Board of Directors Meeting Held in Public

To be held on Wednesday, 28 May 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 26 March 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	Health & Safety Annual Report	-	Note	Supp. Pack
2.3	Safer Staffing Report: Bi-Annual Report (incl Safer Nursing Care Tool)	-	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
3.3	**Delivering Same Sex Accommodation Statement** (Eliminating Mixed Sex Accommodation – EMSA)	Interim Director of Nursing, Midwifery and AHPs	**Approve**	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
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
5.2	**Modern Slavery and Human Trafficking Annual Statement 2025**	Director of People & Culture	**Approve**	Attached
5.3	Public Sector Equality Duty Report	-	Note	Supp. Pack
SECTION 6: Ambition: Enabling Ambitions				
6.1	**Board Assurance Framework:** Digital Transformation and Maturity 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 Finance / 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	**Board Appointed Non-executive Roles:**	Chair	**Approve**	Attached

Item No.	Item	Lead	Action	Paper
	Non-executive Board Committee Membership			
8.3	**NHS Provider Licence Annual Self-Assessment**	Chief Executive	**Approve**	Attached
8.4	**Pledge to the Code of Conduct**	Chief Executive	**Approve**	Attached
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 30 July 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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NHS Foundation Trust

Board of Directors – Register of Interests

As at 16 May 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	Current Current	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 July 2024	February 2024 Current June 2024 Current	1. Executive Director, Chartered Insurance Institute 2. Familial relationship, Health Education England 3. Chief Operating Officer, Institute of the Motor Industry 4. Managing Director, Institute of the Motor Industry
Denise Chong	Interim Non-executive Director	March 2025	Current	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	Current	No interests declared
Jeremy Cross	Non-executive Director	January 2020	Current	1. Chairman, Tipton Building Society 3. Director and Shareholder, Cross Consulting Ltd (dormant)

Board Member	Position	Relevant Dates From	To	Declaration Details
				4. Chairman, Forget Me Not Children's hospice, Huddersfield 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 March 2025 Current	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	Current Current	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	Current	1. Chair, Internal Audit Provider Audit Yorkshire
Russell Nightingale	Chief Operating Officer Deputy Chief Executive (from April 2025)	April 2021	Current	1. Director of ILS and IPS Pathology Joint Venture
Emma Nunez	Director of Nursing Deputy Chief Executive from March 2022	April 2021	March 2025	No interests declared
Andrew Papworth	Non-executive Director	March 2020	Current	1. Chief Finance Officer, Insight222 2. Ambassador for Action for Sport
Laura Robson	Non-executive Director	September 2017	Current	No interests declared
Wallace Sampson OBE	Non-executive Director	March 2020 July 2023 August 2023	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

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Board Member	Position	Relevant Dates From	To	Declaration Details
		September 2023 October 2023 August 2024		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	Current Current	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	Current	1. Director of ILS and IPS Pathology Joint Venture

Harrogate and District NHS Foundation Trust

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

Harrogate and District NHS Foundation Trust

Directors and Attendees
Previously recorded Interests – For the 12 months period pre April 2025

Board Member	Position	Relevant Dates From	To	Declaration Details
Denise Chong	Insight Programme: Non-executive Director	January 2024	September 2024	1. Trustee, Learning Partnerships Leeds (Feb 2023) 2. Member, Kaleidoscope Learning Trust (KLT) (Dec 2023)
Kama Melly	Associate Non-executive Director	November 2022	February 2025	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

BOARD OF DIRECTORS MEETING – PUBLIC (DRAFT)

Wednesday, 26 March 2025

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

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 *from minute BD/03/26/3*
Laura Robson (LR)	Non-executive Director, Chair of Quality Committee
Wallace Sampson OBE (WS)	Non-executive Director, Chair of Innovation Committee
Julia Weldon (JW)	Non-executive Director
Denise Chong (DC)	Interim Non-executive Director
Azlina Bulmer (AB)	Associate Non-executive Director
Sarah Shaw (SS)	Non-executive Director (Insight Programme)
Jacqueline Andrews	Executive Medical Director
Matthew Graham	Director of Strategy
Jordan McKie	Director of Finance
Russell Nightingale	Chief Operating Officer
Alison Smith	Interim Executive Director of Nursing, Midwifery and Allied Health Professionals
Angela Wilkinson	Director of People & Culture

In Attendance:	
Leanne Likaj	Associate Director of Midwifery
Kate Southgate	Associate Director of Quality and Corporate Affairs

Apologies:	
Emma Nunez	Executive Director of Nursing, Midwifery and Allied Health Professionals and Deputy Chief Executive

Observers:	
Governors	• Jonathan Allen (Staff Governor) • Kevin Parry (Public Governor) • Giles Latham, Communication Manager • Sue Grahamslaw, Assistant Company Secretary
Member of the public / press	0 members of the public / press

Item No.	**Item**
BD/03/26/1 **1.1**	**Welcome and Apologies for Absence** The Chair welcomed everyone to the meeting. It was acknowledged that Emma Nunez had now left the Trust and the Chair welcomed Alison Smith to the Board as Interim Executive Director of Nursing, Midwifery and AHPs. The Chair welcomed back Denise Chong to the Trust who was joining the Trust as an Interim Non-executive Director. The Chair also welcomed back Julia Weldon, Non-executive Director after a leave of absence.
1.2	The Chair thanked all observers for attending the Public meeting of the Trust Board.

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1.3	Apologies for absence were noted as above.
BD/03/26/2 **2.1**	**Patient Story** The Chair welcomed Sarah Honzik, Complex Case Nurse and Claire Speight, Named Nurse for Child Protection from the Middlesbrough 0-19 Team to the Board to provide the Patient Story (Louise).
2.2	The Team explained the role of a Complex Case Nurse role. It was noted that the application of the role was unique to the Middlesbrough Team and had been awarded praise by the national panel and the local safeguarding children's partnership. The role used a trauma-informed style to help change the outcome for children and families who have or are experiencing complex trauma through multiple adverse threats, significant harm and abuse.
2.3	The practitioner had a reduced caseload of 15-20 children which was focused on the most complex cases, and where "normal" safeguarding measures had failed to make effective changes. This reduced caseload ensured a slowed down response, allowing practitioners to thoroughly unpick the case history, understand the lived trauma of the child, young person or caregiver and therefore ensured a trusted relationship was built by the practitioner, and empowerment to ensure effective and positive lasting change.
2.4	The team introduced Louise's story. Louise was not in attendance at the meeting, however the Team explained that she was a mother with four children. The Team played a short video of Louise and her children.
2.5	They explained that Louise's case had been allocated to the Complex Case Team due to parental violence and aggression, substance misuse, poor maternal physical and mental health, poor home conditions, an attack dog in the property, domestic abuse, poor school attendance by the children and a lack of routines and boundaries in the home.
2.6	The Team explained the range of support that the family had been provided with including support with meeting health needs, advocacy, support for making the home environment safe and supporting on the understanding of the impact of harmful behaviours on the children.
2.7	The Team played an audio clip from Louise who explained the support she had received from the Complex Case Nurse and talked about the positive experience it had been. In addition, an audio clip was played of Louise's sister who explained the positive changes that had been made.
2.8	The Board heard that a trauma-informed holistic approach was used and that Louise had made significant positive changes. Louise no longer engaged with criminality, substance abuse and had stabilised her mental health. The children were now thriving in education having previously had very poor attendance.
2.9	The Chair thanked the Team for providing the Board with the powerful story.
2.10	The Non-executive Director (JW) noted the significant impact of trauma-informed approaches and noted that the story was unfortunately a very common one. They noted that Louise was very brave and courageous to allow her story to be shared. They queried what the Board could do to ensure, the organisation had a trauma-informed approach.

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2.11	The Executive Medical Director queried the resilience in the Team and for individuals given the significance of the cases they were involved with. The Team confirmed that there was strong peer supervision and regular safeguarding supervision. It was confirmed by the Team that Vicarious Trauma training was available across the footprint.
2.12	The Non-executive Director (CD) commended the impact the Complex Case Nurse had on the family. They queried if the safety of the Team was a concern. It was confirmed that a risk assessment was always completed prior to attending families and individuals. There was the opportunity to work with others if they felt it would be unsafe to meet alone. In addition, individuals carried personal safety devices. The Team noted that part of their role was to unpick individual's triggers. This helped reduce risk when engaging with families and individuals. They noted that this was why the trauma-informed practice was so important.
2.13	The Non-executive Director (WS) noted that for support to work effectively there needed to be a multi professional approach. The Team agreed that ensuring strong professional relationships with partners was vital.
2.14	Non-executive Director (JC) noted that it was important to work to understand what help was required rather than each service proposing what they could offer.
2.15	The Chair thanked the Team for their important work and continuing to promote the work they undertook.
2.16	The Interim Director of Nursing, Midwifery and AHPs noted that she had shadowed the Complex Case Nurse and visited Louise. She noted the significant progress made and the positive impact the Complex Case Nurse can have.
2.17	The Chair and the Chief Executive expressed their thanks to Louise for her bravery in allowing her story to be shared.
2.18	**Resolved:** The patient story was noted.
BD/03/26/3 **3.1**	**Declarations of Conflicts of Interest and Register of Interests** The register of interests was received and noted.
3.2	**Action:** All members to review their declarations for their annual submissions and confirmation.
3.3	**Resolved:** The declarations were noted.
BD/03/26/4 **4.1**	**Minutes of the Previous Board of Directors meeting held on 29 January 2025** The minutes of the meeting were noted with the following amendments: • Minute 16.10 and 19.5 should be (LR) not (LP) • The elements of the BAF that were reviewed at the Resources Committee required a sentence to confirm this. • 15.8 should read *lowest in peer group.* • Numbering to be reviewed
4.2	**Resolved:** The minutes of the meeting on the 29 January 2025 were approved as an accurate record of the meeting noting the amendments.
BD/03/26/5 **5.1**	**Matters Arising and Action Log** The actions were noted as follows:

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5.2	• BD/3/29/36.2 – Board Effectiveness Survey – it was confirmed that the annual effectiveness survey would be circulated in April 2025. Action Closed. • BD/01/29/16.9 – Internal Audit Reports submitted to relevant overseeing committee. Action Closed.
5.3	No further matters arising were raised which were not already noted on the agenda.
5.4	**Resolved:** All actions were agreed as above.
BD/03/26/6 **6.1**	**Overview by the Chair** The Chair noted a range of activities that had taken place since the last meeting of the Board.
6.2	The Chair highlighted the following points:
6.3	A considerable amount of change had occurred since the last meeting of the Board. It was noted that there had been an announcement in relation to NHS England, changes to Integrated Care Systems and the pace of change. It was noted that as an organisation it was important to keep our own focus on how the Trust delivered the best care possible.
6.4	In relation to our teams and workforce, it was noted that since the last meeting of the Board, two new 0-19 services had come online. The Trust had also welcomed new governors and was in the process of recruiting to Non-executive and Associate Non-executive Directors roles.
6.5	It was referenced that it would be a challenging start to the new financial year. Resources were stretched and more people than ever need the support of the organisation and wider NHS.
6.6	The KITE awards ceremony had recently taken place and it was noted that this was a joyful opportunity to celebrate colleagues who go above and beyond. The significant impact of the sponsors on the event was acknowledged. Thanks were expressed to the Lead Governor for their attendance at the event.
6.7	The organisation's Charity would be celebrating its 30th birthday this year. A wide range of events and celebrations were planned.
6.8	Finally, the Chair noted that she had come to the end of her first three year term of office. She noted how quickly the years had passed and her gratitude for being in the role. Following confirmation at the Council of Governors of a further term, she looked forward to the next three years.
6.9	**Resolved:** The Chair's report was noted.
BD/03/26/7 **7.1**	**Chief Executive Report** The Chief Executive presented his report as read. The following points were highlighted:
7.2	The changes in NHS England, Integrated Care Boards and the context of this within the operating and annual planning process was noted. The uncertainty was acknowledged, however it was confirmed that the Trust would continue its focus on the delivery of the Trust's Plan for 2025-26. It was referenced that, in relation to

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	corporate services, discussions had commenced as part of the WYAAT service review as discussed at a recent Board Workshop.
7.3	In relation to HNY ICB, plans were in development for the operational, financial workforce elements. It was noted that this would be discussed in detail later in the Board meeting.
7.4	It was confirmed that the national staff survey results had been publically released. These showed a continued positive trajectory and the Trust compared favourably across regional and national comparators.
7.5	A thematic review into Never Events had been undertaken, which had indicated that learning was not as embedded as the organisation would want. This had been discussed in detail at the Quality Committee.
7.6	Reference was made to the key constitutional standards and it was noted that ED 4-hour performance remained a challenge. Cancer metrics continued to see improvements, as did the delivery of the elective recovery plan.
7.7	It was formally confirmed with the Board, that following the departure of the Executive Director of Nursing, Midwifery and AHPs & Deputy Chief Executive (Emma Nunez), recruitment had been completed for her replacements. It was noted that Breeda Columb from Leeds Teaching Hospitals NHS Trust would be the Trust's new Executive Director of Nursing, Midwifery and AHPs. It was noted that Russell Nightingale, Chief Operating Officer would be the Trust's new Deputy Chief Executive. The Board congratulated both individuals for their appointments. Thanks were also expressed to Alison Smith who would take on the role of Interim Executive Director of Nursing, Midwifery and AHPs.
7.8	Finally, the Chief Executive noted the KITE Awards and the uplifting and positive celebration that had taken place.
7.9	The Non-executive Director (CD) noted that the Stroke Pathway was now in place and queried if there were any other pathways that were flagging from a patient safety or experience perspective that required a similar approach. It was confirmed that there was nothing of significance flagging, however, as services and collaborations continued to review pathways there would be further opportunities for improvements.
7.10	The Non-executive Director (WS) noted the positive 0-19 performance metrics. They noted however, that the performance of services that had recently been acquired did not meet these standards. It was confirmed that this was in relation to mandated contacts rather than safeguarding concerns.
7.11	The Non-executive Director (AP) queried if the 0-19 performance metrics would be tracked through the Resource Committee. This was confirmed.
7.12	The Non-executive Director (LR) noted that the report highlighted that the Trust would be receiving support from an external body on professional standards within the Emergency Department. It was noted that professional standards meant the 7-day standards. This was an opportunity to review roles and responsibilities across the patient pathway
7.13	The Non-executive Director (LR) noted that corporate risk in relation to fire had reduced to 10. They queried if the Board was comfortable with this. It was

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	confirmed that the risk would now be removed from the Corporate Risk Register as it no longer met the threshold. It was noted however, that this would remain on the department risk register where it would continue to be managed. If the risk increased then it would be escalated back to the Corporate Risk Register. It was also confirmed that the risk would be managed through the Performance Review Meetings. It was confirmed that elements of the backlog maintenance programme affecting the fire risk had been prioritised for 2025-26 which would see the risk reduce further.
7.14	**Resolved:** The Chief Executive's Report was noted.
BD/03/26/8 **8.1**	**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.
8.2	**Resolved:** The Board Assurance Framework Summary was approved.
BD/03/26/9 **9.1**	**Corporate Risk Register** **Resolved:** The Corporate Risk Register was noted.
BD/03/26/10 **10.1**	**Board Assurance Framework – Best Quality, Safest Care** The Interim Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Best Quality, Safest Care.
10.2	This Strategic Ambition had two True North metrics for 2024-25. 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 continued with both metrics.
10.3	The Ambition had one Breakthrough Objective in 2024-2025 associated with it: Pressure Ulcers. It was noted that had been closed in January 2025.
10.4	For 2024-2025, both True North metrics were within the Trust's risk appetite (tolerance). There were no corporate risks associated with this ambition.
10.5	The Interim Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Best Quality, Safest Care for 2025-26.
10.6	The Strategic Ambition for 2025-2026 remained with the same two True North metrics. The Corporate Project associated with this ambition remained Patient Engagement with four key workstreams.
10.7	The Moderate and Above metric would have a further 20% step change in reduction in the number of harm events. The Patient Experience metric would have a further 20% step change of increasing Friends and Family Test responses.
10.8	The Chair of the Quality Committee confirmed that this element of the BAF had been discussed in detail at the Committee.
10.9	The Chair of the Quality Committee also confirmed that at the meeting that had been held that morning, that a Gemba visit to the Mortuary had taken place to triangulate information following the Fuller Report being published. This had been a very assuring visit for Non-executive Directors. In addition, Cardiology as a

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	vulnerable service, learning from deaths and 0-19 performance metrics had been discussed in detail.
10.10	The Non-executive Director (AP) noted the Learning From Deaths Report had some examples of poor care. The Chair of the Quality Committee confirmed this had been raised at the meeting that morning. The Executive Medial Director confirmed that the Trust was now undertaking Structured Judgment Reviews for 10% of all deaths per quarter. Previously these were randomly selected, however, teams were now selecting cases where further learning could be achieved. Overall responsibility for review of themes and trends was with the End of Life Committee and the Quality Governance Management Group. It was confirmed that if a case highlighted poor care it was also reviewed at that specialities' mortality meeting.
10.11	The Non-executive Director (WS) noted that increasing engagement was not a measure of positive experience. The Interim Executive Director of Nursing, Midwifery and AHPs noted that this would be reviewed through the corporate project.
10.12	**Resolved:** i. The BAF: Strategic Ambition - Best Quality, Safest Care for 2024-25 was closed. ii. The BAF: Strategic Ambition - Best Quality, Safest Care for 2025-26 was approved.
BD/03/26/11 **11.1**	**Learning from Deaths Quarterly Report** **Resolved:** The Learning from Deaths Quarterly Report was noted.
BD/03/26/12 **12.1**	**Board Assurance Framework – Great Start in Life** The Interim Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on this element of the BAF.
12.2	This Strategic Ambition had three True North metrics for 2024-2025.
12.3	The first metric was children at risk of vulnerabilities. This had three goals, this first focused on the achievement of 90% of mandated contacts. This metric had been met and was reviewed on a monthly basis through Performance Review Meetings. The second and third goal focused on delivery of the Great Start in Life framework in Darlington. It was noted that an outcome measures framework was being developed for this goal and it would be used as a watch metric from 1st April 2025.
12.4	The second metric was an improved positive patient experience which had been closed at the January 2025 Board meeting.
12.5	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.
12.6	All True North metrics were within the Trust's risk tolerance for 2024-2025.
12.7	There was one corporate risk associated with this ambition: CRR34: Autism Assessment currently rated at 15.
12.8	The Strategic Ambition for 2025-2026 remained with the two open True North metrics.

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12.9	A Corporate Project was in development for this Ambition in 2025-26. This related to CYP Public Health Mobilisation. The Chair of the Quality Committee had nothing further to note on this Ambition.
12.10	The Non-executive Director (JW) noted that the autism risk had the same wording as last year. It was confirmed that this needed to be reviewed.
12.11	**Action –** Review of the wording of the risk for autism to take place.
12.12	**Resolved:** i. The BAF: Strategic Ambition - Great Start in Life 2024-25 was closed. ii. The BAF: Strategic Ambition - Great Start in Life for 2025-26 was approved.
BD/03/26/13 **13.1**	**Strengthening Maternity and Neonatal Safety** The Interim Executive Director of Nursing, Midwifery and AHPs and the Associate Director of Midwifery presented the February 2025 Strengthening Maternity and Neonatal Safety Report to the Board.
13.2	The report provided a summary and update on the board level safety measures for the month of February 2025 as set out in the Perinatal Quality Surveillance Model (Ockenden 2020).
13.3	The report provided details on: • Perinatal Culture and Leadership Programme Overview, • Maternity Unit Diverts, • 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.
13.4	The Associate Director of Midwifery noted that there were a number of operational areas of risk and focus, these however were well managed and mitigated. Assurance was provided to the Board that there was nothing of significance to escalate to the Board.
13.5	Discussions took place on the section of the report linked to babies born before arrival. It was confirmed that having reviewed all cases there were no areas of increased concern or risk.
13.6	A national Regulation 28 Prevention of Future Deaths had been received in relation to a baby being unobserved in a sling, breastfeeding and passing away. Work had been undertaken to increase awareness.
13.7	No diverts had taken place in February 2025.
13.8	It was noted that the Maternity Workforce Business Case had been approved at the March meeting of the Strategy Deployment Room.
13.9	The Non-executive Director (LR) noted that extra staff were recruited to for the continuity of care scheme. This scheme had been paused whilst further staff were recruited to. It was queried if this business case allowed for the scheme to be delivered. It was confirmed that there were ongoing discussions to determine if

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	this was feasible. The national request had been amended to focus on the provision of enhanced care to populations at risk. Additional funding had been provided to deliver this. This would be reported on in the future.
13.10	**Resolved:** The Strengthening Maternity and Neonatal Safety report was noted.
BD/03/26/14 **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 for 2024-2025 had four True North metrics.
14.3	Metric 1: 4-Hour ED standards – in February, compliance was at 73.6%. This was in line with the trajectory of delivery. It was noted that the winter ward was closed earlier than expected. The focus remained on the delivery of the target of 78% by the end of March. Countermeasures included the work with an external partner in the Emergency Department, referenced earlier in the meeting
14.4	This metric was currently outside of the risk appetite.
14.5	Metric 2: Length of stay for frailty patients – the target was to be within the top quartile for length of stay. It was noted that length of stay had reduced from 17.7 in January to 14.39 in February.
14.6	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 on track to deliver.
14.7	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.
14.8	The Strategic Ambition for 2025-2026 remained with the four open True North metrics. The Breakthrough objective: Time to Inpatient Bed remained with a second objective of New Elective Care.
14.9	The Ambition's Corporate Projects for 2025-26 were Bed Capacity, Patient Discharge, Ripon Primary Care, and Outpatient Transformation.
14.10	The Chair of the Resource Committee confirmed that this element of the BAF had been discussed in detail at the Committee and had nothing further to add.
14.11	**Resolved:** i. The BAF: Strategic Ambition - person centred, integrated care, strong partnerships 2024-25 was closed. ii. The BAF: Strategic Ambition - person centred, integrated care, strong partnerships 2025-26 was approved.
BD/03/26/15 **15.1**	**Board Assurance Framework – Finance** The Director of Finance provided the Board with an update on the Strategic Ambition: Overarching Finance 2024-25.
15.2	This Ambition had one True North Metric: Financial Sustainability. There were no breakthrough objectives linked to this area.

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15.3	There was a wide range of corporate projects in place which had direct and in-direct positive implications for the financial position.
15.4	The risk rating continued to be at 16 and this was outside of the Trust's risk appetite.
15.5	The Strategic Ambition: Overarching Finance for 2025-2026 had two new True North Objectives: Annual Breakeven, and System Oversight Framework Rating.
15.6	It was noted that a review of the Trust Segmentation rating would take place at the end of April 2025.
15.7	The Breakthrough objective was in development.
15.8	The Corporate Project had been confirmed as the Trust WRAP Schemes and was in development.
15.10	The Chair of Resources Committee gave credit to the team on the clarity and consistency of support and advice provided. This had ensured a clear system message that has supported the breakeven position.
15.11	The Non-executive Director (AP) noted the positive position in relation to the underlying WRAP. They did note however, that the WRAP scheme became more challenged each year as productivity and efficiency programmes had already been completed.
15.12	The Chair of the Resource Committee also noted that the Committee had undertaken a Gemba to observe the use of AI in Imaging. They noted that this had been impressive and inspiring.
15.13	The Non-executive Director (LR) highlighted that a new risk relating to the cash position had been escalated onto the Corporate Risk Register. It was noted that when running at a deficit, this leads to a potential cash flow problem. As highlighted previously, the Trust had been expecting to need to apply for working capital support. The application had been drafted, however with the additional £16.4m flowing to the Trust, this was no longer necessary. The risk would be reviewed as a result. The risk would then be reviewed in the context of the 2025-26 plan
15.14	**Resolved:** i. The BAF: Strategic Ambition – Overarching Finance 2024-25 was closed. ii. The BAF: Strategic Ambition – Overarching Finance 2025-26 was approved.
BD/03/26/16 **16.1**	**HDFT Planning** The Chief Executive noted that the Annual Plan continued to be developed. As such a slide deck was circulated to support the discussion and the detail provided in the report had changed since it was circulated.
16.2	The Director of Strategy described the Strategy Development elements of the plan including: improvement priorities, True North Metrics, Breakthrough Objectives, Corporate Projects and Strategic Programmes.
16.3	The Chief Operating Officer described the Operational Plan including the activity plans for delivery of the constitutional standards.

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16.4	The Non-executive Director (JC) queried if the 2019 figures were comparable. It was confirmed that this was the national benchmark that current delivery was measured against.
16.5	The Non-executive Director (WS) noted that the narrative was changing to what organisations can deliver within their means. It was questioned if this was the organisational narrative, what impact would it have on operational delivery plans. It was noted that this was an area the Executive Team were currently reviewing.
16.6	The Director of People and Culture described the Workforce Plan including the focus on agency and bank staff reduction and a reduction in corporate growth.
16.7	The Director of Finance described the Financial Plan and noted that the detail was similar to the numbers discussed at the March Extra Ordinary Board.
16.8	The Associate Non-executive Director (AB) noted the risk balance against financial impacts such as autism assessment. It was confirmed that the autism service being delivered was at the level of funding received from commissioners. As an organisation, the Trust recognised the level of risks to service users.
16.9	The Non-executive Director (WS) noted the £2.1m backlog maintenance. It was confirmed that the funding would address the fire risks. It was queried of the £30m critical infrastructure, what was the risk to statutory compliance.
16.10	**Action –** Director of Strategy to review the backlog maintenance plan against statutory compliance risks.
16.11	The Non-executive Director (JC) queried if the Board could approve the Plan without system confirmation. It was confirmed that if the system did not sign off the plan and it needed to change significantly then a further discussion would take place with the Board. The ICB continued to work up the risk sharing arrangements.
16.12	**Resolved:** (i) The Board approved the Trust's Annual Plan for 2025-26 consisting of: • 25/26 performance targets and activity plan, • 25/26 workforce establishment and planned substantive, bank and agency staff, and • 25/26 financial plan (revenue and capital). (ii) And noted: • That it is a coherent Annual Plan: the financial plan was sufficient to fund the workforce establishment which was sufficient to deliver the activity plan and performance targets, • That the Board Assurance Framework for 2025-26 would provide assurance on delivery of the Annual Plan, • Directorate activity plans, • Directorate workforce establishments and planned substantive, bank and agency staff, • Directorate financial plans (revenue), • A3s, including metrics, for the Breakthrough Objectives will be developed for May Board, and • That discussions continued with HNY ICB regarding funding for 2025-26.

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BD/03/26/17 **17.1**	**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 Our Best: Making HDFT the Best Place to Work.
17.2	This Strategic Ambition for 2024-2025 had two True North metrics.
17.3	Metric 1: Staff Engagement with a focus on continually improving the Employee Engagement Score. The uptake in response rate for the Inpulse Survey had seen positive improvements. In addition, the overall national staff survey engagement score, had been scored at 7 against a benchmark of 6.84.
17.4	Metric 2: Staff Availability. This metric had performed well during 2024-25. It was noted that sickness absence remained the greatest impact on staff availability.
17.5	Both True North metrics were below the Trust's risk tolerance.
17.6	There were no Corporate Risks linked to this element of the BAF at this time.
17.7	For 2025-26, the True North Metrics remained the same. There would be a continued focus on areas that did not respond to the Inpulse survey and areas where there was a low engagement score.
17.8	A Breakthrough objective for making HDFT the Best Place to Work was in development with a focus on staff involvement.
17.9	The Corporate Project of Medical and Dental Workforce Scheduling and Payment Transformation Project was ongoing.
17.10	The Chair of the People and Culture Committee noted that the Gender Pay Gap and Ethnicity Pay Gap reports were reviewed at the Committee. The new Guardian of Safe Working had also attended the Committee. The interim Freedom to Speak Up arrangements had been noted alongside the recruitment plan.
17.11	**Resolved:** i. The BAF: Strategic Ambition - At Our Best, making HDFT the best place to work (2024-25) was closed. ii. The BAF: Strategic Ambition - At Our Best, making HDFT the best place to work (2025-26) was approved.
BD/03/26/18 **18.1**	**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 for 2024-2025 which had been completed in January 2025.
18.2	A new enabling ambition had been developed for 2025-26, with a focus on: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience.
18.3	The revised Enabling Ambition for 2025-26 had one true north metric: Ultimate ambition was to Achieve a score of 5/5 across all seven What Good Looks Like (WGLL) pillars. For 2025-26 the ambition was to move up to 3/5 through all pillars. The team was in the process of developing countermeasures.

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18.4	There were no associated Breakthrough Objectives or Corporate Projects with this element of the BAF. There were no associated Corporate Risks. There was one Strategic Programme: EPR. This would continue into its second year with a focus on the delivery of the Trust's EPR modules.
18.5	The Chair of Innovation Committee noted that their Gemba had been a presentation on LIMS. In addition, EPR was highlighted as progressing well. The focus will remain in committee on benefits realisation.
18.6	The Non-executive Director (AP) queried the capacity to deliver all of the digital agenda. The Executive Medical Director noted that the Digital Team were highly skilled at project management. EPR would be the main focus for the year, however, a number of other projects would continue to be delivered. The Chair of the Innovation Committee confirmed that a watching brief would be kept. They also noted that a digital roadmap sat behind the digital change programme.
18.7	**Resolved:** i. The BAF: Enabling Ambition – Digital Transformation to Integrate Care and Improve Patient, Child and Staff Experience 2024-25 was closed. ii. The BAF: Strategic Ambition – Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience 2025-26 was approved.
BD/03/26/19	**Board Assurance Framework – Enabling Ambition: Healthcare Innovation to Improve Quality & Safety**
19.1	The Executive Medical Director and the Deputy Director of Strategy provided the Board with an update on the Enabling Ambition: Healthcare Innovation 2024-25.
19.2	This 2024-25 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.
19.3	There were no Breakthrough Objectives or Corporate Projects linked to this Ambition.
19.4	There was a Strategic Programme: HDFT Impact linked.
19.5	The 2025-26 Enabling Ambition: Healthcare Research and Innovation to Improve Quality and Safety retained the True North metrics: Healthcare Innovation, Children's Public Health and Clinical Trials. The Board noted that there had been a discussion regarding the strategic importance of children and young people research at the Innovation Committee.
19.6	There was one Corporate Project linked to this Ambition – Research 3T MRI and CRF.
19.7	The Chair of the Innovation Committee confirmed that there was nothing further to add.
19.8	**Resolved:** i. The BAF: Enabling Ambition – Healthcare Innovation to Improve Quality & Safety 2024-25 was closed. ii. The BAF: Strategic Ambition – Healthcare Innovation to Improve Quality & Safety 2025-26 was approved.

Item No.	Item
BD/03/26/20 **20.1**	**Board Assurance Framework – Enabling Ambitions: An Environment that Promotes Wellbeing** The Director of Strategy provided the Board with an update on the Enabling Ambition: An Environment that Promotes Wellbeing.
20.2	The Enabling Ambition had three True North Metrics for 2024-25: A patient environment that promotes wellbeing; An environment and equipment that promotes best quality, safest care; and Minimise our impact on the environment. The vast majority of programmes been delivered.
20.3	All True North metrics remained below the Trust's risk appetite.
20.4	There were no Breakthrough Objectives or Corporate Projects linked to this ambition.
20.5	The True North metrics for the 2025-26 Ambition were Wellbeing (Capital Programme Delivery), Quality & Safety (Premises Assurance Model Areas requiring more than moderate improvement); Impact on the Environment (monthly natural Gas consumption).
20.6	There were no Breakthrough Objectives with this Ambition.
20.7	There was one Corporate Project: Block C Theatres and Imaging.
20.8	The Chair of the Resource Committee confirmed that there was nothing further to add.
20.9	**Resolved:** i. The BAF: Enabling Ambition – An Environment that Promotes Wellbeing 2024-25 was closed. ii. The BAF: Strategic Ambition – An Environment that Promotes Wellbeing 2025-26 was approved.
BD/03/26/21 **21.1**	**Escalations from Sub-Committees of the Board** The Chair welcomed the Committee Chairs to raise any areas that they wished to escalate from the Committees that had taken place earlier in the day.
21.2	The Committee Chairs noted that all areas of escalation had been discussed earlier in the meeting.
BD/03/26/22 **22.1**	**Audit Committee Update** The Chair of the Audit Committee provided an overview of the discussions held at the Audit Committee in March 2025.
22.2	The meeting had focused on business as usual for Quarter 4. The Committee approved closing out of the year and approving plans for the following year. The meeting had included discussions on the organisation as a Going Concern and this had been endorsed prior to being submitted to the Trust Board.
22.3	Outside of the Committee, the Chair noted that they attend regular WYAAT Audit Committee Chair's meetings. This was noted as a vital part of the role, where they receive further assurance, advice and support from a broad group of experienced board members. The discussions focus on how they can support each other to ensure best practice. At this month's meeting a discussion had taken place on productivity and opportunity costs from Model Hospital.

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22.4	Discussions had also focused on the West Yorkshire ICB risk register and how assurance could be gained that each provider was scoring with similar weighting versus score. They was also a discussion of the BAF alignment.
22.5	The internal audit planning priorities were also discussed, with most trusts moving towards fewer but more significant audits. In addition, a discussion took place on the reporting arrangements for Freedom to Speak Up. It was confirmed that quarterly thematic reporting would still continue to be escalated through the People and Culture Committee, however, an annual process report would be submitted to Audit Committee.
22.6	Finally, the Audit Committee Chair noted that there was an increasing drive for Audit Chairs to visit and observe other trusts' audit committees. In the future, colleagues would observe HDFT's Committee.
22.7	**Resolved:** The Chair's update was noted.
BD/03/26/23 **23.1**	**Going Concern** The Director of Finance presented the report as read. They outlined the principles and background information. The Charity and Group Position were noted as part of the discussion.
23.2	The Non-executive Director (JC) noted that the Going Concern proposition had supported the Trust in receiving £16.4m to lead to a breakeven position basis.
23.3	**Resolved:** i. The Board noted 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. ii. The Board approved the Audit Committee's recommendation that the Accounts should be prepared on a Going Concern basis.
BD/03/26/24 **24.1**	**Board Appointed Non-executive Roles** The Chair presented the report as read. The roles outlined were confirmed.
24.2	The Chair noted that if any Non-executive Director wanted to volunteer for any of the positions, to contact the Chair and the Associate Director of Quality and Corporate Affairs.
24.3	**Resolved:** The roles and designations in the report were approved
BD/03/26/25 **25.1**	**Risk Management Policy** The Interim Director of Nursing, Midwifery and AHPs presented the report as read. They noted the following key changes: • A transition in terminology from Incident to Event • The risk appetite statement had been formed and added as an appendix, appetite threshold had been set and was reflected in the 2025-26 BAFs • Changes in categories: regulations had been made into a sub category under external, cyber security had been included as a new sub-category
25.2	**Resolved:** The Risk Management Policy was approved by the Board.
BD/03/26/26 **26.1**	**Any Other Business** No further business was received.

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26.2	The Chair confirmed approval of 2025-26 Board Assurance Framework in its entirety.
BD/03/26/27 **27.1**	**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/03/26/28 **28.1**	**Date and Time of the Next Meeting** The next meeting would be held on Wednesday, 28 May 2025.
BD/03/26/29 **29.1**	**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 May 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	Complete	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. March 2025 Update: Annual Effectiveness Survey circulated in April 2025. Action to be closed.	Closed
BD/3/26/3.2	26 March 2025	Declaration of Conflicts of Interest and Register of Interests	All members to review their declarations for their annual submissions and confirmation	All	May-25	Complete	Closed
BD/3/26/12.11	26 March 2025	BAF: Great Start In Life	Wording of the Autism Risk to be reviewed	Director of Strategy / Associate Director of Quality and Corporate Affairs	May-25	Complete Review has been undertaken. Further work is being undertaken by the Executive Medical Director working with colleagues in the ICB following discussions. Any amendments to the risk will be made as required.	Closed
BD/3/26/16.10	26 March 2025	HDFT Planning	Backlog maintenance plan to be reviewed against statutory compliance risks	Director of Strategy	May-25		

BOARD OF DIRECTORS (PUBLIC)
28th May 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)
MAY 2025

CHIEF EXECUTIVE'S REPORT

National and system issues

1. At the last Board meeting at the end of March I reported on the changes that were planned across the NHS. These changes included the merging of NHSE into the DHSC, a streamlining of the role and cost of existing ICBs, and a focus on reducing corporate cost growth across Providers. These changes are part of the package of measures to bring greater clarity about roles and responsibilities, in particular, reinforcing the accountability of organisational Boards, and emphasising the need for clear commissioning of services and efficient provision of services. The result would also mean a removal of duplication of roles and a reduction in the cost of the current operating model of the NHS. It is clear that there is also a view that there is greater transparency needed, particularly in the way in which money flows around the NHS.

2. Subsequent to these announcements, a number of developments have followed. There has been the issuing of the 'model ICB' guidance, which defines what roles ICBs will take in the future with an emphasis on their strategic commissioning functions. This is helping to inform the restructures within ICBs which will also see an aggregate 50% running cost reduction. The aim remains to have the new arrangements in place during Q3 of this year.

3. A letter was also issued to all providers with a target to reduce the growth in corporate costs since before the pandemic by 50%. For HDFT, we were one of 13 organisations nationally that did not have a target reduction, as there had been no growth in corporate costs during this period.

4. A draft performance assessment framework has been issued for consultation. There is an option to significantly reduce the number of indicators against which organisations will be assessed. This framework will inform the performance 'tier' of each organisation, which in turn will inform the support or incentive (potentially) available to Trusts/ICBs. There is a proposal currently being discussed about allowing additional capital expenditure as a reward for improved performance.

5. A pay framework has also been issued for VSM roles across the NHS. It is still the responsibility of Remuneration Committees to set VSM pay, but there is an expectation that the new framework will be used. Again, the link to the performance framework is apparent, with options to incentivise performance delivery through additional pay rewards, alongside the expectation that pay awards aren't received for VSMs in organisations that are not delivering as they should.

6. There will be further work that will emerge in respect of a revised financial system to support the development of the new operating model, but even without this being in place, the move towards greater transparency of financial information across the NHS is apparent in the communications we have received. This is to be welcomed.

7. In terms of the planning round for 2025/26, the Board will be aware that the key national and therefore regional and local priorities are to reduce elective waiting lists and times, to improve urgent care (specifically in relation to the 4 hour standard), to improve access to primary care, and to ensure financial balance across the NHS. We submitted a plan through HNY ICB that met these requirements, but which had at the time of submission a significant level of financial risk. We are working through with the system how we appropriately manage this risk. Practically this will need to result in an agreed contract with agreed payment mechanisms for the year ahead. We have met as a system with the Regional Director in respect of the plans for this year. The clear expectation (quite rightly) is that all efficiency schemes are identified by the end of May and are not high risk by the end of June. This expectation is being strengthened by linking the delivery of this ask to the receipt of deficit support funding into the system.

8. Away from the planning process for 2025/26, we have been working with WYAAT and LTHT specifically in respect of future service delivery in line with the review that we collectively undertook. We had a successful joint Executive meeting with colleagues in LTHT, and agreed some initial areas of work that we will take forward. We also discussed some initial governance arrangements for what we hope will be a strengthening partnership for the benefit of both Trusts and our respective populations. Further details will be shared with the Board as we develop the programme of work.

9. In terms of the wider work across WYAAT, there are a number of priorities that are emerging from the service review. Alongside the focus on the geographic partnerships which is being developed through our partnership with LTHT, the key areas include imaging services, pathology services, and pharmacy aseptics services, alongside clinical services such as non-surgical oncology, neurology, and haematology that will require a networked solution to ensure quality and sustainability.

10. The HNY system remains in Tier 1 for Urgent and Emergency Care. Whilst our performance and delivery in this area is good, this is not the case in other organisations. The tiering system allows the system to access support to go alongside the national oversight and scrutiny. In that respect, even though we are performing relatively well, we have taken the opportunity to access some expert clinical support to review our ED pathway which will be helpful.

11. The arrangements for the creation of the Joint Health Committee across North Yorkshire are being put in place and we had a ‘shadow’ meeting in April. We have collectively commissioned some work to review the community services offer across North Yorkshire, and the potential future arrangements. A series of workshops are planned over the next six months to develop thinking, particularly in the context of developing the approach to neighbourhood health.

12. The new stroke pathway continues to be operated between ourselves, LTHT, YSFT, and YAS. This is progressing well, and we have an agreed review point next month. I will report the outcome of this review to the next Board meeting.

13. As the Board is aware, we now work in partnership with Local Authority colleagues across eleven areas in relation to the provision of our 0-19 services, having taken on the two services in Cumberland and Westmoreland & Furness councils on April 1st. the relationships continue to be strong with all Local Authorities as we continue to develop our approach to improving outcomes for children and young people.

14. At the last Board workshop we discussed where we wanted to put our efforts over the next three years as we continue to focus on delivery of our Trust strategy. In terms of our external relationships and partnerships, the emphasis was very much on three areas – how we develop locally through the local care partnership to deliver integrated care and neighbourhood health, how we develop the partnership with West Yorkshire and Leeds to improve quality, productivity and sustainability of services for our population, and how we work with local authorities across the North of England and be a national leader for 0-19 children's pubic health services. We will build on our current strong partnership working as we think through our approach over the coming months.

HDFT issues

Introduction

15. 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. Safe to say that there is a lot of discussion about these issues with partners. Whilst recognising the importance of engaging in these developments to ensure that as an organisation we are best placed to meet future challenges, it is important that we focus on delivering our plans and our priorities as an organisation. This is what will benefit our patients and staff and improve the care that people receive.

16. Before moving onto current issues, it is important to record our achievements and reflect at this time on our delivery of services in the year that has just finished at the end of March. On the national measures, which are the ones identified by the public as being the most important, we had no-one waiting over 52 weeks for planned care, which is a year ahead of the national ambition, we delivered the four hour Emergency Department standard in March, our cancer standards significantly improved, and we met 43/45 of our mandated contacts standards for children across nine local authorities. Away from just the national indicators, we demonstrated less harm and safer care than this time last year, we have strong staffing levels, with vacancies way below where we were and our agency use was down to less than half the national target, which results in better quality care and also saves us money. We also remained in the top quartile nationally in respect of feedback through our staff survey. We delivered our largest capital investment programme, we've been recognised for some of our innovations, and we've done all of this alongside being one of the most productive Trusts in the country.

17. We need to build on the achievements of last year and deliver the planned improvements that we've identified in our plan for the year ahead.

Our people

18. 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. The recent safe staffing review has confirmed that we continue to have suitable establishments for the needs of our patients, which is a positive position to

be in. We are strengthening staffing levels within our maternity service specifically to ensure that we continue to deliver high quality care and reduce the number of occasions when we need to divert patients to other units.

19. The latest quarterly Inpulse survey has been completed. The engagement score remains positive, although the response rate was lower this quarter than previously. Referencing recent workshops for both SMT and Board, our ambition is to have a step change in number of responses from colleagues and then use this feedback and respond to colleagues in a way that delivers our strategic ambition to be a great place to work. As well as the work we continue to do through our Directorate teams in response to colleague feedback, we are thinking through what additional actions we can take to move from good to great in this area. We know that having engaged colleagues is the route to delivering high quality, productive care for our patients, so we will be focusing significant time on this over the year ahead.

20. Given the changes in the NHS nationally and the financial challenges that are across the public sector in general and NHS in particular, there have been a number of provider organisations planning redundancy schemes. Some colleagues have asked about our approach, so I wanted to record that this approach is not something that we will be pursuing as an organisation. The key to delivering productive care that benefits our population is to have our agreed establishments recruited to. We have demonstrated the benefit of this approach over the last three years, as our agency spend has dropped significantly at the same time as our productivity has increased.

21. The Board should be aware that the BMA nationally is currently balloting resident doctors about potential industrial action. The ballot is ongoing and concludes in early July.

Our Quality

22. As I mention in most reports, there continues to be considerable pressure across the country in respect of urgent care demand. 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.

23. We have two thematic reviews to draw attention to the Board. The first relates to our Trauma pathway, where we have identified some actions to improve the care we provide, and the second is a review into the deteriorating patient which is at an earlier stage of development. These will be discussed in more detail through the Quality Committee.

24. We have developed a PSIRF plan for 2025/26, which will cover the areas of our services that we will be focusing on for the year ahead, and we also have our HDFT IMPACT priority in respect of reducing moderate harm, which successfully delivered a significant reduction in pressure sores in 2024/25.

25. We have identified through our recent workshops the need to improve significantly our patient engagement as a means of improving the services we deliver. This will be picked up and developed as part of our improvement work for the year ahead.

26. We had one occasion during April when we had to put in place a temporary divert in respect of our maternity service. One patient was affected. The business case to

strengthen staffing in the maternity service is predicated on ensuring a reduction in the number of times we need to initiate a service divert, so we will be tracking the benefit of this change as the case is implemented.

27. Our Quality Account for 2024/25 has been completed for consideration by external partners. I would encourage people to read the excellent report of how we performed in 2024/25.

Our Services

28. 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.

29. We successfully took over the delivery of the 0-19 services in Cumberland and Westmoreland & Furness from 1st April. This process has gone well. We are now consulting with colleagues in these services about the changes that we want to make as to how the services are delivered, which was a part of our proposal to the commissioners. We are getting positive engagement from colleagues in this consultation process.

30. We have recently launched the great start in life pathway within the Darlington 0-19 service. This pilot, which seeks to target interventions for children, will be implemented and then reviewed later in the year to see whether this approach could deliver benefits in other areas of our footprint.

31. Our urgent care pathway, whilst remaining an area of focus in terms of delivering the quality of service we would like to our population, has improved over the last two months. Our ED 4 hour performance was above the national standard in March and April, we are ahead of our internal plan, and we perform very well when compared with other organisations regionally and nationally. There is always more to do, but we are making good progress in this area.

32. In relation to cancer, as mentioned previously, this continues to be area where we have improved our performance, which is so important to public and patients we serve. Again, we compare favourably against many other organisations.

33. We continue to deliver our elective recovery plan, and we are ahead of our plan to reduce the waiting list this year. We are on track to deliver the waiting times reductions as well, which is a very positive position to be in.

34. One area of risk to highlight relates to the capacity of our Imaging service and the ability of the service to keep up with the demand that is in the system. This is highlighted in our risk register and is an area the team are focused on improving.

Our money

35. In terms of 2024/25, it is important to record that we delivered our plan for the year. The accounts have been prepared which we will receive for approval in June.

36. In relation to 2025/26, our month one position is that we are behind our plan by c£1.4m. This is related to the delivery of our WRAP programme. This is a breakthrough objective for the Trust and is being picked up regularly through the IMPACT process and Performance Review Meetings with our teams. We are focused on ensuring that this position improves as we go through the first quarter of the year, and a part of the solution is to have an agreed contract and agreed payment mechanism that appropriately manages the risk.

37. The cash position is highlighted on our risk register, and a number of actions are in place to manage this.

38. We remain a very productive Trust when comparing ourselves with others using the model hospital information, which is a positive position to be in.

Corporate Risk Register

Since the last meeting of the Board in March 2025 the following changes to the Corporate Risk Register have been made:

- CRR69 – Delivery of the Financial Plan 2024 – 25 has been closed. A new risk is in development for escalation onto the Corporate Risk Register for the Delivery of the Financial Plan 2025-26. In addition, a further financial risk: ID721 Group Cash Position has been escalated onto the Corporate Risk Register. These are both detailed and linked to the financial element of the Board Assurance Framework.
- CRR257 – Imaging for ED Patients has been de-escalated from the Corporate Risk Register to be managed at a Directorate level. A new risk in relation to Imagining Services delivery against targets (ID292) has been escalated to the Corporate Risk Register. This new risk is detailed in the Person Centred Ambition of the Board Assurance Framework.
- A new risk in relation to automated medicines has been escalated onto the Corporate Risk Register. This is detailed in the Person Centred Ambition of the Board Assurance Framework

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.

Other

39. Our major capital scheme in relation to our new theatres and imaging department continues to progress in line with plan.

40. Our Innovation Hub was officially opened in Knaresborough at the end of April. It was a pleasure to be at such a positive event with people attending from HDFT, from local

partners, and from local industry. The Hub was opened by the Mayor of the Combined Authority, who expressed his enthusiastic support for this initiative.

41. I am pleased to report that following a very successful recruitment process, we have recruited a new, full time FTSU Guardian, who will start with us shortly. This will help us strengthen our arrangements in this important area for our colleagues.

42. To conclude, there is a lot of change happening across the NHS and a lot of challenges to meet to ensure that the public have an NHS that they can be confident in. The recent social attitudes survey showed satisfaction with the NHS at a historically low level, and we need to work hard to regain the confidence of our population. We currently deliver better services than many areas of the NHS, but we need to maintain our positive ambition and measured impatience to improve further. This will be achieved by continuing to the do the right things, in the right way, as we know that this will work. We must deliver what we said we would deliver this year and this will enable us to also focus on the future and ensure that we are in the best place for our patients and population for years to come.

43. With the support of our excellent colleagues across HDFT, I am confident that we will retain our ambition to do the best we can for the people that we serve.

Jonathan Coulter
Chief Executive
May 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.

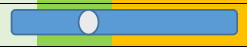
Summary of Risk

Summary of Activity since last report:

The Board Assurance Framework for 2024-25 was closed down at the March 2025 Trust Board in Public. A revised Board Assurance Framework for 2025-26 was reviewed and approved at the March 2025 Trust Board in Public.

This is the summary of the Board Assuramce Framework as at May 2025. Of note:

- The Risk Appetite ratings were reviewed and approved at The March 2025 Trust Board in Public and the levels of appetite for 2025-26 confirmed.
- 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	Length of Stay – Patients with Frailty	Operational: Cautious	
	Equitable, Timely Access to Best Quality Planned Care	Elective Recovery RTT – 18 Weeks	Operational: Cautious	
		Cancer 62 Day Standard – 62 DaysTreatment	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	
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
Healthcare Innovation	Healthcare Innovation		Adopt / develop health innovations that improve	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
			the health and care of our patients and CY&P									
	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 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)

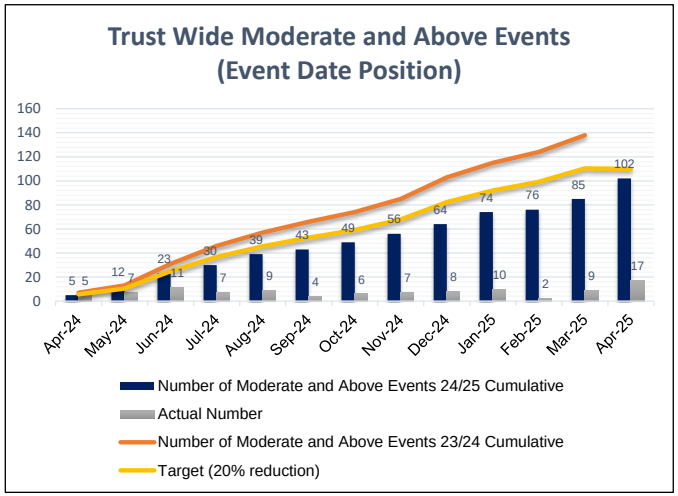
1. **Eliminating Moderate & Above Harm**
2. **Patient Experience Positive Response Rates**

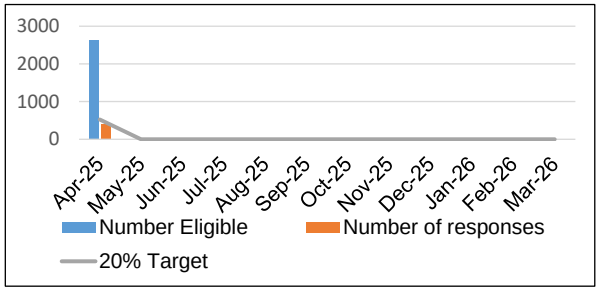
Corporate Project:	Patient Experience
Overarching Risk Appetite:	Clinical - Minimal

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	Current State	Countermeasures	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	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.  It is noted that there were 17 events reported in April 2025, however this number will reduce following validation. Countermeasures are noted. Watch Metrics: • Number of Never Events – 0 year to date – within tolerance • Number of PSIIs – 0 year to date – within tolerance • Level of low and no harm events reported- 56.05 Ratio – within tolerance All other metrics within tolerance levels	Falls Improvement Plan Pressure Ulcers Improvement Plan Quality Governance Framework in place PSIRF Plan – updated for 2025-26 Thematic Review – Diagnosis, Treatment and Procedures Directorate Countermeasures: • LTUC – focus on Pressure Ulcers • PSCC – focus on Deteriorating Patient • CYPD – focus on Deteriorating Patient		

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk To Achieving in year goal	Level of Risk for progres sing 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 **(achieved)** By March 2026: 801 responses per month	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.  The number of FFTs inputted to date for April 2025 is lower than the target, however the number is due to increase once all data has been submitted. Countermeasures are noted. Watch Metrics: • Number of Complaints – 18 complaints opened in April 2025 • Percentage compliance with Complaint Response Times – 90% compliance in April 2025	Corporate Project Increased FFT distribution and collection.		

Corporate Project: Patient Experience

Workstream	True North Metric	Vision	Current State	Countermeasures	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	Since the last meetings in March and April 2025, the focus has been on refreshing the Project Plan for this programme of work. Previous workstreams in 2024-25 have moved back into business as usual activity. These include: • The review of audio comments as part of Friends and Family feedback, and • Increased visibility of the Patient Experience Team. The focus for 2025-26 is on the development of a real time patient engagement tool. In order to achieve this countermeasure are noted in the next column. The development of the Engagement Strategy has commenced with estimated production timescale of Summer 2025. Thematic analysis is underway as part of the HDFT impact work within the Quality Team. Further details of this will be report in the July 2025 report. Scoping has commenced for a software tool – work is ongoing to engage with non-NHS organisations such as fuel stations and supermarkets. BY Summer 2025 this element of scoping will have completed. In addition, work is being undertaken to review NHS options that are used that sit outside the traditional surveys, Friends and Family Test and complaints data. This element of scoping will have completed by Summer 2025.	Development of a focused Engagement Strategy which includes: surveys (national and local), governor activities, patient stories, Making Experiences Count forum and wider governance arrangements, Patient Experience Team. Delivery of Key Objectives: • Thematic analysis of current feedback to inform priorities and improvement. • Reduce the number of complaints linked to communication and / or staff attitude. • Review the implementation of key mechanism or worksteams. • Introduction of Always Events. Implement software for real time engagement		

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 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
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**	

Level of Risk to Achieve Metric – Linked to Risk Appetite: 1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20

True North Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	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.	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. This report is now live in ESR and has been launched with all teams. This will provide assurance that individual practitioners are being performance managed & supported to deliver the HCP in timescales and that supportive measure / actions are in place. Current performance for April 25: 41/45 HCP Mandated Contacts delivered within timescales, overall, 91%. Middlesbrough's mandated contacts fell this month for New Birth and 6-8 week reviews – Root Cause being undertaken. Durham 6-8 89.9 % Wakefield Antenatal- on trajectory to revert to BAU HCP parameters by July 25.  Watch Metrics: Goal 2: Watch Metrics will report and include the outcomes of the GSIL Pathway linked to 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.* • 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 has worked through training plans / preceptorship to identify dates to assess when capacity will be available to work to health child program Antenatal visit timescale. Plan is to be delving all antenatal within timescale by July 25.		

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
					• There is full recruitment to Band 5's across Co Durham. Have moved to this group of staff being deployed across the patch rather than just locally to support pressures in localities where greater vacancies. • Process now live to report compliance of delivery of monthly 'Quality & Performance management supervision' which will be reported via ESR. This will provide assurance that individual practitioners are being performance managed & supported to deliver the HCP in timescales and that supportive measure / actions are in place.		
Hope for Healthcare	Children's Patient Experience	Improve experience of care by considering elements that matter most to children & young people so we can	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	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 month's numbers. Countermeasures are noted.	CYP Patient Experience Tool 'engagement methods' to increase uptake and return being developed with involvement of CYP representatives.		

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
		measure their experience of care and shape services according to their specific needs	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' being developed with involvement of CYP representatives. • CYP Voice Feedback Posters developed by GSIL Young Advisors for the Trust. Completed and available for use in paper and digital format from 2.4.25. Each Directorate has an individual QR code which will be applied to posters displayed and accessible for their areas. • SystmOne push SMS notification and batch reports setup to enable CYP survey to be sent out via S1 after targeted intervention / contact. To launch week commencing 8th May. • Cohort denominator will be CYP who have received targeted intervention each month measured against number of returned surveys. • CYP PH Directorate competition to launch 1st May for 1 month- Contract areas competing against each other for the biggest uptake of CYP Surveys. GSIL Foundation sponsoring prizes. • Application to charity for adaptable devises to support completion of survey by CYP with SEND. 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.	• 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		

Breakthrough Objective:

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

Corporate Project:

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

Strategic Project:

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

Related Corporate Risks

Datix ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR34 / ID1	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 2025~~ March 2026	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

April 2025

Title:	**Strengthening Midwifery and Neonatal Safety Report**
Responsible Director:	Alison Smith, Interim 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 April 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 April 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 May 2025 (April 2025 data)
Matters of concern & risks to escalate
One incident of maternity service suspension due to high activity. One patient diverted.
Major actions commissioned & work underway
MAC call monitoring – awaiting telecomms
Perinatal Culture action plan progressing
Saving Babies Lives Care Bundle 86% compliant
Day unit move to ANC planned for 22nd September
Induction of Labour project on-going
Generation genomics research set up in progress
On-going work regarding improving consent process
RROSE review completed of Neonatal death due to prematurity/congenital anomalies
Maternity Incentive Scheme Year 7 released
On-going monitoring of capacity for elective caesarean sections
Three incidents of Unexpected Term Admission to SCBU
PMRT reviews planned with involvement of MNVP representation.
Work on-going to improve transitional care offer and reduce separation of mum and baby
Positive news & assurance
Maternity Support Worker business case approved at BCRG
No MNSI / moderate harm incidents
Recurrent funding received for RSV vaccination
1.6 WTE Band 7 Delivery Suite Coordinators recruited and 1.92 WTE Band 6 Midwives
Decisions made & decisions required
Maternity Staffing Bi-annual report
LMNS Review Visit report

Narrative in support of the Provider Board Level Measures – April 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 April 2025.

3. Midwifery safe staffing, vacancies and recruitment update

The Birthrate plus establishment setting review was completed in August 2024 and will be required to be repeated in 2027. Following receiving the report and applying professional judgement a business case was submitted and agreed to increase the establishment of midwifery staffing by 5.48WTE Band 7 midwives. This intention is that this staffing increase will enable improved senior support available outside of working hours, increase staffing at night, reduce diverts, increase patient safety and improve staff wellbeing. As part of this review the headroom uplift applied to midwifery has been reviewed, given the increased training requirements for midwives following the Core Competency Framework release and Maternity Incentive Scheme requirements. The headroom uplift applied to all midwives working in maternity services has now been increased to 24% as recommended by Birthrate Plus.

Birthrate plus recommendations 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 was approved at Business Case Review Group in April to increase the establishment by 5.58WTE Band 3 maternity support workers and 0.5 WTE Band 2 Ward Clerks. The bi-annual maternity staffing paper will be submitted alongside this report through the governance process this month.

a. Absence position

Total sickness in February was 2.61 WTE midwifery and 0.07 WTE maternity support workers absence.

9.36 WTE midwives are on maternity leave at present which is slightly higher than over the previous year.

b. Vacancy position

There remains a vacancy of 5.48 Band 7 WTE midwives following last month's business case approval. 1.92WTE Band 6 midwives have been recruited and (three) headcount Band 7s are interviewing in May. A 0.7WTE maternity support worker vacancy remains with 0.6 WTE MSW due to commence in May.

c. NHSP provision

Midwives – Demand has reduced this month following successful recruitment however uptake of NHSP shifts has declined slightly. This is probably due to increased sickness (although still under target) and increased maternity leave.

Maternity Support workers – There has been a small decrease in the NHSP demand of support workers since last month. Uptake of shifts has increased consistently over the last four months. It is not clear what is driving this increase.

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.

Eleven homebirths were booked for the month of April 2025. Of these; two women had a successful homebirth, one woman's baby was born before arrival of the midwife (BBA), two women laboured at home and transferred to hospital, five women birthed in hospital, and one woman didn't birth in April.

In the period 01/04/25 – 30/04/25, the home birth on call provision was unavailable on four occasions due to unexpected sickness and no volunteers to cover. No homebirths were transferred to hospital due to this.

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

a. Neonatal absence position

0.92 WTE nurse sickness absence. 1.99 WTE nurses currently on maternity leave.

b. Neonatal Vacancy

1.7 WTE vacancy for QIS nurse is out to advert.

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) state that the QIS compliance is based on staff in post excluding any vacancy. April QIS compliance was 75%.

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. 100% compliance with one to one care in labour was maintained throughout the month. During the month of April compliance with completion of Birthrate pus was 78.89%. The following was noted from Birthrate Plus. In summary vacant shifts and short term sickness had the biggest impact on staffing over the course of April. In order to manage this inductions of labour were delayed and staff were redeployed from other areas of maternity services, including Pannal, Community and Specialist midwives. Clinical risk is mitigated and delays are kept as minimal as possible.

Staffing factors

Breakdown of Factors	Times occurred	Percentage
Short term sickness	21	36%
Lack of beds	4	7%
Unable to fill vacant shifts	23	39%
Staff redeployed to another area	2	3%
No maternity support worker	9	15%

Clinical Actions

Breakdown of Actions	Times occurred	Percentage
Delay in commencing IOL (Inpatient)	4	7%
Delay in continuing IOL	38	70%
Delay in EL LSCS (delivery suite)	0	0%
Postponed IOL (at home)	4	7%
Delivery Suite coordinator not supernumerary	8	15%

Management actions taken to mitigate the above issues –

Breakdown of Actions	Times occurred	Percentage
Redeploy staff from Pannal	15	52%
Staff unable to take breaks	6	21%
Review of staff on management time	0	0%
Use of Specialist Midwife	6	21%
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	0	0%
Use of community MW	0	0%
Unit on Divert	2	7%
Patient diverted	0	0%

b. Pannal Ward Staffing and impact on clinical workload

During April, according to Birthrate Plus acuity tool, 49% of shifts have been at least one staff member short over the course of the month, with staffing meeting acuity 51% of the time. This has improved significantly since the previous month. Staff have been redeployed where possible to support the ward with the clinical activity.

There were 11 elective section lists with 28 women in total on these lists. There were ten elective caesarean sections completed in Delivery Suite theatre during April.

There were twelve 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 were three Red Flags recorded on Birthrate Plus during April 2025. One was due to ‘Midwife unable to provide 1:1 high dependency care for AN or PN patient’ and two were due to ‘Delayed or cancelled time critical activity’. Appropriate actions were taken to manage the situation.

b. Pannal Ward Red Flags

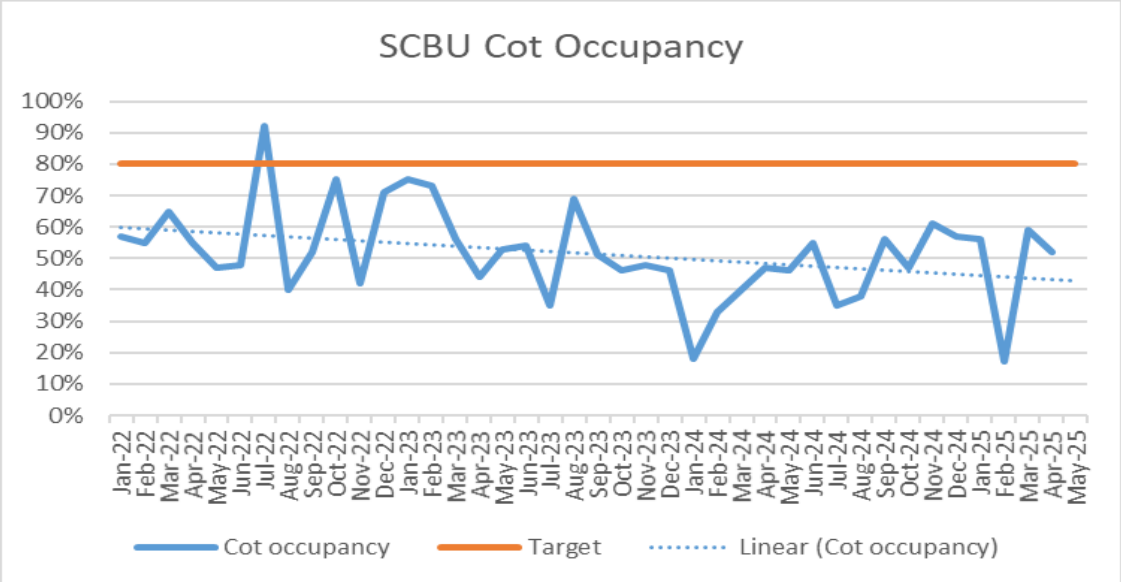
There were nine Red Flags recorded on Birthrate Plus during April 2025. This is an increase from the previous month.

Breakdown of Red Flags	Times occurred	Percentage
Delayed or cancelled time critical activity	**0**	**0%**
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	**2**	**22%**
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	**1**	**11%**
Delay in providing pain relief	**4**	**44%**
Delay between presentation and triage	**0**	**0%**
Full clinical examination not carried out when presenting in labour	**0**	**0%**
Delay between admission for induction and beginning of process	**2**	**22%**
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	**0**	**0%**
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	**0**	**0%**
Total	**9**	

Appropriate actions were taken to manage the situation.

During April there has been six delays in induction of labour of over 24 hours.

8. SCBU Cot Occupancy



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

a. Mandatory training (as at 01/05/25)

Department	Assignment Count	Percentage Compliant
421 Level 4 Ante Natal Clinic	9	77%
421 Level 4 Obs & Gynae - Medical Staffing	26	84%
421 Level 4 Maternity Staffing	49	86%
421 Level 4 Pannal Ward	25	87%
421 Level 4 Community Midwifery	22	90%
421 Level 4 Admin Services - Obs & Gynae	5	96%
421 Level 4 Early Pregnancy Assessment Unit	4	97%
421 Level 4 Women's Unit	14	98%
421 Level 4 Medical Records - CG1	3	100%

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

c.

Steps are being taken to improve compliance in all areas currently reporting below 90%. Saving Babies Lives training has changed and all staff will be compliant by the end of the Maternity Incentive Training Year.

Course Name	Midwives	Obs&Gynae Consultant*	Obs&Gynae (Other Staff)	Anaesthetics Consultant*	Anaesthetics (Other Staff)	Paediatric Consultant*	Paediatric (Other Staff)	Maternity Support Worker
Resuscitation Courses								
Adult Basic Life Support with paediatric modifications	66/73 93%	5/7 71%	11/16 69%			7/9 78%		14/14 100%
Resuscitation - Level 3 - Adult Immediate Life Support	8/13 63%							
Harrogate Advanced Life Support (HALS)				17/18 94%	19/23 83%			
Harrogate Newborn Intermediate Life Support (HNILS)	80/83 96%						6/6 100%	
Harrogate Newborn Advanced Life Support (HNALS)	1/1 100%					7/9 78%	10/13 77%	
RCUK Newborn Life Support	13/14 93%					9/9 100%	11/12 91%	
Maternity Specific Courses								
MAT - Growth Assessment Protocol (GAP)	69/88 78%	5/7 71%	7/10 70%					
Fetal Wellbeing Competency Assessment	72/86 84%	7/7 100%	10/10 100%					
MAT – Maternity Training Day 2	84/86 98%	6/7 86%	10/10 100%					
MAT-PROMPT - Emergency Skills Facilitator Led	86/88 98%	6/7 86%	12/16 75%	7/9 78%	8/9 89%			14/14 100%
MAT - Saving Babies Lives	60/85 71%	2/7 29%	7/10 70%					
Mandatory Training - Safeguarding								
Safeguarding Adults	72/86 84%	6/7 86%	14/16 88%	16/19 84%	22/23 96%	8/9 89%	10/19 53%	14/14 100%
Safeguarding Children	84/86 98%	6/7 86%	11/16 59%	17/19 89%	23/23 100%	7/9 78%	14/19 74%	13/14 90%

10. Risk and Safety

a. Maternity unit divert

There has been one event of divert of the unit in April 2025 with one woman being diverted to another unit for care during this divert.

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 April 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.

d. SCBU Risk Register

QIS cover remains on risk register.

e. Maternity Risk Register Summary

The Risk Register was formally reviewed on the 4th March 25. The next review is planned for the 22nd May 25.

Proposed New Risk:

A new risk relating to the ongoing use of manual Penguin Newborn Suction Devices for neonatal resuscitation at homebirths is being considered. RCUK now recommend battery operated alternative suction devices with adjustable pressures, but this will be at additional cost. For consideration of addition to Risk Register until appropriate funding options defined.

Further incidents have been noted with ANC clerical support. Work plans are in place to support improvements and monitoring of issues. Weekly meetings have commenced with Business Support Officer/ANC Manager and Clerical Staff to review issues and capacity pressures. Consideration will be given regarding upgrading the current risk score.

Twelve active risks

- Risk to safe monitoring and management of Perinatal Mental Health due to insufficient clinic capacity for PNMH appointments (Score 8).
- Risk to patient experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 8).
- 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 to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 6).
- 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).

11. Maternity Incidents

In April 2025 there were 77 total incidents reported through DCIQ. No Moderate Harm (or above) incidents were reported.

12. Perinatal Mortality Review Tool (PMRT)

a. HDFT PMRT Information

Two active PMRT cases ongoing, with a 3rd case notified where baby died at tertiary unit. PMRT reviews planned with involvement of MNVP representation.

13. Feedback

a. SCBU Feedback


To SCBU team,

We would like to say a massive thankyou to the whole team for your support with Lily, you have all been amazing! A special thankyou to Gail who helped to put us at ease and kept us positive, she is such an asset to your team.

b. Maternity Service User feedback

We recently received feedback from one of our bereaved families who recently spent some time in the bereavement suite.

'We found the whole experience to be very positive and supportive throughout. The care we received in the hospital for the labour was excellent and made an awful time the best it could possibly be. So we'd just like to say thank you for everything you guys did for us during that time'

14. Complaints, concerns, compliments

- One formal maternity complaint open in April
  - complaint relating to concerns about maternity notes being missing
- One additional concerns/feedback received and two concerns awaiting consent.

15. Coroner 28 made directly to Trust

No new requests received

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

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

17. Maternity and Newborn Safety Investigation (MNSI)

No new MNSI incidents have been reported in April 2025.

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

Maternity Incentive Scheme year seven details have been released. Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover their trust's element of the contribution relating to the CNST MIS fund and this will be returned to the source of the initial CNST payment. They will also receive a share of any unallocated funds.

Further details about each of the ten Safety Actions can be found here - https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

19. 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 has been finalised as is attached as Appendix B.

b) Vaccinations and Immunisations

102 out of 145 (70.3%) of women who birthed in Harrogate and received antenatal care from HDFT were vaccinated against Respiratory Syncytial Virus (RSV).

c) Stop Smoking

Harrogate Maternity team have commenced participation in the National Smoke Free Pregnancy Incentive Scheme to further enhance the local tobacco dependency advisor's role to encourage people to stop smoking during their pregnancy pathway. In April all six women who smoked tobacco at booking (3.3%) have been referred to the in-house tobacco dependency service. Ten referrals have been made this month to the in-house smoking cessation service, two of these have commenced on the stop smoking incentive scheme, five are yet to have a first appointment and three have declined the service.

Since the Stop Smoking Incentive Scheme commenced eight women have been referred and six have maintained an ongoing quit.

20. Local HDFT Maternity Services Dashboard

Maternity Dashboard

Work continues to ensure accuracy of data and benchmarking is included in all data fields captured in the dashboard since the move to Power BI for the reports.

21. Neonatal admissions

a. Transitional Care

Work is ongoing to look to improve the offer of Transitional Care to babies born at 34-35 weeks gestation.

b. Avoiding Term Admissions in Neonatal Units (ATAIN)

Three incidents of Unexpected Term Admission to SCBU in April. Two related to oxygen saturations and one with hypoglycaemia. All cases are reviewed by the ATAIN MDT panel.

22. 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. The below table demonstrates some key metric for Board oversight.

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 – Q1 (calendar): 38.7% detection (<10th centile; 12 cases)(National average 48.2%) FGR – Q1 (calendar): 28.6% detection (<3rd centile; 2 cases) (National average 38.0%)	
	Jan-March 2025	April 2025
Percentage of babies <3rd centile >37+6 weeks' gestation	1.4% (6/422)	2.7% (4/146 babies born) as % of all babies born
Percentage of babies <10th centile >39+6 weeks' gestation	4.5% (19/422)	2.7% (4/146) as % of all babies born
SBLv3 Element 2 report: Percentage of babies <3rd centile who were born >37+6 weeks	54.5% (6/11) i.e. babies <3rd centile AND >37+6 as proportion of all babies <3rd centile	57.1% (4/7) 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)	50.0% (19/38) i.e. babies <10th centile AND >39+6 as proportion of all babies <10th centile	17.4% (4/23) 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)	1.47% (fetal loss, 6/408) 0.25% (live 1/408)	1 fetal loss born 16-23+6 weeks (0.7%, 1/146)
• Preterm (24+0-36+6 weeks)	3.19% (live, 13/408)[one NND]	4.8% (live, 7/146)[one NND]

20. Maternity Safety Champions

Bi-monthly Safety Champion executive and non-executive director walk around and meetings continue. The next meeting and staff engagement is due in May.

21. 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

Appendix B

HNY Local Maternity & Neonatal System

Trust Review Visits, January/February 2025

Harrogate and District NHS Foundation Trust (HDFT)

27th January 2025

Introduction

The Humber and North Yorkshire (HNY) Local Maternity and Neonatal System (LMNS) are running a series of Trust visits during the 24/25 financial year.

Since July 2022 the LMNS has taken on the portfolio of oversight and assurance from the regional team, including regular assessment of key workstreams and progress toward meeting the key objectives of the Three-Year Delivery Plan for Maternity and Neonatal Services. The last Harrogate and District NHS Foundation Trust (HDFT) visit took place on 13th November 2023 and was led by West Yorkshire (WY) LMNS with attendance from both Becky Case, HNY LMNS Programme Director and Heather McNair, HNY LMNS Director of Midwifery.

This visit to Harrogate District Hospital on 27th January 2025 was co-ordinated by the HNY LMNS with the support of the NHSE Regional Team, colleagues from WYH LMNS and other local and regional stakeholders. We would like to thank Trust colleagues present on the day for their warm welcome and for hosting the proceedings.

The LMNS had already reviewed Clinical Negligence Scheme for Trusts Year 6 requirements and Saving Babies Lives Care Bundle v3 CBv3 submissions with support from WY LMNS, as part of ongoing processes and noted great ongoing improvements and achievement against national and local trajectories.

Additionally, the LMNS are aware of adherence to and progress against the Maternity & Neonatal three-year plan through regular assurance processes but were keen to learn about any remaining gaps or issues, and to identify where system wide support, facilitation or oversight is still required.

Those present also sought to gain overall assurance that the maternity and neonatal units were well run, leadership and governance structures were in place and effective, and that organisational culture and knowledge was sound.

The visit was also an opportunity to encourage all teams to celebrate their successes and highlight where improvement to care had been made since the last assurance visit in 2023.

This report summarises the aims and objectives of the visit, collates the pertinent points noted, acknowledges good practice where it was seen or described and makes recommendations for improvement and further development.

Aims of the visit

The visit aimed to talk with executive, managerial, specialist leads and unit staff to understand their knowledge of and adherence to different aspects of maternity and neonatal care. We did this to ensure there was a clear line of sight for governance, escalation, and learning between the units, and with appropriate support and links to both LMNS.

An outline set of open prompts and questions was developed and co-produced with core LMNS team members and Maternity & Neonatal Voices Partnership (MNVP) colleagues in 2023. Adjustments were made to that existing question set in December 2024 to bring it up to date with current priorities, link to recent CQC reports and effectively support the 2025 visit. Additionally, partners from the Yorkshire & Humber Operational Delivery Network (ODN) contributed to the question set.

The ambition was to have an appreciative inquiry approach with additional questions around specific aspects of care or clinical areas to be asked on the day as relevant.

The outline question set is included at the end of this document.

Stakeholders from the local and regional organisations involved in maternity and neonatal care were invited to participate; to provide a more independent and objective overview of the work done and aspects of the team, and also to ensure they could understand where their projects aligned with the needs of each Trust and where additional support might be offered. The offer of participation was also extended to other LMNS colleagues and regional provider leads to support bi-directional peer review and feedback.

Feedback was requested from all the members of the review group and is incorporated in this report and accompanying slide deck. As in previous years, initial high-level feedback on the day was reported in person in line with the slide deck appended at the end of this document.

Structure

The day commenced with introductory presentations from the LMNS and the HDFT leadership team. The LMNS overview outlined the core team objectives, assurance remit and current projects, as well as describing the ambition of the visit and how information would be gathered, analysed, assessed and fed back to the teams (please see the slides appended at the end of this document). The Trust provided information on their current performance position against key targets and ambitions in accordance with the main themes of the Three-year Plan, including key workstreams and improvement areas they had focused on over the intervening period between this and the previous review meeting. They also described where they wanted to celebrate achievements.

Stakeholders then split into different working groups and went to visit different clinical areas within Harrogate District Hospital or joined discussions with members of staff within the meeting space.

Clinical areas included:

- Delivery Suite
- Maternity Assessment Centre (MAC) – Triage, Antenatal Day Unit, Sonography
- Postnatal Suite (Pannal Ward)
- Bereavement Suite

Areas of discussion included:

- Senior Leadership Team assurance from Emma Nunez, Executive Director for Nursing, Midwifery & Allied Health Professionals, and Leanne Likaj, Associate Director of Midwifery (ADoM).
- Safety Champions and Non-Executive Directors (NED); support from Andy Papworth, NED and other senior leaders.
- Governance and incident reporting; support from Andrew Brown, Lead Midwife for Safety, Quality & Clinical Governance.

- Safeguarding; support from Vanessa Corrigan, named midwife for safeguarding.
- Maternal Medicine and fetal monitoring; support from leads.
- Scanning services and escalation of issues; support from leads.
- Perinatal Mental Health – Anna Sebine.
- Neonatal and Transitional Care – Patricia Gilbertson, Amy Howard.
- Service user input – co-production, equity and accessibility; support from Ruth Charlton, Harrogate MNVP Engagement Lead and other LMNS/MNVP leads.
- Staffing, vacancies, recruitment and retention; all.
- Visibility of the leadership teams and safety champions; all.

Key findings

Areas of good practice

- All of the review team felt the unit was warm and welcoming, ward areas were clean and free from clutter and the environment was calm.
- We saw brilliant visual media in many areas; with a selection of posters, display boards, white boards and televisions.
- Good rapport between staff noted and supportive working environment with clear routes for escalation of concerns was described. The 'open-door' policy described seemed successful because staff described that they felt confident in approaching their senior leadership team who are visible and supportive.
- The visiting team also saw clear examples of how data had informed Quality Improvement (QI) projects. Staff clearly articulated how the change in structure of the directorates had supported collaborative working.
- A weekly incident review meeting allows feedback from incidents/complaints to be effectively communicated. Social media/Padlet/email and training are all used to communicate incidents/complaints information; staff found this helpful.
- There is an accessible named safeguarding midwife and training in place.
- With just 1 WTE Bereavement Midwife in post, all co-ordinators have received bereavement training, including postmortem consent; the Trust is looking into sound proofing the bereavement suite following feedback from service users.
- The visiting team noted that there is a diabetes lead midwife in post and a multidisciplinary clinic in place, the Trust meets SBLCBv3 requirements in this respect (there is an agreed exception approved at WY&H LMNS Board), and bespoke birth planning is offered for those with issues linked to diabetes.
- The Maternal Medicine Consultant has implemented a local clinic and there are good links with haematology, cardiology and endocrinology across the wider network.
- It was noted that staff described recording data with relevant ethnicity and deprivation information wherever possible.
- Integration with new smoking cessation guidance and processes, including the national incentive scheme, is now progressing well.
- HDFT described they are looking at new tools and services to improve safety/quality of experience; for example, 4D pregnancy scanning and the HeyGen translation tool.
- Good support for breastfeeding and diversity in the feeding support group was described and there is clear communication with the Transitional Care unit to support parents with babies who need extra support. Staff generally were seen to be strong advocates for breastfeeding.

Areas for consideration

- Some staff said they were not aware of the term 'safety champion' but had been part of the walkarounds and did feel able to escalate concerns.
- It was noted that some community midwifery staff did not know what the patient information leaflets on BadgerNet contain and how service users can access them.
- HNY LMNS MNVP Group lead noted that personalised care offered through specialist services, especially diabetes and perinatal pelvic health was excellent – in particular asking individuals 'What are your goals?'
- Great environment and dimmed lighting were present in some areas; MNVP leads asked if this could also be considered on the postnatal ward.
- The HNY LMNS Partner Project Lead observed that although partners could sleep over in the cubicles on the postnatal ward (with bedding etc. brought from home), there was an issue with the cubicle curtain length being considerably too short, resulting in a lack of privacy.
- There was reduced obstetric input into the visit on the day due to staff absence, which could not be foreseen. Despite this there were no concerns raised or identified regarding the relationships between midwifery and obstetric colleagues.
- There is an adapted BSOTS (Birmingham Symptom Specific Obstetric Triage System) in place, as the team described being unable to fully implement BSOTS due to the size of the unit. Whilst senior leadership have implemented change in response to the CQC report issued, they acknowledge work is ongoing. The adherence to guidance around mitigations for DGH level hospitals is agreed, but staff described that they were keen to move beyond this level. We are progressing the work around an LMNS wide telephone triage at the front end of the process that may support additional mitigations to be put in place. Meetings around the triage work will commence in May 2025.
- Transitional Care processes still did not feel as robust as the review team thought they could be; the Neonatal Operational Delivery Network offered support to further enhance this and offer mutual aid.
- It was noted there is no epilepsy specialist; medical or nursing, at the Trust. Any women needing this service are seen in Leeds. Links are good but the review team suggested an assessment of the information available for women and birthing people in this category could be compiled and shared by the Trust/Maternal Medicine Network.
- The screening midwife advised of an issue with arranging appointments at Leeds for hip scans within the recommended timescales, which needs to be explored further.
- The change to safety lancets for collecting neonatal blood spots, were recommended as 'worth the expense'.
- Provision of home birth services are still seen as challenging; other small units may be able to provide advice and guidance to support this.
- There are still a number of neonatal nurses needing QIS training; the Neonatal ODN can offer support. The team have subsequently informed us that plans are in place to achieve this with one on training currently and two further staff to be trained on return from maternity leave.
- It was noted that there were gaps in Perinatal Mental Health (PNMH) resourcing – and that demand forecasting would be beneficial to assess and meet future service needs.
- The visiting team were advised that the last three SBLCBv3 training days had been cancelled due to operational pressures.

MNVP and wider service user input

- Jen Baldry, Maternity Voices Partnership Lead, recently stepped down from that position; our thanks go out to her for her dedication in role and the great work progressed.
- Informed choice, noting complexities and possible barriers for service users, was evident to the review team throughout the whole maternity journey.
- There was evidence that MNVP members are proactively contacted and meaningfully involved in all aspects of work that need service user input.
- It felt as though there was a culture to empower women and birthing people through the 'This is your space' poster in all the labour rooms not just the active birth suites, and the 'peanut ball' birth positions poster. These support service users to share their feelings over their own options and experience.
- The review team saw very clear and tidy information presentation on boards which felt accessible and available. There were plenty of staff nearby to ask questions about what was on the boards. This was especially true on labour ward and in the antenatal area.
- Visitors spoke to service users, their birth partners and their family members present on the postnatal ward; and all felt safe throughout their maternity care.
- The MNVP Group Lead wasn't completely confident that a birthing person whose first language wasn't English had received a clear explanation of what her birth choices were; e.g. she didn't know what the birthing pool was.
- Involving service users with lived experience in the development of the Standard Operating Procedures for enhanced Continuity of Carer teams would be welcomed.

Workforce – recruitment and retention

- Senior staff stated that staffing levels were in line with the Birthrate+ establishment review completed in August 2024, but this did not align with the perception of staff we spoke to. The visiting team were informed that additional roles were being taken through the business case process. The LMNS is aware that staffing changes are an ongoing and evolving discussion. A new LMNS wide workforce meeting will be established in May 2025.
- Skill mix can be a challenge; we noted the staff cohort has a high percentage of Band 5 and new Band 6 midwives – this can compound challenges on night shifts.
- We were given the example of Maternity Support Workers (MSW) establishment being short against requirements due to the requirement to cover the Maternity Assessment Centre. The team subsequently informed us that this is being reviewed, and a business case is being developed to support an increase in staffing.
- There is a plan in place for enhanced 'continuity' midwife posts although these are still in development. It was noted that vulnerability caseloads will include the refugee population, teenagers and young adults; all relevant locally.
- The review team noted some difficulties with the availability of medical staffing; this is a small unit and therefore absence of any kind can significantly affect rotas. The current team are maintaining cover. A post visit update advised that this cover has been in place during the period of short notice absence and a locum consultant has been recruited to start in March.
- Staff training is not allocated enough 'head-room' in the existing establishment (as above); it was described as getting increasingly more difficult for new training needs to be supported.

- We advised the team that some staff reported that they did not have capacity to read and respond to unit/LMNS communications.
- The visiting team suggest that senior leadership be mindful that staff can be 'competent' but not necessarily 'confident' around seldom used skills. Senior leadership should ensure staff appraisals include discussions around maintaining confidence in seldom used skills and developing actions where required.

Areas for the LMNS and stakeholders to jointly pick up

- Staff expressed concerns over their ability to obtain police approved interpreters when needed (to protect confidentiality and for safeguarding purposes). The LMNS core team and other external stakeholders could support improvements around this across Humber & North Yorkshire/West Yorkshire and Harrogate if also seen elsewhere.
- Some staff flagged BadgerNet issues around the application of filters for screening and isolating local cohorts for audit purposes; this can be raised by the LMNS with System C as it could be an issue that is shared with other units. Generally, optimisation of the system is ongoing, with support from the HNY LMNS Digital Coordination Group.
- As a small unit HDFT would benefit from continuing to reach out to wider system colleagues and the LMNS(s) for support with areas of challenge; for example; training around 'honour' based abuse or to develop resources for neurodiverse populations.
- Safe sleeping/skin to skin posters co-produced with the MNVP locally were a great piece of messaging; we would like to consider these for adaptation LMNS wide.
- The Humber & North Yorkshire LMNS has developed a 'service specification' to sit alongside the Maternity & Neonatal 3-year strategic plan and pick up areas not otherwise covered in assurance documents; this will be shared with West Yorkshire & Harrogate LMNS shortly and then circulated widely.
- The LMNS representatives were also asked about the impact of Specialised Commissioning of neonatal units moving into ICB Leadership from April 2025, and whether the Neonatal ODN will continue to support guidance and designation queries. The Specialised Commissioning implications are still not clear at the time of this report, but all units will be kept informed. The Neonatal ODN will continue in its current role.

Areas where further information is required for follow up (Summer 2025)

The LMNS anticipate that the HDFT team will take the various learning and development points noted above and ensure actions are identified and monitored. We will revisit the points described above during the Summer of 2025 and continue to offer support for improvement. Please note that there is not a requirement to have a separate action plan for these issues, as long as you can demonstrate which plan they are part of and where we can view evidence and monitor change.

Key themes for action are:

- Workforce sustainability and growth, rota management and skills mix across the small maternity and neonatal units.
- Equitably addressing the needs of our non-English speaking population/women and families from our global majority, and those in areas of deprivation.
- Staff knowledge of availability of support; including MNVP input, LMNS resources, wider Trust governance, incident reporting and QI expertise.

Outputs

- Initial on the day feedback – this was delivered on the day of the visit, and the slides are appended at the end of this document.
- This report – provides information and updates from the day and clear recommendations that will be reviewed in Summer 2025.

Next steps

We want to use the information gathered on this day to best effect; and build on these annual visits to provide assurance around the different aspects of maternity and neonatal care. Please encourage staff to read this report and highlight any things they agree with, any they don't or any other suggestions to improve these visits. Please comment yourselves on any aspects of the day and process.

Actions to progress, to work with the HDFT team to prioritise and support:

- Review period; to arrange a follow up in Summer 2025 and understand what progress has further been made.
- Collation of lessons learnt across the Trust during these visits.
- The LMNS to work with all stakeholders across the four visits in January and February 2025 and use this information to direct workplans for the 25/26 financial year.

Questions to be addressed:

- Suggestions as to the future role of similar visits – is there a review cycle that we could fit in with better?
- Comments on the usefulness and format of the visit – would an expanded peer review approach be useful to Trust leaders?

Many thanks again to all staff for their input and support during the visit and this process; we look forward to setting up a follow-up meeting and progressing the recommendations included.

Appended documents:

Question Set	HNY LMNS Trust Assurance Support Vi:
HDFT Presentation and supporting materials – commencement	LMNS Assurance Presentation Jan25 PI
LMNS Presentation – commencement	LMNS Review Visits 2025 - Intro Presentat
LMNS Presentation – completion	LMNS Review Visits HDFT 270125 - Initial

Becky Case

LMNS Programme Director

February 2025 – Updated April 2025

Strategy Deployment Room

28th May 2025

Title:	**Delivering Same Sex Accommodation – Annual Statement**
Responsible Director:	Alison Smith, Executive Director of Nursing, Midwifery and AHPs
Author:	Kate Southgate, Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	The report provides the Trust Board with the annual declaration on Delivering Same Sex Accommodation. The declaration confirms that there have been no breaches during 2024-25.	
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	
	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 Corporate Risk associated with this paper	
Report History:	The Board reviews and receives this annual deceleration each May. The report was also received at: • SDR on 21st May 2025 • Quality Committee on 28th May 2025.	
Recommendation:	The Board is asked to approve the annual deceleration.	

Freedom of Information:	Available once published as part of Trust Board in Public papers.

TRUST BOARD (in Public)
Delivering Same Sex Accommodation – Annual Statement
28th May 2025

1.0 INTRODUCTION

The Operating Framework 2011-12 made it clear that NHS organisations are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, or reflects their personal choice. During 2024-25 there have been no reported breaches at the organisation.

2.0 ANNUAL DECLERATION

Harrogate and District NHS Foundation Trust (HDFT) can confirm that the organisation is compliant with the government's requirement "to deliver same sex accommodation except where it is in the overall best interest of the patient, or reflects the patient's choice".

HDFT has the necessary facilities, resources and culture to ensure that patients who are admitted to our organisation are treated with respect and dignity and that the principles are adhered to.

Evidence of compliance includes reports of any and all breaches via the organisation's incident reporting system and is monitored through our operational Quality Governance Management Group and to our strategic, sub-committee of the Trust Board the Quality Committee.

3.0 RECOMNMENDATIONS

The Trust Board is requested to note and approve the statement as outlined at Section 2.0 of this report. Following which the statement will be placed on the Trust website.

Alison Smith
Executive Director of Nursing, Midwifery and AHPs

Kate Southgate
Associate Director of Quality & Corporate Affairs

May 2025

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

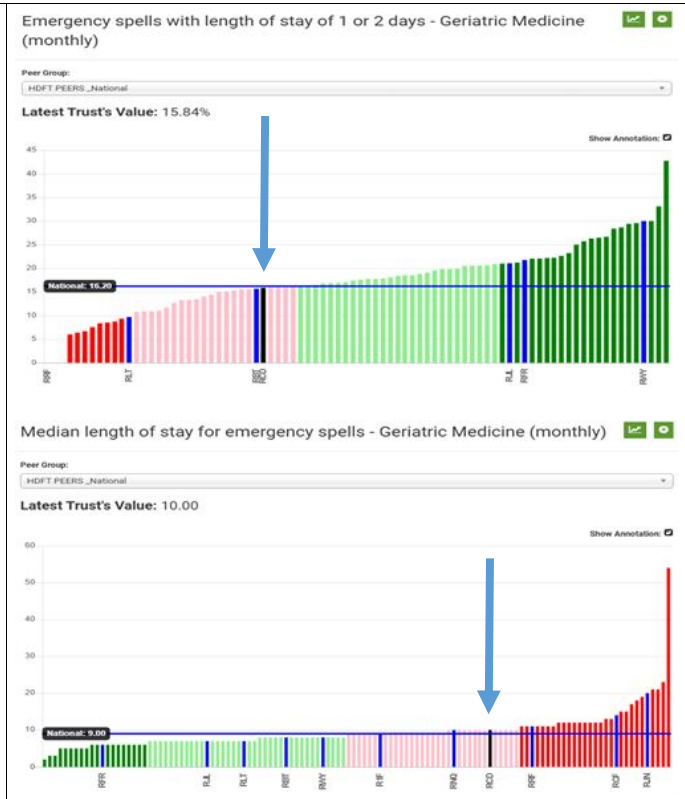
1. ED 4 Hour Standard - 95% of patients admitted or discharged within 4 hours
2. Length of Stay - Top quartile nationally for patients with frailty
3. Elective Recovery RTT - 92% of patients waiting under 18 weeks for treatment
4. Cancer 62 Day Standard - 85% of patients seen and treated within 62 days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

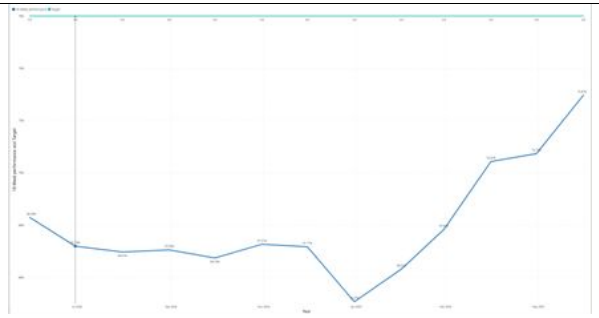
Breakthrough Objective:	Time to Inpatient Bed Reduce Follow Up Activity
Corporate Projects:	1. Bed Capacity 2. Patient Discharge
Overarching Risk Appetite:	Operational - Cautious

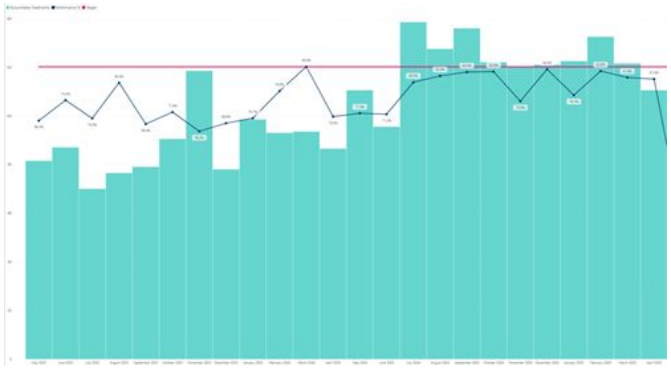
Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite 1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Person Centred, Integrated Care, Strong Partnerships	The best place for person centred urgent and emergency care	4 Hour ED Standard	Operational: 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	Elective Recovery RTT – 18 Weeks	Operational: Optimistic	
		Cancer 62 Day Standard – 62 Days Treatment	Operational: Optimistic	

Strategic Metrics Summary:

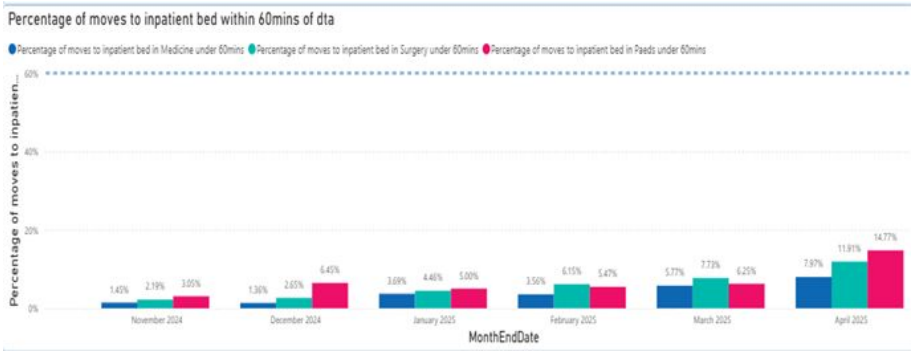
Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care	ED 4 Hour Standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated 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 78% of patients having their care completed within 4 hours. By March 2027, we want to be at 85% of patients having their care completed within 4 hours. By March 2028, we want to be at 95% of patients having their care completed within 4 hours.	The True North Metric of ED 4 Hour Standard continues into its second year (2025-26). The target of a 78% compliance was achieved in March and April 2025. Countermeasures are noted. Breakthrough Objective: Time to Inpatient Bed (see below) Associated/Linked Watch Metrics: (all below threshold) • 12-hour breach numbers • ED 'Harms' • Sepsis screening in ED • Ambulance Handovers • ED Attendances vs Plan Current ED 4 Hour Standard Performance Data:  Performance - Historical - ED performance breaches and LOS - Power BI	ED pathways work. Breakthrough objective (BO): Time to Bed to address greatest breach contributor. Manual audit by ED consultant for all admitted patients over 24 Hours to identify delays. Senior Flow Coordinator Role for 6 months starting 26th May. External Review to commence on 15th May by Steve Bush. See further countermeasures in BO. Corporate Projects: Bed Capacity and Patient Discharge.		
An exemplar system for the care of the elderly and people living with frailty	Length of Stay with Frailty	Top quartile Length of Stay nationally for patients with Frailty by March 2027.	By March 2026, we will achieve top half Length of Stay for Frailty nationally. By March 2027, we will achieve top quartile Length of Stay for Frailty nationally.	The True North Metric of Length of Stay continues into its second year (2025-26). To bring this in line with other goals we will be tracking Length of Stay against the national position aiming to hit top half this year (for Length of Stay and short stay spells) and top quartile by end of 2027. Watch Metrics: • Frailty LOS • Proportion of LLOS Frailty patients • Hospital at Home occupancy • No Criteria to Reside percentage • Occupied Bed Days by Frailty Patients	Development of Data for stratification with advent of new EPR. Optica – optimisation of task function and reasons for 'stay'. Improved identification and visibility of frailty 'scoring' with new EPR. Work on frailty and community alignment. Corporate Projects: Bed Capacity and Patient Discharge.		

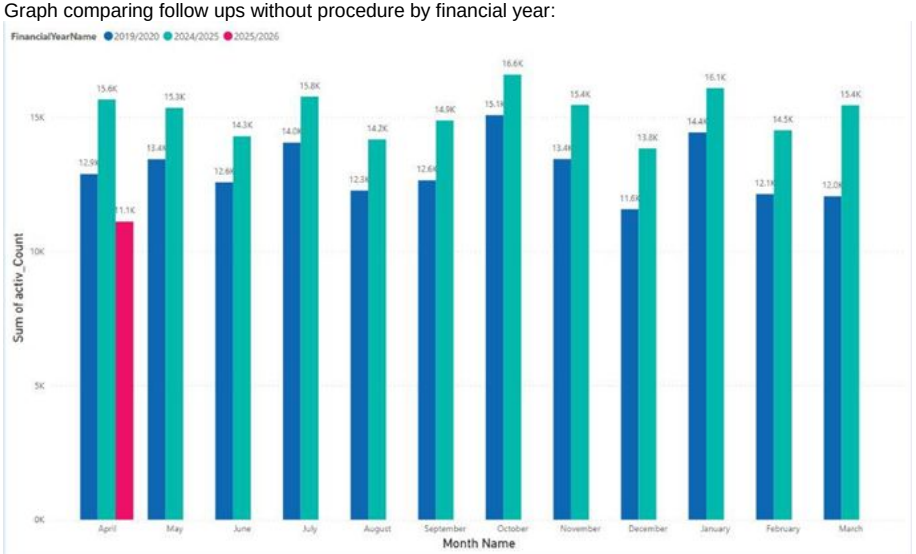
							
Equitable & Timely	Elective Recovery (RTT) Standard	Sustained achievement of the 92% of patients being treated within 18 weeks.	By March 2026, we will achieve 18-week performance at 72% (as per national mandate). By March 2027, we will achieve 18-week performance at 92%.	The True North Metric of Elective Recovery (RTT) Standard continues into its second year (2025-26). Current 18-week performance data: End of April position was 70.1% with May to date at 73%.	HDH Additional Theatres (TIF2) build on track for 2026 delivery. Outpatient Transformation, rollout of further faster programme and track key metrics: • New: follow up ratios • Absolute reduction in follow ups • DNA rates • Clinic cancellation rates • Patient Initiated Follow Up Rate Corporate Projects: Bed Capacity and Patient Discharge.		

				 Trust RTT metrics - RTT waitinglist and trajectories from LUNA - Power BI	Theatres Productivity (85%). Countermeasures updated and set through PSCC PRM discussions/Outpatient Transformation Board: • Streamline processes and unify data - utilise RPA to take over some of the manual processes. • Reduce variation and create a consistent patient experience. • Dedicated SM time to define roles/ responsibilities with the aim to create a seamless end to end patient journey. • Greater look at DNA – have reduced by 1% across the board but still have problematic specialties like ENT causing issues. • A+G – focus on reducing the demand on first appointment working with primary care to improve the uptake. • Ensuring all booked and un-booked appointments are in scope text message validation every 12 weeks. • Maximise OPFA capacity through push on PIFU, skill mix (decision makers) in follow up clinics, converting follow ups to news.		

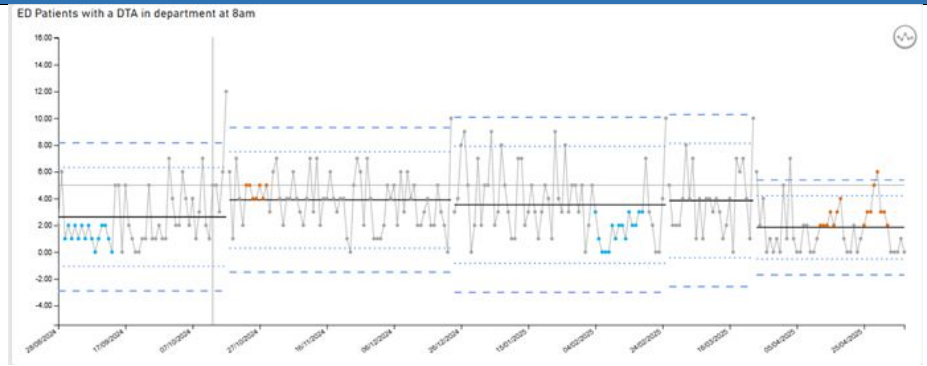
	62 Day Cancer standard	85% of our patients will commence treatment within 62 days of referral.	By March 2026, 85% of patients will have commenced definitive treatment within 62 days of referral for suspected cancer. By March 2027, 85% of patients will have commenced definitive treatment within 62 days of referral for suspected cancer.	Noting that validation and pathway closure for April will continue for another 2 weeks the current position is 81.4% compared to 81.9% validated for March. Cancer Performance Report - Power BI 	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 Corporate Projects: Bed Capacity and Patient Discharge. Outpatient transformation, Theatre productivity board alongside PSCC PRM's will set and edit countermeasures: • Map standardised process for theatre cancellations. • Gemba Walks. • Cross reference stratified data by specialities to identify local themes. • Consistent attendance (including imaging representation) and decision making at 6-4-2. • Job planning exercise - matching clinical availability with scheduled theatre time. • Real time utilisation monitoring. • Weekly Theatre Governance huddle. • Standardisation and streamlining of pre-op pathways.		

Breakthrough Objective:

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	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.	By March 2026, 60% of patients will move to an inpatient bed within 60mins of the decision to admit. By March 2027, 75% of patients will move to an inpatient bed within 60mins of the decision to admit.	This Breakthrough Objective, continues into 2025-26 with the target being reframed to a percentage of patients moved rather than a median time. Improvement seen across all inpatient bed categories in April. However remain a long way from the target of 60% of moves within an hour. Current data for the new measure below:  ED performance breaches and LOS - Power BI	ED pathway work. Admission unit/SDEC/SAU pathway work and Length of Stay work. Corporate Projects: Bed Capacity and Patient Discharge.		

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Reduce Follow Up Activity	Elective Recovery (RTT) standard	Patients will avoid unnecessary follow up appointments using technology and patient initiated follow up enabling an increased in new patient capacity and reduced waiting times.	By March 2026, reduce the number of follow up appointments by 10% from outturn 2024/5. By March 2027, further reduce the number of follow ups to a 15% reduction from outturn 2024/5.	Graph comparing follow ups without procedure by financial year:  Follow up Outpatient - Activity Monitoring 2025 - Power BI	Outpatient transformation project countermeasures: • Increased Patient Initiated Follow Up (PIFU) • Reduce cancellations and DNA rates. In development through Outpatient Transformation program under the Clinical Services Strategy.		

Corporate Project:

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Bed Capacity Project	ED 4 Hour Standard Length of Stay with Frailty Elective Recovery (RTT) Standard Cancer Treatment Standard	Each day will start with a minimum of 6 assessment beds available and no patient will be 'outlying' away from their base specialty ward. There will be no requirement for additional winter ward capacity.	By December 2025, there will be no patients in the emergency department at 8am without an inpatient bed to transfer to. By December 2026, there will be a minimum of 4 empty assessment beds available to start the day.		Right sizing of Admission Unit. Utilisation of same day emergency and day unit capacity. SDEC rebuild. Winter escalation built into established wards.		
Patient Discharge	ED 4 Hour Standard	No patient will remain in hospital after they no longer meet the criteria to reside.	By March 2026, we will achieve NCTR <10%. By March 2026, we will achieve % of patient experiencing a Long LOS reduced: • 7-14 days to 18%. • 15-21days to 6%. • >21 days to 15%. By March 2026, we will achieve Virtual Ward Occupancy >65%. By March 2026, we will achieve 'Outliers' on wards <1%.	https://app.powerbi.com/groups/01a88572-f02f-46fc-8f40-4aabac707bbd/reports/d676ade7-3503-45ee-8101-bf3522c6b1c7/8cb1937b7015a1803e42?experience=power-bi 	Streamline TTO. Criteria led discharge implementation. Discharge lounge utilisation.		

Strategic Programme

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

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR61 / ID3	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~~ March 26	Clinical: Patient Safety	Minimal
CRR87 / ID6	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 ~~August 25~~ March 26	Clinical: Patient Safety	Minimal
CRR96 / ID79	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	4 x 1 = 4 ~~January 25~~ October 25	Clinical: Patient Safety	Minimal
ID379	Patient harm due to Non Compliance with National KPI's for waiting times and reporting in Imaging Services	The primary risk of not implementing the AI solution for chest x-ray interpretation lies in continued reliance on manual processes, which are susceptible to delays and inaccuracies in diagnosis. The current manual methods place a heavy workload on radiologists, prolong diagnosis times, and potentially lead to suboptimal patient outcomes due to delayed treatment. This situation poses a serious risk not only to patient health but also to the operational efficiency and reputation of the healthcare facility. Currently, the radiology department at HDFT relies on traditional, manual interpretation of chest x-rays, which has led to a backlog of cases, inconsistent diagnosis times, and variability in diagnostic accuracy. The system's inability to efficiently manage and prioritize urgent cases further exacerbates these issues. Without the AI solution, the department continues to face challenges in meeting the compliance standards expected for timely and accurate service delivery, directly impacting patient care and throughput in radiological services.	4 x 3 = 12	3 x 1 = 3 ~~March 25~~	Clinical: Patient Safety	Minimal
ID642	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. Current Position/Issues: • inadequate staffing 12.5 PAs down at Consultant level currently filled with locum cover, • lack of continuity of Registrar/middle grade ward cover, • reliance on locum consultant and associated team and quality risks Risk of burnout of current medical and ACP team due to workload pressures.	3 x 4 = 12	3 x 1 = 3 Dec 25	Operational: Business Continuity	Cautious

		Other consequences to these factors include outpatient RTT, angio and echo waiting time breeches. Cardiology Strategy Planning meeting scheduled for November 24. Current position managed through HDFT IMPACT and regular updates provided to LTUC Tri-Team for escalation to the executive team.				
ID292	Automated medicines supply services	There is a risk of failure of the inpatient dispensing robot caused by wear and tear over a number of years and the robot exceeding it predicting lifespan. The impact of this is inability to provide a lean and efficient medicines supply service for top-up, inpatient dispensing and discharge dispensing. The effect on patients would be delays in supplies of medicines for inpatient/discharge and potential delays to discharge as processes would revert to time-consuming manual processes.	4 x 3 = 12	4 x 1 = 4 Sept 25	Operational: Business Continuity	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 2025-2026

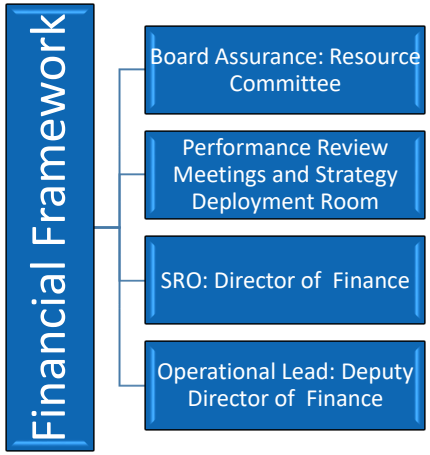
Our ambition is to provide the best quality, safest care whilst being a financially sustainable organisation.

GOALS:

Financial Sustainability

HDFT To be a financial sustainably organisation

GOVERNANCE:



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

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

Breakthrough Objective:	Waste Reduction and Productivity (WRAP)
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:

<table>
<tr><th>True North Metric</th><th>Vision</th><th>Goal</th><th>Current Status</th><th>Countermeasures</th><th>Level of Risk To Achieving Goal</th><th>Level of Risk for progressing actions</th></tr>
<tr>
<td>Financial Sustainability</td>
<td>HDFT to be a financially sustainable organisation</td>
<td>In 2025/26 the Trust, and therefore directorates, should live within the financial resources available to us.

The Trust will return to segment 2 of the National Oversight Framework.</td>
<td>The True North Metric of Financial Sustainability continues into its second year (2025-26). As at M1 the Trust reported £1.9m deficit, £1.7m away from plan. The key drivers includes WRAP delivery, £1m, Risk share with ICB £0.5m and a number of pay overspends that need to be explored.

The Trust ended 2024-25 in Segment 3 in the Oversight Framework due to the in year financial position.
<table>
<tr><th>2024/25 Performance</th><th>Recovery and Sustainability</th><th>Cost Improvement and Productivity</th><th>Governance and Control</th></tr>
<tr><td>Revenue financial plan position delivered</td><td>2024/25 normalised run rate improved from 2023/24 exit run rate</td><td>2024/25 plans established</td><td>Organisational Ownership and Commitment</td></tr>
<tr><td>Capital Plan Delivery meets allocation</td><td>2025/26 plan demonstrates balance or improvement</td><td>2024/25 plans delivered</td><td>Embedded and Robust challenge and reporting processes</td></tr>
<tr><td>CIP target achieved</td><td></td><td>2024/25 plans recurrent</td><td>Evidence above reduces run rate</td></tr>
<tr><td>ERF Plan delivered</td><td></td><td>2025/26 plans</td><td>Organisational compliance</td></tr>
<tr><td>Productivity Improvements delivered (Model Hospital)</td><td></td><td>Demonstrate sound governance and PMO approach</td><td>New requirements by NHSE</td></tr>
<tr><td>Cash management best practice</td><td></td><td></td><td>New requirements by ICB</td></tr>
<tr><td>Workforce WTE</td><td></td><td></td><td>Including 2023/24 close down letter and annex a</td></tr>
</table>
Countermeasures are noted.

Watch Metrics:
<table>
<tr><th>Metric</th><th>Purpose</th></tr>
<tr><td>Capital Spend YTD</td><td>To track delivery of the Capital Programme spend</td></tr>
<tr><td>Financial performance In Mth/YTD</td><td>To track performance against plans (Directorate/Trust)</td></tr>
<tr><td>WRAP delivery YTD</td><td>To track performance against WRAP target (Directorate/Trust)</td></tr>
<tr><td>Cash in Bank</td><td>Ensure sufficient cash to pay Suppliers and Staff</td></tr>
<tr><td>Aged Debt</td><td>Track invoice payment (impacts cash)</td></tr>
<tr><td>Better Payment Practice code</td><td>Keep track on how delivering against national standard 94% (Trust paying Suppliers)</td></tr>
<tr><td>Retrospective PO's</td><td>Track number of orders not following no PO no Payment process</td></tr>
<tr><td>Agency Spend</td><td>Ensure agency spend is within national target and plans in place to reduce usage</td></tr>
<tr><td>Off Framework Spend</td><td>Monitor spend - National requirement to have no off framework spend</td></tr>
<tr><td>ERF</td><td>Performance against 19/20 baseline (Generates additional income)Unclear on reporting needed for 25/26.</td></tr>
<tr><td>WD1 delivered</td><td>Ensure Directorates have a financial summary on working day1</td></tr>
<tr><td>REACH Reporting</td><td>To track budget holders accessing their budget reports</td></tr>
</table>
</td>
<td>In relation to the operational position the current countermeasures will be in place

1. Controls implemented in 24/25 maintained.

2. Delivery of activity plans resulting in ERF allocation.

3. Waste Reduction and Productivity schemes delivered against the Trust target.

4. Continued focus on reducing agency and bank costs.

5. Maintain/Reduce WTE.</td>
<td></td>
<td></td>
</tr>
</table>

Breakthrough Objective:

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal	Level of Risk for progressing actions
Waste Reduction and Productivity (WRAP)		100% Delivery WRAP target	As at M1 34% of WRAP schemes have been actioned. Delivery by Directorate summarised below.	Suggested Countermeasures		

	Target	Actioned	Progress
CYPH	1,474,600	436,900	30%
Corporate	1,271,100	66,100	5%
LTUCC	4,578,600	792,200	17%
PSC	4,801,100	602,200	13%
Central	2,362,300	2,362,300	100%
HIF	0	743,100	
	14,487,700	**5,002,800**	

Strategic Project:

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

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
TBC	Delivery of Financial Plan 25/26	The trust has submitted a breakeven plan for 25/26 however there are a number of risks still to be mitigated including full delivery of WRAP programme, mitigating unfunded cost pressures and how the risk share with the ICB will be managed.	3 x 5 = 15	4 x 2 = 8 March 2026	Financial: revenue, funding and liquidity	Cautious
ID721	Group Cash Position	Due to the underlying financial position of the organisation, cash support is required in March 2025 totalling £18.5 million. A cash forecast has been prepared for 2025/26 and this has highlighted cash concerns for the year which will need managing.	3 x 4 = 12	2 x 2 = 4 March 2026	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	A breakeven plan has been submitted but there are a number of outstanding risks that are being managed through a Risk Share with the ICB. Contracts are due to be signed by the 8th May 25.	3 x 3 = 9	4 x 1 = 4 May 2025	Financial: revenue, funding and liquidity	Cautious

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

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:	Staff Engagement
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	Current Status	Countermeasures	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.	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.	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 27% in April 2025 – which was a reduction from 32% in January. • The Trust tracked above the quarterly Pulse survey benchmark group engagement score consistently. • Jan 2025 Pulse Engagement score for HDFT: 7.15. Benchmark score: 6.49 • 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. Proposed changes to the 4S Appraisal process presented to May People & Culture Programme Board for feedback.	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. Project to strengthen the 4S Appraisal process to address the national staff survey feedback.		
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 deployment to ensure	1. A vacancy rate that does not exceed 6% 2. A Turnover rate that does not exceed 12% (HNY is 12%)	The True North Metric of Staff Availability continues into its second year (2025-26). Last financial year the Trust achieved: • A vacancy rate that did not exceed 6% (3.81% average for the year) • A turnover rate that did not exceed 12% (11.42% average for the year)	Directorates focusing on sickness locally using the new Trust Policy - ongoing Audit local sickness absence management processes, how the newly introduced/updated sickness policy is		

Workstream	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
 New Ways of Working 		quality of care and to enable those staff to have a good experience and do their best.	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 of 4.5% (5.03% average for the year) • Staff leaving within the first year of employment did exceed target of 15% (16.62% average for the year) • Sickness and turnover goals have been reduced for this financial year in line with the Humber and North Yorkshire ICB system targets for these metrics Staff unavailability has seen a further slight decrease in April from 533.78wte to 527.91wte, which is a decrease of 5.88wte. Whilst overall unavailability has reduced compared to the previous month, the number of vacancies have increased by 28.90wte from 149.11wte to 178.01wte, going into the new financial year. PSC is the greatest contributor. The main factor in unavailability decreasing is a reduction in in-month leavers in April and saw a decrease of 21.54wte compared to March. However, it should be noted that the March WTE leavers were an outlier, with a higher than average number of leavers. The Trust vacancy rate is 3.72% at the end of April 2025, which is below the Trust target of 7% (A3 threshold of 6%). -Trust turnover is 11.11% -Sickness is 4.48% -Staff leaving within 1st year is 15.54% (this has decreased from 16.73% last month.)	working to support managers and that staff are appropriately moved through the stages and dismissed in line with the Trusts policy – in progress. Contract with an EAP with improved mental health and wellbeing provision – implemented and impact being monitored		

Breakthrough Objective: Staff Involvement

Workstream	True North Metric	Vision	Goals	Current Status	Countermeasures	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
Making HDFT the best place to work	Staff Engagement	To create an environment within HDFT where staff feel genuinely involved in decisions that affect their work and their team, and where they are able to contribute to and influence improvements to their work. This corresponds with the True North Ambition of improving Staff Engagement.	1. The Trust score for Involvement in the NHS Staff Survey matches the best result for the benchmark group (2024 HDFT scored 6.85 vs best in benchmark of 7.27). To achieve, at Trust level, a score on question 3f, "I am able to make improvements happen in my area of work," matching the best result in benchmark (2024 HDFT 55.37% vs 63.91%).	Focus groups dates and workshop under development	Hold Focus Groups with the 8 teams scoring the lowest for Involvement in the 2024 National Staff Survey to understand reasons for score and what would improve.		

Corporate Project:

Workstream	True North Metric	Vision	Goal	Current Status	Countermeasures	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	Roll out is ongoing. Currently 20 services out of 39 are live, 11 in progress and 8 on hold pending job plans being updated/finalised. A Medical Annual Leave (AL) policy review and consultation is nearing conclusion. The recommendation is AL is calculated and taken in hours as opposed to days, and means it is fit for purpose in ensuring correct entitlements. Although the BMA have threatened to raise a dispute on this matter should the Trust impose the PolicY. An options paper was approved by the project board to fully implement Bank Staff+ for all additional work undertaken by medical and dental staff. This provides significant visibility between contracted and additional hours, as well as a fully digitised e-Rostering and pay experience for managers and	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.		

Workstream	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
			paper/spreadsheet submissions	staff. Implementation forecast to commence October 2025. The supplier has made a number of site support visits to provide direct support. Following a request from LTUCC, they are also setting up a meeting with Great Western NHS Trust directorate managers and rota coordinators who operate similar rosters for their resident doctors, and have agreed to share their experience and how they resolved issues.	Work with the General Managers to help fix any problems that arise and move us away from spreadsheet double running		

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 relevant 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						

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

Board of Directors (Public)
28 May 2025

5.2

Title:	Modern Slavery and Human Trafficking Annual Statement
Responsible Director:	Director of People and Culture
Author:	Director of People and Culture Deputy Director of People and Culture Acting Deputy Head of Procurement

Purpose of the report and summary of key issues:	The Trust is required each year to publish an annual statement setting out the steps they take to prevent modern slavery in their business and their supply chains. This is a requirement under section 54 (Transparency in Supply Chains) of the Modern Slavery Act 2015.	
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	N/A	
Report History:	Strategy Deployment Room (SDR) (May 2025) People & Culture Committee (May 2025)	
Recommendation:	The Board is asked to approve the publishing of this statement.	

Modern Slavery and Human Trafficking Annual Statement

Harrogate and District NHS Foundation Trust is committed to ensuring that there is no modern slavery or human trafficking in any part of our business, including our supply chains.

The aim of this statement is to demonstrate that the Trust follows best practice and that all reasonable steps are taken to prevent slavery and human trafficking.

Policies relating to Modern Slavery

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility for overall compliance.

The Trust has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking. The Trust's internal Safeguarding Adults Policy and Procedures supports our staff to identify and report concerns about slavery and human trafficking.

Our Speaking Up policy and procedures also provide supportive guidance for our employees to raise concerns about poor working practices.

Our People

We confirm the identities of all new employees and their right to work in the United Kingdom and pay all our employees above the National Living Wage.

Our Supply Chain

Members of our Procurement team are Chartered of Institute of Purchasing and Supply (CIPs) qualified and abide by the CIPs code of professional conduct. The Procurement team follow all relevant Procurement laws regarding the Modern Slavery Act 2015 including the Crown Commercial Service standards.

When procuring goods and services, we additionally apply NHS Terms and Conditions (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.

Our Performance

We know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if:

No reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

Risks associated with this Act are managed in accordance with the Trust's Risk Management Policy.

Approval for this statement

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes the Harrogate and District NHS Foundation Trust slavery and human trafficking statement for the financial year ending 31 March 2025.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

Jonathan Coulter
Chief Executive

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)

Digital Framework

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

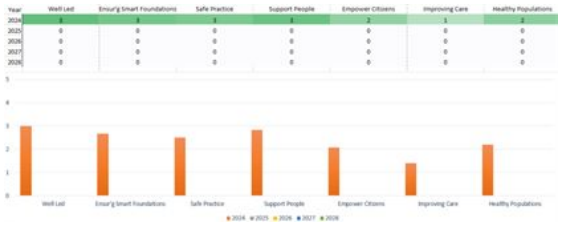
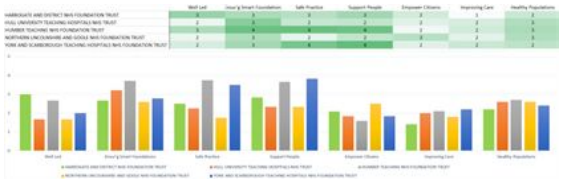
1

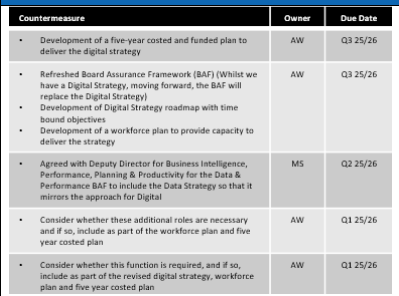
- achieve a score of 5/5 across all seven What Good Looks Like (WGLL) pillars

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	Current Status	Countermeasures	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 "What Good Looks Like" national programme 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.	Our ambition is to improve the organisations digital maturity that promotes best quality, safest care and now continues into its second year (2025-26). The first year (2024-25) focused on the delivery of several 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 and preparation for a new EPR. The key project priority for 2025/26 is the delivery of the new Nervecentre 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 (DMA) tool for both Acute and Community, with the next assessment being submitted by 9th May. Our WGLL current state is now being analysed, with opportunities for improvement being identified and to be planned over the coming years. The table below describes the results of our DMA submitted in Q1 24/25, and these will be updated once this year's results are published.  This also includes a comparison against our counterparts in HNY: 	Planning will be done on a pillar-by-pillar basis, initially focussing on the pillars with the greatest priority, where A3 thinking will be applied to each one. Where pillars are larger and more complex, multiple A3's may be required. Each A3 will include countermeasures for its respective pillar, with dates for delivery over the next five years. Improvements may need funding to deliver, so in these cases, business cases will be developed to secure funding.		

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
	Seven 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 leaders promote digitally enabled transformation to efficiently deliver safe, high quality care	As above	The responses to the Well Led pillar of the national DMA have been analysed and activities required to deliver improvements in 2025/26 have been prioritised, with countermeasures and a high-level plan agreed. These have been documented in an A3 Impact document for this pillar. This Digital BAF will replace the existing Digital Strategy, so any identified shortcomings in the Digital Strategy identified through the DMA, will now be included in the BAF moving forward. The requirement for a data strategy will be mirrored in the Data BAF. Work will be undertaken this year to produce longer term costed roadmaps that include workforce plans, with a view to secure funding. Next Steps: • 9th May – Submit the national Digital Maturity Assessment • May 25 – Mar 26 – Deliver agreed countermeasures (See table on the left) • July – National Digital Maturity Assessment results published 2024/25 results below – These will include the results for 2025/26 when published in July: 			
	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		Next Steps: • April – Agree Digital Maturity Assessment scores • 9th May – Submit the national Digital Maturity Assessment • May – Identify & agree priorities for Digital Maturity improvement for (Pillar & Domains) • May/June - Start A3 development and plan prioritised improvements • June Onwards - Deliver improvements • July – National Digital Maturity Assessment results published	The analysis of the current state of this pillar is to be planned, with A3 development and resulting countermeasures to follow.		
	Safe Practice - We maintain standards for safe care, as set out by		Next Steps: • April – Agree Digital Maturity Assessment scores • 9th May – Submit the national Digital Maturity Assessment	The analysis of the current state of this pillar is to be planned, with A3 development and resulting countermeasures to follow.		

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
	the Digital Technology Assessment Criteria for health & social care (DTAC) & routinely review system-wide security, sustainability & resilience		• May – Identify & agree priorities for Digital Maturity improvement for (Pillar & Domains) • May/June - Start A3 development and plan prioritised improvements • June Onwards - Deliver improvements • July – National Digital Maturity Assessment results published			
	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		Next Steps: • April – Agree Digital Maturity Assessment scores • 9th May – Submit the national Digital Maturity Assessment • May – Identify & agree priorities for Digital Maturity improvement for (Pillar & Domains) • May/June - Start A3 development and plan prioritised improvements • June Onwards - Deliver improvements • July – National Digital Maturity Assessment results published	The analysis of the current state of this pillar is to be planned, with A3 development and resulting countermeasures to follow.		
	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		Next Steps: • April – Agree Digital Maturity Assessment scores • 9th May – Submit the national Digital Maturity Assessment • May – Identify & agree priorities for Digital Maturity improvement for (Pillar & Domains) • May/June - Start A3 development and plan prioritised improvements • June Onwards - Deliver improvements • July – National Digital Maturity Assessment results published	The analysis of the current state of this pillar is to be planned, with A3 development and resulting countermeasures to follow.		
	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		Next Steps: • April – Agree Digital Maturity Assessment scores • 9th May – Submit the national Digital Maturity Assessment • May – Identify & agree priorities for Digital Maturity improvement for (Pillar & Domains) • May/June - Start A3 development and plan prioritised improvements • June Onwards - Deliver improvements • July – National Digital Maturity Assessment results published	The analysis of the current state of this pillar is to be planned, with A3 development and resulting countermeasures to follow.		
	Healthy Populations - We use data to design & deliver improvements		Next Steps: • April – Agree Digital Maturity Assessment scores • 9th May – Submit the national Digital Maturity Assessment	The analysis of the current state of this pillar is to be planned, with A3 development and resulting countermeasures to follow.		

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
	to population health & wellbeing, making best use of collective resources. Insights from data are used to improve outcomes & address health inequalities		• May – Identify & agree priorities for Digital Maturity improvement for (Pillar & Domains) • May/June - Start A3 development and plan prioritised improvements • June Onwards - Deliver improvements • July – National Digital Maturity Assessment results published			

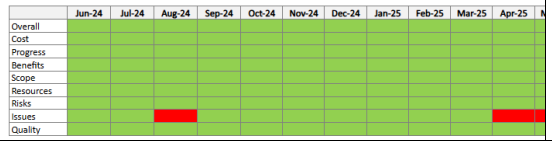
Breakthrough Objective:

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

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
None relevant at present						

Strategic Programme: Electronic Patient Record

True North Metric	Vision	Goal	Current Status	Countermeasures	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. Issues are currently showing red as there are three high issues without resolutions in place. These relate to activities which are currently behind plan and are being worked through. The go lives for Tranche 1 in October 25 and Tranche 3 in March 26 are still on track but now at risk due to these issues. 			

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

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 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

Ambition 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	Current Status	Countermeasures	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 3 x Clinical Entrepreneur Fellowship Scheme 2 external innovations 2 internal innovations	-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. -Innovation Hub official launch complete – April 2024 -Partnership formed with UoY and IRIS to develop Health Innovation Network in region – application to Mayoral Investment Fund to support this activity (in process)	Support offer for internal and external innovations Robust governance procedures Innovation Hub Culture of Innovation		
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 .	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. No report this month due to ODP system from RRDN not being refreshed since end of last financial year. Will resume next month. Countermeasures are noted.	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		

			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. On track and reviewing GCP training numbers increase Year on Year for 0-19 trust staff. Developing system for collating info through learning hub. PRES feedback target for RRDN overall (TBC for 25/26) is achieved and a percentage (10%) comes from 0-19 research participants RRDN not confirming target for PRES until June 25, may need to review system to collate 0-19 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.	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. No report this month as RRDN system has not refreshed stats / performance from year end. Stats report will resume next month. Risk of delay in CRF space and delivery / governance resources may mean delays in increasing commercial studies opening. List of partnership outcomes achieved: Agreed sharing of training and development resource with BDFT re commercial research delivery. UOY agreed collaboration of research studies when MRI up and running Numbers and impact of patient engagement. . Not started this project yet due to lack of resources Countermeasures are noted.	Contractual arrangements with Yorkshire & Humber Research Delivery Network Partnerships via WYATT, NSO and academic and commercial alliances		

Breakthrough Objective

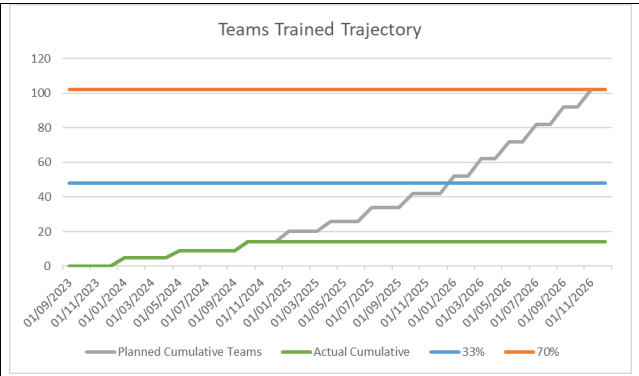
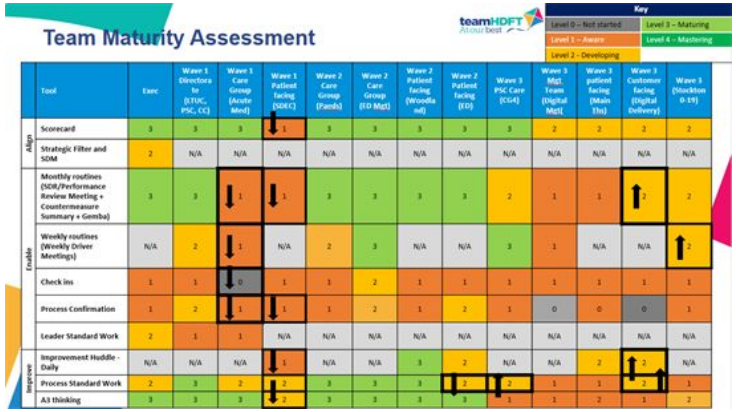
True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
None relevant at present						

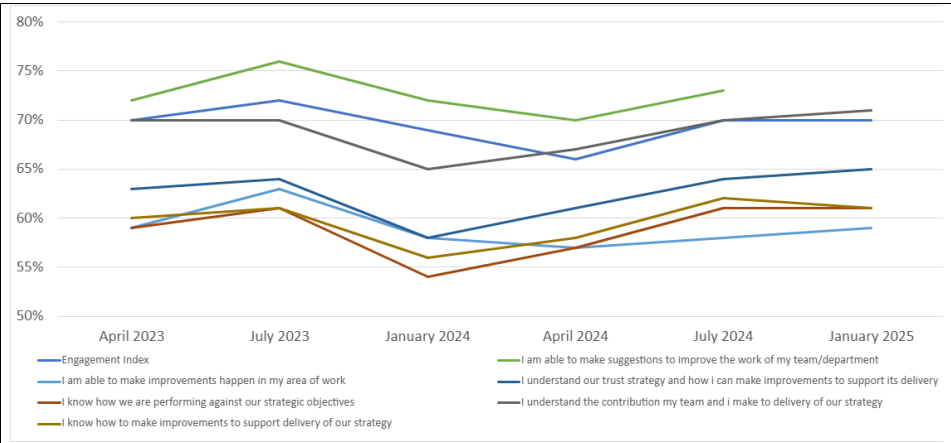
Corporate Project: 3T MRI and CRF

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality Safest Care: Healthcare Innovation 	To have outstanding MRI technology and associated facilities that enable the delivery of our research and innovation ambitions	Procure and install a new 3T MRI scanner.	Scoping phase on track	Supplier specification documents sent to HIF with a request for M&E to obtain a feasibility review on potential locations. MRI Subject Matter Experts consulted on the schedule of accommodation. Capital Planning met with Procurement to update and discuss the potential of the project, including potential costs and supplier engagement. Scheduled meeting with Leeds Research Unit to gain lessons learnt regarding staffing models, training and recruitment, clinical requirements, and suitable research options.		

Strategic Project: HDFT Impact

True North Metric	Vision	Goal	Current Status	Countermeasures	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	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).	Strategy Deployment Governance and Operational Delivery Plan Impact Improvement Operating Model HDFT Impact training strategy		

		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 how I can make improvements to support its delivery' by Mar 2026.	 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)	and updated operational delivery plan including data skills for impact. Improvement Academy capacity and capability development. Impact Communications Strategy and operational delivery.		

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						

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

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

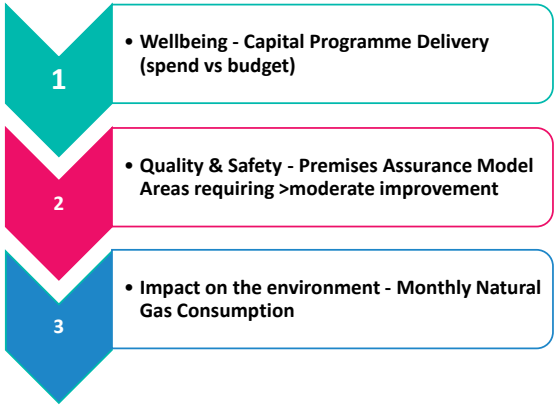
An environment and equipment that promotes best quality, safest care

Environmental Impact

Minimise our impact on the environment

GOVERNANCE:

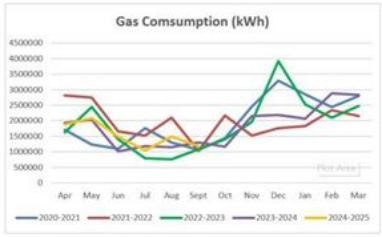
Enabling Ambition Metrics (Executive Lead: 10-15 Year deliverable)



Breakthrough Objective:	N/A
Corporate Project:	Block C Theatres & Imaging
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	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	Current Status	Countermeasures	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)	• 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.	• Deliver 2025/26 Capital Programme (Medium/Minor Schemes) • Deliver Block C Theatres & Imaging Corporate Project (see Corporate Projects below)		
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.	• 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.	• 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		
Environmental Impact 	Minimise our impact on the environment	HDFT to be carbon net zero by 2040 	• 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.	• 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.		

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 / ID 115 & 116	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	1 x 4 = 4 June 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 Oct 25	Operational: Health & Safety	Minimal
CRR98 / ID 264	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 1 = 3 Sept 25	Operational: Health & Safety	Minimal
CRR102 / ID 577	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 Sept 25	Operational: Health & Safety	Minimal
ID117	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

Related External Risks

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

TRUST BOARD (in Public)

28th May 2025

Title:	Committee Membership – Non-executive Directors
Responsible Director:	Sarah Armstrong, Chair of HDFT
Author:	Kate Southgate, Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	The report provides the Trust Board with updates on changes to Non-executive Directors on Sub-Committees of the Board.	
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 approve the Non-executive director membership of each Board sub-committee as outlined in this report.	

Freedom of Information:	Paper can be made available under the Freedom of Information Act once published on the HDFT website.

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

28TH MAY 2025

Non-Executive Director Board Committee Membership from May 2025

With the natural turnover of Non-Executive Directors and the ongoing changes to the duties and responsibilities of each committee as outlined in their Terms of Reference following the introduction of the new Committee and Board format resulting from HDFT Impact work, the Non-Executive Director membership has also been updated to accommodate these changes. The following arrangements have been put in place in the past few months and, as they are working well, the Board is now formally requested to approve the Non-Executive Director memberships from May 2025.

Non-executive Director Committee Membership from February 2025			
Committee	Audit Committee	Charitable Funds Committee	Innovation Committee
Committee Chair	Chiara De Biase	Sarah Armstrong	Wallace Sampson
Non-executive Director (NED) Members	Jeremy Cross	Julia Weldon	Chiara De Biase
	Laura Robson		
Committee	People and Culture Committee	Quality Committee	Resources Committee
Committee Chair	Andy Papworth	Laura Robson	Jeremy Cross
Non-executive Director (NED) Members	Laura Robson	Julia Weldon	Chiara De Biase
	Julia Weldon	Denise Chong	Andy Papworth
	Denise Chong		Azlina Bulmer (Associate NED)
	Azlina Bulmer (Associate NED)		

NOTE: In addition, the Trust has engaged in the Gatenby Sanderson Insight programme for the development of Non-Executive Directors. Whilst not fulfilling a formal role within the organisation, Sarah Shaw will be observing the Trust's work for up to a 12 month period from December 2024.

Harrogate Healthcare Facilities Management Limited

In addition, the shareholder directors on the Harrogate Healthcare Facilities Management Limited Board of Directors are now:

- Matt Graham
- Jeremy Cross

Sarah Armstrong
Chair
May 2025

TRUST BOARD (in Public)

28th May 2025

Title:	Self-certification with regard to the Provider Licence and Review of Compliance with the NHS Foundation Trust Code of Governance
Responsible Director:	Jonathan Coulter, Chief Executive Officer
Author:	Kate Southgate, Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	This report provides the proposed content of the Provider Licence and the review of compliance with the NHS Foundation Trust Code of Governance for approval.	
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:	Non noted	
Report History:	The Report was reviewed by the Audit Committee on the 7th May 2025.	
Recommendation:	The Board is recommended to approve the Compliance declaration.	

Freedom of Information:	Available following approval at the Trust Board in Public

TRUST BOARD (in Public)

Self-certification with regard to the Provider Licence and Review of Compliance with the Code of Governance for NHS Providers

28th May 2025

1.0 INTRODUCTION

NHS Foundation Trusts are required to self-certify annually whether or not they have complied with the conditions of the NHS provider licence. In addition, NHS England (NHSE) requires the Trust to make a number of governance declarations which are certified by the Board of Directors.

NHS England (NHSE) replaced the *NHS Foundation Trust Code of Governance* on 1st April 2023 with the *Code of Governance for NHS Provider Trusts.*

The declarations required in relate to the following conditions of the licence are:

1. Condition GS6(3): Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution by 31st May each year and publish this by 30 June each year.

2. Condition FT4(8): Providers must certify compliance with required governance standards and objectives by 30th June each year.

3. Section 151(5) of the Health and Social Care Act 2012 Training of Governors: Providers must review whether their governors have received enough training and guidance to carry out their roles. It is up to providers how they do this by 30th June each year

4. Conditions to support continuity of service (CoS7): Allows NHSE to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty by 31st May each year.

As reported to the Audit Committee and Board of Directors in 2023, the Guidance on Good Governance and Collaboration was enacted by NHSE in October 2022. Therefore the Trust is also required to review its compliance in relation to this guidance for 2024-25

The key characteristics and illustrative minimum behaviours and KLOEs have been added to the template the Trust has in place for seeking compliance with the Provider Licence (under condition FT4).

The Executive Lead is identified as the Chief Executive Officer, supported by his Executive Directors and the Associate Director of Quality and Corporate Affairs *(company secretary).*

This paper provides a summary of the Provider Licence, the contextual information and sources of assurance.

These documents are presented as follows:

- HDFT self-assessment of compliance with the Provider Licence Conditions (including the information required with regard to Good Governance and Collaboration) (Section 2 of this report and Appendix 1)
- Statements required to be confirmed by the Board and published by the Trust (Appendix 2)

The Board will be required to provide a specific declaration with regard to Condition FT4(8) of the provider licence in the form of the annual report. To support the self-certification against Condition FT4(8), the Board of Directors will be required to certify that they are satisfied with the risks and mitigating actions against each area listed.

The Annual Report will be presented to the Executive Management Team for sign-off prior to final submission to the Board for approval in June 2025.

2.0 SELF-CERTIFICATION

Condition GS6(3) Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution

From the assurance provided the Trust Board of Directors is required to certify that it "is satisfied that, during the financial year most recently ended, it has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution."

It is recommended as outlined in Appendix 1 that this is certified as **Confirmed**

Conditions to support continuity of service (CoS7)

"After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services." NB This declaration depends on the outcome of the financial planning process, therefore further information will be added in relation to the relevant factors once that process is complete.

It is recommended as outlined in Appendix 1 that this is certified as **Confirmed**

Section 151(5) of the Health and Social Care Act 2012 Training of Governors

From the assurance provided the Trust Board is required to certify that it "is satisfied that, during the financial year most recently ended, the Trust has provided necessary training to its governors, as required by S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."

It is recommended as outlined in Appendix 1 that this is certified as **Confirmed**

Condition FT4(8): Providers must certify compliance with required governance standards and objectives by 30th June each year.

Is subject to the above, and it is recommended that this is certified as **Confirmed**

3.0 RECOMMENDATIONS

The Board is recommended to:

- Confirm approval of the self-certification as outline in Section 2 of this report and in Appendix 1

Kate Southgate

Associate Director of Quality & Corporate Affairs

May 2025

Appendix 1 – Self Certification

Condition GS6(3) Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution			
The Trust is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.			
	Statement	**Response (and supporting information/ assurance)**	**Risks and Mitigations**
	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution	**Confirmed** Audit Committee received the draft annual accounts and the draft charitable accounts in late April 2025. A further review was undertaken in May 2025. The Trust's Internal Audit progress report highlighted that they believe that the Head of Internal Audit Opinion would confirm that "there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently". The Head of Internal Assurance Report is planned to be presented to the Audit Committee. This is a key piece of evidence to support compliance against this condition of the provider licence. Further evidence to support this condition includes the Board Workshops and Board meeting discussions on the Annual Plan 2024-25. This includes all known risks to compliance, risk reports presented to each Audit Committee and Board meetings, the development of the Board Assurance Framework supported by the Annual Assurance Framework Opinion from Internal Audit, Resource Committee reports, Quality Committee reports, the Integrated Board Reporting arrangements, the quality governance review and the development of the Corporate Governance Framework. The Trust's information processes provide the opportunity to review performance data across multiple domains, to improve the availability and accuracy of data and the flow of information and assurance through the governance structure.	No risks identified

Conditions to support continuity of service (CoS7)			
The Trust is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.			
	Statement	**Response (and supporting information/ assurance)**	**Risks and Mitigations**
	This condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.	**Confirmed** The Trust complies with this condition and has agreements and contracts in place with Commissioners to continue to provide services. Full details are contained in the Annual Report	No risks identified

Section 151(5) of the Health and Social Care Act 2012 Training of Governors			
The Trust is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.			
	Statement	**Response (and supporting information/ assurance)**	**Risks and Mitigations**
	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed** During the year a wide range of activities have taken place to ensure that Governors have required training. This has included: • Training, learning and development opportunities are available to Governors throughout the year and a comprehensive Governor induction programme is in place for new Governors. • All Governors have access to the external courses programme delivered by Governwell (the National Training Programme for Governors) which is routinely publicised amongst Governors • Communications from a range of sources, including the Kings Fund, NHS Providers, NHS England, CQC, WYAAT, ICB and the local Healthwatch are shared with Governors as appropriate to inform and support the development of their knowledge base with regard to the national and local health economy. • 4 x a year Public and Private Council of Governor meetings which include opportunities to raise key questions important to the wider membership, hear from Non-executive Directors on their roles as well as discussions on Committees of the Board. In addition in depth discussions and learning opportunities have been held prior to the meetings on: Patient Experience, Harrogate Integrated Facilities (the subsidiary company) and Health Inequalities. • Regular informal governor sessions where the Chair, Chief Executives and rotating executive directors meet with governors to brief them on key areas of business as well as respond to a wide range of questions have taken place as follows:	No risk identified

		• April 2024 – With a learning session on Finance in the NHS & Charitable Funds and an focused brief on EPR • July 2024 – With a learning session on PowerBI and the Integrated Board Report. • October 2024 – With a learning session on Counter Fraud and Internal Audit and a focused brief on Winter Planning. • January 2025 – With a learning session on the ICB and systems working. • All sessions included an opportunity for general questions and answers session. • Bespoke training, development and learning sessions have been held in year which have included: a welcome to new governors and a focus on the roles and responsibilities of governors. • 2 x governors observe each sub-committee of the Board • Weekly governor briefing via email	

Condition FT4(8): Providers must certify compliance with required governance standards and objectives			
The Trust is required to respond 'Confirmed' or 'Not confirmed' to the following statements, setting out any risks and mitigating actions planned for each one.			
	Statement	**Response (and supporting information/ assurance)**	**Risks and Mitigations**
1.	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Confirmed** The Annual Governance Statement (AGS) outlines the main arrangements in place to ensure the Trust applies the principles, systems and standards of good corporate governance expected of it as a provider of health and social care services. There is an internal audit programme including clinical audits in place, under the direction of the Audit Committee to ensure systems and processes are appropriately tested. The external auditors will deliver a robust annual audit plan reporting directly to the Audit Committee.	No risks identified
2.	The Board has regard to such guidance on good corporate governance as may be issued by NHS E from time to time.	**Confirmed** Declaration of compliance included in Annual Report; NHSE segmentation as per its Single Oversight Framework; Well Led assessment by the CQC last rated as "Good".	No risks identified
3.	The Board is satisfied that the Licensee implements: (a) Effective Board and Committee structures (b) Clear responsibilities for its Board, for Committees reporting to the Board and for staff reporting to the Board and those Committees; and	**Confirmed** The Board Committee structures reporting to the Board are defined and supported through a review of Committee Terms of Reference and reporting arrangements. The Board has formally delegated specific responsibilities to the Committees listed below: • Quality Committee • Resource Committee • Remuneration Committee	No risks identified

	(c) Clear reporting lines and accountabilities throughout its organisation.	• Audit Committee • People and Culture Committee • Innovation Committee The Trust's governance structure ensures the appropriate flow and review of information at service level and up through the Directorates to Strategy Deployment Room (SDR) formally Senior Management Team (SMT) and supporting groups, providing assurance to the Board and its Committees. The quality/clinical governance structure has been reviewed and revised, with Quality Governance Management Group playing a key role in this. The monthly SDR meeting provides scrutiny and monitoring of the Trust's Ambitions, operational performance, which supports the working of the Board's Committees. An internal audit review of governance through the working of the Board Assurance Framework was carried out during 2024-25, the report of which is expected in May 2025 to the Audit Committee noting High Assurance.	
	The Board is satisfied that the Licensee effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	**Confirmed** The Board's infrastructure includes Board scrutiny/assurance Committees and various operational groups, to ensure that the Board of Directors can be assured that the organisation's decisions and business are monitored effectively and efficiently. There are clear escalation routes up to the Board of Directors (as described above). b) SDR and supporting groups scrutinise key areas of performance including quality, workforce, finance, operational and contractual. The Committees review performance and risk by exception (and in accordance with ToR) at each meeting and subsequently provide assurance to the Board of Directors through the Chair's reports highlighting any key recommendations or key risks identified.	No risks identified

	(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	c) The Quality Committee reviews the patient experience and quality report, with quality performance data available and the Trust's compliance with CQC fundamental standards using an on-line tool to support service self-assessments against the CQC domains. An approved Quality Improvement and Audit Programme is in place, overseen by the Audit Committee. The Trust will also produce a Quality Account in accordance with regulatory requirements. This will be published in June 2025.	
	(d) For effective financial decision-making, management and control *(including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern*);	d) The Trust reviewed its Standing Financial Instructions (SFIs) in 2019/20 to reflect current procurement practices and to respond to COVID; this determines the agreed framework for financial decision making, management and control. Follow consideration by the Audit Committee and Board these temporary changes were made permanent in 2020/21. The SFIs have been reviewed in 2024-25 with further work planned for 2025-26. Systems of internal control are in place and are subject to regular audit on an annual basis through the Trust's internal audit programme and by external auditors. The Resource Committee and Audit Committee are the principal Committees that maintain oversight on this area. It is determined that there are robust systems and processes in place to monitor and oversee all CIP schemes. The Trust has a good track record of effective financial management and of achieving its statutory financial duties and this is of particular note during the COVID pandemic period.	
	(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	e) The Board and Committee meeting dates are scheduled to allow the most up-to-date information to be provided to meetings for scrutiny and assurance.	

		The Standing Orders for the Practice and Procedure of the Board of Directors enable the Chair to call a meeting of the Board at any time. The review of the quality governance framework as well as the introduction of the Corporate Framework is evidence of continued review and refresh required to ensure the information provided to the Board is timely and up to date.	
	(f) To identify and manage (*including but not restricted to manage through forward plans*) material risks to compliance with the Conditions of its Licence;	f) The Trust has an approved Risk Policy in place, the Board Assurance Framework (BAF) and Corporate Risk Register provide the framework through which risks are considered, reviewed and managed. The Board receives a summary of the Corporate Risk Register. The Board Assurance Framework forms the basis of the structure to Trust Board in Public and each section is reviewed at each Sub-Committee of the Board. The Audit Committee retains overall review of the process for the development of the BAF. The BAF had a full revision in 2024-25 to align to the HDFT Impact Programme. This is the principle tool used to oversee the progress of delivery against the Trust Strategy	
	(g) To generate and monitor NHS Improvement delivery of business plans *(including any changes to such plans*) and to receive internal and where appropriate external assurance on such plans and their delivery; and	g) The Trust has an Annual Planning process that ensures future business plans are developed and supported by appropriate engagement across the organisation. The Annual Plan is discussed in detail at the Resource Committee and by the Board before this is approved.	
	(h) To ensure compliance with all applicable legal requirements.	h) The governance, risk and control processes in place ensures that any risks to legal requirements are considered to ensure the Trust remains compliant.	

5.	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision making processes take timely and appropriate account of quality of care considerations; (c) There is collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account, as appropriate, views and information from these sources; and	**Confirmed** a) There are appraisal processes in place to support Board members individually and collectively. The outcome of appraisals are reported to the Remuneration Nomination and Conduct Committee for Non-executive Directors, including the Chair and to the Remuneration Committee for the Executive Directors including the Chief Executive. b) There are QIA and EIA processes in place to support decision making processes for any service development or changes and any impact on the quality of care is carefully considered. c) The Quality Committee supports the monitoring of information on the quality of care; the monthly SDR receive a performance report on the key quality metrics via the BAF reporting framework. The Quality Committee Chair reports any key decisions, risks and escalations to the Board. d) As above - the Board receives a report from the Quality Committee Chair and receives approved minutes of the Committee at the Board meeting held in private. The Board also receives the Quality Account. e) The Board, both Executive and Non-executive Directors play an active part in the organisation and the visibility of this was highlighted in the NHS Staff Survey. This has been further enhanced in year with a programme of "Meet the Executives" and Gembas (Walk-arounds) in place.	No risks identified

		Freedom to Speak Up arrangements were strengthened with the support of associate FTSUGs and champions, the "At Our Best" programme to support the cultural agenda, the health and well-being offer was particular strengthened, which was all overseen by People and Culture Committee. In addition, further resource was allocated to the role with a full time Guardian in the process of being recruited to at the time of writing. One of the Non-executive Directors (NED) is nominated as a NED lead to support 'Freedom to Speak Up' for the Trust and the Executive Director of Nursing, Midwifery and AHPs support the assurance arrangements in place to provide advice and support to the Board as necessary. The members of the Board, meet with the Council of Governors formally 4 times a year with additional informal meetings being held. Ad hoc activities are also programmed in throughout the year.	
	(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	f) There is clear accountability for quality of care through the governance structures in place across the Trust, which reported to the Executive Director of Nursing, Midwifery and AHPs and the Executive Medical Director supported by the Associate Director of Quality and Corporate Affairs.	
6.	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed** All members of the Board, Clinical Directors, relevant Deputy Directors and those that carrying out a role to provide advice to the Board comply with the requirements of the Fit and Proper Persons Regulation. All members of the Board and senior decision makers are required to comply with the declaration of interests including loyalty interest policy, which was refreshed and processes and systems strengthened during the year.	No risks identified

		The annual appraisal process supports effective succession planning through talent conversations and a number of senior managers are engaged in national programmes to support their development to Director level, as appropriate. The Board of Directors during the year had considered its development needs discussing through its Board Workshops. External facilitation was engaged to support the Board development agenda throughout the year.	

Appendix 2 – Statements Required to be Confirmed by Board by May and June 2025

1. Statements required to be confirmed by Board by 31 May 2025

G6 Declaration

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

CoS7 Declarations

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

2. Statements required to be confirmed by Board by 30 June 2025

FT4 Declaration

1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time

3. The Board is satisfied that the Licensee has established and implements: a. Effective board and committee structures; b. Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c. Clear reporting lines and accountabilities throughout its organisation.

4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:

a. To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

b. For timely and effective scrutiny and oversight by the Board of the Licensee's operations;

c. To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

d. For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

e. To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making

f. To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

g. To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h. To ensure compliance with all applicable legal requirements.

5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:

a. That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

b. That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

c. The collection of accurate, comprehensive, timely and up to date information on quality of care;

d. That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

e. That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

f. That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

3. Certification on Training of Governors in accordance with s151(5) of the Health and Social Care Act 2012

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

TRUST BOARD in Public

28th May 2025

Title:	**Pledge to the Code of Conduct, Nolan Principles and HDFT Kite Values**
Responsible Director:	Sarah Armstrong, Chair Jonathan Coulter, Chief Executive
Author:	Kate Southgate, Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	Governance principles are set out in the Nolan Principles: The Seven Principles of Public Life, which sets out the behaviours of senior leaders and Boards of Directors. This is supported by the Health and Social Care Act Regulation 2015 which sets out the requirements for NHS bodies to meet the Fit and Proper Person Test as well as supporting the principles of Duty of Candour which should ensure that the Trust is open, honest and transparent. All NHS Boards and Council of Governors are required to have a Code of Conduct that underpins the behaviours of members. The Trust Board are annually invited to endorse their support to the Code of Conduct for Directors at HDFT.	
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:	No Corporate Risk associated with this paper	
Report History:	The Board reviews and receives this annual declaration each year.	
Recommendation:	The Trust Board are recommended to endorse the Board of Directors Code of Conduct and ensure all Directors of HDFT sign the declaration.	

Freedom of Information:	Available once published as part of Trust Board in Public papers.

8.4

TRUST BOARD (in Public)

PLEDGE TO CODE OF CONDUCT, NOLAN PRINCIPLES AND HDFT KITE VALUES
28th May 2024

1.0 INTRODUCTION

Governance principles are set out in the Nolan Principles: The Seven Principles of Public Life, which sets out the behaviours of senior leaders and Boards of Directors. This is supported by the Health and Social Care Act Regulation 2015 which sets out the requirements for NHS bodies to meet the Fit and Proper Person Test as well as supporting the principles of Duty of Candour which should ensure that the Trust is open, honest and transparent.

All NHS Boards and Council of Governors are required to have a Code of Conduct that underpins the behaviours of members.

The Trust Board are annually invited to endorse their support to the Code of Conduct for Directors at HDFT.

The Council of Governors are bi-annually invited to endorse their support to the Code of Conduct for Governors and the wider Council at HDFT.

2.0 BOARD OF DIRECTORS - CODE OF CONDUCT

The Board of Directors – Code of Conduct is detailed in full at Appendix 1.

3.0 RECOMMENDATIONS

The Board are recommended to endorse the Board of Directors Code of Conduct and ensure all Director of HDFT sign the declaration.

Kate Southgate,
Associate Director of Quality and Corporate Affairs

May 2025

Harrogate and District NHS Foundation Trust
Board of Directors – Code of Conduct

1. Introduction

High standards of corporate and personal conduct are an essential component of public service enabling public confidence and assurance. The purpose of this Code of Conduct ('the Code') is to provide clear guidance on the standards of conduct and behaviour expected of all directors.

As an NHS Foundation Trust, Harrogate and District NHS Foundation Trust (HDFT) complies with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice. The HDFT Board of Directors is a unitary Board, meaning that Directors have equal and shared accountability. This code also applies to non-voting Associate Directors who attend Board of Director meetings.

The purpose of this Code is to provide clear guidance on the standards of conduct and behaviour expected of all Directors. It seeks to outline the appropriate conduct for Directors of Harrogate and District NHS Foundation Trust ('the Trust'). It addresses both the requirements of office and of personal behaviour.

This Code, with the Board Code of Conduct and the NHS constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Trust. The Code is intended to operate in conjunction with the Trust's Constitution, Standing Orders and the Code of Governance for NHS Foundation Trusts. The Code applies at all times when Directors are carrying out the business of the Trust or representing the Trust.

2. Compliance, interpretation & concerns

All Directors are required to give an undertaking that they will comply with the provisions of this Code. Questions and concerns about the application of the Code should be raised with the Company Secretary. The Chair will be the final arbiter of interpretation of the Code.

3. Principles of public life

The principles underpinning this Code of Conduct are drawn from the 'Seven Principles of Public Life'[1] as follows:

- ***Selflessness*:** Holders of public office should act solely in terms of the public interest.
- ***Integrity*:** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- ***Objectivity*:** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

1. 1 https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--

- ***Accountability*:** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- ***Openness*:** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- ***Honesty*:** Holders of public office should be truthful.
- ***Leadership*:** Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

4. The Trust's vision & values

The Trust's purpose is "the patient and child first", meaning improving the health and wellbeing of our patients, children and communities. To do this the Trust's ambitions are to provide:

- Best quality, safest care;
- Person-centred, integrated care; strong partnerships;
- A great start in Life.

The Trust's values lie at the heart of who we are, what we do, and the culture we want to establish, having a direct impact upon both colleagues and the public we service.

Our KITE values are:

- ***Kindness*** - We show compassion, and are understanding and appreciative of other people.
- ***Integrity*** - We display personal and professional integrity, are honest and bring a positive attitude.
- ***Teamwork*** - We are helpful to each other, listen intently and communicate clearly.
- ***Equality*** - We show respect, we are inclusive and we act fairly

5. General principles, directors' duties and liabilities

Foundation Trust Boards' of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board of Directors, and of each director individually, is to:

- Promote the success of the organisation so as to maximise the benefits for the members of the organisation as a whole and for the public.
- Work with the Trust's Council of Governors in an open and transparent way and observe and embed of a duty of candour throughout the organisation.
- Set an example in the conduct of its business and to promote the highest corporate standards of conduct.
- Ensure that the provisions of the Constitution, the Standing Orders, Standing Financial Instructions and accompanying scheme of delegation conform to best practice and serve to enhance standards of conduct. The Board of Directors expects that this code will inform and govern the decisions and conduct of all Directors.

6. Confidentiality and access to information

Directors must comply with the Trust's confidentiality policies and procedures. Directors must not disclose any confidential information, except in specified lawful circumstances, and advisably, only in consultation with the Company Secretary.

Information on decisions made by the Board of Directors and information supporting those decisions should be made easily available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and Directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

The Board of Directors has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by Board of Directors.

Nothing said in this code precludes Directors from making a protected disclosure within the meaning of the Public Disclosure Act 1998. The Company Secretary or the Freedom to Speak Up Guardian should be consulted for guidance.

7. Fit and proper person

It is a condition of the Trust's licence that each Director serving on the Board of Directors is a 'fit and proper person'. A person may not continue as a member of the Board of Directors if they are:

(a) a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged,
(b) a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it,
(c) a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her,
(d) subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986.

Directors must certify on appointment, and each year, that they are/remain a fit and proper person. If circumstances change so that a Director can no longer be regarded as a fit and proper person, or if it comes to light that a Director is not a fit and proper person, they are suspended from being a Director with immediate effect pending confirmation and any appeal. Where it is confirmed that a Director is no longer a fit and proper person, their membership of the Board of Directors is terminated in accordance with the Constitution.

8. Register of interests

Directors are required to register all relevant interests in the Trust's register of interests in accordance with the provisions of the Constitution and the Trust's Conflicts of Interest Policy. It is the responsibility of each Director to provide an update to their register entry (within 7 days) if their interests change. A pro forma is available from the Company Secretary. Failure to register a relevant interest in a timely manner may constitute a breach of this Code.

9. Conflicts of interest

Directors are required to comply with the Trust's Conflicts of Interest Policy. In particular, Directors must avoid a situation in which they have a direct or indirect interest that conflicts or may conflict with the interests of the Trust. Directors must not accept a benefit from a third party by reason of being a Director for doing (or not doing) anything in that capacity. Directors must not offer a benefit to a third party by reason of being a Director for doing (or not doing) anything in that capacity.

Directors are required to declare the nature and extent of any interest at the earliest opportunity. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. It is then for the Chair to advise whether it is necessary for the Director to refrain from participating in discussion of the item or withdraw from the meeting. Failure to comply is likely to constitute a breach of this Code.

10. Gifts & hospitality

The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Foundation Trust budget for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Foundation Trust in the eyes of the community.

The Board of Directors has adopted a policy on gifts and hospitality (The Conflicts of Interest Policy) which will be followed at all times by Directors. Directors must not accept gifts or hospitality other than in compliance with this policy.

11. Whistle-blowing / Speaking Up

The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature and positively establishes a culture for sharing concerns. The Board of Directors has adopted a Speaking Up (whistle-blowing) policy on raising matters of concern which will be followed at all times by Directors and all staff.

12. The Bribery Act 2010

The Board of Directors will ensure that it acts at all times in compliance with the Bribery Act 2010, acknowledging that it is a criminal offence to give, promise, or offer a bribe and to request, agree or receive a bribe.

13. Meetings

Directors have a responsibility to attend meetings of the Board of Directors and of any committees or working groups to which they are appointed. When this is not possible, apologies should be submitted to the Company Secretary in advance of the meeting. Persistent absence from Board of Directors' meetings without good reason is likely to constitute a breach of this Code.

14. Personal conduct

Directors are expected to adopt and promote the values of the Trust and the NHS. Moreover, Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute. Specifically, Directors must:

- Treat each other, Directors and Trust staff with respect; not breach the equality rights and not bully any person.
- Not seek to use their position improperly to confer an advantage or disadvantage on any person and must comply with the Trust's rules on the use of its resources.
- Uphold the seven principles of public life (see above).
- Be honest and act with integrity and probity at all times;
- Respect and treat with dignity and fairness, the public, service users, relatives, carers, NHS staff and partners in other agencies.
- Seek to ensure that fellow Directors are valued as colleagues and that judgements about colleagues are consistent, fair and unbiased and are properly founded;
- Accept responsibility for their actions.
- Show their commitment to working as a team member by working with colleagues in the NHS and wider community.
- Seek to ensure that the membership of the constituency they represent is properly informed and able to influence services.
- Seek to ensure that no one is discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social or economic status or national origin.
- Comply with the Standing Orders and Standing Financial Instructions of Harrogate and District NHS Foundation Trust.
- Respect the confidentiality of individual patients and comply with the confidentiality policies of the Trust.
- Not make, permit, or knowingly allow to be made, any untrue or misleading statement relating to their duties or the functions of the Trust.
- Seek to ensure that the best interests of the membership, general public, service users, stakeholders and staff are upheld in decision making and the decisions are not improperly influenced by gifts or inducements.
- Acknowledge that Harrogate and District NHS Foundation Trust is an apolitical organisation.
- Support and assist the Accountable Officer of the Trust in their responsibility to answer to the Independent Regulator, Commissioners and the public in terms of fully faithfully declaring and explaining the use of resources and the performance of the total NHS in putting national policy into practice and delivering targets.
- Must have regard to advice provided by the Chair, Chief Executive and Company Secretary pursuant to their duties.

It is essential that the conduct and behaviour of Directors at all times support the ethos and values of the Trust. Should there be any concern about the activities of a Director the nature of which might undermine public confidence then the Chair's decision on that person's role will be final.

15. Training & development

The Trust is committed to providing appropriate training and development opportunities for Directors to enable them to carry out their role effectively. Directors are expected to undertake to participate in training and development opportunities that have been

identified as appropriate for them. To that end, Directors will participate in the appraisal process and any skills audit carried out by the Trust.

16. Visits to Harrogate and District NHS Foundation Trust Premises or other services provided by the Trust

Where Directors wish to visit the premises or services of Harrogate and District NHS Foundation Trust in a formal capacity, as opposed to individuals in a personal capacity, the Director should make arrangements in advance.

17. Review and revision of the Code

This Code has been agreed by the Board of Directors on *26 July 2023.* The Company Secretary will lead an annual review of the Code. It is for the Board of Directors to agree to any amendments or revisions to the Code.

18. Declaration

I hereby confirm that I will adopt and comply with this Code of Conduct for the Board of Directors.

Signed: Name:

…… ……

Date: ……..…