describe the current position in relation to annual planning, as well as inform the Board approval of the Annual Financial Plan, the operational and workforce context of this plan, and the operational budgets which support this. These items underpin the delivery of the Strategic Ambitions and wider HDFT Impact work in 2025/26.

As part of the planning process, there are also a series of assurance statements the Board of Directors are asked to approve. These are detailed in the final section of the report.

At the time of drafting the paper, the current Trust position is a balanced plan, however, the Trust is working with Humber and North Yorkshire (HNY) Integrated Care Board (ICB) to ensure income and expenditure assumptions are aligned.

Financial Plan

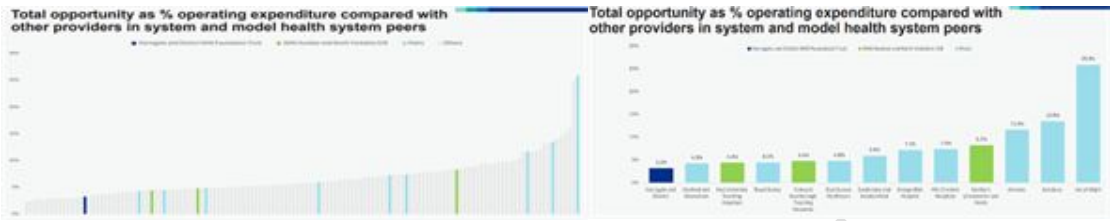
As described at the Board of Directors workshop in February, the Trust has prepared a plan for 2025/26 which results in a break even position. This is summarised in the table below and described in more detail in Appendix 1.

	Forecast Out-turn £'000	Plan £'000
Operating income from patient care activities	344,615	359,141
Other operating income	28,060	24,737
Employee expenses	- 275,951	- 283,117
Operating expenses excluding employee expenses	- 109,887	- 95,575
OPERATING SURPLUS/(DEFICIT)	**- 13,163**	**5,186**
FINANCE COSTS		
Finance income	1,509	200
Finance expense	- 349	- 624
PDC dividend expense	- 4,939	- 5,262
NET FINANCE COSTS	**- 3,779**	**- 5,686**
Other gains/(losses) including disposal of assets	12	-
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**- 16,930**	**- 501**
Adjustments to financial performance surplus/(deficit)	530	501
Adjusted financial performance surplus/(deficit)	**- 16,400**	**-**

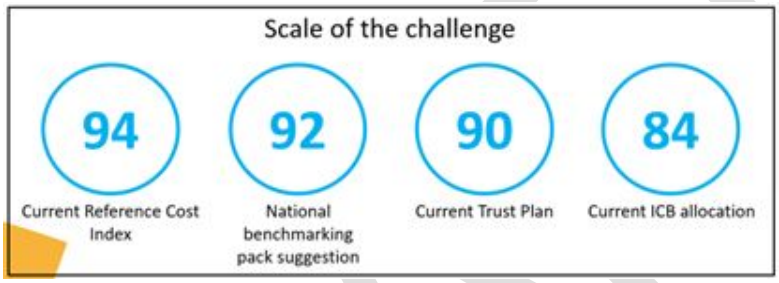
The plan is a significant improvement on the £21.6m deficit forecast for 2024/25 prior to deficit support funding which was received in two lots during 2024/25 (£5.2m at plan sign off, £16.4m at month 12). As described throughout the year and during 2024/25 planning, there are material changes to the provision of services the Trust provides. Trust management is seeking to address this as part of the planning round for 2025/26, ensuring that resource is following the patients appropriately. The Trust is working with HNY ICB and wider partners to deliver a balanced system plan. Discussions are live in relation to how this is managed across the system, as well as the approach to risk associated with this.

Within the annual plan, the Trust aims to deliver a £14.4m Waste Reduction and Productivity (WRAP) requirement. This represents 4.02% of Trust income associated with patient care.

In relation to the Trust approach, the national benchmarking and opportunity analysis has been used as a starting point for plans. The graphs below outline the benchmarking information at region and peer level, as well as the national opportunities by provider. This information was previously shared at Resource Committee.



It should be noted that this challenge sits in the context of the Trust already having a positive reference cost position. The average cost nationally is 100, with rating below 100 being a positive reflection on Trust efficiency. The graphic below outlines the current position, the national opportunity, the current Trust plan and the impact if the Trust accepted the ICB contract allocation.



It is therefore clear that the Trust should take a realistic approach to targeted efficiency, hence maintaining the 4.02% target. There are two further points of note here –

1. In order to reduce the planning gap between Trust and ICB, it is clear that an approach to decommissioning or service change is required. If the Trust was to accept a reduction there are a series of issues which include but are not limited to -

    a. The impact of the Trust Oversight Segment, where one of the key requirements was to move to a break even position

    b. The impact on cash if the Trust continues to spend more than the revenue and resource available

    c. The Equality and Quality Impact Assessment of any impact of decommissioning/reducing capacity would need to be undertaken rapidly.

2. The annual planning guidance described a need to increase productivity and efficacy of elective work. The Trust has included a 4% improvement as part of activity planning, but has not reported this benefit externally from a financial perspective. There is currently a consideration about including this within external reporting if other Trusts are aligning to this approach.

The current planning position is outlined in the table below.

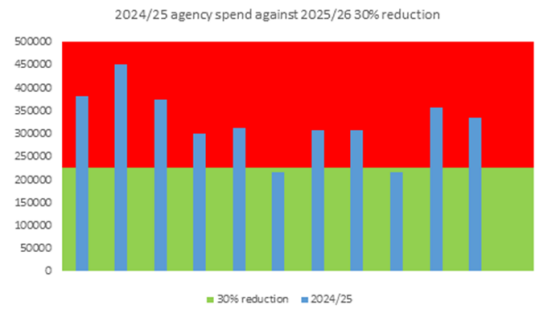
	Target	Actioned	Low	Medium	High	Unidentified	Total	Total %age	Risk Adjusted Plans	Risk adjusted shortfall	Risk Adj %age	Cost Reduction
Central	2,362,398	0	0	0	100,000	2,262,398	100,000	4%	20,000	2,342,398	1%	1,013,400
CYPPH	1,474,617	43,800	0	20,000	2,305,200	-894,383	2,369,000	161%	520,840	953,777	35%	0
LTUCC	4,578,563	145,086	71,000	1,515,885	3,934,246	-1,087,654	5,666,217	124%	2,212,093	2,366,470	48%	0
PSC	4,801,063	211,300	260,000	700,000	2,629,500	1,000,263	3,800,800	79%	1,544,200	3,256,863	32%	56,800
Corporate	1,271,115	-294,000	555,300	350,000	370,000	289,815	981,300	77%	587,535	683,580	46%	749,000
Total Trust	**14,487,756**	**106,186**	**886,300**	**2,585,885**	**9,338,946**	**1,570,439**	**12,917,317**	**89%**	**4,884,668**	**9,603,088**	**34%**	**1,819,200**
HIF	925,000	725,800	70,000	80,000	0	49,200	875,800	95%	856,300	68,700	93%	0
Total Group	**15,412,756**	**831,986**	**956,300**	**2,665,885**	**9,338,946**	**1,619,639**	**13,793,117**	**89%**	**5,740,968**	**9,671,788**	**37%**	**1,819,200**

Directorate budgets which support this plan are outlined in the appendix 2.

Workforce Plan

During the planning round there has been increased external focus on ensuring headcount does not increase and providers are meeting the required levels of temporary staffing reduction. The Trust plan for 2025/26 is aligned to these requirements after the TUPE associated with new 0-19 contracts. There is an increase in staffing within the plan to support maternity and imaging services, both cases will be reviewed as part of the March governance cycle. There is a corresponding reduction in WTE associated with the WRAP programme.

In relation to agency expenditure, the Trust is proposing that the 30% reduction in agency expenditure is achievable. This is the result of the full year impact of 2024/25 changes and positive recruitment to high cost medical staffing roles. The graph below describes this change.



The graph to the left outlines the reduction in spend from quarter 1 onwards, as well as the Trust being able to achieve the 30% reduction in two months of 2024/25. The graph to the right is pareto analysis of agency spend, and where cost centres are crossed out we know there has been positive recruitment to mitigate this spend.

Finally, in terms of bank reduction the anticipated reduction in cost of 10% will be achieved through similar means.

It should be noted that the Trust is forecast to achieve reductions in bank and agency for 2024/25 against 2023/24 of 17% and 46% respectively.

Operational and Performance Plan

At the February Board workshop the operational and performance requirements for the Trust were outlined in detail, as well as the plans associated with achievement. These are summarised below.

The wider system is assured about the approach here, however, the conversation at present is in relation to the uneven achievement of these targets at other providers. The key example relates to HDFT planning to have 0 patients waiting over 52 weeks which is over delivering against plan. This is in contrast to other NHS providers having more significant concerns in this area.

Recommendations

From an internal governance perspective, the Board of Directors is asked to approve the current Financial Plan for 2025/26, as well as the supporting budgets outlined in Appendix 2. This approval is in the context of system plans yet to be finalised, and may need to be considered further at the full Board session at the end of the month. The key issue here will be how the risk and gain share approach supports finalisation of plans in the current available time.

The Board of Directors is asked to approve the operational and workforce plans associated with this plan as described above.

Finally, the following assurance statement is to be submitted alongside the annual planning process. The Board is asked to discuss and approve these to be submitted alongside the Annual Plan documents to NHS England.

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.	Yes	Described in Board workshop sessions during 2024/25 and as part of board pack for workshop in February.
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	Yes	Revised as part of HDFT IMPACT and Strategy Deployment Approach which has been reviewed by the Board throughout 2024/25.
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	Yes	Described in Board workshop sessions during 2024/25 and as part of board pack for workshop in February.
A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.	Partial	The process in place is robust but is in the process of reviewing WRAP and Cost Pressure decisions at the time of drafting,
The organisation's plan was developed with appropriate input from and engagement with system partners.	Partial	As per description above, input and engagement has occurred, however, the addressing areas of risk has to either start in places or finalise decisions. Examples include agreements as part of UEC tier 1 sessions and the risk associated with Autism Assessments. Engagement with collaboratives (WY and HNY) is continuous, as well as working with Local Authority Partners on the provision of 0-19 service areas.

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	Yes	Included as part of February Board Workshop and as part of March Extra Ordinary Board, including provider productivity packs, model hospital opportunity matrix.
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.	Yes	See discussion above.
The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.	Partial	Will be confirmed as part of the QEIA process above. May also have impact if decommissioning decisions are decided. Clearly risks, as described in the check in sessions with the system, are in place and do not have full mitigation. Autism Assessment waiting times is an example of this. The Trust risk register is available to support the partial position.
The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.	Partial	Yes but based on the points described above, in particular the impacts of elements associated with QEIA and decommissioning discussions.

Harrogate and District NHS Foundation Trust (HARROGATE / RCD)
04. SoCI

1	**Statement of comprehensive income**		Expected Sign	04FOTPY Forecast Out-turn 31/03/2025 Year Ending £'000	04PLANCY Plan 31/03/2026 Year Ending £'000	Maincode Subcode
	Operating income from patient care activities		+	344,615	**359,626**	SCI0100
	Other operating income		+	28,060	**24,737**	SCI0110
	Employee expenses		-	(275,951)	**(283,117)**	SCI0120
	Operating expenses excluding employee expenses		-	(109,887)	**(96,012)**	SCI0130
	OPERATING SURPLUS/(DEFICIT)		+/-	**(13,163)**	**5,234**	SCI0140
	FINANCE COSTS					
	Finance income		+	1,509	**200**	SCI0150
	Finance expense		+/-	(349)	**(624)**	SCI0160
	PDC dividend expense	*i*	+/-	(4,939)	**(5,262)**	SCI0170
	NET FINANCE COSTS		+/-	**(3,779)**	**(5,686)**	SCI0180
	Other gains/(losses) including disposal of assets		+/-	12	**0**	SCI0190
	Share of profit/(loss) of associates/joint ventures		+/-	0	**0**	SCI0200
	Gains/(losses) from transfers by absorption	*i*	+/-	0	**0**	SCI0210
	Movements in fair value of investments, investment property, financial liabilities and finance lease receivables		+/-	0	**0**	SCI0220
	Corporation tax expense		-	0	**0**	SCI0230
	SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR		+/-	**(16,930)**	**(452)**	SCI0240

2	**Adjusted financial performance**		Expected Sign	04FOTPY Forecast Out-turn 31/03/2025 Year Ending £'000	04PLANCY Plan 31/03/2026 Year Ending £'000	Maincode Subcode
	Surplus/(deficit) for the period/year		+/-	(16,930)	**(452)**	SCI0270
	Add back all I&E impairments/(reversals)	*i*	+/-	0	**0**	SCI0280
	Adjust (gains)/losses on transfers by absorption		+/-	0	**0**	SCI0290
	Surplus/(deficit) before impairments and transfers		+/-	**(16,930)**	**(452)**	SCI0300
	Retain impact of DEL I&E (impairments)/reversals	*i*	+/-	0	0	SCI0310
	Remove capital donations/grants/peppercorn lease I&E impact	*i*	+/-	530	452	SCI0320
	Prior period adjustments to correct errors and other performance adjustments	*i*	+/-	0		SCI0330
	Remove net impact of consumables donated from other DHSC bodies		+/-	0		SCI0338
	Remove loss recognised on peppercorn lease disposals		+/-	0	**0**	SCI0343
	Remove PFI revenue costs on an IFRS 16 basis		+/-	0	**0**	SCI0352
	Add back PFI revenue costs on a UK GAAP basis		+/-	0	**0**	SCI0353
	Adjusted financial performance surplus/(deficit)		+/-	**(16,400)**	**0**	SCI0340
	Adjusted financial performance excluding Non-Recurrent Deficit Funding					
	Adjusted financial performance surplus/(deficit)		+/-	(16,400)	0	SCI0362
	Less Non-Recurrent Deficit Funding		-	(5,297)	0	SCI0395
	Adjusted financial peformance surplus (deficit) excluding Non-Recurrent Deficit Funding		+/-	(21,697)	0	SCI0396

3	**Earnings before interest, taxation, depreciation and amortisation (EBITDA)**	Expected Sign	04FOTPY Forecast Out-turn 31/03/2025 Year Ending £'000	04PLANCY Plan 31/03/2026 Year Ending £'000	Maincode Subcode
	Operating surplus/(deficit)	+/-	(13,163)	**5,234**	SCI0370
	Add back depreciation and amortisation	+	13,746	**11,552**	SCI0380
	Add back all I&E impairments/(reversals)	+/-	0	**0**	SCI0390
	Less donations of physical assets and peppercorn leases (non-cash)	-	0	**0**	SCI0392
	Less cash donations / grants for the purchase of capital assets	-	0	**0**	SCI0394
	EBITDA	+/-	**583**	**16,786**	SCI0400
	Income relating to EBITDA	+	372,675	384,363	SCI0402
	EBITDA percentage	%	**0.2%**	**4.4%**	SCI0404

Harrogate and District NHS Foundation Trust (HARROGATE / RCD)
08. Op Inc (source)

Income from patient care activities (by source)		Expected Sign	08FOTPY Forecast Out-turn 31/03/2025 Year Ending £'000	08PLANCY Plan 31/03/2026 Year Ending £'000	Maincode Subcode
NHS England		+		21,809	INC1100
Integrated Care Boards		+		263,519	INC1110
NHS foundation trusts		+		328	INC1120
NHS trusts		+		0	INC1130
Local authorities		+		66,410	INC1140
Department of Health and Social Care		+		0	INC1150
NHS other (including UKHSA and MHRA)		+		0	INC1160
Non-NHS: private patients		+		752	INC1170
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)		+		69	INC1180
Injury cost recovery scheme		+		400	INC1190
Non-NHS: other		+		6,339	INC1200
Total income from patient care activities		+		359,626	INC1220

Other operating income		Expected Sign	08FOTPY Forecast Out-turn 31/03/2025 Year Ending £'000	08PLANCY Plan 31/03/2026 Year Ending £'000	Maincode Subcode
Research and development (both IFRS 15 and non-IFRS 15 income)		+		1,000	INC1230
Other operating income recognised in accordance with IFRS 15:					
Education and training (excluding notional apprenticeship levy income)	i	+		10,500	INC1240A
Non-patient care services to other WGA bodies	i	+		649	INC1280
Non-patient care services to other Non WGA bodies	i	+		1,476	INC1290
Income in respect of employee benefits accounted on a gross basis		+		3,867	INC1320
Other (recognised in accordance with IFRS 15)	i	+		6,637	INC1350
Other operating income recognised in accordance with other standards:					
Education and training - notional income from apprenticeship fund	i	+		0	INC1240B
Donations of physical assets and peppercorn leases (non-cash)		+	0	0	INC1250
Cash donations / grants for the purchase of capital assets		+	0	0	INC1260
Charitable and other contributions to expenditure		+		0	INC1270
Support from DHSC for mergers	i	+		0	INC1300
Rental revenue from finance leases		+		0	INC1330
Rental revenue from operating leases		+		26	INC1340
Other (recognised in accordance with standards other than IFRS 15)	i	+		582	INC1355
Total other operating income		+		24,737	INC1360
Of which NHSE specialised commissioning		+		0	INC1361

Information on 'other (recognised in accordance with IFRS 15)' in other operating income		Expected Sign	08FOTPY Forecast Out-turn 31/03/2025 Year Ending £'000	08PLANCY Plan 31/03/2026 Year Ending £'000	Maincode Subcode
PFI support income		+		0	INC1370
Car parking income		+		1,191	INC1380
Catering		+		1,000	INC1390
Pharmacy sales	i	+		0	INC1400
Staff accommodation rental		+		376	INC1420
Non-clinical services recharged to other bodies		+		0	INC1430
Other income not covered by table 2 and the other rows in table 3		+		3,487	INC1430
Other income generation schemes (recognised under IFRS 15)	i	+		583	INC1440
Total		+		6,637	INC1450

Analysis of NHSE and ICB patient care income		Expected Sign	08FOTPY Forecast Out-turn 31/03/2025 Year Ending £'000	08PLANCY Plan 31/03/2026 Year Ending £'000	Maincode Subcode
Specialised Commissioning Service Contract Income					
Specialised Commissioning Core Service Contract Income (not including drugs)	i	+		15,644	INC1853
Specialised High Cost Drugs Baseline Income	i	+		0	INC1856
Total specialised Local commissioner core service income		+		15,644	INC1860
Plus adjustments for specialised high cost drug income received from national specialised commissioning (13Q)					
Cancer drugs fund and innovative medicines fund	i	+		0	INC1865
Hep C	i	+		0	INC1870
Variation against other specialised cost and volume high cost drugs paid by 13Q	i	+/-		0	INC1875
Specialised devices excluded from contract baselines	i	+/-		0	INC1880
Specialised core service income from 13Q national	i	+/-		0	INC1882
Total Specialised core service income from 13Q national		+/-		0	INC1883
Total specialised commissioning patient care income		+		15,644	INC1885
Other patient care income from NHSE		+		6,165	INC1900
Total patient care income from NHSE		+		21,809	INC1905
Specific revenue support fund for the short-term revenue impacts of national capital programmes	i	+		0	INC1953
Non Recurrent Deficit Funding from ICB		+	5,297	0	INC1965
Delegated Specialised Commissioning Income from ICB	i	+		227,000	INC1967
Other patient care income from ICB		+		36,519	INC1955
Total patient care income from ICB		+		263,519	INC1960

Memorandum: Income from the Workforce, Training and Education (WT&E) Directorate		Expected Sign	08FOTPY Forecast Out-turn 31/03/2025 Year Ending £'000	08PLANCY Plan 31/03/2026 Year Ending £'000	08PLANCYMOVE Year on year movement Plan 31/03/2026 Year Ending £'000
Postgraduate Medical and Dental	i	+	5,760	6,888	1,128
Undergraduate Medical and Dental	i	+	933	1,008	75
Clinical (non-medical)	i	+	3,345	2,988	(357)
Other (includes Education Support, Workforce Development and National Activities)	i	+	843	792	(51)
Total		+	**10,881**	**11,676**	**795**
Plan WT&E income >10% of total provider income	i				

Validations			
Signage	Blank cells	Significant year on year movement identified	Benchmark check against SoCI - commentary
OK	OK	OK	
OK		OK	
OK		OK	
OK		OK	
		OK	
			OK
0	0	0	0

Recovery of Non-NHS:overseas patients revenue (non-reciprocal, chargeable to patient)		Expected Sign
Total Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	i	+
Maximum chargeable value Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	i	+
Percentage of maximum overseas patients revenue recovered (non-reciprocal, chargeable to patients)		

Overseas visitors (relating to patients charged directly by the provider)	Expected Sign	08FOTPY Forecast Out-turn 31/03/2025 Year Ending £'000	08PLANCY Plan 31/03/2026 Year Ending £'000	Maincode Subcode
Income recognised this year	+		69	OPP0010
Cash payments received in year (relating to invoices raised in current and previous years)	+		0	OPP0020
Amounts added to allowance for impairment of receivables (relating to invoices raised in current and prior years)	+		0	OPP0030
Amounts written off in year (relating to invoices raised in current and previous years) - total	+		0	OPP0040
Of which amounts written off in year (relating to invoices raised in current and previous years) - write off due to financial hardship	+		0	OPP0060
Of which amounts written off in year (relating to invoices raised in current and previous years) - written off due to other reasons	+		0	OPP0050

Harrogate and District NHS Foundation Trust (HARROGATE / RCD)
10. Op Ex

				10FOTPY	10PLANCY	10PLANCOMM	Maincode
1	**Operating expenditure**			Forecast Out-turn 31/03/2025 Year Ending	Plan 31/03/2026 Year Ending	Plan 31/03/2026 Year Ending	
			Expected Sign	£'000	£'000	FREE TEXT	Subcode
	Purchase of healthcare from NHS and DHSC group bodies (excl. expense as a lead MH provider collaborative)	i	+		0		EXP0100
	Purchase of healthcare from non-NHS and non-DHSC group bodies (excl. expense as a lead MH provider collaborative)	i	+		0		EXP0110
	Purchase of healthcare from NHS and DHSC group bodies (expense as a lead MH provider collaborative)	i	+		0		EXP0102
	Purchase of healthcare from non-NHS and non-DHSC group bodies (expense as a lead MH provider collaborative)	i	+		0		EXP0112
	Purchase of social care	i	+		0		EXP0120
	Staff and executive directors costs		+		283,117		EXP0130
	Non-executive directors		+		206		EXP0140
	Supplies and services – clinical (excluding drugs costs)	i	+		26,544		EXP0150
	Supplies and services - general	i	+		3,383		EXP0160
	Drugs costs (drug inventory consumed and purchase of non-inventory drugs)		+		23,260		EXP0170
	Consultancy	i	+		204		EXP0190
	Establishment	i	+		2,310		EXP0200
	Premises - business rates collected by local authorities		+		1,342		EXP0210
	Premises - other		+		13,909		EXP0220
	Transport	i	+		1,920		EXP0230
	Depreciation		+	12,131	9,140		EXP0240
	Amortisation		+	1,615	2,412		EXP0250
	Impairments net of (reversals)		+/-	0	0		EXP0260
	Movement in credit loss allowance on receivables and financial assets	i	+/-		0		EXP0270
	Audit fees and other auditor remuneration	i	+		228		EXP0280
	Clinical negligence		+		8,653		EXP0290
	Research and development - staff costs		+		0		EXP0300
	Research and development - non-staff	i	+		0		EXP0310
	Education and training - staff costs		+		0		EXP0320
	Education and training - non-staff		+		735		EXP0330
	Lease expenditure	i	+		1,766		EXP0340
	Redundancy costs - staff costs		+		0		EXP0350
	Redundancy costs - non-staff		+		0		EXP0360
	Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	i	+		0		EXP0370
	Charges to operating expenditure for off-SoFP PFI/LIFT schemes	i	+		0		EXP0375
	Other		+		0		EXP0380
	Total operating expenditure		+		379,129		EXP0390

			10FOTPY	10PLANCY	10PLANCOMM	Maincode
2	**Reconciliation to operating expenditure excluding employee expenses**		Forecast Out-turn 31/03/2025 Year Ending	Plan 31/03/2026 Year Ending	Plan 31/03/2026 Year Ending	
		Expected Sign	£'000	£'000	FREE TEXT	Subcode
	Total operating expenditure	+	0	379,129		EXP0400
	Less staff costs disclosed as employee expenses:					
	Research and development	-	0	0		EXP0410
	Education and training	-	0	0		EXP0420
	Redundancy	-	0	0		EXP0430
	Other	-	0	0		EXP0440
	Staff and executive director costs	-	0	(283,117)		EXP0450
	Total operating expenditure excluding employee expenses	+	0	96,012		EXP0460

			10FOTPY	10PLANCY	10PLANCOMM	Maincode
3	**Depreciation expenditure**		Forecast Out-turn 31/03/2025 Year Ending	Plan 31/03/2026 Year Ending	Plan 31/03/2026 Year Ending	
		Expected Sign	£'000	£'000	FREE TEXT	Subcode
	Depreciation: owned assets	+	9,484	6,500		EXP0470
	Depreciation: donated and government granted assets	+	530	440		EXP0500
	Depreciation: PFI / LIFT (IFRIC 12) assets	+	0	0		EXP0490
	Depreciation: Right of use assets - leased assets	+	2,117	2,200		EXP0480
	Depreciation: Right of use assets - peppercorn leases	i +	0	0		EXP0505
	Total depreciation expenditure	+	12,131	9,140		EXP0510

			10FOTPY	10PLANCY	10PLANCOMM	Maincode
4	**Amortisation expenditure**		Forecast Out-turn 31/03/2025 Year Ending	Plan 31/03/2026 Year Ending	Plan 31/03/2026 Year Ending	
		Expected Sign	£'000	£'000	FREE TEXT	Subcode
	Amortisation: Intangibles - owned assets	+	1,615	2,400		EXP0520
	Amortisation: Intangibles - donated and government granted assets	+	0	12		EXP0540
	Amortisation: Right of use intangibles - leased assets (existing IAS 17 leases only)	i +	0	0		EXP0525
	Total amortisation expenditure	+	1,615	2,412		EXP0550

			10FOTPY	10PLANCY	10PLANCOMM	Maincode
5	**Drug costs**		Forecast Out-turn 31/03/2025 Year Ending	Plan 31/03/2026 Year Ending	Plan 31/03/2026 Year Ending	
		Expected Sign	£'000	£'000	FREE TEXT	Subcode
	High cost drugs (PbR excl & CDF)	+		19,060		EXP0560
	Other drug costs	+		4,200		EXP0570
	Total drug costs (drug inventory consumed and purchase of non-inventory drugs)	+		23,260		EXP0580

			10FOTPY	10PLANCY	10PLANCOMM	Maincode
6	**Memorandum: Breakdown of Premises other between energy and other costs**		Forecast Out-turn 31/03/2025 Year Ending	Plan 31/03/2026 Year Ending	Plan 31/03/2026 Year Ending	
		Expected Sign	£'000	£'000	FREE TEXT	Subcode
	Electricity costs	+		1,152		EXP0670
	Gas costs	+		780		EXP0671
	Oil costs	+		0		EXP0672
	Coal costs	+		0		EXP0673
	Electricity costs - green energy tariff	+		0		EXP0674
	Electricity costs - third party owned renewable	+		0		EXP0675
	Other energy costs	+		0		EXP0676
	Total Energy costs	+		1,932		EXP0680
	Other premises costs (excluding energy and business rates)	+		11,977		EXP0685
	Total Premises - Other	+		13,909		EXP0890

				10FOTPY	10PLANCY	10PLANCOMM	Maincode
7	**Memorandum: Digital and Technology Expenditure**	i		Forecast Out-turn 31/03/2025 Year Ending	Plan 31/03/2026 Year Ending	Plan 31/03/2026 Year Ending	
			Expected Sign	£'000	£'000	FREE TEXT	Subcode
	Pay		+		3,900		EXP0700
	Non Pay		+		4,788		EXP0705
	Total Digital and Technology Expenditure		+	0	8,688		EXP0710
	Plan Tech expenditure >10% of total provider expenditure	i					EXP0725

				10FOTPY	10PLANCY	10PLANCOMM	Maincode
8	**Memorandum: Virtual Wards Expenditure**	i		Forecast Out-turn 31/03/2025 Year Ending	Plan 31/03/2026 Year Ending	Plan 31/03/2026 Year Ending	
			Expected Sign	£'000	£'000	FREE TEXT	Subcode
	Virtual Wards Expenditure Pay		+		1,308		EXP0801
	Virtual Wards Expenditure Non Pay		+		4		EXP0802
	Total Virtual Wards Expenditure		+	0	1,312		EXP0810
	Plan Virtual Wards expenditure >2% of total provider expenditure	i					EXP0815

Directorate Summary Budget

Directorate	Budget (£'s)
CHILDRENS AND YOUNG PEOPLES PUBLIC HEALTH	-£5,656,267
CORPORATE SERVICES	£60,406,100
LONG TERM URGENT CANCER AND COMMUNITY	£98,060,800
PLANNED SURGICAL AND CHILDRENS	£60,526,465
Total Operational Directorate Budgets	**£213,337,098**

Directorate Budget - Detailed changes

Budget 25/26	RE - Opening Budget	RE - Cost Pressures	RE - Rec Allocations	RE - Internal Adjustments (Within Directorate)	RE - WRAP	NR - Non Recurrent	RE - Budget Setting Adjustments	RE - Pay Award	NR - WRAP	RE - New Contracts	NR - Budget Setting Adjustments	Grand Total
CAPITAL CHARGES	**£8,800,000**		**£100,000**									**£8,900,000**
Non Pay Expenditure	£8,800,000		£100,000									£8,900,000
CENTRAL	**-£41,051,200**	**£6,438,700**	**£32,041,002**		**-£3,131,800**	**-£210,000**	**-£500,000**	**£4,474,700**				**-£1,938,598**
Income	-£4,029,400		-£83,400				-£500,000					-£4,612,800
Non Pay Expenditure	-£26,386,000	£6,438,700	£23,391,102		-£3,131,800	-£210,000	-£5,208,800					-£5,106,798
Pay Expenditure	-£10,635,800		£8,733,300				£5,208,800	£4,474,700				£7,781,000
CHILDRENS AND YOUNG PEOPLES PUBLIC HEALTH	**£7,900**		**-£839,767**		**-£1,824,400**			**-£3,000,000**				**-£5,656,267**
Income	-£58,682,200		£302,033					-£3,000,000				-£61,380,167
Non Pay Expenditure	£3,439,000				-£1,824,400							£1,614,600
Pay Expenditure	£55,251,100		-£1,141,800									£54,109,300
COMMISSIONER INCOME	**-£186,547,800**	**£1,026,900**	**-£39,436,100**				**£4,654,200**					**-£220,302,800**
Income	-£183,068,800	-£2,416,800	-£39,436,100				£4,654,200					-£220,267,500
Non Pay Expenditure	-£3,479,000	£3,443,700										-£35,300
CORPORATE SERVICES	**£57,978,500**	**£1,435,300**	**£1,257,700**	**£0**	**-£265,400**							**£60,406,100**
Income	-£5,599,700	£10,000		-£32,800								-£5,622,500
Non Pay Expenditure	£39,893,500	£828,600	£1,257,400	-£53,900	-£291,000							£41,634,600
Pay Expenditure	£23,684,700	£596,700	£300	£86,700	£25,600							£24,394,000
HIF	**£0**	**£734,700**	**£0**		**-£341,600**		**-£393,100**		**£0**	**£0**	**£0**	**£0**
Income	-£26,646,800	£6,400	-£312,200		-£240,000		-£309,900		-£86,000	-£138,200	-£189,700	-£27,916,400
Non Pay Expenditure	£13,773,100	£693,100			-£24,100		£31,800		£237,800	£58,200		£14,769,900
Pay Expenditure	£12,873,700	£35,200	£312,200		-£77,500		-£115,000		-£151,800	£80,000	£189,700	£13,146,500
LONG TERM URGENT CANCER AND COMMUNITY	**£97,693,900**	**£3,144,700**	**£25,800**	**£0**	**-£3,013,600**	**£210,000**						**£98,060,800**
Income	-£21,260,200	£150,000	-£262,800									-£21,373,000
Non Pay Expenditure	£30,722,600	£2,994,700	£186,400	£0	-£3,013,600	£210,000						£31,100,100
Pay Expenditure	£88,231,500		£102,200									£88,333,700
OTHER SERVICES	**£4,300**											**£4,300**
Pay Expenditure	£4,300											£4,300
PLANNED SURGICAL AND CHILDRENS	**£63,114,400**	**£245,500**	**-£1,068,635**	**£0**	**-£1,764,800**							**£60,526,465**
Income	-£46,960,100		-£946,500									-£47,906,600
Non Pay Expenditure	£18,148,300	£55,500	-£174,956		-£1,764,800							£16,264,044
Pay Expenditure	£91,926,200	£190,000	£52,821	£0								£92,169,021
Grand Total	**£0**	**£13,025,800**	**-£7,920,000**	**£0**	**-£10,341,600**	**£0**	**£3,761,100**	**£1,474,700**	**£0**	**£0**	**£0**	**£0**

STRATEGIC AMBITION: MAKING HDFT THE BEST PLACE TO WORK 2024-2025

Our People & Culture Strategy, 'At Our Best', follows the NHS People Plan themes and our teamHDFT 'KITE' values and culture. Our ambition is to make HDFT the best place to work. We will provide physical and emotional support to enable us all to be 'At Our Best'. We will build strong teams with excellent leadership and promote equality and diversity so everyone is valued and recognised and we are all proud to work for HDFT. We will offer everyone opportunities to develop their career at HDFT through training and education. We will design our workforce, develop our people, recruit and retain, so we have the right people, with the right skills in the right roles to provide care to our patients and to support our children and young people.

GOALS:

Looking after our people

Physical and emotional support to be "At Our Best"

Belonging

Teams with excellent leadership, where everyone is valued and recognised; where we are proud to work

New ways of working

The right people, with the right skills, in the right roles

Growing for the future

Education, training and career development for everyone

GOVERNANCE:

People & Culture Framework

- Board Assurance: People & Culture Committee
- Programme Board: People & Culture Programme Board
- SRO: Director of People & Culture
- Operational Lead: Deputy Director of People & Culture

True North Metrics (Executive Lead: 10-15 Year deliverable)

1. • Staff Engagement Index
2. • Staff Availability

Breakthrough Objective:	Closed last month – Trust identifying new Trust wide BO
Corporate Project:	Medical and Dental Workforce Scheduling and Payment Transformation Project
Overarching Risk Appetite:	Workforce - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
At Our Best – Making HDFT the Best Place to Work	Looking After our people	Staff Engagement	Workforce: Cautious	
	Belonging			
	Growing for the future	Staff Availability	Workforce: Cautious	
	New ways of working			

Strategic Metrics Summary:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Looking after our people  Belonging 	Staff Engagement Index	Central to HDFT's strategic vision is that it should create a great place to work with the right people, with the right skills in the right roles. This includes providing a caring working environment that promotes wellbeing and innovation whilst improving quality and safety. The ambition is to understand how colleagues are feeling towards HDFT as a place to work and as an employer using a range of emotional indicators. The twin ambitions are to: 1. Continuously improve the level of survey response rates. 2. Improve the overall Staff Engagement Score	To continually improve our Employee Engagement Score against Pulse survey benchmark by having a framework for leaders and line managers which supports colleagues to bring their whole selves to work and that they belong, that they feel they can influence their role and suggest improvements and that they feel their Health & Wellbeing is a key priority in the Trust **Goals:** 1. Maintain Inpulse survey response rate. 2. Continuously tracking above our benchmark group engagement score. 3. Validate the improvement by seeing an improvement in the National Staff Survey Overall Engagement Score in the 2024 survey results.	Incorporating the NHSE "Expectations of Line Managers" into HDFT people management infrastructure and developing appraisal and diagnostic tool to reflect IMPACT behaviours. Implementation of Workforce Disability Equality Standard action plan and a focused piece of work on age and disability discrimination. (Also implementing the Workforce Race Equality Standard action plan.) HDFT IMPACT programme (Transformation and Continuous Improvement): methodology implementation across the Trust will enable staff to influence how their role is carried out. Additional countermeasure added to the Staff Engagement A3 showing data regarding the teams with a below 5% completion rate. This data to be included in Clinical Directorate Performance Review Meetings and additionally followed up via Directorate Boards.	Trust National Staff Survey response rate is 49% against a 50% benchmark for Acute/Community Trusts. This is a 3% increase on last year's response rate. Inpulse Kindness Survey closed on 31 January, with a completion rate of 32% - which is our highest completion rate for quarterly surveys since they commenced. People Promise Manager – Cohort 2 Exemplar Programme presented to the National NHSE Team in York on 22 January, and the HDFT presentation was well received. Feedback on progress from the 12 month fixed term, externally funded contract, is being presented to the People & Culture Committee in May 2025. The annual Mandatory Training Review process has been completed. As a result Bullying & Harassment has been made mandatory training for all staff (previously only for line managers) and COSHH training has been introduced for Porters. Additionally we have signed the national MOU for the portability of Mandatory Training. Full alignment is still required for 7 of the 9 elements of Resuscitation Training and NHSE are aware. Executive Director Appraisal process up-dated to incorporate HFDT IMPACT Leadership Behaviours and methodology and NHSE Competency Framework for Board Level Leaders.		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
					Work programme underway to introduce Line Manager appraisal and strengthen the 4S appraisal for all staff to align with HDFT IMPACT and address feedback regarding the efficacy of the current process in aiding colleagues to understand their objectives and how their improve their area of work. Reasonable Adjustments Toolkit launched 1 November 2024 to assist colleagues and line managers in establishing appropriate adjustments to enable them to remain in or return to work. The passport is reviewed annually as a maximum timescale and the colleague takes the passport with them if they change roles, avoiding the need to repeat discussions and agreement to adjustments.		
Growing for the future 	Staff Availability (Staff unavailability = vacancies WTE + WTE lost to sickness + Career Break WTE + Maternity WTE + Secondment WTE + Turnover WTE + Inefficient rostering practice + time to hire) .	To ensure HDFT is the 'best place to work' there must be the right number of staffing available each day for deployment to ensure quality of care and to enable those staff to have a good experience and do their best. The combination of vacancies against the budgeted establishment or service line versus the number of staff that can be deployed from it at any given time determines how many staff are available for work. The budgeted establishment figures in August were 4,528.34	To reduce the establishment gap we will focus on vacancy rates and on increasing workforce deployment. Where we know a vacancy cannot be filled through recruitment advertising (e.g. National or Local shortage occupations) we will ensure there is a plan to cover this gap longer term through apprenticeships, training programmes or the development of new roles. **Goals:**	Directorates focusing on sickness locally using the new Trust Policy.	Current strong educational performance and commitment to high-quality training. Key tools like MPET, NETS, and GMC NTS reflect positive feedback and benchmarks. Harrogate is well above the peer average in several areas, with a 95% positive placement rating, marking continuous improvement. Notable achievements include record "green flags" and exemplary areas such as geriatrics and sexual safety, with minimal "red flags." The Trust's governance framework is maturing, emphasising interprofessional collaboration and responding effectively to feedback data. This governance approach supports learner satisfaction, educational quality, and a safe		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
New Ways of Working 		WTE for the whole of HDFT with an overall 4,179.37 WTE in post (this equates to 349 WTE vacancies). However, there are a further 392 WTE unavailable for work for a variety of reasons including sick leave, turnover, maternity/paternity leave and careers breaks and time to hire that expand the vacancy position by creating a "workforce deployment gap". Therefore, the total gap in establishments of vacancy plus deployment gap equates to 764 WTE that were unavailable in August.	1. A vacancy rate that does not exceed 6% 2. A Turnover rate that does not exceed 12% (HNY is 12.2%) 3. Staff leaving within their first year of employment to not exceed 15% 4. 100% of rosters signed off and issued 8 weeks before. 5. Sickness levels throughout HDFT to not exceed 4.5% (HNY is 4.8%) 6. Apprenticeship or training plan/development of new role in the medium to longer term for shortage occupations		learning environment, with the organisation recognised as an "exemplar site" by the GMC for its work in sexual safety. Staff unavailability has seen a small decrease in February from 571.26wte to 540.50wte, which is a decrease of 30.75wte. This is predominantly due to a decrease in in-month turnover by 17.52wte and employees on maternity leave by 10.46wte. Whilst overall the unavailability has decreased, sickness has seen a net increase of 3.14wte and is due to an increase within the CYPPH Directorate, which saw an increase of 9.26wte. The Trust vacancy rate is 3.35% at the end of February 2025, which is below the Trust target of 7% (A3 threshold of 6%). -Trust turnover is 11.01% -Sickness is 5.24% -Staff leaving within 1st year is 16.11% (this has increased from 15.30% last month.)		

Breakthrough Objective: N/A

Workstream	True North Metric	Vision	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
Closed last month – Trust identifying new Trust wide BO					Breakthrough Objective Closed	Breakthrough Objective Closed

Corporate Project:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Medical and Dental Workforce Scheduling and Payment Transformation Project	Staff Availability	To have all Medical Staff on the rostering system and managers really engaged in using it as a tool to help improve patient care delivery. This will help enable us to fully align the workforce with service requirements/improvements	• To ensure medical and dental staff are deployed to maximum effect • To enable workforce gaps to be planned and managed • For the locum bank to be managed via the e-Rostering system achieving visibility and accountability • To ensure best practice roster rollout • To have full visibility of having the right people in the right place at the right time • To have all unavailability's of staff reported • For all additional payments to be digitised for payment and removing all paper/spreadsheet submissions	Local Medical A/L processes will not enable it to work in the roster system as they are not calculated in hours. Review of bank staff module and payroll processes/interface with Optima system. To put all medical and dental staff on the electronic rostering system. Job plans have not being reviewed regularly. Work with the General Managers to help fix any problems that arise and move us away from spreadsheet double running	Final draft of updated policy following engagement events ready to be approved at Strategy Deployment Room. Session held on Wednesday 15th January 2025 to process map detail. 15 out of 40 services are now live. Of the remaining 25. 4 are in the migration process, 4 have not commenced migration (and also need job plans) and 17 have commenced migration and are on hold due to not having current job plans. RL Datix (Optima) session run on 4 March 2025. Extra RL Datix support being put in to resolve local issues, RL Datix Relationship Manager also joining Project Board.		

Strategic Project:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
None at present							

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
None relevant at present						

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
None relevant at present						

STRATEGIC AMBITION: MAKING HDFT THE BEST PLACE TO WORK 2025-2026

Our People & Culture Strategy, 'At Our Best', follows the NHS People Plan themes and our teamHDFT 'KITE' values and culture. Our ambition is to make HDFT the best place to work. We will provide physical and emotional support to enable us all to be 'At Our Best'. We will build strong teams with excellent leadership and promote equality and diversity so everyone is valued and recognised and we are all proud to work for HDFT. We will offer everyone opportunities to develop their career at HDFT through training and education. We will design our workforce, develop our people, recruit and retain, so we have the right people, with the right skills in the right roles to provide care to our patients and to support our children and young people.

GOALS:

Looking after our people

Physical and emotional support to be "At Our Best"

Belonging

Teams with excellent leadership, where everyone is valued and recognised; where we are proud to work

New ways of working

The right people, with the right skills, in the right roles

Growing for the future

Education, training and career development for everyone

True North Metrics (Executive Lead: 10-15 Year deliverable)

People & Culture Framework

- Board Assurance: People & Culture Committee
- Programme Board: People & Culture Programme Board
- SRO: Director of People & Culture
- Operational Lead: Deputy Director of People & Culture

1. • Staff Engagement Index
2. • Staff Availability

Breakthrough Objective:	In Development for making HDFT the best place to work
Corporate Project:	Medical and Dental Workforce Scheduling and Payment Transformation Project
Overarching Risk Appetite:	Workforce - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
At Our Best – Making HDFT the Best Place to Work	Looking After our people Belonging	Staff Engagement	Workforce: Cautious								
	Growing for the future New ways of working	Staff Availability	Workforce: Cautious								

Strategic Metrics Summary:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Looking after our people  Belonging 	Staff Engagement Index	The ambition is to understand how colleagues are feeling towards HDFT as a place to work and as an employer using a range of emotional indicators. The twin ambitions are to: 1. Continuously improve the level of survey response rates. 2. Improve the overall Staff Engagement Score.	**Goals:** 1. Maintain Inpulse survey response rate. 2. Continuously tracking above our benchmark group engagement score. 3. Validate the improvement by seeing an improvement in the National Staff Survey Overall Engagement Score in the 2025 survey results.	Incorporating the NHSE "Expectations of Line Managers" into HDFT people management infrastructure and developing appraisal and diagnostic tool to reflect IMPACT behaviours. Implementation of Workforce Disability Equality Standard action plan and a focused piece of work on age and disability discrimination. (Also implementing the Workforce Race Equality Standard action plan.) HDFT IMPACT programme (Transformation and Continuous Improvement): methodology implementation across the Trust will enable staff to influence how their role is carried out. Additional countermeasure added to the Staff Engagement A3 showing data regarding the teams with a below 5% completion rate. This data to be included in Clinical Directorate Performance Review Meetings and additionally followed up via Directorate Boards.	The True North Metric of Staff Engagement continues into its second year (2025-26). The goal was met in March 2025 with: • The response rate to Inpulse Surveys reached 32% in January 2025 – which was the highest response rate since commencement. • The Trust tracked above the quarterly Pulse survey benchmark group engagement score consistently. • The National Staff Survey Overall Engagement score maintained was 7.00 against a benchmark score of 6.84. This year the focus will be on maintaining the inpulse survey response rate, tracking above our benchmark group for our engagement score and continued improvement in the overall engagement score for the National Staff Survey 2025. Work will be undertaken to identify teams with low survey response rates/ low engagement scores and advocacy. Support will be offered to these teams. Countermeasures are noted.		
Growing for the future	Staff Availability	To ensure HDFT is the 'best place to work' there must be the right number of staffing available each day for	1. A vacancy rate that does not exceed 6% 2. A Turnover rate that does not	Directorates focusing on sickness locally using the new Trust Policy.	The True North Metric of Staff Availability continues into its second year (2025-26). The goal was met in March 2025 with: • A vacancy rate that did not exceed 6% (3.35% at Feb 25) • A turnover rate that did not exceed 12% (11.01%)		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
		deployment to ensure quality of care and to enable those staff to have a good experience and do their best.	exceed 12% (HNY is 12%) 3. Staff leaving within their first year of employment to not exceed 15% 4. 100% of rosters signed off and issued 8 weeks before. 5. Sickness levels throughout HDFT to not exceed 4.2% (HNY is 4.2%) 6. Apprenticeship or training plan/development of new role in the medium to longer term for shortage occupations		• However, Sickness levels did exceed target 3.9% (5.24%) and • Staff leaving within the first year of employment was slightly higher than plan with the target of not exceeding 15% (16.11%) This year the focus will be on • supporting line managers with the management of short term and long term sickness absence. • Continuing to support teams with timely and accurate rostering of colleagues to ensure shifts are appropriately filled with substantive colleagues as much as possible to reduce reliance on agency/locum resource. Countermeasures are noted.		
New Ways of Working 							

Breakthrough Objective: N/A

Workstream	True North Metric	Vision	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
New – Making HDFT the best place to work	TBC	TBC	TBC	TBC	TBC	TBC

Corporate Project:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Medical and Dental Workforce Scheduling and Payment Transformation Project	Staff Availability	To have all Medical Staff on the rostering system and managers really engaged in using it as a tool to help improve patient care delivery. This will help enable us to fully align the workforce with service requirements/improvements	• To ensure medical and dental staff are deployed to maximum effect • To enable workforce gaps to be planned and managed • For the locum bank to be managed via the e-Rostering system achieving visibility and accountability • To ensure best practice roster rollout • To have full visibility of having the right people in the right place at the right time • To have all unavailability's of staff reported • For all additional payments to be digitised for payment and removing all paper/spreadsheet submissions	Local Medical A/L processes will not enable it to work in the roster system as they are not calculated in hours. Review of bank staff module and payroll processes/interface with Optima system. To put all medical and dental staff on the electronic rostering system. Job plans have not being reviewed regularly. Work with the General Managers to help fix any problems that arise and move us away from spreadsheet double running	Final draft of updated policy following engagement events ready to be approved at Strategy Deployment Room. Session held on Wednesday 15th January 2025 to process map detail. Options paper developed to agree Trust position with Bankstaff+ module 15 out of 40 services are now live. Of the remaining 25, 4 are in the migration process, 4 have not commenced migration (and also need job plans) and 17 have commenced migration and are on hold due to not having current job plans. RL Datix (Optima) session run on 4 March 2025. Extra RL Datix support being put in to resolve local issues, RL Datix Relationship Manager also joining Project Board.		

Strategic Project:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
None at present							

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
None relevant at present						

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
None relevant at present						

ENABLING AMBITION: DIGITAL TRANSFORMATION TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE 2024-25

Digital technology is an essential part of delivering high quality healthcare, but it is also important to remember that it is a tool, not an end in itself. Our ambition at HDFT is provide digital tools and services which make it easier for us to provide the best quality, safest care and which help us provide person centred, integrated care that improves patient experience. Through digitisation we can also collect huge amounts of data about our services – we will increase our ability to create useful information which enables us to learn and continuously improve our services. Over the next few years, we intend to implement a new electronic health record that will revolutionise how we provide care.

GOALS:

Quality & Safety

Systems which enable staff to improve the quality and safety of care

Information

Timely, Accurate Information to enable continuous improvement

Electronic Health Record

An Electronic Health Record to enable effective collaboration across all care pathways

GOVERNANCE:

Digital Framework

- Board Assurance: Innovation Committee
- Programme Board: Digital Board / EPR Programme Board
- SRO: Executive Medical Director
- Operational Lead: Digital Information Officer

True North Metrics (Executive Lead: 10-15 Year deliverable)

1

- **Quality & Safety - 100% Completion of the countermeasures**

Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Operational - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Digital Transformation	Quality & Safety	100% Completion of the countermeasures	Operational: Cautious								

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Quality & Safety 	Systems which enable staff to improve the quality and safety of care	Revised Goals for 2025-26 currently in development.	Revised Countermeasures for 2025-26 currently in development.	The programmes of work for 2024-25 have completed as detailed below. Whilst not all benefits realisation were fully achieved in year, significant progress on the digital agenda has been made. A revised programme of work for 2025-26 is in development and will be detailed in April 2025.		

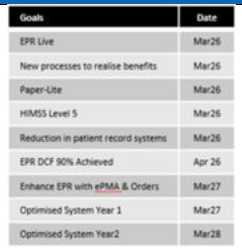
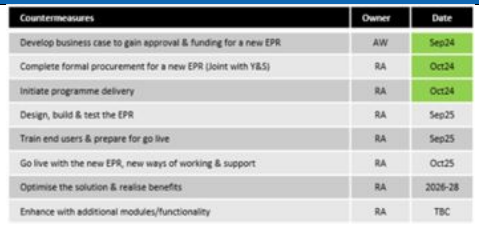
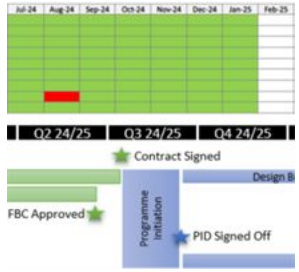
Breakthrough Objective:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
None						

Corporate Project:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions

Strategic Programme: Electronic Patient Record

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality & Safest Care						

Goals	Date
EPR Live	Mar26
New processes to realise benefits	Mar26
Paper-Lite	Mar26
HIMSS Level 5	Mar26
Reduction in patient record systems	Mar26
EPR DCF 90% Achieved	Apr 26
Enhance EPR with ePMA & Orders	Mar27
Optimised System Year 1	Mar27
Optimised System Year2	Mar28

Countermeasures	Owner	Date
Develop business case to gain approval & funding for a new EPR	AW	Sep24
Complete formal procurement for a new EPR (Joint with Y&S)	RA	Oct24
Initiate programme delivery	RA	Oct24
Design, build & test the EPR	RA	Sep25
Train end users & prepare for go live	RA	Sep25
Go live with the new EPR, new ways of working & support	RA	Oct25
Optimise the solution & realise benefits	RA	2026-28
Enhance with additional modules/functionality	RA	TBC

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	None					

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

ENABLING AMBITION: DIGITAL TRANSFORMATION AND MATURITY TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE 2025-2026

Digital technology is an essential part of delivering high quality healthcare, but it is also important to remember that it is a tool, not an end in itself. Our ambition at HDFT is provide digital tools and services which make it easier for us to provide the best quality, safest care and which help us provide person centred, integrated care that improves patient experience. Through digitisation we can also collect huge amounts of data about our services – we will increase our ability to create useful information which enables us to learn and continuously improve our services. Over the next few years, we intend to implement a new electronic health record that will revolutionise how we provide care.

GOALS:

Quality & Safety

Systems which enable staff to improve the quality and safety of care

Information

Timely, Accurate Information to enable continuous improvement

Electronic Health Record

An Electronic Health Record to enable effective collaboration across all care pathways

Ambition Metrics (Executive Lead: 10-15 Year deliverable)

Breakthrough Objective:	None
Corporate Project:	None
Overarching Risk Appetite:	Operational - Cautious

Ambition	True North Metric	Workstream	Ambition Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
					1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
DIGITAL TRANSFORMATION & MATURITY TO INTEGRATE CARE & IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE	All	Well Led	Achieve a score of 5/5 across all seven What Good Looks like (WGLL) pillars	Operational: Cautious	
		Ensuring Smart Foundations		Operational: Cautious	
		Safe Practice		Operational: Cautious	
		Support People		Operational: Cautious	
		Empower Citizens		Operational: Cautious	
		Improving Care		Operational: Cautious	
		Healthy Populations		Operational: Cautious	

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality & Safest Care Person Centred, Integrated Care Great Start in Life Making HDFT The Best Place to Work	***Overarching Vision:*** To improve our Digital Maturity in keeping with the national programme "What Good Looks Like" for Digital Services in the NHS, so that our colleagues will have improved leadership skills, more advanced solutions, safe and secure digital foundations and practices, improved support and services, and will be better empowered to perform their roles. In turn, this will lead to better and more informative data and improvements in patient care and clinical services.	We aspire to achieve a score of 5/5 across all seven What Good Looks Like (WGLL) pillars. Work has progressed during 24/25 to further improve our Digital Maturity score, and the aim is to build on this over the next five years. For 25/26, we aim to achieve a minimum score of 3/5 across all seven pillars.	Being developed. We will break down the planning and delivery into smaller chunks, initially focussing on the pillars with the greatest priority. We will develop a roadmap plan and apply A3 thinking for each pillar. Improvements may need funding to deliver, which will require development of a business case.	Our ambition to improve the organisations digital maturity that promotes best quality, safest care continues into its second year (2025-26). The first year (2024-25) focused on the delivery of a number of projects including a new Laboratory system, further transition to paper-lite processes, patient engagement portals (PEP), cyber essentials, robot process automation, Artificial Intelligence and rostering solutions. The key project priority for 2025/26 is the delivery of a new EPR solution. However, we are also focussing on how we can improve our overall digital maturity against WGLL. We assess ourselves annually using the National Digital Maturity Assessment tool, with the next assessment due in Q1 2025/26. Our current state will be evaluated ongoing, with improvements planned, delivered, and monitored against WGLL:  We also monitor how we compare with our counterparts in HNY: 		
	7 Pillars of WGLL: ***1. Well Led*** – A clear strategy for digital transformation & collaboration. Our leaders collectively own & drive the digital transformation journey, placing citizens & frontline perspectives at the centre. All	As above	In Development			

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
	leaders promote digitally enabled transformation to efficiently deliver safe, high quality care					
	Ensuring Smart Foundations - Digital, data & infrastructure operating environments are reliable, modern, secure, sustainable & resilient. We have well-resourced teams who are competent to deliver modern digital & data services					
	Safe Practice - We maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health & social care (DTAC) & routinely review system-wide security, sustainability & resilience					
	Support People - Our workforce is digitally literate & able to work optimally with data & technology. Digital & data tools & systems are fit for purpose & support staff to do their jobs well					
	Empower Citizens - Citizens are at the centre of service design & have access to a standard set of digital services that suit all literacy & digital inclusion needs. Citizens can access & contribute to their healthcare information, taking an active role in their health & well-being					
	Improving Care - We embed digital & data within our improvement capability to transform care pathways, reduce unwarranted variation & improve health & wellbeing. Digital solutions enhance services for patients & ensure that they get the right care when they need it & in the right place					
	Healthy Populations - We use data to design & deliver improvements to population health & wellbeing, making best use of collective resources. Insights from data are used to					

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
	improve outcomes & address health inequalities					

Breakthrough Objective:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
None						

Corporate Project:

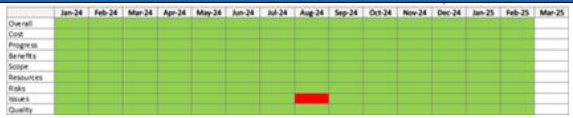
True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions

Strategic Programme: Electronic Patient Record

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality & Safest Care				This Strategic Programme for the delivery of the Nervecentre EPR continues into its second year (2025-26). The first year (2024-25) focused on completing the business case and procuring the EPR solution. 2025/26 focusses on delivering the Nervecentre EPR solution. 2026 onwards will seek to deliver enhanced functionality, optimise the solution and start to realise benefits. The delivery is monitored and reported via the monthly EPR highlight report. As we progress further into delivery, we will add further metrics related to testing and training. For now, the table below describes performance against key delivery criteria.		

Goals	*Date*
EPR Live	*Mar26*
New processes to realise benefits	*Mar26*
Paper-Lite	*Mar26*
HIMSS Level 5	*Mar26*
Reduction in patient record systems	*Mar26*
EPR DCF 90% Achieved	*Apr 26*
Enhance EPR with ePMA & Orders	*Mar27*
Optimised System Year 1	*Mar27*
Optimised System Year2	*Mar28*

Countermeasures	Owner	Date
Design, build & test the EPR	RA	Sep 25
Train end users & prepare for go live	RA	Sep 25
Go live with the new EPR, new ways of working & support	RA	Oct 25
Optimise the solution & realise benefits	RA	2026-28
Enhance with additional modules/functionality	RA	TBC

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
						

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	None					

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite

ENABLING AMBTION: HEALTHCARE RESEARCH AND INNOVATION TO IMPROVE QUALITY AND SAFETY 2024-25

As an agile and innovative district general hospital and also the largest provider of children's public health services in England, HDFT has two key opportunities. First, to use our agility to become the first choice for testing healthcare innovations to improve care for patients. We will develop partnerships with industry, academia, government, the voluntary sector and our local system to offer a real world testbed for health technology and digital innovations. Second, to use our scale and expertise to be the leading NHS trust for research and innovation in children's public health services. There is strong evidence that being a research and innovation active Trust, improves quality and outcomes for patients and increases staff satisfaction. Therefore our ambition is to grow our R&I portfolio to maximise opportunities for our patients and families to take part in leading edge research studies.

GOALS:

Healthcare Innovation

To be a leading trust for the Testing, Adoption and Spread of Healthcare Innovation

Children's Public Health Research

To be a leading trust for the Children's Public Health Services Research

Research studies

To increase access for patients to clinical trials through growth and partnerships

GOVERNANCE:

Healthcare R&I Framework

- Board Assurance: Innovation Committee
- Programme Board: Research & Innovation Executive Management Group
- SRO: Executive Medical Director
- Clinical Lead: Associate Medical Director for R&I
  Operational Lead: R&I Manager

True North Metrics (Executive Lead: 10-15 Year deliverable)

1. Healthcare Innovation- support of external and internal innovations and strategic partnership with industry
2. Children's Public Health (in the process of being updated)
3. Clinical Trials - increased recruitment of patients into reseach studies. All studies to be delivered to time and target.

Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Operational - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Healthcare Research and Innovation	Healthcare Innovation	Revised True North Metric in development for 2025-26 programme of work	Operational: Cautious								
	Children's Public Health Research	Revised True North Metric in development for 2025-26 programme of work	Operational: Cautious								
	Research Studies	Revised True North Metric in development for 2025-26 programme of work	Operational Cautious								

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Healthcare Innovation 	To be a leading trust for the testing, adoption and spread of Healthcare Innovation and to facilitate and accelerate the growth of innovative healthcare solutions in HDFT	Support at least 2 external innovations, at least 2 internal innovations and establish at least 1 strategic partnership with industry.	1. Establishment of a regional Innovation Hub 2. Develop workforce to help create a culture of innovation 3. Develop a robust innovation governance structure 4. Develop innovation infrastructure and create self-sustainable funding model 5. Establish strong, professional innovation partnerships 6. Support internal and external innovations	1. Innovation Hub established in new office in Knaresborough - complete Launch event planned Thursday 24th April 10.30-12.30 2. 2 x cohorts of Innovation Training Programme executed in partnership with local Trusts, Medipex and Health Innovation Network. >20 HDFT staff trained. Networking event planned for May 2025. A 2 year Clinical Entrepreneur Fellows cycle in place. 3 x FY1 doctors on scheme. Presentation at 2 x preceptorship sessions and 3 planned for March. New training plan developed with consisting of regular 'intro to innovation' sessions at least quarterly and 1 x in-depth training programme tailored for staff with an innovation idea. 3. Governance Structures continue to be developed. NIP process and IP policy in place. New SOPs for pathway of new innovation ideas and agreements in development - May 2025 4. Business case for funding from York and NY Combined Authority Submitted. Clinical Advice Service and Innovation Hub membership model in development to generate income – March 2025 5. Collab agreement signed with B Braun, working on further strategic partnership. Projects with Microsoft in development. Wider service level agreement in development with Visfo. 6. Working with external partners to support 5 x internal innovation ideas.		

				Collaborating with 2 groups at University of York to pilot new ultrasound technologies, patient monitoring system and telesystem to alleviate loneliness in elderly patients.		
Children's Public Health 	To be a leading trust for the Children's Public Health Services Research	Identify the key priority research needs for children and PH before end March 2025 . Sponsor at least one research study in the children and public health based around the trust needs identified . .	An evidence base for Children's PH Services to improve outcomes for children Identified some key Children's public health needs and research priorities.	Identified National validated 'SORT tool' to scope training needs of 0-19 workforce. Plan to implement in trust by March 25 Continue BaBi Harrogate: target for 2024-2025 = 172, current recruitment 819 Research prioritisation workshop March 25. Trust sponsored research in development : "Outcomes of prescribed pathways of targeted early intervention and prevention programmes for children identified at risk of vulnerability": Developing academic relationship with 3 key partners and ARC for possible funding, collaboration and future development of above study . UoHull: Joined Centre for Addiction and Mental Health Research stakeholder group. Team secured large NIHR grant to examine how to improve pathways and outcomes for young people with mental health problems. Feb : submitted bid to RRDN for strategic funding for 0-19 research project staff .		

Clinical Trials 	To increase access for patients to clinical trials through growth and partnerships	To continue to deliver contractual agreement with RD partner organisation to provide research opportunities and sustain Research Delivery Network (RDN) income through delivery of HLOs. a) trust recruitment target of 2001 annually b) 80% of studies recruiting to time and target c) Patient experience survey annual target 60 To increase commercial research by 10% this year and to generate income to maintain and increase research staffing . Develop 2 new academic partnerships by end March 2025 Develop clinical leadership Increase Patient engagement in research. Develop 4 patients ambassadors and one speciality patient research group by end March 25	Contractual Agreements Academic Partnerships	Current recruitment at 2659 – over target for this financial year by 658. Currently 8th position in region. Studies on time and target 98%. PRES (Patient Research Evaluation Survey 15 returned - active campaign to improve - new monthly reviews in place. Plans for a dedicated CRF underway, charitable funding secured – plan to open Q4 2024 delayed due to new plan development and costing delays .Now estimated March 2025 . Feb 25 : New detailed costs for refurb received , increased considerably . Reviewing ways to find extra funds . Opened, recruited & closed 5 commercial studies last year. This year opened 3 commercial studies and will open another 3 (now in set up) by end of financial year to meet target increase of 10%. Commercial Income to sustain current staffing on track. Talking with NIHR workforce lead regarding possible funding opportunities for staffing for future of CRF. Feb :Submitted bid to RRDN for further funding to increase staffing resources for CRF . New commercial partnership with INCYTE & ABBvie formed. (Oncology and Dermatology trials) . Academic partnerships : UoY: Skin Research Centre - internal grant secured ; Department of Engineering OTC - PhD student ; Working with Peter Knapp ; Prof Inclusion, York University bidding for RFPB grant to undertake a study reviewing usage of Happi info in under represented groups .		

				Clinical Lead for Research appointed June 2024 writing interim commercial research strategy Patient engagement: Delays in developing ambassadors due to team staffing issues:. 0-19 PPi group being explored. Next due end of March 25		

Breakthrough Objective

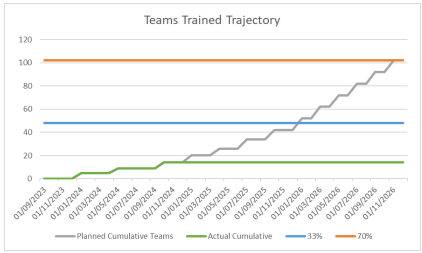
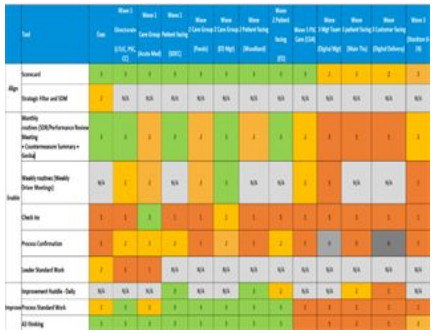
True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions

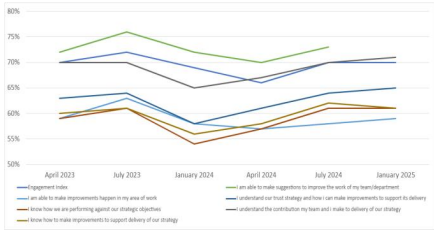
Corporate Project

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions

Strategic Project

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
All	To develop our capacity and capability and to embed the culture for continuous improvement through the Implementation of the Impact Improvement Operating Model. To align and enable everyone in the Trust to make improvement in line with our Strategy as part of their daily work so that local improvements	**Strategy Deployment**: Establish consistent and reliable operational and governance process to ensure focus and resources are directed to improvement of True North Metrics throughout organisational layers and functions.	Review Breakthrough Objectives and ensure alignment of Directorate Driver Metrics.	In progress.		
			Identify and deliver Strategic Programmes and Corporate Projects.	Strategic Programmes agreed and in flight. Corporate projects under review connected with Annual Planning cycle		

	reinforce and amplify each other to deliver significant improvement in our True North Ambitions (as measured by our True North Metrics) at Trust level.		Practice and refine performance review systems within Directorates through Care Groups to Frontline teams In progress.	Directorate PRMs & SDR established and under refinement. Variation in reliability of intra-directorate improvement operating model processes		
		Impact Improvement Operating Model: 70% of teams trained by July 26	Wave 5, Jan 2025 Wave 6, Apr 2025 Wave 7, Jun/Jul 2025 Roadmap implementation for waves 5 and 6, Jan 2025.	20 Teams Trained 8 In process On track 		
		All trained teams rated as “Level 3 – Maturing” across all tools and processes by Mar 2025	Process Confirmation – target 90% green tickets by Apr 2025.	On track 		
		Improvement Academy: Build capacity and capability to support high quality training, coaching and facilitation.	Develop & refine the Impact training offer to maximise value to participants and reliability of implementation.	On track.		

			Explore focussed training for individuals within directorates to enable co-delivery of Impact model. Review training format to explore accelerated delivery model options			
		Communications: 67% "strongly agree" or "agree" with Impact Inpulse survey question by Mar 25. 	Design and deliver a communications and engagement strategy that will support the IOM roll-out, generate awareness and understanding of Impact**.** Review work stream activities to identify targeted opportunities.	Latest survey *65% positive* response to the question: 'I understand our trust strategy and how I can make improvements to support its delivery.' In progress		

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related Corporate Risks at this time					

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related external risks					

ENABLING AMBTION: HEALTHCARE RESEARCH AND INNOVATION TO IMPROVE QUALITY AND SAFETY 2025-2026

As an agile and innovative district general hospital and also the largest provider of children's public health services in England, HDFT has two key opportunities. First, to use our agility to become the first choice for testing healthcare innovations to improve care for patients. We will develop partnerships with industry, academia, government, the voluntary sector and our local system to offer a real world testbed for health technology and digital innovations. Second, to use our scale and expertise to be the leading NHS trust for research and innovation in children's public health services. There is strong evidence that being a research and innovation active Trust, improves quality and outcomes for patients and increases staff satisfaction. Therefore our ambition is to grow our R&I portfolio to maximise opportunities for our patients and families to take part in leading edge research studies.

GOALS:

Healthcare Innovation

To be a leading trust for the Testing, Adoption and Spread of Healthcare Innovation

Children's Public Health Research

To be a leading trust for the Children's Public Health Services Research

Research studies

To increase access for patients to clinical trials through growth and partnerships

GOVERNANCE:

Healthcare R&I Framework

- Board Assurance: Innovation Committee
- Programme Board: Research & Innovation Executive Management Group
- SRO: Executive Medical Director
- Clinical Lead: Associate Medical Director for R&I
- Operational Lead: R&I Manager

Ambiton Metrics
(Executive Lead: 10-15 Year deliverable)

1. Healthcare Innovation- support of external and internal innovations and strategic partnership with industry
2. Children's Public Health
3. Clinical Trials - increased recruitment of patients into reseach studies. All studies to be delivered to time and target.

Breakthrough Objective:	None
Corporate Project:	Research 3T MRI and CRF -
Overarching Risk Appetite:	Operational - Cautious

Ambition	True North Metric	Workstream	Ambition Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
					1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Healthcare Research and Innovation	All	Healthcare Innovation	Adopt / develop health innovations that improve the health and care of our patients and CY&P	Operational: Cautious	
		Children's Public Health Research	To be a leading trust for 0- 19 research and undertake research and evidence based around our CYP populations needs.	Operational: Cautious	
		Research Studies	To be a self funding department , providing opportunities for all potential participants to have access to research.	Operational Cautious	

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Healthcare Innovation 	To be a leading trust for the testing, adoption and spread of Healthcare Innovation and to facilitate and accelerate the growth of innovative healthcare solutions in HDFT	Generate >£50,000 income Deliver 6 x Clinical Entrepreneur Fellowship Scheme 2 external innovations	Support offer for internal and external innovations Robust governance procedures Innovation Hub Culture of Innovation	This Enabling Ambition for Healthcare Innovation continues into its second year (2025-26). The first year (2024-25) focused on: • the development of a new Innovation Hub, • the development of a new Innovation Training Programme, • the development of our governance structures, • the development of a business model for income generation, • the development of external strategic partnerships with B Braun. The focus for 2025-26 will be building on our support offer for internal and external innovations, embedding our innovation hub and further developing our culture of innovation. This will be monitored through our Goals as detailed. Countermeasures are noted.		
Children's Public Health 	To be a leading trust for 0- 19 research and undertake research and evidence based around our CYP populations needs.	Develop 2 sponsored research studies relevant to HDFT 0-19 population Deliver at least 1 portfolio research study Deliver at least 1 0-19 showcase events .	Utilising Babi research prioritisation data Developing research partnerships with CAMHR at York and ARC Cultivate a research active culture and infrastructure Develop and implement a 0-19 pathway for delivery of research. Source funding and create infrastructure for delivery of research Support , guide, mentor and monitor the delivery of research to ensure governance and targets are achieved Disseminate the findings and outcomes of any studies delivered to the 0-19 HDFT service via appropriate media Regional networks and ARC	This Enabling Ambition for Children's Public Health continues into its second year (2025-26). The first year (2024-25) focused on: • the development of an evidence base for Children's Public Health Services with the aim of improving outcomes for Children and Young People • identification of key Children's Public Health needs and research priorities The focus for 2025-26 will be around building pathways, infrastructure and funding for creating new research and delivering national and local programmes of research and working with academic partnerships that develop our ambitions further . This will be monitored through monthly updates on Research studies in development or open. The number of staff or patients involved in this research and the amount of research evidence or staff learning opportunities/ events disseminated Countermeasures are noted. Watch Metrics: To ensure SOPS for department in relation to 0-19 research are updated by end of 2025 and system in place to review regularly. GCP training numbers increase Year on Year for 0-19 trust staff .		

				PRES feedback target for RRDN overall (TBC for 25/26) is achieved and a percentage (10%) comes from 0-19 research participants .		
Clinical Trials 	To increase access for patients to clinical trials through growth and partnerships	Sustain partnership and funding for department with Y&H Research Delivery Network Deliver contractual agreement and high-level objectives. (Still to be confirmed for 2025/26). To Increase commercial research by at least 20 % to generate more income for research staffing and trust. . Continue to develop new partnerships to progress research via WYATT, NSO and academic and commercial alliances. Increase patient engagement for research. Develop 4 patient ambassadors and at least one research speciality patient engagement group. .	Contractual arrangements with Yorkshire & Humber Research Delivery Network Partnerships via WYATT, NSO and academic and commercial alliances	This Enabling Ambition for Clinical Trials continues into its second year (2025-26). The first year (2024-25) focused on: • Delivery of contractual agreement with Research and Development Partner • Increase commercial research • Development of academic partnerships • Development of clinical leadership • Increased patient engagement The focus for 2025-26 will be the same as 2024 -25 This will be monitored through : Number of studies open (commercial and non-commercial ;number of patients recruited into studies ; number of studies recruiting to time and target. Comparisons with other trust in the Y&H region. List of partnership outcomes achieved. Numbers and impact of patient engagement. Countermeasures are noted.		

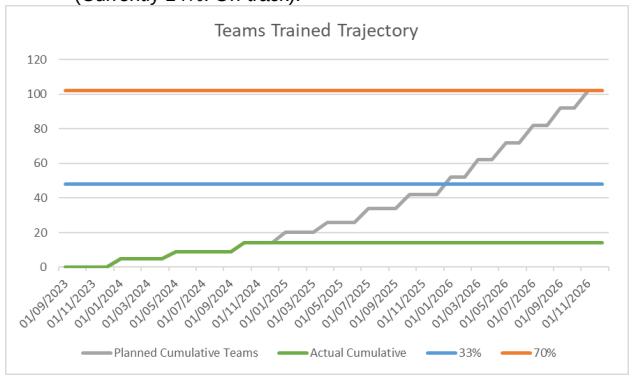
Breakthrough Objective

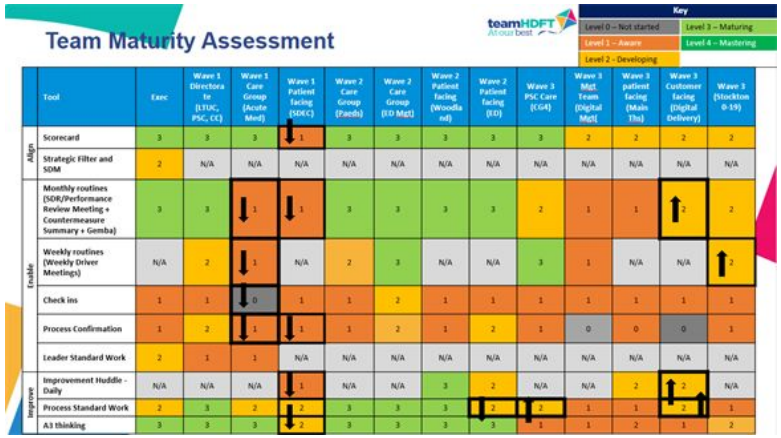
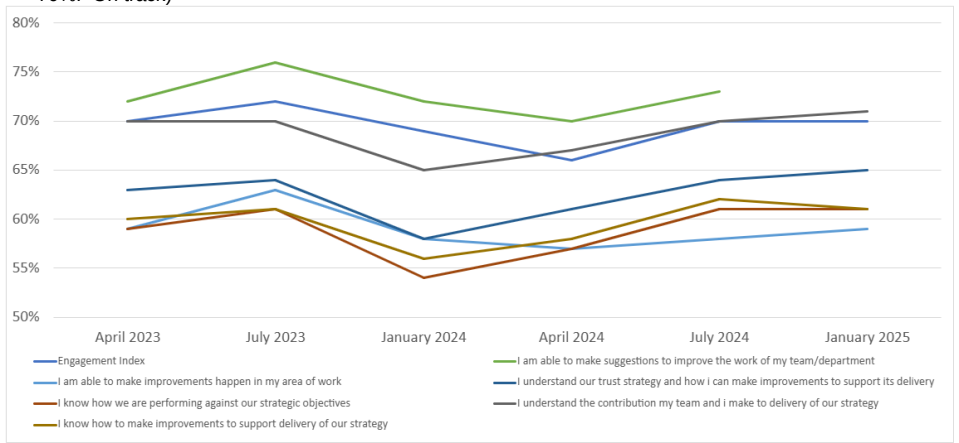
True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
None						

Corporate Project:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Research 3T MRI and CRF	In development					

Strategic Project: HDFT Impact

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
All	To develop our capacity and capability and to embed the culture for continuous improvement through the Implementation of the Impact Improvement Operating Model.	• 70% of Teams will be trained to use HDFT Impact by Sept 2026 • 90% of those who have completed training will have embedded the routines and processes of the Improvement Operating Model after 4 months. • 75% of HDFT staff will answer positively to the question: 'I understand our trust strategy and	Strategy Deployment Governance and Operational Delivery Plan Impact Improvement Operating Model HDFT Impact training strategy and updated operational delivery plan including data skills for impact. Improvement Academy capacity and capability development. Impact Communications Strategy and	This Strategic Programme for HDFT Impact continues into its second year (2025-26). The first year (2024-25) focused on the development of HDFT Impact at a strategic level with a focus on our Operating Model, Governance Arrangements and Training Programme. Due to the scale of this it will continue as the focus for 2025-26. Performance of our key goals will be monitored with three driver metrics: 1. The percentage of teams trained across HDFT. (Currently 14%: On-track).  		

		how I can make improvements to support its delivery' by Mar 2026.	operational delivery.	2. Teams who have completed the HDFT Impact training will reach level 3 maturity (sustainable independence with routines & processes). (Currently 30%, target 90% - Off track.).  3. The percentage of staff positively responding to the Inpulse Survey on the Trust Strategy. (Currently 70%: On track) 		

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related Corporate Risks at this time					

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related external risks					

ENABLING AMBTION: AN ENVIRONMENT THAT PROMOTES WELLBEING 2024-25

The environment in which we work or are cared for has a huge impact on our physical and emotional wellbeing. At HDFT we will continuously improve our estate and our equipment to promote wellbeing and enable us to deliver the best quality, safest care. We will prioritise investments and design new facilities to promote wellbeing and best quality. As the largest employer in Harrogate and District, and covering a huge footprint across the North East and Yorkshire, we have an important leadership role in reducing our impact on the planet through our buildings, energy use, transport and food. We will build on our strong track record to continuously reduce our impact on the environment and achieve net zero carbon by 2040.

GOALS:

Wellbeing

A patient and staff environment that promotes wellbeing

Quality & Safety

An environment and equipment that promotes best quality, safest care

Environmental Impact

Minimise our impact on the environment

GOVERNANCE:

Environment Framework

- Board Assurance: Resource Committee
- Programme Board: Environment Board
- SRO: Director of Strategy
- Operational: Associate Director of Capital Planning

True North Metrics (Executive Lead: 10-15 Year deliverable)

1. **Wellbeing - Wellbeing Works Capital Spend vs Budget**
2. **Quality & Safety - Major Projects Capital Spend vs Budget; High Risk Backlog Maintenance Cost**
3. **Impact on the environment - Natural Gas Consumption**

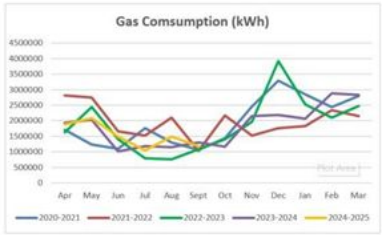
Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Operational - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
An Environment that promotes wellbeing	Wellbeing	Wellbeing works capital spend vs Budget	Operational: Cautious	
	Quality & Safety	Major projects capital spend vs Budget; High risk backlog maintenance cost	Operational: Cautious	
	Environmental Impact	Natural gas consumption	Operational: Cautious	

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
Wellbeing 	A patient environment that promotes wellbeing	To improve the working environment of staff	• 24/25 Staff Wellbeing Works - minor refurbishments and redecoration – March 2025	• On target		
Quality & Safety 	An environment and equipment that promotes best quality, safest care	**Aseptics** To meet standards for aseptic production for medicines safety and staff safety	• Initial Design complete – Aug 22 • Tender & Contract award and Design – Mar 23 • Build complete – November 23 • Commissioning complete – Due Dec 23 • In service – Due Dec 23	• Complete • Complete • Complete (delayed to Feb 24 due to Drainage issues, AHU, Design sign off, supply chain issues) • Delayed. Further works currently being undertaken. Due to be completed by end of March 2025. Further pressure testing and assurance needed in April 2025.		
		RAAC – Block C, Therapies To eradicate RAAC from Block C, Therapies by demolishing and rebuilding the block	• Relocation of services to new locations – end of Mar 24 • Pre-construction for demolition complete – Mar 24 • Demolition starts – Apr 24 • Demolition complete – Sep 24 • Pre-construction for new block starts – Oct 24 • New block (shell) construction starts – Feb 25	• Complete - June 2024 • Complete - complete June 2024 • Complete – commenced June 2024 • Complete – complete October 2024 • Complete – complete November 2024 • Complete – complete February 2025		
		HDH New Theatres, Treatment Rooms and Ward (TIF2) To increase elective operating capacity and improve waiting time performance.	• NHSE BC approval Sep 22 • HDFT capital to support enabling schemes agreed – Dec 22 • Internal BC approval – Jan 23 • Complete tender, appoint contractor – Jun 23 • Decision to revise project from a standalone block on the Briary Wing carpark to fitting out the first floor of the new block replacing Block C – Oct 23 • Pre-construction phase complete – Sep 24 • New block (shell) construction starts – Feb 25 • • Stage Completion due – Aug 26	• Complete • Complete • Complete • Complete • Complete • Complete – complete November 2024 • Complete – complete February 2025 • On Track		

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
		Imaging Department To improve reliability and capacity of imaging services	• Feasibility study, including phasing – Sep 22 • Initial costs – Oct 22 • Design concept – Jan 23 • Decision to revise project from reconfiguration of the existing imaging department to fitting out the ground floor of the new block replacing Block C – Oct 23 • Pre-construction phase complete – Sep 24 • New block (shell) construction starts – Feb 25 • Stage Completion due – Oct 26	• Complete • Complete • Complete • Complete • Complete – complete November 2024 • Complete – complete February 2025 • On Track		
Environmental Impact 	Minimise our impact on the environment	HDFT to be net zero by 2040	• People & Leadership- New Sustainability Governance Structure developed to provide clear accountability and reporting lines for HDFT & HIF responsibilities and the sub work groups. The Green Plan is required to be refreshed for April 2025. • Estates & Facilities – HIF lead on submissions for Salix / PSDS funding and working with CEF (Carbon and Energy Fund) to support the decarbonisation of the hospital site. Procurement of fleet for Euro 6 ULEZ compliant and an electric can. • Travel & Transport-HIF manage the Travel Plan with its own action plan, liaising with local public transport companies to provide staff discount and promoting modal hierarchy. • Food –HIF undertaking a Food waste project in line with the ERIC return requirements	• New governance structure to be socialised and meeting arranged with the HDFT & HIF leads identified for the sub working groups. Funding required for Green Plan refresh. This will also shape the actions going forward and align with national and local priorities. • HIF looking at feasibility for new carbon reduction technologies and innovation. Development of a decarbonisation strategy. New vans have been ordered –arrival first quarter 2025. • A travel survey is required this year and funding needs to be identified • HIF at feasibility stage in looking at technologies and software solutions which will improve meal ordering and wastage		

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
			• Medicines. • Delivery a “Nitrous Oxide Project” following a recognised methodology which has identified system waste and will improve medical gas management- Nitrous oxide project (nitrous oxide (N2O) which is used as an anaesthetic gas is 300 times more harmful than CO2 • Supply Chain & Procurement. Mandatory 10% net zero and social value weighting for every tender. • Digital Transformation. The sub group has been involved in this process and agreed necessary sustainability and carbon reduction wording and criteria to be included in the new digital strategy. Sustainable Models of Care- To understand what opportunities there are to deliver care in a more sustainable way and connect these new models of care to reduction of carbon 	• External funding has been identified and order placed for Trolleys to house localised canisters. Then the piped network will be capped off. Entonox project to be initiated following this. • Further Supply Chain & Procurement initiatives need to be identified such as by 2025 we are required to use 50% less office paper and use 100% recycled paper. • Produce standard carbon reduction criteria within the digital investment decision making process. • Review of recent innovations and changes to models and pathways of patient care to review the sustainability benefits of work which we have already undertaken. Sustainability manager has summarised potential opportunities/projects for the group to review, are there any they wish to peruse. Carbon reduction as a criteria within service change decisions and to be included within the business case approval process.		

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR75	CHS2 – Health & Safety: HDH Goods Yard	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.	4 x 3 = 12	4 x 1 = 4 Mar 25	Operational: Health & Safety	Minimal
	CHS3 – Health & Safety: Managing the risk of injury from fire.	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others due to the failure to ensure that suitable and sufficient assessment of the risk from fire has been carried out, and that the necessary control measures are in place. H&S Managing the risk of injury from fire	5 x 3 = 15	5 x 2 = 10 April 25	Operational: Health & Safety	Minimal
	CHS5 – Violence and aggression against staff	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality or permanent disability to employees due to the failure to manage the risk of staff being subjected to acts of violence and aggression whilst carrying out normal duties, due to lack of suitable control measures and appropriate training.	4 x 3 = 12	4 x 2 = 8 July 25	Operational: Health & Safety	Minimal
CRR98	Containment Level 3 Laboratory	The unavailability of the onsite Containment Level 3 (CL3) laboratory at HDFT, deemed unfit for purpose in November 2022, has led to the outsourcing of Hazard Group 3 microbiology work to external providers. Initially outsourced to NHS Trusts within WYAAT and, since June 2024, to a private laboratory in London, this situation poses risks to quality, safety, and financial sustainability, including potential delays in clinical diagnosis, risk of inappropriate treatment, and significant ongoing cost pressures.	3 x 5 = 15	3 x 2 = 6 Date TBC	Operational: Health & Safety	Minimal
CRR102	Physical security provisions, training and support resources	Organisational risk to compliance with legislative requirements, and the risk of major injuries, fatality or permanent disability to employees, patients, visitors or others due lack of suitable policies and procedures, and the subsequent lack of suitable and sufficient control measures, including physical security provision, training, resources to support implementation.	4 x 4 = 16	4 X 2 = 8 April 2025	Operational: Health & Safety	Minimal

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite

No Related External Risks

ENABLING AMBTION: AN ENVIRONMENT THAT PROMOTES WELLBEING 2025-26

The environment in which we work or are cared for has a huge impact on our physical and emotional wellbeing. At HDFT we will continuously improve our estate and our equipment to promote wellbeing and enable us to deliver the best quality, safest care. We will prioritise investments and design new facilities to promote wellbeing and best quality. As the largest employer in Harrogate and District, and covering a huge footprint across the North East and Yorkshire, we have an important leadership role in reducing our impact on the planet through our buildings, energy use, transport and food. We will build on our strong track record to continuously reduce our impact on the environment and achieve net zero carbon by 2040.

GOALS:

Wellbeing

A patient and staff environment that promotes wellbeing

Quality & Safety

An environment and equipment that promotes best quality, safest care

Environmental Impact

Minimise our impact on the environment

GOVERNANCE:

Environment Framework

- Board Assurance: Resource Committee
- Programme Board: Environment Board
- SRO: Director of Strategy
- Operational: Assistant Director of Strategy (Capital Planning)

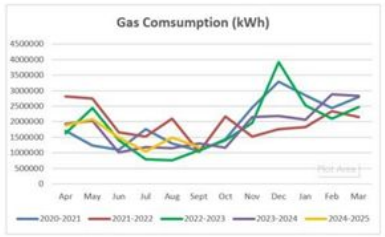
Enabling Ambition Metrics (Executive Lead: 10-15 Year deliverable)

1. **Wellbeing - Capital Programme Delivery (spend vs budget)**
2. **Quality & Safety - Premises Assurance Model Areas requiring >moderate improvement**
3. **Impact on the environment - Monthly Natural Gas Consumption**

Breakthrough Objective:	N/A
Corporate Project:	Block C Theatres & Imaging
Overarching Risk Appetite:	Operational - Cautious

Ambition	True North Metric	Workstream	Ambition Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
					1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
An Environment that promotes wellbeing	All	Wellbeing	Capital Programme Delivery (Spend vs Budget)	Operational: Cautious	
		Quality & Safety	PAM >moderate improvement	Operational: Cautious	
		Environmental Impact	Natural gas consumption	Operational: Cautious	

Enabling Ambitions Metrics Summary:

Enabling Ambition Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
Wellbeing 	A patient and staff environment that promotes wellbeing	To improve the environment for patients and staff Capital spend vs budget – TBC (once full capital allocation confirmed)	• Deliver 2025/26 Capital Programme (Medium/Minor Schemes) • Deliver Block C Theatres & Imaging Corporate Project (see Corporate Projects below)	• 2025/26 Capital allocation still TBC • Funding available for other projects (not Block C or infrastructure risk) not known so goal and actions rated amber • On Track.		
Quality & Safety 	An environment and equipment that promotes best quality, safest care	To improve the Trust's premises infrastructure and services. 2022/23 • 20 Moderate Improvement SAQs 2023/24 PAM • 22 Moderate Improvement SAQs To reduce critical infrastructure backlog maintenance risks.	• Premises Assurance Model ○ Expand coverage to include Ripon CH ○ Deliver 25/26 action plan • Deliver £2.1m fire systems improvement programme. • RAAC – eradicate remaining RAAC (outside Block C) on HDH site	• On Track • Awaiting confirmation of critical infrastructure risk funding from HNY ICB • Business case submitted to NHSE for additional RAAC funding outside of Block C (£7.2m 25/26, £8.0m 26/27). Awaiting approval.		
Environmental Impact 	Minimise our impact on the environment	HDFT to be carbon net zero by 2040 	• Refreshed Green Plan developed and approved • Deliver 25/26 action plan • Estates & Facilities ○ Replacement of CHP with more modern, efficient system ○ Investigate geothermal energy ○ ULEV for HIF transport fleet ○ Investigate onsite waste to energy system • Medicines. • Complete nitrous oxide removal and develop Entonox reduction plan.	• On Track • To be determined once new Green Plan in place • TBC depending on 25/26 funding • On Track • On Track • On Track • External funding has been identified and order placed for Trolleys to house localised canisters. Then the piped network will be capped off. Entonox project to be initiated following this.		

Related Corporate Project

Enabling Ambition Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
Wellbeing 	To increase elective capacity and improve quality and patient experience in imaging services	To deliver a new facility that provides: • 2x operating theatres • 2x treatment rooms • 14 bed daycase ward • New imaging equipment: 2xCT, 2xMRI, 3x XR, 1x Fluoroscopy, 7x Ultrasound	• Start on site for main construction • Theatres floor complete • Imaging floor complete	• Complete • On Track – August 2026 • On Track – October 2026		

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR75	CHS2 – Health & Safety: HDH Goods Yard	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.	4 x 3 = 12	4 x 2 = 8 Apr 25	Operational: Health & Safety	Minimal
	CHS3 – Health & Safety: Managing the risk of injury from fire.	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others due to the failure to ensure that suitable and sufficient assessment of the risk from fire has been carried out, and that the necessary control measures are in place. H&S Managing the risk of injury from fire	5 x 2 = 10 *Reduced to target in March 25*	5 x 2 = 10 Apr 25	Operational: Health & Safety	Minimal
CRR98	Containment Level 3 Laboratory	The unavailability of the onsite Containment Level 3 (CL3) laboratory at HDFT, deemed unfit for purpose in November 2022, has led to the outsourcing of Hazard Group 3 microbiology work to external providers. Initially outsourced to NHS Trusts within WYAAT and, since June 2024, to a private laboratory in London, this situation poses risks to quality, safety, and financial sustainability, including potential delays in clinical diagnosis, risk of inappropriate treatment, and significant ongoing cost pressures.	3 x 5 = 15	3 x 2 = 6 TBC	Operational: Health & Safety	Minimal
CRR102	Physical security provisions, training and support resources	Organisational risk to compliance with legislative requirements, and the risk of major injuries, fatality or permanent disability to employees, patients, visitors or others due lack of suitable policies and procedures, and the subsequent lack of suitable and sufficient control measures, including physical security provision, training, resources to support implementation.	4 X 4 = 16	4 X 2 = 8 Apr 25	Operational: Health & Safety	Minimal

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite

From: **Jordan McKie – Director of Finance**

To: **Board of Directors**

Date: **26 March 2025**

CONSIDERATION OF THE GOING CONCERN PRINCIPLE

Harrogate and District NHS Foundation Trust

The 2024-25 Department of Health and Social Care Group Accounting Manual (DHSC GAM) refers to paragraphs 4.18 to 4.27 regarding the adoption of the going concern basis extract below:

Going concern

4.18 The *FReM notes that in applying paragraphs 25 to 26 of IAS 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context.

4.19 For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

4.20 A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

4.21 Sponsored entities whose statements of financial position show total net liabilities must prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate.

4.22 Where an entity ceases to exist, it must consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements.

4.23 While an entity will disclose its demise in various areas of its Annual Report and Accounts such as in the Performance Report and cross reference this in its going concern disclosure, this event does not prevent the accounts being prepared on a going concern basis or give rise to a material uncertainty in relation to the going concern of the entity.

4.24 DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

4.25 Where a DHSC group body is aware of material uncertainties in respect of events or conditions that may bring into question the going concern ability of the entity, these uncertainties must be disclosed.

4.26 As the continued provision of service approach, per paragraph 4.22, applies to DHSC group bodies, material uncertainties requiring disclosure, will only arise in very exceptional circumstances.

4.27 Should a DHSC group body have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether), or whether a material uncertainty is required to be disclosed (which will only arise in exceptional circumstances), it must raise the issue with its sponsor division or relevant national body as soon as possible.

**HM Treasury – The Government Financial Reporting Manual 2024/25 (FReM).*

The DHSC GAM also states that it is only expected in extremely limited circumstances that the Going Concern basis might be called into doubt.

Actions Requested:

- The Board of Directors is asked to note the Audit Committee review of the guidance extracted from the DHSC GAM and the appropriateness of preparing the 2024/25 Accounts on a Going Concern basis and;
- The Board of Directors is asked to approve the Audit Committee recommendation that the Accounts should be prepared on a Going Concern basis.

Group Accounts incorporating Harrogate Healthcare Facilities Management Ltd (HHFM) and the Harrogate Hospital and Community Charity (Charity).

The Trust's wholly owned subsidiary company HHFM and Charity Accounts will be incorporated into the Group Accounts (excluding inter-company transactions). These Group Accounts will be aligned to the Trust Accounts and will be prepared on a Going Concern basis.

The directors of HHFM will need to formerly make their own consideration of Going Concern having prepared/reviewed future cash flows forecasts etc. prior to adopting their Accounts.

The Trustee of the Charity will also need to formerly make their own consideration of Going Concern, in practice this may be delegated to the Charitable Funds Committee. Again cash flow forecasts will form part of the decision process for the Trustee to consider.

Note:

- The Audit Committee agreed to approve the Group (consolidated Accounts) be prepared on a Going Concern basis, following the above consideration at Board of Directors.

Board of Directors (Public)

26 March 2025

Title:	Enhancing Board Oversight
Responsible Director:	Chair
Author:	Kate Southgate, Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	In December 2021, NHS England issued a document *"Enhancing Board Oversight – A new approach to non-executive director champion roles".* This document confirmed that there are a small number of statutory requirements that still require a designated individual, however there are many issues where NHSE consider progress will be best made through existing committee structures rather than through individual Non-Executive Champion roles. It is believed that this approach will enhance Board oversight. HDFT considered the recommended approach and, in January 2022, approved the appointment of Non-executive Directors to the various Champion roles recommended by NHSE to provide assurance to the board on specific issues. This was in addition to the assurance provided by Board sub-committee reports. It is considered appropriate and good practice to review the outcomes of the approach of this assurance.	
Trust Strategy and Strategic Ambitions:	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	x
	Person Centred, Integrated Care; Strong Partnerships	x
	Great Start in Life	x
	At Our Best: Making HDFT the best place to work	x
	An environment that promotes wellbeing	x
	Digital transformation to integrate care and improve patient, child and staff experience	x
	Healthcare innovation to improve quality	x
Corporate Risks:	All	
Report History:	Initial report approved by Trust Board in January 2022.	
Recommendation:	The Board is recommended to review the content of this report and approve: • the continued use of the recommended champion roles; and • the Non-executive Directors either in place for each role.	
Freedom of Information:	The paper can be made available under the Freedom of Information Act once published with the Board papers on the HDFT website.	

8.3

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
TRUST BOARD (PUBLIC)

ENHANCING BOARD OVERSIGHT

1.0 PURPOSE

In December 2021, NHS England issued a document *"Enhancing Board Oversight – A new approach to non-executive director champion roles".* This document confirmed that there are a small number of statutory requirements that still required a designated individual, however there were many issues where NHSE considered progress would be best made through existing committee structures rather than through individual Non-executive Champion roles. It was believed that this approach would enhance Board oversight.

HDFT considered the recommended approach and, in January 2022, approved the appointment of Non-executive Directors (NEDs) to the various Champion roles recommended by NHSE to provide assurance to the board on specific issues. This was in addition to the assurance provided by Board sub-committee reports.

As this method of assurance has been in place for two years, it is considered appropriate to review the outcomes of the approach.

8.3

2.0 Retained NED Champion Roles

Role	Type of Role	Legal Basis	Background	Named Individual
Maternity Board Safety Champion	Assurance	Recommended	In response to the Morecambe Bay Investigation (2015), the Safer Maternity Care (2016) and the Ockenden Review (2020)	**Andy Papworth**
Wellbeing Guardian	Assurance	Recommended	In response to the Pearson Report and adopted through the "We are the NHS People Plan 2020-2"	**Sarah Armstrong**
Freedom to Speak Up	Functional	Recommended	In response to the Robert Francis Freedom to Speak Up Report (2015)	**Laura Robson** (as Senior Independent Director)

Role	Type of Role	Legal Basis	Background	Named Individual
Doctors disciplinary champion / independent member	Functional	Statutory	In response to the 2003 Maintaining High Professional Standards in the modern NHS: A framework for the Initial Handling of Concerns about Doctors and Dentists in the NHs and the associated Directions on Disciplinary Procedures 2005.	**A Non-executive Director is assigned to each case.**
Security Management	Assurance	Statutory	Under the Directors to NHS Bodies on Security Management Measures 2004.	**Chiara De Biase** (as Chair of Audit Committee)

Additional Roles

Whilst the review was undertaken for 2022, the organisation also determined that a Non-Executive Director Lead for Equality and Diversity was required. This is noted as Wallace Sampson, Non-executive Director.

2.3 Issues to be overseen through Committee Structures

This section provides information on areas that were recommended to review within the Committee Structure, which HDFT implemented:

Quality Committee

Issue / Topic	Detail	Position
Hip fractures, falls and dementia	The focus in on hip fractures and other serious harms resulting from inpatient falls can be linked to dementia. It is suggested that the executive lead for dementia attends the Quality Committee as well as the Dementia Steering Group.	Falls, including themes such as dementia are regularly reviewed in the Patient Safety Forum and escalated through Quality Governance Management Group and on to the Quality Committee.
Palliative and End of Life Care	The focus is on the six ambitions for the improvement of Palliative and End of Life Care as outlined in Ambitions for Palliative and End of Life Care National Framework 2021-26. The Board should be aware of standards of care in PEoLC.	The Executive lead is the Director of Nursing, Midwifery and AHPs. End of Life feeds into the HDFT Making Experiences Count Forum and is escalated through the Governance Structure. The End of Life and Mortality Committee reports to the Quality Board Sub Committee bi-monthly.
Resuscitation	The Health Service Circular Services: HSC 2000/028 stated that all trusts should give a NED designated responsibility on behalf of the Board for ensuring the resuscitation policy is agreed, implemented and regularly reviewed within the clinical governance framework. It is suggested that the Quality Committee may wish to discharge this duty rather than a specific Non-executive Director.	The Resuscitation Policy is managed via the Patient Safety Forum with Annual Reports submitted to the Quality Committee.
Learning from Deaths	All Non-executive Directors play a crucial role in constructively challenging the executives to satisfy themselves that clinical quality controls and risk management systems are robust and defensible. It is suggested that the Quality Committee should understand the Learning from Deaths review process, champion quality improvement that leads to actions that improve patient safety.	A Medical Examiner is in place and a well-established process is in place with Quarterly Reports submitted to the Board with numbers, themes and trends.
Health and Safety	Strong leadership at board level and a strong safety culture, combined with NED scrutiny are essential. The wide range of issues that this encompasses could be better scrutinised within a Committee structure.	As recommended, the Health and Safety Committee was moved to Level 3, reporting to the Quality Committee. This commenced in the fourth quarter of 2022/23 as planned.

Issue / Topic	Detail	Position
Safeguarding	The Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff suggests that boards should consider the appointment of a Non-executive Director, however, this could be discharged by a committee in ensuring appropriate scrutiny of the safeguarding performance, all Board members should have Level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents.	The Executive Lead for Safeguarding (Children and Adults) is the Director of Nursing, Midwifery and AHPs. Safeguarding is managed through the Safeguarding Forum as well as regular reports through the Quality Committee and Annual Reports to the Board.
Safety and Risk	The CQC Well-Led framework notes that a range of Non-executives will be interviewed who have safety and risk as their priority. It is noted in the report that organisations can determine if they wish to designate the role to a Committee or a specific Non-executive Director.	A well-established process is in place with reports submitted on a monthly basis to Quality Committee and escalated to Board as required.
Children and Young People	The CQC Children and Young People Framework states that a Non-executive will be interviewed. This could be a designated Non-executive Director with this responsibility or the Quality Committee Chair.	A Children and Young People Programme Board and relevant working groups is well established. In addition, the Trust has Laura Robson, Non-executive Director and Chair of Quality Committee as the lead for Children and Young People.

Audit Committee

Issue / Topic	Detail	Position
Counter Fraud	The role is primarily a senior manager within an organisation, however the Audit Committee Chair will be required to ensure that Counter Fraud is considered at the Committee.	The executive lead is Jordan McKie, Director of Finance. Kim Zamiteas, Financial Controller, is the HDFT champion with updates provided at every Audit Committee.
Emergency Preparedness	The NHSE Emergency Preparedness, Resilience and Response Framework sets out the responsibility of the accountable emergency officer (AEO). The Framework suggests that a Non-executive could have responsibility for holding the AEO to account, however, the Board will want to ensure that they have oversight.	The AEO is Russell Nightingale, Chief Operating Officer. The Emergency Preparedness Report and Statement is submitted annually in November for scrutiny at Resource Committee for onward recommendation to be approved at Board.

Resource Committee

Issue / Topic	Detail	Position
Procurement	This should be overseen by the Audit Committee with escalation to the Board as required.	Well established process of review at the Audit Committee.
Cyber security	Each organisation should have a Senior Information Risk Owner (SIRO). The Board or Committee should regularly review cyber security risks. This should include information on the removal of unsupported systems from Trust networks, timely patching of systems and prompt action on high severity Alerts when they are issued and ensuring robust and immutable backups are in place. It is recommended that the Board undertake annual cyber awareness training.	The SIRO is Russell Nightingale, Chief Operating Officer. Cyber Risks are discussed on a monthly basis at the IT Steering Group.

People and Culture Committee

Issue / Topic	Detail	Position
Security management - violence and aggression	As set out in the NHS People Plan and the NHS Violence Prevention and Reduction Standard 2020, organisations should commit to develop a violence prevention and reduction strategy that is endorsed by the Board and a senior management review is undertaken twice a year as a minimum to evaluate and assess the Violence Prevention and Reduction programme.	Violence and aggression is overseen by the Quality Governance Management Group and escalated as required to the Quality Committee. Full scale review completed and in line with NHS England and HSE requirements.

3.0 RECOMMENDATIONS

The Board is recommended to review the content of this report and approve:

- The continued appointment of Non-executive Director champions to the roles recommended by NHSE and highlighted as a need by the Trust.
- The governance arrangements for the management of all highlighted issues in section 2.3 of this report and confirm that these will be managed via the Committee Structure rather than a designated Non-executive Director.

Kate Southgate
Company Secretary

19 March 2025

Status Active PolicyStat ID 16979580

Origination	20 Nov, 2024
Last Approved	20 Nov, 2024
Effective	20 Nov, 2024
Last Revised	20 Nov, 2024
Next Review	20 Nov, 2027
Owner	Yasser Hussain: Quality Assurance Lead
Area	CS Corporate Affairs and Quality
Document Types	Policy

Risk Management Policy

Version	Date	Purpose of Issue/Description of Change	Review Date
1.0	June 2014	Developed from Risk Management Strategy	June 2016
2.0	Oct 2015	Updated	October 2017
2.1	Dec 2015	Addition sections 3.3, 3.4	
2.2	Jan 2016	Amendments 2.2.4 and 2.2.5 re risk escalation	
2.3	April 2017	Updated hyperlink p6	
3.0	Sept 2017	Updated	October 2020
4.0	Sept 2021	Scheduled review - minor amends	September 2023
4.1	Oct 2022	Full review and revision	October 2025
4.2	July 2024	Full Review and revision	July 2027

Status	Open	
FOI Classification	Our policies and procedures	
Document Type	Policy	
Key Words	Risk, Event, Learning, Register, BAF, Board Assurance Framework, Safety, PSIRF	
Executive Lead	Director of Nursing, Midwifery and AHPs	
Policy Lead	Associate Director of Quality and Corporate Affairs	
Author	Associate Director of Quality and Corporate Affairs	
Governance Group	Senior Management Team	
Approval Body	Senior Management Team	Date/s
Review Date	August 2024	

1. PURPOSE

Harrogate and District NHS Foundation Trust (the Trust or HDFT) acknowledges that some of its activities will unless properly controlled, create organisational risks and/or risks to staff, patients and

others. This policy and appended documents set out the governance structures in place to ensure that risks are managed and escalated through the Trust as appropriate.

The attached risk management procedure offers guidance on evaluating, scoring, and documenting risks, and helps in creating mitigation action plans. The attached risk appetite statement clarifies how to identify target scores, ensuring proper control of risks

The overall purpose of the risk management policy is to:

a) Reduce the level of exposure to harm for patients, staff or visitors by proactively identifying and managing personal risk to a level that is as low as reasonably practicable

b) Promote success and protect everything of value to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income

c) Continuously improve performance by proactively adapting and remaining resilient to changing circumstances or events.

2. BACKGROUND/CONTEXT

Risk management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects in order to improve the health and wellbeing of patients, service users and staff alike. Through the risk management process the Board of Directors is informed of the significant risks that face the organisation. Significant risks are defined as "risks that are significant to the fulfilment of the (organisation's) strategic ambitions".

The Board of Directors recognises that risk management is an integral part of good management practice and to be most effective it must be part of the Trust's culture. The Board is, therefore, committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans rather than it being viewed or practised as a separate programme; and that responsibility for its implementation is accepted at all levels of the organisation.

The Board acknowledges that the provision of appropriate training is central to the achievement of this aim.

Good risk management awareness and practice at all levels is a critical success factor for an organisation such as the Trust. Risk is inherent in everything that we do. HDFT will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risks.

The aim of this Risk Management Policy is to provide a clear risk management framework that ensures:

- integration of risk management into activities across the organisation as well as into policy making, planning and decision making processes;
- chances of adverse events, risks and complaints are minimised by effective risk identification, prioritisation, treatment and management
- a risk management framework is maintained, which provides assurance to the Board that strategic and operational risks are being managed

- risk management is an integral part of HDFT culture and encourages learning from events
- risk associated with the health, safety & wellbeing of staff, fraud, project and programme management and information security are minimised
- staff, reputation, finances and business continuity are protected through the process of risk identification, assessment, control and mitigation.

This policy represents a dynamic approach to the management of all risks.

3. DEFINITIONS

- **Board Assurance Framework**: A document which records the threats to the strategic objectives or ambitions (goals) of the Trust.
- **Risk:** Effect of uncertainty on meeting objectives
- **Risk assessment:** Overall process of risk identification, risk analysis and risk evaluation
- **Operational Risk:** The risk of loss or gain, resulting from inadequate or failed internal processes, people and systems or from external events
- **Initial risk score**: The risk score prior to any mitigating action
- **Control:** Measure to mitigate or fully address the cause of the risk
- **Gaps in Control:** Missing controls or weaknesses in identified controls
- **Current risk score**: The risk score remaining after the taking into consideration of controls
- **Further Mitigating Actions**: Actions required to address gaps in control
- **Corporate Risk Register:** The document which records the most serious risks faced by the Trust
- **Risk acceptance**: Informed decision to take a particular risk
- **Risk analysis:** Process to comprehend the nature of risk and to determine the level of risk
- **Exposure:** Extent to which the organisation is subject to an event
- **Risk appetite**: Amount and type of risk the organisation is prepared to seek, accept or tolerate
- **Risk tolerance**: The range of risk score the Trust will accept within the risk appetite category
- **Risk tolerance threshold:** The level of risk exposure which will require some form of further response such as escalation, reporting or monitoring to the relevant governance function
- **Hazard:** Anything that has potential for harm
- **Risk avoidance:** Decision not to be involved in, or to withdraw from, an activity based on the level of risk
- **Event:** Event or incident in which a loss occurred or could have occurred regardless of severity
- **Risk management**: Coordinated activities to direct and control the organisation with regard to risk
- **Risk owner:** Person or entity with the specific accountability and authority for managing the risk and any associated risk treatments
- **Near Miss:** Operational failure that did not result in a loss or give rise to an inadvertent gain
- **Target risk score:** The score at which the risk becomes acceptable

4. POLICY EFFECT

The organisational structure is supported by the Risk Management Framework. This enables HDFT to monitor and address the strategic risks that would prevent the organisation achieving its strategic aims and business plan objectives, it sets out the controls (or the ways the risks are being mitigated), and the sources of assurance that those controls are effective. As well as setting out the treatment plans for those risks that require action to bring them within the risk appetite where possible

Risks are linked to objectives and strategic aims, which exist at different levels:

- Strategic risks – risks that affect HDFT's ability to deliver the strategy or function as an organisation as a whole
- Corporate Operational Risks – risks that affect the delivery of HDFT's business plan or common team risks that require a corporate response
- Directorate, Department, Speciality risks - risks that are related to the delivery of departmental operations and objectives
- Programmes and their project outcomes – risks associated with time limited activities and the medium- to long-term delivery of benefits.

HDFT maintains a strategic risk (Board Assurance Framework or BAF), Trust operational and local department risk registers. These registers record non-project risks. All projects risks will be managed through the appropriate project boards with reporting and escalation through the change management governance process.

Risk Management Framework

The following section describes the steps in the process of identifying, assessing and managing risks in the Risk Management Process:

Identify - Risk identification:

When identifying a risk consideration should be given to what could pose a potential threat (or opportunity) to assets of the organisation. Assets can be considered as:

- Information assets, as identified on the asset register
- Business processes, objectives and Key Performance Indicators
- Our staff

Once identified and described the risk should be added to the risk register and scored. Guidance on the elements that should be included in a risk can be found in **Appendix A**.

Systems

The Trust has a dedicated DCIQ module to record, document and manage risks.

The Enterprise Risk Module is open for all staff to report risks and is the primary system deployed by the trust for risk management.

The trust may, by discretion provide access to Subsidiary Organisations. To utilise the module for them to record and manage their risks. By providing access to the system, the trust does not accept transfer of the risk or management of the risk.

Recording risks - The risk register

The risk register provides a framework where risks that may be a threat (or opportunity) to the achievement of objectives are to be recorded. HDFT has in place registers for departments/specialities, directorates and Trust operational and strategic risks (BAF)

The Department / Speciality / Directorate risk registers are recorded and managed via an electronic risk management system known as Datix. Within this system, the following information is recorded:

- Risk ID – a unique reference number to identify the risk
- Risk title – describing the primary risk
- The date the risk was raised
- Description and current position
- Controls – the actions in place currently to mitigate the impact or likelihood of the risk materialising
- Gaps in Control and treatment plan – the areas not currently controlled and which lead to the current risk rating
- Treatment plan – the actions which must be implemented to mitigate the impact or likelihood of the risk materialising
- Services and locations – name of the department, speciality or directorate where the risk applies
- Risk owner – who is responsible for overseeing the risk
- Risk type – the risk taxonomy
- Risk Grading- initial, current and target
- Risk Appetite- as per the appetite statement

- Risk register – the register the risk is currently assigned to
- Objectives – The strategic objectives the risk impacts

The Trust Risk Register will be managed via a database approach and will be linked to the Care Quality Commission domains of Safe, Effective, Caring, Responsive, Well-Led; and Use of Resources.

5. ROLES AND RESPONSIBILITIES

All staff employed by the Trust must adhere to the Trust Policies and Procedures, as well as local guidelines, regarding any concerns for staff, service users and the public.

The Trust has a governance framework that addresses and manages risk. This system ensures that controls are in place, allowing the organization to achieve its policies, aims, and objectives, and to safeguard public funds and assets. Board subcommittees provide assurance to the Board that risk is being effectively managed.

5.1. Board of Directors

The Board of Directors is responsible for the effectiveness of internal controls – clinical, financial, organisational and strategic. The Board is required to endorse an annual governance statement which records the stewardship of the organisation to supplement the accounts. This statement will draw together statements and evidence reflecting the organisation's systems and processes of governance and risk management.

5.2. Chief Executive

The Chief Executive has overall responsibility for risk within the Trust. As accountable officer, the Chief Executive is required to present the annual governance statement to the Audit Committee and the Board of Directors.

5.3. Director of Nursing, Midwifery & AHPs

The Director of Nursing, Midwifery & AHPs will work closely with the Executive Medical Director on all aspects of risk management. The Director of Nursing, Midwifery & AHPs is the executive lead for patient experience and as such they will have particular responsibility for ensuring efficient, effective and timely responses to complaints and patient feedback to promote an open and just learning culture. The Director of Nursing, Midwifery & AHPs is also the executive lead for patient safety and has particular responsibility for ensuring systems and processes are in place for reporting, co-ordinating and investigating events and serious events in order to promote an open and just learning culture.

5.4. Executive Medical Director

The Executive Medical Director will work closely with the Director of Nursing, Midwifery & AHPs on all aspects of risk management.

5.5. Director of Finance

The Director of Finance has executive director responsibility for financial risk.

5.6. Chief Operating Officer

The Chief Operating Officer is responsible for non-clinical risk management and as the Trust nominated SIRO will advise the Board on the effectiveness of information governance and risk management across the organisation.

5.7. Associate Director of Quality and Corporate Affairs

The Associate Director of Quality and Corporate Affairs will ensure the provision of appropriate support and advice to staff in all aspects of risk management.

5.8. Senior Management Team

The Senior Management Team (SMT) brings corporate and clinical directors and senior managers together to operationally manage the Trust. SMT will oversee the work of its subgroups to ensure effective risk management.

5.9. Executive Risk Review Group

The Executive Risk Review Group is responsible for reviewing high scoring risks on directorate and HIF risk registers, identifying risks for escalation to the Trust risk register and reporting to SMT, the Audit Committee and the Board of Directors. It is also responsible for ensuring appropriate training for managing risk registers effectively within the organisation.

5.10. Responsibility of Directorates

Directorates are responsible for the following, by appointing staff to undertake specific roles where appropriate:

- Ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility; and that all staff are made aware of the risks within their work environment and of their personal responsibilities.
- Establishing local quality of care teams and risk registers at care group level
- Implementing and monitoring any identified and appropriate risk management control measures within their designated area(s) and scope of responsibility.

5.11. Risk Owner / Risk Reviewer

Perform risk assessment and report findings in accordance with the process for managing risk.

5.12. Risk Register Owner

Review and prepare their Risk Register. Ensure treatment plans for risks, are in place. Risks are being reviewed and escalated in
adherence to policy.

5.13. All Staff

Responsible for reporting all risks line with the appropriate policy; comply with policies, standard operating procedures and
instructions to enable management of risks.

6. GOVERNANCE

At HDFT we have three key things that help us manage risk. The “three lines of defence” model provides a simple and effective way to help delegate and coordinate risk management roles and responsibilities within and across the organisation. The Corporate Governance Framework provides clear guidelines, structures, and processes to ensure accountability, transparency, and effective decision-making within the organisation.

7. TRAINING

The Trust has a targeted approach to risk management training established through training needs analysis. The Associate Director of Quality and Corporate Affairs ensures Board members and directors are aware of their risk management responsibilities and that appropriate training is provided.

Bespoke training is available to all senior managers on risk management training and a structured training programme is available to all employees.

8. EQUALITY ANALYSIS

As part of its development, this policy and its impact on equality have been reviewed in consultation with trade union and other employee representatives in line with NHS Resolution’s Equal Opportunities Policy and the public sector equality duty. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on employees and service users in relation to the protected characteristics: race, sex, disability, age, sexual orientation, religious or other belief, marriage and civil partnership, gender reassignment and pregnancy and maternity. No detriment was identified.

9. CONSULTATION, REVIEW AND COMMUNICATION

As part of the development and review process of this policy the following consultation was undertaken:

- Executive Risk Review Group
- Senior Management Team
- Directorate Triumvirate
- Harrogate Integrated Facilities Governance and Compliance Committee

In order to ensure full communication of this policy, as well as taking this document for review and discussion at the above meetings. A full training and communication package will be developed for all updates to this document.

This policy will be reviewed on the review date or sooner if there is a local or national requirement.

10. STANDARDS/ KEY PERFORMANCE INDICATORS

The following methods will review performance:

- Annual audit that the Board Assurance Framework was reviewed at each Trust Board Meeting
- Annual audit that the Trust Risk Register was reviewed at the Executive Risk Review Group on a monthly basis

11. MONITORING COMPLIANCE AND EFFECTIVENESS

Policy element to be monitored	Standards and Performance indicators	Process for monitoring	Individual or group responsible for monitoring	Frequency or monitoring	Responsible individual or group for development of action plan	Responsible group for review of assurance reports and oversight of action plan
Board Assurance Framework	*Monthly reviewed at Trust Board*	Audit of Board Minutes	Associate Director of Quality and Corporate Affairs	Annual	Associate Director of Quality and Corporate Affairs	Executive Risk Review Group
Trust Risk Register	*Monthly reviewed at Executive Risk Review Group*	Audit of Executive Risk Review Group Actions	Associate Director of Quality and Corporate Affairs	Annual	Associate Director of Quality and Corporate Affairs	Executive Risk Review Group
Organisational performance on risk management	*Report to Audit Committee*	Audit of findings from risk management system	Risk manager	Annual	Risk Manager	Risk Manager
Risk Management Training	*Risk Management training attendance and completion*	Annual report and accounts provided to the Audit Committee.	Risk Manager	Annual	Risk Manager	Risk Manager

12. REFERENCES/ASSOCIATED DOCUMENTATION

The following policies, guidelines or processes are linked to HDFTs risk management framework:

- Risk Appetite Statement
- Risk Management Procedure
- Patient Safety Incident Response Framework
- Being Open and Duty of Candour
- Speaking up and Whistleblowing
- Claims
- Maternity Risk Management Strategy
- Health and Safety Policy

Appendix A

Appendix A - Risk Management Procedure

Identify - Risk identification:

Risk, Events and issues can often get confused and a useful way of remembering the difference is;

- **Risks** are things that **might happen** and stop us achieving objectives, or otherwise impact on the success of the organisation
- **Events** (previously known as incidents) are things that **have happened**, were not planned and require management action, must be reported as appropriate and where required in line with the Safety Events Policy.
- **Issues** are things that **are happening**, were not planned and require management action and will be monitored via our Business as Usual activities

Once identified, the risk needs to be described clearly to ensure the risk is understood with a risk statement. The risk statement should state clearly:

1. The Risk Source (Cause): Describe what may give rise to the risk.

   Example: "Due to a shortage of skilled labour…"

2. What the trigger is for the risk (Event): State the potential event or condition that could occur.

   Example: "...there is a risk that project deadlines will be delayed..."

3. What the impact of the risk is if it happens (Consequence): Highlight the possible impact or consequences if the event occurs.

   Example: "..Which could lead to increased costs and loss of client trust."

4. The Context/Objective: Relate the risk to a specific organisational objective or business process.

   Example: "...affecting our ability to deliver on-time for the project."

""If <Cause > happens then there is a risk of <Event > which will result in <consequence> this will effect <Objective>"

Assess and evaluate - Risk assessment and evaluation

A risk assessment is a qualitative or quantitative evaluation of the nature and magnitude of the risk. The assessment is completed by scoring the likelihood of the risk occurring and the impact should it occur **Appendix B** sets out HDFT's scoring matrix which are based on a scale of 1 - 5 and the risk rating matrix which gives the scoring a RAG status.

The risk evaluation involves making a decision about what should be done to manage the risk. It includes determining the appropriate controls and or treatments for the risk, and what level of risk can be tolerated within the organisations risk appetite.

- **A Control** is an existing strategy and process currently in place such as systems, policies, procedures, standard business processes, practices.
- **A Treatment** is an additional strategy/activity we need to develop and implement should the risk level be unacceptable after controls are applied.

Following identification and assessment, consideration on what to do with the risk is taken; this is the risk response:

Terminate	Where an activity or system gives rise to significant risk to HDFT the activity will be carried out differently or ended hence the risk is no longer relevant.
Tolerate	Where it is considered that nothing more can be done at a reasonable cost to reduce the risk; or if the risk is low.
Treat	This is where action can be taken to reduce the impact or the likelihood of the risk identified
Transfer	HDFT may on occasion transfer a risk to a third party potentially via business management arrangements or through risk pooling schemes.

Treatment Plan

Where it has been considered the risk requires further action to reduce the likelihood and/or impact of a threat or maximise the likelihood of opportunities, a risk treatment plan should be devised.

The treatment plan must have an owner; it should be specific to the risk and SMART (specific, measurable, attainable, relevant and time bound) to evidence how the risk score can be reduced.

Monitor and Review

The implementation of the risk treatment plan must be kept under review along with the risk score to measure its effectiveness. If the treatment is not reducing the risk a new treatment plan should be

considered. Once a treatment plan has been implemented the risk will be re-assessed and rescored and that treatment plan will become a control.

Reviews of the risk registers and the treatment plans will be carried out in discussion with:

- Departments and Specialities – within the department/speciality and escalated through the Directorate Governance Structures
- Directorates – within the directorates and escalated through Resource Review Meetings
- Trust – with Executive Directors and escalated through the Executive Risk Review Group (ERRG) and at the Senior Management Team (SMT) on a monthly basis. It was also be reviewed at the Audit Committee on a quarterly basis.
- Strategic – with Executive Directors and escalated via the Board Assurance Framework to the Trust Board and its Sub-Committees as a minimum on a bi-monthly basis

Risk Escalation and Responsibilities in **Appendix C** sets out the process for how risks can be escalated for inclusion on the Trust Operational and Strategic risk registers.

Frequency of Review

The level of risk determines the minimum frequency for review:

- Low (Green) – once a quarter
- Medium (Amber) – Every other month
- High (Red) – Every month

Risk Scoring Matrix

		Clinical	Operational	Reputational	Financial	Workforce	Legal / Regulatory
Consequence	**5 Catastrophic**	Multiple deaths caused by an event; **major impact on** patient experience	**Prolonged failure or severe disruption** of **multiple** services. Multiple deaths caused by an event; **major impact on** patient experience	**Widespread permanent loss of patient trust and public confidence** threatening the Trust's independence / sustainability Hospital closure	**>£5m** directly attributable loss / unplanned cost / reduction in change related benefits	Workforce experience / engagement is **fundamentally undermined** and the Trust's reputation as an employer damaged	Breach of regulation Trust put into Special administration / Suspension of CQC Registration Civil / Criminal **Liability > £10m**
	4	Severe permanent harm or	**Prolonged failure or severe**	**Prolonged** adverse social / local	**£1m - £5m** directly attributable	**Widespread material impact** on	Breach of regulation likely to result

	Severe	death caused by an event; **significant impact on** patient experience	**disruption** of a **single** service. Severe permanent harm or death caused by an event; **significant impact on** patient experience	/ national media coverage with **serious impact** on patient trust and public confidence	loss / unplanned cost / reduction in change related benefits	workforce experience / engagement	in enforcement action. Civil / Criminal **Liability <£10m**
	3 Moderate	Moderate harm where medical treatment is required up to 1 year Temporary disruption to one or more departments Resulting in poor patient experience	**Operation of a number of** patient facing services is disrupted. Moderate harm where medical treatment is required up to 1 year Temporary disruption to one or more departments Resulting in poor patient experience	**Sustained** adverse social / local / national media coverage with **temporary impact** on patient trust and public confidence	**£100k - £1m** directly attributable loss / unplanned cost / reduction in change related benefits	**Site material impact** on workforce experience / engagement	Breach of regulation or other circumstances likely to effect our standing with our regulators. Civil / Criminal **Liability <£5m**
	2 Minor	Minor harm where treatment is required up to 1 month **Minor impact on** patient experience	**Operation of a single** patient facing services is disrupted. Minor harm where treatment is required up to 1 month Temporary disruption to single department **Minor impact on** patient experience	**Short lived** adverse social / local / national media coverage with **may impact** on patient trust and public confidence	**£50k - £100k** directly attributable loss / unplanned cost / reduction in change related benefits	**Department / Directorate material impact** on workforce experience / engagement	Breach of regulation or other circumstances which may affect our standing with our regulators, with minor impact on patient outcomes Civil / Criminal **Liability <£2.5m**
	1 Limited	**Service continues with limited / no impact**	**Service continues with limited / no impact**	**Short lived** adverse social / local / national	**£nil - £50k** directly attributable loss /	**Material impact** on workforce experience /	Breach of regulation or other circumstances

		on patient(s)	**on patient(s)**	media coverage with **no impact** on patient trust and public confidence	unplanned cost / reduction in change related benefits	engagement for a **small number of colleagues**	with no impact on our standing with regulators Civil / Criminal **Liability <1m**

This table sets out a general guide for likelihood of an event happening:

Likelihood Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Extremely Unlikely / Rare**	**Unlikely**	**Possible**	**Likely**	**Very Likely / Certain**
Frequency	Not expected to happen for years	Expected to happen at least once in a year	Expected to occur up to once a month	Expected to occur at least weekly	This type of event will happen frequently (potentially daily)

		LIKELIHOOD				
		1 Extremely Unlikely / Rare	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Very Likely / Certain**
IMPACT / CONSEQUENCE	**5 Catastrophic**	5	10	15	20	25
	4 Severe	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Limited	1	2	3	4	5

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Appendix B

NHS Harrogate and District NHS Foundation Trust

Appendix B Risk Appetite Statement

TRUST RISK APPETITE STATEMENT

1. Introduction

Risk management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects in order to improve the health and wellbeing of patients, service users and staff alike. Through the risk management process the Board of Directors is informed of the significant risks that face the organisation.

Good risk management awareness and practice at all levels is a critical success factor for an organisation such as the Trust. Risk is inherent in everything that we do. HDFT will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risks.

At HDFT we use certain types of "risk language" on a regular basis. This includes the types of risk we have. These are broken down into two levels of risk. Level 1 is our 6 overarching types of risk: Clinical, Operational, Reputational, Financial, Workforce and External/Regulatory. Level 2 defines our risk categories that sit underneath each of these risk types.

Risk appetite as a concept is often referenced in organisations, without clearly defining what it is. Similarly, the terms risk appetite and risk tolerance are often used interchangeably. For our guide we will use the following definitions:

Tolerable risk position: the level of risk with which **we are willing** to operate.

Risk Appetite – how much risk we are willing to take in order to deliver the HDFT strategy, whilst ensuring we provide safe and effective outcomes for our patients and service users.

2. Use of the Trust Risk Appetite

By adopting a risk appetite statement, the trust is able to manage risks and determine an acceptable risk target score. It should be noted that the risk statement is not absolute and should be used to guide risk management by indicating the Target score and assisting in setting controls and mitigating actions required.

Occasionally more information related to a risk will become apparent or because of change of circumstances, the level or type of consequence will change. In this case, when reviewing the risk the assessor should consider the risk appetite statement again and ensure the controls align with the appetite level.

The trust commits to considering the risk appetite statement as part of strategic planning. When making decisions and committee proposals staff should consider their impact on the risk profile and the risk appetite adherence. Where risks are identified and do not adhere to our risk appetite, then these instances must be escalated through the appropriate channels.

The risk statement cannot encompass every possibility or scenario; as such, management of risks can occasionally require the level of tolerance and controls to be outside the scope of the appetite

statement. In this case, the rationale should be documented and feedback provided for future consideration of the risk appetite statement.

3. Risk Appetite Target Scores

At HDFT we have adopted an approach to risk appetite as described in "The Orange Book". This means we have determined a 5-point scale of risk appetite. Each risk category at level 1 and 2 is assigned a target risk score range.

Risk Appetite Matrix	Risk Appetite (Level of risk in which we aim to operate)	Tolerance (level of risk with which we are willing to operate)
Averse: Avoidance of risk and uncertainty is a key objective	**1-3**	**<5**
Minimal: (As little as reasonably possible) Preference for a safe option that has a low degree of inherent risk	**3-5**	**<10**
Cautious: Preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward.	**5-9**	**<12**
Open: Willing to consider all potential delivery options and choose one that is most likely to result in successful delivery, whilst also providing an acceptable level of reward (and VFM)	**9-12**	**<15**
Eager: Eager to be innovative and to choose options that suspend previous held assumptions and accept a greater uncertainty(despite greater inherent risk)	**10-15**	**<20**

4. Appetite Statement

The Trust exists to serve two groups: the patients who we care for in our hospitals and community services in Harrogate and District, and wider North Yorkshire; and the children and young people who we support through our Children's Public Health Services across large parts of the North East and Yorkshire.

The Trust recognises the importance of delivering high quality healthcare services and has formed its strategy to guide its decisions to support its purpose and long-term ambitions. The Trust will manage Clinical, Operational, Financial, Workforce and External risks in order to deliver its objectives in a controlled manner. The Trust's current risk appetite is set out below:

RISK APPETITE STATEMENT

Clinical

The trusts overall appetite for clinical risk is *minimal*. Meaning that we will only accept very limited clinical risks if essential to patient care and outcomes, aiming to optimise patient experience. We will ensure that capacity is planned at a level to meet demand within both our acute setting and our community framework, our appetite for capacity planning is *Cautious*.

The Trust is supportive of innovation and has an *open* (high) risk appetite in pursuing innovation and challenging current working practices without compromising the quality of patient care.

Operational

HDFTs appetite overall for operational risk is *cautious*. Meaning that we have an ongoing commitment to meeting minimum good practice standards. We will seek to priorities upgrades and business cases based on our desire to meet these standards. We will not accept operational risks that could directly affect upon the safe delivery of care. Where the operational risk is to Health and Safety, the trust holds a *minimal* appetite and aims to protect the health and wellbeing of our patients and colleagues by delivering services and environments in line with health and safety laws and guidelines

Finance

HDFTs appetite overall for financial risk is *cautious*. Value for money and patient care and outcomes being a key factor in our decision-making. We will accept risks that have limited financial impact or losses on the basis that there may be upside opportunities with the safe and effective delivery of patient care, but we will not accept risks that may lead to material variances to forecast, reporting misstatements or unplanned overspend against our agreed revenue control target. The trusts recognises supply chain management requires fluidity and has an *Open* appetite for managing suppliers in a manner that protects our interests and service to our patients and service users. We have a zero-tolerance *(Averse)* approach to fraud.

Workforce

HDFTs appetite overall for workforce risk is cautious. We will only accept limited risks if by taking them we could yield improvements to our patient and service user outcomes and experience. We will not accept risks if this is not the case.

Reputation

We endeavour to have systems and processes in place that inspire confidence in our patients and the public. HDFTs appetite overall for reputational risk is *minimal.*

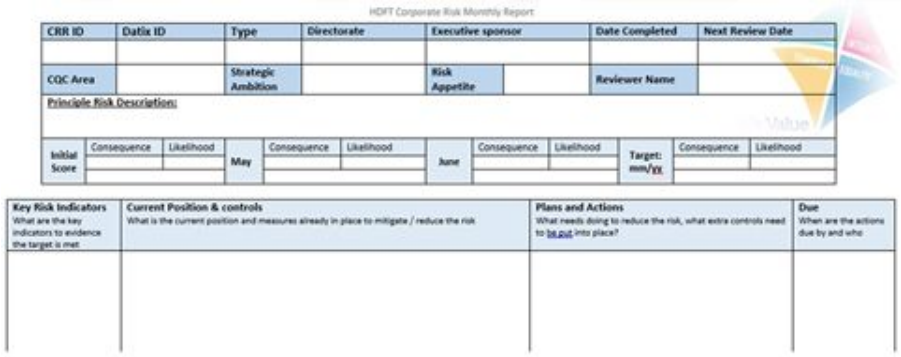
Regulatory

HDFTs appetite overall for regulatory risk is *averse*. Meaning that we have zero appetite for any management decisions that present risks to HDFT maintain its CQC registration or compliance with the law. We will deliver our strategic ambitions as outlined in our Trust Strategy and hold a *Cautious* approach to strategic planning.

Appendix C - Risk Review and Escalation Process

A risk must be escalated to the Trust Corporate Risk Register (CRR):

- If it has a risk rating score of 12 or more *or*
- The risk grading exceeds the tolerance threshold ***and***
- it is outside of the control of the risk owner and directorate leads to reduce the risk to an acceptable level in the immediate future


HDFT Corporate Risk Monthly Report

CRR ID	Datix ID	Type	Directorate	Executive sponsor	Date Completed	Next Review Date
CQC Area		Strategic Ambition		Risk Appetite	Reviewer Name	

Principle Risk Description:

	Consequence	Likelihood		Consequence	Likelihood		Consequence	Likelihood		Consequence	Likelihood
Initial Score			May			June			Target: mm/yy		

Key Risk Indicators What are the key indicators to evidence the target is met	Current Position & controls What is the current position and measures already in place to mitigate / reduce the risk	Plans and Actions What needs doing to reduce the risk, what extra controls need to be put into place?	Due When are the actions due by and who

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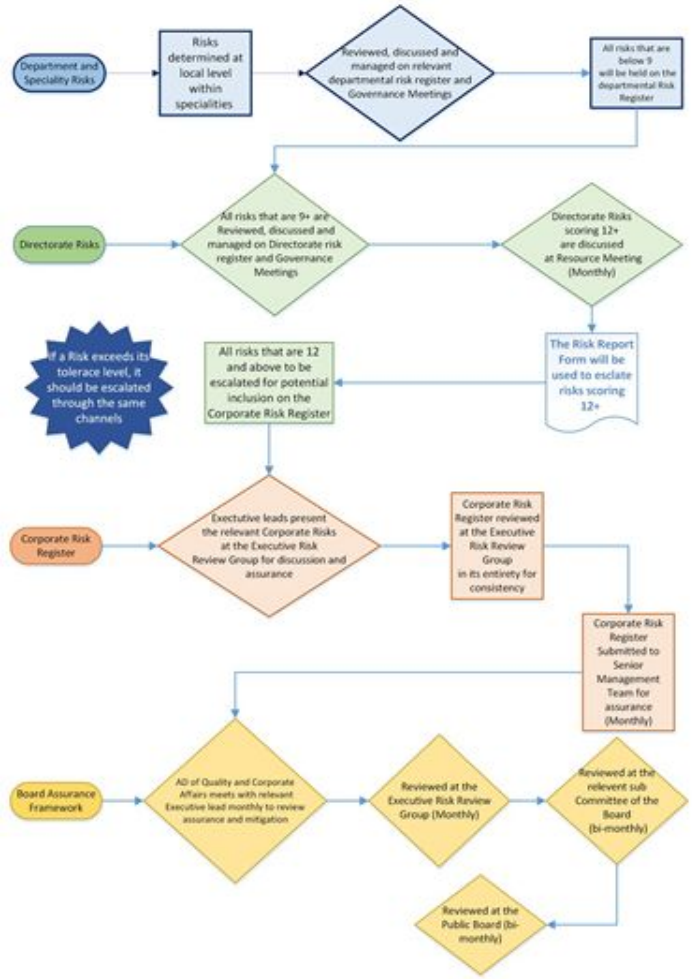

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Attachments

- Appendix C Risk.jpg
- HDFT Banner.jpg
- Risk Manangement Process.jpg
- Risk Appetite and Categories.jpg
- Risk Review and Escalation Process.jpg

Approval Signatures

Step Description	Approver	Date

Senior Management Team	SMT Senior Management Team [RH]	20 Nov, 2024
QGMG	Paula Chyzy: Administration Assistant	11 Nov, 2024
Policy Governance Team Review	Paula Chyzy: Administration Assistant	11 Nov, 2024
Policy Governance Team Review	PGT Policy Governance Team [KK]	11 Nov, 2024
	Yasser Hussain: Quality Assurance Lead	11 Nov, 2024