DRAFT/Board of Directors Meeting Held in Public

To be held on Wednesday, 26 November 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**	Director of Nursing, Midwifery and AHPs	Discuss	Verbal
1.3	**Register of Interests and Declarations of Conflicts of Interest**	Chair	Note	Attached
1.4	**Minutes of the meeting held on 24th September 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 1.7.1	**Chief Executive's Report** • Corporate Risk Register	Deputy Chief Executive	Note Note	Attached Supp. Pack Attached
SECTION 2: Ambition: Best Quality, Safest Care				
2.1	**Board Assurance Framework:** Best Quality, Safest Care	Director of Nursing, Midwifery and AHPs & Quality Committee Chair	**Approve**	Attached
2.2	Quarterly Report: Learning from Deaths (Quarter 2: July – Sept 2025)	Executive Medical Director	Note	Supp. Pack Attached
2.3	Safeguarding Annual Report	Director of Nursing, Midwifery and AHPs	Note	Supp. Pack Attached
2.4	Safer Staffing Report	Director of Nursing, Midwifery and AHPs	Note	Supp. Pack Attached
2.5	Nursing and Midwifery Quality and Safe Staffing Report	Director of Nursing and Midwifery and AHPs	Note	Supp. Pack Attached

Item No.	Item	Lead	Action	Paper
SECTION 3: Ambition: Great Start in Life				
3.1	**Board Assurance Framework:** Great Start in Life	Director of Nursing, Midwifery and AHPs & Quality Committee Chair	**Approve**	Attached
3.2	**Strengthening Maternity and Neo-Natal Safety**	Director of Nursing, Midwifery and AHPs / Associate Director of Midwifery	Note	Attached
SECTION 4: Ambition: Person Centred; Integrated Care; Strong Partnerships				
4.1	**Board Assurance Framework:** Person Centred; Integrated Care; Strong Partnerships	Chief Operating Officer & Deputy Chief Executive/ 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	Freedom to Speak Up Guardian Annual Report	Director of Nursing, Midwifery and AHPs	**Note**	Supp pack Attached
5.3	Guardian of Safe Working Hours Quarter 2 Report	Executive Medical Director	**Note**	Supp pack Attached
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: BAF Summary and Escalation from Committees				
7.1	**Escalation from Sub-Committees of the Board**	All Executive and Non-Executive Directors	Discuss	Verbal

Item No.	Item	Lead	Action	Paper
SECTION 8: Governance Arrangements				
8.1	Emergency Preparedness Resilience and Response Report 2025-26	Chief Operating Officer/Accountable Emergency Officer	Note	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 28th January 2026 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 on our website. Minutes of this meeting will also be published in due course on our website.

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Board of Directors – Register of Interests

As at 1st November 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 August 2025	April 2024 Current Current Current August 2025 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) 6. Trustee, Healthcare Quality Improvement Partnership (Charity number 1127049)
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
Denise Chong	Interim Non-executive Director	March 2025	Current	1. Trustee, Learning Partnerships Leeds (Feb 2023) 2. Member, Kaleidoscope Learning Trust (KLT) (Dec 2023)
Breeda Columb	Executive Director of Nursing, Midwifery & AHPs	June 2025	Current	1. Familial relationship with a Leeds Teaching Hospitals NHS Trust employee
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

Board Member	Position	Relevant Dates From	To	Declaration Details
				3. Director and Shareholder, Cross Consulting Ltd (dormant) 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
Colin Melville	Non-Executive Director	September 2025	Current	1. Trustee, Faculty of Medical Leadership and Management 2. Fellow, Royal College of Physicians, London 3. Fellow, Royal College of Anaesthetists 4. Fellow, faculty of Intensive Care Medicine 5. Honorary Fellow, Academy of Medical Educators 6. Senior Fellow, Faculty of Medical Leadership and Management 7. Honorary Professor, University of Manchester 8. Visiting Professor, Anglia Ruskin University 9. Nephew is an employee of HDFT (non-decision maker)

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Board Member	Position	Relevant Dates From	To	Declaration Details
Russell Nightingale	Chief Operating Officer & Deputy Chief Executive	April 2021	Current	10. Director of ILS and IPS Pathology Joint Venture
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 September 2023 October 2023 August 2024	Current Current Current March 2025 Current Current	1. Member of Society of Local Authority Chief Executives 2. Advisory Board Consultant – Commercial Service Kent Ltd. 3. Commissioner – Local Government Boundary Commission for England 4. Chair – Middlesbrough Independent Improvement Advisory Board. 5. Director and Shareholder – Sampson Management Services Ltd. 6. Member – Council of Governors, Leeds University
Julia Weldon	Non-executive Director	May 2024 September 2025	Current Current	1. Fellow of the Faculty of Public Health (FPH) FPH Assessor and Advisor 2. Associate of Local Government Association (LGA) 3. Director of Julia Weldon Executive Leadership Ltd
Angela Wilkinson	Director of People & Culture	October 2019	Current	1. Director of ILS and IPS Pathology Joint Venture

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

Name	Position	Declaration Details
Dr Zakyeya Atcha	Clinical Director (Children and Young People's Public Health)	No interests declared
Emma Anderson	Associate Director of Nursing (Children and Young People's Public Health)	No interests declared
Rob Armstrong	Deputy Chief Operating Officer	No interests declared
Rob Eames	Deputy Director of People & Culture	No interests declared
Dr Dave Earl	Deputy Medical Director	1. Medical Director of ILS and IPS Pathology Joint Venture 2. Treasurer, Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice
Emma Edgar	Clinical Director (Long term, Urgent, Cancer and Community)	No interests declared
Mike Forster	Operational Director (Children and Young People's Public Health)	1. Chair of King James and Knaresborough Tennis Club
Charly Gill	Associate Director of Nursing (Long term, Urgent, Cancer and Community)	1. Familial relationship with HDFT employee
Dr Katherine Johnson	Clinical Director (Planned, Surgical and Children's Care)	No interests declared
Sam Layfield	Operational Director (Planned, Surgical and Children's Care)	*(to be advised)*
Leanne Likaj	Associate Director of Midwifery (Planned, Surgical and Children's Care)	No interests declared
Jenny Nolan	Deputy Director of Nursing, Midwifery and AHPs	No interests declared
Karen Scarth	Deputy Director of Finance	No interests declared

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Name	Position	Declaration Details
Dr Matthew Shepherd	Deputy Director of Business Intelligence, Planning, Performance and Productivity	1. Director of Shepherd Property – company lease flat.
Dr Sarah Sherliker	Deputy Medical Director	1. Clinical Private Practice providing anaesthesia services (ad hoc very occasional) 2. Shareholder TheSmartTHING Ltd (49%)
Shirley Silvester	Deputy Director of People & Culture	No interests declared
Kate Southgate	Associate Director, Quality & Corporate Affairs	1. Familial relationship with Director in NHS England
Rachael Stray	Operational Director (Long term, Urgent, Cancer and Community)	No interests declared
Julie Walker	Associate Director of Nursing (Planned, Surgical and Children's Care)	No interests declared

Harrogate and District NHS Foundation Trust

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

Board Member	Position	Relevant Dates From	To	Declaration Details
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
Emma Nunez	Director of Nursing Deputy Chief Executive	April 2021	March 2025	1. No interests declared
Alison Smith	Interim Director of Nursing, Midwifery & AHPs	24 March 2025	June 2025	1. No interests declared
Julia Weldon	Non-Executive Director	November 2022	September 2025	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

BOARD OF DIRECTORS MEETING – PUBLIC (DRAFT)

Wednesday, 24th September 2025

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

Present:	
Sarah Armstrong	Trust Chair
Jonathan Coulter	Chief Executive
Colin Melville (CM)	Non-executive Director
Andy Papworth (AP)	Non-executive Director, Chair of People & Culture Committee
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
Sarah Shaw (SS)	Non-executive Director (Insight Programme)
Jacqueline Andrews	Executive Medical Director
Breeda Columb	Executive Director of Nursing, Midwifery and Allied Health Professionals
Matthew Graham	Director of Strategy
Jordan McKie	Director of Finance
Russell Nightingale	Deputy Chief Executive and Chief Operating Officer

In Attendance:	
Leanne Likaj	Associate Director of Midwifery
Kate Southgate	Associate Director of Quality and Corporate Affairs
Rob Eames	Deputy Director of People and Culture
Rachel Hewson	Corporate Affairs Team Leader
Jenny Nolan	Deputy Director of Nursing, Midwifery and AHPs *for the Patient Story*

Apologies:	
Jeremy Cross (JC)	Non-executive Director, Chair of Resource Committee
Chiara DeBiase (CD)	Non-executive Director, Chair of Audit Committee
Angela Wilkinson	Director of People & Culture

Observers:	
Governors	Jackie Lincoln
Member of the public / press	1
Colleagues	Rob Armstrong, Deputy Chief Operating Officer
External Partners	Kim Betts, Audit Yorkshire
	Sue Stanton, CQC Relationship Manager

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BD/09/24/1 **1.1**	**Welcome and Apologies for Absence** The Chair welcomed everyone to the meeting. The Chair made special reference to Rachel Hewson and Rob Eames for joining the meeting. Colin Melville, new Non-executive Director was welcomed to his first meeting of the Board.
1.2	The Chair thanked all observers for attending the Public meeting of the Trust Board.
1.3	Apologies for absence were noted as above.

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BD/09/24/2 **2.1**	**Patient Story** The Chair and the Director of Nursing, Midwifery and AHPs outlined the patient story which was shown via video.
2.2	"Jade" was 16 years of age when she was referred to the Family Nurse Partnership (FNP) and she was living at home. She was attending college and starting her A-levels when she found out she was pregnant. She was in an abusive relationship with her partner at the time of becoming pregnant.
2.3	The Family Nurse Partnership (FNP) is a national evidence-based programme. The aim of the programme is to improve the antenatal health, child health and development and parent's economic self-sufficiency in disadvantaged young families.
2.4	Family Nurses provide proactive, responsive and intensive support for first-time teenage mothers under 19, to ensure they '*become the best that they can be'* and mitigate potential health and wellbeing risks. They provide enhanced visiting until the child is 2 years old, visiting weekly during key times such as the first month of antenatal care, and for the first 6 weeks after the birth of the baby.
2.5	Jade told the Board via the video, how the FNP supported her and the difference it had made to her. Her Family nurse also described the impact of the programme on Jade and her son.
2.6	The Deputy Director of Nursing, Midwifery and AHPs updated the Board on the progress Jade had made since the video was made. The Board heard how following the support, Jade had been able to go back to gain her A-Levels and was now studying towards a degree.
2.7	The Non-executive Director (LR) noted the FNP was not in all areas as it was a specialist commissioned service.
2.8	The Non-executive Director (JW) noted the courage of Jade and the overarching message from Jade of feeling safe with the Family Nurse and the Family Hub. Noting that the early intervention programme had a significant impact on service users.
2.9	The Chief Executive noted that not all areas have a FNP and the ongoing discussions with partners on the importance of this evidence based programme.
2.10	**Resolved:** The patient story was noted.
BD/09/24/3 **3.1**	**Declarations of Conflicts of Interest and Register of Interests** The Non-executive Director (JW) noted a new interest in relation to owning a business: Julia Weldon Executive Leadership Ltd. They also noted that they were standing down as Director of Public Health.
3.2	**Resolved:** The register of interests was received and noted.
BD/09/24/4 **4.1**	**Minutes of the Previous Board of Directors meeting held on 30 July 2025** The minutes of the meeting were noted and a number of grammatical updates were made that did not substantially change the context of the minutes.
4.2	**Resolved:** The minutes of the meeting on the 30 July 2025 were approved as an accurate record of the meeting noting the amendments.

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BD/09/24/5 **5.1**	**Matters Arising and Action Log** The Director of Nursing, Midwifery and AHPs provided an update on a previous patient story from the July 2025 meeting. It was noted that the patient had sadly died. The thoughts of the Board were sent to Jane's family and friends as well as our colleagues who had supported her.
5.2	No further matters arising were raised which were not already noted on the agenda.
5.3	**Resolved:** All actions were agreed as above.
BD/09/24/6 **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 **6.3** **6.4** **6.5** **6.6** **6.7** **6.8** **6.9**	The Chair highlighted the following points: • Annual Members Meeting (AMM):– the AMM had taken place on the 22nd September 2025. Thanks were expressed to all who had contributed and attended a very successful event. • Non-executive Director recruitment: – a very successful recruitment campaign had been held and two new Non-executive Directors had been recruited. Colin Melville had joined the Board as a Non-executive Director with Medical experience. Andrew Alldred would be joining the Board in 2026 as a Non-executive Director with other Clinical experience. An update was also provided on the Associate Non-executive Director recruitment campaign. Thanks were expressed to Azlina Bulmer, Associate Non-executive Director who was stepping down from the role. • Appraisal process: – an in depth Non-executive Director appraisal process had taken place and thanks were expressed to all involved. • Winter planning: – The Trust's plans were underway and at the forefront of the Trust's current activity. • The new national league tables were acknowledged. The Non-executive Director (AP) noted how well the AMM had gone. It was noted that it would support greater attendance if the date was circulated earlier. **Resolved:** The Chair's report was noted.
BD/09/24/7 **7.1**	**Chief Executive Report** The Chief Executive presented his report as read. The following points were highlighted:
7.2 **7.3**	The first league tables for NHS Trusts were noted as having been published in month. It was confirmed that the tables were created using a wide range of indicators producing a score of between 1 (highest performing) and 4 (lowest performing). Overall HDFT had a score of 1.96 which was noted as being positive. It was however confirmed that due to the Trust holding a financial deficit, the score could not be greater than a 3 overall. It was highlighted that despite this adjustment, the Trust was 35th out of 134 similar organisations. In addition to the league tables, a self-assessment: *Provider Capability Assessment* is in the process of being completed and will be reviewed by the Board in October 2025.

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7.4	It was confirmed that the national maternity review had been officially announced with fourteen trusts selected for the focused review. HDFT had not been selected to be part of the review.
7.5	At the last meeting of the Public Board, the resident doctor industrial action had just concluded. It was reported that, following analysis, the impact on our patients had been minimal. It was noted that a national communication had been received from NHS England in respect of a 10 point plan to improve the working lives of resident doctors.
7.6	The Board were reminded of the CQC inspection into maternity services that had taken place in July 2025. The report was initially expected at the end of August 2025. It was now anticipated that it would be received in October 2025.
7.7	The CQC had released the results of the national annual in-patient survey. The Trust would be undertaking detailed analysis of the results, however it was confirmed that the results indicated that HDFT were 5th out of the 21 Trusts in the region.
7.8	The Trust had declared a Never Event in September 2025, further details of the investigation would be provided later in the meeting.
7.9	The provision of autism assessments in a timely way remained a significant risk to HDFT with ongoing discussions with commissioners taking place.
7.10	The Non-executive Director (WS) queried if the ICB structural change was fully funded and if there would be a cost implication for partners. It was confirmed that it was an ongoing discussion at a national level.
7.11	The Non-executive Director (AP) noted the Provider Capability Assessment and what are the implications and queried the links to the Well-Led assessments with the CQC. The Chief Executive noted that it was a self-assessment based on the Trust's own evidence. Discussions were ongoing at a national level regarding the support that would be provided to Trusts that require it. There were clear links with regulatory compliance. It was noted that this was the first year that the Assessment would take place and it was a process that would continue to develop.
7.12	The Non-executive Director (AP) queried if there had been any feedback on why the Trust and its partners had not been selected as part of the Neighbourhood Health Implementation Programme. It was confirmed that no feedback had been received.
7.13	The Non-executive Director (CM) noted that in relation to the 10 point plan for improving resident doctors working lives, that a response was due to be provided by mid-October. The importance of an open dialogue with our resident doctors was noted. The Medical Director confirmed that the organisation was in a strong position to respond on the local requirements.
7.14	**Resolved:** The Chief Executive's Report was noted.
BD/09/24/8 **8.1**	**Board Assurance Framework – Best Quality, Safest Care** The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Best Quality, Safest Care.
8.2	This Strategic Ambition had two True North metrics for 2025-26. The first metric was eliminating moderate and above harm. The second metric was an improved

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	positive patient experience, which had a corporate project linked to it: Patient Experience. Achievement in line with trajectory continued with both metrics. It was noted that given the publishing of the 10 Year Plan, the corporate project may change as a result.
8.3	The Ambition had no Breakthrough Objective in 2025-26 associated with it.
8.4	It was noted that both True North metrics were within the Trust's risk appetite (tolerance). There were no corporate risks associated with this ambition.
8.5	The Driver Metric for Moderate and Above Harm was on track to deliver, all watch metrics were within tolerance, however, it was noted that a Never Event had been declared.
8.6	The Driver Metric for Patient Experience in relation to our Friends and Family Test was on track to deliver and watch metrics remained within tolerance. The Corporate Project associated with this area was being realigned to focus on the development of a Trust wide Engagement Strategy.
8.7	The National In-patient Survey had been received and showed a positive trajectory. Further details had been provided to the Board in the supplementary pack.
8.8	The Chair of the Quality Committee noted that a strong discussion had taken place on the development of the Engagement Strategy at the Committee. The Chair of the Committee also noted that the Quarterly Report on Learning from Deaths had been discussed in detail and the positive trajectory of the SHMI noted.
8.9	The Director of Nursing, Midwifery and AHPs also noted the new Nursing and Midwifery Quality and Safe Staffing Report that had been discussed in detail at the Committee. The Board had received the full report as part of the Supplementary Papers.
8.10	**Resolved:** The Board Assurance Framework: Best Quality, Safest Care was noted and approved.
BD/09/24/9 **9.1**	**Learning from Deaths Quarterly Report (Quarter 1: April 25 – June 25)** **Resolved:** Following review at the Quality Committee, The Learning from Deaths Quarterly Report was noted.
BD/09/24/10 **10.1**	**National Inpatient Survey** **Resolved:** Following review at the Quality Committee, The National Inpatient Survey was noted.
BD/09/24/11 **11.1**	**Annual Report: Guardian of Safe Working** **Resolved:** Following review at the People and Culture Committee, The Guardian of Safe Working Report was noted.
BD/09/24/12 **12.1**	**Nursing and Midwifery Quality and Safe Staffing Report** **Resolved:** Following review at the Quality Committee, The Nursing and Midwifery Quality and Safe Staffing Report was noted.

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BD/09/24/13 **13.1**	**Board Assurance Framework – Great Start in Life** The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Great Start in Life.
13.2	This Strategic Ambition had two True North metrics for 2025-26:
13.3	**1. Early Intervention and Prevention**: Compliance reporting was now included in the metric which highlighted 42 out of 45 of Mandated Contacts delivered within timescales. With overall performance at 93.3%. An update was provided on recruitment in the Wakefield area.
13.4	**2. Child Patient Experience**: This was on track with an increasing number of surveys being returned each month. 928 responses received via the text messaging service was noted. A range of countermeasures were highlighted including changing the timing of when surveys would be sent out. A number of pilots of different methods would be undertaken over the next few months to determine which options provided a positive increase. 37 responses for face to face contacts were received. It was noted that this was a low response rate.
13.5	The Ambition had no Breakthrough Objective in 2025-26 associated with it.
13.6	All True North metrics were within the Trust's risk tolerance for 2025-2026.
13.7	There was one Corporate Risk associated with this ambition: CRR34: Autism Assessment which had been updated since the previous board meeting.
13.8	The Chair of the Quality Committee had nothing further from the Committee to note on this Ambition. It was highlighted however, that the Committee had discussed some potential difficulties in relation to the US stance on paracetamol and vaccinations.
13.9	**Resolved:** The Board Assurance Framework: Great Start in Life was noted and approved.
BD/09/24/14 **14.1**	**Strengthening Maternity and Neonatal Safety** The Associate Director of Midwifery presented the August 2025 Strengthening Maternity and Neonatal Safety Report to the Board.
14.2	The dashboard was highlighted and the metrics that were off track were noted. Two new risks were highlighted however it was noted that they did not meet the level for submission onto the Corporate Risk Register.
14.3	The report provided a summary and update on the board level safety measures for the month of August 2025 as set out in the Perinatal Quality Surveillance Model (Ockenden 2020).
14.4	A breach of compliance with the Maternity Incentive Scheme was noted.
14.5	It was confirmed that HDFT were the only Trust to have Gold Accreditation for both Neo-natal and Maternity Services.
14.6	The report provided details on: • Perinatal Culture and Leadership Programme Overview, • Maternity Unit Diverts,

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	• Avoiding Term Admissions in Neonatal Units (ATAIN) and Transitional Care provision report Quarter 1 • Saving Babies Lives Care Bundle Quarter 4, • Perinatal Mortality Review Tool (PMRT) Quarterly Report, and • Hospital Readmissions of babies within 30 days of life Quarter 1
14.7	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.
14.8	The Non-executive Director (AP) as Maternity Safety Champion noted that a walkaround had taken place since the last meeting of the Board. Positive discussions with the team were noted. Environmental factors had been raised which would be discussed with the Director of Finance.
14.9	The Associate Director of Maternity noted the recent recruitment in relation to both Midwives and Obstetricians.
14.10	The Chair of the Quality Committee highlighted that the Committee had been to Maternity Services for their Gemba earlier in the day. It had been a positive experience and excellent feedback had been received from colleagues. The Chair of the Committee also noted that the report had been discussed in detail at the Committee.
14.11	The Non-executive Director (WS) noted that a summary would be helpful due to the significant amount of detail in the report. The Chief Executive noted that the level of information required of the Board to consider would potentially be streamlined in the future.
14.12	The Chief Executive, on behalf of the Board, congratulated the Associate Director of Midwifery and the wider team on the strong quarterly staff survey results that had been received.
14.13	**Resolved:** The Strengthening Maternity and Neonatal Safety report was noted.
BD/09/24/15	**Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships**
15.1	The Chief Operating Officer provided the Board with an update on the Strategic Ambition: Person Centred, Integrated Care, Strong Partnerships.
15.2	The Strategic Ambition for 2025-2026 had four True North metrics.
15.3	**Metric 1: 4-Hour ED standards:**– It was noted that August had achieved 82% which was above plan. ED attendances were noted as 106% of our plan. A new Clinical Lead had commenced in post which would provide added support and leadership. A visit had also taken place to Calderdale and Huddersfield to review and learn from their SDEC model. The Trust was 7th in the Country for 4 hour performance and 3rd for 12 hour performance.
15.4	**Metric 2: Length of stay for frailty patients:**– the target was for HDFT to be within the top quartile for length of stay by 2027. Staff engagement with the Corporate Project of Patient Discharge continued at pace with positive progress noted. A gastro ward was being introduced as part of winter planning which would support this element of the workstream.

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15.5	**Metric 3: Elective Recovery Standard (RTT):**– the target was for 72% of patients to be treated within 18 weeks by March 2026. In August 71% was achieved which was above trajectory. The Trust was 7th in the Country. The Trust was on target to achieve the target, noting the countermeasures provided in the BAF.
15.6	**Metric 4: Cancer 62-day treatment standard:**– the target was for 85% of patients to be waiting less than 62 days for treatment. Currently the Trust was at 82% in August 2025. The metric was on track to deliver. A wide range of countermeasures were noted with a focus on theatre utilisation and improvements around breast performance.
15.7	There were two Breakthrough Objectives linked to this Ambition: Time to move to medical bed from decision to admit in the Emergency Department and Reduce Follow Up Activity. Both were on track.
15.8	There were two Corporate Projects linked to this Ambition: Bed Capacity and Patient Discharge. Both noted some risk to delivery.
15.9	The Corporate Risks related to this Ambition were highlighted. The risk in relation to diagnostics was highlighted and a Corporate Project had been introduced led by the Chief Operating Officer and the Director of Finance to support mitigation of this risk.
15.10	There was nothing further to add from the Non-executive Director (AP) who had chaired Resource Committee.
15.11	The Non-executive Director (WS) noted the RTT target for 2027 and the step change required. The Chief Operating Officer noted that commissioning of services was being discussed to support the trajectory. Countermeasures in relation to Ophthalmology and Trauma and Orthopaedics were noted.
15.12	The Non-executive Director (CM) queried if the teams themselves had belief that the target could be achieved. The Chief Operating Officer noted that the team had been involved in the development of the target and setting of the trajectory via the HDFT Impact programme.
15.13	**Resolved:** The Board Assurance Framework: Person Centred, Integrated Care, Strong Partnerships was noted and approved.
BD/09/24/16 **16.1**	**Board Assurance Framework – Finance** The Director of Finance provided the Board with an update on the Strategic Ambition: Overarching Finance 2025-26.
16.2	The Strategic Ambition, Overarching Finance for 2025-2026, had two True North Objectives: Annual Breakeven and Strategic Oversight Framework Rating. It was noted that organisations in receipt of deficit funding could not achieve higher than a rating of 3. Discussions were ongoing within the ICB regarding the impact on HDFT as result.
16.3	The Breakthrough Objective linked to this Ambition was Waste Reduction and Productivity (WRAP). Noted a positive trajectory for a challenging target.
16.4	Elective recovery was noted as behind plan with work ongoing to mitigate this.

Item No.	Item
16.5	There were no Corporate Projects linked to the Ambition.
16.6	There were three Corporate Risks linked to this ambition: Delivery of the Financial Plan (816), Group Cash Position (721) and Recurrent Delivery of the Efficiency Programme (WRAP) (73).
16.7	The Non-executive Director (AP) who had chaired the Resource Committee had nothing further from the Committee to note on this Ambition. They confirmed that detailed discussions had taken place at the Committee.
16.8	**Resolved:** The Board Assurance Framework: Finance was noted and approved.
BD/09/24/17	**Board Assurance Framework – At Our Best: Making HDFT the Best Place to Work**
17.1	The Deputy 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 2025-2026 had two True North metrics:
17.3	**Metric 1: Staff Engagement Index and to continually improve the Employee Engagement Score** – there had been a 12% increase in the quarterly response rate in July 2025 from April 2025 survey.
17.4	**Metric 2: Staff Availability** – overall composite measure used to understand how many colleagues are available to work at any one time. Factors impacting were noted as wide ranging. Availability had dipped slightly in month, however, this had been impacted by additional services coming on line in recent months. The focus for mitigation continued to be on sickness absence.
17.5	The Breakthrough Objective was noted as Staff Involvement and was on track to deliver.
17.6	Both True North metrics were within the Trust's risk tolerance.
17.7	There were no Corporate Risks linked to this element of the BAF at this time.
17.8	The Corporate Projects of Medical and Dental Workforce Scheduling and Payment Transformation were progressing well.
17.9	The Chair of People and Culture noted that the Committee had met one of the new Freedom to Speak Up Guardians and highlighted their level of compassion and enthusiasm.
17.10	The Committee had discussed in detail WRES and WDES which were noted as in the supplementary pack for the Board. A detailed discussion had taken place on the wider equality programme that had developed in the Trust. Key workstreams were noted in relation to recruitment practices for BAME candidates and the experience disabled colleagues had within the Trust. A rich discussion had taken place and it was confirmed that the action plan and workstreams would be monitored via the Committee on behalf of the body.
17.11	A Gemba had been undertaken to meet a number of Network Chairs.
17.12	The Non-executive Director (WS) noted that the EDI Lead and the Deputy Director of People and Culture had met with the Non-executive Director in their EDI

Item No.	Item
	Champion role to discuss the WRES and WDES workstreams and his thanks were expressed.
17.13	The Non-executive Director (WS) noted the importance of ensuring that EDI objectives were included in Executive Director objectives.
17.14	The Non-executive Director (DC) noted our patient and service user base with particular note in relation to the areas of service where deprivation is heightened. A strong discussion had taken place in the People and Culture Committee with this regard.
17.15	**Action:** To consider a Board Workshop on the diversity of the communities the Trust serves.
17.16	The Chief Executive noted that following the Board Workshop in August 2025, the executive team had met, and all Executives had key objectives as a Team and individuals in relation to equality and diversity.
17.17	The Non-executive Director (JW) noted that feedback had been received in some areas around the ability of colleagues to join our Staff Networks.
17.18	**Resolved:** The Board Assurance Framework: At Our Best: Making HDFT the Best Place to Work was noted and approved.
BD/09/24/18 **18.1**	**Workforce Race Equality Standards Report (WRES)** **Resolved:** Following review at the People and Culture Committee, The Workforce Race Equality Standards Report (WRES) was noted.
BD/09/24/19 **19.1**	**Workforce Disability Equality Standards Report (WDES)** **Resolved:** Following review at the People and Culture Committee, The Workforce Disability Equality Standards Report (WRES) was noted.
BD/09/24/20	**Board Assurance Framework – Enabling Ambition: Digital Transformation to Integrate Care and Improve Patient, Child and Staff Experience**
20.1	The Executive Medical Director provided the Board with an update on the Enabling Ambition: Digital Transformation for 2025-26: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience.
20.2	The Enabling Ambition had one true north metric: Achieve a score of 5/5 across all seven What Good Looks Like (WGLL) pillars.
20.3	It was noted that all items on the BAF for this Ambition were on track. The focus was on the What Good Looks Like (WGLL) pillars and the Trust had benchmarked itself the previous year believing it would score 2 out of 7 with the ambition to achieve 3 out of 7.
20.4	There were no Corporate Projects directly linked to this Ambition, however, it was noted that all projects had links to the digital transformation programme.
20.5	The major strategic programme was the Electronic Patient Record (EPR). It was noted that a Gemba had taken place by the Innovation Committee to view the training programme.

Item No.	Item
20.6	The Chair of the Innovation Committee noted that non-EPR projects were equally important and had a significant impact on the Trust's digital maturity.
20.7	**Resolved:** Board Assurance Framework: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience 2025-26 was noted and approved.
BD/09/24/21	**Board Assurance Framework – Enabling Ambition: Healthcare Innovation to Improve Quality & Safety**
21.1	The Executive Medical Director provided the Board with an update on the Enabling Ambition: Healthcare Research and Innovation to Improve Quality and Safety 2025-26 which had three True North metrics: Healthcare Innovation, Children's Public Health, and Clinical Trials.
21.2	The Innovation Committee had discussed the research trials and studies that were currently taking place. The Genomics and the Born and Bred study were highlighted.
21.3	The Children's Public Health element was on track to deliver with a wide range of activities taking place. Three key projects linked to partnership working on research programmes were noted.
21.4	The HDFT Impact programme was on target to deliver against trajectory.
21.5	The Chair of the Innovation Committee noted the wide range of activity linked to this Ambition.
21.6	The Non-executive Director (AP) noted that there were a number of commercial research studies that could potentially be utilised. The Executive Medical Director noted the importance of the development of the Clinical Research Facility.
21.7	**Resolved:** Board Assurance Framework: Healthcare Innovation to Improve Quality & Safety was noted and approved.
BD/09/24/22	**Board Assurance Framework – Enabling Ambitions: An Environment that Promotes Wellbeing**
22.1	The Director of Finance provided the Board with an update on the Enabling Ambition: An Environment that Promotes Wellbeing.
22.2	The True North metrics for the 2025-26 Ambition were:
22.3	**Wellbeing (capital programme delivery):** this had been discussed in detail at the Resource Committee. Currently forecasting a small over-spend in relation to backlog maintenance.
22.4	**Quality & Safety (Premises Assurance Model areas requiring more than moderate improvement):** the Premises Assurance Model had been discussed previously at the Resource Committee.
22.5	**Impact on the Environment (monthly natural gas consumption):** the Green Plan had previously been approved by the Board.
22.6	All areas were noted as on track to deliver.

Item No.	Item
22.7	There were no Breakthrough Objectives linked with this Ambition.
22.8	There was one Corporate Project: Block C Theatres and Imaging.
22.9	Corporate risks linked to this area were highlighted.
22.10	The Non-executive Director (AP) who chaired the Resource Committee noted that they had nothing further to add.
22.11	**Resolved:** Board Assurance Framework: An Environment that Promotes Wellbeing was noted and approved.
BD/09/24/23 **23.1**	**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.
2.3.2	The Committee Chairs noted that all areas of escalation had been discussed earlier in the meeting.
BD/09/24/24 **24.1**	**Corporate Risk Register** **Resolved:** The Corporate Risk Register was noted and confirmed that they had been reviewed via the Board Assurance Framework.
BD/09/24/25 **25.1**	**Audit Committee Update** The Director of Finance, on behalf of the Chair of the Audit Committee, noted that:
25.2	The financial stewardship via the Committee continued with the approval of the Treasury Management Policy and a discussion relating to Post Project Evaluations. An oversight report on backlog maintenance would be taken through the Committee at a later date.
25.3	An informative procurement report had been received into the Committee. The Procurement lead had taken the Committee through a review of the year, the highlights and areas of continuous improvement. The Committee gained significant assurance from the report and detailed discussions.
25.4	In terms of the internal audit programme, the Committee received significant assurance opinion on Safer Staffing and heard from the People and Culture Team regarding the mitigation in place following the limited assurance opinion report for Sickness Absence Management.
25.5	A detailed discussion had been held at Committee on counter fraud and the training implications for fraud across staff groups with a detailed presentation from the Audit Yorkshire Counter Fraud Manager on the new 'Failure to Prevent Fraud' offence and the implications for the Trust.
25.6	**Resolved:** The update was noted.
BD/09/24/26 **26.1**	**Board Assurance Statement: Winter Plan** The Chief Operating Officer noted that the Winter Plan had been discussed in detail at the August 2025 workshop. The Plan remained as presented at the Workshop and was submitted to the Board for formal approval.

Item No.	Item
26.2	The Non-executive Director (AP) who had chaired the Resource Committee noted that the Plan had also been discussed in detail at the Committee.
26.3	The Non-executive Director (CM) noted that there was potential to flex between acute provision in Winter and elective in Summer. They also queried if modelling had taken place on this Plan against the previous year's activity. The Chief Operating Officer noted that it had been modelled and as a result a Gastro Ward would be created for this winter.
26.4	The Non-executive Director (LR) noted that in the national priorities there was nothing linked to corridor care. The Chief Operating Officer noted that corridor care was not something the Trust would tolerate for our patients.
26.5	**Resolved:** The Board approved the Board Assurance Statement: Winter Plan
BD/09/24/27 **27.1**	**Any Other Business** No further business was received.
BD/09/24/28 **28.1**	**Board Evaluation** It was noted that a wide range of business had been discussed.
BD/09/24/29 **29.1**	**Date and Time of the Next Meeting** The next meeting would be held on Wednesday, 26th November 2025.
BD/09/24/30 **30.1**	**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 November 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/09/24/17.14	24 September 2025	Patient and service user base - heightened deprivation in certain areas serviced by the Trust	To consider a Board Workshop on the diversity of the communities the Trust serves	Director of Strategy	Nov-25		

BOARD OF DIRECTORS (PUBLIC)
26th November 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)
NOVEMBER 2025

CHIEF EXECUTIVE'S REPORT

National and system issues

1. The medium term planning framework was published in October, which sets out the commitments between now and 2028/29. It is written in the context of the 10 Year Plan for Health, recognising that the first three years of this period will be focused upon delivering the constitutional standards, and laying the foundations for the period ahead.

2. The expectations in terms of delivering standards over three years are less ambitious than our own plans for this period, so as well as our focus on these improvements, we will look to develop our organisation building upon the strength of our preventative offer, the opportunity we have to integrate services more deeply across the Harrogate district, work positively in partnership with WYAAT and LTHT in particular, and use our Impact improvement approach to deliver what we do to the highest standard possible.

3. There is further detail to emerge – such as a model neighbourhood framework, a draft foundation trust framework, and a system archetypes blueprint which will explain how new parts of the operating model (for example, new Foundation Trusts, Integrated Health Organisations) will work across the NHS. We will consider these developments as part of planning for the next three years.

4. A key part of the framework relates to the financial system that will operate. The framework states that to support the better alignment of incentives, that block contracts will be dismantled, that there will be a new UEC payment model based upon a price x activity fixed element and a variable payment to reflect activity changes, and an expansion of Best Practice Tariffs. These arrangements, particularly the UEC changes, will assist in the development of neighbourhood health models, as the left shift of activity from hospital to community can be matched with a left shift of resources.

5. As the Board is aware through previous discussions, our assessment of the new financial framework and dismantling of block contracts is that this will enable our financial pressures to be addressed in a manner that is appropriate to the productivity and level of service that we deliver. This will be either through additional resources being available to pay for the work that we now do, or through a sensible decommissioning of services that can't be afforded by the system. It will avoid the current situation of efficiently delivering a level of service that is not resourced appropriately.

6. As part of the new oversight framework, providers have had mid-year reviews undertaken in the main by the Regional offices of NHSE. Our review took place at the end of October, with the main discussion relating to the degree by which we could provide further support to the system in terms of some of the access standards that we are meeting but that others are struggling to meet, and the financial position of the organisation both this year and going forward. It was a helpful session, and has helped reinforce the need for further discussions about the level of resource that we receive in relation to the level of service that we deliver. This links to the new financial framework being put in place, and the

opportunity to be financially sustainable. As a Board we have considered this approach for a few years, and this year is the opportunity through the planning process and contracting round to ensure that this is delivered.

7. The provider self-assessment submissions have all been done by providers across the NHS and received by the Regional Offices of NHSE. Joining this assessment up with the new planning framework and mid-year reviews allows the questions of financial sustainability to be triangulated and addressed.

8. The changes to how the NHS is organised and the role and size of NHSE and ICBs have taken a step forward through the announcement that there will be funding available to implement the necessary restructuring this year. Whilst it is helpful to get some certainty in respect of these changes, we need to recognise the pressure that this puts our partners under and the personal concerns that many people working in the NHS will now have.

9. The next period of Industrial Action by Resident Doctors has taken place, covering the period from 14th – 19th November. This is a national dispute between the Resident Doctors and the government, but the message quite rightly is for organisations to plan and deliver as close to normal services as possible, recognising the need to ensure fully safe provision.

10. Finally in relation to national issues, as the Board is aware, a national maternity review has commenced. Originally, this review covered fourteen trusts, but two Trusts (Leeds and Shrewsbury & Telford) are not now a part of this particular process. The aim of the review is to provide a single view of what has gone wrong and what should be done, because at the moment there have been many maternity reviews and a lot of advice given to organisations that isn't always consistent. We had a session with WYAAT Chief Executives and the WY LMNS to discuss consistency and clarity of reporting, to ensure that Boards in particular are receiving information in a way that is helpful in terms of the oversight of the quality of our maternity services. I will update the Board at a future meeting about this, and also any outputs from the national review.

11. In relation to the West Yorkshire system and WYAAT in particular, we are focused on delivering the priorities identified in the Case for Change. There is a WYAAT clinical board being set up that will oversee the services where we work together, to ensure that we maintain oversight and delivery of services when they move beyond a specific change project. The focus will be on delivering benefits and ensuring that services are delivering effectively and efficiently as part of 'business as usual' going forward.

12. In respect of our partnership with LTHT, there has understandably been a slight pause in our programme, but we are now moving forward our work, in particular how we can best utilise Wharfedale Hospital for the benefit of both organisation in the future. We are also discussing the opportunity for a networked clinical service in respect of neurology, in line with a WYAAT wide neuroscience programme.

13. We continue to work across our local care partnership and the wider North Yorkshire place to further our thinking in respect of integrated care and neighbourhood health. Work has been developed in respect of the core community offer, we are a part of discussions about how the health and wellbeing board works to best effect, and a recent session organised for local GPs and HDFT Consultants to come together and discuss common interface issues was very well attended.

14. Discussions are being held with HNY ICB in respect of the future provision of community dental services. As the Board is aware, we are commissioned to provide these services currently, and negotiated funding to enable us to continue to deliver the service this year. The ICB have officially communicated with us to say that they will be running a procurement process for the future service delivery, as the funding is not available next year to provide the service as it is currently provided.

15. 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. These relationships continue to be positive with all Local Authorities as we work with them to deliver services to children and young people.

16. There are a lot of moving parts that we are managing at the moment across a number of issues and systems. It is a complicated time across the NHS and the Board should be assured that as an Executive team in particular, we are engaged and navigating our way through the important issues to ensure that we are in the best place for our patients and population.

HDFT issues

Introduction

17. As is appropriate, the first part of this report has focused significantly on the important national and regional issues that impact upon HDFT, whilst also outlining the appropriate engagement we have with partners across a number of systems to deliver high quality care. It is fair to say that there is significant pressure coming from a number of places and I am focused on maintaining a balanced and calm approach with our colleagues so that we continue to focus on doing what is important with behaviours in line with our values. This is what will deliver the quality, finance, and performance requirements and ambitions over the coming period.

Our people

18. At the time of writing this report, as I mentioned above, the Resident Doctor industrial action had just concluded. It is pleasing to report that the impact upon patients was minimal, although we did cancel a small number of clinics, and for each individual patient due to be seen in those clinics, this will have been worrying and frustrating.

19. As the Board is aware, there is a national 10 point plan to improve the working lives of Resident Doctors, which each organisation has been requested to implement where it applies to them. We have met with Resident Doctors' forum to discuss the requirements of the plan and any improvements that might need implementing. This was a generally positive discussion, with the biggest issue being the Resident Doctor awareness of what we provide by way of support. We continue to liaise with our Resident Doctors, with Angela Wilkinson being our Board representative in this ongoing work.

20. The national staff survey is ongoing, with the closing date for returns being the end of this month. We currently have a return rate from colleagues of over 50%, already above the

level of last year. This is really encouraging, as it is important to receive feedback from colleagues to check how people are and whether there are improvements we need to focus on as an organisation as a whole or in individual areas. As always, when we have the results in the New Year, we will analyse the output and discuss through the People and Culture Committee and the Board.

21. It doesn't need reinforcing, but as a reminder to ourselves and anyone externally reading this report, our people and how they are engaged and motivated is the most important thing we can focus on. Quality, finance, and performance delivery are dependent upon and closely associated with colleague engagement and motivation, and we will be successful for our patients only through the support of all who work for HDFT.

Our Quality

22. As I updated at our last Board meeting, the CQC came to the Trust for an unannounced CQC inspection of our maternity services in July, and we were waiting for the draft report. We have received a draft report in October for factual accuracy checking, which we have responded to. We are now waiting for the final report to be published.

23. A thematic review of the deteriorating patient has been undertaken and an initial report drafted. There is still a bit of work to do, but we will be in a position to bring this report through the quality governance process early in the New Year.

24. Our winter plans are in place, with our additional medical assessment bed capacity due to come on stream in early December, as we complete the refurbishment of our Littondale ward. We are expecting a challenging winter period, but colleagues are well prepared and our oversight and governance arrangements are in place to ensure that we continue to provide safe services. In respect of the staff flu vaccination programme, at the time of writing this report we had over 50% of staff vaccinated, which is ahead of last year, and in the top five organisations nationally, which is a credit to our teams.

Our Services

25. 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. This strong performance is also being seen within our new services in Cumberland and Westmoreland & Furness. The Board workshop in October demonstrated the work undertaken across our new services and the commitment of colleagues to what is a significant change and improvement programme.

26. Our urgent care pathway, whilst remaining an area of focus in terms of delivering the quality of service we would like for our population, continues to improve and be ahead of our plan for the first six months of the year. We are aiming to continue to improve the service we provide to patients who need to attend our Emergency Department, and ensure that the expected winter pressures do not mean a significant worsening of our access times and the experience for our patients.

27. To support our urgent care pathway, the Ripon Urgent Treatment Centre has opened, to replace the Minor Injuries Unit. This service will mean that there is an extended service scope on offer and also longer opening hours. Further developments will take place later this year to improve the facilities further in Ripon.

28. In relation to cancer, our performance remains a positive one, as demonstrated in the latest cancer league tables recently published. As at the end of October, our performance against both the FDS and the 62 day standard remains top quartile nationally.

29. 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. This is a particular national priority at the moment, and it is positive to report our significant progress in this area, which is so valued by our patients.

30. We continue to struggle to meet our diagnostic waiting times standards due to the ongoing mismatch between capacity and demand for our CT/MRI services. Discussions are ongoing in respect creating additional permanent capacity through a Harrogate based Community Diagnostic Centre. This would require capital investment, which we are working to secure.

31. The provision of autism assessments in a timely way continues to be a significant risk to HDFT. As reported at the last meeting, we are having active discussions with the Commissioner in respect of this issue, with the current level of service being unacceptable for those families waiting. We will update the Board how these discussions are progressing when we meet.

Our money

32. Our position at the end of Month 7 is that we are behind our plan by £7m. The key drivers are our undelivered WRAP (we have now delivered 132% of our annual programme, however, when adjusted to remove cost avoidance schemes this reduces to 83%) and some specific ward and medical agency costs. Delivery of our WRAP is a breakthrough objective for the Trust and is being picked up regularly along with specific items of challenge through the IMPACT process and Performance Review Meetings with our teams. We continue to focus on our immediate financial position and recovery actions through our governance process, as well as set out the route to financial sustainability which is deliverable as part of planning for 2026/27.

33. As well as the action we need to take as an organisation, both the recovery of this year's position and the future plans are linked to discussions with the ICB in respect of risk management and support for the service and demand shifts that we have experienced.

34. As part of the financial position, our cash position is being closely managed.

35. We continue to be a very productive Trust when comparing ourselves with others. This is positive and we need to maintain our level of performance as we work through planning and contracting issues for next year.

Corporate Risk Register

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

- CYPD Pay Award Impact (CRR827) – Funding confirmation from seven local authorities has reduced the financial risk associated with the 25/26 pay award. The risk score has decreased to 8, and the risk has been de-escalated to the Directorate Risk Register for continued oversight.
- Histopathology Space and Safety (CRR597) – Following review at PRM and the Executive Risk Review Group, this risk, currently scoring 15, has been accepted onto the Corporate Risk Register.
- Fire Safety – Risk of Injury (CRR116) – The risk score has reduced from 15 to 10 following measures to address fire safety. Further updates have been made to reflect changes relating to the fire alarm, and the scoring is currently under review, with a potential update expected. The risk remains on the Corporate Risk Register, with a further review scheduled next month. The target completion date has been extended to December 2025.
- Governance of Security (CRR577) – Updates to the risk have been noted, with no change to the current score. The target completion date has been extended to April 2026.
- Delivery of the 25/26 Financial Plan (CRR816) – The risk score has increased from 15 to 20, and the position continues to be closely monitored

37. I can confirm that risks on the Corporate Risk Register continued to be reviewed 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

38. I am delighted to share that our new EPR, Nervecentre, is now live in the organisation. Working closely with national and regional colleagues over many months within significant external assurances process, we gained national approval from Sir Jim Mackey to go live on the 19th of November. The Board will be aware of some concerns in respect to the recent EPR Nervecentre implementation at Nottingham University Hospitals. Our digital team have been working closely with colleagues from Nervecentre and Nottingham to share learning, but the scale of the go live at Nottingham was very different to our approach, which is a modular phased go live over a number of months. I would like to personally thank the digital team and clinical and operational colleagues who have worked for over 2 years to ensure a smooth and controlled go live. We are already seeing some of the clinical benefits our new EPR will bring, which I will share more on once we are further on with our roll out.

39. It was great to attend a SAS celebration event last month, which did exactly what it said – celebrated the significant contribution that our SAS colleagues make to the Trust and the patient we look after.

40. It was also brilliant to attend the Charity Ball in October to celebrate 30 years of our charity and to raise funds for some pathology equipment. Thanks to all who organised a wonderful and successful evening.

41. As I always seem to reflect, there continues to be 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. What I can say though is that our colleagues who work in all parts of the Trust do a fantastic job in providing care and support to the patients and population who rely upon on us. It is important to always recognise this often-selfless contribution, particularly at times of challenge, such as through industrial action, through winter, through periods of colleague sickness, and through difficult and life-changing experiences that our work brings each day. It is therefore great to report that we have had approaching 300 nominations for this year's KITE awards. These are nominations for colleagues by colleagues and demonstrates the mutual respect and shared commitment that our people have for each other across the Trust. I look forward to judging the nominations and celebrating with many of them in the New Year.

Jonathan Coulter
Chief Executive
November 2025

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

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)

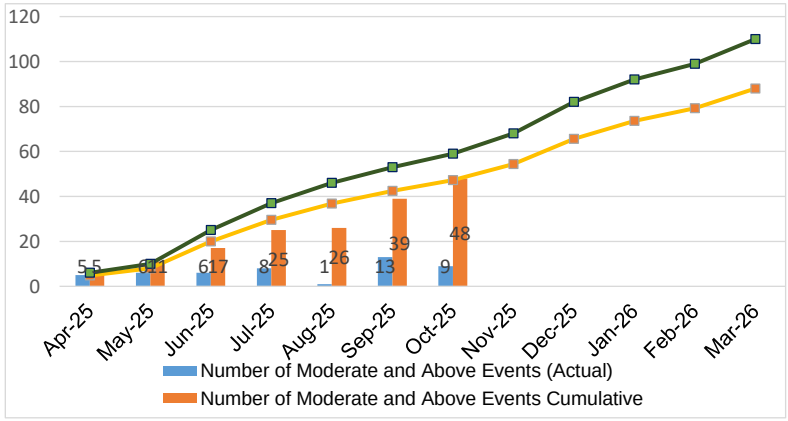
1. • **Eliminating Moderate & Above Harm**
2. • **Patient Experience Positive Response Rates**

Corporate Project:	Patient Experience: Real Time Feedback
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. Of note: • There were **5** moderate and above events reported in April 2025 • There were **6** moderate and above events reported in May 2025 • There were **6** moderate and above events reported in June 2025 • There were **8** moderate and above events reported in July 2025 • There were **1** moderate and above events reported in August 2025 • There were **13** moderate and above events reported in September 2025 – validation continues. • There were **9** moderate and above events reported in October 2025 – validation continues. The total for year to date is 48 with a threshold of 48 – therefore we are on trajectory to achieve our overall targeted reduction. It is anticipated that following validation, the figures for September and October will potentially reduce further bringing us well within our delivery threshold. 	Falls Improvement Plan Pressure Ulcers Improvement Plan Quality Governance Framework in place PSIRF Plan Thematic Review – Diagnosis, Treatment and Procedures Directorate Countermeasures		

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk To Achieving in year goal	Level of Risk for progres sing actions
				Of note, CYPP have had no moderate and above events in this financial year. The work with the Deteriorating Patient Thematic Review continues. The safety actions identified through this work will seek to reduce the number of moderate and above events. Countermeasures are noted. Watch Metrics: • Number of Never Events – **1** declared in year • Number of PSIIs – **4** declared in year and **1** thematic review (deteriorating patients) • Level of low and no harm events reported – ratio maintaining at **98%** with numbers maintaining approximately **1,200**			
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	Significant work has taken place over the summer months to support the development of a trust wide patient and service user Engagement Strategy. A draft document is in the process of being finalised and is due for ratification in Quarter 4. This will set the Trust's framework for our engagement activities over the next 1 – 3 years and beyond. The 10 year plan places considerable emphasis on engagement activity and the Trust strategy will be our delivery tool to enact the requirements. A clear governance framework is in development with the re-design of the Making Experiences Count forum to act as the Steering Group for the programme. It is acknowledged that the Friends and Family Test (FFT) can be a useful tool to quickly assess the current experience of our patients. The percentage of responses for inpatients rating their experience as good or very good was 96.45% in September and 96% in Outpatients. Countermeasures are noted. Watch Metrics: • Number of Complaints – 22 new in October 2025 • Percentage compliance with Complaint Response Times – **71%** compliance in October	Corporate Project		

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 a Trust Wide Engagement Strategy	A productive workshop took place in October that included representatives from all clinical directorates, the Trust's subsidiary company and 3rd sector partners. The workshop sought to further develop the draft Engagement Strategy. Key updates were made to workstreams, programmes of engagement and metrics. These are currently being reflected in the draft strategy which is due to be ratified in Quarter 4. In addition, the governance framework to support the project is being finalised and will also be ratified in Quarter 4.	Draft Engagement Strategy Development of Governance Framework Making Experiences Count Forum		

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
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Great Start In Life	**National Leader for Children & Young People's Public Health Services**	**Children at Risk of Vulnerability**	**Clinical: Minimal**	
	Hopes for Healthcare	**Children's Patient Experience**	**Clinical: Minimal**	

True North Metrics Summary:

Workstreams	True North Metric	Vision	Goal	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. Quality and Performance Management Supervision compliance for Oct 25: Performance was 76.58%% (inclusive of Westmoreland and Furness and Cumberland). We have 11 LA Commissioned 0-19 Services. There are five mandated contacts in each service making 55 contacts. Target is to have 55 at 90% (delivering with HCP Timescales) Oct 25 data inclusive of Westmoreland and Furness and Cumberland 49/55. Metric: Great start in Life – *Improve outcomes by identifying children by ensuring we achieve >90% for all mandated contracts* Target: Zero mandated contacts in all our contract areas breaching business rules (four consecutive months) — Aug-25: 11; Sep-25: 8; Oct-25: 7 Target: All mandated contacts at 90% or above (55 contracts) — Aug-25: 42; Sep-25: 46; Oct-25: 48 There are now in total 55 contacts across 11 LA 0-19 Services (increased from 45). In October 48 of these achieved >90%, CYPH Directorate Driver to focus on HCP Mandated Contacts not delivered within timescales over three consecutive months with associated countermeasures. There are seven HCP Contacts breaching business rules (1XWakefeield, 3x Westmoreland and Furness and 3x Cumberland).	*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.* • 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. *Wakefield:* • *Wakefield HDFT Impact Driver focused on Antenatal Coverage, triumvirate coaching to support improvement. Focused countermeasures currently being developed by the IMT and application of HDFT Workforce Sufficiency Tools.* • *Demand and Capacity Management Tool to be performed by Wakefield and shared with EA so overall capacity including skill mix*		

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
				Sept and Oct 25 Wakefield successfully achieved 90% antenatal. W&F has now fit the 12 month review for three consecutive months.  Watch Metrics: Goal 2: Watch Metrics will report and include the outcomes of the GSIL Pathway linked to High Impact Areas. Sept data- 97% of eligible children recruited to the GSIL Pathway	*can be reviewed against establishment.* *Westmoreland and Furness & Cumberland:* *TNA and Preceptorship of new management team to ensure competency in:* • *Quality and Performance Management Supervision (Compliance to be monitored – target for 90% by January 26)* • *HDFT Workforce Sufficiency Tools applied and equitable Caseload allocation* • *SystmOne process, reporting and associated action-following validation standard work and batch breach reports.*		
Hope for Healthcare	Children's Patient Experience	Improve experience of care by considering elements that matter	Goal 1: Engage with children and young people with lived experience across HDFT	The Trust North Metric of improving Children's Patient Experience continues into its second year (2025-26).	CYP Patient Experience Tool 'engagement methods' to increase uptake and return being developed		

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
		most to children & young people so we can measure their experience of care and shape services according to their specific needs	geography to consult with on our CYP Strategy which will for part of the Clinical Strategy Goal 2: CYP Patient Experience Tool Developed-Return rate significantly low - distribution, engagement, and accesses to the tool to be developed with CYP and approach embedded with teams and professionals working with CYP.	Increase in number of CYP surveys returned by 17% on previous month's numbers. Countermeasures are noted. • Every Contract area are developing Countermeasures using HDFT Impact methodology to increase return rate. • Darlington and Wakefield are piloting in addition to the digital CYP Patient Experience Tool, a paper Survey with 3 quick questions identifying what we did well, what we didn't do well and what we could improve on? • Practitioners will bring with them the returned paper surveys to QPMS. • Data will be reported as a percentage for each Contract area and monitored via Governance Huddle with each HoN. • Approach to ensuring the sample we have is representative of the CYP population. Once we reach a threshold of responses (to be agreed once we have a denominator) we work with young people to consider how the questions might be amended to support this driver. • Trial in July & August 25 of sending out survey via SystmOne next working day (following contact with service) to see if earlier contact increases rate of returns. This will be in Middlesbrough, Stockton and Sunderland. Also trailing different times with Middlesbrough & Stockton 11am-12pm each day and Sunderland 4pm-5pm. Will evaluate October reflecting up to end September 25 data. Survey area / Number of responses received in October Co Durham 18 Cumberland 0 Darlington 6 Gateshead 1 Middlesbrough 3 North Yorkshire 1 Northumberland 17 Stockton 6 Sunderland 1 Wakefield 4 Westmorland & Furness 0 TOTAL 57  Watch Metrics:	with involvement of CYP representatives. • Focus Groups held with GSIL Young Advisor Committees and individual advisors. • Poster design to be finalised, digitised and circulated to school's W/C 7th April 25. • Standardise paper version of survey for use. • Hopes for Health presentation to increase staff awareness and importance of gathering feedback (at all team huddles) • Assurance Survey for completion by staff to review awareness - this will inform future promotion and target support. • Meeting with S1 & IG scheduled 13th March to explore use of S1 to send survey link and push notification. • Application to charity for adaptable devises to support completion of survey by CYP		

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
				• Directorate CYP Patient Experience Champions to produces a monthly report with themes, trends and areas for improvement. This will be shared with the central patient experience team and reported into MEC Forum. We will review after 6 months data to identify key themes which will inform future counter measures and metrics.			

Breakthrough Objective:

Workstreams	Strategic Metric	Vision	Goal	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					

Strengthening Maternity and Neonatal Safety Report

Harrogate and District NHS Foundation Trust

3.2

October 2025

Title:	**Strengthening Midwifery and Neonatal Safety Report**
Responsible Director:	Breeda Columb, Executive Director of Nursing, Midwifery & AHP's
Author:	Leanne Likaj (Associate Director of Midwifery and Paediatrics/Children's Services) Rachael Fawcett (Head of Midwifery) Andrew 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 October 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:	The Board is asked to note the updated information provided in the report and for further discussion.	
Appendices attached for oversight	Appendix A - Explanatory notes Appendix B – Saving Babies Lives LMNS Quarter One Review Appendix C - Perinatal Mortality Review Tool Quarter Two Report Appendix D - Bi-annual Midwifery Staffing Report Appendix E – Neonatal Staffing Appendix F - Hospital Readmissions of Babies Within 30 Days of Life Quarter 2 report Appendix G - Avoiding Term Admissions into Neonatal Units Quarter Two report	

Strengthening Maternity and Neonatal Safety Report

1) Summary

This paper provides a summary and update of the detail on the board level measures for the month of October 2025 as set out in the Perinatal Quality Oversight Model (2025).

2) Introduction

The Perinatal Quality Oversight 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.

3) Proposal

The Board is asked to note the information provided in the report that provides a local update on progress and identify any areas in which further assurance is required.

4) Quality Implications and Clinical Input

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

5) Equality Analysis

Not applicable.

6) Risks and Mitigating Actions

No new risks added to the risk register.

7) Recommendation

Positive news

- Maintained compliance with QIS nursing ratio and Delivery suite co-ordinator supernumerary status.
- Fully recruited in SCBU

Areas of concern

- Increase in complaints received
- Increased number of women diverted

Work underway

- On-going review of the homebirth service provision
- Work ongoing to increase implementation of balloon catheters to reduce induction of labour delays

Decisions required of Board

- The Board is asked to note the updated information provided in the report, including in Appendices B to G.

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

1. Introduction

The Perinatal Quality Oversight Model was updated in August, 2025 and provides a model for consistent and methodical oversight of perinatal services. It supports Trusts to discharge their duties and provide a mechanism for emerging risks, trends or issues that cannot be resolved at a local level or would benefit from wider sharing. The PQOM dictates that each trust should have the following in place to ensure that board oversight for perinatal quality and safety is robust:

1. A Board safety champion non-executive director (NED) is visibly working alongside the board safety champion for perinatal (midwifery, obstetric and neonatal) to provide objective, external challenge and enquiry
2. An identified frontline midwifery, obstetric and neonatal safety champion who meets on a regular basis with the board safety champion(s)
3. The trust board (or an appropriate sub-committee with delegated responsibility) discusses perinatal safety intelligence at least quarterly, demonstrates professional curiosity and is responsible for shared learning across the organisation. Discussions must include:
    a. ongoing monitoring of services and trends over a longer time frame
    b. concerns raised by staff and service users
    c. progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF)
4. A board report should be presented by a member of the perinatal leadership team, who will provide supporting context. While the specific content may vary and will be agreed locally, it is recommended that the report includes the measures outlined in Annex 1. Where possible, data should be broken down by subgroups – at a minimum by ethnic group and deprivation based on the mother's postcode – to help identify potential health inequalities for investigation and action.
5. As a minimum, trust boards should consider the following data measures at least quarterly.
    a. Findings of review of all perinatal deaths using the real time data monitoring tool with actions
    b. Findings of review of all cases eligible for referral to Maternity and Newborn Safety Investigations (MNSI) programme with actions
    c. Report on:
        i. Themes and actions from patient safety incidents
        ii. Training compliance for all staff groups in maternity and neonatal critical care related to the core competency framework and wider job essential training (%)
        iii. Minimum safe staffing in maternity and neonatal services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing. Planned cover versus actual
    d. Service user voice feedback – themes
    e. Staff feedback from frontline champion and walkabouts – themes
    f. Maternity and Newborn Safety Investigations (MNSI) programme, NHS Resolution, Care Quality Commission (CQC) or other organisation with a concern with or request for action made directly to the trust
    g. Coroner Reg. 28 made directly to trust, where applicable
    h. Progress in achievement of Maternity Incentive Scheme – 10 safety actions
    i. Proportion of midwives responding 'agree' or 'strongly agree' to whether they would recommend their trust as a place to work or receive treatment (reported annually)

j. Proportion of specialty trainees in obstetrics and gynaecology rating the quality of clinical supervision out of hours as 'excellent' or 'good' (reported annually)

2. Obstetric cover on Delivery Suite, gaps in rota

The required level of obstetric medical staffing at HDFT is outlined below. Cover includes Delivery Suite, Pannal Ward, Maternity Assessment Centre (MAC), Early Pregnancy Assessment Unit (EPAU), support for community midwifery and patients presenting to the Emergency Department, as well as gynaecology.

Safe levels of cover on Delivery Suite has been maintained with any gaps filled by locum shifts, extra sessions from the substantive team, and a small number of external bank doctors.

All shifts met Maternity Incentive Scheme requirements in October.

3. Midwifery safe staffing, vacancies and recruitment update

a. Absence position

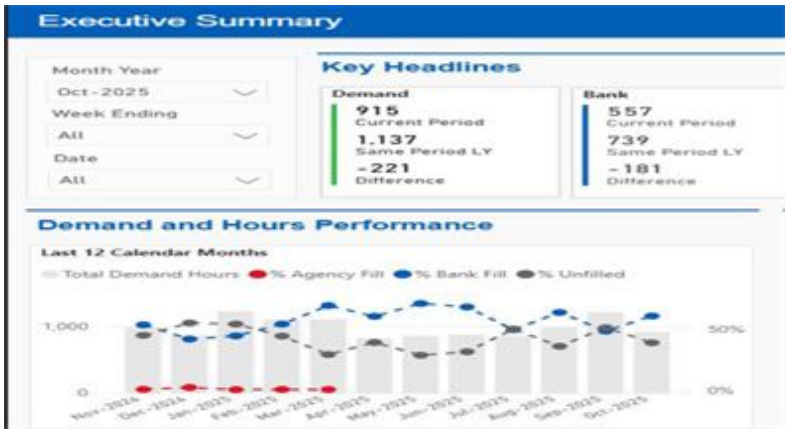
Total sickness in October was 4.19 WTE midwifery and 1.82 WTE maternity support workers absence. There has been an increase in absence due to stress. 5.61 WTE midwives on maternity leave at present.

b. Vacancy position

There is also 1 WTE Band 5 vacancy. There is currently no maternity support worker vacancy.

c. NHSP provision

Midwives – demand has reduced this month as recruited midwives have come in to post.



Maternity Support workers – Demand and uptake has remained consistent this month.

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

a. Neonatal absence position

1.35 WTE nurse sickness absence – not theme noted.

0.77 WTE QIS nurses currently on maternity leave.

b. Neonatal Vacancy

No neonatal nursing vacancy at present.

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. October QIS compliance was 74%.

5. 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. According to the data captured in Birthrate Plus acuity tool staffing met the acuity requirements 69% of the time and was up 1.5 midwives short 29% of the time. Compliance with data capture was 91.4%.

In order to manage workload during times of high activity and acuity inductions of labour were delayed and staff were redeployed from other areas of maternity services, including Pannal, Community and Specialist midwives. Clinical risk was mitigated and delays were kept as minimal as possible.

b. Pannal Ward Staffing and impact on clinical workload

According to the data capture in the Birthrate plus acuity tool, 68% of the time staffing has not met acuity on Pannal. The data capture is being reviewed due to come concerns about accuracy of data capture. Staff being redeployed to support the ward with the clinical activity is not currently being captured within the data. Staffing not meeting acuity most frequently occurs at the 8pm and 2am data capture entry points. The additional member of staff available

on a night will be rolled out from December roster following successful recruitment. This should improve the compliance figures.

There were 13 elective section lists with 28 caesareans performed in total on these lists. There was one elective caesarean sections completed in Delivery Suite theatre during October.

6. 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.

Eight homebirths were booked for the month of October 2025. Of these; one woman had a successful homebirth, three woman birthed in the hospital by choice, one woman transferred during labour having been supported at home and one woman was transferred to another unit due to services being on divert. The remaining people did not birth in October. Two additional women had a baby born before the arrival of a midwife (BBA).

In the period 01/10/25 – 31/10/25, the home birth on call provision was unavailable on ten occasions due to no volunteers to cover sickness absence.

7. Red Flag Events Recorded on Birthrate Plus

a. Delivery Suite Red Flags

There were no Red Flags noted on Birthrate plus in October.

b. Pannal Ward Red Flags

There were nine Red Flags recorded on Birthrate Plus during October 2025. Appropriate actions were taken to manage the situation.

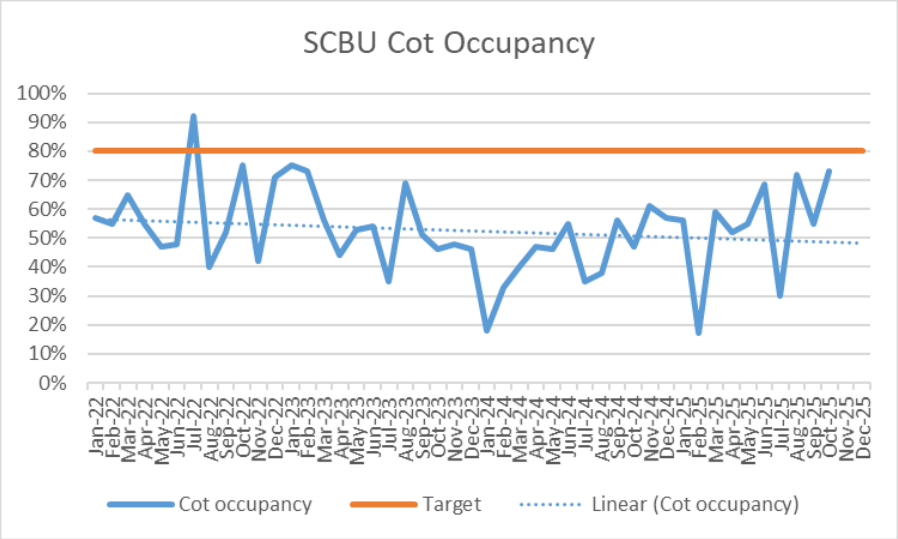
Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	2	22%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	2	22%
RF5	Delay between presentation and triage	1	11%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	3	33%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	11%
TOTAL		9	

During October there were 22 episodes of delayed induction/augmentation of labour, of these:

- 11 were delays in transfer/admission for artificial rupture of membranes (ARM) over 24 hours (Without the use of prostaglandins/balloon catheter)

- 2 were prolonged rupture of membranes (PROM) awaiting augmentation over 6 hours
- 9 were delays in admission to commence induction of labour with cervical ripening (with Propess/balloon catheter) over 24 hours

8. SCBU Cot Occupancy



One baby was transferred out to a tertiary unit for clinical reasons.

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

a. Mandatory training (as at 4/11/25)

Department	Assignment Count	Percentage Compliant
421 Level 4 Obs & Gynae - Medical Staffing	29	81%
421 Level 4 Community Midwifery	22	86%
421 Level 4 Pannal Ward	28	87%
421 Level 4 Ante Natal Clinic	10	88%
421 Level 4 Maternity Staffing	53	91%
421 Level 4 Early Pregnancy Assessment Unit	4	100%

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

Steps are being taken to improve compliance in all areas currently reporting below 90%. 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 Consultants	Obs& Gynae (Other Staff)	Anaesthetics Consultants	Anaesthetics (Other Staff)	Paediatric Consultants	Paediatric Medical (Other Staff)	Maternity Support Worker	SCBU Nurses
Adult Basic Life Support with paediatric modifications	93%	100%	95%			78%	88%	100%	87%
Harrogate Newborn Intermediate Life Support (HNILS)	93%						100%		100%
RCUK Newborn Life Support	92%					89%	80%		
Resuscitation - Level 3 - Adult Immediate Life Support	75%								
Fetal Wellbeing Competency Assessment	96%	100%	91%						
MAT - Birthing Pool Hoist	99%							92%	
MAT - Growth Assessment Protocol (GAP)	94%	100%	80%						
MAT – Maternity Training Day 2	99%	100%	100%						
MAT - Saving Babies Lives	82%	71%	50%						
MAT 3 - Personalised Care & Care in Labour	97%								
MAT-PROMPT - Emergency Skills Facilitator Led	94%	100%	90%	80%	90%			100%	
Mandatory Training - Safeguarding	**Midwives**	**Obs& Gynae Consultants**	**Obs& Gynae (Other Staff)**	**Anaesthetics Consultants**	**Anaesthetics (Other Staff)**	**Paediatric Consultants**	**Paediatric Medical (Other Staff)**	**Maternity Support Worker**	**SCBU Nurses**
Safeguarding Adults	86%	71%	70%	95%	90%	89%	76%	94%	100%
Safeguarding Children	96%	43%	50%	75%	95%	80%	71%	88%	93%

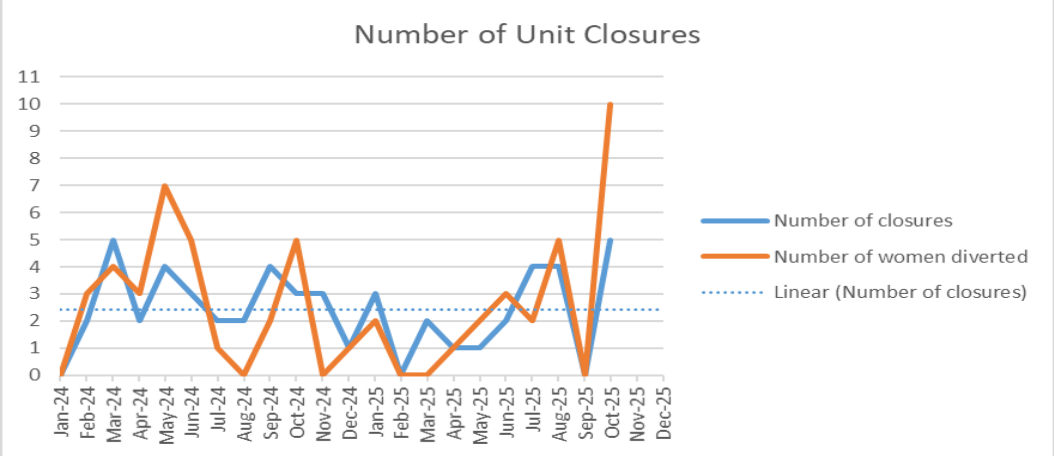
10. Appraisal Compliance (as at 31/10/25)

Department	Assignments Appraised	Assignment Count	Percentage Compliant
Obs & Gynae - Medical Staffing	11	14	79%
Ante Natal Clinic	12	12	100%
Community Midwifery	18	22	82%
Maternity Staffing	48	50	96%
Pannal Ward	21	23	91%
Early Pregnancy Assessment Unit	4	4	100%
Total	114	125	91.2%

11. Risk and Safety

a. Maternity unit divert

There has been five events of divert of the unit in October 2025 with ten women 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 October one women was transferred to Harrogate maternity service from elsewhere in the region for artificial rupture of membranes, on-going induction process or labour care.

c. SCBU Incidents

No moderate harm incidents.

d. SCBU Risk Register

QIS cover and the recognition that there may be an inability to perform infrequent clinically complex procedures both remain on the risk register.

e. Maternity Risk Register Summary

Risk Register formally reviewed 28/8/25. Next review 27/11/25.

There is fourteen current active risks:

- Risk to delivery of safe and quality care due to inability to share records electronically between healthcare providers when patients being transferred or receiving shared care between Trusts **(Score 9).** Risk requested to be added by WY&H LMNS. Currently recorded as risk score 16 across the LMNS. Local booking in place for out of area patients. Options for sharing of Badgernet; temporary K2 token and access through Yorkshire Humber Care Record. Work ongoing at LMNS level.
- Risk to provision of effective and safe triage due to inability to implement national Birmingham Symptom-specific Obstetric Triage System (BSOTS) within Badgernet (Score 8). Inability to implement nationally recommended BSOTS tool due to unit size and required staffing levels. Work ongoing at LMNS level to seek group action to enable small units to be able to implement.
- Risk to patient safety and experience and staff burnout due to Obstetric staffing pressures (Score 8). Consultant and Obstetric recruitment undertaken. Likely improvement and for consideration of downgrading at next review.
- Risk to safe monitoring and management of Perinatal Mental Health due to insufficient clinic capacity for PNMH appointments (Score 8). Work ongoing to review Perinatal Mental Health service and clinic requirements. Patients currently being triaged according to priority and to try to remove unnecessary appointments. No current change to score.
- Risk to patient experience and breach of triage timescales due to insufficient midwifery staffing in Maternity Assessment Centre (Score 8). Scheduled activity now moved to Day Unit since September and working well. Work ongoing to review MAC functioning and guideline being reviewed and updated to ensure consistency of RAG rating and management. Score to remain the same.
- Risk to patient satisfaction and safety, resulting from delays in facilitating induction of labour (IOL) (Score 8). Some current challenges relating to delayed IOL and some incidents of delayed ARM over 24 hours. Work ongoing to plan implementation of balloon catheters. For additional documentation by obstetric staff regarding prioritisation. Patient flow coordinator role under discussion. Recent increased activity which may have impacted. Increase in score due to increased frequency.
- Risk to patient safety and experience associated with need to divert patients to other units in times of escalation (Score 6). During episodes of closure of the maternity unit in times of high activity it may be necessary to divert patients to other units for clinical care to maintain patient safety. However, the decision to divert each patient should be appropriately risk assessed to confirm that the patient is not at risk of deterioration or development of complications during the diversion. Currently the risk assessment process is not sufficiently robust and has resulted in diversion of patients at risk of precipitate labour and delivery, or who may have been clinically unsuitable.
- Risk to patient experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 6). Work progressing with videos and additional actions from last review. Maternity CQC survey reported consent for IOL improved. Not current theme of complaints. Consideration of additional planned Quality Improvement work for development of additional materials or video around expectations of consent, and including what consent looks like when making decisions for assisted delivery in emergencies. For additional sharing with MNVP/Badgernotes. Score downgraded.
- Risk to patient satisfaction and safety, resulting from delays in facilitating ultrasound growth scans (USS) (Score 6). Remain some issues in scheduling and communication. Requires additional effective triaging and review of scan requests as some unnecessary or not cancelled when no longer required. Work undertaken to reduce Midwife

Sonographer slot duration to 30 minutes to facilitate additional slots. Score downgraded as not currently weekly frequency.

- Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 6). Additional staffing recruited and in process. Anticipate significant improvement towards end of the year once all in post and through induction/supernumerary period. Score currently to remain the same.
- Risk of breaching NIPE-SO4 standard and key performance indicator for review and clinical assessment by orthopaedic specialist (Score 6). No new information. Score remains unchanged at present.
- Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 6). Staff training undertaken and risk score reduced from directorate risk register. Some additional incidents noted and being managed and tracked on MS Teams channel. HDFT Impact work ongoing. No change
- Risk due to inability to meet gold standard requirements for clinical documentation (Score 5). Work and communication by Digital Midwife to improve risk assessment and management plans, and some minor improvement. Additional targeted work with frontline staff ongoing. Some improvement noted in personalisation and updating of management plans and risk assessments. No change in score at present.
- 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). Plans in place for continuity of carer implementation for vulnerable groups and teenage pregnant patients. Role recruited and awaiting starting date.

12. Maternity Incidents

In October 2025 there were 85 total incidents reported through DCIQ (including 16 incidents occurring in SCBU location; 8 occurring in EPAU).

One Moderate Harm incident reported by SCBU relating to an incident of incorrect test completed by Leeds Genetics.

One After Action Review occurred to review Neonatal Death in 2023 following information received from parents regarding timing of diagnosis.

There has sadly recently been an unexpected Neonatal Death. A RROSE review has been completed and a PSII will be completed. The Coroner has been notified and post-mortem is being undertaken.

13. Perinatal Mortality Review Tool (PMRT)

PMRT completed relating to antenatal stillbirth. Some concerns about checking and management of pathology results and delayed attendance with reduced fetal movements. Report finalised. Quarterly report included at Appendix C.

PMRT for Term intrapartum stillbirth reported to MNSI now completed. Final report to be completed. Some care issues identified but not considered to have been contributory to outcome (involves aspects of communication).

New PMRT relating to recent neonatal death detailed above to be convened.

14. Feedback

a. GMC National Training Survey

Each year the GMC asks doctors in training for their views on the training they receive. These results help improve training programmes and posts across the UK. This years' survey ran from 18 March to 29 April 2025. Overall Harrogate ranked 112th nationally, with a mean satisfaction score of 78.08. This places Harrogate in the 6th decile nationally, which is above

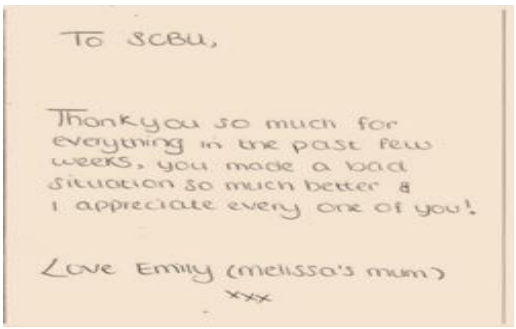
the national benchmark. Harrogate and District NHS Foundation Trust achieves the highest overall satisfaction across all HEYH Trusts, scoring just under 80. In relation to Obstetrics and Gynaecology speciality trainees specifically the results were positive with all three overall theme indicators being within the interquartile range; Overall Satisfaction, Clinical Supervision and Clinical Supervision Out of Hours. 100% of the Obstetric and Gynaecology speciality trainees rated the clinical supervision out of hours as being 'good' or 'very good'.

Year	Post specialty	Trust/board	Question category	Question	Answer	N	Trainee %	UK Wide N	UK Wide %
2025	Obstetrics and gynaecology	Harrogate and District NHS Foundation Trust	Clinical Supervision out of hours	GENHQ166 - Please rate the quality of clinical supervision, OUT OF HOURS, in this post.	Very good	6 to 10	57.14%	41091 to 41095	27.77%
					Good	6 to 10	42.86%	41091 to 41095	46.89%
					Neither good nor poor	6 to 10	0.00%	41091 to 41095	17.09%
					Poor	6 to 10	0.00%	41091 to 41095	4.57%
					Very poor	6 to 10	0.00%	41091 to 41095	1.65%
					Not applicable	6 to 10	0.00%	41091 to 41095	2.02%

b. Staff Feedback – Inpulse, NHS Staff Survey

The NHS Staff survey is currently open to responses until 28th November.

c. SCBU Feedback



d. Maternity and Neonatal Voice Partnership Feedback

Date feedback collected	Date of care	What was good about your experience with maternity services in Harrogate within the last 5 years?	What would you have liked to have been different about your experience with maternity services?	Do you have any ideas and suggestions?
08/09/25	Currently pregnant, previously used service in 2016 and 2025 Feedback received in ANC	Very responsive. Practitioners have all been kind and compassionate.	More follow up/check ins after I miscarried. Wad no further contact after care was completed. Miscarried at home, once pregnancy unit was happy it would be straight forward but no further	Previously miscarried. Did not feel much support was available after care was completed. I feel further signposting to mental health support services would have been helpful as I found this difficult.

			check in to see if it was complete or further support was needed.	
08/09/25	Currently pregnant, previously used service in 2021 and 2023 Feedback received in ANC	Very efficient, always pleased with service Very supportive	Maybe a bit more support once the baby is born	Midwives providing more support on breastfeeding/hand expressing. Particularly during pregnancy in preparation and on the postnatal ward before discharge

15. Complaints, concerns, compliments

Six formal complaints have been received in October which seems to be a significant increase this month. There isn't a clear theme to the complaints although two do relate to care in labour. It's not clear whether the negative media coverage of maternity services locally is impacting on the number of complaints coming through. All complaints have been responded to in the required timescales and appropriate actions taken in relation to concerns identified.

16. Coroner 28 made directly to Trust

No requests received.

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

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

18. Maternity and Newborn Safety Investigation (MNSI)

In Oct 2025: No new MNSI incidents reported.

Draft report from the current open MNSI case received and factual accuracy comments returned and incorporated. Parents have now withdrawn consent from MNSI investigation but final report still issued and now received by Trust. No Safety Recommendations or Safety Prompts noted.

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

Work is on-going to ensure that the service will meet all the requirements of the Maternity Incentive Scheme however we are aware that unless there is a change to the requirements we will not meet the requirements due to breaching the Obstetric workforce requirements as highlighted previously.

20. National priorities

a. Actions to improve care for women, babies and families: next steps

NHS England wrote to all Trusts in October to advise on next steps to improve care for women, babies and families. The following elements were detailed;

i) **Perinatal Equity and Anti-Discrimination Programme:** this will give perinatal teams the skills and tools they need to improve the experiences and outcomes of

ethnic minority groups and those from deprived communities, and to improve the working lives of staff from these groups. The programme's focus is on effecting the behavioural, cultural and organisational changes needed to tackle inequalities and sustain change.

ii) **Submit a Perinatal Event Notification (SPEN) service:** this portal streamlines the administrative time required by frontline staff to notify perinatal safety events to MBRRACE-UK, Maternity and Newborn Safety Investigations; and NHS Resolution Early Notification Scheme. SPEN has been implemented at HDFT.

iii) Maternity and Neonatal Performance Dashboard: This set of metrics will be used to monitor performance in maternity and neonatal services in all parts of the system, supporting trusts and integrated care boards to monitor and have insight into their own progress. The dashboard represents a balanced scorecard of operational, outcome and patient experience measures. All trusts must report regularly to their boards on maternity and neonatal safety, and NHS England will shortly be offering a model board report template for this. These metrics, together with the broader Perinatal Quality Surveillance Model published recently and the rollout of the Maternity Outcomes Signal System (MOSS), will enable trusts and integrated care boards to monitor their own progress, while supporting our collective work to drive improvements across all maternity and neonatal services and identifying trusts that may need additional support. HDFT provide the LMNS with data for the "Heatmap" and will start reporting to the Daily SitRep on 8th December 2025.

b. 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 the Three Year Delivery Plan. The remaining actions relate to saving babies lives, continuity of carer, and National maternity early warning score and newborn early warning track and trigger 2 (NEWTT2) which are currently being rolled out across the country.

c. Vaccinations and Immunisations

84.3% of women who birthed in Harrogate in October were offered Respiratory Syncytial Virus (RSV) vaccination. 82.5% of the women who birthed this month received a RSV vaccination.

d. Stop Smoking

Harrogate Maternity team continue to participate 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. 6 out of the 7 women who booked in October (85.7%) who smoked were referred for tobacco dependency treatment. Smoking at time of Delivery for October was 2.8%. Overall 27 women are currently enrolled on the national Stopping Smoking in Pregnancy Incentive Scheme, 26 have set a quit date, nine women have achieved being smoke free at four weeks and eight women have achieved being smoke free at birth.

21. Local HDFT Maternity Services Dashboard

All the data/watch metrics regarding Maternity can be found on PowerBI by following the link below.

Maternity Dashboard

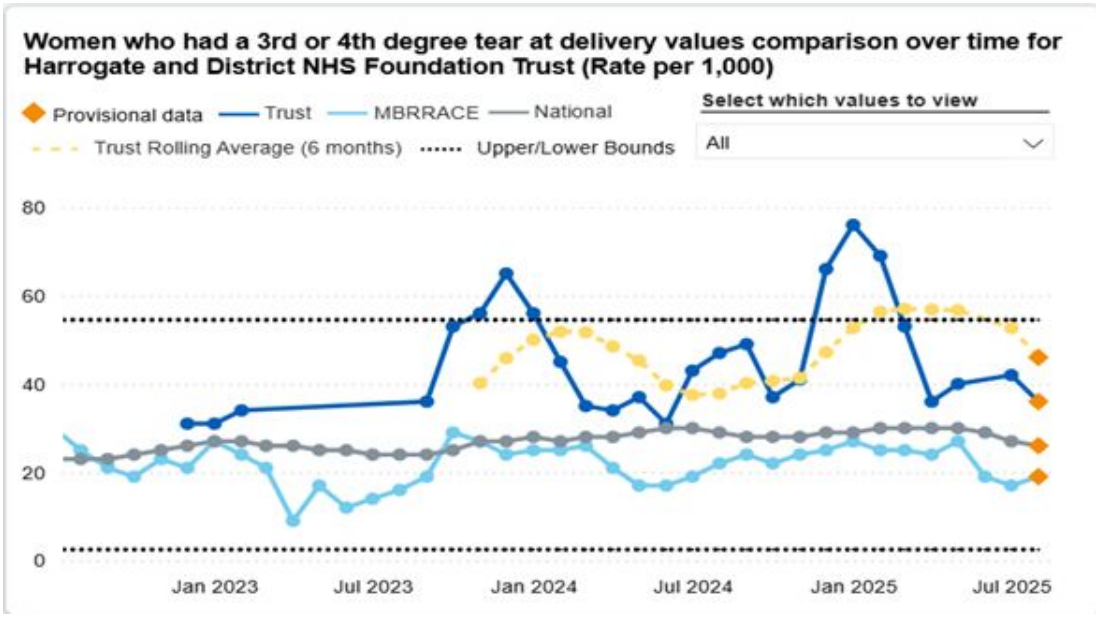
Work continues to ensure accuracy of data and benchmarking is included in all data fields captured in the dashboard since the move to Power BI for the reports.

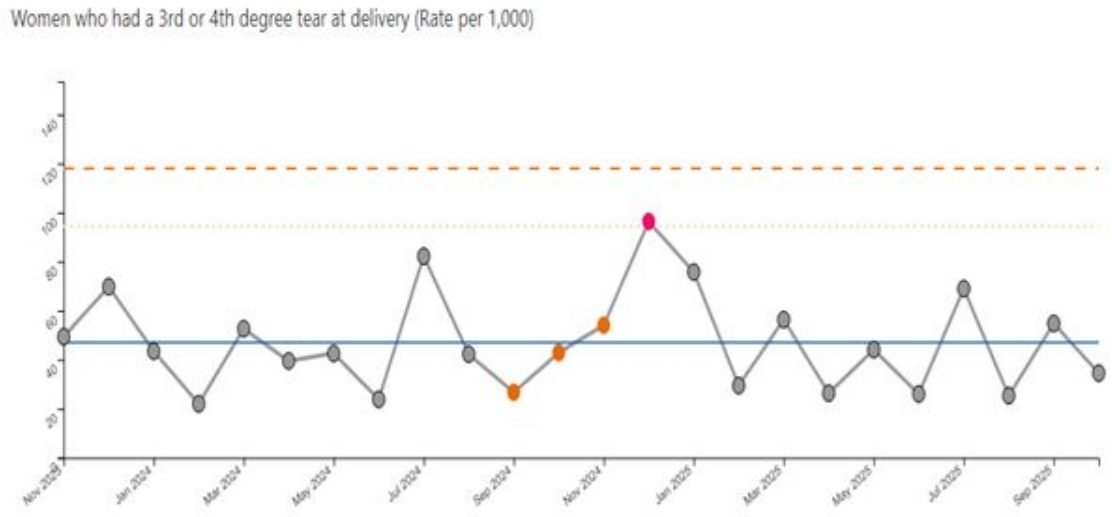
The National Maternity dashboard is available at the following link- National Maternity Dashboard. The data available in the dashboard is up to August 2025. The Clinical Quality

Improvement Metric comparison (CQIM+) tabs gives the opportunity to compare HDFT Maternity services against National services, Regional Peers, the Local Maternity and Neonatal System (HNY LMNS) peers and MBRRACE peers (other maternity services with under 2000 births per year at 24 weeks or later).

Areas of concern on review of the National dashboard relate to the following –

Women who have a third or fourth degree tear – Harrogate's position has not changed in the last month and work is on-going in this area. The local dashboard suggests that the rate has remained consistent over the last few months.

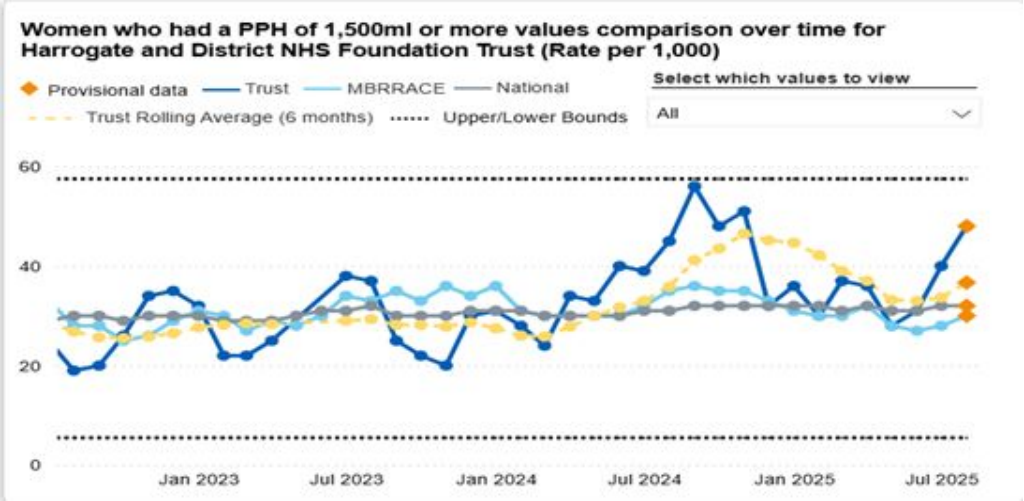




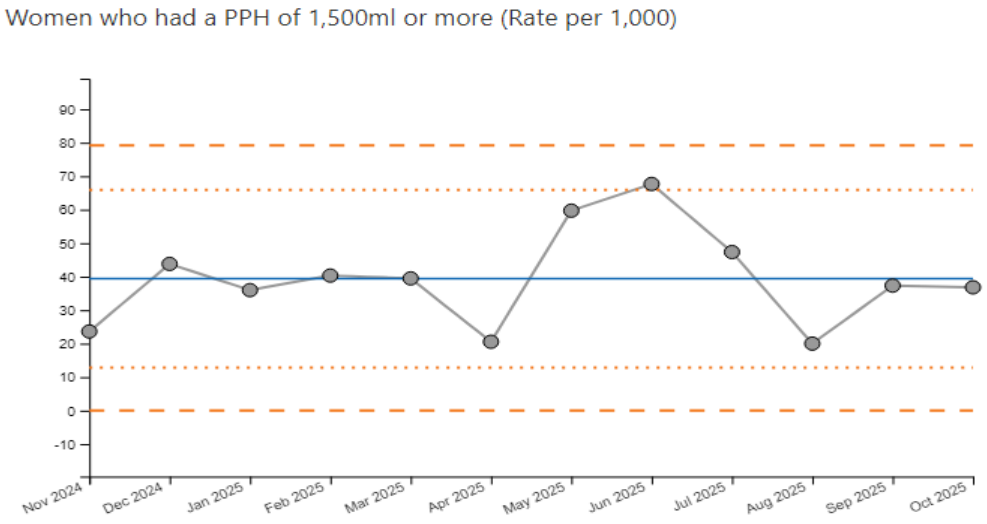
Open in Power BI

Maternity dshboardv2auto
Data as of 07/11/25, 16:10
Filtered by **MonthEndDate** (11/11/2023 - 10/11/2025)

Women who had a postpartum haemorrhage (PPH) of 1500ml or more – the national dashboard demonstrates that PPH rates at HDFT appear to have increased again this month having previously returned to being in line with National averages. When tracking the PPH rates over a more prolonged historic time period the peak seen recently is normal variation with previous peaks in rates. Small numbers have a significant impact on the dashboard, based on the average HDFT birth rate one additional person having a PPH per month is equivalent to an increase of 6 - 7 per 1000 on the CQIM graph. Increased caesarean section and induction of labour rates will be contributory factors to the rate of PPH.



Local data suggests that the rate of PPH will return to baseline as per the below graph.



Open in Power BI
Maternity dshboardv2auto
Data as of 07/11/25, 16:10
Filtered by **MonthEndDate** (11/11/2024 - 10/11/2025)

22. Neonatal admissions

a. Transitional Care (TC)

Work is ongoing to look to improve the offer of Transitional Care to babies born at 34-35 weeks gestation. Twelve babies received Transitional Care provision on Pannal Ward this month. Quarterly report included at Appendix G.

b. Neonatal Readmissions

There were two neonatal readmissions in October. A quarterly report is included in Appendix F.

c. Avoiding Term Admissions in Neonatal Units (ATAIN)

There were six incidents of term babies being admitted to the Special Care Baby Unit this month. All cases are reviewed at the multidisciplinary ATAIN meeting. A Quarterly report is included at Appendix G

23. Saving Babies Lives' v3.2 (released April 2025)

An action plan is in place, work is on-going, and compliance is reassessed by the LMNS quarterly. The next assessment is scheduled to be completed on 14th November 2025.

23. Maternity Safety Champions

Bi-monthly Safety Champion executive and non-executive director walk around and meetings continue. The next walk around and meeting is scheduled for 17th November.

24. Conclusion and Recommendations

a) Positive news
- Maintained compliance with QIS nursing ratio and Delivery suite co-ordinator supernumerary status.
- Fully recruited in SCBU

b) Areas of concern
- Increase in complaints received
- Increased number of women diverted

c) Work underway
- On-going review of the homebirth service provision
- Work ongoing to increase implementation of balloon catheters to reduce induction of labour delays

d) Decisions required of Board
- The Board is asked to note the updated information provided in the report, including in Appendices B to G.

Appendix A - Explanatory notes

1. Birthrate Plus Establishment

The HDFT Birthrate plus establishment setting review was completed in August 2024 and will be required to be repeated in 2027. Following receiving the Birthrate plus report, applying professional judgement and submitting the required business cases, the maternity staffing establishment has been increased as detailed below. The headroom uplift applied to all midwives working in maternity services has now been increased to 24% as recommended by Birthrate Plus.

3.6 WTE Band 2 (Admin/Ward Clerks)
19.18 WTE Band 3 (Maternity Support Workers/Screening Admin)
0.6 WTE Band 4 (Tobacco Dependency Advisor)
81.69 WTE Band 5-8d (Midwives)

2. 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)

3. 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.*

4. Perinatal Mortality Review Tool (PMRT)

Principles for the conduct of local perinatal mortality reviews:

The fundamental aim of the Perinatal Mortality Review Tool (PMRT) is to support objective, robust and standardised local reviews of care when babies die. This is to provide answers for bereaved parents and their families about whether the care that they and their baby received was appropriately safe and personalised or whether different care may have changed the outcome. The second, but nonetheless important, aim is to ensure local and national learning results from review findings to improve care, reduce safety-related adverse events, and prevent future baby deaths.

The PMRT is designed to support the review of baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths, and neonatal deaths. For about 90% of parents, the PMRT review process is likely to be the only hospital review of their baby's death that will take place.

The aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland, Wales and Northern Ireland. The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a technical clinical report. This should be used for discussion with parents from which a meaningful, plain language explanation of why their baby died whether, with different actions, the death of their baby might have been prevented, and any implications for future pregnancies they may have;

Which perinatal deaths can we review using the PMRT?

- Late fetal losses (also called late miscarriages) where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g. For the rare stillbirths which are unattended at home and where no antenatal care had been received, the review should focus on any postnatal and bereavement care provided;
- All neonatal deaths where the baby is born alive from 22+0 weeks of pregnancy but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g;
- All neonatal deaths where the baby dies in the community up to 28 days after birth or later, who have not received any neonatal care, should nevertheless be reviewed to ensure that the baby was indeed well at discharge and that appropriate bereavement care was provided;
- Post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

Which perinatal deaths should we not use the PMRT to review?

- Termination of pregnancy at any gestation;
- Babies with brain injury who survive.

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

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.

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/

6. 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.

7. Saving Babies Lives' v3.2 (released 24 April 2025)

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

The NHS has worked hard towards meeting the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020. Office for National Statistics (ONS) data showed a 25% reduction in stillbirths in 2020, but against the same baseline only 20% in 2021 during the COVID-19 pandemic. Much has been achieved in the past few years, but more recent data shows there is more to do to achieve the ambition in 2025.

Version 3 of the Saving Babies' Lives Care Bundle (SBLCBv3) has been co-developed with clinical experts including frontline clinicians, Royal Colleges and professional societies; service users and maternity voices partnerships; and national organisations including charities, the Department of Health and Social Care (DHSC) and a number of arm's length bodies.

Building on the achievements of previous iterations, version 3 refreshes all existing elements, drawing on national guidance, such as that from the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) Green Top guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It adds a new element on the management of pre-existing diabetes in pregnancy, based on data from the National Pregnancy in Diabetes (NPID) Audit.

This means there are now 6 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

In addition to the provision of safe and personalised care, achieving equity and reducing health inequalities is a key aim for all maternity and neonatal services and is essential to achieving the national maternity safety ambition. In developing each element in SBLCBv3, actions to improve equity have been considered, including for babies from Black, Asian and

mixed ethnic groups and for those born to mothers living in the most deprived areas, in accordance with the NHS equity and equality guidance.

As part of the Three year delivery plan for maternity and neonatal services, NHS trusts have been responsible for implementing SBLCBv3 by March 2024 and integrated care boards for agreeing a local improvement trajectory with providers, along with overseeing, supporting and challenging local delivery.

SBLCBv3 also sets out the important wider principles to consider during implementation. These reflect best practice care and following them in conjunction with the 6 elements is recommended, but are not mandated by the SBLCB.

Further information can be found at https://www.england.nhs.uk/long-read/saving-babies-lives-version-3-2/

Appendix B - Saving Babies Lives Quarter One Review

_SBLCBv3.2_Tool_Q1 25-26 HDFT final.pdf

Appendix C – Perinatal Mortality Review Tool Quarter Two Report

Compliance of completion of Perinatal Mortality Review Tool

Quarter 2, July to September 2025

This document provides a summary of current compliance against Safety Action 1 of the Maternity Incentive Scheme (MIS) for the second quarter, July to September 2025.

Safety action 1: *Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?*

Requirements of the Maternity Incentive Scheme Safety Action 1:

1. **Notify all deaths:** All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.
2. **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.
3. **Review the death and complete the review:** For deaths of babies who were born and died in your Trust from 1st December 2024 onwards, multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.
4. **Report to the Trust Executive:** Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an on-going basis from 1 December 2024.

MBRRACE-UK Case ID	Reported to MBRRACE (within 7 working days)	Review started (within 2 months)	Report published (within 6 months)	Parents informed of review and questions/concerns sought
98090	Yes	Yes	Completed	Yes
98640	Yes	Yes	Report in writing	Yes
99258	Yes	Yes	In progress	Yes
Overall Compliance against targets of Safety Action 1	100% - Compliant (Target 100%)	100% - Compliant (Target 100%)	100% - Compliant (Target 100%)	100% - Compliant (Target 100%)

Table 1: Eligible perinatal death against MIS requirements

Compliance of eligible perinatal deaths with MIS requirements

During Quarter 2, there was one perinatal death eligible to be reported to MBRRACE-UK. This was a medical termination of pregnancy at 21 weeks gestation that resulted in a neonatal death. No PMRT review is required in view of this being a medical termination of pregnancy.

There are currently two ongoing case reviews, one PMRT that is in the report writing stage, one other that is awaiting panel review in line with the MIS requirements.

Ongoing Action Plan following PMRT review

Root Cause/ Contributory Factor	Action/s	Target Date	Risk at review
Parental feedback about issues with contacting MAC.	Single Point of Contact number in place. Continuous audit for successful calls and call diversion to SPOC including time to answer. Review the planned wait time duration to determine whether it is appropriate to reduce the interval before diversion. Investigate options for additional recorded message to encourage patients to stay on the line.	01/11/25	Medium
Missed 36 week routine midwifery appointment.	Development of a fail-safe system to ensure community midwives can track when service users are being seen in community.	01/11/25	Medium
Joint issue with LTH's about missed 36 week appointment relating to lack of clarity when patients receiving shared care between trusts, and inability to access blood results.	Joint working with HDFT and LTH team leaders to clarify care responsibilities and remits.	01/11/25	Medium
This mother presented with reduced fetal movements and the mother was not risk assessed and the management was not appropriate.	Shared learning with the MDT and update through mandatory training.	01/08/25	Complete
Patient's perspectives and feedback.	Shared learning with multidisciplinary team.	01/08/25	Complete
Management and escalation of pathology results	For clearer definition of roles and responsibilities, and pathway for checking and managing pathology results in all clinical areas.	28/02/26	Medium
The baby was small for gestational age at birth, scans were indicated and performed but the baby was not identified as IUGR.	Ongoing audit on the accuracy of growth scans compared with birth weight, to confirm accuracy and offer learning points.	01/01/26	Low

Fundal height measurements performed alongside serial scanning pathway.	Reinforcement on mandatory training day and case study learning.	01/01/26	Low
Delay in attendance with RFM's.	Learning to be shared with MDT and MNVP as part of case study. MNVP to share information about early attendance to hospital with any episode of RFM's.	30/11/26	Low

Appendix D - Bi-annual Midwifery Staffing Report

Bi Annual Staffing Report	
	Time Period of Data **1st April 2025 – 30th September 2025**
Name & designation of person completing the summary	**Emma Barker, Matron for Maternity Service and EPAU** **Rachael Fawcett, Head of Midwifery** **Leanne Likaj, Associate Director of Midwifery and Children's Services**
Clinical area/s covered by summary:	Delivery Suite Maternity Assessment Centre (MAC) Pannal Ward Community Midwifery Antenatal Clinic
Sources of data collection	Information obtained from E-Roster, BirthRate Plus acuity tool, NHS professionals.

Executive Summary

1. The aim of this bi-annual report (1st April 2025 – 30th September 2025) is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels in the maternity department. This is a requirement of the NHS Resolution Maternity Incentive Scheme, Safety Action 5.

2. The report provides assurance that there is the following:

- A systematic evidence based process that has been used to calculate midwifery staffing establishment within the last three years
- A midwifery staffing budget that reflects the establishment calculated above.
- A process is in place to manage daily workload activity and to address any shortfall in planned versus actual midwifery staffing levels.
- A calculated midwife to birth ratio.
- An appropriate percentage of specialist midwives employed and mitigation to cover any inconsistencies.
- 100% compliance with a midwifery coordinator in charge of labour ward who has supernumerary status; (defined as having a rostered planned supernumerary coordinator and an actual supernumerary coordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service.
- An escalation plan which includes the process for providing a substitute coordinator in situations where there is no coordinator available at the start of a shift.

- One-to-one midwifery care for all women in active labour
- Monitoring of red flag incidents associated with midwifery staffing

3. The evidence described in this paper provides assurance that Harrogate and District NHS Foundation Trust (HDFT) has an effective system of midwifery workforce planning and monitoring of safe staffing levels in place.

Midwifery Establishment

NHS Resolution's maternity incentive scheme requires that a systematic, evidence-based process to calculate midwifery staffing establishment is completed and suggests Birthrate Plus (BR+) is utilised to provide this. The Royal College of Midwives (RCM) also strongly recommends using BR+ to undertake a systematic assessment of workforce requirements since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per NICE (2018) recommendation 1.1.3). It must however be recognised that one of the Ockenden (2022) recommendations was that

> *The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSEI, RCOG, RCM and RCPCH. Minimum staffing levels should be those agreed nationally or, where there are no agreed national levels, staffing levels should be locally agreed with the local maternity and neonatal system (LMNS). This must encompass the increased acuity and complexity of women, vulnerable families and additional mandatory training to ensure trusts are able to safely meet organizational Clinical Negligence Scheme for Trusts and CQC requirements. Minimum staffing levels must include a locally calculated uplift, representative of the 3 previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.*

A BR+ establishment review was last completed in August 2024 utilising three months data for December 2023, January and March 2024 and annual birth activity from 2023/24 (see Appendix A). The total births in 2023/24 review period was 1714. The Birthrate Plus establishment staffing is based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care. The 2024 BR+ establishment review recommended a total Clinical, Specialist and Management whole time equivalent (WTE) of 77.86 midwives, 10.45WTE of which are specialist and management. This is an overall increase of 1.65 WTE midwives from the previous BR+ report in 2021 and is based on a 20.78% headroom/uplift for absence. Given the increased training requirements for midwives it was proposed to move to an uplift of 24% which is more in line with other maternity departments across the UK. BR+ therefore proposed that 80.56 WTE midwives are required. Two business cases were written to uplift the midwifery and maternity support worker staffing in line with the Birthrate Plus report and professional judgment. The first business case was agreed to increase the establishment of midwifery staffing by 5.48WTE Band 7 midwives giving a funded establishment of 82.87WTE. The 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. Previously there was a funded establishment for support staff of 13.6 WTE. An additional business case was approved at Business Case Review Group in April 2025 to increase the establishment by 5.58 WTE Band 3 maternity support workers and 0.5 WTE Band 2 Ward Clerks.

The HDFT funding for midwives currently is 81.75 WTE and there is currently 78.92 WTE in post (plus 6.61 WTE midwives on Maternity Leave) as at the end of September 2025. See below month on month breakdown of WTE midwives in post.

Midwives (Band 5-8A)	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25
Budgeted Establishment	76.17	76.17	78.17	78.77	80.17	81.75 (+0.8WTE LMNS funded post for Enhanced Continuity)
Staff in Post (including maternity leave)	79.00	79.01	79.01	77.71	78.07	78.92

In addition to establishment setting, BR+ also provide an acuity monitoring tool. The BR+ workforce planning calculation determines the required total midwifery workforce establishment for all hospital and community services, whilst the Acuity App assesses real time staffing based on the clinical needs of women and babies for intrapartum and ward areas. Together they support the provision of safe and effective care which is both sensitive and responsive to changes in acuity and workforce. The BR+ acuity tool was purchased in September 2018 and BR+ updated the ward tool in 2024. Information from this BR+ tool is included within this report. Information is collected from in-patient areas only (Delivery Suite and Pannal ward). Unfortunately there isn't currently any system available to monitor acuity in a triage area like MAC.

The agreed staffing levels in all areas of the maternity department are outlined in the Minimum Staffing Guideline (Maternity). The minimum staffing levels have been agreed based on activity levels, current bed base and the numbers of midwives required to provide safe care to women and their babies. The maternity escalation policy provides clear guidance for the midwife in charge to follow in order to manage a shortfall in staffing (including the absence of a supernumerary Delivery Suite Coordinator) and the clinical and/or management actions to be taken. The clinical and management actions are also detailed in the BR+ acuity tool in order to capture the management of this shortfall. A review of the current and planned activity is undertaken to support the decision.

Establishment Deficits

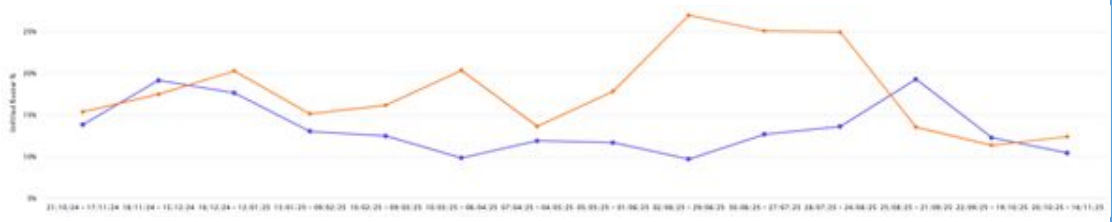
Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.

- There is an escalation policy for staff to use in the event of staffing short falls.
- A gap analysis will be completed against the recommended staffing levels in the BR+ report with any deficit being identified and actions taken to mitigate in the short and long term.

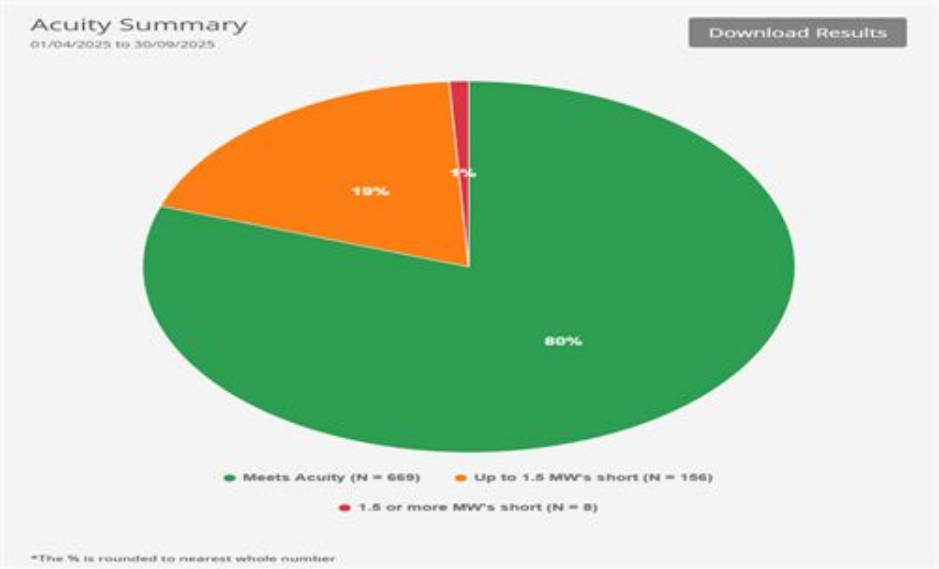
The maternity department continues to actively recruit new staff as required. The table below shows the number of starters (in WTE) balanced against the numbers of leavers between October 2024 and the end of September 2025.

	Midwives	Maternity Support Workers (MSW's)
New Starters	9.16	3.98
Leavers	4.37	2.69
Career break	1.8	0
Maternity Leave	7.7	0.6
Secondment	1.6	0

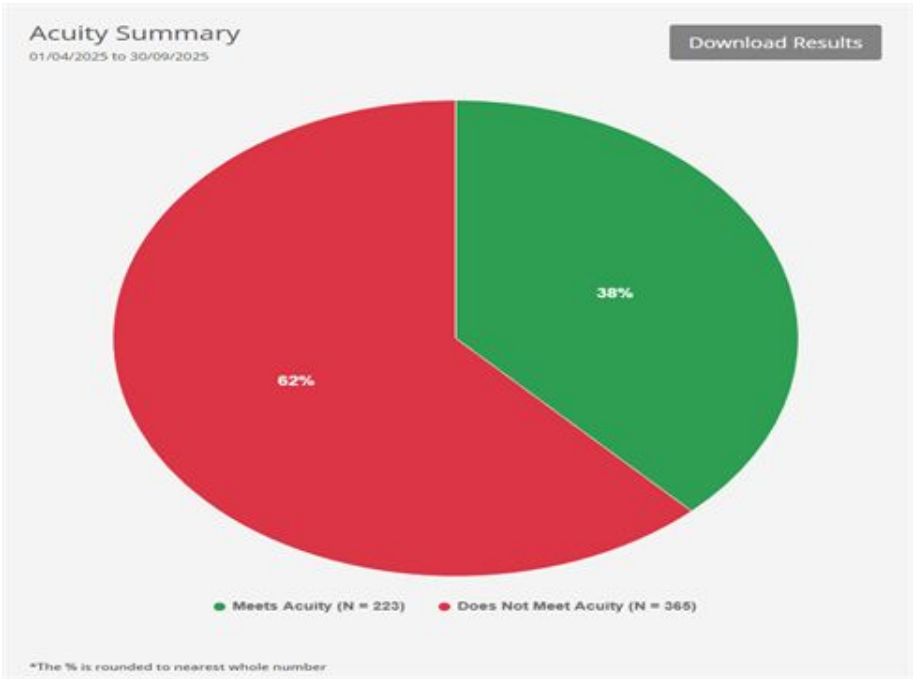
The below graph demonstrates the unfilled roster percentage October 24 to October 2025 as shown by the purple line. The orange line provides a reference point against the previous calendar year.



From the data submitted on BR+ over the six month period, staffing met the acuity on Delivery Suite 80% of the time, 19% of the time staffing was up to 1.5 midwives short and 1% of the time more than 1.5 midwives short (this is equal to 8 occasions). Compliance with completing the tool was 75.87%.

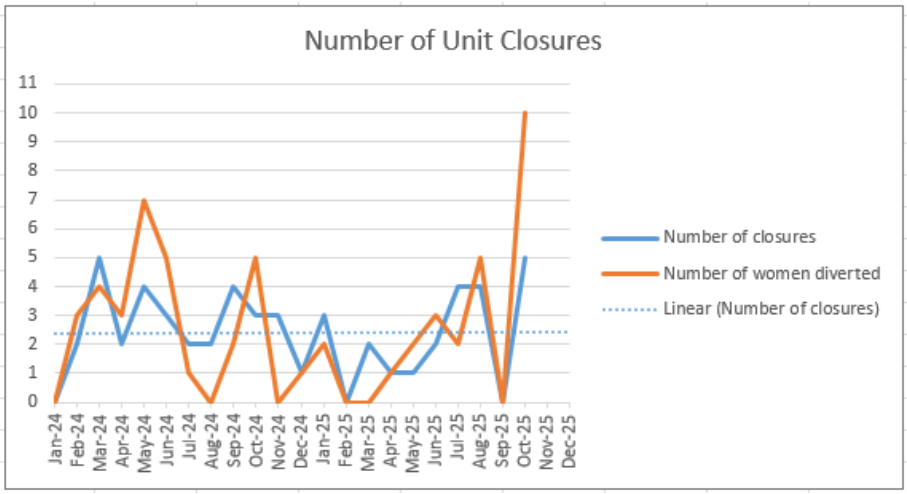


BR+ have developed the acuity app for Pannal ward for antenatal and postnatal care. The tool demonstrates that staffing does not meet acuity on Pannal 62% of the time.



The maternity unit has the ability to move staff around the unit and between inpatient and outpatient areas dependent on activity and acuity as and when required. Mitigation to cover shortfalls is incorporated in the maternity escalation guideline and achieved in the short term by implementing clinical and management actions, collected in the BR+ acuity tool. Due to the nature of maternity services there will be periods of high and low activity and the unit has the ability to move staff accordingly or temporarily close to further admissions. During this period the maternity unit was on divert on 14 occasions with 16 women diverted to other

hospitals. The graph below demonstrates a steady increase in the number of diversions in the last six months.



A Datix incident form is completed when there is increased activity and the unit has closed or women in labour diverted to another unit as a consequence. All women diverted elsewhere are sent a letter apologising for the inconvenience of the diversion. All closures are reviewed by the Matron with the Labour Ward coordinator to discuss the activity, staffing and decision making before the escalation paperwork is signed off. There is an oversight of staffing issues through Maternity Risk Management Group (MRMG) meetings and monitored through Datix.

Planned Versus Actual Midwifery Staffing Levels

A weekly midwifery manager's huddle is in place to review the planned staffing against the agreed establishment for each clinical area with the ability to redeploy staff when required.

Daily staffing reviews are also held by the Manager of the Day/Delivery Suite Coordinator to ensure a fast response with mitigating actions to address any highlighted staffing shortfall.

Actions have been taken as per the Maternity Escalation Policy to mitigate against unfilled shifts. This included "staff movement between areas" and "specialist midwives and team leaders working clinically " as reflected in the Red Flags reported, as well addressing staff shortfall by using the on-call midwife during the night shift.

NHSP bank staff are requested to fill all roster gaps which the majority of the time are due to sickness or vacancy. NHS Professionals demand and fill is demonstrated below.

Midwife: Birth Ratio

The monthly midwife to birth ratio is currently calculated by taking the total number of births per month, multiplying by 12 then dividing by the number of clinical midwives (not including specialist roles). This calculation does not take into account midwives who were unavailable for shifts due to sickness, maternity leave or absence. The midwife: birth ratio does not take into consideration the acuity/requirements of the woman being cared for in labour. The Associate Director of Midwifery and Matron are not included in the midwife to birth ratio however team leaders have their clinical time included.

HDFT midwife to birth ratio

Midwife to Birth ratio	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025
Ratio	1:22	1:20	1:20	1:26	1:23	1:20
Number of births	145	132	131	168	150	132
Midwives in post	79.00	79.01	79.01	77.71	78.07	78.92

Specialist Midwives

BR+ suggests 15.5% (10.45WTE) of the midwifery establishment are not included in clinical numbers. This includes those in management positions and specialist midwives

The current percentage of specialist midwives employed is 15.1%. All midwives within this staff group support the maternity unit by working clinically if required at times high activity or acute sickness within office hours. A significant number of them also provide clinical care as part of their specialist role.

The specialist roles support national recommendations to ensure the service has the correct specialist posts for the demographic served and are in line with current national initiatives. The service has a wide range of specialist midwifery posts at Band 6, Band 7 and 8A as detailed below totalling 11.92 WTE;

- Bereavement Specialist Midwife 1.0 WTE
- Infant feeding Specialist Midwife 0.8 WTE

- Quality and Safety & Governance Lead 1.00 WTE
- Named Midwife for Safeguarding 1.0 WTE
- Antenatal and New-born Screening Specialist Midwife 1.0 WTE
- Digital Midwife 0.8 WTE
- Midwife Sonographer 0.80 WTE
- Recruitment and Retention Midwife 0.72 WTE
- Perinatal Pelvic Health Midwife 0.4 WTE
- 2 x Professional Development Midwives 1.3 WTE (Inc. Fetal Monitoring Lead role)
- Clinical Educator Midwife 0.4 WTE
- Perinatal Mental Health Midwife 0.8 WTE
- Audit Midwife 0.7 WTE
- Diabetes Specialist Midwife 0.6 WTE
- MSW Education and Development Midwife 0.6 WTE
- Professional Midwifery Advocate Lead Midwife 0.6 WTE (Corporate funding)
- Research Midwives (research funded)

Compliance with Supernumerary Labour Ward Coordinator Status and Provision of One to One (1:1) Care in Active Labour

Data extracted from Birthrate plus during the six months shows there was a completion rate of 75.87% on the Delivery Suite and 80.33% for Pannal. A higher compliance completion rate provides more assurance that the interpretation of the results is accurate.

The labour ward coordinator has supernumerary status, (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift (NHS Resolution, Maternity Incentive Scheme, 2024) to enable oversight of all the birth activity within the service.

There is always a delivery suite coordinator (or suitably experienced band 6 midwife in exceptional circumstances) rostered to be in charge on Delivery Suite and they will aim to be supernumerary in order to provide oversight of all birth activity in the service. 100% compliance was achieved with having a rostered planned supernumerary coordinator and an actual supernumerary coordinator at the start of every shift.

Harrogate is a small maternity unit and there is full recognition of the advantages of the Delivery Suite coordinator being supernumerary in improving outcomes for both mother and baby.

All information was collated using the Birthrate Plus acuity tool. During this six month time period there were 27 occasions when during the shift the Delivery Suite coordinator became not supernumerary out of a 1098 opportunities to record (833 recorded occasions) which equates to 97% supernumerary status. Each completion refers to a four hour period and the occasions of none supernumerary status may only occur for a small amount of time during each four hour period. Predominantly these occasions were during the night and at weekends when there is no additional staff available to support the service (ward managers and specialist's midwives). There is a clear escalation process in place when the coordinator cannot be supernumerary which includes contacting the community teams at a weekend and the hospital midwife on call at night.

During this time period 1:1 care in labour was achieved 100% of the time for women admitted to the unit.

- 858 women birthed
- 5 women experienced a baby being born before the arrival (BBA) of the midwife,

- 10 women had a homebirth

Red Flags

Red flag events have been agreed locally (including guidance from NICE) and are captured on the BR+ acuity tool on Delivery Suite. During the 6-month period between the following red flag events were identified on Delivery Suite;

Number of Red Flags recorded

01/04/2025 to 30/09/2025

Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	7	54%
RF2	Missed or delayed care	2	15%
RF3	Missed or delayed mediation > 30 mins	0	0%
RF4	Delay in providing pain relief > 30 mins	0	0%
RF5	Delay between presentation and triage >30 mins	1	8%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	2	15%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	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%
RF10	Midwife unable to provide 1:1 high dependency care for AN or PN patient	1	8%
TOTAL		13	

*The % is rounded to nearest whole number

Within Birthrate plus there are a number of Management Actions listed which can be used with the aim of preventing progression to a red flag incident. These include delay in elective activity, use of non-clinical staff, and use of managers in clinical areas. Red flags are set to highlight when there is a safety issue that has not been prevented by utilising the management actions. HDFT strive to have no red flag incidents however, high acuity or staffing issues can lead to one or more of the red flag incidents occurring. Staff are encouraged to be open and honest in the recording of red flag incidents so that accurate oversight can be maintained of the maternity service, and action can be taken if necessary. There is a well embedded escalation policy which is followed in periods of high acuity or inadequate staffing cover.

Any time a red flag event occurs, a senior obstetric review will be required and a clinical pathway will be put in place. Good communication is shown with our service users during this time, keeping them informed of reasons for any delays, and likely timeframes for resuming their normal care pathway.

If the escalation policy is triggered, details of all activity during this time is recorded, and reviewed by the senior management team. This is to consider if alternative management could have prevented pressure on the service, and to review if all safety measures were taken to minimise the risk of harm. Learning from the review will be discussed with the relevant team members.

Summary

Staffing levels are continually reviewed by the Associate Director of Midwifery and Children's Services, Head of Midwifery, Matron and senior midwifery team leaders in line with known workload and projected maternity bookings in Maternity Services and information from the BR+ acuity tool. The minimum staffing levels are agreed within the Maternity staffing guideline for the department and the BR+ acuity tool offers additional information on these levels and the acuity of the women however, it is for in-patient areas only and does not include Antenatal clinic (ANC) or community midwifery teams.

Once fully recruited in to the increased establishment the number of diverts of service should reduce and compliance with staffing levels on Pannal Ward should improve.

Recommendations

1. Increased establishment recruited staff will enable new night shift safe staffing requirements of two Band 7 midwives and two Band 5 or 6 midwives on Delivery Suite and three midwives on Pannal Ward. This should reduce the number of diverts of the service.
2. New patient flow role created and funded to enable better flow across the maternity unit, currently in recruitment process
3. Government funding awarded to create 2 WTE additional band 5 midwives

Appendix E

Neonatal Staffing Report 2025

Harrogate Special Care Baby Unit (SCBU)

The Neonatal Unit (NNU) staffing is captured on a Badgernet database twice a day, the staffing levels and acuity are defined by the BAPM (British Association of Perinatal Medicine) staffing toolkit. The data is analysed using the Dinning neonatal staffing tool which provides a quick analysis of cot-side nurse staffing based on a unit's care activity and nursing budget, identifying any shortfall against the national neonatal service specification. As well as nurse staffing requirements, the tool calculates unit occupancy and provides a suggested cot configuration based on one year's activity entered either retrospectively or prospectively. The tool was shared across all neonatal operational delivery networks (ODNs) in England in 2013 and has been in regular use by neonatal ODNs since then. The tool was reviewed by the Clinical Reference Group (CRG) and adopted as part of the National Neonatal Review to provide a national audit of nurse staffing.

The chance of survival of the smallest and most preterm babies relates not only to nurse staffing ratios but also to the specialist levels of education and experience of nurses delivering care. Specialised neonatal nursing requires specific knowledge and skills. All nurses attending births and/or involved in direct clinical care of the neonate are required to undertake a Newborn Life Support course appropriate to their role as recommended by the Resuscitation Council UK, and receive regular training updates.

BAPM (2019) state that because of the acute nature of neonatal practice and the difficulty of predicting patient activity, there will be times when recommended nurse staffing levels are not able to be met, and conversely times when the nursing staff provision is more generous. It is essential that the average nurse:patient ratio meets recommended standards. Periods of relatively less intense NNU activity should be seen as an opportunity for neonatal nursing staff to undertake self-directed learning or participate in unit-based teaching, e.g. simulation sessions.

Day to day management of nursing care provision on Neonatal Units should be undertaken by a senior nurse (generally Band 7 level) who has no clinical commitment during the shift (often referred to as the shift coordinator). This role may also include supporting other nurses during periods when additional workload impacts on their bedside caring time, e.g., during the acute period of admissions or the internal and external transfer of babies (BAPM 2022). Harrogate SCBU do not have a supernumerary shift co-ordinator on every shift however there is a Band 7 Unit Manager on site Monday - Friday 09:00-17:00 to support shift responsibilities. Cross cover is also provided from the co-located Paediatric ward in event of unwell baby being born. This is acknowledged on our risk register and discussed regularly when the risk register is reviewed.

Harrogate SCBU has seven special care cots which are commissioned. The below tables demonstrate that care is provided by a mix of Band 5 and Band 6 nurses, some of whom are Qualified in Speciality (QIS). During quarter 2 there has been a 24% vacancy rate, 9.68% sickness rate and 7.78% maternity leave. These absences have been covered by 4.44 WTE bank usage.

Definitions –

Declared Cots:	The number of cots, by care level, which a unit are operating.
Required Cots:	The number of cots, by HRG, required to deliver the activity undertaken in the reporting period at an average occupancy of 80%.
HRG 1:	Intensive Care as per HRG 2016
HRG 2:	High Dependency as per HRG 2016
HRG 3-5:	Special Care, and any other care HRG 3-5 that takes place on NNU, as per HRG 2016
WTE:	Whole time equivalent

ADDITIONAL NEONATAL UNIT DATA - *NURSES WORKING ON NEONATAL UNIT ONLY*				
	From	To	WTE	Head Count
New Starters	01/07/2025	30/09/2025	0.92	1
Leavers	01/07/2025	30/09/2025	0.92	1
Net Gain / Loss	01/07/2025	30/09/2025	0	0
Turnover (%)	01/07/2025	30/09/2025	0%	0%
Current vacancies (WTE)	01/07/2025	30/09/2025	1.19	
Current maternity Leave (WTE)	01/07/2025	30/09/2025	1.86	
			WTE	Hours used
Sickness in quarter	01/07/2025	30/09/2025	0.6	299
Bank Usage in quarter	01/07/2025	30/09/2025	1.9	920
Agency Usage in quarter	01/07/2025	30/09/2025	0.0	0

BAPM (2019) states that the minimum nurse to baby ratio should be 1:1 for babies receiving intensive care (QIS nurses only), 1:2 for high dependency care (QIS nurses either directly delivering care or supervising registered nurses) and 1:4 for special care. In order to manage the fluctuations in activity cot occupancy should be set at 80% and QIS nurse staffing at 70%. The below table demonstrates that Harrogate SCBU have maintained compliance within these requirements.

Activity calculations (HRG 2016)							
	Activity	For calculations		Commissioned cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	12	*0.0*	*6.07*	0		1	-1
HRG 2	81	*0.3*	*3.04*	0		0	0
HRG 3	1,037	*3.6*	*1.52*	7	40.59%	3	4
Total	**1,130**			**7**	**44.23%**	**4**	**3**

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 16.69, of which 11.68 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	13.36	12.22	12.55	0.81	-0.33
Total reg nurses	12.66	11.46	12.14	0.52	-0.68
Total QIS	10.21	8.40	8.50	1.71	-0.10
Total non-QIS	2.45	3.06	3.64	-1.19	-0.58
Total non-reg	0.70	0.76	1.62	-0.92	-0.86
Reg nurses as % nursing staff	94.8%	93.8%	96.7%		
QIS as % reg nurses	80.6%	73.3%	70.0%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependency care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

BAPM also states that in relation to Paediatric Medical staff the following is required –

Recommended numbers of staff for a Special Care Baby Unit:

• Tier 1: Rotas should be European working time directive (EWTD) compliant (58) and have a minimum of 8 whole-time equivalent (WTE) staff who may additionally cover paediatrics if this does not reduce safety and quality of care delivery.

• There should be a resident Tier 1 practitioner dedicated to the neonatal service during weekday day-time hours and an immediately available resident Tier 1 practitioner 24/7.

• Tier 2: Shared rota with paediatrics comprising a minimum of 8 WTE staff.

• Tier 3: A minimum of 7 WTE consultants on the on-call rota with a minimum of 1 consultant with a designated lead interest in neonatology.

The action plan below demonstrates the actions that are being taken to meet this requirement. There currently is 1:7 Tier 3 doctors on the rota however there is cover for the unit 24 hours a day.

BAPM Action Plan 2025-2026

BAPM standards Action Plan

ID no.	Root Cause/Contributory Factor	Initial risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date	Current Status (Complete, Ongoing and on Track, Ongoing and Off-track)	Evidence of Progress/Completion	Further action/s to ensure completion	New target date if original passed
1	BAPM standard for medical staffing - Tier 1 should have a minimum of 1 in 8	Low	Review BAPM requirements against S	Dr P Gilbertson	Dr Patricia Gilbertson	01 August 2024	Complete	As of August 2024 there are now 8 Tier 1 Doctors on the rota.		
2	Lack of "shift co-ordinator" on every shift as per BAPM guidelines.	Low	Review BAPM requirements against SCBU activity	SCBU Ward Manager	Matron, Paediatric Services	N/A	Complete	The unit has a maximum of 7 level 1 cots therefore professional opinion is that the unit does not require 3 registered nurses on every shift. A Band 7 Unit Manager is on site Monday - Friday 08:00-16:00 to support shift responsibilities. Cross cover is provided from co-located Paediatric ward in event of unwell baby being born.		
3	BAPM standards for medical staffing - Tier 2 should have a minimum of 1 in 8 on the rota	Low	Review BAPM requirements against SCBU activity	Dr P Gilbertson	Dr Patricia Gilbertson	N/A	Complete	There is 1 in 7 on the rota. This is compliant with the working time directive, and there is cover 24 hours a day.		
4	Lack of shift Co-ordinator on every shift as per BAPM guidelines	Low	Reflect on risk register	SCBU Ward Manager	Matron, Paediatric Services	N/A	Complete	Listed as a risk on risk register as per BAPM guidance		

References

BAPM (2019) - Calculating Unit Cot numbers and Nurse Staffing Establishment and Determining Cot Capacity, October 2019. Accessed at Calculating Unit Cot numbers and Nurse Staffing Establishment and Determining Cot Capacity

BAPM (2022) - The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK, November 2022. Accessed at BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com

Appendix F

Hospital Readmissions of Babies within 30 Days of Life

Quarter 2 July – Sept 2025

Report Overview

Potentially preventable readmissions, such as for jaundice or feeding problems, make up the majority of early neonatal readmissions across the UK. Theoretically, such admissions could be reduced either through additional support during the newborn hospital stay, or increased levels of follow-up after discharge. Evidence on safe early discharge is conflicting as most of the evidence comes from the United States where postnatal care in the community is very different. UK studies have demonstrated that decreasing the length of postpartum stay does not increase readmission rates, given adequate postnatal care outside of hospital.

There should be cautious interpretation of data between Trusts across the UK due to differing admission criteria, breastfeeding rates and levels of supplementation of breastfed babies in the community. Although lower readmissions is often measured as a positive marker this may be at the detriment of exclusive breastfeeding. Breastfeeding initiation in Harrogate is currently 91.7% and supplementation rates continue to be within World Health Organisation and Unicef UK parameters (2024/25).

1.1 Process For Data Collection

A Datix report is completed for all babies readmitted within 28 days with Jaundice and /or feeding issues (weight loss). Datix reports are then investigated by the infant feeding co-ordinator to determine if care was appropriate in the days before admission. Individual feedback is given to staff when appropriate and general themes and trends are examined in more detail and discussed at the Maternity Risk Management group (MRMG).

1.2 External Reporting

Health Care Evaluation data (HED) is an external reporting system used by HDFT which compares *all* readmissions of babies in the first month of life. The aim is to enable healthcare organisations to drive clinical performance in order to improve patient care and deliver financial savings.

1.3 National Guidance

Both maternity and paediatrics follow NICE guidance on recognising, measuring, monitoring and treating jaundice in the newborn. Maternity and paediatrics also use UK-WHO information and growth charts for monitoring weight loss and growth in babies and children.

1.4 Local Guidance and Preventative Measures

- Unicef UK Baby Friendly weight loss guidance has been adapted locally to ensure plans of care are introduced early and are supportive of long term breastfeeding.
- A breast pump loan scheme supports mothers to implement plans of care.
- Specialist help with breastfeeding is available to all mothers via a weekly support group at Harrogate Library and a frenulotomy service is provided for those needing referral for tongue tie.

1.5 Individual Readmission Data of Babies with Jaundice and/or Feeding Issues in the First Month of Life

Jaundice	Age when readmitted	Gestation at birth	Treatment	Length of stay
Baby 1	2 days	40+5	Phototherapy	30 hours
Baby 2*	2 days	37	Phototherapy (intensified)	24 hours
Baby 3	3 days	40+2	Phototherapy	2 days
Baby 4	4 days	35	Phototherapy	3 days
Baby 5	2 days	37+6	Phototherapy	2 days
Baby 6	3 days	37+4	Phototherapy	22 hours
Baby 7	5 days	40	Phototherapy & feeding plan	24 hours
Baby 8	5 days	39+2	Phototherapy	36 hours
Baby 9*	4 days	38+3	Phototherapy (intensified)	2 days
Baby 10	6 days	37+3	Phototherapy	18 hours

Feeding issues	Age when readmitted	Gestation At birth	Weight loss	Treatment	Length of stay
Baby 1	4 days	39+6	12.5%	Feeding plan	24 hours
Baby 2	3 days	40+2	13%	Feeding plan	2 days
Baby 3	3 days	39+1	13.4%	Feeding plan	24 hours
Baby 4	3 days	39+1	12.8%	Feeding plan	26 hours
Baby 5*	3 days	40+5	20.8%	Feeding plan	24 hours
Baby 6*	8 days	35+4	11.9%	Feeding plan	2 days

Comments * see below

Babies with jaundice:

- **Baby 2** received intensive phototherapy and was noted to have three recognised risk factors for jaundice: prematurity, exclusive breastfeeding, and a sibling who previously required phototherapy. No signs of jaundice were evident prior to transfer to community care. A referral to paediatrics for a serum bilirubin (SBR) was made at the first home visit. On readmission, weight loss was just over 10%, but the baby was noted to be receiving good volumes of breastmilk.
- **Baby 9** also required intensive phototherapy. A Biliflash reading the day before admission was just below the referral threshold; the community midwife arranged an early repeat visit the following day, leading to referral for an SBR and subsequent admission. Weight loss was 7%, and the baby was feeding well.
- **Baby 8** experienced an initial 8% weight loss, however this was followed by two static weights and a further small loss, prompting the introduction of a feeding plan including expressed breastmilk (EBM) and formula.

Both babies who required intensive phototherapy received small formula supplements alongside expressed breastmilk via nasogastric tube. The remaining seven babies continued to be exclusively breastfed.

One additional baby had a Datix submitted for jaundice; however, the baby was still an inpatient on day 2 when phototherapy was commenced (gestation 37+4 weeks and cephalohaematoma following forceps delivery)

Babies with weight loss:

- **Baby 5** had a large weight loss of 20.8%, weight was rechecked on admission and the parents had a photo of the birthweight. Baby appeared well, urea and electrolytes were all within normal range and the parents felt breastfeeding was going well. A feeding plan of breastfeeding and supplements of EBM was commenced and the baby was discharged the next day following a 40g weight gain.
- **Baby 6** was a preterm infant cared for on transitional care while on the postnatal ward and discharged on day 4 with a minimal weight loss of 7% and no other concerns. The baby was readmitted four days later with a weight loss of 11.9%; no interim weight measurements were available as the baby was out of area. The neonatal team were not asked to review the baby on the day of discharge and there was no ward round. Staff involved have been reminded of the transitional care guidance, including the requirement for a daily review.

Two further babies attended for feeding support. One baby was referred by the community midwife in line with guidance; following review, the mother declined admission and returned home with a feeding plan. The baby had a significant weight gain the following day. The second baby was **birthed in another Trust** while Harrogate was on divert; the family self-referred for feeding support and reassurance and remained for six hours.

Chart 1 Statistical process control chart (SPC) for readmissions with feeding issues / weight loss since April 2020

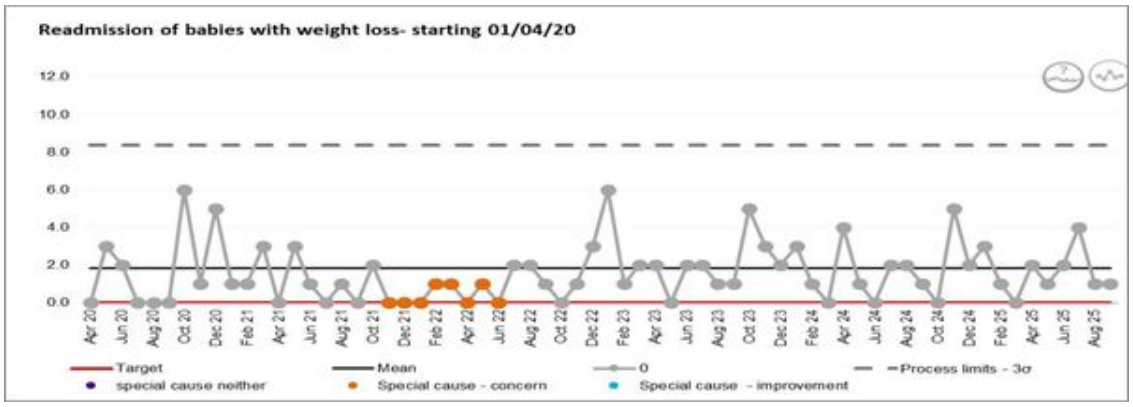


Chart 2 SPC chart for readmissions with jaundice since April 2020

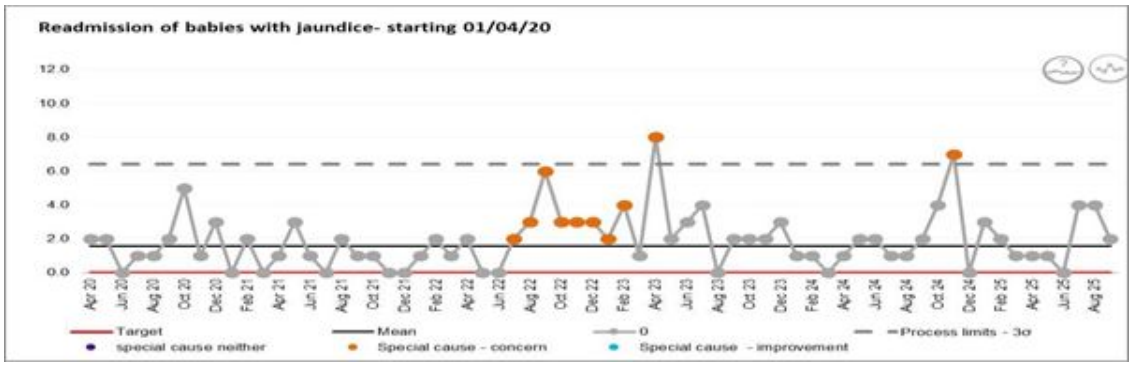
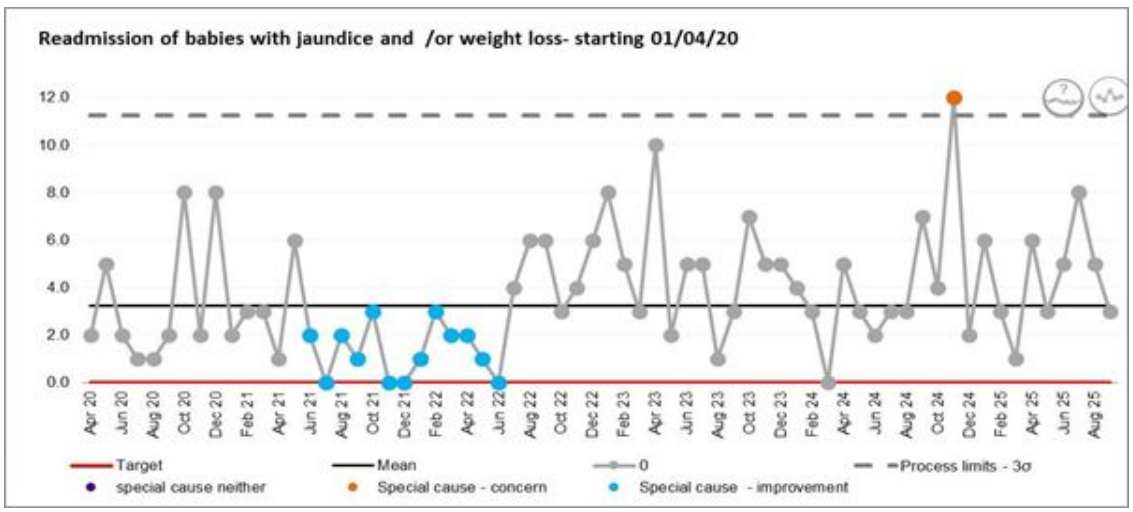


Chart 3 SPC chart including *all* babies' readmitted for jaundice and/or feeding problems since 2020



1.6 Findings Summary

Over Quarter 2, ten babies were readmitted to Pannal Ward / SCBU due to jaundice and six babies due to feeding issues. There has been no significant change in the rate of readmission. Each case is reviewed individually and an action plan is in place.

1.7 Recommendations

Action plan

Recommendations from datix review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date	Comments
Ensure accurate weighing and recording of babies weights in hospital and community	Ensure staff: • Check weight with another person, except where not possible in exceptional circumstances • Take a photograph for evidence. • Enter the weight on BadgerNet immediately. • Take care not to transpose digits. • Make sure equipment is set to zero prior to placing baby on the surface. • Baby to be weighed naked.	Andy Brown	**Completed**	'Learning from incidents' news letter sent to all staff
When possible avoid overnight stays for babies with weight loss that have normal blood test results	1. Explore cost of purchasing a hospital grade double breastpump to loan to parents overnight to help with feeding plan. 2. Remind staff to give parents an individual plan of care, which where appropriate, includes a plan to re weigh baby on the postnatal ward in 24 hours.	Jo Orgles	**April 2025**	October 2024: Bereavement support group contacted but no available funding at present. Jan 2025: Application submitted to HDFT charities March 2025: Awaiting response from charities.

				July 2025: No further response from charities. Other funding to be considered. Oct 2025: Consideration to be given to using small loan pumps on a trial basis, To be discussed at neonatal obstetric meeting.
Ensure feeding plans are consistent for babies readmitted with weight loss.	1. Arrange meeting with the Paediatric clinical lead for postnatal and the infant feeding co-ordinator to discuss more formal feeding plans for larger weight loss in babies. Include when to supplement and when to repeat weight and bloods. 2. Update guideline to reflect outcomes of decisions made at meeting. 3. Communicate updated guideline to staff. 4. Ensure training includes updated guidance.	Pat Gilbertson Jo Orgles	**Completed**	October 2024: Draft SOP completed. Requires discussion with paediatric clinical lead and then agreement at Paediatric governance. Jan 2025: Meeting arranged with paediatric consultant. March 2025: 1. Draft plans agreed 2. Readmission guideline updated 3. Feeding plans added to Mat 3 update for 2026/7. Will be added to next infant feeding newsletter for staff 4. Readmissions and feeding plans included in full infant feeding training
Ensure moderately preterm babies on the postnatal ward receive the same level of care as babies on SCBU	1. Work with neonatal nurses to develop a plan of care for moderate/late preterm babies on the postnatal ward. Include feeding, thermoregulation, increased risk of jaundice and neurodevelopmental care. 2. Train all midwives in care of late preterm babies 3. Develop an information package for parents. 4. Ensure any changes to care are included in appropriate guidelines	Jo Orgles Amy Howard	**Completed**	March2025: 1. Plan of care developed and agreed 2. Care of late preterm babies is the theme for Mat 3 infant feeding update 2025/6. 3.Parent package in draft, nearly complete 4.Guidleines to be reviewed July 2025: 3) Parent package completed, to be agreed at MQAM. 4) Guideline updated

Share learning with the community team to improve care and consistency	1. Arrange dates to meet with community midwives 2. Share good practice and discuss individual cases where care could possibly be improved 3. Develop plans of care for static weight / weight loss following introduction of a feeding plan	Jo Orgles Ellie Kay	**Completed**	

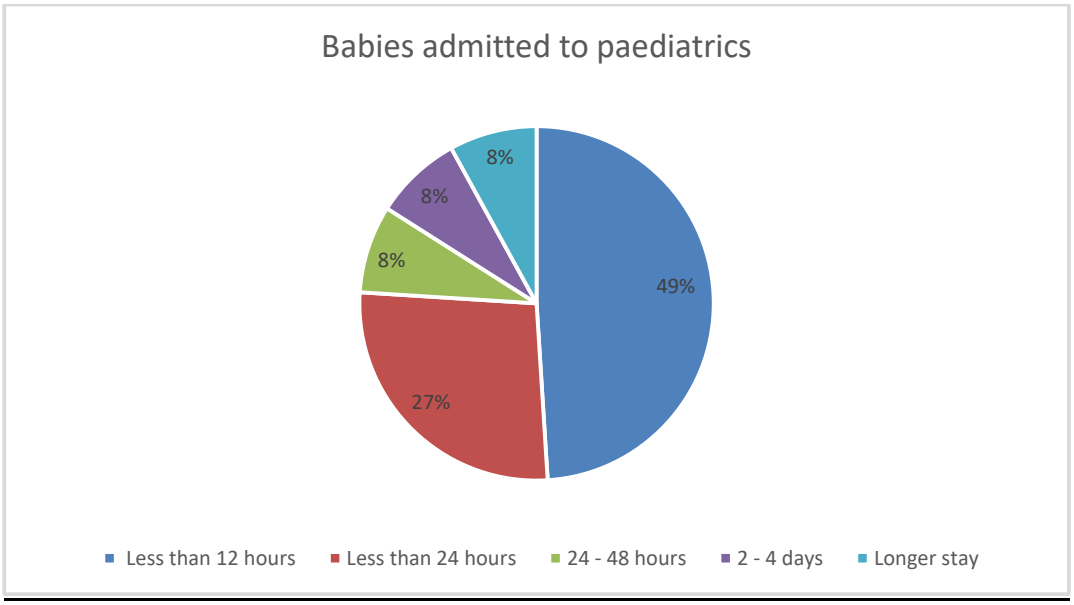
1.8 Readmissions to paediatrics

All babies with no concerns other than jaundice and/or feeding are seen directly on Pannal ward. This pathway ensures a suitable environment for the needs of mothers and babies, supports breastfeeding and reduces the risk of hospital acquired infections. Babies returning to the hospital due to other reasons are admitted to Woodlands ward as appropriate.

1.9 Paediatric readmission data

A total of 26 babies, with an age range between 2 and 27 days, were admitted for a variety of reasons during this quarter. 13 babies were discharged within 12 hours following arrival. Work is ongoing to ensure babies that are reviewed and discharged within 12 hours are not recorded as admissions.

Chart 4 Length of stay of babies admitted to paediatrics in the first month of life.



1.10 Conclusion

Readmission of a baby to hospital causes stress and anxiety for parents and families and the aim is to avoid this whenever possible. For some babies' there are no alternatives to admission and care in a hospital setting is essential. However, there are a small number of babies where,

for differing reasons, admission is preventable and for some, care could potentially be improved in the community.

We continue to assess individual cases and learn from each event to prevent recurrence. We also aim to find modifiable predictors and develop interventions to reduce risk in certain categories. Presently the highest reason for readmission to maternity is jaundice with prematurity being a significant risk factor. All actions will be implemented (see action plan 1.7) and evaluated. Progress will be monitored via Maternity Quality Assurance Meeting.

Appendix G – Avoiding Term Admissions into Neonatal Units Quarter Two

ATAIN and Transitional Care provision report

Quarter 2 (1st July 2025 – 30th September 2025)

1. **Report Overview**

ATAIN is an acronym for Avoiding Term Admissions into Neonatal units. It is a national programme of work initiated under patient safety to identify harm leading to term neonatal admissions. The current focus is on reducing harm and avoiding unnecessary separation of mothers and babies.

2. **The National Ambition**

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on;

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, team work and improvement capability within maternity units.

3. **Why is it important?**

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

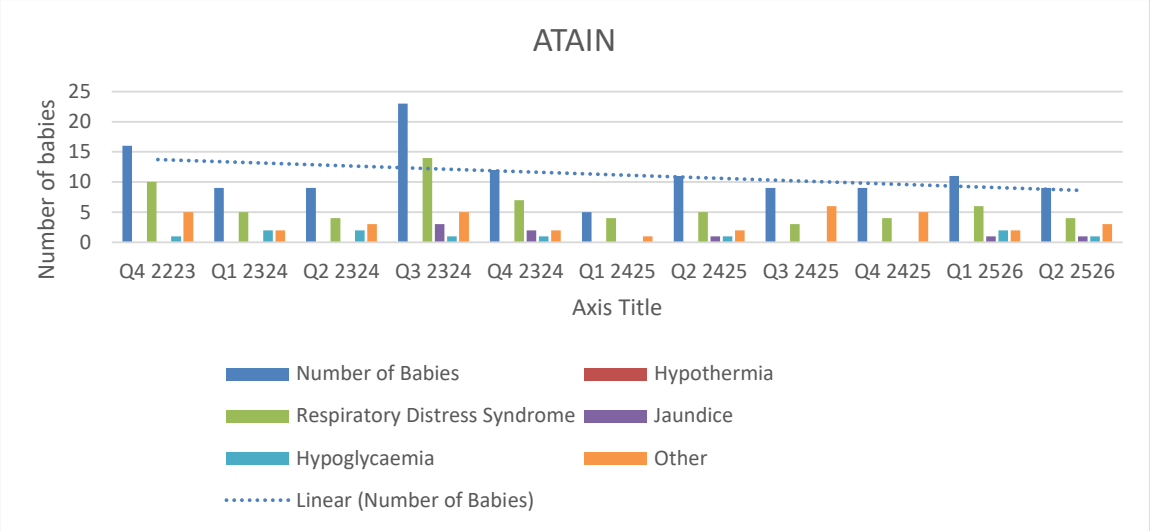
The maternity and neonatal teams review the babies born at or over 37 weeks (term) who were admitted to Special Care Baby Unit (SCBU) at designated monthly ATAIN meetings and the joint maternity and neonatal meeting. The monthly term admission rate for Harrogate and District Foundation Trust (HDFT) is reviewed and tracked on the dashboard and shared with the local maternity and neonatal system. Actions are also generated in response to any themes or concerns.

4. **ATAIN data: Quarter 2 2025/2026**

During Quarter 2 there were a total of 450 registerable babies of all gestations born at HDFT. 426 of these were born at term and therefore admissible for ATAIN audit. Of the 426, nine babies were admitted to SCBU. SCBU admissions for this quarter were similar to previous quarters, as below:

Reason for admission to SCBU	Respiratory distress syndrome (RDS)	Hypoglycaemia	Jaundice	Should have gone to TCU	Other	Total
Number of babies	4	1	1	0	3	9

5. ATAIN data trend



6. ATAIN action plan

- Learning shared amongst maternity staff regarding importance of '2222' call for all neonates on Pannal identified as cyanosed and requiring resuscitation, rather than bleeping paediatric team – in order to ensure immediate response from appropriate team.
- Learning shared with paediatric team regarding individualised care plans for all neonates, in view of a twin admitted to SCBU due to prior sibling admission – determined as an avoidable term admission to SCBU.
- Learning shared with paediatric and maternity team regarding documentation of Newborn Physical Infant Examination (NIPE) on Badgernet and ensuring abnormal findings clearly documented as a specialist review.
- Learning shared amongst paediatric team regarding awaiting investigations and appropriate/avoidable term admissions to SCBU when reviewing results.

7. Transitional Care Provision and Standards

Through family integrated care, families have been encouraged to take an active role in caring for babies on the neonatal units (NNU/SCBU). Introducing Transitional Care (TC) follows the same philosophy and thus services should be created with the needs of the family at the forefront.

One of the key advantages of TC is offering early intervention makes it less likely the neonate's condition will deteriorate. Therefore reducing the risk of maternal and neonatal separation, increases the chance that neonates remain well. This also ensures that care is cost effective.

It is important that the staff working on SCBU and the postnatal ward understand the difference between 'normal' postnatal care and TC. It is also vital that maternity and neonatal staff can evaluate and respond to the maternal and neonatal needs whilst being able to detect signs of deterioration as early as possible, therefore multidisciplinary collaboration is essential.

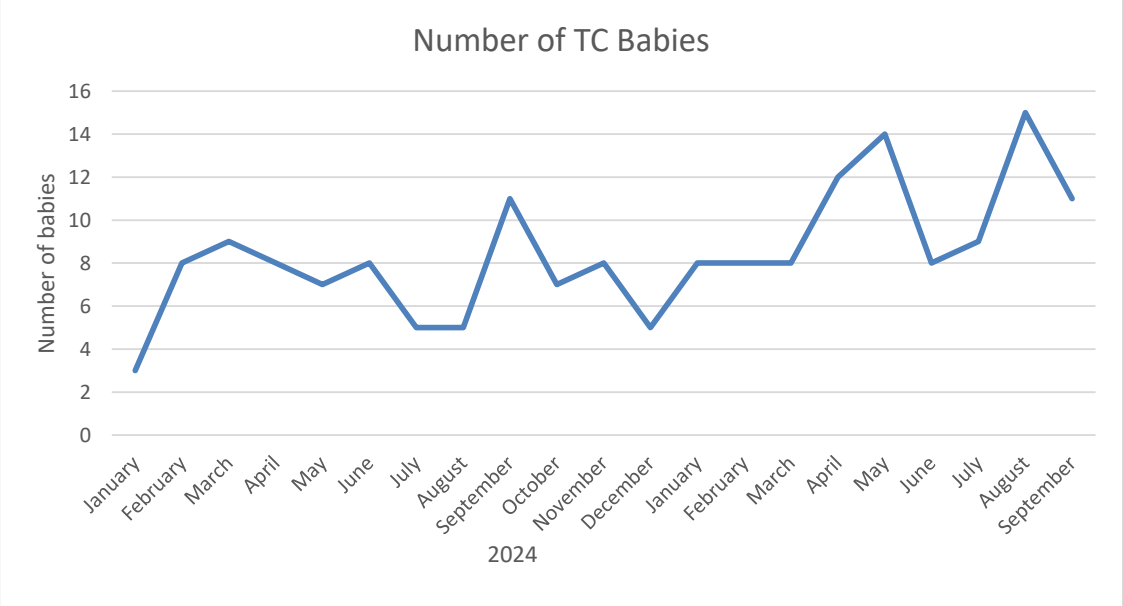
At HDFT, a review of TC babies occurs daily during dedicated ward rounds, where assessment takes place and plans of care are made. This review takes place using the jointly

approved neonatal/maternity document. There is an escalation policy for any babies which are unwell which is well known by the team and followed should the need arise. We are continuing, within our MDT, to ensure these occur at a set time every day and increase representation from both services.

8. Transitional Care babies: includes pre-term as separate from ATAIN

Month	July	August	September	Total TCU
Number of babies	9	15	11	35

9. Transitional Care provision January 2024 – September 2025



10. Quarter 2 Transitional Care Data

During this quarter we have had 35 babies on TCU on Pannal, rationale for TCU as below:

Reason for TCU	IV Antibiotics	Additional care needs: weight loss	Additional care needs: other	Jaundice	Babies stepped down from SCBU	Gestation 35-35+6	Total TCU
Number of babies	13	1	1	13	5	2	35

11. TCU action log

- Transitional care reconfigured on postnatal ward 1st August 2025 with all babies and parents receiving a door label, cot card and bedside booklet with reason for Transitional care included.
- Feedback ongoing from service users in collaboration with MNVP following launch of TC on Pannal ward – QR code and paper surveys in circulation. Currently only one piece of parental feedback received, but further support sought from MNVP to assess capacity for regular visits to Pannal, with the aim to increase reported feedback.
- Work towards serum bilirubin (SBR) quality improvement (QI) project continues for determining possibility of SBR samples being run on SCBU blood gas analyser. Red, Amber, Green (RAG) rating tool commenced for determining process of SBR samples being run on SCBU blood gas analyser versus SBR samples to be sent to clinical sciences – to be reviewed at paediatric governance.
- Trial of micro-dot heel lancets for neonatal blood sampling, to ascertain whether this will improve numbers of haemolysed/insufficient SBR samples and repeat newborn blood spot samples – following significant reductions in repeat NBBS observed in community following utilisation of micro-dot heel lancets.

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

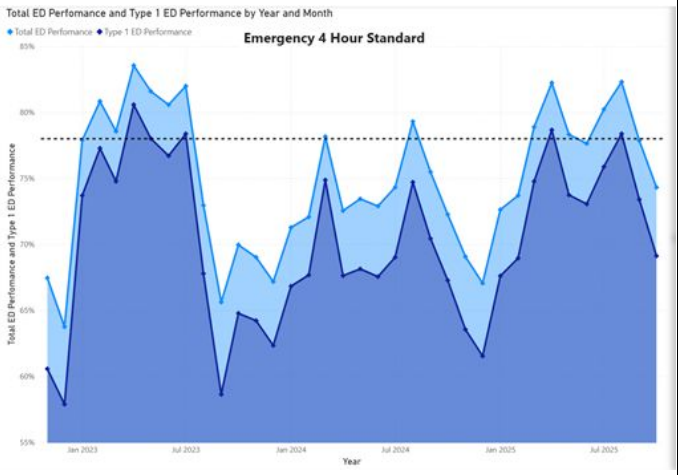
True North Metrics

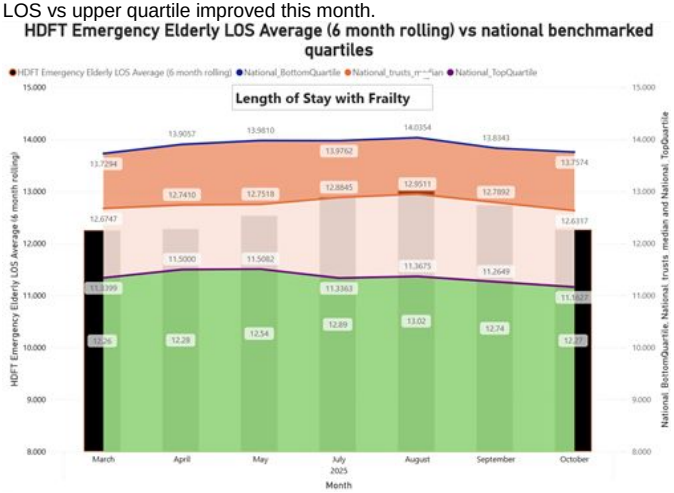
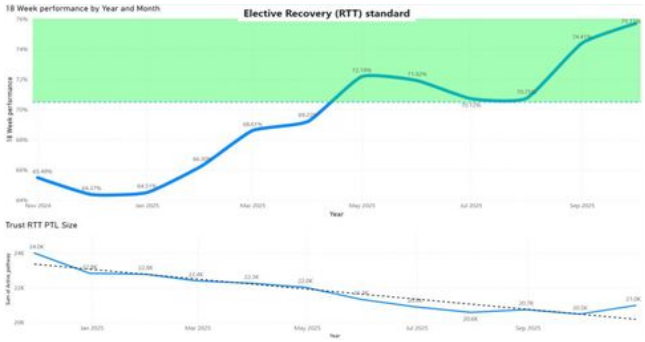
1. **ED 4 Hour Standard - 95% of patients admitted or discharged within 4 hours**
2. **Length of Stay - Top quartile nationally for patients with frailty**
3. **Elective Recovery RTT - 92% of patients waiting under 18 weeks for treatment**
4. **Cancer 62 Day Standard - 85% of patients seen and treated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

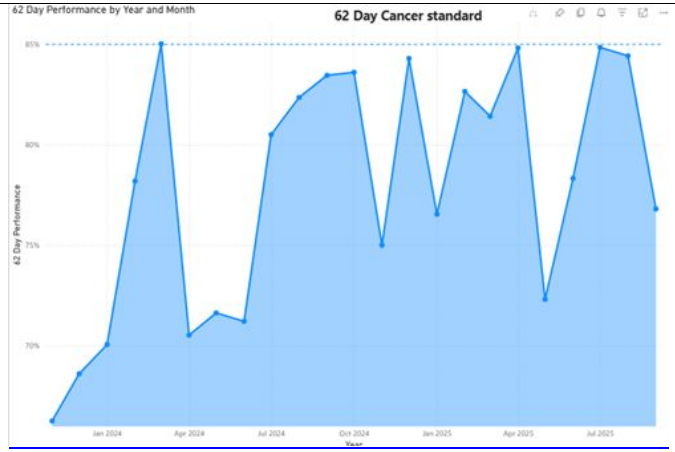
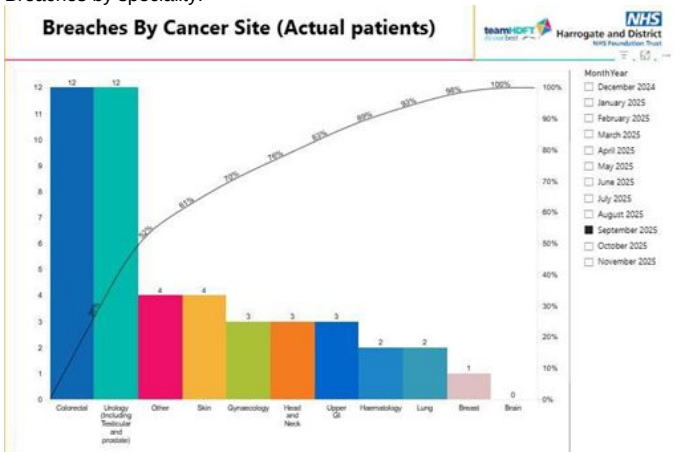
Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite 1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Person Centred, Integrated Care, Strong Partnerships	The best place for person centred urgent and emergency care	4 Hour ED Standard	Operational: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

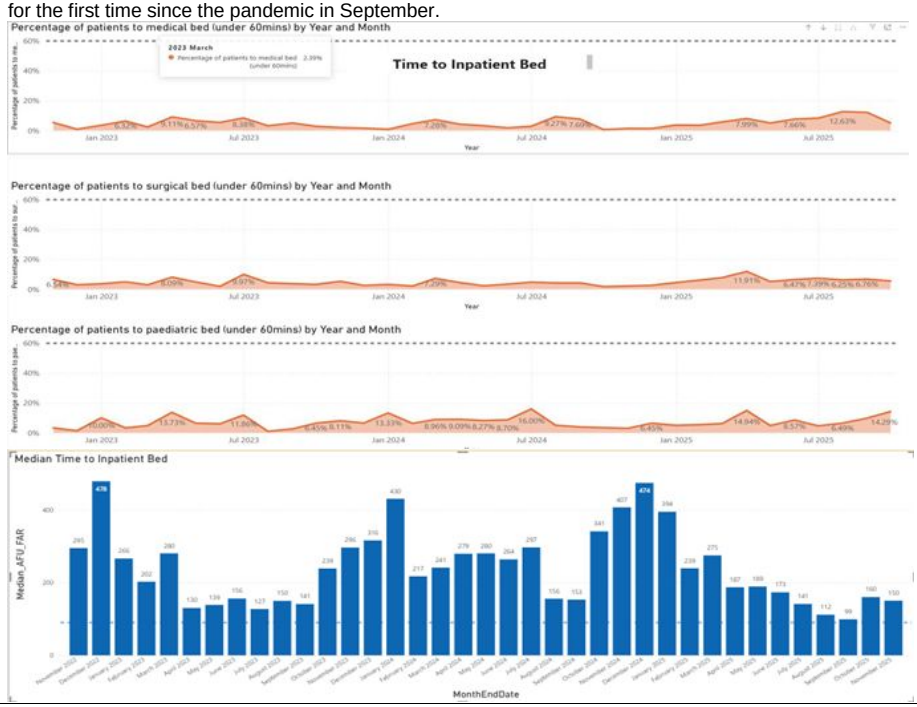
Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care	ED 4 Hour Standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated 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.	Current ED 4 Hour Standard Performance Data: 74.3% (additional validation may bring this up to target) Performance - Historical - ED performance breaches and LOS - Power BI The target of a 78% compliance has been achieved since March 2025 with the exception of in June (77.6%), Sept (77.9%) and this month (74.3%). Countermeasures are noted. Breakthrough Objective: Time to Inpatient Bed (see below) Associated/Linked Watch Metrics: (all below threshold unless indicated) • 12-hour breach numbers • ED 'Harms' • Sepsis screening in ED • Ambulance Handovers • ED Attendances vs Plan (**at 102% YTD – additional growth and 14% growth in ED attendances compared to 2019**) 	ED pathways work. Breakthrough objective (BO): Time to Bed to address greatest breach contributor. Median time to medical admission bed reported as 91 minutes in September. A 60-minute improvement vs September 2024. AMU to move to Littondale from 1st Dec (+7 beds). Winter Plan Board Assurance Statement submitted to NHSE. UTC designation at Ripon Unit now live. See Corporate Project updates: Bed Capacity and Patient Discharge. See further countermeasures in BO.		
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 2026, we will achieve top half Length of Stay for Frailty nationally.	HDFT vs National Upper Quartile LOS – last full month validated: **12.27** (Goal 11.16) To bring this in line with other goals LTUCC and the Corporate Discharge Project will be tracking Length of Stay against the national position aiming to	Development of Data for stratification with advent of new EPR. Frailty Team Driver Metric now: meeting discharge targets.		

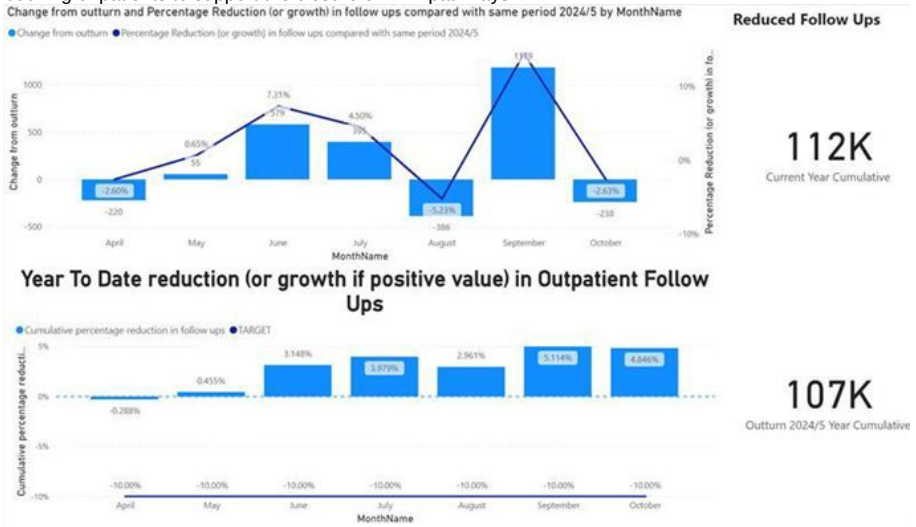
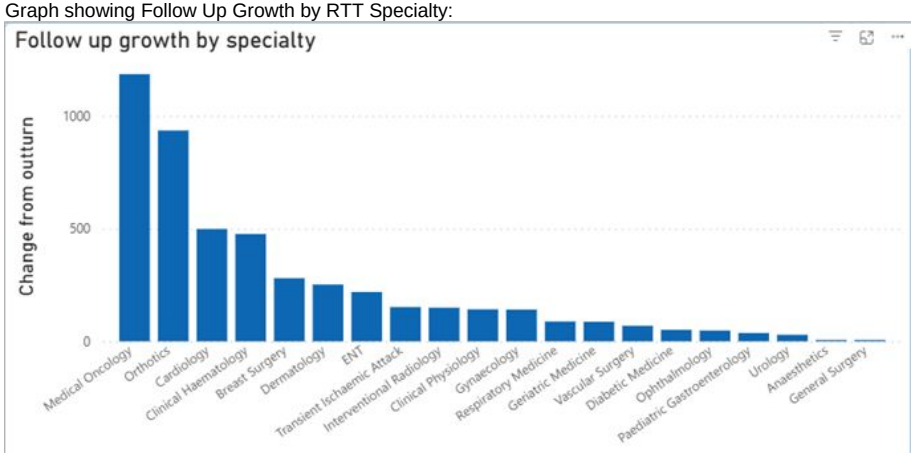
		by March 2027.	By March 2027, we will achieve top quartile Length of Stay for Frailty nationally.	hit top half this year (for Length of Stay and short stay spells) and top quartile by end of 2027. LOS vs upper quartile improved this month. 	Acute Medicine Matron now covering AFU with a focus on discharge. Proposed restructure to support closer working with Frailty/Community. Recruitment to consultant (0.8wte) - incl. covering Fridays. 1x additional dedicated UCR/ Hospital @ Home ACP post (started in June). Original 3 x trainee ACPs joined rota in August (18 months). New UCP practitioner in UCR (experienced). Pathway review from UCR -> Hospital@Home. Development of a step-up pathway from Primary Care. See Corporate Project updates: 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 70.49% (as per national mandate). By March 2027, we will achieve 18-week performance at 92%.	Current 18-week performance data: Trust RTT metrics - RTT waitinglist and trajectories from LUNA - Power BI End of October **75.7**%. 	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. TPAM meetings. Occurring weekly to review RTT performance. Ops colleagues signed up to NHSE led Impact training for RTT performance. Discussions ongoing with YSFT about SLAs for services that are provided to HDFT and not meeting activity thresholds.		

					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. • Wharfedale and General Theatre Utilisation set as Driver Metrics.		
	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.	Cancer Performance Report - Power BI Validated Sept position **76.8**%.	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. Upcoming opportunity to bid for Cancer Alliance revenue in Q3. Development of 6-4-2 in endoscopy to improve list utilisation and use of bowel cancer screening capacity.		

				 Breaches by speciality: 	Stratify impact of complex imaging waits on cancer performance - data now available (August 2024): Imaging - Power BI. See Corporate Project updates: Bed Capacity and Patient Discharge. Outpatient transformation, Theatre productivity board alongside PSCC PRM's will set and edit countermeasures: • Calling patients 48-hours pre-theatre to reduce on the day cancellations. • Deep dive into Ophthalmology Scheduling. • New theatre scheduling process gone live 1st Sept. • Theatre management team reaching out to individuals where performance <80%.		

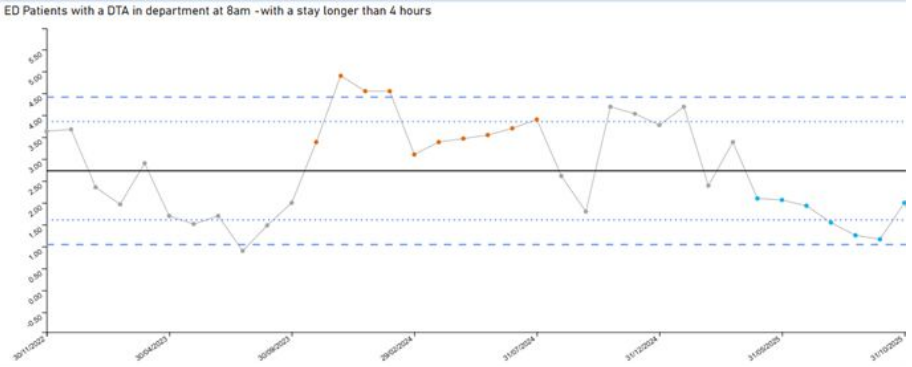
Breakthrough Objective:

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.	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** There has been a sustained and significant reduction in median time to bed which is now below 100 mins for the first time since the pandemic in September. 	Role and responsibilities review on AMU complete to allow 1 RN on each day shift to be identified as ED "puller". Continuous flow embedded. Corporate project – ward configuration on AMU (Nov 25). Clinical Services strategy – now supported by GIRFT COS. Escalated as corporate risk - new ED Clinical lead for interface with imaging, sharing of data RE imaging delays. Ward discharge targets established for base wards and Driver Metric within Care Groups to improve delivery. Corporate project: Discharge – AFU/ Farndale piloting criteria- led discharge.		

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 showing Follow Up Outpatients (RTT Specialities) compared to same period last year. There is an in month reduction, but year-to-date remains 4.8% ahead of same period last year against the target of a 10 % reduction. September FU increase linked to September RTT sprint with focus on chronological booking of patients to support the closure of RTT pathways:  Graph showing Follow Up Growth by RTT Specialty:  Follow up Outpatient - Activity Monitoring 2025 - Power BI	Outpatient transformation project countermeasures: • Increased Patient Initiated Follow Up (PIFU) (also monitored through TPAM). • Develop performance data pack on outpatients for individual clinicians including benchmarking. • Use performance data of teams (Model Hospital) and individuals to challenge. • Influence change in practice through effective clinical leadership/ coaching. • Introduce demand led, data driven job planning to optimise clinic configuration and reduce unnecessary follow ups.		

					• Weekly TPAM with focus on FU activity.		

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. AMU to move to Littondale from 1 Dec (+7 beds). 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	https://app.powerbi.com/groups/01a88572-f02f-46fc-8f40-4aabac707bbd/reports/d676ade7-3503-45ee-8101-bf3522c6b1c7/8cb1937b7015a1803e42?experience=power-bi Virtual Ward Occupancy whilst improved remains well below target. NCTR also reduced but remains above target. NCTR, LOS and H@H occupancy have improved, but are not yet at target. The project has been undergoing a re-planning activity in order to focus on areas that will achieve the best outcomes for the project over the next 6 months. The Diagnostic Delays workstream has delivered against its KPIs and has been retired. Positive improvements were delivered, especially in Cardiology and Endoscopy/Gastro. The ICT workstream is being re-focused to target activity around Leeds patients, care homes and equipment. Transport will be focusing on influencing the ambulance contract re-tender process and looking for ways to trial improvements. Criteria-Led Discharge, Pharmacy and Discharge Lounge workstreams will continue with existing planned activities. Two new workstreams are in planning: Policy and Comms, and Education and Training. The project governance model is being improved to increase focus and scrutiny on workstream driver metrics. Part of this includes a review of the project's targets.	Criteria led discharge implementation (now in place on 2 wards and further implementation underway). Improved admissions data gathering for discharge planning. Accelerated turnaround of discharge dependent interventions (now complete). More accurate, faster and earlier submission of TTOs. Faster delivery of TTOs to wards and units.		

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
			Occupancy >65%. By March 2026, we will achieve 'Outliers' on wards <1%.		Improved and streamlined Discharge Lounge admission criteria and processes, and increased utilisation. Improved/faster transport solutions. Increased usage of H&H / work towards 7-day service. Improved and accelerated processes for Equipment and Leeds patients. Updated Discharge Policy, SOP(s) and communications. Programme of Discharge Education and Training activities.		

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 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 October 25	Clinical: Patient Safety	Minimal
ID884	Risk to Patient Safety & Experience due to non-compliance with National KPI's for waiting times and reporting in Imaging Services	Due to the delays in routine diagnostic imaging there is an unknown risk of patients waiting up to 5.5 months for diagnostics which should be delivered within 6 weeks. This is causing delays in treatment, diagnosis and decision making for care plans for patients. It impacts on RTT performance, organisational reputation and patient experience. There is also a risk due to our non compliance with National KPI's for waiting times and reporting.	4 x 4 = 16	3 x 1 = 3 March 26	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. 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.	3 x 4 = 12	3 x 1 = 3 Dec 25	Operational: Business Continuity	Cautious

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

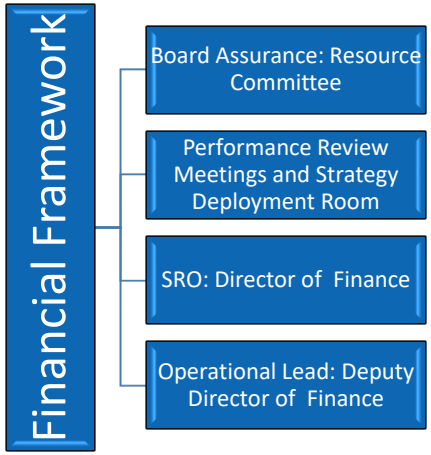
Our ambition is to provide the best quality, safest care whilst being a financially sustainable organisation.

GOALS:

Financial Sustainability

HDFT To be a financial sustainably organisation

GOVERNANCE:



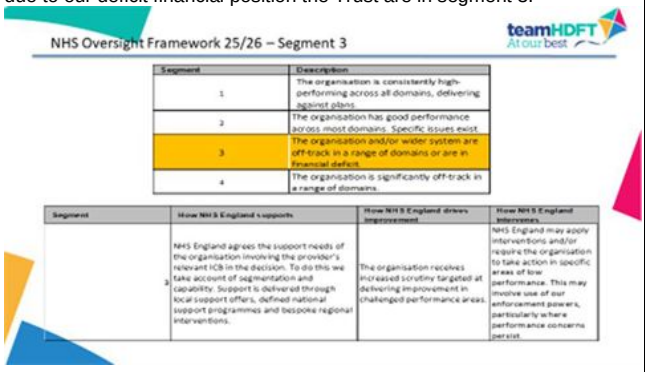
True North Metrics (Executive Lead: 10-15 Year deliverable)

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

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

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

True North Metrics Summary:

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal	Level of Risk for progressing actions
Financial Sustainability	HDFT to be a financially sustainable organisation	In 2025/26 the Trust, and therefore directorates, should live within the financial resources available to us.	The True North Metric of Financial Sustainability continues into its second year (2025-26). As at M7 the Trust reported £11.6 deficit, £6.7m away from plan. It is important to note the plan is now phased to improve by £971k each month. The key drivers include undelivered WRAP, £2.6m, prior year charges £1.3m, wards, £1.2m, Drugs £1.6m and Medical Staffing £0.8m. Countermeasures are noted. Watch Metrics: Capital Spend YTD — To track delivery of the Capital Programme spend Financial performance In Mth/YTD — To track performance against plans (Directorate/Trust) WRAP delivery YTD — To track performance against WRAP target (Directorate/Trust) Cash in Bank — Ensure sufficient cash to pay Suppliers and Staff Aged Debt — Track invoice payment (impacts cash) Better Payment Practice code — Keep track on how delivering against national standard 94% (Trust paying Suppliers) Retrospective PO's — Track number of orders not following no PO no Payment process Agency Spend — Ensure agency spend is within national target and plans in place to reduce usage Off Framework Spend — Monitor spend - National requirement to have no off framework spend ERF — Performance against 19/20 baseline (Generates additional income)Unclear on reporting needed for 25/26. WD1 delivered — Ensure Directorates have a financial summary on working day1 REACH Reporting — To track budget holders accessing their budget reports	In relation to the operational position the current countermeasures will be in place (updated M7) 1. Recovery Actions – Directorate Led PSC - £2m • Theatre Utilisation 85/90% • Wards • Medical Staffing LTUC • Drugs • Biofire Testing • Wards • LLP – Endoscopy/Dermatology • ERF recovery 2. Recovery Actions – Trustwide • Vacancy Freeze Corporate - £0.5m • Delivery of WRAP - £5m still to action • Review of key non pay expenditure (Theatres/Pathology) 3. Recovery Actions – ICB Prior year commitments - £2.1m 4. Recovery Actions – Systemwide • Controlling direct access/Boundary diverts/HCD - £1m 5. Recovery Actions – LVA • Look to recover funding for any areas overperforming • Explored the opportunity to stop activity but due to patient choice this is not possible 6. Recovery Action – Wharfedale • Deliver activity levels in line with original cases - £1m • Establish detailed SLA with LTHT In terms of the oversight framework we continue to work through the use of deconstruction of contracts with the system. Planning work continues to address efficiency asks in future years.		
		The Trust will move out of segment 3	The oversight framework has been reviewed and updated for 25/26 and due to our deficit financial position the Trust are in segment 3. 		

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)	Recurrent delivery of the WAP programme.	100% Delivery WRAP target	As at M7 73% of WRAP schemes have been actioned, £10.6m. 48% of current actioned schemes is Non Recurrent. Delivery by Directorate summarised below.	Suggested Countermeasures • A3's developed for all un-actioned WRAP schemes with an estimated value of £100k or more. • All outstanding schemes to be reviewed for October PRM's so the risks can be understood. • Updates at PRM • Risk measurement clarified in line with NHSE expectations		

Directorate	Target £000	Actioned %	Actioned £000	Low £000	Medium £000	High £000	Unidentified £000	Total Plans £000	Identified %	Cost Reduction £000
Central	2,342	104%	2,442	0	0	0	-100	2,442	104%	422
Corporate	1,271	100%	1,271	0	0	0	0	1,271	100%	863
CYPPH	1,475	100%	1,475	0	0	0	-0	1,475	100%	470
HIF	1,019	100%	1,020	0	0	0	-1	1,020	100%	0
LTUCC	4,579	38%	1,748	1,054	363	0	1,413	3,166	69%	4,177
PSCC	4,801	55%	2,641	1,415	218	0	528	4,273	89%	1,029
Total	15,486	68%	10,596	2,469	581	0	1,840	13,646	88%	6,962
Reporting Total*	14,468	73%	10,596	2,469	581	0	821	13,646	94%	6,962
Last Month	14,468	61%	8,868	2,658	999	202	1,740	12,728	88%	6,738

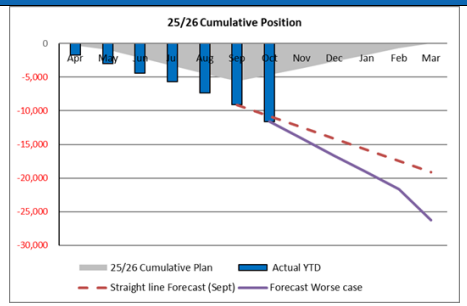
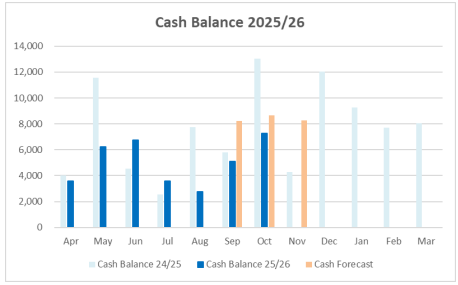
*Excludes HIF target which is not part of Trust target but includes the actuals as reported in the PFR (Provider Financial Return)

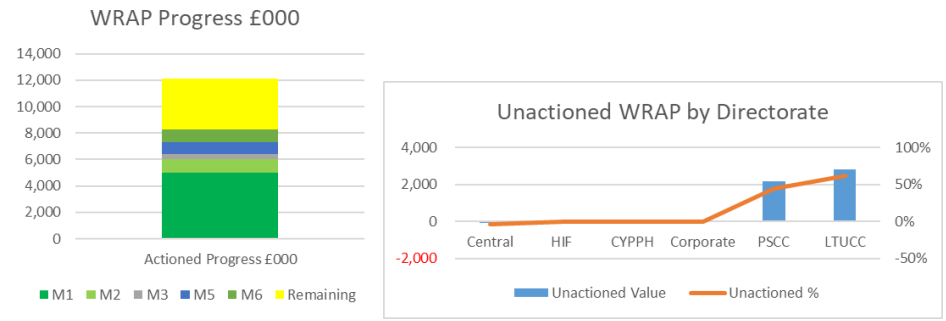
Strategic Project:

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
ID 816	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, £6m. HNY have confirmed the contract is fixed for 25/26, activity plans are being reviewed to ensure activity is delivered within the financial envelope. As at the end of October, the Trust reported a £11.7m deficit this is £7.1m away from plan. The plan includes a risk share arrangement of £12m, the £6m HDFT need to identify has been phased into the second half of the year (M12). Deficit funding, £5.2m is at risk if the financial plan is not delivered across the system (secured for Qtr1 and Qtr2). Forecast Protocol Process to be considered.	5 x 4 = 20	4 x 2 = 8 March 2026	Financial: revenue, funding and liquidity	Cautious

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
						
ID 721	Group Cash Position	Cash support may be required through the year but is dependent on the above risk not materialising. In May HNY ICB supported the Trust with an early payment £6m due to Local Authority late payments. Local authority payments are now up to date bar pay award contributions which will be resolved in the main by the end of November. NR funding for the LA NI contributions has been received but leaves a £400k cost pressure. As at October £9m supplier payments remain outstanding and the BPPC has dropped to 27.9%(No of invoices)/67.7% (Value of invoices) target is 95%. 	4 x 3 = 12	4 x 2 = 8 March 2026	Financial: revenue, funding and liquidity	Cautious
ID73	Recurrent Delivery of the Efficiency programme (WRAP)	Recurrent delivery of the WRAP is crucial to the long term financial standing of the Trust. 73% of the WRAP programme has been delivered however 48% of this is NR. PSC and LTUCC have £5m of WRAP outstanding to be delivered. CYPPH, HIF and Corporate have fully delivered the WRAP targets however a large proportion is non recurrent. Cost Avoidance schemes total £6.7m.	4 x 3 = 12	3 x 2 = 6	Financial Revenue, funding and liquidity	Cautious

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

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	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 have now been signed and presentation of the contract agreed.	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:	Involvement
Corporate Project:	Medical and Dental Workforce Scheduling and Payment Transformation Project
Overarching Risk Appetite:	Workforce - Cautious

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

Strategic Metrics Summary:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Looking after our people  Belonging 	Staff Engagement Index	The ambition is to understand how colleagues are feeling towards HDFT as a place to work and as an employer using a range of emotional indicators. The twin ambitions are to: 1. Continuously improve the level of survey response rates. 2. Improve the overall Staff Engagement Score. To realise our True North Ambition of being the best place to work by improving our employee Engagement scores and response rates in both national and quarterly staff surveys.	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. 4. Maintain a continuously improving trend on both NQPS (Inpulse) and the NHS Staff Survey response rates and aspire to be best within our benchmark group. 5. Achieve and maintain the best engagement score within our benchmark group. 6. Improve WRES metric regarding relative likelihood of appointment from shortlisting and increase diversity within senior leadership roles.	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. Implementation of Workforce Disability Equality Standard action plan and a focused piece of work on disability discrimination. (Also implementing the Workforce Race Equality Standard action plan.) Embedding Equality Programme 1. The implementation of Independent Panel Members to sit on all recruitment at Band 8a and above.	The True North Metric of Staff Engagement continues into its second year (2025-26). The goals were enhanced in March 2025 and current status is: • The response rate achieved in the July 2025 Inpulse Survey was 38%. This is the highest response rate achieved by HDFT in the quarterly Pulse surveys and places HDFT in 2nd place in our benchmark group. The Trust consistently tracks above the quarterly Pulse survey benchmark group engagement score and in the July 2025 survey, the Pulse engagement score for HDFT was 7.09 (3rd place) against a benchmark average score of 6.36. • In the 2024 NHS Staff Survey, HDFT achieved a response rate of 48.7% compared with the highest response rate of 70.92% and an average response rate of 48.6% in our benchmark group. The Engagement score 2024 NHS Staff Survey was 7.00 (31st place) against a benchmark average 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. New and improved 4S Appraisal launched on 4 June, taking into account feedback from National Staff Survey and Inpulse Surveys, following the You Said, We Did model. The new template strengthens the setting of objectives and support for how to improve in your role elements of the appraisal. Appraisal focussed questions have been added into the quarterly Inpulse survey to enable tracking of feedback on how the improvements in the 4S appraisal translate into improvements in employee experience of their appraisal. 1. Training for Independent Panel Members is scheduled for 15 January 2026 and expressions of interest for the role were circulated and discussed with the People & Culture Programme Board membership on 4 November.		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
			3. Embedding Equality by focussed work based around the 6 EDI High Impact Actions (HIA). Progress to be made on: HIA1: Chief Executives, Chairs and Board Members should put EDI objectives in place that they are personally responsible for. The goal is: • Each Director to have an EDI objective HIA 2: Employ & Develop Staff in a fair and inclusive way and target groups that are under-represented in the organisation. The goal is: • Improve the relative likelihood of recruitment from shortlisting for BME applicants. • Increase the diversity of the workforce senior leadership roles • Improve the reported lived experience of colleagues who are BME or have a disability or long-term condition	2. The introduction of Equality & Diversity Champions in each Directorate. 3. The sharing of Directorate level EDI data in the monthly Workforce Information Pack and discussed at quarterly Directorate Board Meetings 4. Review of support for career progression for BME colleagues and colleagues with a Disability or Long Term Condition	3. EDI Data was included in the October 2025 Clinical Directorate Workforce Information Packs. The Staff Support Network Reignition Event was run on 15 September in Herriotts Restaurant. The Reciprocal Mentoring Programme for colleagues with a disability or long term condition started in September 2025. 12 pairs of aspiring and established leaders are signed-up to the programme and the initial sessions were hugely impactful. A listening event for colleagues with a disability or long-term condition has been scheduled for early December to give the opportunity for further learning about the lived experience. Embedding Equality paper presented to August Board Workshop and gained full support.		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Growing for the future  New Ways of Working 	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 quality of care and to enable those staff to have a good experience and do their best.	1. A vacancy rate that does not exceed 6% 2. A Turnover rate that does not exceed 12% (HNY is 12%) 3. Staff leaving within their first year of employment to not exceed 15% 4. 100% of rosters signed off and issued 8 weeks before. 5. Sickness levels throughout HDFT to not exceed 4.2% (HNY is 4.2%) 6. Apprenticeship or training plan/development of new role in the medium to longer term for shortage occupations 7. Delivery of the 10 Point Plan for Resident Doctors	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 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	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) • 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 an increasing trend since April 2025 and is 689.53wte in October. Unavailability has increased by 16.54wte this month, when compared to September. Sickness is the main factor accounting for the increase in unavailability in October, rising by 18.44wte from 252.50wte last month to 270.94wte. The Trust has seen an increasing trend in sickness since April 2025. The Directorates which contribute the greatest to the rise in sickness this month are LTUCC and CYPPH. CYPPH has the highest sickness rate in October, with a rate of 8.34%, which is an increase from 7.76% in September. The data shows that sickness absence has predominantly increased across the Trust this month due to a rise in sickness indue to 'Cold, Cough, Flu – Influenza'. Turnover saw a decrease of 7.27wte leavers in October and all Directorates contribute to this reduction. Turnover across the Trust has decreased from 10.22% to 9.93% this month. The Trust vacancy rate is 5.72% at the end of October 2025, which is below the Trust target of 7% (A3 threshold of 6%). -Trust turnover is 9.93% -Sickness is 5.85% -Staff leaving within 1st year is 15.28% (this remains at a similar position to last month, which saw a rate of 15.30%.) The Trust undertook a baseline assessment for each of the ten areas of the ten point plan and submitted this to NHS		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
					England. The detail of this is reported through the People and Culture Committee.		

Breakthrough Objective: Staff Involvement.

Workstream	True North Metric	Vision	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
Making HDFT the best place to work	Staff Engagement Breakthrough Objective - Involvement	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. **Goals** 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). 2. 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%).	Hold Focus Groups with the 9 teams scoring the lowest for Involvement in the 2024 National Staff Survey to understand reasons for score and what would improve.	Work occurred to identify teams with low survey response rates/low engagement scores and advocacy and the top performing teams as well. 14 focus groups have been held across 9 care groups/services, with a total of 107 people being involved in these. The outputs from the focus groups were be used to inform the development of an Involvement Toolkit, which was launched in September 2025. Directorate level feedback on the output from the focus groups was provided to Directorate Triumvirate Teams and Composite Summary Feedback provided to SDR, People & Culture Programme Board and People & Culture Committee.		

Corporate Project.

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Medical and Dental Workforce Scheduling and Payment Transformation Project	Staff Availability	To have all Medical Staff on the rostering system and managers really engaged in using it as a tool to help improve patient care delivery. This will help enable us to fully align the workforce with service requirements/improvements	• To ensure medical and dental staff are deployed to maximum effect • To enable workforce gaps to be planned and managed • For the locum bank to be managed via the e-Rostering system achieving visibility and accountability • To ensure best practice roster rollout • To have full visibility of having the right people in the right place at the right time • To have all unavailability's of staff reported	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.	28 services out of 40 are live. In line with the National priority for 95% of all Job Plans to be reviewed/completed by end of March 2026, Operational Teams are working to complete this key enabling action by end of October 2025. Job planning compliance was at 86.8% at the end of October. Further rollout across specialties continues to be paused whilst this occurs and the rostering team is re-focused on post-implementation optimisation of resident doctors rotas and digital locum payments, including implementation of bankstaff+ by the E-Rostering Team in December. The Job Planning updates will likely case some further review of rosters where the system is already live.		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
			• For all additional payments to be digitised for payment and removing all paper/spreadsheet submissions	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 at present							

Related Corporate Risks.

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

Related External Risks.

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

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

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

GOALS:

Quality & Safety

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

Information

Timely, Accurate Information to enable continuous improvement

Electronic Health Record

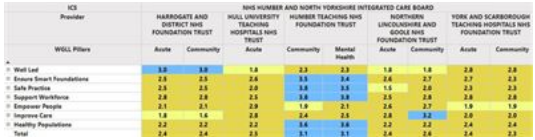
An Electronic Health Record to enable effective collaboration across all care pathways

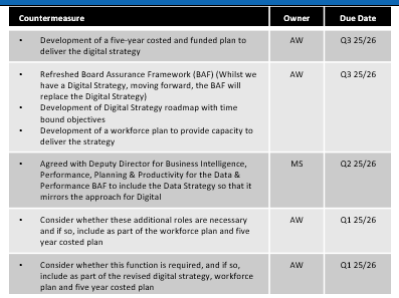
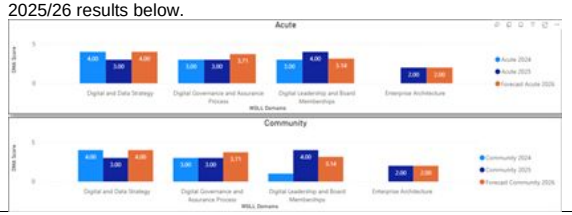
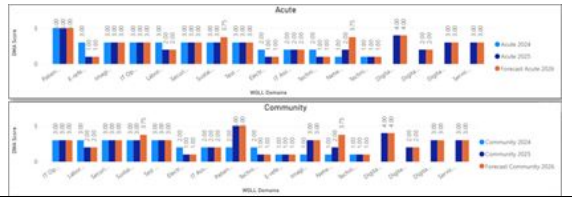
Ambition Metrics (Executive Lead: 10-15 Year deliverable)

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

True North Metrics Summary:

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 Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality & Safest Care Person Centred, Integrated Care Great Start in Life Making HDFT The Best Place to Work	***Overarching Vision:*** To improve our Digital Maturity in keeping with the "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. For 25/26, we aim to achieve an average score of 3/5 across the seven pillars.	Planning will be done on a domain-by-domain basis, initially focussing on the domains 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.	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. The results from this year's DMA were published at the end of July 2025. 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 this year's DMA submitted in Q1 24/25. The forecast scores shown below include last year's results as the minimum expected score, but where A3 work has been developed and further improvements planned, it includes the improved forecast scores for these areas.  This also includes a comparison against our counterparts in HNY: 		

True North Metric	Vision	Goal	Countermeasures	Current Status	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	 **Countermeasure** / **Owner** / **Due Date** • Development of a five-year costed and funded plan to deliver the digital strategy — AW — Q3 25/26 • Refreshed Board Assurance Framework (BAF) (Whilst we have a Digital Strategy, moving forward, the BAF will replace the Digital Strategy) • Development of Digital Strategy roadmap with time bound objectives • Development of a workforce plan to provide capacity to deliver the strategy — AW — Q3 25/26 • Agreed with Deputy Director for Business Intelligence, Performance, Planning & Productivity for the Data & Performance BAF to include the Data Strategy so that it mirrors the approach for Digital — MS — Q2 25/26 • Consider whether these additional roles are necessary and if so, include as part of the workforce plan and five year costed plan — AW — Q1 25/26 • Consider whether this function is required, and if so, include as part of the revised digital strategy, workforce plan and five year costed plan — AW — Q1 25/26	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: • May 25 – Mar 26 – Deliver agreed countermeasures (See table on the left) • July 25 – National Digital Maturity Assessment results published 2025/26 results below. 		
	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		June 25 – Digital SLT agreed dates to develop individual A3's throughout 25/26 - These are likely to be a collection of domains within this pillar rather than one A3 for the pillar as the size and complexity will make this challenging	Next Steps: • June Onwards – A3 and countermeasures to be developed • July – National Digital Maturity Assessment results published • Aug 25 – A3 complete for the Sustainability Agenda domain • Sep 25 - A3 complete for the Networking domain 		
	Safe Practice - We maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health & social care (DTAC) & routinely review system-wide security, sustainability & resilience		June 25 – Digital SLT agreed dates to develop individual A3's throughout 25/26 - These are likely to be a collection of domains within this pillar rather than one A3 for the pillar as the size and complexity will make this challenging	Next Steps: • June Onwards – A3 and countermeasures to be developed • July – National Digital Maturity Assessment results published		

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
	Support Workforce- 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		June 25 – Digital SLT agreed dates to develop individual A3's throughout 25/26 - These are likely to be a collection of domains within this pillar rather than one A3 for the pillar as the size and complexity will make this challenging	Next Steps: • June Onwards – A3 and countermeasures to be developed • July – National Digital Maturity Assessment results published • Sep 25 – A3 complete for the Supply Chain Management domain 		
	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		June 25 – Digital SLT agreed dates to develop individual A3's throughout 25/26 - These are likely to be a collection of domains within this pillar rather than one A3 for the pillar as the size and complexity will make this challenging	Next Steps: • June Onwards – A3 and countermeasures to be developed • July – National Digital Maturity Assessment results published		
	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		June 25 – Digital SLT agreed dates to develop individual A3's throughout 25/26 - These are likely to be a collection of domains within this pillar rather than one A3 for the pillar as the size and complexity will make this challenging	Next Steps: • June Onwards – A3 and countermeasures to be developed • July – National Digital Maturity Assessment results published		
	Healthy Populations - We use data to design & deliver improvements to population health & wellbeing, making best use of collective resources. Insights from data are used to improve outcomes & address health inequalities		June 25 – Digital SLT agreed dates to develop individual A3's throughout 25/26 - These are likely to be a collection of domains within this pillar rather than one A3 for the pillar as the size and complexity will make this challenging	Next Steps: • June Onwards – A3 and countermeasures to be developed • 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						

Corporate Project: [MAJOR PROJECTS ONLY]

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality & Safest Care	Upgrade to the cloud version of Chemocare in readiness for a possible future regional cloud solution	Chemotherapy Prescribing System Upgrade	• Engage with supplier/service • Complete discovery • Plan & deliver solution	• Discovery in progress		
Best Quality & Safest Care	Radiology booking office with ability for patients to book direct into appointments	Radiology Electronic Booking Office	• Develop business case and secure funding • Complete procurement • Complete discovery • Plan & deliver solution	• Draft business case presented to BCRG, requires further work on benefits • YIC funding requires spending by Mar 26 • PM resource allocated to support discovery and funding from the service		
Best Quality & Safest Care	Replace the current Cardiology system	Cardiology System Replacement	• Engage with supplier/service • Complete discovery • Plan & deliver solution	• Discovery completed • Dec 25 Slot for Project Initiation • Funding TBC before Project Initiation		
Best Quality & Safest Care	Electronic meal ordering system so patient can order their own meals and provide efficiencies to the catering team/Trust	Meal Ordering, Portering & Domestics System	• Piggyback off LTHT procurement • Complete business case and secure funding • Engage with supplier/service • Complete discovery • Plan & deliver solution	• Preferred supplier for Meal Ordering confirmed by LTHT • HIF would like to merge the Meal Ordering Project with Portering and Domestics as they will possibly be the same system • Business case drafted but requires financials completing before seeking approval		
Best Quality & Safest Care	Delivery of a regional integrated PACS and RIS solution	Regional PACS & RIS Replacement	• Regional procurement and business case to be developed and funding secured • Work with supplier/service - regional programme to plan delivery • Deliver solution	• Awaiting procurement, business case and funding to be secured • Procurement plan shared		
Best Quality & Safest Care	Electronic Pre-Operative Assessment questionnaire to be completed by patient on PKB	Pre-Operative Assessment Questionnaire (PKB)	• Plan & deliver solution	• Project Initiated – PID/Plan signed off • Go Live – Feb 26		
Best Quality & Safest Care	Job planning solution for AHP's	Job Planning for AHP's	• Confirm approach to procurement – Existing job planning solution (SARD) in the Trust already – AHP service would like another solution as it does not meet their needs • Complete procurement, business case and secure funding • Plan & deliver solution	• Awaiting confirmation of approach before proceeding further		
Best Quality & Safest Care	Replacement dental solution for Soel health (out of support/end of life)	Systems for Dentists	• Plan & deliver solution	• Procurement complete Sept • Business Case not approved so unable to complete procurement until done		

Strategic Programme: Electronic Patient Record

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality & Safest Care		See Goals table below	See Countermeasures table below	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 and 2026/27 focusses on delivering the Nervecentre EPR solution and delivering enhanced functionality, optimising the solution and starting 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. There are still several high issues that needs resolving, with some activities at risk as we approach go live. However, Go Live is currently planned for Wednesday 19th November and on track. 		

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

Countermeasures	Owner	Date
Design, build & test the EPR (T1)	RA	Sep 25
Train end users & prepare for go live (T1a)	RA	Oct 25
Go live with the new EPR, new ways of working & support (T1a)	RA	Nov 25
Design, build & test the EPR (T1b & T3a)	RA	Apr 26
Train end users & prepare for go live (T1b & T3a)	RA	Apr 26
Go live with the new EPR, new ways of working & support (T1b & T3a)	RA	Apr 26
Design, build & test the EPR (T3b&c)	RA	Oct 26
Train end users & prepare for go live (T3b&c)	RA	Oct 26
Go live with the new EPR, new ways of working & support (T3b&c)	RA	Oct 26
Optimise the solution & realise benefits	RA	2026-28
Enhance with additional modules/functionality	RA	TBC

Related Corporate Risks

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

Related External Risks

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

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

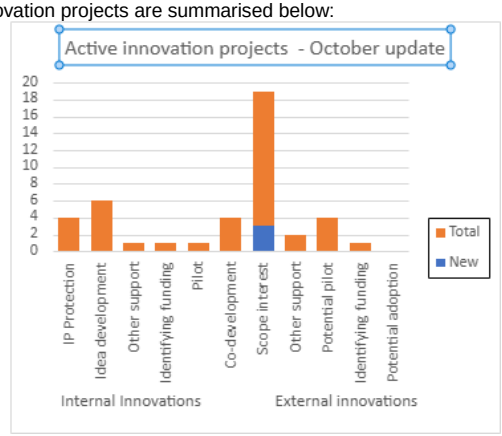
Ambition Metrics
(Executive Lead: 10-15 Year deliverable)

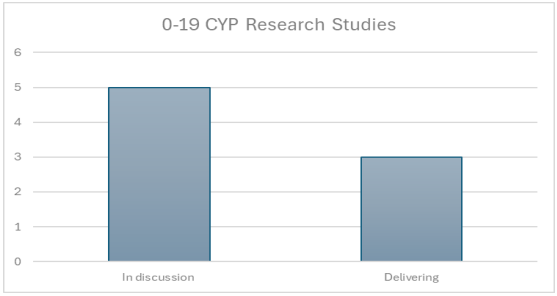
1. Healthcare Innovation- support of external and internal innovations and strategic partnership with industry
2. Children's Public Health
3. Clinical Trials - increased recruitment of patients into reseach studies. All studies to be delivered to time and target.

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

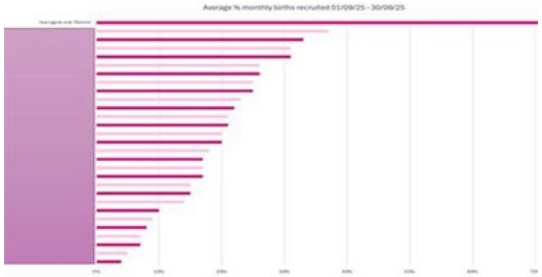
Ambition	True North Metric	Workstream	Ambition Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
					1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Healthcare Research and Innovation	All	Healthcare Innovation	Adopt / develop health innovations that improve the health and 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
		
		Support ≥ 2 external innovations
		
		Support ≥ 2 internal innovations
			• Clinical advice service under development - to be launched Jan 2026
			  ○ Subsidy available to support companies/organisations from North Yorkshire with funding from YNYCA Mayoral investment fund
			  ○ Raising awareness of new scheme amongst innovation community regionally and nationally
			• Second cohort of Clinical Entrepreneur Fellows (3 x FY2s) have commenced the CEF scheme (Aug 25)
			  ○ Exploring opportunity for larger cohort in 2026 and building further collaborations with external organisations
			• Multiple regional collaborations in progress
			  ○ Strategic partnerships with University of York / Hull York Medical School in discussion
			  ○ Exploring bid to UKRI Local Innovation Partnership Fund - potentially worth £2 million regionally (to be submitted Feb 26)
			  ○ Supporting YNY Combined Authority initiatives to attract international health tech companies to the region
			• Innovation training planned with WYAAT, Health Innovation and Medipex (to re-commence in Jan 26)
			• Active innovation projects are summarised below:
			 
				Support offers 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 discussion, development or open alongside monitoring the rationale for declining studies.*  **New studies in discussion:** Care UK IRAS 1009041 Escalator (ELIM -1) NIHR 207059 Circle by the Sea NIHR 162162 **New studies open**: Journey IRAS 334045 **Declined studies:** Core Kids Knee IRAS 348278 - AHP physiotherapy; reason staffing Superpenguin NIHR IRAS 333572 study 1 study 2 NIHR 333389– AHP Speech & Language, reason staffing **Accrual activity** | Study	August	September	October | |---|---|---|---| | **BaBI** | 44 | 43 | 26 | | **Generation** (monthly target 42) | 89 | 100 | 76 | The Fit for the future: 10 Year plan for England (2025) highlights the importance of the Generation study as it provides the opportunity to inform longer-term ambition to make genomic sequencing at birth universally available.	Utilising Babi research prioritisation data *prioritisation event completed, currently drafting report.* Developing research partnerships with CAMHR at York and ARC; YH ARC - *presented YH ARC Babi`s arrival – A HDFT perspective.* Cultivate a research active culture and infrastructure *Liaising with the Education team to integrate GCP training on learning lab, centralised space to promote research focused carer development opportunities. Supporting NIHR Doctoral application* Develop and implement a 0-19 briefing and pathway for delivery of research. *Briefing paper completed. Next steps meeting arranged 6/11/25.* 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. *Actioning examples: include the Housing Project.* Disseminate the findings and outcomes of any studies delivered to the 0-19 HDFT service via appropriate media. Regional networks and YH ARC - *presented YH ARC Babi`s arrival – A HDFT perspective.* *Presented at the 0-19 Regional Network meeting.* Collaborating with MSc data analytic course UoYto identify opportunities for evaluating CYP datasets.		

Recruitment continues to be strong; in October the team successfully recruited 79 women which represents 56% of our birth rate. Harrogate continues to lead recruitment regionally as seen in the graph below.



0-19 Brief for Research

Month	Stage 1	Stage 2	Stage 3	Stage 4
June	In development			
July		Circulated for comments	Integrate initial feedback & wider dissemination	
August - October			Wider dissemination Develop short staff survey	
November				Next steps meeting

Countermeasures are noted.

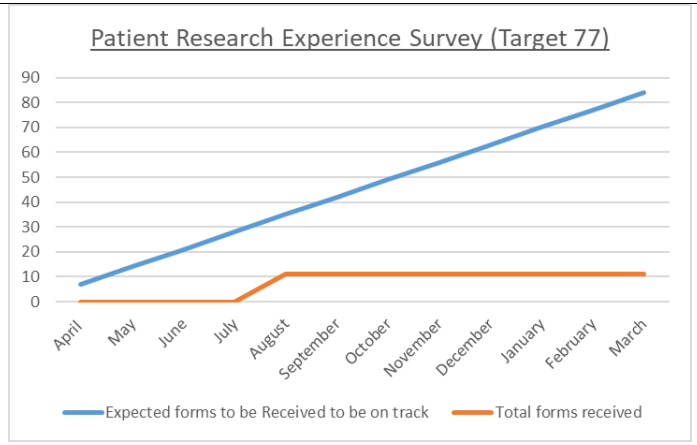
Watch Metrics:

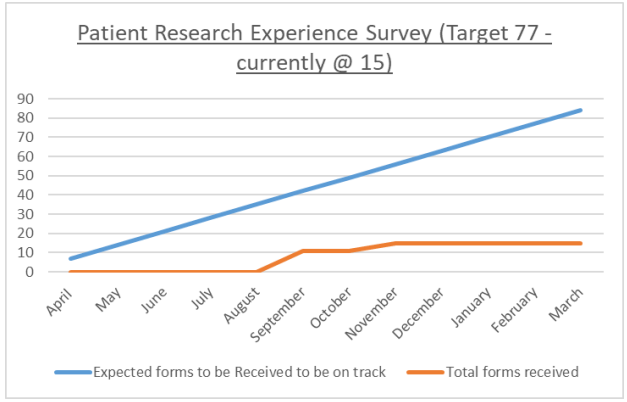
To ensure SOPS for department in relation to 0-19 research are updated by end of 2025 and system in place to review regularly n = 17, *Gantt chart developed, allocated & in development*

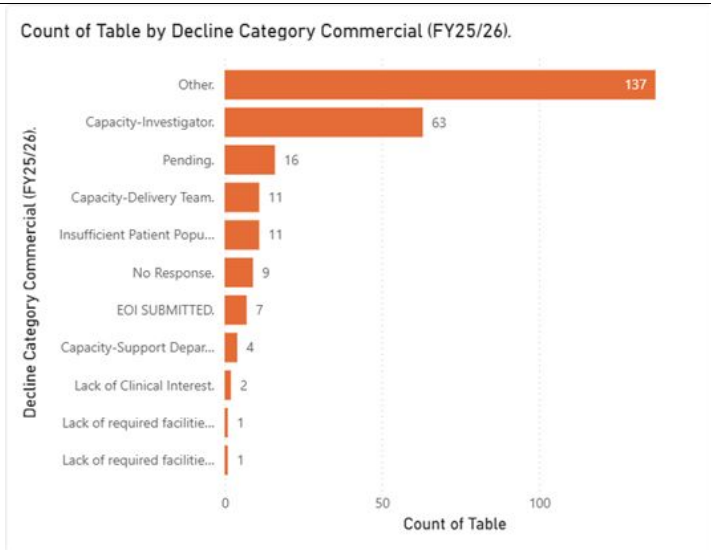
GCP training numbers increase Year on Year for 0-19 trust staff. *Awaiting support from the Education team to integrate GCP access onto the learning lab platform.*

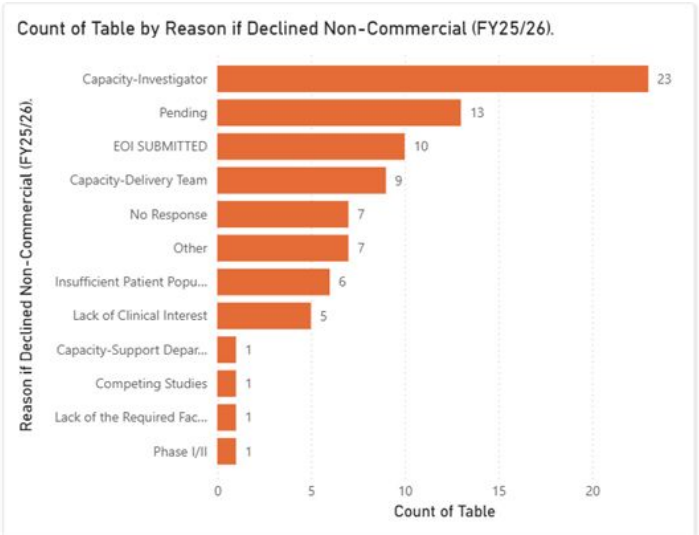
PRES feedback target for RRDN overall (TBC for 25/26) is achieved and a percentage target (10%) is received from 0-19 research participants.

Further opportunities identified through the centre of excellence DAIM (Data Science, AI and Modelling) University of Hull.

			 Patient Research Experience Survey (Target 77) 90 80 70 60 50 40 30 20 10 0 April May June July August September October November December January February March Expected forms to be Received to be on track Total forms received			

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. List of partnership outcomes achieved. Numbers and impact of patient engagement. Countermeasures are noted. 	Contractual arrangements with Yorkshire & Humber Research Delivery Network Partnerships via WYATT, NSO and academic and commercial alliances		


Count of Table by Decline Category Commercial (FY25/26).
Decline Category Commercial (FY25/26).
Other.
137
Capacity-Investigator.
63
Pending.
16
Capacity-Delivery Team.
11
Insufficient Patient Popu...
11
No Response.
9
EOI SUBMITTED.
7
Capacity-Support Depar...
4
Lack of Clinical Interest.
2
Lack of required facilitie...
1
Lack of required facilitie...
1
0
50
100
Count of Table


Count of Table by Reason if Declined Non-Commercial (FY25/26).
Reason if Declined Non-Commercial (FY25/26).
Capacity-Investigator
23
Pending
13
EOI SUBMITTED
10
Capacity-Delivery Team
9
No Response
7
Other
7
Insufficient Patient Popu...
6
Lack of Clinical Interest
5
Capacity-Support Depar...
1
Competing Studies
1
Lack of the Required Fac...
1
Phase I/II
1
0
5
10
15
20
Count of Table

			(Other = Phase I/II studies or patient pathway not performed at HDFT). **N B:** Year-on-year data on **commercial study income** from 2022 is currently being collated and will be included in the next BAF. Additionally, **research setup times for both commercial and non-commercial trials** will be tracked and reported in the next BAF, as this has become a national objective for all research departments..			

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						

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 behind original trajectory although not affecting overall plan at present. TIF2 timeline ahead of trajectory and therefore not a risk to this project at present.	• Information from interested suppliers received, currently under procurements review. • Mechanical and Engineering report awaited with early highlights indicating ventilation needing further investigation – plant sizing exercise underway. Electrical supply thought to be adequate. Both pairs of chillers requiring replacement. • Business case to include staffing requirements awaited.		

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

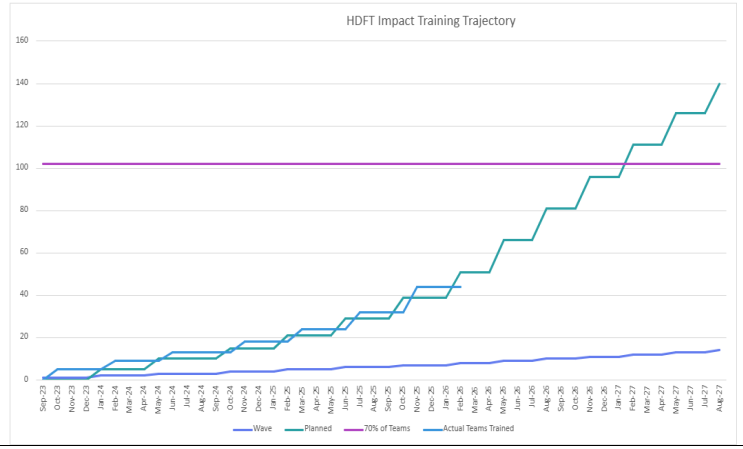
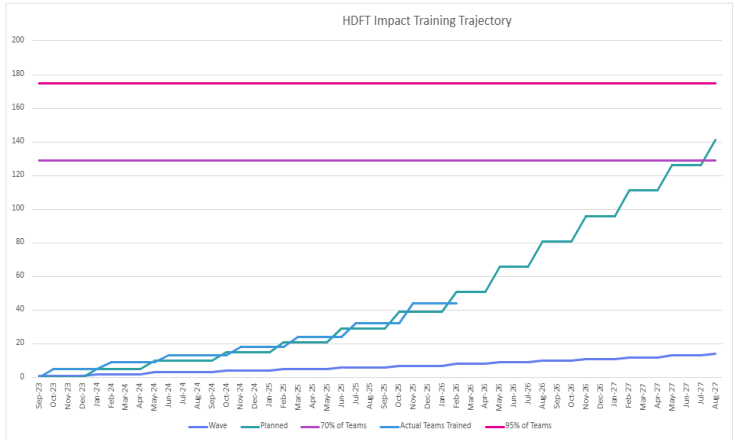
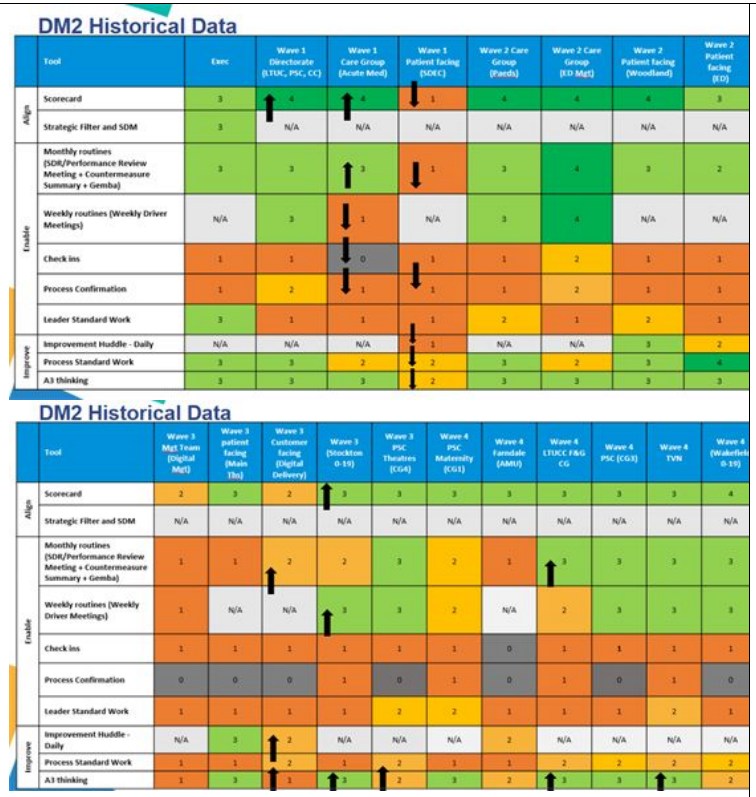
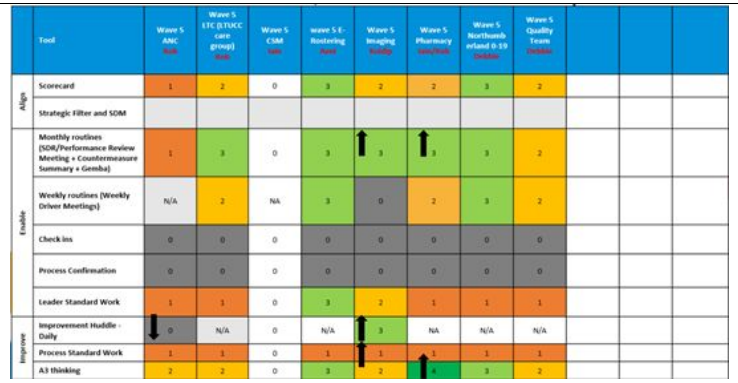
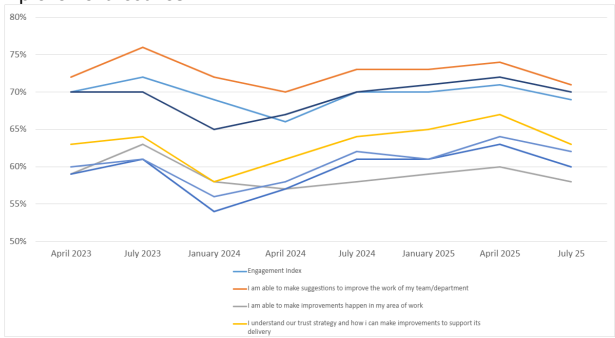
All	To develop our capacity and capability and to embed the culture for continuous improvement through the Implementation of the Impact Improvement Operating Model.	Training: 70% of Teams will be trained to use HDFT Impact by Sept 2026	This Strategic Programme for HDFT Impact continues into its second 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 the first is the percentage of teams trained across HDFT. • There are now 44 teams in or who have completed training. Using the original denominator of 146 teams in the Trust this equates to 27% of the total. (See chart 1 below). • Significant increased delivery in the last 2 training Waves (up from 8 to15 teams per wave) has removed the deficit against the original plan. There are two notable changes that introduce risk to prospective performance for this metric and influence the amber achievement rating. • The expansion of the Children & Young People's Public Health (CYPPH) services has added and estimated 38 teams who will require Impact training bringing the total to an estimated 184 teams. Consequently, adjustments have been made to the trajectory which demonstrates the 70% target will be achieved by Aug 2027 (9-months beyond original plan). This is illustrated in chart 2 below. • An emerging risk to achieving this modified target relates to an anticipated 40% reduction in the capacity of the Improvement Academy from April 2026 due to the cessation of capital funding for 2.0 WTE Improvement Managers. Without significant changes to the delivery model this will further delay training delivery. Chart 1: Original baseline 146 teams to train. 	Redesign & focus of HDFT Impact Strategic programme board for Nov.25 Impact Improvement Operating Model development: Testing of a revised delivery model for frontline training developed with CYPPH. Adaptation to rationalise the standard model to 12-week delivery cycle from Feb'26 (Wave 8). Progressive increase in independent delivery of Impact by senior team members in CYPPH directorate. Scheduling of the single day intensive HDFT Impact for Leaders offer based on demand after 3 pilot sessions successful. Collaboration with other organisations to explore alternative delivery		

			Chart 2: Training trajectory adjusted for additional teams (Approx 184 total). 			
		Sustainability: 90% of those who have completed training will have embedded the routines and processes of the Improvement Operating Model after 4 months.	Teams who have completed the HDFT Impact training will reach level 3 maturity (sustainable independence with routines & processes). This metric comprises process confirmation scores for Wave 1-5; teams who completed HDFT Impact training over 4 months ago. The overall sustainability score is 36% (-2% from the last report). Wave 5 data is new since the last report. This Wave currently scores 29%. There is significant variation across the 8 teams in the Wave with scores ranging from 0 to 83%. Monthly routines (e.g. PRMs) and A3 thinking score consistently well in contrast to tools such as 'process standard work' and 'check-in' which have low reliability. These patterns are consistent with Waves 1-4.	Review of the HDFT Impact strategic programme is complete. A revised governance model is now in place with excellent engagement from directorate leadership and corporate services. The new programme board will begin formally later in Nov '25. There is agreement that the sustainability workstream will need a collective endeavour to achieve the 90% ambition given the current position. Gathering insight into the root cause of variation will be the initial focus. This work will elicit countermeasures to be tested with the collective support of leadership through and across operational layers. Consideration is being given to tracking sustainability performance using a simpler metric which would not rely on the Improvement Academy assessments. Earlier work to digitise the original metric has been paused.		

				There is optimism that enhanced visibility can improve performance for this metric and a proposal to include adherence to essential Impact routines as a watch metric in PRMs will go to the programme board this month.		

					
		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.	There is no new data for this metric to report in November. Latest results are from the July '25 HDFT Inpulse survey which showed a dip in performance for this metric to 63% (-4% from Apr'25). Other questions in the survey related to strategy also showed modest decline of 2-3%. While there is caution not to over-react to a single adverse data point, the new countermeasures will include a review of the HDFT communication approach as the expectation would be that this metric would progressively improve as more colleagues receive Impact training and adopt improvement routines. 	As previously reported, awareness of the Trust strategy is one of 3 workstreams in the revised programme format. Countermeasures have been offered, and programme board members are considering how target groups can be influenced most effectively, especially through existing channels. Changes to organisation-wide comms are still in a design phase; having been limited by capacity in the communications team and a need to ensure consultation with programme board members. The quarterly strategy progress update is circulated via various channels to increase visibility. This also features in the monthly team brief.		

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 at this time					

ENABLING AMBTION: AN ENVIRONMENT THAT PROMOTES WELLBEING 2024-25

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

GOALS:

Wellbeing

A patient and staff environment that promotes wellbeing

Quality & Safety

An environment and equipment that promotes best quality, safest care

Environmental Impact

Minimise our impact on the environment

GOVERNANCE:

Environment Framework

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

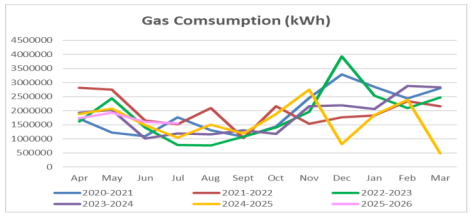
Enabling Ambition Metrics (Executive Lead: 10-15 Year deliverable)

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

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

Ambition	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	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
Wellbeing 	A patient and staff environment that promotes wellbeing	To improve the environment for patients and staff Capital spend vs budget – to ensure delivery against allocated budget.	• Deliver 2025/26 Capital Programme • Deliver Block C Theatres & Imaging Corporate Project (see Corporate Projects below)	• 2025/26 Capital Programme plan is £36,296m. • Spend YTD is 29% • Predicted spend forecast is 113% • On Track.		
Quality & Safety 	An environment and equipment that promotes best quality, safest care	To improve the Trust's premises infrastructure and services. 2022/23 • 21 Moderate Improvement SAQs 2023/24 PAM • 37 Moderate Improvement SAQs 2024/25 PAM • 28 Moderate Improvement SAQs To reduce critical infrastructure backlog maintenance risks.	• Premises Assurance Model ○ Expand coverage to include Ripon CH ○ Deliver 25/26 action plan • Deliver £1.6m fire systems improvement programme. • RAAC – eradicate remaining RAAC (outside Block C) on HDH site ○ Water tank room/Swaledale Fire Exit ○ 50 Lancaster Park Road – Decant facility refurbishment ○ Site wide design work	• On Track • Ripon CH included in 24/25 submission • Critical infrastructure risk funding from HNY ICB confirmed. • Business case for additional RAAC funding outside of Block C - Approved. Programme TBC. Tight timescales for delivery.		
Environmental Impact 	Minimise our impact on the environment	HDFT to be carbon net zero by 2040 Achieve 1,700 tCO2e reduction in Scope 1 and 2 emissions by 2028 	• Refreshed Green Plan developed and approved • Carbon accounting process implemented • Estates & Facilities ○ Replacement of CHP with more modern, efficient system ○ Investigate geothermal energy ○ Investigate onsite waste to energy system ○ PSDS 4 Works • Medicines- Complete nitrous oxide removal and develop Entonox reduction plan.	• Complete • On Track • TBC depending on funding • On Track • On Track • On Track • External funding has been received and order placed for Trolleys to house localised canisters. Then the piped network will be capped off. Entonox project to be initiated following this.		

Related Corporate Project

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

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR75 / ID 116	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
ID 117	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 March 2026		
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 April 26	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 Sep 25	Operational: Health & Safety	Minimal

Related External Risks

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

Trust Board

26th November 2025

Title:	Emergency Preparedness, Resilience & Response Report 2025-26
Responsible Director:	Russell Nightingale, Accountable Emergency Officer
Author:	*Alexander Chatten, EPRR & Site Support Officer*

Purpose of the report and summary of key issues:	*The Civil Contingencies Act 2004 identifies NHS Acute Trusts as Category 1 responders, giving them legal responsibility to plan for and respond to emergencies, working in co-operation with other responders and communicating with the public.* *This report updates the Board on the range of actions undertaken this year as part of the Emergency Preparedness, Resilience and Response ("EPRR") agenda by the Trust.* *The NHS EPRR Framework identifies that NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. It also provides a set of core standards for all NHS funded organisations in England to help with meeting the legislative requirements.* *The report outlines key activities undertaken since the last report in November 2024 by the Trusts' EPRR Team and the wider health emergency planning community in Humber and North Yorkshire.* *The Trust has been assessed against the 10 domains containing 62 applicable core standards.* • *This year, the Trust has been determined to have:* *33 Fully-Compliant Standards* *27 Partially-Compliant Standards* *2 Non-Compliant Standards* *The Trusts' overall compliance rating against the NHSE Core Standards is therefore categorised as 'non-compliant.' (<76% of standards fully compliant). Despite the compliance rating of the Trust remaining as non-compliant, the percentage of compliance has still risen.* *The process usually involves an additional assessment of a separate domain which is a deep dive investigation into a particular area that isn't included in the main assurance process. This year, NHS England did not include a deep dive in the assurance process.*

8.1

<table>
<tr><td></td><td colspan="2">Appendix A – Statement of Compliance

Appendix B – EPRR Financial Forecast

Appendix C – 2024-25 EPRR Core Standards Action Plan</td></tr>
<tr><td rowspan="8">Trust Strategy and Strategic Ambitions</td><td colspan="2">The Patient and Child First
Improving the health and wellbeing of our patients, children and communities</td></tr>
<tr><td>Best Quality, Safest Care</td><td>X</td></tr>
<tr><td>Person Centred, Integrated Care; Strong Partnerships</td><td>X</td></tr>
<tr><td>Great Start in Life</td><td></td></tr>
<tr><td>At Our Best: Making HDFT the best place to work</td><td>X</td></tr>
<tr><td>An environment that promotes wellbeing</td><td></td></tr>
<tr><td>Digital transformation to integrate care and improve patient, child and staff experience</td><td></td></tr>
<tr><td>Healthcare innovation to improve quality</td><td></td></tr>
<tr><td>Corporate Risks</td><td colspan="2"></td></tr>
<tr><td>Report History:</td><td colspan="2">HDFT’s previous EPRR Core Standards Assurance ratings:

2023 10% Non-compliant
2024 45% Non-compliant</td></tr>
<tr><td>Recommendation:</td><td colspan="2">The HDFT Final Self-Assessment Submission automatically creates an associated action plan (appendix C) to work towards achieving better compliance in the next Core Standards Assurance.

The Board is asked to:

• Consider the compliance self-assessment, rating and associated guidance and provide feedback accordingly.
• Formally approve the self-assessment, overall compliance rating and associated action plan for the 2025-26 work programme that has been agreed by the organisations EPRR Team and Accountable Emergency Officer.
• Approve recommendation to bring adjunct paper in May outlining progress towards compliance in 2026-27.</td></tr>
</table>

1. INTRODUCTION

This report updates the Board on the range of actions undertaken this year as part of the Emergency Preparedness, Resilience and Response ("EPRR") agenda by the Trust. Acute Trusts are identified as Category 1 (Cat 1) responders which are those organisations deemed to be at the core of emergency response. This puts them on equal response footing with the ICB, ambulance services and local authorities, as well as Police and Fire and Rescue Services.

The report outlines key activities undertaken since the last report in November 2024 by the Trusts' EPRR Team and the wider health emergency planning community in Humber and North Yorkshire.

2. BACKGROUND

The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. Under the Civil Contingencies Act (2004) and Health and Social Care Act 2012, NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR).

One of the requirements of the EPRR Core Standards is that organisations report annually to their board on the result of their annual self-assessment against the standards but also report on any incidents responded to, outputs of training and exercising and lessons identified.

The Trusts' EPRR agenda is delivered by the EPRR Team (currently made up of one subject matter expert) and the Accountable Emergency Officer (the Trusts' Chief Operating Officer and Deputy Chief Executive) who are supported in the execution of these duties by the Deputy Chief Operating Officer.

The Trusts' on-call rota ensures that a Tactical Commander and Strategic Commander are available to support in responding to incidents and emergencies at all times.

3. ASSESSMENT

As part of preparing for incidents, the Trust, along with other NHS providers, have undertaken the following:

3.1. Risk Assessment

The top risks assessed by the Local Health Resilience Forum on behalf of the whole ICB/ICS are:

- Denial of Access to Systems
- Adverse Weather
- Infectious Diseases & Pandemics
- Loss of Utilities (including energy & telecommunications)
- COMAH Site Release, Explosion or Malicious Attack (contaminated bodies)

These risks were selected by the LHRP from the North East and Yorkshire NHS Risk Register (derived from the national and community risk registers) as a priority for focus given local contextualisation and geography.

4. RESPONSE TO INCIDENTS

Since the last report, the Trust has had to respond to a variety of Incidents, including:

- Health Care Industrial Action (BMA Resident Doctors)
- Adverse Weather
- High Consequence Infectious Diseases
- IT/ Systems Outages
- Power Outages

5. TRAINING

A significant range of work has been undertaken to align the Trusts' EPRR training plan with the Minimum Occupational Standards for EPRR. In April 2024, personal development portfolios were rolled out to all ICB commanders and EPRR advisors, with supportive 'drop-in' style sessions in January and February 2025 teaching commanders how to use the portfolios, and access the required training.

The On-call Managers and Directors Portfolio Team has been expanded to include the training needs analysis and training log. Work was undertaken to add the requirements to LearningLab but the set-up on Microsoft Teams has proven to be the best way to organise the PDPs, with work ongoing to report compliance to LearningLab to add to Commanders accounts. Commanders have their own portfolios to log training attendance but also complete reflective practice on their experiences. Portfolios need to be reviewed once in a 3 year cycle, and the EPRR team are working through the practicalities and governance surrounding this.

All health organisations that are members of the LHRP are also using the same portfolios and system, to allow portability of the portfolios, and collaborative delivery and design. Compliance with the courses listed in the portfolios is reported quarterly through LHRP and up to the Regional Health Resilience Partnership. Portfolio completion is seen below:-

Overall Compliance Against the Portfolio						
Number of Strategic Health Commanders	17			32.46%		
Number of Tactical Health Commanders	20					
Number of EPRR specialists/advisors	3					
Compliance against the relevant portfolio	0-24%	25-49%	50-74%	75-99%	100%	
Strategic compliance against Health Commander Portfolios	3	10	4	0	0	
Tactical compliance against Health Commander Portfolios	12	4	0	2	2	
EPRR compliance against Health Commander Portfolios	1	0	2	0	0	

With support from the Corporate Affairs team and planning future commander training sessions and exercises, we aim to either have improved to 75% or be booked onto training that would take them to 75% excluding those training sessions that can't be provided in house by April 2025.

The regional NHS England EPRR Team have collectively developed short, helpful courses to improve access and relevance which has allowed us to access the majority of the training for commanders. The other elements, regarded as 'experience elements' will be covered in the future commanders training sessions and exercises.

6. EXERCISING

The Trust is required to complete a communications exercise every six months, a table top exercise annually and command-post and live exercises every 3 years. The Trust has responded to Incidents such as Industrial Action and Power Outages which has negated the need for a full live exercise, however, we have recently completed a live, no-notice exercise of the Trusts' Chemical, Biological, Radiological and Nuclear (CBRN) plan as this plan has not been exercised in some time. A full list of exercises can be seen below. Those in red were hosted by other providers:-

Communications Test		Sep 2024
Border Terrier (Mass Casualty)	Table top	Nov 2024
Golden Retriever (Mass Casualty)	Table top	Nov 2024
Evacuation Workshop (York District Hospital)	Table top	Dec 2024
Communications Test		Apr 2025
Exercise Flanders (CBRN)	Live	Nov 2025

Future scheduled Exercises:-

Inpatient Ward BCP Exercise	Table top	Nov 2025
Command-Post Exercise		Mar 2026

7. LESSONS IDENTIFIED

The Trust is required to ensure it commits to a continuous cycle of learning and improvement as a result of any incidents, training sessions or exercises. The below table summarises some of the high-level lessons identified since the last report; the actions for which are monitored by the EPRR Team on the single Master Action Tracker.

Exercise or Incident	Lessons Identified	Resulting Actions
Communications Test (Sep 2024)	• Inconsistencies with response forms leading to lack of uniformity • ASCOM system works well however users to ensure devices are carried and switched on at all times.	• Standardised format to be introduced
Communications Test (Apr 2025)	• No Loggists responded which assumed to be due to invalid format on bleep system	• Bleep system updated with correct format
Power Outage (Oct 2025)	• Declare incidents early to mobile resources, can always be stepped down if not required. • A 4G/5G survey is needed to understand the gaps during a Wi-Fi outage.	• 4G/5G Survey to be completed. • Documentation to explain where generators are, where they each provide power for and where any UPS' are located. • Ensure Incident Response Plan is clear with command structure in/out of hours.
Severe Weather (Jan 2025)	• Severe weather plan lacked some actions that would have been helpful to have considered early on – such as checking rosters and issuing communications.	• Plan to be updated for managers to look ahead at rosters when weather warnings issued. • Communications to go out ahead of severe weather with actions for managers/ staff • Staff to be offered accommodation beforehand to ensure they get to work safely.

		• Re-embedding of weather alerts and WhatsApp groups to support staff.

8. BUSINESS CONTINUITY

The Trust has a Business Continuity Management Strategy which outlines our Business Continuity Management System (BCSM). The key performance indicators have been developed for inclusion in the board report every year to provide assurance to the board on effectiveness of the BCMS.

All directorates to have completed a BIA	To be completed by April 2026
Strategic BIA has been reviewed	Completed Sep 2024 (next review Sep 2026).
Exercise(s) have been completed to test all aspects business continuity arrangements.	Planned for November 2025 ahead of new EPR go-live.
Any business continuity incidents have been entered onto the EPRR Team Incident Log	Completed - work ongoing to ensure staff are aware this needs to be communicated to EPRR staff.
Any business continuity exercises have been entered onto the EPRR Team Exercise Log	Completed – work ongoing to ensure staff are aware this needs to be communicated to EPRR staff.
Any lessons identified from incidents and exercises and their resultant actions have been captured on the Master Action Tracker	Yes
Business continuity plans has been reviewed, incorporating any changes to BIAs and/or changes due to lessons identified through incidents or exercising	In progress once exercise(s) have been completed.

The Emergency Planning Steering Group (EPSG) has recently established a Business Continuity Working Group (BCWG) in order to better coordinate the Business Continuity requirement of the organisation. Membership is required across directorates and Business Continuity Leads have been appointed.

The Trust was audited in April 2025 by Audit Yorkshire. The Master Action Tracker was updated with recommendations from their report and will be reviewed at the Business Continuity Working Group.

9. NHSE EPRR CORE STANDARDS ASSURANCE PROCESS

The NHS EPRR Core Standards were introduced to clearly set out the minimum standards expected of NHS organisations and providers of NHS funded care with respect to emergency preparedness, resilience, and response.

The NHSE EPRR Core Standards enable agencies across the country to share a common purpose and to coordinate EPRR activities in proportion to the organisation's size and scope. In addition, they provide a consistent cohesive framework for self-assessment, peer review and assurance processes.

These standards will be reviewed and updated as lessons are identified from testing, national legislation, and guidance changes and/ or as part of the rolling NHSE EPRR governance programme.

The assurance process changed in 2023 to include evidence submission against each core standard, formal peer-review and subsequently a check and challenge. In the wake of lessons identified from recent incidents such as the Manchester Arena, Grenfell and COVID-19, it is clear that the standard which organisations must achieve is one which requires a dedicated robust assurance process which can ensure our collective system resilience.

Last year's model remained the same as the 2024 process except organisations were asked to only provide evidence against any standards that have been increased from Non or Partially-Compliant to Fully-Compliant.

The process continues to be an open, honest and transparent review of evidence associated with the core standards with the objective of improving our collective resilience for our patients and communities.

Assurance Rating Thresholds

- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core Standards.

9.1. PREVIOUS YEAR'S POSITION (2024-25)

In the 2024-25 NHSE Core standards assurance process, the Trust was determined to have a compliance rating of 45% - 'Non-Compliant.'

Percentage Compliance	**45%**
Overall Assessment	**Non-Compliant**

9.1.1. Domains

A breakdown of the 10 domains, and the deep dive into Cyber Security, is seen below:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	2	4	0
Duty to risk assess	2	1	1	0
Duty to maintain plans	11	4	7	0
Command and control	2	2	0	0
Training and exercising	4	2	1	1
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	3	5	2
Hazmat/CBRN	12	0	11	1
CBRN Support to acute Trusts	0	0	0	0
Total	62	28	30	4

9.1.2. Deep Dive

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Cyber Security	11	3	2	6
Total	11	3	2	6

9.2. CURRENT POSITION

This year, the EPRR team have self-assessed the Trust against the 62 applicable core standards.

The overall position for this year has therefore been determined as non-compliant. Our total percentage of compliance for 2025 is 53%, being fully compliant with 33 of the 62 core standards.

Any standard that has been rated as partially or non-compliant has been automatically transferred into an action plan that will form part of the Trusts EPRR Work plan for the following 12 months.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisations Board has agreed with this position
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisations Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisations Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisations Board has agreed an action plan to meet compliance within the next 12 months. The action plan will be monitored on a quarterly basis to demonstrate progress towards compliance.

9.3. Summary of compliance with Core Standards for 2025-26

A breakdown of the 10 domains can be seen below:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	4	2	0
Duty to risk assess	2	1	1	0
Duty to maintain plans	11	6	5	0
Command and control	2	2	0	0
Training and exercising	4	2	1	1
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	4	6	0
Hazmat/CBRN	12	0	11	1
CBRN Support to acute Trusts	0	0	0	0
Total	62	33	27	2

8.1

9.3.1. Deep Dive

There was no deep dive in the 2025 Core Standards Assurance Process

9.3.2. Overall position

Percentage Compliance	**53%**
Overall Assessment	**Non-compliant**

9.4. This year

Over the course of this year, the EPRR team has experienced considerable staffing constraints, primarily resulting from unforeseen long-term absences due to illness. These unexpected circumstances have significantly reduced the team's operational capacity and directly limited the volume of improvements able to be implemented.

Plans to mitigate this gap within the EPRR team through collaboration with EPRR colleagues at LTHT were unable to be transacted due to the turnover of key personnel within LTHT's EPRR team. Despite the continued commitment to progress and quality, the reduced availability of personnel has posed substantial challenges to maintaining momentum across key initiatives.

9.5. Resource benchmarking

Other Trusts' in North and West Yorkshire have been asked to provide us with the numbers and grades of their Trusts' EPRR Workforce for benchmarking purposes. Results can be seen below:

Harrogate & District	8A	6
York & Scarborough	8A	7
Humber Health Partnership	8D	3
	8A	5
	8A	5
Airedale Teaching Hospitals	8A*	
Mid Yorkshire	8A	3
Bradford Teaching Hospitals	8A	7
	= Non-dedicated EPRR workforce	
	= Dedicated EPRR workforce	

*Heavily supported by various specialists and leads, e.g. infection prevention on infectious diseases, IT on cyber, etc.

10. ACTIONS

Actions identified from the Core Standards process have been compiled into an action plan contained within the EPRR Core Standards Self-Assessment Tool and then transferred into the EPRR Action Tracker that is reviewed regularly at Emergency Planning Steering Group (EPSG) or the relevant sub-groups.

Please see 'Appendix B' for the EPRR Core Standards Action Plan

Any outstanding actions will continue to form the basis for the 2026-27 EPRR Work Programme.

Looking ahead, the Trust will establish a structured and ongoing engagement with the ICB EPRR Team to actively solicit their feedback and insights. This collaborative approach will serve as a critical mechanism for identifying areas of improvement and reinforcing best practices. By integrating their perspectives into HDFTs planning and review cycles, the Trust will enhance compliance outcomes and ensure continuous improvement throughout the next assurance process.

11. CONCLUSION

Whilst the summary position for EPRR Core Standards Assurance Process has remained the same, significant work has been completed to raise the Trusts percentage of compliance from the previous year. A breakdown of the changes can be seen below:

	Standards		
	Fully Compliant	**Partially Compliant**	**Non-Compliant**
2024	28	30	4
2025	33	27	2
Difference	**+5**	**-3**	**-2**

2024 Compliance	45.16%
2025 Compliance	53.22%
Difference	**+8.06%**

There has been a visible improvement in compliance compared to last year's position, notwithstanding the considerable staffing constraints faced by the EPRR team due to unforeseen long-term illness. The implementation and expansion of the new Action Tracker and Business Continuity Working Group are expected to facilitate further enhancements and sustain continued progress in compliance.

The EPRR team now meets with the Deputy Chief Operating Officer on a fortnightly basis to review the EPRR Action Tracker and Core Standards Action Plan, thereby enhancing assurance in the ongoing efforts to improve compliance.

Given the Trust has been non-compliant for the previous 2 Core Standards Assurances, the EPRR Team will bring an additional paper to Board in 6 months' time with an update on the actions in the tracker.

12. RECCOMENDATIONS

The Trust Board are asked to:

- Consider the compliance self-assessment, rating and associated guidance and provide feedback accordingly.
- Formally approve the self-assessment, overall compliance rating and associated action plan for the 2025-26 work programme that has been agreed by the organisations EPRR Team and Accountable Emergency Officer.
- Approve recommendation to bring adjunct paper in May outlining progress towards compliance in 2026-27.

13. APPENDICES

Appendix A – Statement of Compliance

Appendix B – EPRR Financial Forecast

Appendix C – 2024-25 EPRR Core Standards Action Plan

Appendix A – Statement of Compliance 2025-26 (double-click to view)

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-26

STATEMENT OF COMPLIANCE

Harrogate & District NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool V2.

Where areas require further action, Harrogate & District NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's Accountable Emergency Officer (AEO) pending submission to the Board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer:

Date Signed: 07/11/2025

Date of Board/Governing Body meeting:	Date to be presented at public Board:	Date to be published in Annual Report:
26/11/2025	26/11/2025	30/06/2026

Appendix B – EPRR Financial Forecast

EPRR FINANCIAL FORECAST

YEAR	2025-26

ITEM/SERVICE	DATE	COST
Legal Awareness Training x4 Directors	February 2026	£1,490
Media Training x6 Directors	February 2026	£860
TOTAL		**£2,350.00**

Other considerations:

- Staff training to complete PDPs.
- Staff to participate in exercises.

YEAR	2026-27

ITEM/SERVICE	DATE	COST
PRPS Suit Servicing (x7 suits)	Nov/ Dec 2026	£1,953.21.00
Decontamination Unit Servicing	November 2026	£990.00
Single New PRPS Suit including: • 1 Training suit • Life servicing upfront	August 2026	£4,633.14
TOTAL		**£7,576.35**

Other considerations:

- Staff to participate in exercises.

Appendix C – Core Standards Action Plan

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	RAG	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance										
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	EPRR Board Report 2024 Minutes of Public Board Jan 2025	Partially compliant	EPRR Board Reports to go every 2 months on BC/ Training & Exercising/ Incidents/ Assurance. Include linking in with ICB EPRR team and provide feedback from them regularly and resource struggles. To include Comms test/ texting system.	Roseanne Kirkham	30/11/2025	
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Job Descriptions EPRR Strategy	Partially compliant	EPRR Board Report to include recommendations on this.	Alex Chatten	30/11/2025	
Domain 2 - Duty to risk assess										

8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Risk Management Policy EPRR Strategy	Partially compliant	PRM to consider EPRR. Risk Management Policy to be updated to include EPRR	Roseanne Kirkham	31/12/2025	
Domain 3 - Duty to maintain Plans										
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Pandemic Respiratory Virus Plan	Partially compliant	Operational Plan in draft, in consultation with IPC team then wider. Then to go to SDR 21/01/26.	Roseanne Kirkham	30/01/2026	

14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Countermeasures Plan in draft but not yet finished or consulted	Partially compliant	EPRR Plans to go to consultation then back to EPSG if significant changes. Countermeasures plan included in this		30/01/2026	

15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Mass Casualty Plan in draft but not yet consulted	Partially compliant	EPRR Plans to go to consultation then back to EPSG if significant changes. Mass Casualty plan included in this	Alex Chatten	31/01/2026	
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown plan	Partially Compliant	Plan should consider an alternative location for the ICC in case of restricted access	Matt Johnson	30/01/2026	
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	High Profile Person Policy	Partially compliant	Consideration needs to be added for those under police protection/ high profile prisoners, including decontamination	Giles Latham	30/01/2025	
Domain 5 - Training and exercising										

22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	EPRR Strategy EPRR TNA EPRR Portfolio training log	Partially compliant	PDPs to be made mandatory on LearningLab to affect compliance. Sessions to be held to cover off certain elements of PDPs	Alex Chatten	31/01/2026	
25	**Training and**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	No evidence currently	Non compliant	e-learning mandatory on learninglab for all staff	Alex Chatten	26/12/2025	
Domain 6 - Response										
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Loggist List	Partially compliant	Loggists due refresher training. Response to Communications Tests (comms test requires update). To be included in Board Report in November.	Alex Chatten	30/11/2025	
Domain 9 - Business Continuity										

46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.		Partially compliant	BCPs require review/ testing and exercising. BIAs required for directorates to understand BC requirements for each directorate and act as a gap analysis. Create an action plan to undertake full directorate Business Impact Analyses. Governed by BCWG. Reminder to be sent 06/11/2025 and weekly going forward. Directorate BIA to be completed by March 2026 and BC to go to Board in April 2026	Alex Chatten	28/02/2026	

47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices		Partially compliant	Require update, exercise and testing Create an action plan to undertake full directorate Business Impact Analyses. To go to board in 2026	Alex Chatten	28/02/2026	
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans		Partially compliant	All BCPs require annual test/ exercise and needs to be logged with EPRR team for documentation. New BC template to include date of latest test	Alex Chatten	28/02/2026	

50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers		Partially compliant	Report BC to Board		30/04/2026	
51	Business Continuity	BC Audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Audit completed in 2025 by Audit Yorkshire		The BCMS references the audit programme/ schedule of auditing. The actions are on the EPRR Action Tracker but not as a result of the Audit (i.e. we already knew prior to audit). The actions should reference the BC audit	Alex Chatten	31/12/2025	
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers		Partially compliant	Meeting with Head of Contracting regarding commissioned suppliers.	Roseanne Kirkham	30/04/2026	
Domain 10 - CBRN										

55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation		Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services		Non compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient		Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	

58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: • command and control structures • Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability • Procedures to manage and coordinate communications with other key stakeholders and other responders • Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) • Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control • Distinction between dry and wet decontamination and the decision making process for the appropriate deployment • Identification of lockdown/isolation procedures for patients waiting for decontamination • Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • Arrangements for staff decontamination and access to staff welfare • Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes • Plans for the management of hazardous waste • Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities • Description of process for obtaining		Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	

				replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident						
59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource		Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	

60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.		Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	

61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53		Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	

62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53		Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment		Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	

64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records		Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	

65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS		Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning		Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	