Board of Directors Meeting Held in Public

To be held on Wednesday, 28th January 2026 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 26th November 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	Nursing and Midwifery Quality and Safe Staffing Report	Director of Nursing and Midwifery and AHPs	Note	Supp. Pack Attached
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 **3.2.1** **3.2.2**	**Strengthening Maternity and Neo-Natal Safety Report** **MIS 7 Year report** **MIS Safety Action Year 7**	Director of Nursing, Midwifery and AHPs / Associate Director of Midwifery	Note	Attached Attached Attached

Item No.	Item	Lead	Action	Paper
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
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
SECTION 8: Governance Arrangements				
8.1	Use of Trust Seal Report *Note – no usage of Trust seal since last report*	Company Secretary	Note	Verbal
8.2	Board Appointed Non Executive Roles	Chair	Note	Verbal
8.3	Committee membership – Non Executive Directors	Chair	Note	Verbal
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 25th March 2026 at 1.00 – 3.45pm Venue: Boardroom, Trust Headquarters, Harrogate District Hospital			

Item No.	Item	Lead	Action	Paper

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.

Harrogate and District NHS Foundation Trust

Board of Directors – Register of Interests

As at 12th January 2026

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	April 2022 November 2025	Current Current	1. 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) 2. Trustee of Harrogate & District Community Action
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)
Russell Nightingale	Chief Operating Officer & Deputy Chief Executive	April 2021	Current	10. Director of ILS and IPS Pathology Joint Venture

Board Member	Position	Relevant Dates From	To	Declaration Details
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

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
Andy Williams	Chief Interim Digital Officer	1. Shareholder (50%) in The Human Digital Collaborative Ltd 2. Shareholder (25%) in One Clinical Ltd. 3. Shareholder (100%) in AHLC Solutions Ltd.

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

Board Member	Position	Relevant Dates From	To	Declaration Details
Matt Graham	Director of Strategy	September 2021	December 2025	1. Member: Local Governing Body, Malton School (part of Pathfinder Multi-Academy Trust)
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, 26th November 2025

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

Present:	
Sarah Armstrong	Trust Chair
Russell Nightingale	Deputy Chief Executive and Chief Operating Officer
Jeremy Cross (JC)	Non-executive Director, Chair of Resource Committee
Chiara DeBiase (CD)	Non-executive Director, Chair of Audit Committee
Andy Papworth (AP)	Non-executive Director, Chair of People & Culture Committee
Laura Robson (LR)	Non-executive Director, Chair of Quality Committee
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)
Breeda Columb	Executive Director of Nursing, Midwifery and Allied Health Professionals
Matthew Graham	Director of Strategy
Jordan McKie	Director of Finance
Angela Wilkinson	Director of People and Culture

In Attendance:	
Kate Southgate	Associate Director of Quality and Corporate Affairs
Dave Earl	Deputy Medical Director
Rachel Hewson	Company Secretary
Jenny Nolan	Deputy Director of Nursing, Midwifery and AHPs *for the Patient Story*
Leanne Likaj	Associate Director of Midwifery and Children's Services for the *Strengthening Maternity and Neonatal Safety report*
Satty Ali	Freedom to Speak Up Guardian *for the FTSU Guardian report*

Apologies:	
Jonathan Coulter	Chief Executive
Jacqueline Andrews	Executive Medical Director
Colin Melville	Non-executive Director

Observers:	
Governors	Jackie Lincoln, Rachel Carter, Richard Farrar, Kevin Parry
Member of the public / press	1
Colleagues	Jess Kelsey, Giles Latham
External Partners	Kim Betts, Audit Yorkshire

Item No.	Item
BD/11/26/1.1 **1.1.1**	**Welcome and Apologies for Absence** The Chair welcomed everyone to the meeting. The Chair made reference to Rob Armstrong, Deputy Chief Operating Officer and Dave Earl, Deputy Medical Director for joining the meeting.
1.1.2	The Chair thanked all observers for attending the Public meeting of the Trust Board.

Item No.	Item
1.1.3	Apologies for absence were noted as above.
BD/11/26/1.2 **1.2.1**	**Patient Story** The Deputy Director of Nursing, Midwifery and AHPs outlined the patient story which was shown via video. The patient story was of a HDFT-employed Care Support Worker on Granby Ward and his experiences of care after he became unwell. The Deputy Director of Nursing, Midwifery and AHPs highlighted the service from Yorkshire Ambulance Service as well as neighbouring organisations that helped the patient to get to the right service at the right time.
1.2.2	The patient had suffered a stroke in May 2023 and was initially taken to Leeds General Infirmary before being transferred to Harrogate Hospital. He noted in the video that despite initial feelings of embarrassment to be cared for by colleagues, that they had demonstrated absolute respect and professionalism during his stay in hospital and in his ongoing care with the community stroke team.
1.2.3	Despite being unable to return to his original role, the patient had successfully secured a role as a Nutritional Assistant upon returning to work on Oakdale Ward and had had a very positive experience of a phased return to work. He noted feeling reassured by colleagues and having excellent support on his return to work.
1.2.4	The non-executive Director (JW) noted both the recognition of the system approach in the story as well as the importance of the journey back to work from sickness. She also noted her own experience of this being shared at People and Culture Committee.
1.2.5	The non-executive Director (AP) observed that it was not just physical support that the patient had received but also mental support.
1.2.6	The interim non-executive Director (DC) observed that cultural differences had also been considered.
1.2.7	The Chair expressed thanks to the patient for sharing his story and confirmed that a thank you letter would be sent on behalf of herself and the Board.
1.2.8	The Chair commented that the digital format of the Patient Story had worked well and thanks were given to the Deputy Director of Nursing, Midwifery and AHPS, and to the Communications team for their valuable input.
1.2.9	**Resolved:** The patient story was noted.
BD/11/26/1.3 **1.3.1**	**Declarations of Conflicts of Interest and Register of Interests** The Director of Strategy declared a new interest as a Trustee of Harrogate and Community Action.
1.3.2	**Resolved:** The register of interests was received and noted.
BD/11/26/1.4 **1.4.1**	**Minutes of the Previous Board of Directors meeting held on 24 September 2025** The following amendments were noted: • Item 14.5 – amend “gold accreditation” to “baby-friendly gold accreditation” • Item 17.10 to read “on behalf of the Trust” • Item 17.17 to read “availability” not “ability” • Item 24.1 to read “it had been reviewed”

Item No.	Item
1.4.2	**Resolved:** The minutes of the meeting on the 24 September 2025 were approved as an accurate record of the meeting noting the amendments.
BD/11/26/1.5 **1.5.1** **1.5.2** **1.5.3**	**Matters Arising and Action Log** There was one item on the action log - to consider a Board Workshop on the diversity of the communities the Trust serves and it was noted that this was planned for February 2026. Action closed. No further matters arising were raised which were not already noted on the agenda. **Resolved:** All actions were agreed as above.
BD/11/26/1.6 **1.6.1** **1.6.2** **1.6.3** **1.6.4** **1.6.5** **1.6.6** **1.6.7** **1.6.8** **1.6.9** **1.6.10** **1.6.11** **1.6.12**	**Overview by the Chair** The Chair noted a range of activities that had taken place since the last meeting of the Board. The Chair highlighted the following points: • Thanks were expressed to colleagues delivering services as winter weather had arrived earlier than expected. • Flu vaccinations – the Trust was noted as being in the top 5 of Trusts nationally for flu vaccination rates. • A Board Capability Assessment had recently been completed, and the first mid-year review had taken place giving the Trust an opportunity to reflect on its effectiveness. • It was noted that finances have been a consistent area of difficulty but there is awareness of the help required from system colleagues and the impact it has on our colleagues. • The quality of our services remains good despite our financial situation, delivering safe effective care for our service users. • A Board workshop was held in Cumbria in October 2025 to meet new colleagues delivering 0-19 services, this provided an excellent opportunity to receive feedback on the experience of joining HDFT from colleagues. Very positive feedback was received. • EPR is live and continues to be rolled out with positive signs. • Further information has been received on the opportunity to apply for Advanced Foundation Trust status. This will be a new marker of excellence and would allow us to benefit from substantial additional freedoms. It was noted this would be a process the Trust would work through alongside our governors. The non-executive Director (AP) reiterated the benefit of the visit to Cumbria in helping to understand feedback from colleagues. **Resolved:** The Chair's report was noted.
BD/11/26/1.7 **1.7.1** **1.7.2** **1.7.3**	**Chief Executive Report** The Deputy Chief Executive presented his report as read. The following points were highlighted: • A medium-term planning framework has been published with a focus on constitutional standards, noting that these are less ambitious than our own plans for the period. • HNY ICB consultation is now live and closing early January. NHSE have asked to reduce head count by 50% by January.

Item No.	Item
1.7.4 1.7.5 1.7.6 1.7.7 1.7.8 1.7.9 1.7.10 1.7.11 1.7.12 1.7.13 1.7.14 1.7.15	• Recent Resident Doctor Industrial action had had a minimal impact on flow and it was noted approximately 60-70% had been on strike. • A national maternity review was underway. • Partnership with Leeds had been reinstated. • Work continues on locally integrated neighbourhood health models • HDFT would not be applying for the tender for the reprovision of community dental services. • Staff survey responses were noted at encouraging levels. • Draft CQC maternity report has been received and responded to for factual accuracy checking. • A new contract for 0-19 services in South Tyneside has been awarded. • Ripon Urgent Treatment Centre has replaced the Minor Injuries Unit allowing an extended service. • Autism provision – the Trust continues to have active discussions with commissioners in respect of this issue. • Harrogate Hospital and Community Charity held a Charity ball in October celebrating 30 years of the charity and raising funds for equipment. • Over 300 KITE award nominations have been received for the awards taking place early next year.
1.7.16	The non-executive Director (AP) congratulated HIF for their 75% response rate on the staff survey.
1.7.17	**Resolved:** The Chief Executive's Report was noted
BD/11/26/2.1 2.1.1	**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.
2.1.2	This Strategic Ambition had two True North metrics for 2025-26. The first metric was eliminating moderate and above harm and was noted as on track for delivery. This was the second year of this ambition which was achieved last year and the target this year is for a 20% reduction.
2.1.3	A thematic review on deteriorating patients has been completed, and the data will be reviewed and actions focused on by directorates.
2.1.4	Low and no harm events continue to be monitored – maintained at 98%
2.1.5	There are no corporate risks associated with this metric.
2.1.6	The second metric was an improved positive patient experience, also on track for delivery. It had been agreed to monitor the Friends and Family Test (FFT) experience rating which is at 96%.
2.1.7	Work continues on the Corporate project on engagement strategy with a workshop held on engagement in October and a draft strategy to be ratified in Q4.
2.1.8	The Chair of the Quality Committee had nothing further to note on this Ambition.
2.1.9	The non-executive Director (AP) queried the next steps in relation to the Never Event and it was confirmed that the investigation is ongoing and will be reported at private Board.
2.1.10	The response rate on engagement was noted as 9% in both in and outpatients.

Item No.	Item
	Systems to monitor this have been investigated but there is the possibility that the NHS app will be used for support with the patient engagement strategy. National guidance is awaited for this before any other systems are procured.
2.1.11	**Resolved:** The Board Assurance Framework: Best Quality, Safest Care was noted and approved.
BD/11/26/2.2 **2.2.1**	**Learning from Deaths Quarterly Report (Quarter 2: July 25 – Sept 25)** The non-executive Director (CD) raised a query on page 35 of the supplementary pack on patients with a learning disability who will receive a second review as part of the LeDeR process.
2.2.2	The Deputy Medical Director advised that in previous years any patient with a learning disability had further feedback from the team but that in recent years this had come to a stop and is now feeding into the national report. He noted that in 4 years there had been 1 patient with a learning disability who had only adequate care but there had been internal learnings from this.
2.2.3	**Resolved:** Following review at the Quality Committee, The Learning from Deaths Quarterly Report was noted.
BD/11/26/2.3 **2.3.1**	**Safeguarding Annual Report** **Resolved:** Following review at the Quality Committee, The Safeguarding Annual Report was noted.
BD/11/26/2.4 **2.4.1**	**Safer Staffing Report** **Resolved:** Following review at the Quality Committee, The Safer Staffing Report was noted.
BD/11/26/2.5 **2.5.1**	**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.
BD/11/26/3.1 **3.1.1**	**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.
3.1.2	This Strategic Ambition had two True North metrics for 2025-26:
3.1.3	Early intervention and prevention - in 11 Local Authority commissioned 0-19 Services, the target is to have 90 % of all Healthy Child Programme mandated contacts delivered within national timescales. The current position with October's data now including Cumberland and Westmorland is achieving 48 of the 55 contacts. The 7 breaches were in Wakefield (1), Cumberland (3) and Westmorland (3)
3.1.4	Child Patient Experience continues to see good feedback on services, although response rates are only 9%, work is ongoing to improve this.
3.1.5	There was one Corporate Risk associated with this ambition: CRR34: Autism Assessment.
3.1.6	The Chair of the Quality Committee noted that 0-19 services are a significant agenda for HDFT. There was nothing further from the Quality Committee to note on this Ambition.

Item No.	Item
3.1.7	**Resolved:** The Board Assurance Framework: Great Start in Life was noted and approved.
BD/11/26/3.2 **3.2.1**	**Strengthening Maternity and Neonatal Safety** The Associate Director of Midwifery and Children's Services took the report as read.
3.2.2	It was noted that compliance was maintained with QIS nursing ratio and Delivery suite co-ordinator supernumerary status; and that SCBU was fully recruited to.
3.2.3	Areas of concern were highlighted as; an increased number of complaints possibly in relation to national negative media on maternity services; and an increased number of diverts in October. The Associate Director of Midwifery and Children's Services advised that governance is in place regarding diverts, letters are sent to individuals apologising for diverts. Responses with complaints have recently been received to these letters which hadn't previously occurred. The business case for an increase in establishment will be implemented in December so there will now be an increased number of midwives available on night shifts which should result in a reduction in diverts to services.
3.2.4	Home births continue to see issues with service provision. There has been a recent coroner report from another region about a case of maternal and neonatal death. This case has caused an increase in concern locally and community midwives being reluctant to pick on calls at short notice. A supervision session was confirmed to have taken place with the team and the issue is improving. Work is ongoing to ensure the services has appropriate governance and oversight.
3.2.5	Work is ongoing to increase the implementation of balloon catheters which will allow more people to go home whilst being induced and improve flow.
3.2.6	It was noted that there is nothing of concern in the appendices to the report but to note for maternity incentive schemes and for Board assurance:
3.2.7	- Appendix C - Perinatal mortality review tool – nothing to note of concern, meeting timescale requirements of reviewing deaths. Action plan included.
3.2.8	- Appendix D – Midwifery bi-annual staffing report – business case has been completed to increase establishment. Midwifery establishment staffing is in line with Birthrate Plus requirements. The number of red flags should reduce with the increased staffing and will be demonstrated in the next bi-annual report.
3.2.9	- Appendix E – neonatal staffing report – no change to the staffing of neonatal nurses and medical staffing in relation to BAPM standards. An action plan is in place and attached to the report.
3.2.10	- Appendix F – hospital readmission of babies – nothing of concern to note.
3.2.11	- Appendix G – avoiding term admissions – nothing of concern to note. Action plan attached.
3.2.12	The non-executive Director (AP) noted that a maternity walkaround had taken place recently with the Executive Director of Nursing, Midwifery and AHPs and that work also continues with the Maternity Voices Partnership.

Item No.	Item
3.2.13	The non-executive Director (Insight Programme) (SS) raised a query on the increase on home births and the Associate Director of Midwifery and Children's Services advised that the staff work hard to ensure that communication continues with people to ensure choices are facilitated as safely as possible. Also noted national recommendations, Prevention of Future Deaths will be made following the coroner's case in Rochdale mentioned above.
3.2.14	The non-executive Director (WS) Wallace questioned the sickness levels and the Associate Director of Midwifery and Children's Services clarified that this was approximately 5% but that this was due to a number of staff with long term conditions.
3.2.15	The Executive Director of Nursing, Midwifery and AHPs noted that there are a large number of national requests to respond to and acknowledge all the work the team have done on the report, with particular reference to the Associate Director of Midwifery and Children's Services.
3.2.16	The non-executive Director (LR) noted that the summary included in the report of key issues was very helpful to focus on key areas.
3.2.17	**Resolved:** The Strengthening Maternity and Neonatal Safety report was noted.
BD/11/26/4.1	**Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships**
4.1.1	The Deputy Chief Operating Officer provided the Board with an update on the Strategic Ambition: Person Centred, Integrated Care, Strong Partnerships.
4.1.2	The Strategic Ambition for 2025-2026 had four True North metrics.
4.1.3	**Metric 1: 4-Hour ED standards:**– it was noted that year to date had achieved 78.49 %. However there has been a deterioration in month after the early onset of winter. Flu had arrived 5 to 6 weeks early and there were reports on the efficacy of the vaccine not being as high. The Trust was 36 out of 118 trusts for performance.
4.1.4	**Metric 2: Frailty:-** October was the best performing month supported by the discharge project and LOS was 12.27 days against goal of 11.16.
4.1.5	**Metric 3: Elective Recovery Standard (RTT):**– the target was for 70.49% within 18 weeks and currently at 75.7% - 3rd out of 118 Trusts in the country. There has been a 5% improvement in the last 2 months alone.
4.1.6	**Metric 4: Cancer 62-day treatment standard:**– the target was for 85% of patients to be waiting less than 62 days for treatment. September performance dropped slightly. The Trust is 22nd of 118 Trusts for cancer performance.
4.1.7	There was nothing further to add from the Non-executive Director (JC) who had chaired Resource Committee.
4.1.8	The non-executive Director (JW) commented favourably on the performance of the Trust.
4.1.9	It was noted that there had not been any requests for diverts from HNY for the last 8 weeks although there had been one today from Airedale which had been agreed.
4.1.10	**Resolved:** The Board Assurance Framework: Person Centred, Integrated Care, Strong Partnerships was noted and approved.

Item No.	Item
BD/11/26/4.2 **4.2.1**	**Board Assurance Framework – Finance** The Director of Finance provided the Board with an update on the Strategic Ambition: Overarching Finance 2025-26.
4.2.2	It was noted that the Trust is behind on plan for the Financial Sustainability metric and that this had been discussed at Resources Committee
4.2.3	Waste reduction was noted as a breakthrough objective and that significant work had taken place on this with £10.6 million savings YTD.
4.2.4	Forecast change process and protocols had been discussed at Resources Committee.
4.2.5	It was noted that due to the cash pressure, working capital would be applied for if the situation did not improve. Different controls would come with this and it was noted that audits had previously been carried out by PwC and Grant Thornton.
4.2.5	Support could be offered in terms of turnaround or financial review to pull together for the forecast position which would involve conversations with region and NHSE.
4.2.6	The non-executive Directors (JC and AP) noted that there had been much discussion at Resources Committee and that it has been agreed to move the Committee to a monthly meeting. It was confirmed that the level of oversight for non-executive Directors was excellent with very good transparency.
4.2.7	The non-executive Director (WS) queried if WRAP were to be RAG rated what would the status be and the Director of Finance noted that 2.5 to 3 would be low to medium risk, rest pretty high risk. Some plans have not come to fruition, avoiding inflation but not to the national assumption.
4.2.8	The non-executive Director (JW) questioned the opportunities with the neighbourhood model and refreshed financial system and it was suggested that this would be a useful topic for a Board workshop.
4.2.9	The Director of Strategy remarked on the HELPs business case – investing in something that improved quality and should be able to realise bed savings, noting the difficulty in going from quality improvement to cash releasing.
4.2.10	**Resolved:** The Board Assurance Framework: Finance was noted and approved.
BD/11/26/5.1 **5.1.1**	**Board Assurance Framework – At Our Best: Making HDFT the Best Place to Work** The Director of People and Culture provided the Board with an update on the Strategic Ambition: At Our Best: Making HDFT the Best Place to Work.
5.1.2	This Strategic Ambition for 2025-2026 had two True North metrics:
5.1.3	**Metric 1: Staff Engagement Index and to continually improve the Employee Engagement Score** – it was noted this can only be reported on after latest quarters data and that ambition had already been exceeded on the staff survey, data will be available in February.
5.1.4	**Metric 2: Staff Availability** – there is an average threshold of 560 WTEs which as been exceeded since May this year – vacancies, turnover, maternity leave and

Item No.	Item
	sickness all feed into this. It was noted that sickness is the primary driver of staff unavailability to work with the majority of countermeasures on managing this.
5.1.5	There was discussion on the resident doctors 10 point plan with a full report going to the People and Culture Committee. Nationally the expectation on improvements made is that this is reported at Board level and will be reported through the BAF.
5.1.6	There were no Corporate Risks associated with this ambition.
5.1.7	The non-executive Director and Chair of the People and Culture Committee (AP) noted the positive responses to the staff survey especially within CYPPH and remarked on the progression of work for independent panel members He also highlighted the good work now being done by the FTSU Guardians; and that the People and Culture Committee were seeing the volumes of reports raised by the Guardian of Safe Working as there is a new framework for exception reporting.
5.1.8	It was noted that for the 10-point resident doctors plan, Angela Wilkinson is the Executive lead and Matthew Raban Williams is the Peer lead.
5.1.9	The non-executive Director (WS) commented on the launch of the independent panel members and requested an update on the take-up of this at a future Board meeting. He queried whether EDI data is now going to directorate teams, if not it would be useful for it to go to People and Culture Committee to have oversight of workforce information. He noted feedback on the reciprocal mentoring programme from minority colleagues has been very positive and questioned the current status of EDI objectives for Executives.
5.1.10	The Director of People & Culture confirmed that all Executives have individual objectives but would discuss with the Chief Executive a mechanism to make this more visible.
5.1.11	The Director of Strategy noted that he had taken on the staff networks.
5.1.12	**Resolved:** The Board Assurance Framework: At Our Best: Making HDFT the Best Place to Work was noted and approved.
BD/11/26/5.2	**Freedom to Speak Up Guardian Annual Report**
5.2.1	The Chair welcomed Satty Ali, one of the new FTSU Guardians to discuss the FTSU Guardian Annual Report.
5.2.2	The FTSU Guardian took the report as read. Highlights included:
5.2.3 **5.2.4** **5.2.5** **5.2.6** **5.2.7**	• Focus on promotion and engagement of the role and meeting people on the ground and being visible in the community. • Whilst the role has previously been reactive, now looking to be proactive. • Better engagement with Board – meeting regularly with the Chair and CEO. • Regular attendance at People and Culture Committee. • Focus on Fairness Champions.
5.2.8	The Chair thanked the FTSU Guardian for her report.
5.2.9	**Resolved:** Following review at the People and Culture Committee, The Freedom to Speak Up Guardian Annual Report was noted.
BD/11/26/5.3	**Guardian of Safe Working Hours Quarter 2 Report**

Item No.	Item
5.3.1	**Resolved:** Following review at the People and Culture Committee, The Guardian of Safe Working Hours Quarter 2 Report was noted.
BD/11/26/6.1 **6.1.1** **6.1.2** **6.1.3** **6.1.4** **6.1.5** **6.1.6** **6.1.7** **6.1.8** **6.1.9**	**Board Assurance Framework – Enabling Ambition: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience** The Deputy 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. The Enabling Ambition had one true north metric: Achieve a score of 5/5 across all seven What Good Looks Like (WGLL) pillars with the goal to achieve 3 out of 5 this year. First tranche of EPR had launched on Wednesday 19th November and the launch had gone very well with the level of engagement well received. The next target was to view results with April as the date for clinical noting. The non-executive Director and Chair of the Innovation Committee (WS) noted the Gemba to Wensleydale Ward had taken place for a second time and that it was good to see the evolution in continuous improvement from paper based to hand held and now EPR integration. There had been a lot of positive feedback from staff on the ward, using technology to reduce repetitive questions that patients might be faced with. The non-executive Director and Chair of the Innovation Committee (WS) also noted discussion had taken place at the Committee about achieving digital maturity for the Trust as a whole. In addition, there had been a conversation on Artificial Intelligence and there would be future discussion on AI policy and how tools are being deployed. A paper had been presented to the Committee on how we know that HDFT Impact methodology is working. It was noted that the Director of Strategy's team had responded well to the challenge and done random samples of the improvement journey. At worst this was neutral so this was positive. It was noted that this would also be a useful topic for a Board Workshop in future. The non-executive Director and Chair of the Innovation Committee (WS) observed that EPR launch had gone well and praised the decision to adopt the modular approach. Thanks for the team were to be recorded in the minutes. The Interim non-executive Director (DC) queried if there was an update from patient experience and the non-executive Director and Chair of the Innovation Committee noted that it was too soon to gauge this. **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/11/26/6.2 **6.2.1**	**Board Assurance Framework – Enabling Ambition: Healthcare Innovation to Improve Quality & Safety** The Deputy 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.

Item No.	Item
6.2.2	It was noted that externally there are two big research trials but internally not where we would like to be. It was noted that commercial trials have to be declined due to the lack of a Clinical Research Fund.
6.2.3	Other projects are on track, research MRI is progressing, and a bid has gone to Elsie Sykes charitable fund to be involved with this.
6.2.4	The Chair of the Innovation Committee had nothing further to add linked to this Ambition.
6.2.5	The non-executive Director (AP) queried the timeline for a research facility and the Director of Finance noted that this was tentatively April. The non-executive Director (JW) questioned whether this facility would need to be on site and the Deputy Medical Director confirmed that studies would be limited if the facility were off-site.
6.2.6	**Resolved:** Board Assurance Framework: Healthcare Innovation to Improve Quality & Safety was noted and approved.
BD/11/26/6.3	**Board Assurance Framework – Enabling Ambitions: An Environment that Promotes Wellbeing**
6.3.1	The Director of Finance provided the Board with an update on the Enabling Ambition: An Environment that Promotes Wellbeing.
6.3.2	The True North metrics for the 2025-26 Ambition were:
6.3.3	**Wellbeing (capital programme delivery)** – positive progression was noted on Block C as well as work on Littondale to be ready for winter.
6.3.4	**Quality and Safety** – there was a moderate improvement in safety reducing year on year, notably with the eradication of RAAC across site.
6.3.5	**Impact on the Environment** – a refreshed Green Plan had been developed and approved.
6.3.6	Corporate risks linked to fire and security were highlighted.
6.3.7	The Non-executive Director (JC) noted that the subject matter expert sits in HIF but the risk sits with HDFT.
6.3.8	The Deputy Chief Executive commented on the requirement to have a medium-term strategy for site and it was suggested this would be a useful topic for a Board Workshop.
6.3.9	**Resolved:** Board Assurance Framework: An Environment that Promotes Wellbeing was noted and approved.
BD/11/26/7.1	**Escalations from Sub-Committees of the Board**
7.1.1	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.
7.1.2	The non-executive Director (AP) noted that this is covered in discussions on the BAF and also a the lunchtime meeting of escalation.
7.1.3	The Committee Chairs noted that all areas of escalation had been discussed earlier in the meeting.

Item No.	Item
BD/11/26/8.1 **8.1.1**	**Emergency Preparedness Resilience and Response Report 2025-26** The Deputy Chief Operating Officer presented the Emergency Preparedness Resilience and Response Report 2025-26.
8.1.2	It was noted that the Trust would be reporting as non-compliant despite improvement in year. There had been unexpected long term sickness which had hindered the delivery of improvement expected to be seen.
8.1.3	The Trust would be reporting 53% compliance. A Business continuity working group had been established to allow plans to be brought through from all areas.
8.1.4	Emergency Planning and Steering Group had Terms of Reference and membership refreshed and the Deputy Chief Operating Officer was meeting with them fortnightly on action plans.
8.1.5	A CBRNE exercise had been conducted in the Emergency Department in November 2025.
8.1.6	It was proposed to bring back an updated paper in 6 months to review progress to the Board.
8.1.7	The non-executive Director (AP) questioned whether this should be brought back to Board earlier than 6 months and the Deputy Chief Operating Officer confirmed 6 months would be the appropriate amount of time to show improvement.
8.1.8	The Interim non-executive Director (DC) queried whether there were consequences of non-compliance. The Deputy Chief Operating Officer noted that there were not and that support was being received from the ICB EPRR teams.
8.1.9	The non-executive Director (JW) questioned on whether HIF were involved in the exercise and the Deputy Chief Operating Officer confirmed details would be shared.
8.1.10	It was confirmed that this risk is on a Risk Register.
8.1.11	The non-executive Director (WS) queried the risk of a single individual as that type of incident is not on the list of exercises. The Deputy Chief Operating Officer noted the most likely attacks are cyber, denial of access to systems and loss of utilities. He noted that tabletop exercises take place and a further was planned for the summer.
8.1.12	**The Emergency Preparedness Resilience and Response report 2025-26 was noted and approved.**
BD/11/26/9.0	**Any Other Business** No further business was received.
BD/11/26/10.0	**Board Evaluation** It was noted that a wide range of business had been discussed.
BD/11/26/11.0	**Date and Time of the Next Meeting** The next meeting would be held on Wednesday 28th January 2026.

Item No.	Item
BD/11/26/12.0	**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/11/26/5.1.10	26-Nov-25	EDI Objectives	The Director of People & Culture confirmed that all Executives have individual objectives but would discuss with the Chief Executive a mechanism to make this more visible.	Director of People and Culture	Jan-26		

BOARD OF DIRECTORS (PUBLIC)
28th January 2026

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)
JANUARY 2026

CHIEF EXECUTIVE'S REPORT

National and system issues

1. We are at a point in time of the year when there is a need to deliver the priorities for 2025/26, whilst putting in place plans for 2026/27. At a national and regional level, the focus is very much on planning for 2026/27 and beyond, with the first national submissions of plans sent in in mid-December. These submissions were to be in line with the planning framework published in October.

2. As a reminder, 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.

3. We have responded to this framework with an initial plan for 2026/27 that meets the standards that patients have expressed as being most important, i.e. the constitutional standards, whilst ensuring we achieve a break-even financial position. Strategically, we are also building upon the strength of our preventative offer, the opportunity to integrate services across the Harrogate district, and the opportunity to work across WYAAT and LTHT in particular to secure strong, effective and productive services that our patients and population can benefit from.

4. As referenced in previous Board reports, there is further detail still to emerge or be confirmed – 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 are aware of the direction of travel of the NHS, and we will consider these as they emerge – they will not change our strategy as an organisation but will hopefully help us to deliver on this strategy over the coming years.

5. A key part of the framework relates to the financial system that will operate. The new financial system will better align the delivery of patient services to the funding received, with variable payments for activity delivered. This will in turn highlight areas where there is variation in productivity, as the income received will be independent of the cost incurred by providers. This is a positive step, and will enable the future shift of resources to pathways which deliver the best value, in particular pathways and services out of hospital.

6. Our financial plan for 2026/27 reflects the new financial arrangements and has been constructed based upon the level of service we anticipate needing to deliver for our patients.

7. In relation to our contract with HNY ICB, there is currently a significant difference between our expected level of income and the proposal from the ICB. The difference stands at c£40m. Given the level of patient care that we anticipate delivering next year, and the standards that we are planning to meet, it is clear that discussions need to be focused on

which services cannot be provided. We are engaging with the ICB in these discussions, and we are clear that before any significant changes are made, that we have a jointly agreed implementation plan that is deliverable and has been suitably assessed for any impact on quality. We are engaging well across our system, and with Regional colleagues, as we have difficult but necessary discussions.

8. The latest national oversight framework information has been published for all providers across the NHS. This reflects the Q2 position. For ourselves we remain in segment 3, which is solely driven by the financial override mechanism, without which we would be in segment 1. This gives further impetus to ensuring that we have a financial plan for 2026/27 that delivers a breakeven, sustainable position alongside delivery of the quality and performance standards that we do very well against.

9. As the Board will be aware, we submitted our provider self-assessment in October. We are expecting to receive feedback shortly in respect of our declaration.

10. The latest period of Industrial Action by Resident Doctors has taken place, covering five days over the weekend before Xmas. This remains 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.

11. Finally in relation to national issues, all Trusts received correspondence from NHSE to review the safety and quality of homebirth services following a Prevention of Future Deaths report issued by a coroner. This review is being undertaken and the full report will be brought through the Quality Committee and onto our Board for consideration. The homebirth service is a relatively fragile service, but the safety of women is the overriding priority, even if that means that on some occasions we cannot offer a home birth service. This is not an uncommon position across the country.

12. In relation to the West Yorkshire system and WYAAT in particular, we continue to focus on delivering the priorities identified in the Case for Change. There is a WYAAT clinical board now in place 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. In terms of the key programmes, the aseptic programme is on track, as is the Imaging programme. The pathology programme is an area of discussion currently, as we need to assess the feasibility of continuing on our WYAAT journey in respect of further consolidation. We have discussed this internally through the Joint Venture, and we will be engaged in the work being undertaken over the next few months.

13. In respect of our partnership with LTHT, we have our next joint executive team meeting in Leeds on 26th January. Active and positive discussions are taking place in respect of how we utilise the capacity at Wharfedale Hospital to deliver the greatest benefit for patients across Harrogate and Leeds. We will also continue our work towards more sustainable services in respect of neurology, stroke and cardiology. The Board should be assured of the genuine commitment from both LTHT and ourselves to strengthen the partnership and deliver tangible benefits.

14. 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, and we are a part of discussions

about how the health and wellbeing board works to best effect, with a paper coming to the Health and Wellbeing Board in March outlining some changes following a recent workshop that will reinforce the strength of Place. As an executive team, we are also engaging with our local GP federation (Yorkshire Health Network) to build relationships and develop areas where we could work more closely together.

15. The new ICB structure has been published, and there are some concerns about the level of capacity and commitment to local Places across HNY. As part of the NY health collaborative we have communicated these concerns and are hopeful that there is an opportunity to further develop the future arrangements going forward.

16. As the Board is aware, the ICB has run a procurement process for the future provision of community dental services across North Yorkshire (including Craven). We did not bid to retain the service. The contract has now been awarded to a community interest company from the Midlands, and we are working with colleagues to ensure a safe and effective transfer. We have last week been formally asked to extend the current arrangement into next year, but we need to consider the risks involved and ensure these can be mitigated before we respond formally.

17. We 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.

18. As ever, there are a lot of moving parts that we are managing at the moment across a number of issues and systems. As always though, we are engaged in all of the discussions and are working positively with partners to deliver benefits for the population.

HDFT issues

Introduction

19. 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. There are occasions when the level of response to external organisations is a challenge to manage, but we are focused on maintaining the appropriate balance that engages externally for the benefit of patients across our systems whilst recognising the absolute importance of supporting colleagues within the organisation, which is where the improvements to services will actually be delivered.

Our people

20. The national staff survey closed at the end of November. I am pleased to report that our response rate increased to over 60% (from 48% last year), which is a significant achievement. We have also received initial feedback on our results which shows that for all areas of the people promise, including the engagement and morale scores, that our colleagues have reported an improved position from last year. Recognising that the baseline of last year was already very good, this feedback is very positive. We will get the full comparator scores against other organisations next month, and we will use some of the February workshop to explore our results in more detail. There will always be areas to provide more support to, but we should reflect on the positive feedback received.

21. As referenced earlier in the report, the latest round of industrial action took place before Xmas. At HDFT, this was well managed, with minimal impact on patients, although we do absolutely recognise that for any individual patient to have planned appointments changed is significant for that patient and not what we want to provide as a Trust.

22. In respect of our EDI objectives, we have trained a number of colleagues to be Independent Panel Members for any recruitment panels for posts that are band 8a or above. This positive development, which we plan to expand further once the initial period has been implemented successfully, emerged directly from our reciprocal mentoring programme. We will update the Board through the People and Culture Committee about how this initiative is progressing.

Our Quality

23. As I have updated at a number of Board meetings, the CQC came to the Trust for an unannounced CQC inspection of our maternity services in July. The final report was received in December and published in early January. The outcome is that the service has been rated Good overall, and Good across all five domains. This is a credit to the service and the colleagues who work within it, and should be celebrated. There are always areas to improve, and we have provided our action plan to the CQC on the points they raised for improvement. These actions will be monitored through our internal governance processes, which will include the Quality Committee providing suitable Board oversight.

24. The maternity incentive scheme year seven report is a part of today's papers, and the Board will note that we are declaring non-compliance as a result of failing to meet one of the ten standards. This failure related to three dates where we utilised a locum in the service to cover short-term absence where the locum was not working within HDFT or did not have a separate certificate of eligibility. The locum was known to colleagues as someone who worked elsewhere in the system, but the standard required was not met as described. Actions have been taken to prevent this happening in the future.

25. Our winter plans have been enacted, including the opening of our escalation beds as planned at the end of December. These beds supplemented the opening of our new Acute Medical Unit in early December. Whilst there have been the expected challenges through this winter period, the quality and safety of our patients has been, as always, our priority. We have clear processes in place to monitor the impact of longer waits in the Emergency Department, as we know that patients who wait for over 12 hours in the department can have worse outcomes. There have been no identifiable harms for patients who have waited over 12 hours in the ED, but it is acknowledged that this doesn't mean that the experience of patients hasn't been adversely affected. We also do not utilise the concept of 'corridor care', we have clear policies in place for our 'one-up' process on the wards and we ensure that ambulance handover times are minimised.

26. In respect of the staff flu vaccination programme, our vaccination rates are the highest in the country. This is a credit to our teams, and is a strong indicator of people taking steps to minimise the risk to the patients and population we serve.

27. I am sorry to report that we had a never event earlier this month. This occurred within the Podiatry service. We will investigate this and there will be learning that we can take from this investigation once completed.

Our Services

28. Our 0-19 services continue to deliver strong performance across the majority of our geographic footprint and across the vast majority of the KPIs that we measure ourselves against. This strong performance is also being seen within our new services in Cumberland and Westmoreland & Furness.

29. Our national influence continues as our work in 0-19 services has been used as a case study in the recently published NHSE 'Improving postnatal care' toolkit. The case study is based upon learning from our service in Durham.

30. The Board will be aware that we were successful in our bid to provide the 0-19 service for South Tyneside local authority. This will commence in April, and the mobilisation work is well underway. Welcome visits are being planned and I look forward to welcoming our new colleagues into HDFT shortly.

31. Our urgent care pathway is an area of concern, simply because we are in the winter period and the delivery of the four hour standard has reduced, as anticipated. The performance in December was 73% (December 2024 66%), and the position in January is equally difficult. It is a breakthrough objective and therefore a key priority that teams are focused on, and there are further improvements that we are working on, the next being the agreement in respect of clinical operational standards. As the Board will note, improving the urgent care pathway requires many complimentary improvements within our processes, and is therefore well suited to our Impact methodology. This methodology is working, and will continue to be the route to further improvement over the coming year, recognising that we need to do better for our patients.

32. In relation to cancer, our performance remains a positive one, with significant improvement achieved since the start of 2025/26.

33. We continue to deliver our elective recovery plan, and we are ahead of our plan to reduce the waiting list this year. We are on track to deliver the waiting times reductions as well, which is a very positive position to be in. We have signed up to a 'Q4 sprint', which is available to Trusts who are delivering ahead of plans. This will bring our waiting times down further and improve our RTT position by the end of March, accompanied by around £3m of income to enable this to happen. Elective recovery remains 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.

34. Our earlier success in delivering improved waiting times resulted in receipt of additional capital funding of £2m. As a result of our delivery, the national NHSE team have been in touch to arrange a visit to see if there is learning from our achievement that can be shared across the NHS.

35. 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 of creating additional permanent capacity through a Harrogate based

Community Diagnostic Centre. The discussions are promising, with capital now earmarked for such a scheme and the revenue required to support such a development being negotiated. I am confident that this will form a positive part of our improvement plan in this area for 2026/27.

36. The delivery of our diagnostic waiting times for CT was further impacted by a failure of our internal CT scanner just before Xmas, when we declared a business continuity incident with the system. This brings into sharp focus the need for the greater resilience and capacity that our new Imaging department and the proposed CDC will provide. This is a key priority for the Trust to deliver in 2026/27.

37. The provision of autism assessments in a timely way continues to be a significant risk to HDFT. Discussions with the Commissioner are wrapped up in our overall planning discussions, which are challenging. We will continue to update the Board how these discussions are progressing, as we are very aware of the poor service currently being provided.

Our money

38. Our position at the end of Month 9 is that we are behind our plan by £15m. The key drivers are our undelivered WRAP (we have now delivered 89% of our annual programme), some specific ward and medical agency costs, and the difficulty in managing financial risk across the system. 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.

39. As a result of our financial position, we have submitted a revised forecast outturn of a deficit of £20.8m. We have utilised the forecast change protocol, and we are awaiting feedback from the national finance team at NHSE. Alongside this action, we have requested cash support to reflect the deficit forecast for this year. We are currently awaiting feedback on this application, but as a result we have increased our risk score within the corporate risk register.

40. The route to financial balance and sustainability lies in the agreement of a contract with HNY ICB for 2026/27 that reflects the demands of the services we are providing. There are ongoing discussions that the Board is very aware of.

41. As reflected in our cash application, as part of the financial position, our cash position is being closely managed.

42. 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

As per the HDFT protocol on the 14th and 15th January 2026, Directorates, through their Performance Review Meetings (PRM) reviewed the risks rated 9 and above on their

Directorate Risk Register. Discussions were held on any risks to escalate or de-escalate from the Corporate Risk Register.

As per the HDFT protocol on the 15th January 2026, Executive Risk Review Group was held, where Executives reviewed all risks currently on the Corporate Risk Register and any risks that had been escalated or de-escalated by Directorates. At the meeting, the following was confirmed:

- 116 – Managing the risk of injury from fire Risk scoring 10, discussed at PRM and Exec Risk Review Group and confirmed for the risk to be de-escalated to the Health & Safety Risk Register. Risk updated to reflect updates relating to the fire alarm
- 381 – Risk of harm to patients due to unreliability of aged equipment (CT) - Mobile scanner (NEW) in place and now operational. Mobile scanner (EXISTING) is also now operational. Static scanner now condemned. x2 CTs running (both external). CTC patients going to the Spire. Score reduced to 16.
- 721 – Group Cash Position - Change to score from 20 to 25. Position continues to be closely monitored.

No further risks were escalated from Directorates in month for inclusion on the Corporate Risk Register

No further risks were de-escalated from the Corporate Risk Register for management on directorate risk registers.

Other

43. We continue to roll out our Impact programme across the organisation, and we continue to share our learning with other organisations. We recently hosted people from Mid Yorkshire Trust, The Dudley Group, and the University Hospitals Teesside, as part of supporting their improvement journey.

44. It was great to open our new Acute Medical Unit in what was previously Littondale ward. It is a lovely facility that will provide an environment for patients and staff that will allow improved care to be delivered.

45. It was also great to host a visit from Sir Jim Mackey, Chief Executive of NHSE. Jim spent a morning at the Trust where we discussed our future plans, showed him our acute service areas, and demonstrated the work we are doing in radiology using AI technology.

46. As is usually reflected in my report, there is a lot happening across the NHS and across the organisation at the moment. We are at a point in the year when more than ever we need to maintain the ability to think both about delivering services today and also planning the delivery of services tomorrow. However, whilst there is always a lot happening, what is consistent is the contribution and commitment of our colleagues to improving the health and care of the population we serve. We have great people working across HDFT, and our role is to provide the environment within which they can flourish. In this way, we can be positive and optimistic for what we can achieve together in 2026.

Jonathan Coulter
Chief Executive
January 2026

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)

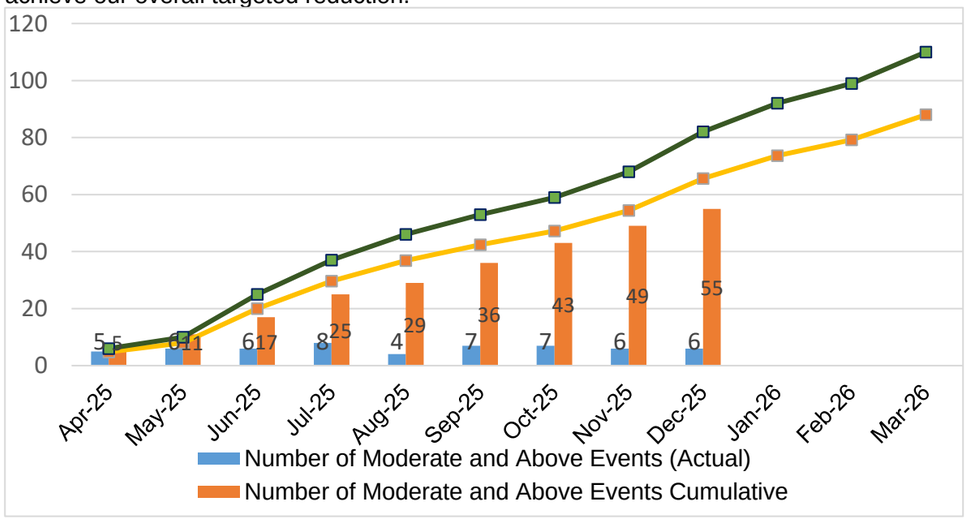
1. • **Eliminating Moderate & Above Harm**
2. • **Patient Experience Positive Response Rates**

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 progressing 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 **4** moderate and above events reported in August 2025 • There were **7** moderate and above events reported in September 2025 • There were **7** moderate and above events reported in October 2025 • There were **6** moderate and above events in November 2025 – validation continues. • There were **6** moderate and above events in December 2025 – validation continues. The total for year to date is 55 with a threshold of 63 – therefore we are on trajectory to achieve our overall targeted reduction. 	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 and is within the final governance stages. Following final review, directorates and specialities will review and determine next steps for their specific areas. Countermeasures are noted. Watch Metrics: • Number of Never Events – **1** declared in year • Number of PSIIs – **6** declared in year and **1** thematic review (deteriorating patients) • Level of low and no harm events reported – ratio maintaining at **99%** with numbers maintaining approximately **1,317**			
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	As noted previously, this workstream has been re-designed to focus on the development of the Engagement Strategy. In Quarter 3, this has been reviewed further to ensure a clear alignment with the national 10 Year Plan priorities. The Strategy 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 November and 96% in Outpatients. Countermeasures are noted. Watch Metrics: • Number of Complaints – 27 new in December 2025 • Percentage compliance with Complaint Response Times – **75%** compliance in December 2025	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.					

Title:	Nursing and Midwifery Quality and Safe Staffing Report
Responsible Director:	Breeda Columb. Executive Director of Nursing, Midwifery and AHPs
Author:	Kate Southgate, Associate Director of Quality and Corporate Affairs Jenny Nolan, Deputy Director of Nursing, Midwifery and AHPs Brenda Mckenzie, Workforce Assurance Lead

Purpose of the report and summary of key issues:	The report provides Quality Committee with: • Assurance on nursing and midwifery quality indicators triangulated with nurse and midwifery staffing data, • Assurance that daily monitoring of patient safety and quality risks in relation to the workforce are in place.	
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	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks:	None	
Report History:	Report reviewed at the Quality Committee	
Recommendation:	The Board is asked to note the content of the report.	

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

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

Quality Committee

Nursing and Midwifery Quality and Safe Staffing Report

1.0 Introduction

The purpose of the report is to provide assurance on key patient safety, quality and workforce data.

Data in this report is provided for October and November 2025.

HDFT has a comprehensive suite of quality and safety indicators that are reviewed on a daily and monthly basis as described within the Integrated Board Report. The Trust, through Power Bi, is developing an integrated dashboard that supports a triangulated approach to data on key quality and safety KPIs linked to staffing levels.

As per the Safer Staffing Policy, the threshold for enhanced monitoring of performance is where nursing establishment levels have fallen below the 90% threshold in month.

Further information on all in-patient nurse staffing levels is present to NHS England on a monthly basis to provide assurance that the Trust is responding to National Quality Board (NQB) 2016 guidance in relation to: *Safe, Sustainable and Productive Staffing.*

2.0 Hard Truths Data

HDFT reports nursing and midwifery staffing numbers including registered, unregistered, substantive and temporary to NHS England via a monthly Nurse Staffing Return (Hard Truths).

HDFT have set a threshold of 90% with regards to achieving its planned nursing numbers by shift. Any ward / in patient area, that falls below 90% will be reviewed in line with several quality metrics to see if patient care and outcomes has been affected due to planned establishment not being fully met. It has been identified that planned hours that fall below 90% in October and November are due to a reduction in bed occupancy or redeployment of staff to meet the acuity and dependency of patients in accordance with our safer staffing processes.

The Hard Truths report reviews inpatient areas. Wards that were closed during the reporting period, have not been included in the submission. Wards that are opened on a temporary basis to create temporary capacity are not required to form part of the national submission. If a temporary ward was opened for more than one roster period (4 weeks) the detail would be included where necessary in this report.

The table below shows all wards and the percentage fill rate for days and nights, split by registered (RN) and unregistered (CSW).

November								October							
	Day		Night		CHPPD				Day		Night		CHPPD		
Ward	RN Fill (%)	CSW Fill (%)	RN Fill (%)	CSW Fill (%)	RN	CSW	Overall		RN Fill (%)	CSW Fill (%)	RN Fill (%)	CSW Fill (%)	RN	CSW	Overall
Acute Frailty Unit	94%	91%	106%	123%	5.9	5.0	10.9	Acute Frailty Unit	94%	95%	105%	113%	4.9	4.1	9.0
Bolton	116%	102%	128%	130%	4.7	3.3	7.9	Bolton	101%	106%	105%	116%	4.3	3.5	7.8
Byland	105%	88%	104%	97%	3.8	3.2	7.0	Byland	98%	90%	100%	96%	3.5	3.1	6.6
Fountains	100%	97%	98%	122%	3.8	3.4	7.3	Fountains	97%	100%	95%	126%	4.0	3.8	7.8
Farndale	94%	89%	95%	91%	8.1	5.3	13.3	Farndale	95%	89%	93%	96%	6.0	4.0	10.0
Granby	102%	97%	100%	96%	3.5	3.6	7.1	Granby	100%	96%	101%	103%	3.4	3.5	6.9
ITU/HDU	94%	36%	98%	20%	28.9	1.5	30.4	ITU/HDU	103%	31%	121%	65%	25.4	1.9	27.3
Jervaulx	105%	87%	100%	99%	3.5	3.0	6.5	Jervaulx	100%	91%	100%	97%	3.6	3.2	6.8
Lascelles	104%	97%	98%	107%	4.3	3.4	7.7	Lascelles	94%	88%	100%	100%	4.8	3.6	8.4
Maternity	90%	106%	102%	105%	8.0	2.7	10.7	Maternity	88%	90%	101%	106%	8.1	2.5	10.6
Nidderdale	103%	110%	100%	119%	4.2	3.4	7.6	Nidderdale	103%	94%	100%	108%	4.0	2.8	6.8
Oakdale	106%	100%	103%	128%	3.8	3.2	7.0	Oakdale	102%	101%	100%	130%	3.6	3.2	6.8
Rowan	100%	74%	92%	43%	8.2	2.9	11.1	Rowan	98%	84%	93%	65%	8.5	3.7	12.1
Special Care Baby Unit	99%	0	100%	0	24.7	0.0	24.7	Special Care Baby Unit	98%	0	99%	0	16.4	0.0	16.4
Trinity	105%	80%	100%	105%	4.3	3.4	7.7	Trinity	101%	82%	96%	100%	3.9	3.1	7.1
Wensleydale	98%	93%	96%	91%	6.3	2.8	9.1	Wensleydale	97%	91%	95%	95%	6.0	2.7	8.8
Woodlands	116%	80%	100%	95%	10.7	2.8	13.5	Woodlands	97%	81%	99%	97%	10.9	3.3	14.2
Total	**101%**	**93%**	**101%**	**103%**	**5.1**	**3.1**	**8.3**		**94%**	**90%**	**96%**	**93%**	**5.8**	**3.6**	**9.3**

3.0 October and November 2025 Results

During October and November 2025, 17 eligible inpatient areas were reviewed.

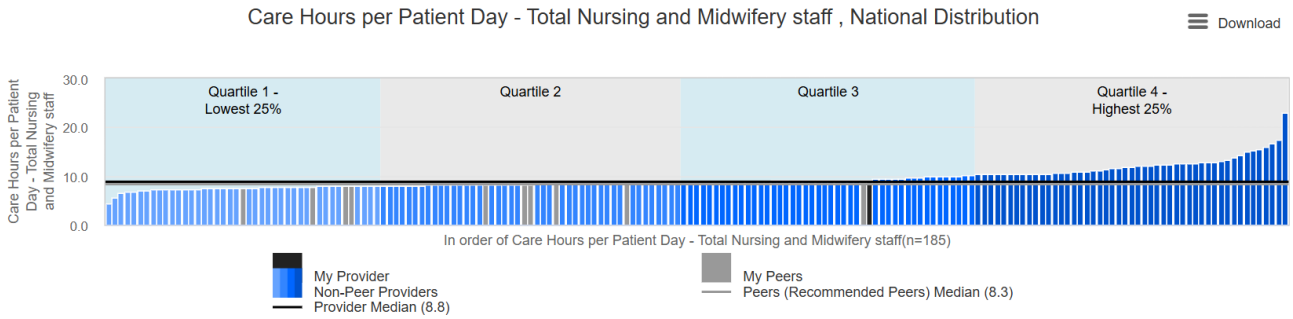
Planned vs actual fill rate data shows that one department fell below the 90% threshold for Registered Midwives and no department fell below the threshold for Registered Nurses. Care Support Worker fill rates varied across wards, with some areas below and others above threshold. This variation reflects the effective and responsive deployment of the unregistered workforce in line with patient acuity and dependency, in accordance with safer staffing processes.

Care Hours Per Patient Day, is a metric used in healthcare to measure the amount of direct care provided to patients by registered nurses, midwives, and healthcare support workers over a 24-hour period. Care Hours Per Patient Day (CHPPD) remain above the national 'peer' hospital median, placing the organisation in national quartile 3. This position demonstrates staffing levels that are comparable with, and in some areas exceed, peer performance.

Further detail on Midwifery and Neonatal staffing is provided within the monthly Maternity and Neonatal Safety Report. The midwifery workforce position is also detailed in the Perinatal Assurance Report and should be read in conjunction with this section.

Maternity services had a zero-midwifery vacancy position in November however 4.4WTE midwives were in recruitment. Sickness was also impacting on service fill rates with long term sickness impacting the service and giving a sickness absence of 4.71% to 5.17% which is an improvement from 9.29% in September. Shifts were released to NHSP but fill rates were insufficient. An incentive remained in place during this period to improve NHSP fill.

The table below demonstrates that HDFT CHPPD is in the third quartile, which places us above our peers and equal to the national median. This data is taken from Model Health System on 9th January 2026.



The following data breaks down the HDFT Registered and Unregistered CHPPD and benchmarks against the 'Peer' average and the National values.

Care Hours Per Patient Day	Data period	Provider value	Peer average	National value	National value method	Chart
Care Hours per Patient Day - Total Nursing and Midwifery staff	Sep 2025	9.3	8.3	8.8	Provider median	
Care Hours per Patient Day - Healthcare Support Workers	Sep 2025	3.6	3.6	3.6	Provider median	
Care Hours per Patient Day - Registered Nurses and Midwives	Sep 2025	5.8	4.6	4.7	Provider median	

4.0 Temporary Workforce Usage

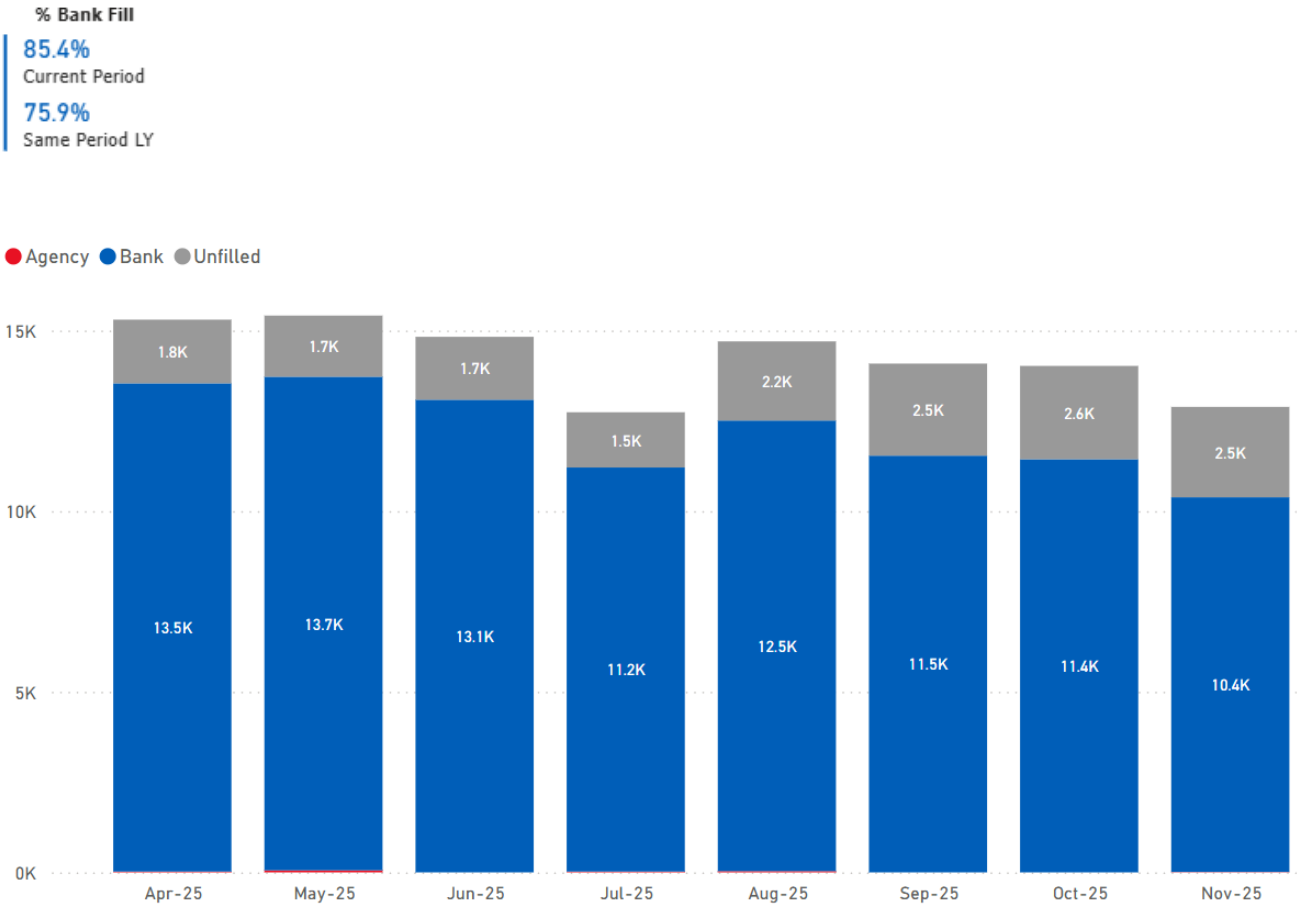
Temporary workforce usage continues to decline. There has been no agency usage in the Emergency Department or Adult Inpatient wards since May 2025. Limited agency use has occurred within the Children's Inpatient Ward and the Special Care Baby Unit, on authorisation of the ADoM.

On Adult Inpatient wards, the introduction of strengthened assessment processes for Enhanced Therapeutic Observational Care has significantly reduced the requirement for temporary staffing. Alongside full recruitment to Registered Nurse vacancies, these measures have delivered a sustained reduction in agency reliance and increased workforce stability.

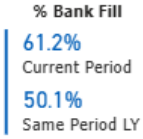
Recruitment to Clinical Support Worker (CSW) vacancies is progressing, with posts now being recruited to Band 3 following the conclusion of the Band 2 role review. In the interim, these vacancies are being safely managed through the use of NHSP, ensuring continuity of care while substantive appointments are finalised.

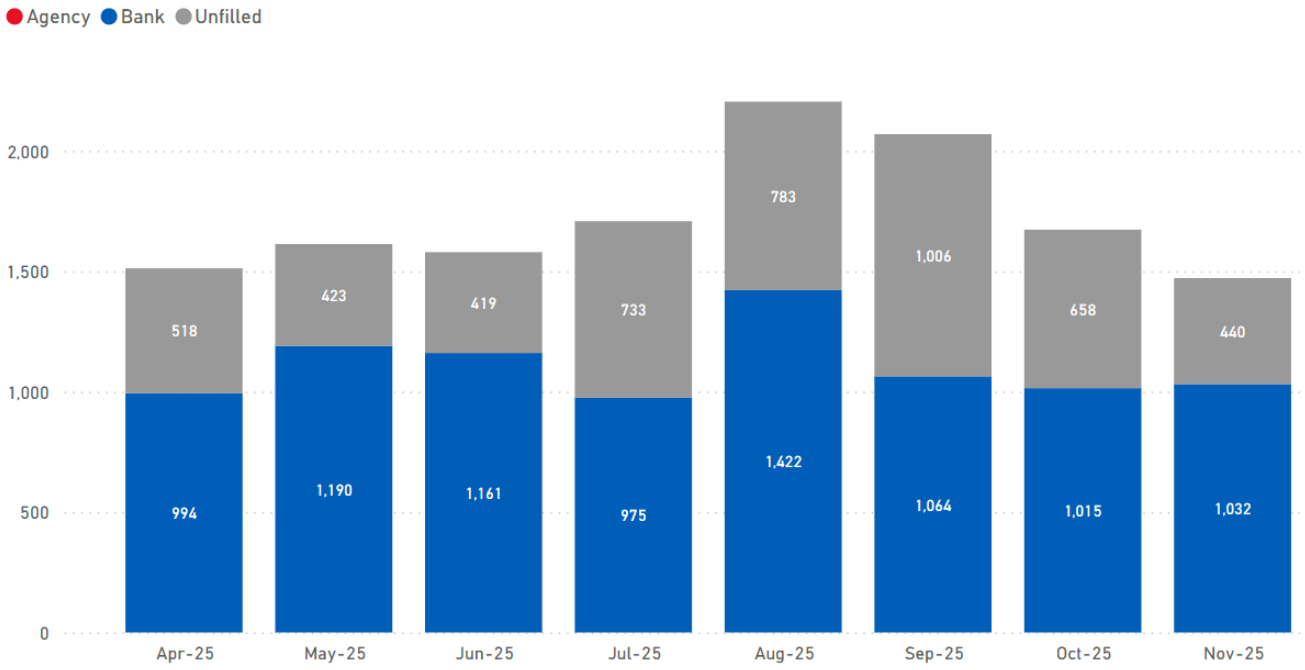
Overall, temporary workforce utilisation is reducing month on month and year on year. This reflects effective recruitment, improved workforce controls, and increased assurance that services are staffed with the right staff, with the right skills, in the right place and at the right time.

Registered and Unregistered Nursing Temporary Workforce (April – November 2025)



Midwifery Temporary Workforce (April – November 2025)





5.0 Key Performance Indicators

Between October and November 2025, there were 23 moderate and above events reported (nb – these are still to be fully validated).

The events occurred across five categories: pressure ulcers, falls, diagnosis, treatment, procedure and tests, equipment and medication.

Falls:

In October three falls with moderate harm occurred, of these two identified no omissions in care found following investigation at Quality Oversight panel. Learning has been identified and shared

In November: two falls withmoderate or above harm occurred. Both identified as omissions following investigation at Quality Oversight panel. Learning has been identified and shared

Pressure ulcers:

In October one severe pressure ulcer and four moderate harm pressure ulcers were identified. Of these two had omissions in care identified, with a further three awaiting final investigation.

In November two moderate harm pressure ulcers were identified, both are awaiting final investigation.

6.0 Assurance Report

There are no wards currently in an escalation stage – i.e.

- no areas have fallen below the 90% threshold for three consecutive months for staffing
- no areas have fallen below the expected range for key quality indicators for three consecutive months

Of note, the Trust is in the process of developing an SOP for a revised safe staffing escalation and monitoring process. A bespoke dashboard is also in development to support the monitoring of this.

Rapid reviews are undertaken at the request of the Executive Director of Nursing, Midwifery and AHPs, the Deputy Director of Nursing, Midwifery and AHPs, the Associate Director of Quality and Corporate Affairs or Associate Directors of Nursing/Midwifery in response to any concerns which may have been raised through a variety of means (patient experience, freedom to speak up concerns, Patient Safety Incident Investigations, After Action Reviews). During the reporting period no areas had issues escalated for rapid review.

7.0 Escalation and Reporting Nurse and Midwifery staffing concerns

The Safer Nursing Care Tool (SNCT) is used by HDFT to support the establishment setting bi annual process to determine optimal nurse staffing levels. It is an evidence-based tool that enables nurses to assess patient's acuity and dependency to ensure that nursing establishments reflect patient needs. In September 2023, the SafeCare module of Allocate was rolled out across the inpatient wards and some departments. This system links the acuity and dependency to staffing levels to support the management of workforce requirements on a shift by shift basis.

The Nurse in Charge on each adult inpatient ward is responsible for scoring the acuity and dependency of every patient using SNCT levels of care. The patients must be assessed at the start of the early shift (before 10am) and the start of the night shift, and the scores entered into the SafeCare census. Concerns about patient need exceeding available nursing care hours, must be escalated in a timely manner to the matron or designated deputy for that area. Patients will receive a care score level between 0 and 3, with four sub sections of level 1 (a-d).

Matrons are expected to visit the wards they are responsible for to carry out their assurance checks each morning. On days where Matrons are not available (AL/study leave etc.) a designated deputy should carry out the checks. At this time, any 1c (continuous, arm's length observation required) should be peer reviewed to check accuracy of scoring, identify the needs of the patients and ensure they are met.

All patients who score 1d (continuous, arm's length observation required by two members of staff) must be escalated immediately to the Directorate ADoN.

After discussion with the nurse in charge/unit manager, the matron will add professional judgement to SafeCare, documenting any mitigation they have made. Once any moves, mitigations and professional judgement have been added, all matrons and deputies join the 10.30 safe staffing meeting. During this meeting, the lead matron will complete a systematic

review of each area, asking for any concerns or safety risks to be raised. Each matron or deputy will highlight any areas where there is still a staffing risk or other concerns, and where they have been unable to mitigate this risk from within their own care group.

The matron leading the meeting will then review the enhanced care requirements, all supernumerary staff on duty and areas where there is no identified risk, to mitigate in other areas. In the meeting, staffing moves will be agreed, staff will be redeployed on SafeCare and any additional professional judgements added. A rating of a 'red' shift in SafeCare indicates unmitigated safety concerns.

Following the Safe Staffing meeting, any areas that remain red without Matron mitigation or professional judgement must be escalated to the ADoN within their directorate.

If the ADoN for their directorate is not available, this should be escalated to another ADoN or ADoM.

In the absence of an ADoN staffing concerns should be escalated to the Deputy Director of Nursing, Midwifery and AHP's.

If staffing safety issues cannot be mitigated at this level, they must be escalated to the Director of Nursing, Midwifery and AHP's.

8.0 October and November 2025 SafeCare Red Shifts

There was one Red Shift escalated during the months of October and November. A review of patient safety was undertaken and no actual patient harms were reported.

Recommendations

The Quality Committee is asked to:

- Note the safety, quality and staffing information detailed for October and November 2025,
- Note assurance of the daily process for monitoring and managing nurse and midwifery staffing levels at inpatient level through the SafeCare system.
- Note that actions are ongoing to monitor the standards of nursing care given within the Trust and support any identified areas with reduced performance.

Kate Southgate, Associate Director of Quality and Corporate Affairs
Jenny Nolan, Deputy Director of Nursing, Midwifery and AHPs
Brenda Mckenzie, Workforce Assurance Lead

January 2026

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:

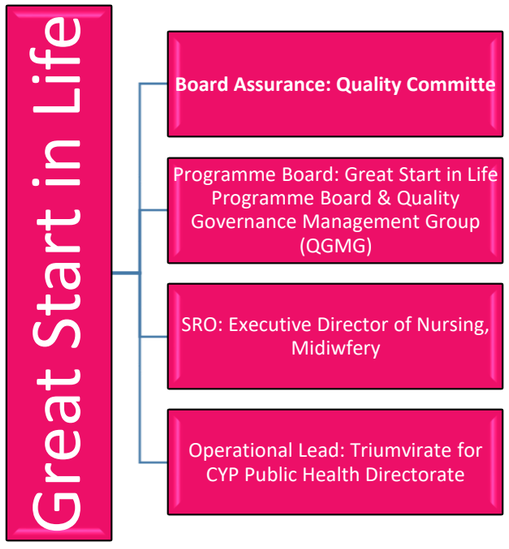
Public Health

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

Hopes for Healthcare

Services which meet the needs of children & young people

GOVERNANCE:



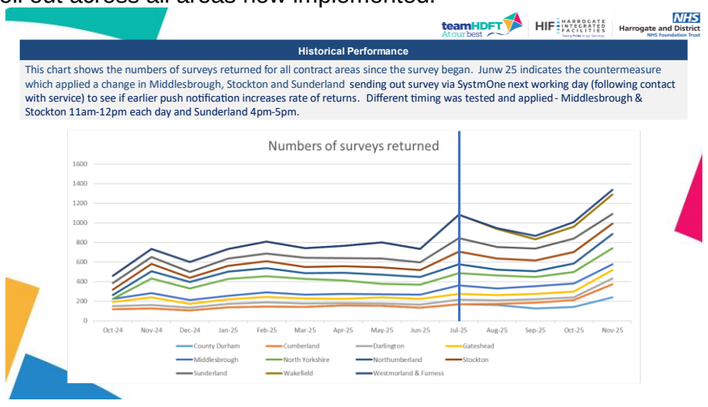
True Metrics (Executive Lead: 10-15 Year deliverable)

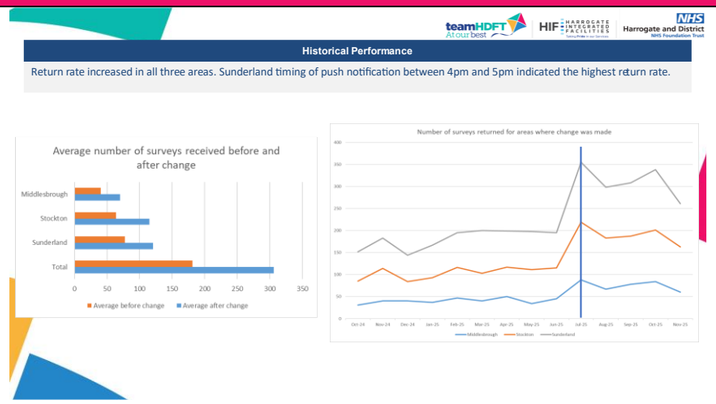
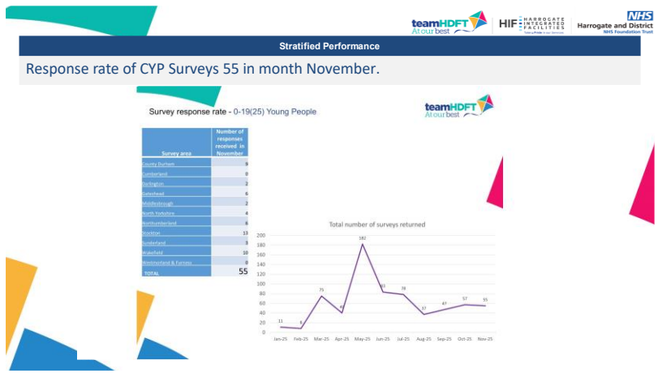
Breakthrough Objective:	None
Corporate Project:	CYP Public Health Mobilisation
Overarching Risk Appetite:	Clinical - Minimal

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) Dec 25 data inclusive of Westmoreland and Furness and Cumberland 50/55 and continues to increase month on month. Great start in Life *Improve outcomes by identifying children by ensuring we achieve >90% for all mandated contracts* Zero mandated contacts in all our contract areas breaching business rules (four consecutive months): 11 8 7 6 5 All mandated contacts at 90% or above (55 contracts): 41 43 43 43 42 46 48 48 50 CYPH Directorate Driver to focus on HCP Mandated Contacts not delivered within timescales over three consecutive months with associated countermeasures. There are now only five HCP Contacts breaching business rules with significant and sustained improvement in performance, W&F and Cumberland. Wakefield have sustained antenatal performance above 90% for 4 consecutive months and are therefore now 'Watch'. 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			
Hope for Healthcare	Children's Patient Experience	Improve experience of care by considering elements that matter most to children & young people so we can measure their	Goal 1: Engage with children and young people with lived experience across HDFT geography to consult with on our CYP Strategy which will for part of the Clinical Strategy	The Trust North Metric of improving Children's Patient Experience continues into its second year (2025-26). Increase in number of CYP surveys returned by 17% on previous month's numbers. Countermeasures are noted.	CYP Patient Experience Tool 'engagement methods' to increase uptake and return being developed with involvement of CYP representatives. • Focus Groups held with GSIL Young Advisor		

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
		experience of care and shape services according to their specific needs	Goal 2: CYP Patient Experience Tool Developed-Return rate significantly low - distribution, engagement, and accesses to the tool to be developed with CYP and approach embedded with teams and professionals working with CYP.	• 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 was be in Middlesbrough, Stockton and Sunderland. Also trailed different times with Middlesbrough & Stockton 11am-12pm each day and Sunderland 4pm-5pm. Evaluation clearly demonstrated increase with roll out across all areas now implemented. 	• 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
				  December data incomplete however we can report 1045 Parent surveys returned and 63 CYP Surveys. Watch Metrics: • Directorate CYP Patient Experience Champions to produces a monthly report with themes, trends and areas for improvement. This will be shared with the central patient experience team and reported into MEC Forum. We will review after 6 months data to identify key themes which will inform future counter measures and metrics.			

Breakthrough Objective:

Workstreams	Strategic Metric	Vision	Goal	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

December 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 December as set out in the Perinatal Quality Oversight Model (2025).	
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 corporate risks	
Report History:	Maternity Risk Management Group Maternity Quality Assurance Meeting Maternity Safety Champions	
Recommendation:	Board is asked to note the updated information provided in the report and for further discussion.	
Appendices attached for oversight	Appendix A - Explanatory notes Appendix B – PMRT Quarterly Report Appendix C – Maternity Incentive Scheme Appendix D – Neonatal Readmissions	

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 December 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

Three new risks have been added to the risk register.

- Risk to Information Governance and breach of confidentiality resulting from lack of training in redaction of patient record requests (Score 9)
- Risk to operational running and governance surrounding safety and quality of homebirth service (Score 6)
- Clinical risk related to inconsistent access to Maternity medical records related to Medi-viewer (Score 4)

One risk scoring has increased –

- Risk to patient experience and breach of triage timescales due to insufficient midwifery staffing in Maternity Assessment Centre (Score 10)

7) Recommendation

a) Positive news
   - CQC Inspection rating received - Good overall and in each domain.
   - Maintained compliance with QIS nursing ratio and Delivery suite co-ordinator supernumerary status.

b) Areas of concern
   - Three new risks and one increased risk score
   - Significant increased scrutiny and reporting to NHS England nationally

c) Work underway
   - On-going review of the homebirth service provision
   - Work ongoing in Maternity Assessment centre regarding activity
   - On-going work to prevent induction of labour delays

d) Decisions required of Board
   - Maternity Incentive Scheme Declaration

Narrative in support of the Provider Board Level Measures – December 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

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

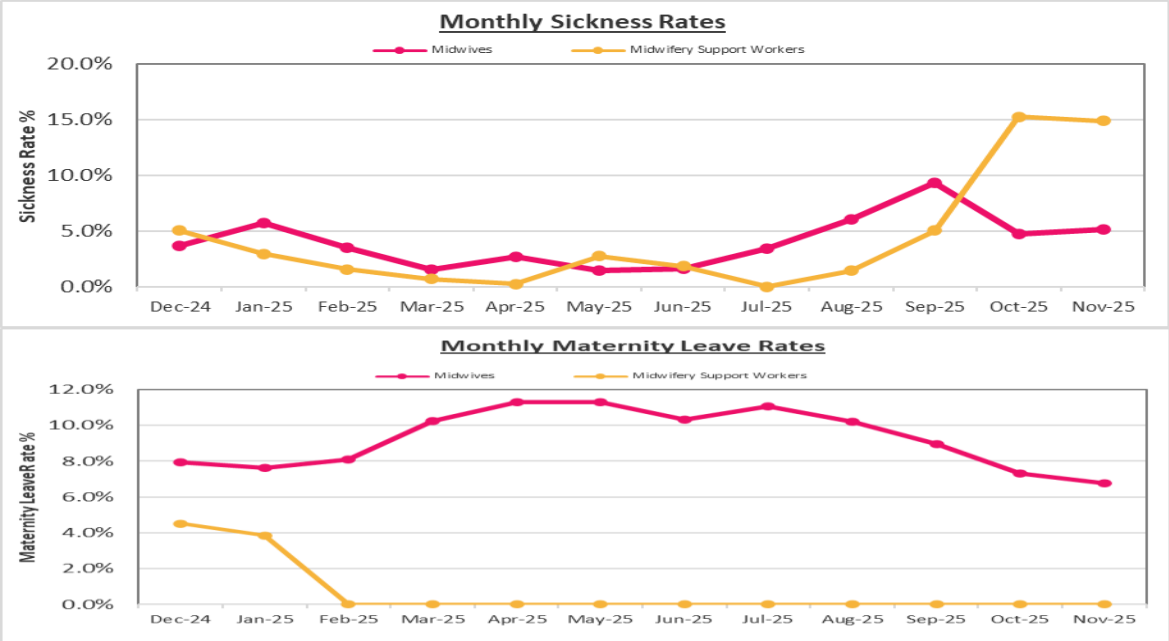
Recruitment
Following the recent round of recruitment, start dates are in place for the two new members of the team. One candidate is already working as a locum consultant and will begin their substantive role in March 2026 when another colleague returns from maternity leave. The other candidate is able to start in April 2026 so the rest of the team will continue to cover any consultant on call gaps until both new consultants are in post.
Three resident locally employed doctors have been recruited to fill gaps on the Tier 1 rota, created by gaps in the doctors rotating to Obstetrics and Gynaecology from February 2026.

Compensatory rest progress
Three consultants currently have job plans that are not compliant with RCOG compensatory rest recommendations. Following completion of recruitment, job plans will be reviewed with the aim of achieving full compliance.

3. Midwifery safe staffing, vacancies and recruitment update

a. Absence position

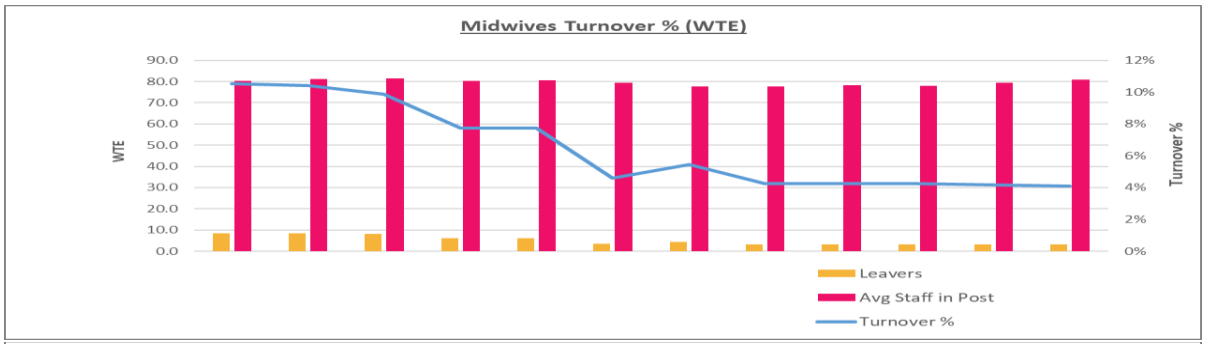
Total sickness in December was 5.86 WTE midwifery and 2.08 WTE maternity support workers absence. The main causes of absence relate to stress, cancer and musculoskeletal issues. 5.91 WTE midwives on maternity leave at present. The monthly sickness and maternity leave trend can be seen below.

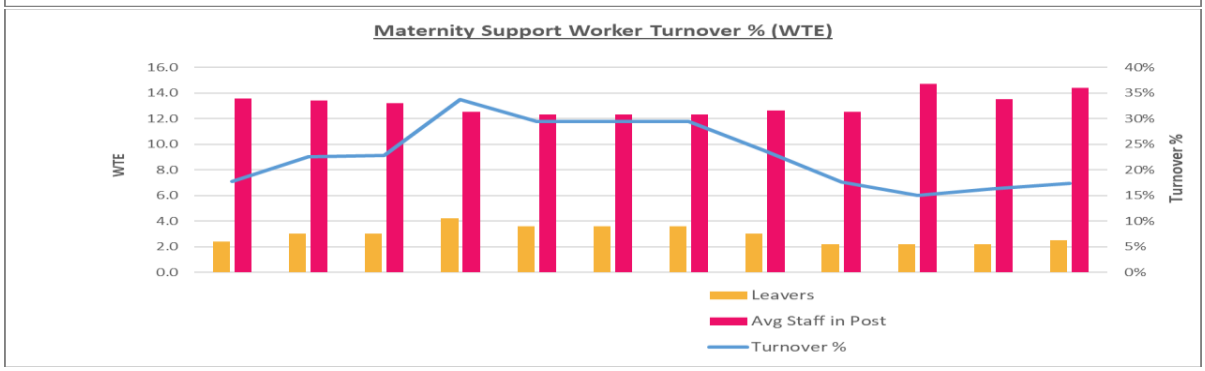


b. Vacancy position

There is 1.6 WTE permanent midwifery vacancy and 2.2 WTE fixed term midwifery vacancy out to advert. 4.49 WTE midwives have commenced in post over the last month.
There is 2 WTE maternity support worker vacancy out to advert and 1.8 WTE maternity support workers commenced in post over the last month.

Turnover continues to be below Trust target for midwives. The monthly trend over the last twelve months is shown below.

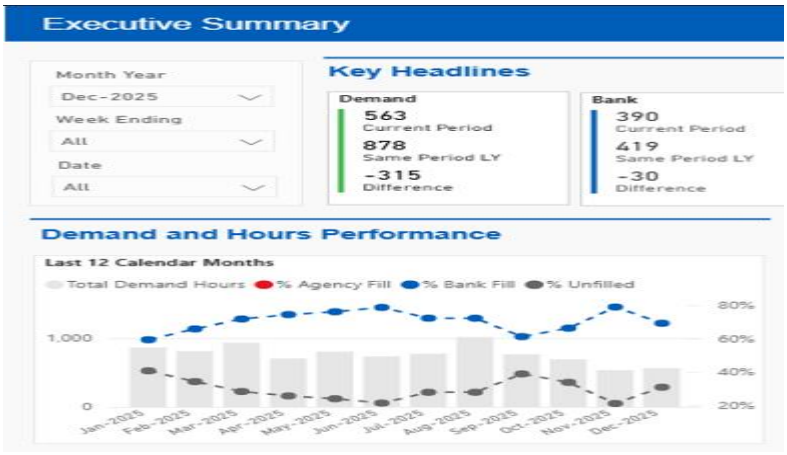




c. NHSP provision

Midwives – demand has remained consistent this month. There has been no agency use for nine months.

Maternity Support workers – Demand and uptake have seen a slight reduction over the last two months as newly recruited staff have completed their induction.



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

a. Neonatal absence position

1.39 WTE nurse sickness absence – not theme noted.

2.47 WTE QIS nurses currently on maternity leave.

b. Neonatal Vacancy

2.2 WTE neonatal nursing vacancy

c. Qualified in Speciality (QIS) Nurses

To meet British Association Perinatal Medicine (BAPM) standards 70% of the budget establishment 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. There currently is 10.01 WTE QIS in post however some are on maternity leave and therefore QIS compliance for December was 74%.

5. Birthrate Plus Acuity Staffing Data

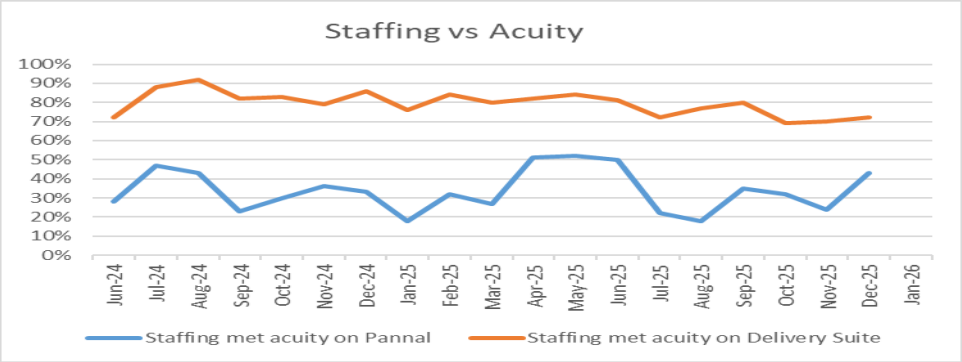
a. Delivery Suite Staffing and impact on clinical workload

A supernumerary delivery suite co-ordinator was rostered and available at the start of every shift in December. 99.2% 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 72% of the time, was up 1.5 midwives short 25% of the time and 3% of the time the service was over 1.5 midwives short. Compliance with data capture was 93.55%.

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, 43% of the time staffing has met acuity on Pannal. The trend can be seen in the below graph.



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.

Five homebirths were booked for the month of December 2025. Of these; one woman had a successful homebirth, two woman did not birth in December and two women chose to change to a hospital birth.

In the period 01/12/25 – 31/12/25, the home birth on call provision was unavailable on eleven occasions due to no volunteers to cover sickness absence. No homebirths were affected. Work is ongoing to improve the resilience of the homebirth service.

7. Red Flag Events Recorded on Birthrate Plus

a. Delivery Suite Red Flags

There were two Red Flags noted on Birthrate plus in December, one related to a delay between admission for induction and beginning the process, and one due 'delayed or cancelled time critical activity'. Both Red Flags occurred in the same week but on separate days and were due to short notice staff sickness. Actions included safety netting patients as required.

b. Pannal Ward Red Flags

There were four Red Flags recorded on Birthrate Plus during December 2025.

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	1	25%
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	0	0%
RF5	Delay between presentation and triage	1	25%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	2	50%
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%

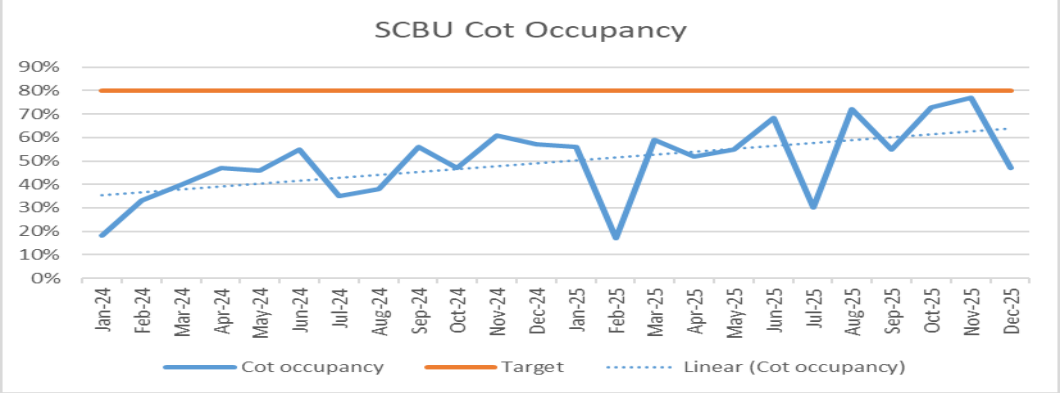
Red Flags	Breakdown of Red Flags	Times occurred	Percentage
TOTAL		4	

The following 'management actions' were taken to mitigate the red flags.

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	6	60%
MA2	Staff unable to take allocated breaks	1	10%
MA3	Redeploy staff from training	0	0%
MA4	Specialist MW working clinically	1	10%
MA5	Manager/Matron working clinically	1	10%
MA6	Utilise on call MW	0	0%
MA7	Redeploy from community	0	0%
MA8	Maternity Unit on Divert	0	0%
MA9	Staff sourced from bank/agency	0	0%
MA10	Staff stayed beyond rostered hours	0	0%
MA11	Escalate to manager on call	1	10%
TOTAL		10	

During December there was six episodes of delayed induction of labour over 24 hours with the use of prostaglandin and five episodes of delayed induction of labour over 24 hours without the use of prostaglandin.

8. SCBU Cot Occupancy



Five babies were 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

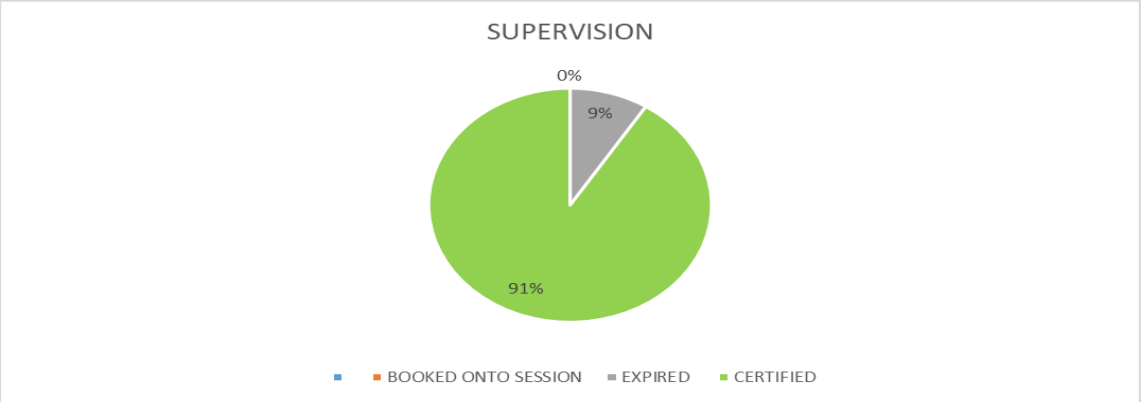
a. Mandatory training (as at 08/01/26)

Department	Assignment Count	Percentage Compliant
421 Level 4 Ante Natal Clinic	10	81%
421 Level 4 Community Midwifery	18	84%
421 Level 4 Obs & Gynae - Medical Staffing	28	85%
421 Level 4 Pannal Ward	30	85%
421 Level 4 Maternity Staffing	59	92%

421 Level 4 Early Pregnancy Assessment Unit	4	100%

b. Safeguarding Supervision Compliance (as at 07/01/2026)

Supervision completed via 1:1 sessions with caseloading midwives, within specific study days for non- caseloading staff and via ad hoc sessions delivered via MS Teams at least four times per month. Currently within Learning Lab there are difficulties reporting and capturing supervision data and therefore a manual upload is completed.



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

The below table demonstrates that the service has achieved 90% compliance with attendance at the following training.

1. Fetal monitoring Training
2. Multi-professional maternity emergencies training
3. Neonatal resuscitation training

which is required for Maternity Incentive Scheme requirements.

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
Adult Basic Life Support with paediatric modifications	96%	100%	95%			78%	89%	100 %	92 %
Harrogate Newborn Intermediate Life Support (HNILS)	97%						100 %		100 %
RCUK Newborn Life Support	94%					100%	91%		
Resuscitation - Level 3 - Adult Immediate Life Support	63%								
Maternity Specific Courses									

Fetal Wellbeing Competency Assessment	96%	100%	91%						
MAT - Birthing Pool Hoist	91%							93%	
MAT - Growth Assessment Protocol (GAP)	90%	100%	100%						
MAT – Maternity Training Day 2	96%	100%	100%						
MAT - Saving Babies Lives	82%	100%	73%						
MAT 3 - Personalised Care & Care in Labour	96%								
MAT-PROMPT - Emergency Skills Facilitator Led	95%	100%	84%	100%	100%			82%	
Mandatory Training - Safeguarding									
Safeguarding Adults	85%	71%	89%	95%	91%	89%	78%	94%	100%
Safeguarding Children	96%	57%	53%	90%	91%	90%	61%	94%	100%

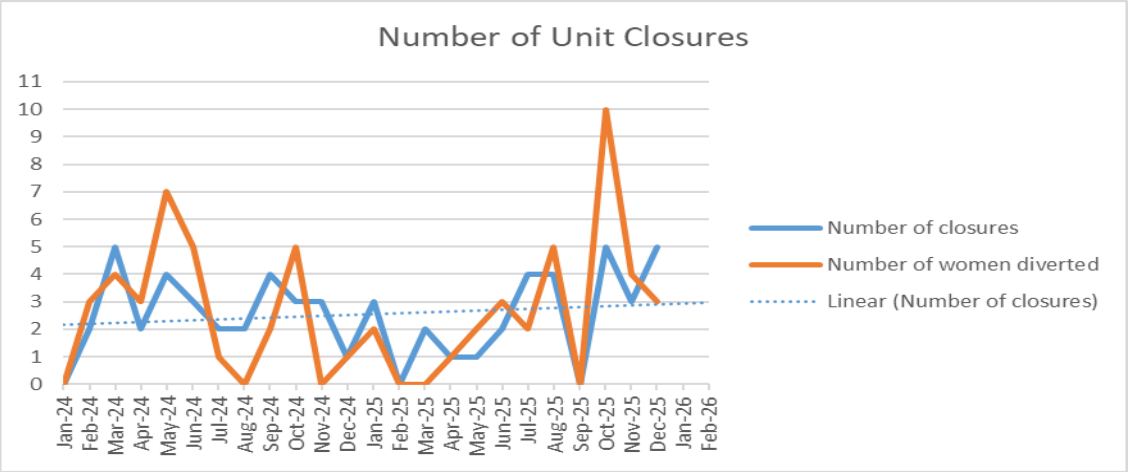
4. Appraisal Compliance (as at 31/12/25)

Department	Assignments Appraised	Assignment Count	Percentage Compliant
Obs & Gynae - Medical Staffing	**13**	**14**	**93%**
Ante Natal Clinic	**11**	**12**	**92%**
Community Midwifery	**16**	**19**	**84%**
Maternity Staffing	**49**	**56**	**88%**
Pannal Ward	**21**	**22**	**95%**
Early Pregnancy Assessment Unit	**4**	**4**	**100%**
Total	**114**	**127**	**89.8%**

5. Risk and Safety

a. Maternity Unit Divert

There has been five events of divert of the unit in December 2025 with three women being diverted to another unit for care during these periods. A number of actions are underway to reduce the number of diverts including the ongoing recruitment of staff and the implementation of a Patient Flow Midwife.



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 December three women were 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

No new risks have been added to the 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 27/11/25. Next review 26/02/26.

There are sixteen current active risks:

- **Risk to patient experience and breach of triage timescales due to insufficient midwifery staffing in Maternity Assessment Centre (Score 10)** ***[Score increased].*** Launch of ANDU has not had desired improvement on MAC attendances at present. Concerns have been further expressed about safety by staff members. Plan for additional midwife staffing on MAC. Risk score increased and escalated to Directorate Risk Register.
- **Risk to Information Governance and breach of confidentiality resulting from lack of training in redaction of patient record requests (Score 9)** ***[New Risk]*** Risk related to lack of appropriate training in redaction which may result in sharing of sensitive and inappropriate information with patients
- **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 recorded as risk score 16 across WYH LMNS. Local booking in place for out of area patients. Options for sharing of Badgernet; temporary K2 token and access through YHCR. 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. Plans in place for completion of declaration forms.

- **Risk to patient safety and experience and staff burnout due to Obstetric staffing pressures (Score 8).** Some shortfall in consultant staffing remains. Score to remain the same until improved further.
- **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. No current change to score.
- **Risk to patient satisfaction and safety, resulting from delays in facilitating induction of labour (IOL) (Score 8).** Work ongoing to plan implementation of balloon catheters. Patient flow coordinator role appointed. No change to score at present.
- **Risk to operational running and governance surrounding safety and quality of homebirth service (Score 6)** ***[New Risk]***
  Relating to letter from Chief Midwifery Officer requesting review and assurance about the safety and governance of the homebirth service within all Maternity Units (see point 16 below for further information).
- **Risk to patient safety and experience associated with need to divert patients to other units in times of escalation (Score 6).** Work ongoing. Risk score to remain the same until showing improvements.
- **Risk to patient experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 6)**. Some recent incidents being followed up on an individual level. For additional work
- **Risk to patient satisfaction and safety, resulting from delays in facilitating ultrasound growth scans (USS)(Score 6).** Situation improved at present. No change in score until sustained improvement.
- **Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 6).** Fully recruited but issues remain. Score currently to remain the same.
- **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)**. 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. Role recruited and awaiting starting date.
- **Clinical risk related to inconsistent access to Maternity medical records related to Medi-viewer (Score 4)** ***[New Risk]***
  Risk relating to issues with unexpected implementation of Medi-viewer within Maternity

6. Maternity Incidents

In December 2025 there were 80 total incidents reported through DCIQ. Note: some Datix subcategories have been amended.

One Moderate Harm incident requiring RROSE review for patient who sustained a DVT. Upon investigation it appears that her VTE risk assessment score had been miscalculated. A DoC letter has been sent and action plan in progress.

Two additional RROSE reviews undertaken in response to recent stillbirths. It has been agreed that all stillbirths will have RROSE review completed. Multidisciplinary PMRT reviews will also be completed in accordance with national requirements

Additional incidents of note include:

- 10 incidents of Lost/Missed follow up appointments. Predominantly relating to clerical issues of consultant appointments [8 cases] or ultrasound scan appointments not being made
- 10 incidents of Readmission of Mother/Babies (all neonatal)
- 5 incidents of Suspension of Maternity Services
- 7 incidents of Term Admission to SCBU
- 4 incidents of Incorrect treatment/test/procedure
- 3 incidents of In utero Transfer due to suspected preterm labour (two incidents with same patient)
- 3 incidents of PPH≥1500ml (all at elective LSCS).

7. Perinatal Mortality Review Tool (PMRT)

One PMRT relating to recent NND in November in progress (PSII in progress). PMRT for stillbirth 33+4 in November in progress (RROSE review completed). PMRT for stillbirth 35 weeks in December in progress (RROSE review completed). No themes identified. Quarterly report included at Appendix B.

8. Feedback

a. Staff Feedback – Inpulse, NHS Staff Survey

The NHS Staff survey had 83 responses for the Maternity and Gynaecology care group according to the report received by IQVIA. A more detailed breakdown by department will be available at the end of January to enable maternity results to be reviewed specifically. The results are embargoed until March 2026 however a high-level review suggests that the following are working well across the Maternity and Gynaecology Care Group –

- Kind, supportive culture in teams
- Psychological safety for speaking up
- Appraisals coverage
- Voice that counts

However further attention is needed in relation to -

- Staffing levels
- Burnout

b. Maternity and Neonatal Voice Partnership Feedback

The MNVP attended a pre-natal yoga group in Harrogate, a SCBU coffee morning and Antenatal clinics to gain feedback from service users during November. They have started to also collect information regarding ethnicity and postcode to enable analysis of any impact of ethnicity and deprivation. Snippets of the feedback are below –

It is my first baby and I would like a homebirth but was worried there would be push back. I raised it from the start, at my booking in app and felt it was very positively encouraged. Now working with a doula to support alongside my midwifery care.

My Community Midwife didn't explain anything, for example what the tests etc in my appointment were for or ask for consent. There was a feeling they were very busy.

We were aware once we got to a certain point in my pregnancy that we would likely spend some time on SCBU but we were never invited to have a look around. Once we were on SCBU the staff were incredible, and we are so grateful to them.

Previous experience wasn't good at all but this experience has been a lot better. I have been listened to and felt cared for.

It is very good experience. They booked extra appointments to check the growth of the babies and detect any harms. That's very appreciated.

I have delivered one baby before in HDFT. The antenatal, labour and postnatal services are all very good. Being a patient is very lovely.

Friendly staff, informative scans, quick response to issues during pregnancy

Very accommodating and supportive through the service so far. Any queries or worries answered and reassured.

15. Complaints, concerns, compliments

One new complaint was received in December regarding postnatal care in relation to breastfeeding advice and expectations.

There are two previous open complaints however both are awaiting consent.

16. Coroner Regulation 28 made directly to trust

No direct requests received however NHS England have circulated a request to urgently review the safety and quality of homebirth services following a Prevention of Future Deaths report issued by the Senior Coroner for Manchester North. The request states that Trusts should review the following;

- The operational running of your service: including how it ensures that prompt midwifery care is available 24 hours a day; that staff are properly equipped, trained, prepared and skilled for providing birth and neonatal care in a home setting; that staff have senior multidisciplinary support available to them at all times and have sufficient rest periods; and that potential transfer and extraction processes are clear and planned for each birth.
- Care planning and risk assessment: including systematic assessment of complexity and risk; how the multidisciplinary team (MDT) ensures a personalised approach to women in planning care in light of any identified issues (particularly when homebirth is not recommended); how the MDT continues to maintain good communication at all stages of care with women and between all teams including ambulance services; and how dynamic risk assessment is managed and responded to throughout pregnancy, birth and the postnatal period.
- Governance and oversight: including how governance is structured to ensure robust oversight of homebirth services by the whole organisation, so the executive board has appropriate oversight; that there is an audit programme that covers outcomes and clinical and operational guidance and leads to continual improvement; and that there is comprehensive homebirth guidance including standard operating procedures for all stages and aspects of care.

The letter also states that *Trusts have a continuing responsibility to offer homebirth as a choice for women. Where this review identifies concerns, please take prompt action to address them to ensure your homebirth service remains safe and high quality. While no formal response is required, we expect that the outcome of the review be reported to your Trust board.*

The homebirth services has been reviewed and plans to make improvements are in place. A full report on the review and actions will be brought to the Trust Board Meeting.

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

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

The CQC Maternity Inspection report was published on 7th January. The on-site inspection took place 22-24th July 2025. The report contains positive feedback and the maternity service has been rated Good overall. The CQC assessed the service against 34 quality statements within their Single Assessment Framework, focusing on five key areas for patients: Safe,

Effective, Caring, Responsive, and Well-led. A rating of Good was apportioned to all five areas, representing an improvement on the findings from the November 2022 inspection.

The report also identifies some areas for improvement and issued a Regulation 12 (2) (a) –

The trust must ensure they embed a system of oversight for women attending the maternity assessment centre during the day and the delivery suite at night. This should ensure women's care is prioritised and monitored appropriately and deterioration and risk processes are all completed and documented.

An action plan has been developed and is progressing at pace.

NHS England Regional Maternity Team are undertaking a deep dive into the maternal mortality causes and factors affecting our communities. This will aid an understanding of how closely the population data mirrors the national MBRRACE-UK data and therefore the associated themes, trends and recommendations. This will enable local learning and may as a consequence enable a future reduction in maternal mortality in North east and Yorkshire. HDFT have ben asked to participate in the review of three cases in which the service was involved.

18. Maternity and Newborn Safety Investigation (MNSI)

No new MNSI incidents reported.

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

Trust Board is asked to review the evidence submitted, note the information provided in the report (Appendix C) and discuss if sufficient assurance is gained to satisfy all of the requirements of the Maternity Incentive Scheme – year seven. The Board is recommended to declare non-compliance with the Maternity Incentive Scheme Year Seven Standards due to the non-compliance with short term locums as previously reported.

20. National priorities

a. Maternity Care Bundle (MCB)

NHS England has published the Maternal Care Bundle on 6th January 2026, which sets out best practice standards across five areas of clinical care; with the aim to reduce maternal mortality and morbidity. It is for implementation by NHS providers and commissioners across England and should be implemented in line with the medium-term planning framework. In this first version, it establishes a baseline of best practice in five areas of care associated with higher rates of maternal mortality and morbidity. The five elements are:

Element 1: Venous thromboembolism
Element 2: Pre-hospital and acute care
Element 3: Epilepsy in pregnancy
Element 4: Maternal mental health
Element 5: Obstetric haemorrhage

All NHS trusts providing maternity services and ICBs are responsible for fully implementing the MCB by March 2027. NHS trusts providing maternity services are primarily responsible for implementing the MCB locally, including:

- benchmarking current compliance and developing an improvement plan with trajectories for sign off by the trust board
- providing regular reports to the trust board on implementation against this plan and trajectories, so that the board can oversee, support and challenge local delivery. Trust boards should also ensure the involvement of all relevant services in the planning and delivery of interventions. This will include relevant medical and surgical specialties, gynaecology and urgent and emergency care, as appropriate

- ensuring that where local plans do not meet nationally recommended pathways, timescales or performance, or where local delivery subsequently deviates from these plans, this is escalated to the regional NHS England team
- engaging with maternal medicine networks. This means co-producing and complying with the local network's protocol for the management and referral of medical problems in pregnancy, across all relevant medical specialties and settings
- local reporting of routine care data relating to key process and outcome measures for each element as defined in the national implementation tool which will be made available to trusts on the FutureNHS platform in quarter 4 2025/26.

Work is underway to benchmark our services against the MCB and develop an action plan to improve services as required to meet the recommendations. The benchmarking will be completed by February and oversight of the action plan will be provided by Q1.

b. Improving postnatal care: a toolkit for integrated care boards, partners and providers

This NHS England postnatal toolkit was released on 6th January 2026 and recommends actions across four domains for ICBs, partners and providers to deliver consistent high-quality, personalised, kind and equitable postnatal care and support. These four domains are based on good practice, findings of national and local experience surveys and the National Maternity and Neonatal Recommendations Register but do not provide an exhaustive list. The four domains are as follows;

- Domain 1: Listening to women and taking a family approach
- Domain 2: Addressing inequalities
- Domain 3: Workforce, training and education
- Domain 4: Take a public health approach

These domains underpin the 3 shifts essential to achieving the 10 Year Plan for Health.

Work is underway to benchmark our services against this toolkit and develop an action plan to improve services as required to meet the recommendations.

c. 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;

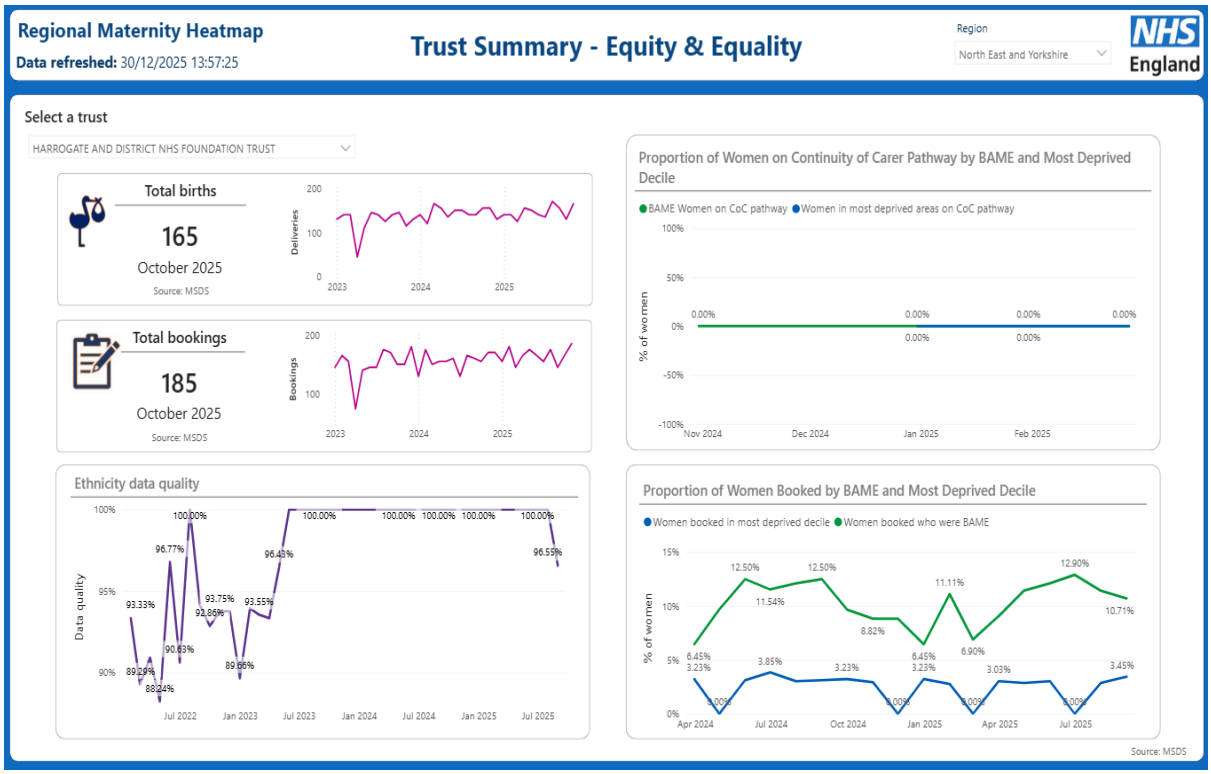
i) **Perinatal Equity and Anti-Discrimination Programme:** this will give perinatal teams the skills and tools they need to improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and to improve the working lives of staff from these groups. The programme's focus is on effecting the behavioural, cultural and organisational changes needed to tackle inequalities and sustain change. Further details are expected in Quarter 4.

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 commenced reporting to the Daily SitRep on 15th December 2025. The regional maternity heat map is an analytical tool that pulls information around trusts CQC status, regulatory notices and regulatory body/stakeholder concerns, progress towards national priorities, safe staffing, MBRRACE mortality, service user and staff feedback surveys. The heat map enables monthly oversight of the triangulated data and then scores each element to read the signals of trusts that require additional early intervention and support. The heat map is produced in a format for systems to use the information to direct work programmes to the right areas. The data is updated monthly and reports two months behind similar to the National Dashboard. The data for September is from the pilot month, with data completeness and accuracy work continuing throughout Q3 25/26. Please see below screenshot taken from the Regional Heatmap system.



d. 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, and continuity of carer. National maternity early warning score and newborn early warning track and trigger 2 (NEWTT2) are now in place following the transition to Nervecentre.

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

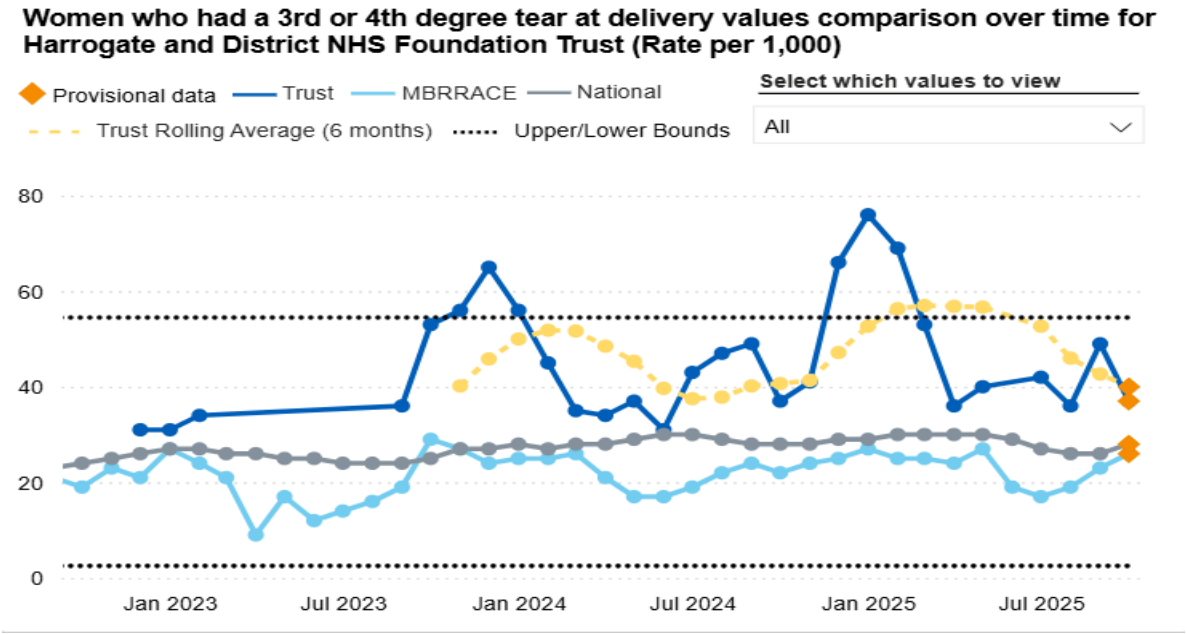
Work continues to ensure accuracy of data and benchmarking is included in all data fields captured in the dashboard since the move to Power BI for the reports.

The National Maternity dashboard is available at the following link- National Maternity Dashboard. The data available in the National dashboard is up to October 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).

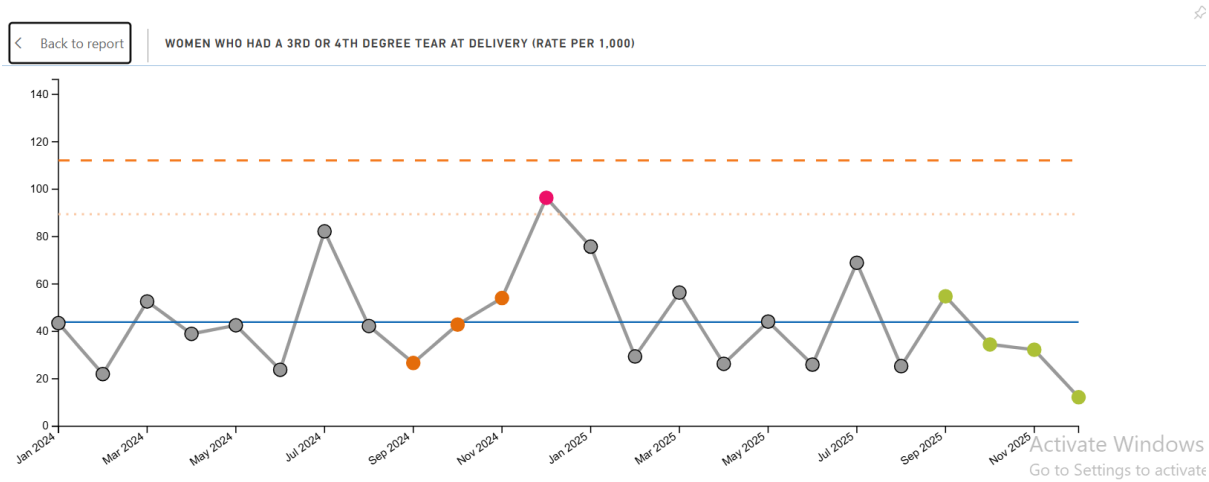
Areas of concern on review of the National dashboard relate to the following –

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 reduced over the last few months.

National dashboard -

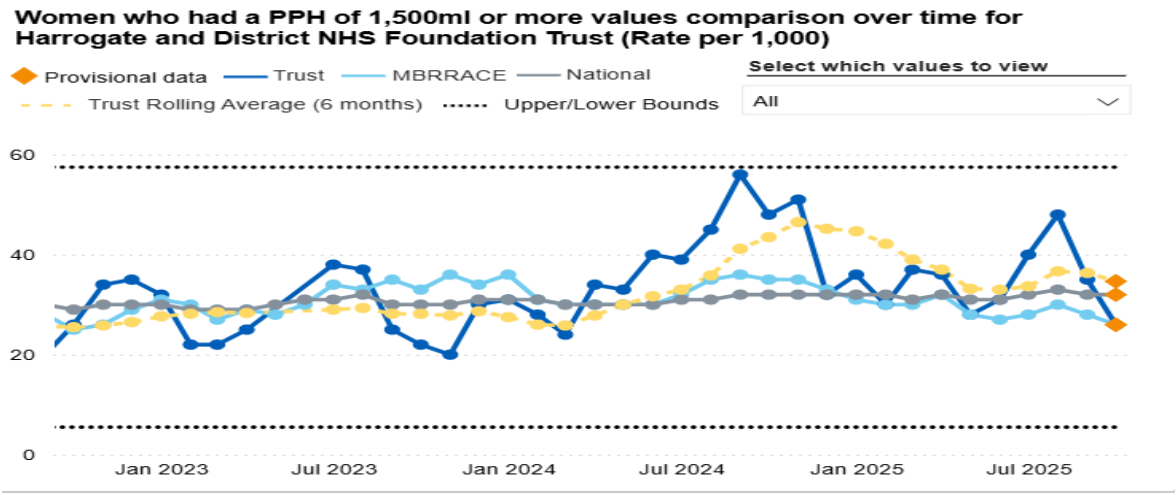


Local dashboard –

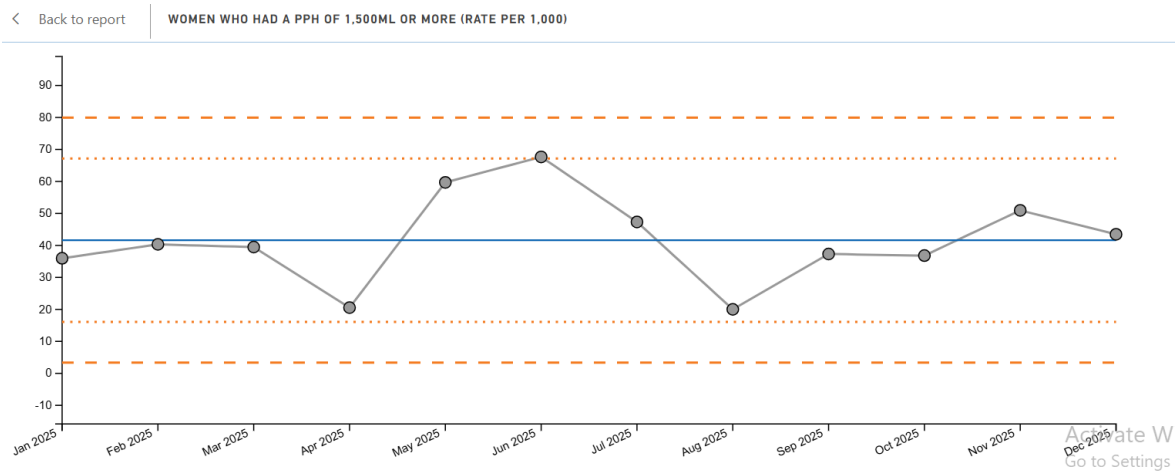


Women who had a postpartum haemorrhage (PPH) of 1500ml or more – the national dashboard demonstrates that PPH rates at HDFT appear to have returned to being in line with National averages. When tracking the PPH rates over a more prolonged historic time period the peak seen recently is normal variation 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.

National dashboard -



Local dashboard –



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. Fifteen babies received Transitional Care provision on Pannal Ward this month.

b. Neonatal Readmissions

There were ten neonatal readmissions in December. A quarterly report is included in Appendix D. Four babies readmitted with weight loss in line with local guideline; Four babies were readmitted with jaundice and requiring phototherapy; one baby was readmitted following a dusky episode; and one baby was readmitted with facial bruising/swelling.

c. Avoiding Term Admissions in Neonatal Units (ATAIN)

There were seven incidents of term babies being admitted to the Special Care Baby Unit this month. All cases are reviewed at the multidisciplinary ATAIN meeting. Five babies requiring respiratory support for low oxygen saturations/grunting/tachypnoea; one for persistent vomiting, and one baby having dusky episode.

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. Harrogate maternity services have demonstrated progress in achieving compliance with all six elements Saving Babies Lives Care Bundle version three. The most recent compliance review meeting occurred in November and the Trust's overall compliance had

increased from 88% (Q1 25-26) to 93% (Q2 25-26), there was evidence of improvements with meeting ambitions following the implementation of previous improvement actions.

The LMNS stated that the evidence submitted was of a high quality and there was evidence through the elements of sustained improvement where high levels of reliability had already been achieved.

17. Maternity Safety Champions

Bi-monthly Safety Champion executive and non-executive director walk around and meetings continue. The most recent walkaround and meeting occurred on 17th November. Staff were busy and therefore engagement was limited on the walkaround however good feedback was received from midwifery students who were on placement in the department. They reported that they had been made to feel welcome and supported in their placement

18. Conclusion and Recommendations

a) Positive news

CQC Inspection rating Good overall and in each domain.

b) Areas of concern

- Three new risks and one increased risk score
- Significant increased scrutiny and reporting to NHS England

c) Work underway

- On-going review of the homebirth service provision
- Work ongoing in Maternity Assessment centre regarding activity
- On-going work to prevent induction of labour delays

d) Decisions required of Board

- Maternity Incentive Scheme Declaration

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

Compliance of completion of Perinatal Mortality Review Tool

Quarter 3, October to December 2025

This document provides a summary of current compliance against Safety Action 1 of the Maternity Incentive Scheme (MIS) for the third quarter, October to December 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
98640	Yes	Yes	Completed	Yes
99258	Yes	Yes	Completed	Yes
101001	Yes	Yes	In progress	Yes
101309	Yes	Yes	In progress	Yes
101529	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 3, there was three perinatal deaths eligible to be reported to MBRRACE-UK. This was an early neonatal death, and two third trimester stillbirths.

There are currently three ongoing case reviews, and all three are awaiting panel review in line with the MIS requirements.

Ongoing Action Plan following PMRT review

Root Cause/Contributory Factor	Action/s	Responsible Lead	Target Date	ID no.	Risk at review (H/M/L or complete)
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.	Switchboard Bereavement Midwife Lead Midwife for Safety, Quality & Clinical Governance	01/11/ 2025	96659	Completed
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.	Community Team Leader	01/11/ 2025	96659	Completed
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. Ongoing project with LMNS regarding patient pregnancy care passports for	Community Team Leader and Antenatal Team Leader working alongside team leaders at LTH's	01/11/ 2025	96659	Completed
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.	Team leaders	28/02/ 2026	98640	Medium
The baby was small for gestational age at birth, scans were indicated and performed but the baby was not identified as IUGR.	Continue auditing cases of fetal growth restriction and reporting to the LMNS and Trust Board in line with SBLCB. There is an ongoing audit on the accuracy of growth scans compared with birth weight, to confirm accuracy and offer learning points.	Audit and Clinical Effectiveness Lead Midwife Lead Midwife for Safety, Quality & Clinical Governance	01/01/ 2026	98640	Low

Fundal height measurements performed alongside serial scanning pathway.	Reinforcement on mandatory training day and case study learning.	Professional Development midwives Bereavement Midwives	01/01/ 2026	98640	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.	Bereavement Midwives MNVP	30/11/ 2026	98640	Completed
Difference in perspectives on communication content and ongoing plan of care in relation to reduced fetal movements attendance.	Additional training for obstetric and midwifery staff regarding communication and discussions of recommendations for ongoing planning of care.	Professional Development midwives	01/08/ 2026	99258	Medium
Missed opportunity for earlier antenatal clinic appointment with obstetric team to review low ferritin level.	Continuous improvement plans ongoing. Individual feedback to staff member. Case study to be shared with MDT.	Community Team Leader Bereavement Midwives	31/03/ 2026	99258	Low
Challenges in contacting community midwifery team with non-urgent queries.	Reinforcement of SPOC contact details to service users and communications from MNVP team.	MNVP	31/03/ 2026	99258	Low

Appendix C

Harrogate and District NHS Foundation Trust

Final Report for the Maternity Incentive Scheme – Year 7

Trust Board

January 2026

Title:	Final Report for the Maternity Incentive Scheme – Year 7
Responsible Director:	Breeda Columb, Executive Director of Nursing, Midwifery & AHP's
Author:	Leanne Likaj (Associate Director of Midwifery and Children's Services), Sam Layfield (Operations Director) Kat Johnson (Clinical Director)

Purpose of the report and summary of key issues:	The purpose of this report is to detail the status of compliance against the ten Maternity Incentive Scheme safety actions and to highlight areas of potential non-compliance.	
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		
Report History:	Quality and Governance Management Group Quality Committee Senior Management Team - SDR Maternity Risk Management Group Safety Champions Meeting	
Recommendation:	Board are asked to review the evidence submission, note the compliance position against each of the standards and agree declaration of non – compliance due to a breach in Safety Action Four.	

Final Report for the Maternity Incentive Scheme – Year 7

1.0 Executive Summary

This report details the standards required to demonstrate full compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year seven.

2.0 Introduction

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.

This report provides detail of position and progress with compliance with the ten maternity safety actions.

3.0 Proposal

Trust Board is asked to review the evidence submitted, note the information provided in the report and discuss if sufficient assurance is gained to satisfy all of the requirements of the Maternity Incentive Scheme – year seven.

4.0 Quality Implications and Clinical Input

This report provides information on position and progress with compliance with the ten maternity safety actions.

5.0 Equality Analysis

An equality analysis has not been undertaken

6.0 Risks and Mitigating Actions

The MIS is a self-certification scheme, with all scheme submissions requiring sign-off by Trust Boards and ICBs following conversations with trust commissioners.

All submissions also undergo an external verification process and are sense-checked by the Care Quality Commission (CQC).

7.0 Recommendation

The Board is recommended to declare **non-compliance** with the Maternity Incentive Scheme Year Seven Standards.

The Board is required to give their permission to the CEO to sign the Board declaration form, and action plan, prior to submission to NHS Resolution.

Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in order to confirm compliance. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering either 2024/25 financial year or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration.

Maternity Incentive Scheme – Year Seven

Introduction

The Maternity Incentive Scheme (MIS) incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the Clinical Negligence Scheme for Trusts (CNST) maternity incentive fund.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution. The balance of unallocated funds will be shared with the trusts who have achieved all ten safety actions.

Full guidance regarding the required standards can be found at https://resolution.nhs.uk/wp-content/uploads/2025/04/MIS-Year-7-guidance.pdf

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

- MBRRACE-UK data (safety action 1 standards a, b and c).
- NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).
- Maternity and Newborn Safety Investigations (MNSI) will cross-check the National Neonatal Research Database (NNRD) and NHS Resolution will cross-check the NHS Resolution database for qualifying MNSI and Early Notification (EN) incidents reportable (safety action 10) and externally verify that standards A and B have been met in the relevant reporting period. In addition, for standards B and C (i) there is a requirement to complete the field on NHS Resolution's Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement. Completion of this will also be monitored and externally validated

Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year

The evidence for each Safety Action can be found in the following location - 2025

Safety Action One

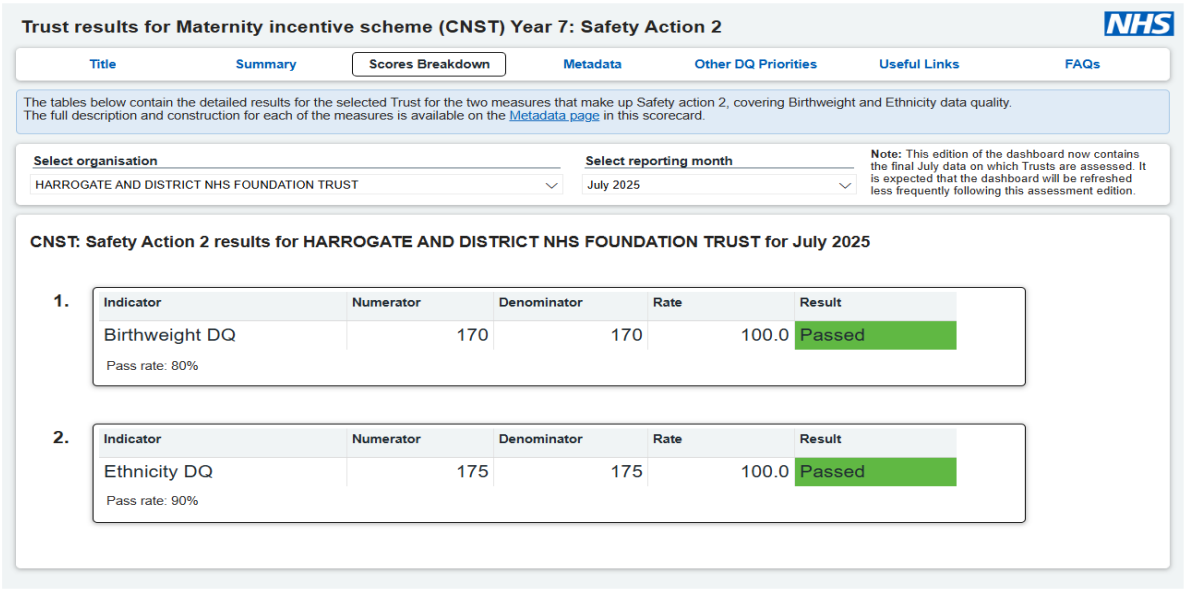
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?		***Required standard –*** ***Pages 11-12 and 29-36 of Maternity Safety Incentive Scheme Document*** ***Recommendation – Compliant***

a) All eligible perinatal deaths have been notified to MBRRACE-UK within seven working days.
b) Parents have been 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 100% of the time.
c) The multi-disciplinary team always review the care within two months using the perinatal mortality review tool (PMRT), and all reports are published within six months. An external member is always present at the multidisciplinary review panel meeting.
d) Quarterly reports of reviews of all deaths are discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis, which include action plans, within the Strengthening Maternity and Neonatal Safety Board Report.

Safety Action Two

2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		***Required standard –*** ***Pages 13 and 37 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

July 2025 data contained a valid birthweight for 100% of babies born in the month and a valid ethnic category (Mother) for 100% of women booked in the month.



Trust results for Maternity incentive scheme (CNST) Year 7: Safety Action 2

Title | Summary | Scores Breakdown | Metadata | Other DQ Priorities | Useful Links | FAQs

The tables below contain the detailed results for the selected Trust for the two measures that make up Safety action 2, covering Birthweight and Ethnicity data quality.
The full description and construction for each of the measures is available on the Metadata page in this scorecard.

Select organisation: HARROGATE AND DISTRICT NHS FOUNDATION TRUST
Select reporting month: July 2025
Note: This edition of the dashboard now contains the final July data on which Trusts are assessed. It is expected that the dashboard will be refreshed less frequently following this assessment edition.

CNST: Safety Action 2 results for HARROGATE AND DISTRICT NHS FOUNDATION TRUST for July 2025

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	170	170	100.0	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	175	175	100.0	Passed

Pass rate: 90%

Safety Action Three

3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?		***Required standard –*** ***Pages 14 and 38 - 39 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

A Transitional Care pathway is in place on to reduce separation of mums and babies born between 35+0 and 35+6 weeks however a pathway is not in place for babies born from 34+0 as is required. Babies born below 35+0 weeks ae currently admitted to Special Care Baby Unit (SCBU) to ensure all appropriate care is provided. Babies admitted to Transitional care on Pannal Ward are reviewed on a daily basis by a paediatrician. Joint maternity and neonatal reviews are in place. An action plan detailing the Quality Improvement Projects is in place and progressing to improve care and extend the gestational boundary to include babies born below 35+0. A patient information leaflet has been developed and is in use for parents, and babies receiving Transitional Care are now more easily identifiable by use of door and cot labels on both Pannal and SCBU.

Safety action 4

4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		***Required standard –*** ***Pages 15-17 and 40-46 of Maternity Safety Incentive Scheme Document*** ***Recommendation –*** ***Non-Compliant***

The Maternity Incentive Scheme requires the following criteria to be met for any medical staff -

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a) currently work in their unit on the tier 2 or 3 rota or

b) have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or

c) hold a certificate of eligibility (CEL) to undertake short-term locums.

On 12-13th April 2025 and 13th July 2025 a short-term sickness gap was covered by a regional trainee who, although known to the consultant body, had not worked in the unit within the last five years and did not hold a CEL.

This constituted a breach of MIS safety criteria. Maternity Incentive Scheme Technical Guidance states –

Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?

No. An action plan must be developed to prevent this happening in the future, but Trusts would still need to declare non-compliance with this action.

No safety concerns arose as a result of this non-compliance, and the MIS requirements have since been clarified and re-circulated to all colleagues involved in rota management to ensure full compliance going forward. An action plan is required to be submitted to NHS Resolution alongside the compliance submission. The action plan confirms the actions taken and the plan to also explore ensuring the Regional rotational doctors are made aware of the RCOG Certificate of Eligibility requirement and supported to complete this process.

The Obstetric medical workforce is in line with RCOG guidance in relation to long term locums and a guideline is in place to implement compensatory rest.

The audit of compliance with consultant attendance for the clinical situations listed in the RCOG workforce document demonstrated 81.2% compliance with 11 out of 16 cases where a consultant must be present, and 100% compliance with 72 cases where a consultant must attend of be immediately available if the staff on duty have not been assessed as competent. The audit in relation to this is presented in Appendix 1.

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

British Association of Perinatal Medicine (BAPM) standards are not met for neonatal medical and neonatal nurse staffing and an action plan is in place. Harrogate Special Care Baby Unit (SCBU) do not have a supernumerary shift co-ordinator on every shift however there is a Band 7 Unit Manager on site Monday - Friday 08:00 - 16:00 to support shift responsibilities. Cross cover is also provided from co-located Paediatric ward in event of unwell baby being born.

For the neonatal medical workforce there currently is one in seven on the Tier 3 doctors rota (rather than one in eight) however there is cover for the unit 24 hours a day.

A neonatal staffing report and action plan are available in the evidence folder to demonstrate full compliance with this safety standard for neonatal medical and nursing staff.

Safety action 5

5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		***Required standard –*** ***Pages 18-19 and 47–48 of Maternity Safety Incentive Scheme Document*** ***Recommendation – Compliant***

Midwifery staffing establishment is calculated using BirthRate plus. An updated establishment calculation was completed in August 2024. The maternity budget was adjusted in line with this in April 2025. There is a supernumerary Labour Ward Co-ordinator rostered for every shift and this is ensured to be in place at the start of every shift. Women receive one to one care in active labour. The bi-annual midwifery staffing report demonstrating compliance was submitted to the Board May 2025 and November 2025 and is available in the evidence folder.

Safety action 6

6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		***Required standard –*** ***Pages 20-21 and 49 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

Harrogate maternity services have demonstrated progress in achieving compliance with all six elements Saving Babies Lives Care Bundle version three. Progress and detailed conversations have occurred at three quarterly quality improvement discussions with the ICB/LMNS. Work is ongoing to sustain and embed the actions. The compliance report has also been shared with Trust Board. The most recent compliance review meeting occurred in November and the Trust's overall compliance had increased from 88% (Q1 25-26) to 93% (Q2 25-26), there was evidence of improvements with meeting ambitions following the implementation of previous improvement actions.

The LMNS stated that the evidence submitted was of a high quality and there was evidence through the elements of sustained improvement where high levels of reliability had already been achieved.

Safety action 7

7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users		***Required standard –*** ***Pages 22-23 and 50-51 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

The Maternity and Neonatal Voices Partnership (MNVP) works closely with maternity service leaders and service users to co-produce services and review service provision. The MNVP engages with the local community and prioritises hearing the voices of those with the worst outcomes. Terms of reference are in place showing the MNVP Lead as a member at maternity safety and governance meetings.

Infrastructure for the MNVP is in place although concerns have been raised by West Yorkshire and Harrogate Local Maternity and Neonatal System (WYH LMNS) MNVP Lead to the WYH LMNS Board regarding whether the funding across WYH LMNS is sufficient to ensure appropriate training and support are in place to enable the MNVP Lead to be a quorate member of the Perinatal Mortality Review Meeting. Escalation within the Trust and to the LMNS has also occurred as required. Humber and North Yorkshire LMNS consider the funding and support in place to be sufficient.

Harrogate MNVP have engaged with the local community and prioritised hearing from those experiencing the worst outcomes.

The annual CQC Maternity Survey free text data has been reviewed with the MNVP Lead and an action plan is in place.

Safety action 8

8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? 90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal Life Support Training		***Required standard –*** ***Pages 24 and 52 – 56 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**

Over 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring. Over 90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day that includes maternity emergencies. At least one emergency scenario is conducted in a clinical area as part of each emergency training day. Over 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Resuscitation Council UK (RCUK) Newborn Life Support (NLS) course. Registered Resuscitation Council UK trained instructors deliver the local NLS courses and the in-house neonatal basic life support annual updates. All neonatal staff undertaking responsibilities as an unsupervised first attender / primary resuscitator attending any birth have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework. An SOP is in place to ensure that there is an up-to-date RCUK trained member of staff present at each neonatal resuscitation event.

Safety action 9

9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?		***Required standard*** ***Pages 25-26 and 57 –63 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**

All Trust requirements of the Perinatal Quality Surveillance Model are fully embedded and have been updated to reflect the requirements of the Perinatal Quality Oversight Model (PQOM).

Discussions regarding safety intelligence take place at the Quality Committee and Trust Board, presented by a member of the Perinatal Leadership Team, and this includes ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient

Safety Incident Response Framework (PSIRF) and demonstrate evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

There is a visible Maternity and Neonatal Board Safety Champion (BSC) and non-executive Board Safety Champion who are able to support the perinatal leadership team in their work to better understand and craft local cultures. Board Safety Champions meet with the Perinatal Leadership Team and the MNVP lead bi-monthly and progress with the maternity and neonatal culture improvement plan is being monitored and supported as required.

On-going engagement sessions with staff occur bi-monthly and progress against actions in relation to any concerns raised are visible to staff.

The Trust's NHS Resolution claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level meeting.

Safety action 10

10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025		***Required standard –*** ***Pages 27 and 64-67 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**

There has been one qualifying case from 1 December 2024 to 30 November 2025 which has required reporting to MNSI. This case was reported within the required timescales, Duty of Candour was followed and the family were provided with information regarding the role of MNSI and NHS Resolution Scheme.

Conclusion

This report provides the information required to demonstrate HDFT's level of compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year seven.

The Trust Board need to be satisfied that the information within this report and evidence folder satisfies these requirements prior to final sign off by the Chief Executive and submission to NHS Resolution by 12 noon on 3rd March 2026. Due to the non-compliance with Safety Action Four it is recommended to declare non-compliance overall and the required action plan is included in the below document.

MIS_SafetyAction_Year7_Protected_V9 (2).:

Appendix 1

TO ENSURE COMPLIANCE WITH DATA PROTECTION, COMPLETED REPORTS MUST NOT BE SHARED EXTERNALLY WITHOUT PERMISSION FROM THE CLINICAL EFFECTIVENESS TEAM (HDFT.CLINICALAUDIT@NHS.NET)

Planned and Surgical Care

Maternity

Consultant Attendance in Clinical Situations 2025

Project Sponsor(s):		**Leanne Likaj, Rachael Tabram**	
Report Author(s):		**Dr Saima Abid (Specialty Doctor) O&G**	
Draft Report Distributed to:	**Andy Brown**	Date:	5/11/25
Final Report Distributed to:	**Andy Brown**	Date:	13/11/25

QUALITY ASSURANCE CHECKLIST (to be completed by the Project Lead(s))	
• Does final report include 'Key Successes & Concerns'?	**Yes ☒** **No ☐**
• Does final report include 'Recommendations'?	**Yes ☒** **No ☐**
• Does final report include an 'Action Plan'?	**Yes ☒** **No ☐**
Please note that a report cannot be considered "complete" until the items above are submitted	

Contents

1. INTRODUCTION

The RCOG produces workforce guidance as an aid to good clinical practice. It presents recognised methods and techniques for clinical practice, based on published evidence, for consideration by obstetricians/gynaecologists and other health care professionals. It is committed to supporting the delivery of high-quality women's healthcare and has developed a range of resources to inform and support healthcare professionals.

The RCOG 2021 document "Roles and Responsibilities of the Consultant" identifies the need for the consultant to 'promote positive team working, good information flow and clinical prioritisation'. It also identifies the link between shallow authority gradients and psychological safety, key to staff feeling able to raise concerns and learn from events.

As the most experienced clinician, consultants are now often needed to be physically present, including out-of-hours, to support the care of more complex women or during high levels of activity. It is not unusual for a clinician whose primary role is gynaecology to be the most experienced clinician on labour ward and be required to attend a complex emergency. There is a need for O&G consultants who provide out-of-hours cover for both obstetrics and gynaecology to continue to develop post CCT/CESR and maintain their skillset across both modalities. This particularly applies to less common emergency obstetric scenarios as these are time-critical situations where the confidence, skillset and support of the attending consultant will often define the outcome.

As well as this, the "Towards Safer Childbirth" document arose from continuing concerns in a number of areas about the quality of care that women and their babies were receiving during labour and birth. The RCOG had worrying evidence that, in some circumstances, consultant obstetricians did not see the labour ward as a part of their regular duties and so the care of women with potential or actual serious conditions fell below an acceptable standard.

The document describes the role of the consultant obstetrician on the labour ward as 'to ensure a high standard of care for women and their babies with complex medical or obstetric needs and to be available for the acute, severe and often life-threatening emergencies which are a feature of obstetric practice.'

All consultant obstetricians who work on the labour ward should:

- Provide clinical leadership and lead by example
- Train and educate staff in a multidisciplinary team
- Ensure effective teamwork
- Develop and implement standards of obstetric practice and have a major role in risk management
- Bring experience to clinical diagnosis and opinion
- Audit the effectiveness of practice and modify it as required

2. CURRENT PROCESS

The on-call consultant is responsible for covering obstetrics and gynaecology, including labour ward and is expected to be resident on site during the following hours:

Monday – Friday 08:00 – 20:30h

Saturday/Sunday 08:00 – 12:00h & 20:00 – 20:30

Each morning begins with a thirty minute multi-professional handover, followed by a ward round. It is expected that the ward round will include a consultant review of all high risk obstetric patients on labour ward, all obstetric antenatal patients, any postnatal readmissions and any gynaecology non-elective admissions. Elective gynaecology patients may be

reviewed by the consultant of care or the middle grade on call, with the on call consultant reviewing where there are clinical concerns. Any staffing concerns should be discussed during the handover and it is the responsibility of the consultant on call to ensure appropriate contingency plans are made where there is staff absence. If the on call consultant is expected to change during the on call period, any contingency plans should be relayed to them as soon as known.

The multi-professional evening handover occurs at 20:00–20:30h. As a minimum a consultant review of all high risk patients on labour ward, any new postnatal readmissions and any new gynaecology admissions should occur before the consultant goes home. The consultant may choose to undertake the reviews before the ward round due to time constraints. This will ensure that all new admissions, antenatal, postnatal and gynaecological are reviewed by a consultant within 14 hours.

Where possible, the same consultant will be on call for the whole 24 hours. Where this is not possible, the incoming consultant must come to labour ward and undertake a ward round of any high risk patients. The on call consultant should be immediately available to offer advice and supervision of the junior medical staff. The on call consultant may sometimes change during the day, and it is expected that the incoming consultant comes to the labour ward and undertakes a 'board round' and sees any patients as necessary.

At the weekend, the on call consultant should undertake a morning ward round in person each morning and is expected to be resident between the hours of 08:00 and 12:30h. The exception to this would be where the on call consultant has been in after midnight and may need to take compensatory rest. Where this occurs, the consultant is responsible for ensuring appropriate delegated review of patients occurs and any concerns are appropriately escalated pending consultant presence on site. The frequency of subsequent ward rounds/ telephone rounds will depend on the level of activity in the unit.

The on call consultant is required to stay within 30 minutes of the hospital during the on call period. The following clinical conditions should be discussed with them:

- Fetal distress requiring delivery in theatre (trial of operative delivery or caesarean section)
- Failure to progress (delayed progress in labour) requiring delivery in theatre
- Fetal distress where a third fetal blood sample is being considered
- Significant/ ongoing antepartum haemorrhage
- Severe pre-eclampsia
- Sepsis
- Multiple pregnancy in labour
- Malpresentation in labour e.g. breech
- Preterm labour less than 34 weeks gestation
- Threatened preterm labour less than 34 weeks gestation
- Any other cause for concern

Usually the second on call doctor (middle grade) will liaise with the consultant on call. However, where this is not possible or where the midwifery staff have concerns it is appropriate for any member of the medical or midwifery staff to call the consultant directly.

In the following situations the consultant must attend in person (*Adapted from roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG 2021)*:

Situations in which the consultant MUST attend in person
General
In the event of high levels of activity (e.g. a second obstetric theatre being opened or unit closure due to high levels of activity requiring consultant input)
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
Obstetrics
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU/ITU care is likely to become necessary
Caesarean birth for major placenta praevia/abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <32 weeks
Caesarean section for premature twins <32 weeks
Vaginal twin delivery – consultant to be present for delivery
Vaginal breech birth
4th degree tear repair
Unexpected stillbirth – antepartum or intrapartum
Eclampsia
Maternal collapse (e.g. septic shock, massive abruption)
PPH > 2L where the haemorrhage is continuing and massive obstetric haemorrhage protocol has been instigated

In the following situations the consultant should attend in person or be immediately available if the Second on call (middle grade) doctor on duty has not been assessed as competent; usually by OSATs where available (*Adapted from roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG 2022):*

Situations in which the consultant MUST attend in person, unless the most senior doctor present has documented evidence as being signed off as competent
General
Any patients in obstetrics OR gynaecology with and EBL >1.5 litres and ongoing bleeding
Obstetrics
Trial of instrumental birth
Caesarean birth at full dilatation
Caesarean birth for women with a BMI >40
Caesarean birth for transverse lie
Third degree tear repair

*note in these situations the consultant should attend the hospital in case of urgent obstetric cases even if not needed to supervise in the gynaecology theatre.

3. OBJECTIVES

This re-audit is designed to assess compliance with consultant attendance in clinical situations between 1st April 2025 and 30th June 2025 at Harrogate Hospital.

4. METHODOLOGY

The Electronic Birth Register (Badgernet) identified how many babies were born between 1st April 2025 and 30th June 2025 at Harrogate Hospital. From this, it was then possible to identify births in which consultant attendance should have been compulsory. Additionally, DATIX submissions for unit closures and Badgernet maternity records were reviewed.

5. RESULTS

5.1. Clinical situations in which a consultant must attend

5.1.1. Event of high levels of activity (second theatre or unit closure where obstetric input required)

There were five instances when the unit was closed during the timeframe. **All** of these were discussed with and agreed upon by the consultant on call. Consultant was not required as obstetric input was not needed.

There was no occasion when a second theatre needed to be opened in this timeframe.

5.1.2. Any return to theatre for obstetrics or gynaecology

The were no cases requiring return to theatre in this period.

5.1.3. Caesarean birth for major placenta praevia/abnormally invasive placenta

During the time scale, there were no planned caesarean sections performed for placenta praevia. However, two undiagnosed placenta accrete were identified and the on-call consultant attended for both.

5.1.4. Caesarean birth for women with a BMI over 50

There was one elective caesarean section with BMI >50 in the timeframe which was done by a senior SAS grade who was acting in consultant capacity, so this was appropriate.

5.1.5. Caesarean birth below 32 weeks or Caesarean for preterm twins below 32 weeks

There were two caesareans with gestations of less than 32 weeks, both were singleton pregnancies, assisted by consultants.

5.1.6. Vaginal twin delivery

There was one set of twins delivered vaginally. A consultant was present at the time of delivery.

5.1.7. Vaginal breech birth

There was one vaginal breech birth (singleton pregnancy) in the timeframe. A consultant was present. The second twin was delivered by the consultant.

5.1.8. Fourth degree tear repair

There were no fourth degree repairs in the timeframe.

5.1.9. Unexpected stillbirth

There was one antepartum stillbirth and the consultant was present.

5.1.10. Eclampsia

There was one case of severe pre-eclamptic toxaemia (PET) where magnesium sulphate was started after discussion with a consultant on phone: no cases of eclampsia.

5.1.11. Maternal Collapse

There was no maternal collapse (cardiac arrest) during the timeframe.

5.1.12. Estimated blood loss over 2000ml or ongoing bleeding

There were eight cases in Badgernet with over 2000ml of blood loss. In four of these, a consultant was present while the bleeding was ongoing. In two out of four, the consultant was informed, and the blood loss had settled. In both of these two registrars were present, one of them was a senior registrar.

In one case, it is documented that registrar and consultant were busy in gynae theatre when the registrar was pulled from there. Consequently, it is likely that the consultant was aware but unable to attend due to being busy with other case. A consultant anaesthetist was present.

In another case, the registrar involved had worked as a consultant previously so was considered acceptable that the consultant was not called as the case was being appropriately managed.

5.2. Clinical situations in which a consultant must attend or be immediately available if the middle grade on duty has not been assessed as competent

5.2.1. Any patients in obstetrics OR gynaecology with and estimated blood loss (EBL) over 1.5 litres and ongoing bleeding

There were eight patients (excluding over 2 litre PPH which has already been discussed) who had blood losses over 1.5 litres. In six cases, a consultant attended. In the remaining cases, the bleeding was controlled either pharmacologically or following suturing.

5.2.2. Trial of instrumental birth

There were 41 trials of rotational instrumental deliveries during the time frame which were performed by doctors who are signed off, or by the consultant.

Seven of these resulted in caesarean section. Of these seven, the consultant was present at three. In one, the consultant was asked to attend whilst not on-site due to difficult extraction of baby. In three of the cases there is no documentation of consultant presence but was informed afterwards.

5.2.3. Caesarean birth at full dilatation

There were nine caesarean sections performed at full cervical dilatation (or caesareans performed in the second stage, as recorded in Badgernet). A consultant was present for six of them, and rest were performed by a competent middle-grade doctor.

5.2.4. Caesarean birth for women with Body Mass Index (BMI) over 40

Seven women were identified as having a caesarean birth with a BMI >40. Four of these cases were performed by a consultant. In the remaining three, a consultant was present, or the procedure was performed by a competent middle-grade doctor.

5.2.5. Caesarean birth for transverse lie

There were no caesarean births for transverse lie in the time frame.

5.2.6. Third degree tear repair

There were seven third degree tear repairs, all performed by doctors competent in the procedure or in the presence of a consultant assisting.

6. CONCLUSION AND KEY SUCCESSES/CONCERNS

- The findings out this audit are positive with almost all women being seen by the appropriate medical staff considering the risk factors during labour.
- 16 cases required a consultant present, and on 11 of these occasions this was the case.
- In the two out of four cases where consultant did not attend with blood loss over 2000ml, the blood loss had settled and the consultant was contacted. One case had no documentation of consultant present, and in another case the consultant was busy with an acute gynae case and unable to attend.
- The four cases of PPH >2 litre mentioned above have been reviewed again subsequently and the clinical opinion was that these cases were not inappropriately managed without consultant. Obstetric knowledge and the most

senior personnel were present and able to effectively manage the PPH. The consultant not being present had no detrimental impact on the patient's care and safety.

- Caesarean section with BMI over 50 was an elective procedure done by a senior SAS grade who was acting in consultant capacity, so this was appropriate.
- All five unit closures had documentation demonstrating consultant presence or communication.
- It is also worth highlighting that in many cases where a doctor had been assessed as competent, there was also a consultant present too. This shows a willingness of consultant attendance when requested but not necessarily required – demonstrating effective working relationships and good patient care.
- A total of 72 clinical situations in which a consultant must attend or be immediately available if the middle grade on duty has not been assessed as competent were identified during this audit time period.

Criteria	Expected level of performance	Actual level of performance
Clinical situations in which a consultant must attend	100%	81.2%
Clinical situations in which a consultant must attend or be immediately available if the middle grade on duty has not been assessed as competent	100%	100%

7. RECOMMENDATIONS

- Ensure documentation of all names which are present in the labour room and not referring to individuals as their job titles. This enables us to clearly see on review whether consultant attendance was required
- Disseminate results to all staff.
- Ensure that second on call doctors are aware of the clinical situations when a consultant must be present, and that if there is any variation from this, that there is adequate documentation to demonstrate the discussion and decision-making process.

8. ACTION PLAN

Project Title: Consultant Attendance in Clinical Situations Audit 2025

Project Lead: Rachel Tabram

Project Sponsor: Leanne Likaj

Action Plan Monitoring Group / Owner: Rachel Tabram

Issue no:	Issue / Audit Finding / Theme	Recommendations - Action/s	Person Responsible	Target Date	Progress on actions
1	Disseminate results of audit	Share at next audit meeting	Rachel Tabram	October 2025	Completed
2	Ensure documentation of names present in labour room	Liaise with Delivery Suite Manager about recording of names on room whiteboards	Rachel Tabram	November 2025	Completed
3	Ensure awareness of criteria	Reinforce awareness to all second on-call doctors of indications for consultant presence and ensuring clear documentation of any deviation	Obstetric Governance Leads	November 2025	Completed

Appendix D

Hospital readmissions of babies within 30 days of life

Quarter 3 *Oct – Dec 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 are 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).

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).

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 to improve patient care and deliver financial savings.

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.

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.

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	Feeding at birth	Length of stay
Baby 1	4 days	39+4	Phototherapy	Formula	24 hours
Baby 2*	2 days	38+3	Phototherapy	Breast	3 days
Baby 3*	7 days	36+4	Phototherapy	Breast	2 days
Baby 4*	3 days	39+2	Phototherapy	Breast	2 days
Baby 5	5 days	39+1	Phototherapy	Breast	2 days
Baby 6	3 days	39+3	Phototherapy	Mixed	24 hours
Baby 7*	3 days	39+5	Phototherapy	Breast	24 hours
Baby 8*	5 days	36+3	Phototherapy	Mixed	2 days
Baby 9*	4 days	37+4	Phototherapy	Mixed	24 hours
Baby 10	3 days	40+3	Phototherapy	Mixed	30 hours
Baby 11	3 days	39+1	Phototherapy	Breast	24 hours
Baby 12	3 days	39+1	Phototherapy	Breast	2 days

Feeding issues	Age when readmitted	Gestation At birth	Weight loss	Treatment	Length of stay
Baby 1*	7 days	39	13.5%	Feeding plan	2 days
Baby 2	4 days	39+2	13.6%	Feeding plan	2 days
Baby 3*	4 days	39+3	11.9%	Feeding plan	Overnight
Baby 4*	3 days	39+6	8.4%	Feeding plan	Overnight
Baby 5	3 days	40+4	12.7%	Feeding plan	Overnight
Baby 6*	3 days	38+2	12.6%	Feeding plan	2 days

Baby 7*	5 days	40+1	13.7%	Feeding plan	2 days
Baby 8	5 days	39+3	12.7%	Feeding plan	Overnight
Baby 9*	3 days	41	12.8%	Feeding plan	3 days
Baby 10*	5 days	37+2	13.6%*	Observed	Overnight
Baby 11	3 days	39+6	13%	Feeding plan	30 hours

Comments *

Babies with jaundice:

- **Baby 2** diagnosed with pathological jaundice at 16 hours old, appropriate investigations completed. Suspected infection following admission and treated with antibiotics.
- **Baby 3** required treatment for pathological jaundice when less than 24 hours old. Readmitted at 37+6 weeks (corrected gestation) for further phototherapy. No recorded weight during admission.
- **Baby 4** noted to have jaundice on day 2 in community but not measured. Readmitted on day 3 following Billiflash and appropriate care given. Baby required single phototherapy only.
- **Baby 7** treated with antibiotics for 48 hours due to risk factors, blood cultures negative

- **Baby 8** (twin), born prematurely due to low birth weight, ventouse delivery.
- **Baby 9** treated with phototherapy when SBR (serum bilirubin) was 10mmol/l below treatment threshold. Initial plan was for the family to go home and attend the next day for a repeat SBR. There were no other risk factors for this baby.

Babies with weight loss:

- **Baby 1** initial weight loss of 10% day 3 then static for next two weights followed by large loss. Mixed feeding on admission, via bottle, vomiting after feeds. Shown paced feeding and volumes required calculated. Out of area community care.
- **Baby 3** admitted for reduced urine output. Weight loss in community 11.9% however on admission was 9.1% and sodium normal. Feeding plan introduced.
- **Baby 4** attended ward for jaundice, no treatment required, however mother concerned about feeding, sodium taken with SBR (serum bilirubin) and raised. Stayed for feeding support.
- **Baby 6** lethargic and not feeding well, sleepiness increased and commenced on antibiotics.
- **Baby 7** weight loss in community 11.3% day 3, feeding plan implemented but no follow up weight as per guidance on day 4.

- **Baby 9** excellent weight gain next day, however stayed two further nights for feeding support.
- **Baby 10** fully formula fed, weight in community prior to admission inaccurate, loss only 10.6%, sodium normal, out of area community care.

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

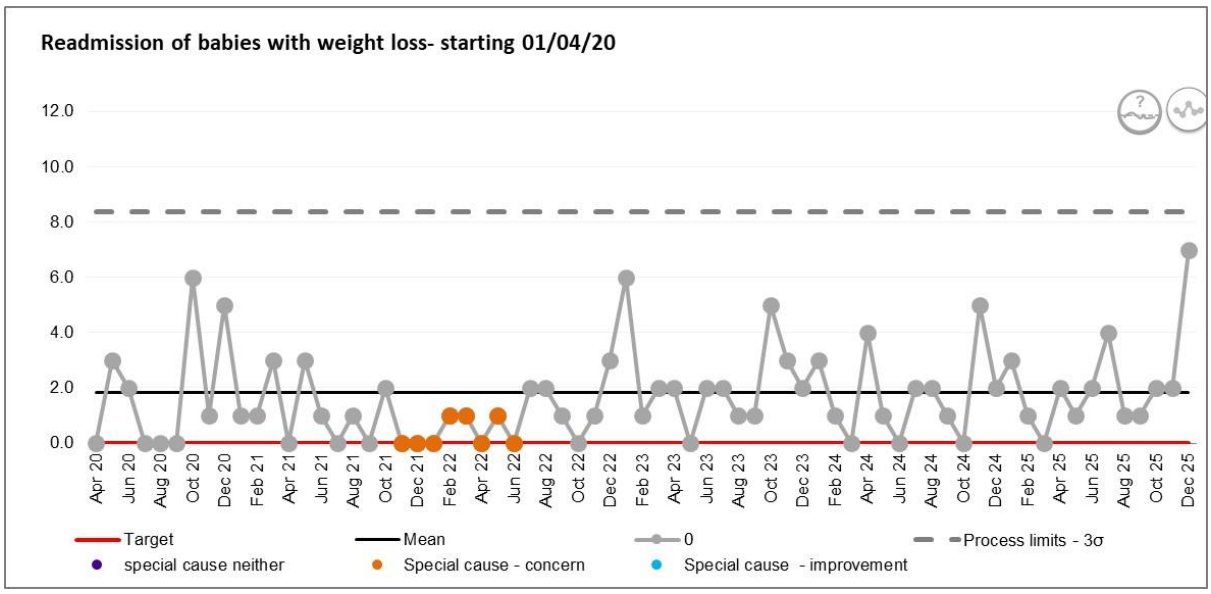


Chart 2 SPC chart for readmissions with jaundice

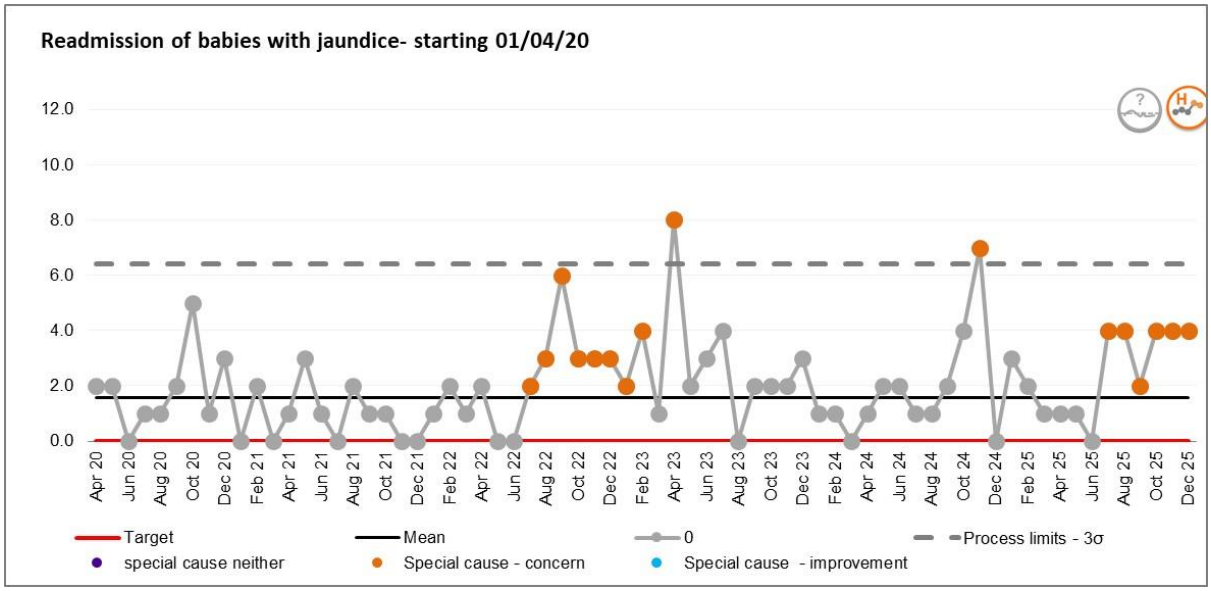
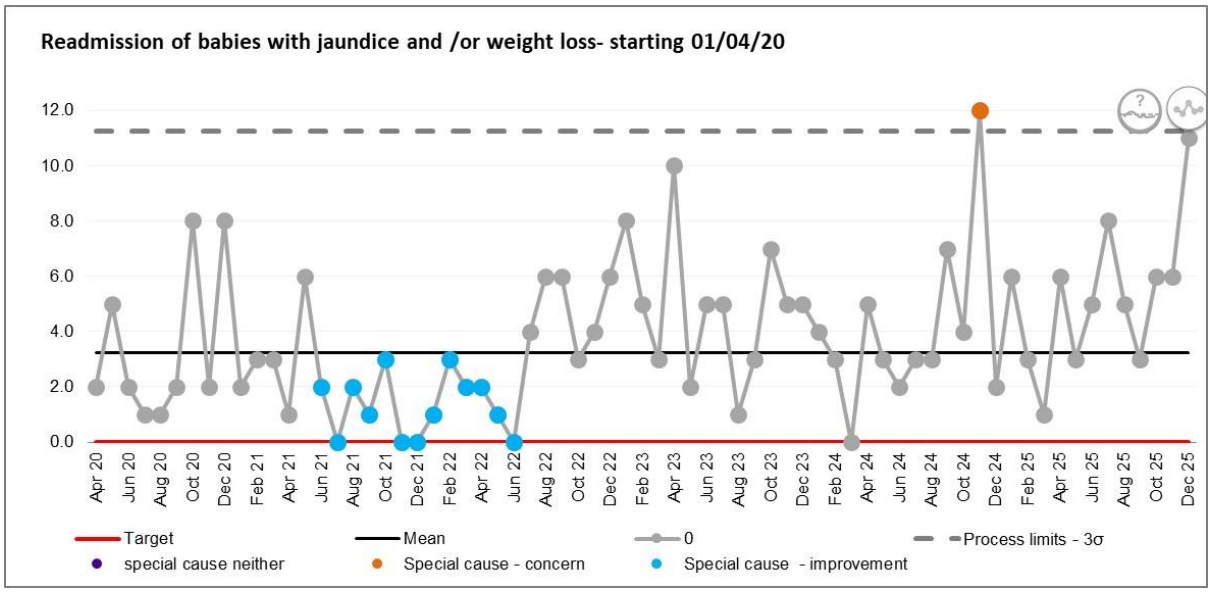


Chart 3 SPC chart including *all* babies readmitted for jaundice and/or feeding issues



Findings Summary

During Quarter 3, twelve babies were readmitted to Pannal Ward or SCBU due to jaundice and eleven due to feeding issues. Due to the above-mean trend in jaundice related readmissions identified this quarter, a deep dive will be undertaken to explore causative factors and identify potential preventative measures (see action plan 1.8). All cases are reviewed individually, and an action plan is in place.

Recommendations

Action plan

Recommendations from datix review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date	Comments
Review current practice to ensure all preventable measures to reduce readmissions of babies with jaundice have been identified and implemented	Review a cohort of babies previously admitted, and all new admissions over the next two quarters • Agree the data set to be collected, including a more comprehensive review of maternal history, and adapt the current proforma accordingly • Utilise previously collected data, alongside data from ongoing readmissions, to inform the analysis • Submit a report of findings to MRMG for review and discussion	Infant Feeding Co-ordinator Lead Midwife for Safety, Quality & Clinical Governance	**Dec 2026**	Jan 2026 Proforma adapted – Data set to be agreed at neonatal obstetric meeting
Ensure NICE guidance and local policies on newborn jaundice are followed	Refresher for midwives, neonatal nurses and paediatricians • NICE guidance on when to commence phototherapy including risks • Not relying on visual assessment to assess level of jaundice • Daily weight when being treated with phototherapy	Infant Feeding Co-ordinator	**Jan 2026**	
Ensure weight loss guidance is followed	• Write a newsletter for staff to support weight loss guidance • Write supporting guidance for babies with further weight loss following day 3 • Ensure out of area Trusts have HDFT guidance • Discuss admissions that may not be required and length of stays at neonatal obstetric meeting	Infant Feeding Co-ordinator	**Feb 2026**	

	• Individual feedback to be continued			
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 Badger Net 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.	Lead Midwife for Safety, Quality & Clinical Governance	**Completed**	'Learning from incidents' newsletter sent to all staff
Avoid overnight stays for babies with weight loss that have normal blood test results	• Explore cost of purchasing a hospital grade double breast pump to loan to parents overnight to help with feeding plan. • 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.	Infant Feeding Co-ordinator	**Completed**	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	• Arrange meeting with the Paediatric clinical lead for postnatal and	Neonatal Clinical Lead	**Completed**	October 2024: Draft SOP completed.

for babies readmitted with weight loss.	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. • Update guideline to reflect outcomes of decisions made at meeting. • Communicate updated guideline to staff. • Ensure training includes updated guidance.	Infant Feeding Co-ordinator		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	• 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. • Train all midwives in care of late preterm babies • Develop an information package for parents. • Ensure any changes to care are included in appropriate guidelines	Infant Feeding Co-ordinator Neonatal Educator and Governance Lead	**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	• Arrange dates to meet with community midwives • Share good practice and discuss individual cases where care could possibly be improved • Develop plans of care for static weight / weight loss following introduction of a feeding plan	Infant Feeding Co-ordinator Community Team Leader	**Completed**	

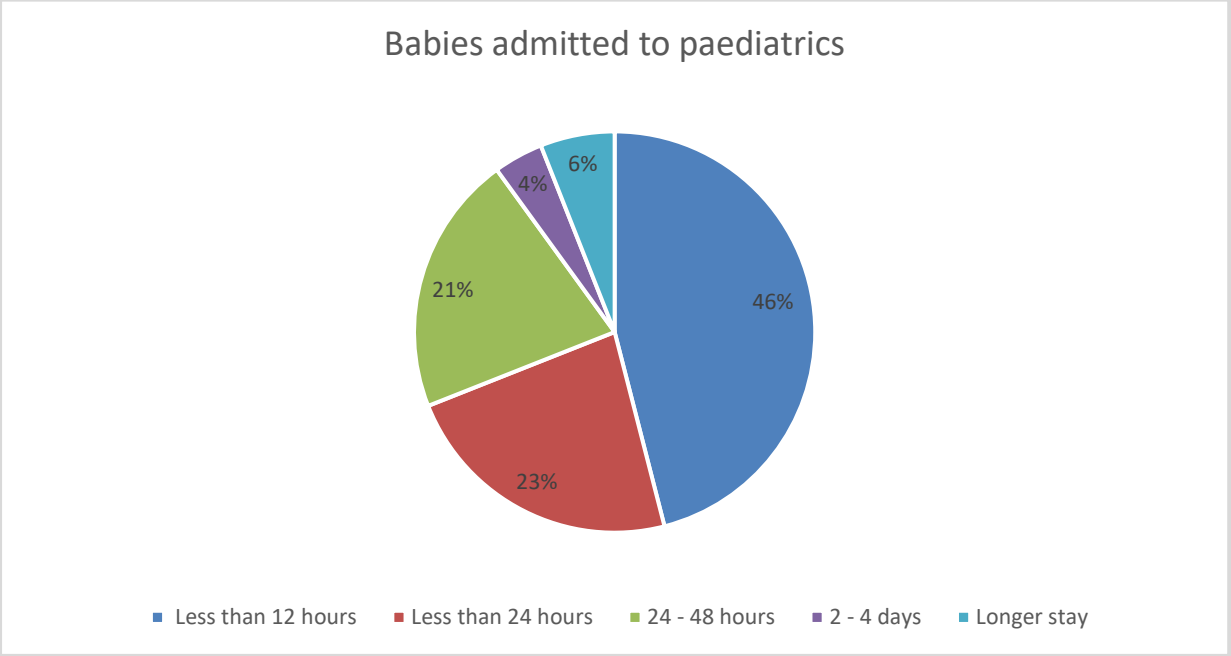
Readmissions to paediatrics

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 Woodland's ward as appropriate.

Paediatric readmission data

A total of 52 babies, with an age range between 2 and 27 days, were admitted for a variety of reasons during this quarter. 24 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.



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.

Harrogate and District NHS Foundation Trust

Final Report for the Maternity Incentive Scheme – Year 7

Trust Board

January 2026

Title:	Final Report for the Maternity Incentive Scheme – Year 7
Responsible Director:	Breeda Columb, Executive Director of Nursing, Midwifery & AHP's
Author:	Leanne Likaj (Associate Director of Midwifery and Children's Services), Sam Layfield (Operations Director) Kat Johnson (Clinical Director)

Purpose of the report and summary of key issues:	The purpose of this report is to detail the status of compliance against the ten Maternity Incentive Scheme safety actions and to highlight areas of potential non-compliance.	
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		
Report History:	Quality and Governance Management Group Quality Committee Senior Management Team - SDR Maternity Risk Management Group Safety Champions Meeting	
Recommendation:	Board are asked to review the evidence submission, note the compliance position against each of the standards and agree declaration of non – compliance due to a breach in Safety Action Four.	

Final Report for the Maternity Incentive Scheme – Year 7

1.0 Executive Summary

This report details the standards required to demonstrate full compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year seven.

2.0 Introduction

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.

This report provides detail of position and progress with compliance with the ten maternity safety actions.

3.0 Proposal

Trust Board is asked to review the evidence submitted, note the information provided in the report and discuss if sufficient assurance is gained to satisfy all of the requirements of the Maternity Incentive Scheme – year seven.

4.0 Quality Implications and Clinical Input

This report provides information on position and progress with compliance with the ten maternity safety actions.

5.0 Equality Analysis

An equality analysis has not been undertaken

6.0 Risks and Mitigating Actions

The MIS is a self-certification scheme, with all scheme submissions requiring sign-off by Trust Boards and ICBs following conversations with trust commissioners.

All submissions also undergo an external verification process and are sense-checked by the Care Quality Commission (CQC).

7.0 Recommendation

The Board is recommended to declare **non-compliance** with the Maternity Incentive Scheme Year Seven Standards.

The Board is required to give their permission to the CEO to sign the Board declaration form, and action plan, prior to submission to NHS Resolution.

Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in order to confirm compliance. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering either 2024/25 financial year or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration.

Maternity Incentive Scheme – Year Seven

Introduction

The Maternity Incentive Scheme (MIS) incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the Clinical Negligence Scheme for Trusts (CNST) maternity incentive fund.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution. The balance of unallocated funds will be shared with the trusts who have achieved all ten safety actions.

Full guidance regarding the required standards can be found at https://resolution.nhs.uk/wp-content/uploads/2025/04/MIS-Year-7-guidance.pdf

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

- MBRRACE-UK data (safety action 1 standards a, b and c).
- NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).
- Maternity and Newborn Safety Investigations (MNSI) will cross-check the National Neonatal Research Database (NNRD) and NHS Resolution will cross-check the NHS Resolution database for qualifying MNSI and Early Notification (EN) incidents reportable (safety action 10) and externally verify that standards A and B have been met in the relevant reporting period. In addition, for standards B and C (i) there is a requirement to complete the field on NHS Resolution's Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement. Completion of this will also be monitored and externally validated

Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year

The evidence for each Safety Action can be found in the following location - 2025

Safety Action One

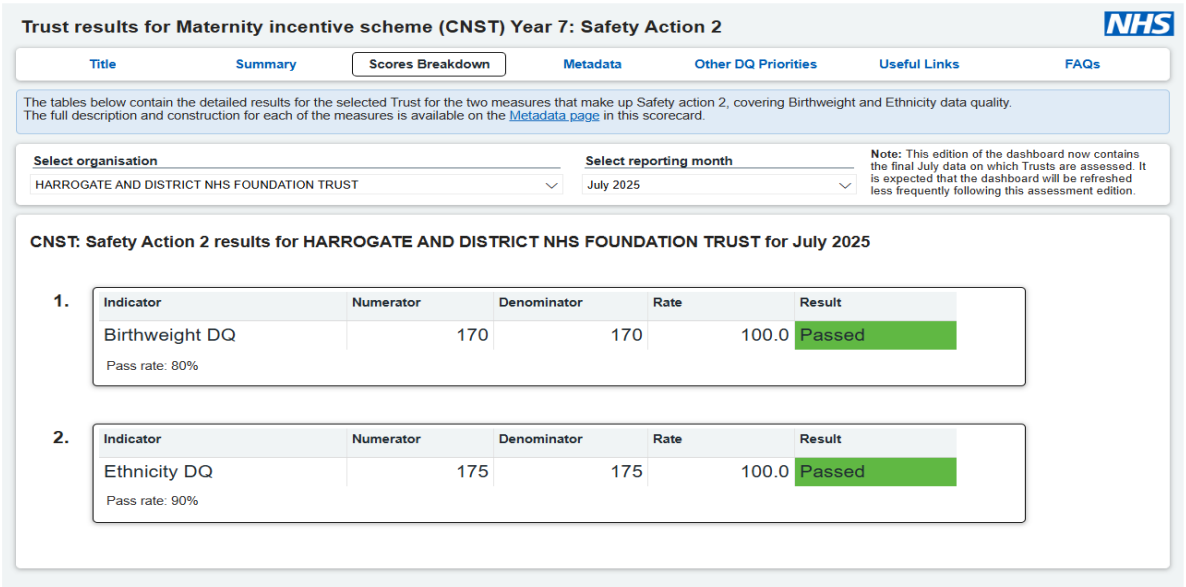
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?		***Required standard –*** ***Pages 11-12 and 29-36 of Maternity Safety Incentive Scheme Document*** ***Recommendation – Compliant***

a) All eligible perinatal deaths have been notified to MBRRACE-UK within seven working days.
b) Parents have been 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 100% of the time.
c) The multi-disciplinary team always review the care within two months using the perinatal mortality review tool (PMRT), and all reports are published within six months. An external member is always present at the multidisciplinary review panel meeting.
d) Quarterly reports of reviews of all deaths are discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis, which include action plans, within the Strengthening Maternity and Neonatal Safety Board Report.

Safety Action Two

2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		***Required standard –*** ***Pages 13 and 37 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

July 2025 data contained a valid birthweight for 100% of babies born in the month and a valid ethnic category (Mother) for 100% of women booked in the month.



Trust results for Maternity incentive scheme (CNST) Year 7: Safety Action 2

Title | Summary | Scores Breakdown | Metadata | Other DQ Priorities | Useful Links | FAQs

The tables below contain the detailed results for the selected Trust for the two measures that make up Safety action 2, covering Birthweight and Ethnicity data quality.
The full description and construction for each of the measures is available on the Metadata page in this scorecard.

Select organisation: HARROGATE AND DISTRICT NHS FOUNDATION TRUST
Select reporting month: July 2025

Note: This edition of the dashboard now contains the final July data on which Trusts are assessed. It is expected that the dashboard will be refreshed less frequently following this assessment edition.

CNST: Safety Action 2 results for HARROGATE AND DISTRICT NHS FOUNDATION TRUST for July 2025

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	170	170	100.0	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	175	175	100.0	Passed

Pass rate: 90%

Safety Action Three

3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?		***Required standard –*** ***Pages 14 and 38 - 39 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

A Transitional Care pathway is in place on to reduce separation of mums and babies born between 35+0 and 35+6 weeks however a pathway is not in place for babies born from 34+0 as is required. Babies born below 35+0 weeks ae currently admitted to Special Care Baby Unit (SCBU) to ensure all appropriate care is provided. Babies admitted to Transitional care on Pannal Ward are reviewed on a daily basis by a paediatrician. Joint maternity and neonatal reviews are in place. An action plan detailing the Quality Improvement Projects is in place and progressing to improve care and extend the gestational boundary to include babies born below 35+0. A patient information leaflet has been developed and is in use for parents, and babies receiving Transitional Care are now more easily identifiable by use of door and cot labels on both Pannal and SCBU.

Safety action 4

4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		***Required standard –*** ***Pages 15-17 and 40-46 of Maternity Safety Incentive Scheme Document*** ***Recommendation –*** ***Non-Compliant***

The Maternity Incentive Scheme requires the following criteria to be met for any medical staff -

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a) currently work in their unit on the tier 2 or 3 rota or

b) have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or

c) hold a certificate of eligibility (CEL) to undertake short-term locums.

On 12-13th April 2025 and 13th July 2025 a short-term sickness gap was covered by a regional trainee who, although known to the consultant body, had not worked in the unit within the last five years and did not hold a CEL.

This constituted a breach of MIS safety criteria. Maternity Incentive Scheme Technical Guidance states –

Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?

No. An action plan must be developed to prevent this happening in the future, but Trusts would still need to declare non-compliance with this action.

No safety concerns arose as a result of this non-compliance, and the MIS requirements have since been clarified and re-circulated to all colleagues involved in rota management to ensure full compliance going forward. An action plan is required to be submitted to NHS Resolution alongside the compliance submission. The action plan confirms the actions taken and the plan to also explore ensuring the Regional rotational doctors are made aware of the RCOG Certificate of Eligibility requirement and supported to complete this process.

The Obstetric medical workforce is in line with RCOG guidance in relation to long term locums and a guideline is in place to implement compensatory rest.

The audit of compliance with consultant attendance for the clinical situations listed in the RCOG workforce document demonstrated 81.2% compliance with 11 out of 16 cases where a consultant must be present, and 100% compliance with 72 cases where a consultant must attend of be immediately available if the staff on duty have not been assessed as competent. The audit in relation to this is presented in Appendix A.

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

British Association of Perinatal Medicine (BAPM) standards are not met for neonatal medical and neonatal nurse staffing and an action plan is in place. Harrogate Special Care Baby Unit (SCBU) do not have a supernumerary shift co-ordinator on every shift however there is a Band 7 Unit Manager on site Monday - Friday 08:00 - 16:00 to support shift responsibilities. Cross cover is also provided from co-located Paediatric ward in event of unwell baby being born.

For the neonatal medical workforce there currently is one in seven on the Tier 3 doctors rota (rather than one in eight) however there is cover for the unit 24 hours a day.

A neonatal staffing report and action plan are available in the evidence folder to demonstrate full compliance with this safety standard for neonatal medical and nursing staff.

Safety action 5

5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		***Required standard –*** ***Pages 18-19 and 47–48 of Maternity Safety Incentive Scheme Document*** ***Recommendation – Compliant***

Midwifery staffing establishment is calculated using BirthRate plus. An updated establishment calculation was completed in August 2024. The maternity budget was adjusted in line with this in April 2025. There is a supernumerary Labour Ward Co-ordinator rostered for every shift and this is ensured to be in place at the start of every shift. Women receive one to one care in active labour. The bi-annual midwifery staffing report demonstrating compliance was submitted to the Board May 2025 and November 2025 and is available in the evidence folder.

Safety action 6

6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		***Required standard –*** ***Pages 20-21 and 49 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

Harrogate maternity services have demonstrated progress in achieving compliance with all six elements Saving Babies Lives Care Bundle version three. Progress and detailed conversations have occurred at three quarterly quality improvement discussions with the ICB/LMNS. Work is ongoing to sustain and embed the actions. The compliance report has also been shared with Trust Board. The most recent compliance review meeting occurred in November and the Trust's overall compliance had increased from 88% (Q1 25-26) to 93% (Q2 25-26), there was evidence of improvements with meeting ambitions following the implementation of previous improvement actions.

The LMNS stated that the evidence submitted was of a high quality and there was evidence through the elements of sustained improvement where high levels of reliability had already been achieved.

Safety action 7

7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users		***Required standard –*** ***Pages 22-23 and 50-51 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

The Maternity and Neonatal Voices Partnership (MNVP) works closely with maternity service leaders and service users to co-produce services and review service provision. The MNVP engages with the local community and prioritises hearing the voices of those with the worst outcomes. Terms of reference are in place showing the MNVP Lead as a member at maternity safety and governance meetings.

Infrastructure for the MNVP is in place although concerns have been raised by West Yorkshire and Harrogate Local Maternity and Neonatal System (WYH LMNS) MNVP Lead to the WYH LMNS Board regarding whether the funding across WYH LMNS is sufficient to ensure appropriate training and support are in place to enable the MNVP Lead to be a quorate member of the Perinatal Mortality Review Meeting. Escalation within the Trust and to the LMNS has also occurred as required. Humber and North Yorkshire LMNS consider the funding and support in place to be sufficient.

Harrogate MNVP have engaged with the local community and prioritised hearing from those experiencing the worst outcomes.

The annual CQC Maternity Survey free text data has been reviewed with the MNVP Lead and an action plan is in place.

Safety action 8

8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? 90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal Life Support Training		***Required standard –*** ***Pages 24 and 52 – 56 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**

Over 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring. Over 90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day that includes maternity emergencies. At least one emergency scenario is conducted in a clinical area as part of each emergency training day. Over 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Resuscitation Council UK (RCUK) Newborn Life Support (NLS) course. Registered Resuscitation Council UK trained instructors deliver the local NLS courses and the in-house neonatal basic life support annual updates. All neonatal staff undertaking responsibilities as an unsupervised first attender / primary resuscitator attending any birth have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework. An SOP is in place to ensure that there is an up-to-date RCUK trained member of staff present at each neonatal resuscitation event.

Safety action 9

9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?		***Required standard*** ***Pages 25-26 and 57 –63 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**

All Trust requirements of the Perinatal Quality Surveillance Model are fully embedded and have been updated to reflect the requirements of the Perinatal Quality Oversight Model (PQOM).

Discussions regarding safety intelligence take place at the Quality Committee and Trust Board, presented by a member of the Perinatal Leadership Team, and this includes ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient

Safety Incident Response Framework (PSIRF) and demonstrate evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

There is a visible Maternity and Neonatal Board Safety Champion (BSC) and non-executive Board Safety Champion who are able to support the perinatal leadership team in their work to better understand and craft local cultures. Board Safety Champions meet with the Perinatal Leadership Team and the MNVP lead bi-monthly and progress with the maternity and neonatal culture improvement plan is being monitored and supported as required.

On-going engagement sessions with staff occur bi-monthly and progress against actions in relation to any concerns raised are visible to staff.

The Trust's NHS Resolution claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level meeting.

Safety action 10

10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025		***Required standard –*** ***Pages 27 and 64-67 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**

There has been one qualifying case from 1 December 2024 to 30 November 2025 which has required reporting to MNSI. This case was reported within the required timescales, Duty of Candour was followed and the family were provided with information regarding the role of MNSI and NHS Resolution Scheme.

Conclusion

This report provides the information required to demonstrate HDFT's level of compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year seven.

The Trust Board need to be satisfied that the information within this report and evidence folder satisfies these requirements prior to final sign off by the Chief Executive and submission to NHS Resolution by 12 noon on 3rd March 2026. Due to the non-compliance with Safety Action Four it is recommended to declare non-compliance overall and the required action plan is included in the below document.

MIS_SafetyAction_Year7_Protected_V9 (2).:

Appendix A

TO ENSURE COMPLIANCE WITH DATA PROTECTION, COMPLETED REPORTS MUST NOT BE SHARED EXTERNALLY WITHOUT PERMISSION FROM THE CLINICAL EFFECTIVENESS TEAM (HDFT.CLINICALAUDIT@NHS.NET)

Planned and Surgical Care

Maternity

Consultant Attendance in Clinical Situations 2025

Project Sponsor(s):		**Leanne Likaj, Rachael Tabram**	
Report Author(s):		**Dr Saima Abid (Specialty Doctor) O&G**	
Draft Report Distributed to:	**Andy Brown**	Date:	5/11/25
Final Report Distributed to:	**Andy Brown**	Date:	13/11/25

QUALITY ASSURANCE CHECKLIST (to be completed by the Project Lead(s))	
• Does final report include 'Key Successes & Concerns'?	**Yes ☒** **No ☐**
• Does final report include 'Recommendations'?	**Yes ☒** **No ☐**
• Does final report include an 'Action Plan'?	**Yes ☒** **No ☐**
Please note that a report cannot be considered "complete" until the items above are submitted	

Contents

1. INTRODUCTION

The RCOG produces workforce guidance as an aid to good clinical practice. It presents recognised methods and techniques for clinical practice, based on published evidence, for consideration by obstetricians/gynaecologists and other health care professionals. It is committed to supporting the delivery of high-quality women's healthcare and has developed a range of resources to inform and support healthcare professionals.

The RCOG 2021 document "Roles and Responsibilities of the Consultant" identifies the need for the consultant to 'promote positive team working, good information flow and clinical prioritisation'. It also identifies the link between shallow authority gradients and psychological safety, key to staff feeling able to raise concerns and learn from events.

As the most experienced clinician, consultants are now often needed to be physically present, including out-of-hours, to support the care of more complex women or during high levels of activity. It is not unusual for a clinician whose primary role is gynaecology to be the most experienced clinician on labour ward and be required to attend a complex emergency. There is a need for O&G consultants who provide out-of-hours cover for both obstetrics and gynaecology to continue to develop post CCT/CESR and maintain their skillset across both modalities. This particularly applies to less common emergency obstetric scenarios as these are time-critical situations where the confidence, skillset and support of the attending consultant will often define the outcome.

As well as this, the "Towards Safer Childbirth" document arose from continuing concerns in a number of areas about the quality of care that women and their babies were receiving during labour and birth. The RCOG had worrying evidence that, in some circumstances, consultant obstetricians did not see the labour ward as a part of their regular duties and so the care of women with potential or actual serious conditions fell below an acceptable standard.

The document describes the role of the consultant obstetrician on the labour ward as 'to ensure a high standard of care for women and their babies with complex medical or obstetric needs and to be available for the acute, severe and often life-threatening emergencies which are a feature of obstetric practice.'

All consultant obstetricians who work on the labour ward should:

- Provide clinical leadership and lead by example
- Train and educate staff in a multidisciplinary team
- Ensure effective teamwork
- Develop and implement standards of obstetric practice and have a major role in risk management
- Bring experience to clinical diagnosis and opinion
- Audit the effectiveness of practice and modify it as required

2. CURRENT PROCESS

The on-call consultant is responsible for covering obstetrics and gynaecology, including labour ward and is expected to be resident on site during the following hours:

Monday – Friday 08:00 – 20:30h

Saturday/Sunday 08:00 – 12:00h & 20:00 – 20:30

Each morning begins with a thirty minute multi-professional handover, followed by a ward round. It is expected that the ward round will include a consultant review of all high risk obstetric patients on labour ward, all obstetric antenatal patients, any postnatal readmissions and any gynaecology non-elective admissions. Elective gynaecology patients may be

reviewed by the consultant of care or the middle grade on call, with the on call consultant reviewing where there are clinical concerns. Any staffing concerns should be discussed during the handover and it is the responsibility of the consultant on call to ensure appropriate contingency plans are made where there is staff absence. If the on call consultant is expected to change during the on call period, any contingency plans should be relayed to them as soon as known.

The multi-professional evening handover occurs at 20:00–20:30h. As a minimum a consultant review of all high risk patients on labour ward, any new postnatal readmissions and any new gynaecology admissions should occur before the consultant goes home. The consultant may choose to undertake the reviews before the ward round due to time constraints. This will ensure that all new admissions, antenatal, postnatal and gynaecological are reviewed by a consultant within 14 hours.

Where possible, the same consultant will be on call for the whole 24 hours. Where this is not possible, the incoming consultant must come to labour ward and undertake a ward round of any high risk patients. The on call consultant should be immediately available to offer advice and supervision of the junior medical staff. The on call consultant may sometimes change during the day, and it is expected that the incoming consultant comes to the labour ward and undertakes a 'board round' and sees any patients as necessary.

At the weekend, the on call consultant should undertake a morning ward round in person each morning and is expected to be resident between the hours of 08:00 and 12:30h. The exception to this would be where the on call consultant has been in after midnight and may need to take compensatory rest. Where this occurs, the consultant is responsible for ensuring appropriate delegated review of patients occurs and any concerns are appropriately escalated pending consultant presence on site. The frequency of subsequent ward rounds/ telephone rounds will depend on the level of activity in the unit.

The on call consultant is required to stay within 30 minutes of the hospital during the on call period. The following clinical conditions should be discussed with them:

- Fetal distress requiring delivery in theatre (trial of operative delivery or caesarean section)
- Failure to progress (delayed progress in labour) requiring delivery in theatre
- Fetal distress where a third fetal blood sample is being considered
- Significant/ ongoing antepartum haemorrhage
- Severe pre-eclampsia
- Sepsis
- Multiple pregnancy in labour
- Malpresentation in labour e.g. breech
- Preterm labour less than 34 weeks gestation
- Threatened preterm labour less than 34 weeks gestation
- Any other cause for concern

Usually the second on call doctor (middle grade) will liaise with the consultant on call. However, where this is not possible or where the midwifery staff have concerns it is appropriate for any member of the medical or midwifery staff to call the consultant directly.

In the following situations the consultant must attend in person (*Adapted from roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG 2021)*:

Situations in which the consultant MUST attend in person
General
In the event of high levels of activity (e.g. a second obstetric theatre being opened or unit closure due to high levels of activity requiring consultant input)
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
Obstetrics
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU/ITU care is likely to become necessary
Caesarean birth for major placenta praevia/abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <32 weeks
Caesarean section for premature twins <32 weeks
Vaginal twin delivery – consultant to be present for delivery
Vaginal breech birth
4th degree tear repair
Unexpected stillbirth – antepartum or intrapartum
Eclampsia
Maternal collapse (e.g. septic shock, massive abruption)
PPH > 2L where the haemorrhage is continuing and massive obstetric haemorrhage protocol has been instigated

In the following situations the consultant should attend in person or be immediately available if the Second on call (middle grade) doctor on duty has not been assessed as competent; usually by OSATs where available (*Adapted from roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG 2022):*

Situations in which the consultant MUST attend in person, unless the most senior doctor present has documented evidence as being signed off as competent
General
Any patients in obstetrics OR gynaecology with and EBL >1.5 litres and ongoing bleeding
Obstetrics
Trial of instrumental birth
Caesarean birth at full dilatation
Caesarean birth for women with a BMI >40
Caesarean birth for transverse lie
Third degree tear repair

*note in these situations the consultant should attend the hospital in case of urgent obstetric cases even if not needed to supervise in the gynaecology theatre.

3. OBJECTIVES

This re-audit is designed to assess compliance with consultant attendance in clinical situations between 1st April 2025 and 30th June 2025 at Harrogate Hospital.

4. METHODOLOGY

The Electronic Birth Register (Badgernet) identified how many babies were born between 1st April 2025 and 30th June 2025 at Harrogate Hospital. From this, it was then possible to identify births in which consultant attendance should have been compulsory. Additionally, DATIX submissions for unit closures and Badgernet maternity records were reviewed.

5. RESULTS

5.1. Clinical situations in which a consultant must attend

5.1.1. Event of high levels of activity (second theatre or unit closure where obstetric input required)

There were five instances when the unit was closed during the timeframe. **All** of these were discussed with and agreed upon by the consultant on call. Consultant was not required as obstetric input was not needed.

There was no occasion when a second theatre needed to be opened in this timeframe.

5.1.2. Any return to theatre for obstetrics or gynaecology

The were no cases requiring return to theatre in this period.

5.1.3. Caesarean birth for major placenta praevia/abnormally invasive placenta

During the time scale, there were no planned caesarean sections performed for placenta praevia. However, two undiagnosed placenta accrete were identified and the on-call consultant attended for both.

5.1.4. Caesarean birth for women with a BMI over 50

There was one elective caesarean section with BMI >50 in the timeframe which was done by a senior SAS grade who was acting in consultant capacity, so this was appropriate.

5.1.5. Caesarean birth below 32 weeks or Caesarean for preterm twins below 32 weeks

There were two caesareans with gestations of less than 32 weeks, both were singleton pregnancies, assisted by consultants.

5.1.6. Vaginal twin delivery

There was one set of twins delivered vaginally. A consultant was present at the time of delivery.

5.1.7. Vaginal breech birth

There was one vaginal breech birth (singleton pregnancy) in the timeframe. A consultant was present. The second twin was delivered by the consultant.

5.1.8. Fourth degree tear repair

There were no fourth degree repairs in the timeframe.

5.1.9. Unexpected stillbirth

There was one antepartum stillbirth and the consultant was present.

5.1.10. Eclampsia

There was one case of severe pre-eclamptic toxaemia (PET) where magnesium sulphate was started after discussion with a consultant on phone: no cases of eclampsia.

5.1.11. Maternal Collapse

There was no maternal collapse (cardiac arrest) during the timeframe.

5.1.12. Estimated blood loss over 2000ml or ongoing bleeding

There were eight cases in Badgernet with over 2000ml of blood loss. In four of these, a consultant was present while the bleeding was ongoing. In two out of four, the consultant was informed, and the blood loss had settled. In both of these two registrars were present, one of them was a senior registrar.

In one case, it is documented that registrar and consultant were busy in gynae theatre when the registrar was pulled from there. Consequently, it is likely that the consultant was aware but unable to attend due to being busy with other case. A consultant anaesthetist was present.

In another case, the registrar involved had worked as a consultant previously so was considered acceptable that the consultant was not called as the case was being appropriately managed.

5.2. Clinical situations in which a consultant must attend or be immediately available if the middle grade on duty has not been assessed as competent

5.2.1. Any patients in obstetrics OR gynaecology with and estimated blood loss (EBL) over 1.5 litres and ongoing bleeding

There were eight patients (excluding over 2 litre PPH which has already been discussed) who had blood losses over 1.5 litres. In six cases, a consultant attended. In the remaining cases, the bleeding was controlled either pharmacologically or following suturing.

5.2.2. Trial of instrumental birth

There were 41 trials of rotational instrumental deliveries during the time frame which were performed by doctors who are signed off, or by the consultant.

Seven of these resulted in caesarean section. Of these seven, the consultant was present at three. In one, the consultant was asked to attend whilst not on-site due to difficult extraction of baby. In three of the cases there is no documentation of consultant presence but was informed afterwards.

5.2.3. Caesarean birth at full dilatation

There were nine caesarean sections performed at full cervical dilatation (or caesareans performed in the second stage, as recorded in Badgernet). A consultant was present for six of them, and rest were performed by a competent middle-grade doctor.

5.2.4. Caesarean birth for women with Body Mass Index (BMI) over 40

Seven women were identified as having a caesarean birth with a BMI >40. Four of these cases were performed by a consultant. In the remaining three, a consultant was present, or the procedure was performed by a competent middle-grade doctor.

5.2.5. Caesarean birth for transverse lie

There were no caesarean births for transverse lie in the time frame.

5.2.6. Third degree tear repair

There were seven third degree tear repairs, all performed by doctors competent in the procedure or in the presence of a consultant assisting.

6. CONCLUSION AND KEY SUCCESSES/CONCERNS

- The findings out this audit are positive with almost all women being seen by the appropriate medical staff considering the risk factors during labour.
- 16 cases required a consultant present, and on 11 of these occasions this was the case.
- In the two out of four cases where consultant did not attend with blood loss over 2000ml, the blood loss had settled and the consultant was contacted. One case had no documentation of consultant present, and in another case the consultant was busy with an acute gynae case and unable to attend.
- The four cases of PPH >2 litre mentioned above have been reviewed again subsequently and the clinical opinion was that these cases were not inappropriately managed without consultant. Obstetric knowledge and the most

senior personnel were present and able to effectively manage the PPH. The consultant not being present had no detrimental impact on the patient's care and safety.

- Caesarean section with BMI over 50 was an elective procedure done by a senior SAS grade who was acting in consultant capacity, so this was appropriate.
- All five unit closures had documentation demonstrating consultant presence or communication.
- It is also worth highlighting that in many cases where a doctor had been assessed as competent, there was also a consultant present too. This shows a willingness of consultant attendance when requested but not necessarily required – demonstrating effective working relationships and good patient care.
- A total of 72 clinical situations in which a consultant must attend or be immediately available if the middle grade on duty has not been assessed as competent were identified during this audit time period.

Criteria	Expected level of performance	Actual level of performance
Clinical situations in which a consultant must attend	100%	81.2%
Clinical situations in which a consultant must attend or be immediately available if the middle grade on duty has not been assessed as competent	100%	100%

7. RECOMMENDATIONS

- Ensure documentation of all names which are present in the labour room and not referring to individuals as their job titles. This enables us to clearly see on review whether consultant attendance was required
- Disseminate results to all staff.
- Ensure that second on call doctors are aware of the clinical situations when a consultant must be present, and that if there is any variation from this, that there is adequate documentation to demonstrate the discussion and decision-making process.

8. ACTION PLAN

Project Title: Consultant Attendance in Clinical Situations Audit 2025

Project Lead: Rachel Tabram

Project Sponsor: Leanne Likaj

Action Plan Monitoring Group / Owner: Rachel Tabram

Issue no:	Issue / Audit Finding / Theme	Recommendations - Action/s	Person Responsible	Target Date	Progress on actions
1	Disseminate results of audit	Share at next audit meeting	Rachel Tabram	October 2025	Completed
2	Ensure documentation of names present in labour room	Liaise with Delivery Suite Manager about recording of names on room whiteboards	Rachel Tabram	November 2025	Completed
3	Ensure awareness of criteria	Reinforce awareness to all second on-call doctors of indications for consultant presence and ensuring clear documentation of any deviation	Obstetric Governance Leads	November 2025	Completed

Section B : Action plan details for Harrogate and District NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Please refer to the guidance sheet to ensure correct entries into the action plan: Return to Guidance Sheet

Action plan 1

Safety action	Q4 Clinical workforce planning	**To be met by**	Q2 = 2026/27

Work to meet action	*Communications to be sent to all Tier 2 and 3 Doctors regionally regarding requirement for a Certificate of Eligibility to be gained prior to wor locum shift.* *Increased awareness of team and rota co-ordinator of RCOG and Maternity Incentive Scheme requirement for the employment of short term*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Claire Harding*
Lead executive director	*Breeda Columb*
Amount requested from the incentive fund, if required	*£0*
Reason for not meeting action	*All shifts met MIS requirements, with the exception of three shifts. A short term sickness gap was covered by a regional trainee who, althoug the consultant body, had not worked in the unit within the last five years and didn't have a certificate of eligibility to locum from the RCOG. Th constituted a breach of MIS safety criteria. The incident was identified, no safety concerns arose, and the MIS requirements have since beer*
Rationale	*The Trust had previously had six years of compliance with this metric. Significant changes are not required to ensure compliance going forw*
Benefits	*As above.*
Risk assessment	*If doctors are allocated shifts who are not compliant with RCOG/MIS criteria there could be a risk to patient safety as referenced in the RCO and further to concerns raised by Coroner's Regulation 28 reports nationally. In this instance safe services were maintained by ensuring that was a regional trainee and therefore provided regionally with the same training, pre-employment checks and induction as the trainees workir*

	How?	**Who?**	**When?**
Monitoring	Rota co-ordinator with oversight from Service Manager	Service Manager	Weekly review of any doctor rota gaps and planned cover.

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safe* *Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safe* *Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safe* *Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safe* *Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safe* *Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safe* *Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safe* *Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safe* *Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

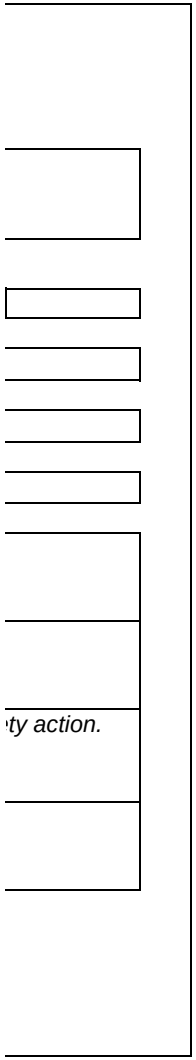
Action plan 10

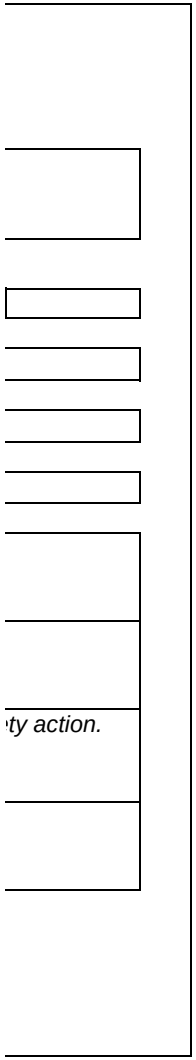
Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safe* *Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

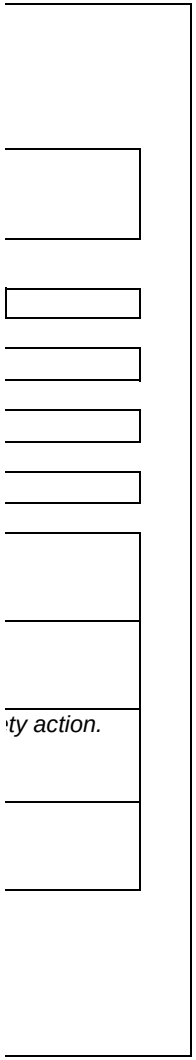
	How?	**Who?**	**When?**
Monitoring			

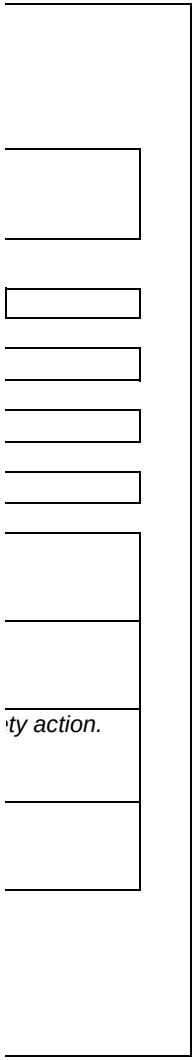
olution

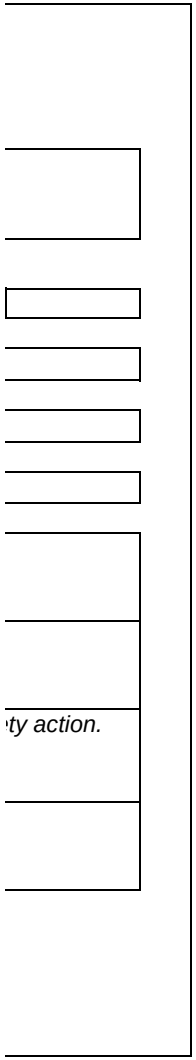
king a locums.
Yes
.00
h known to is clarified ard.
G guidance t the locum ng within the

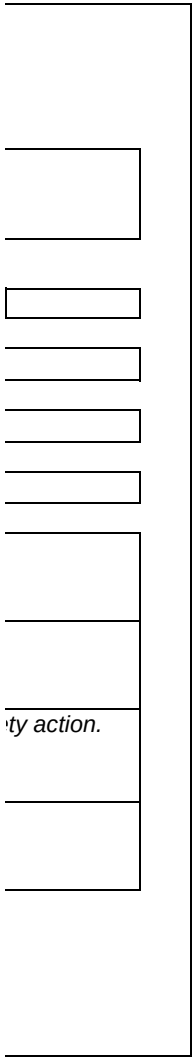

ty action.

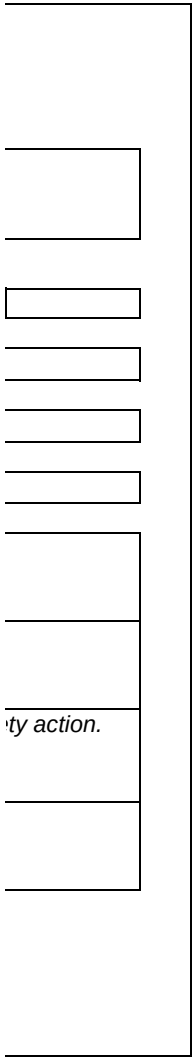

ty action.

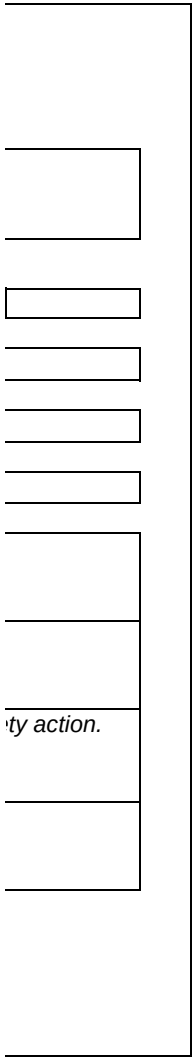

ty action.

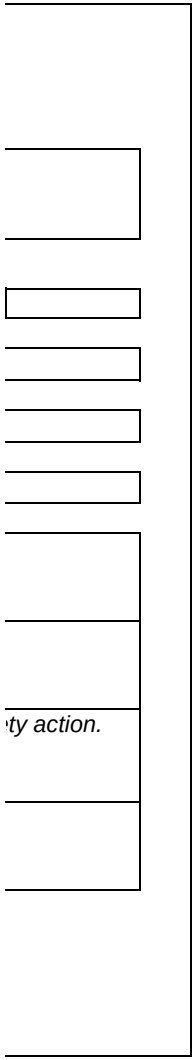

ty action.


ty action.


ty action.


ty action.


ty action.


ty action.

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

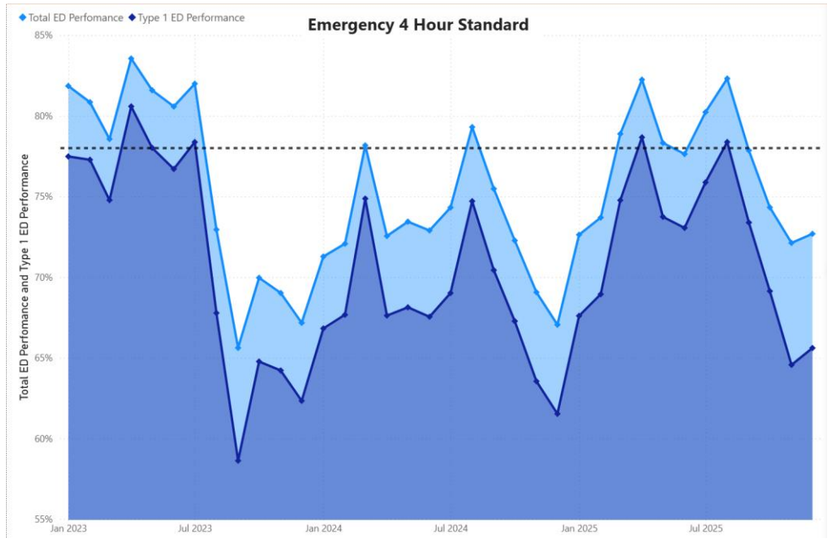
True North Metrics

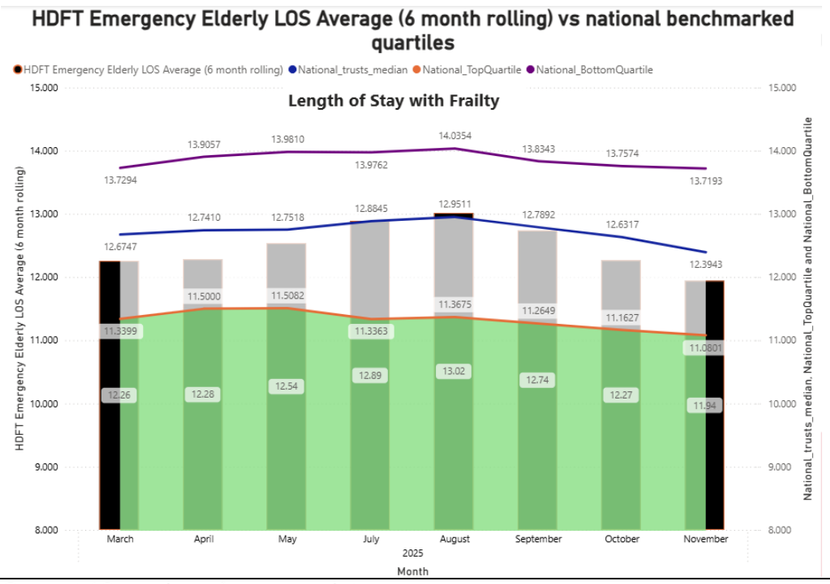
1. **ED 4 Hour Standard - 95% of patients admitted or discharged within 4 hours**
2. **Length of Stay - Top quartile nationally for patients with frailty**
3. **Elective Recovery RTT - 92% of patients waiting under 18 weeks for treatment**
4. **Cancer 62 Day Standard - 85% of patients seen and treated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

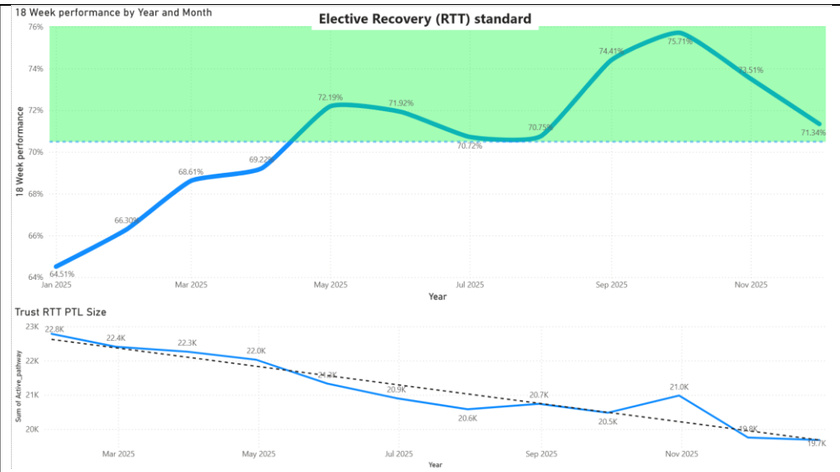
Breakthrough Objective:	Time to Inpatient Bed Reduce Follow Up Activity
Corporate Projects:	1. Bed Capacity 2. Patient Discharge
Overarching Risk Appetite:	Operational - Cautious

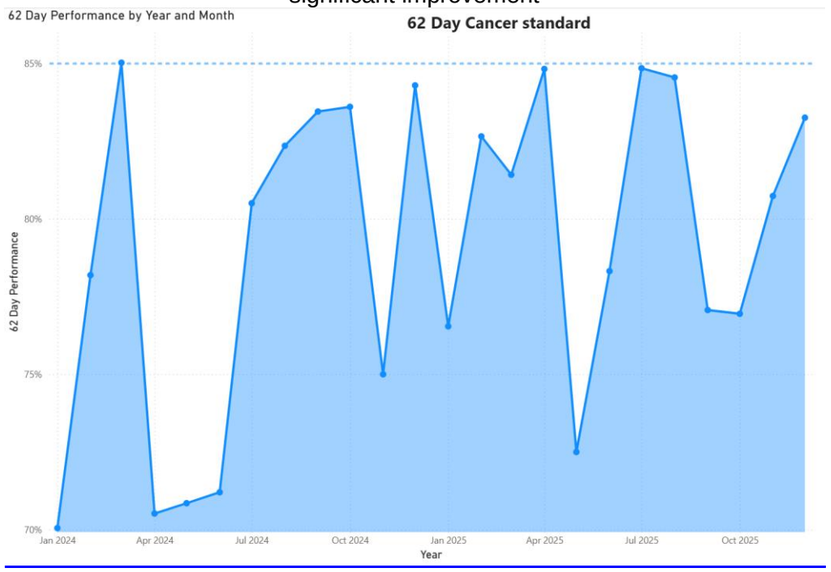
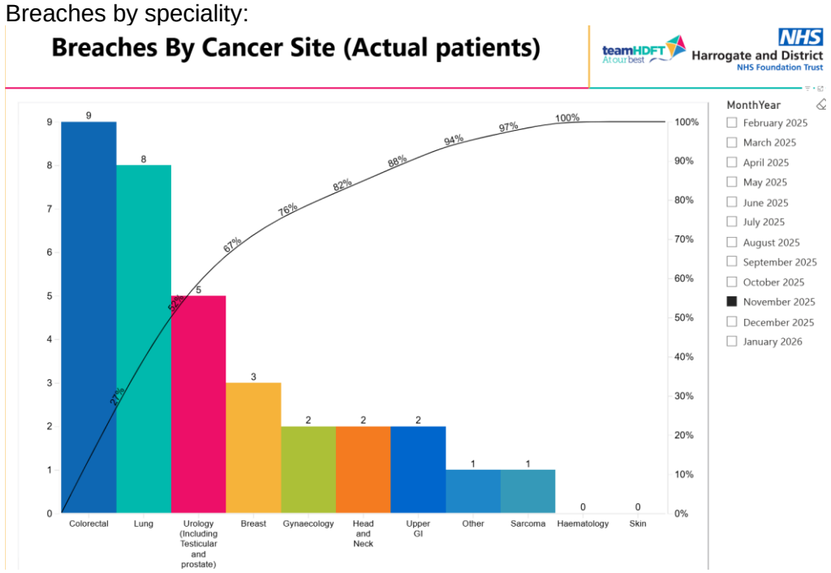
Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite 1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Person Centred, Integrated Care, Strong Partnerships	**The best place for person centred urgent and emergency care**	**4 Hour ED Standard**	**Operational: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

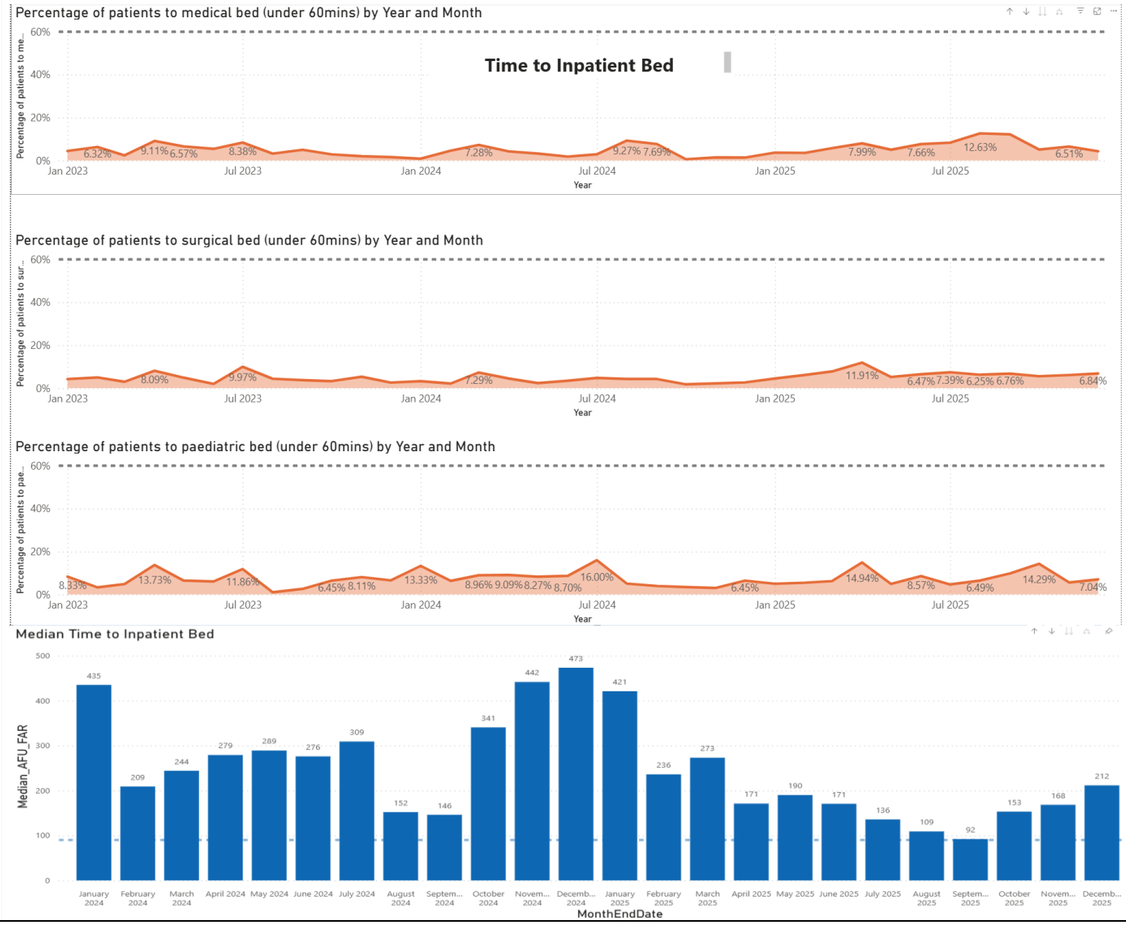
Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care 	ED 4 Hour Standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated 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-May and July-August 2025 with June (77.6%), Sept (77.9%) just below. October (74.3%), November (72.1%) and December (72.7%) have seen a significant deterioration. Episodes of pressure relating to high respiratory virus prevalence delaying inpatient flow but also a reduction in non-admitted performance (20/day through Jan-Sept now at 35/day) 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 105% 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). Additional ED Senior Decision maker on twilight shift to deliver see and treat model as part of Winter Plan from 29th December. Winter Ward opened on 29th December. 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	Length of Stay with Frailty	Top quartile Length of Stay	By March 2026, we will achieve top half	HDFT vs National Upper Quartile LOS – last full month validated: **11.94** (Goal 11.08) – whilst there remains a gap to upper quartile performance this is the	Development of Data for stratification with advent of new EPR.		

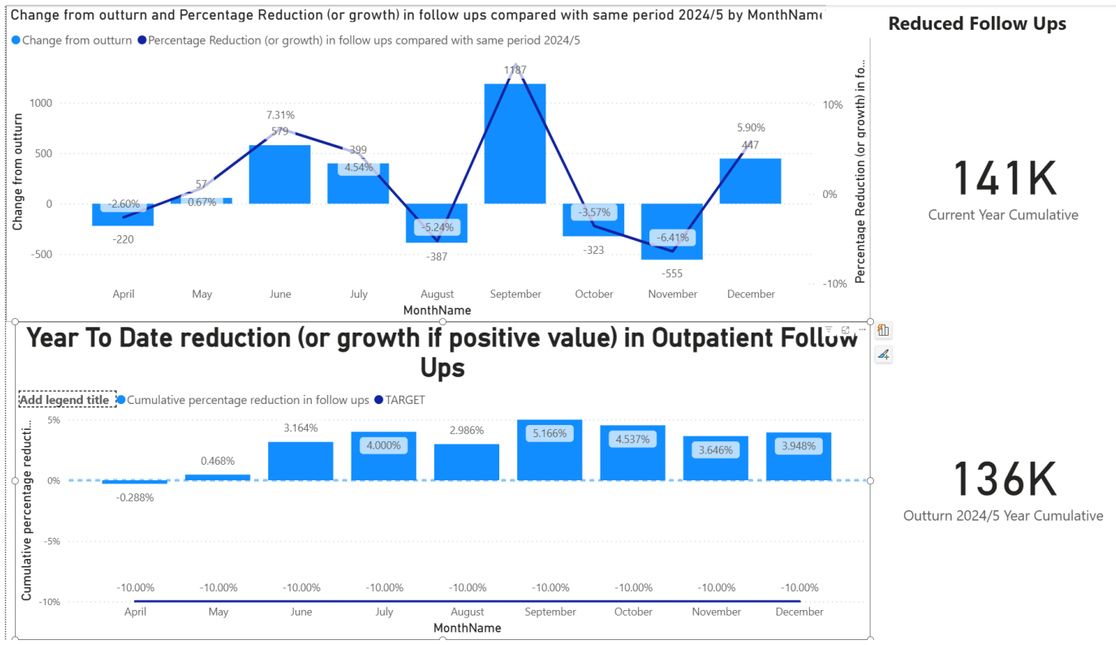
elderly and people living with frailty		nationally for patients with Frailty by March 2027.	Length of Stay for Frailty nationally. By March 2027, we will achieve top quartile Length of Stay for Frailty nationally.	narrowest it has been this year and there is now a clear gap from the national median. 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 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. 	Frailty Team Driver Metric now: meeting discharge targets. 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. 7-day frailty assessment model trial as part of Winter plan begins 3rd Jan. 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 December **71.34**%. An expected drop from previous month driven by the focus on closing pathways over 18 weeks and reducing the overall size of the PTL. Watch metrics – theatre utilisation below target at 80%.	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. 1st OP NHSE sprint starts in Q4. HDFT plan submitted to deliver 9,000 additional outpatient activity. WDH theatre utilisation focus as part of move to corporate services to deliver more theatre sessions and increase patient throughput.		
	62 Day Cancer standard	85% of our patients will commence	By March 2026, 85% of patients will have commenced definitive	Cancer Performance Report - Power BI Validated Sept position **77.1**%, October position **77**%	Developing workforce capability and expertise to better guide		

		treatment within 62 days of referral.	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.	November **80.7**% (unvalidated), December **83.3**% (unvalidated) After 2 months of deterioration this is now showing a second month of significant improvement  Breaches by speciality: 	analyst time in creation of stratified data dashboard for cancer waiting times. Ensure capacity to deliver first appointments within 19 days. £100k secured from cancer alliance in Q4 to be used to insource CT capacity Development of 6-4-2 in endoscopy to improve list utilisation and use of bowel cancer screening capacity. Stratify impact of complex imaging waits on cancer performance - data now available (August 2024): Imaging - Power BI. RCAs to be completed on all 104-day cancer breaches to understand themes and opportunities 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. • New theatre scheduling process gone live 1st Sept. • Theatre management team reaching out to individuals where performance <80%.		

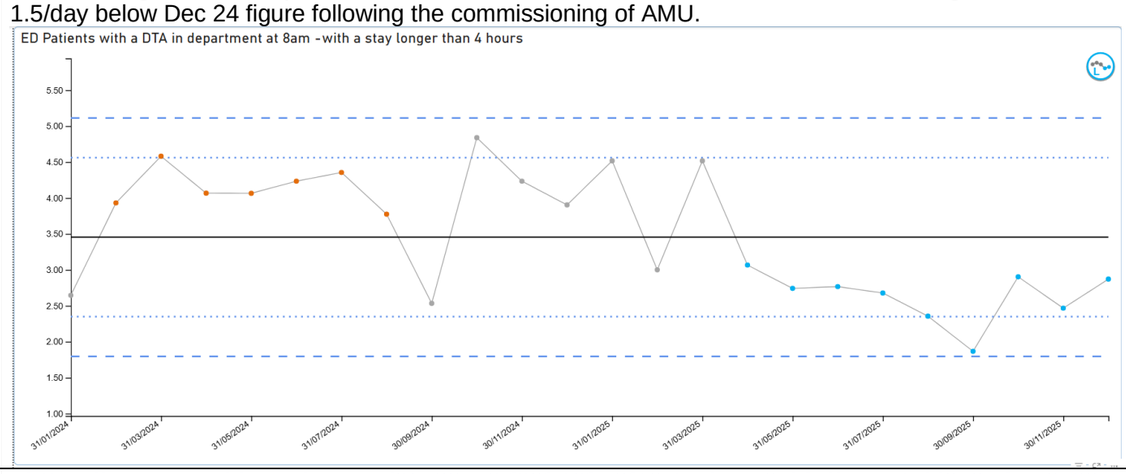
Breakthrough Objective:

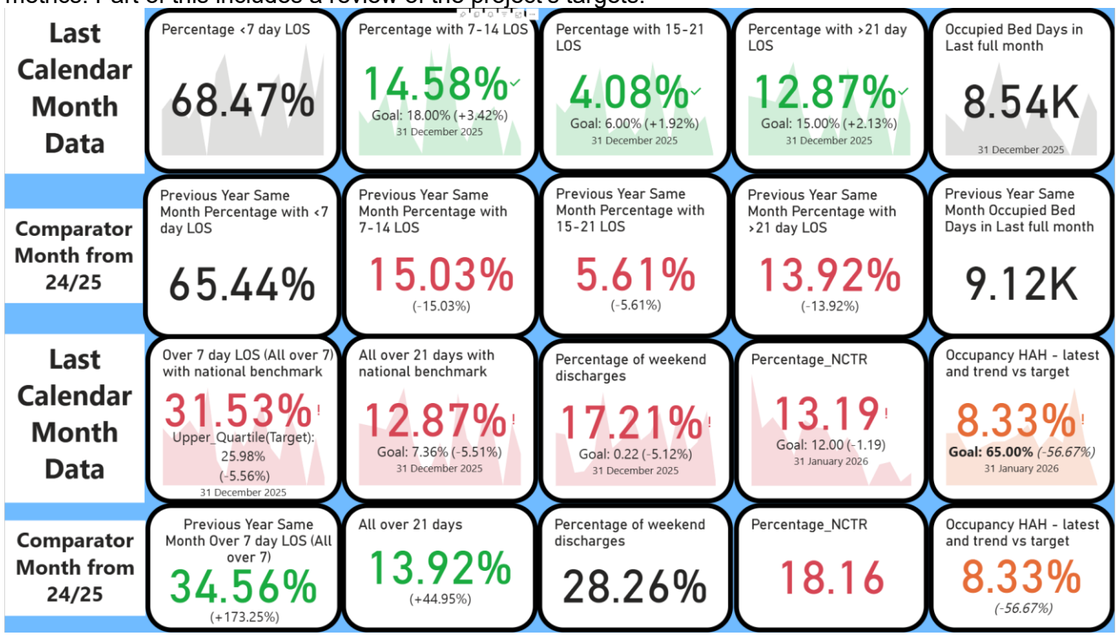
Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Time to move to medical bed from decision to admit in Emergency Department	ED 4 Hour Standard	95% of admitted patients to be moved to required department 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.	Moves to medical beds within the hour have deteriorated in December to 4% from 6.5% in November. There was a sustained and significant reduction in median time to bed up to September but a progressive deterioration since back to 232mins for December which is roughly half the value for December 2024. Current data for the new measure below: **ED performance breaches and LOS - Power BI** 	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 3.95 % ahead of same period last year against the target of a 10 % reduction. October and November were the first consecutive months to see a reduction vs last year in month however December saw an increase on Dec24.  Follow up Outpatient - Activity Monitoring 2025 - Power BI	**Reduced Follow Ups** 141K Current Year Cumulative 136K Outturn 2024/5 Year Cumulative	1st OP NHSE sprint starts in Q4. HDFT plan submitted to deliver 9,000 additional outpatient activity. 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.	The average number of patients in ED at 8am with a DTA remains lower than the average and is 1.5/day below Dec 24 figure following the commissioning of AMU. 	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.		
atient 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%.	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.	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).		

Workstreams	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
			By March 2026, we will achieve Virtual Ward Occupancy >65%. By March 2026, we will achieve 'Outliers' on wards <1%.	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. 	More accurate, faster and earlier submission of TTOs. Faster delivery of TTOs to wards and units. 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 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

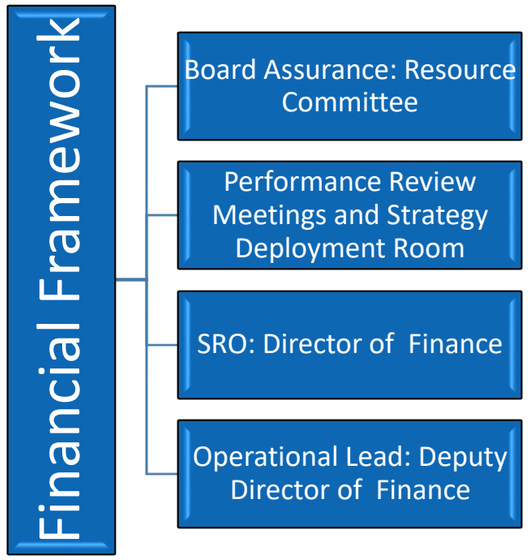
Our ambition is to provide the best quality, safest care whilst being a financially sustainable organisation.

GOALS:

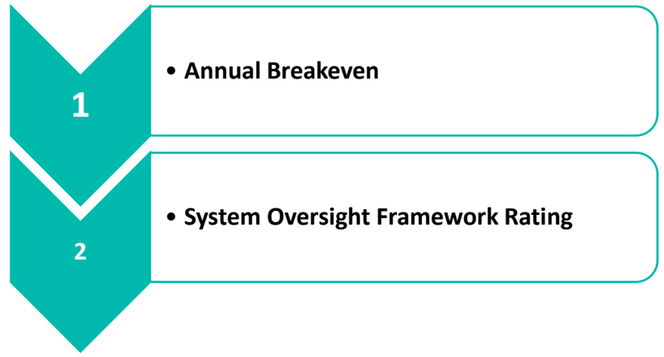
Financial Sustainability

HDFT To be a financial sustainably organisation

GOVERNANCE:



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



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 M9 the Trust reported £18.2m deficit, £15m away from plan. It is important to note the plan is now phased to improve by £971k each month. In month there has been £177k costs associated with re-banding Band 2 to 3 care support workers (dates back to 2021) all staff have now been processed, total cost £572k. In addition to this £179k of further strike costs have been incurred in month (total unfunded strike costs year to date £574k). In month the transaction of fixed assets transferring to Trust from HIF was processed, this has resulted in no fixed assets in HIF, loan arrangements settled and depreciation applicable only in trust. There has been financial pressure in month due to the transaction as there is no further interest due to the loan being settled and interest in HIF was previously capitalised, £318k Main drivers of the overall position include, WRAP delivery, Wards, Medical Staffing, Pathology and Drugs. WRAP - 89% of WRAP has been actioned to date, PSC have made good progress and the majority now identified. LTUC is only at 43% of their target. A significant amount is non recurrent and will make next years plans challenging. Wards – £1.8m pay overspend year to date, winter escalation has been opened in month. It is important to note £0.2m is in relation to the 1:1 care needed 247 for specific patients. Medical Staffing – £0.8m pay overspend, A3's have been developed but do highlight temporary cover as one of the most significant drivers along with LLP and WLI. Drugs and Devices – £1.6m overspent Pathology - £1.2m overspent, direct access continues to grow. Lateral flow tests are being piloted over biofire testing. The above are all now contributing to needing a revised forecast position and cash support. Countermeasures are noted. Watch Metrics:	In relation to the operational position the current countermeasures will be in place. A monthly recovery plan can be found in the Finance Board pack. 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		

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal	Level of Risk for progressing actions
			<table><tr><th>Metric</th><th>Purpose</th></tr><tr><td>Capital Spend YTD</td><td>To track delivery of the Capital Programme spend</td></tr><tr><td>Financial performance In Mth/YTD</td><td>To track performance against plans (Directorate/Trust)</td></tr><tr><td>WRAP delivery YTD</td><td>To track performance against WRAP target (Directorate/Trust)</td></tr><tr><td>Cash in Bank</td><td>Ensure sufficient cash to pay Suppliers and Staff</td></tr><tr><td>Aged Debt</td><td>Track invoice payment (impacts cash)</td></tr><tr><td>Better Payment Practice code</td><td>Keep track on how delivering against national standard 94% (Trust paying Suppliers)</td></tr><tr><td>Retrospective PO's</td><td>Track number of orders not following no PO no Payment process</td></tr><tr><td>Agency Spend</td><td>Ensure agency spend is within national target and plans in place to reduce usage</td></tr><tr><td>Off Framework Spend</td><td>Monitor spend - National requirement to have no off framework spend</td></tr><tr><td>ERF</td><td>Performance against 19/20 baseline (Generates additional income)Unclear on reporting needed for 25/26.</td></tr><tr><td>WD1 delivered</td><td>Ensure Directorates have a financial summary on working day1</td></tr><tr><td>REACH Reporting</td><td>To track budget holders accessing their budget reports</td></tr></table>	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 however due to our deficit financial position and in receipt of deficit support funding the Trust are in segment 3 and will be unable to move out of this segment. NHS Oversight Framework 25/26 – Segment 3 <table><tr><th>Segment</th><th>Description</th></tr><tr><td>1</td><td>The organisation is consistently high-performing across all domains, delivering against plans.</td></tr><tr><td>2</td><td>The organisation has good performance across most domains. Specific issues exist.</td></tr><tr><td>3</td><td>The organisation and/or wider system are off-track in a range of domains or are in financial deficit.</td></tr><tr><td>4</td><td>The organisation is significantly off-track in a range of domains.</td></tr></table> <table><tr><th>Segment</th><th>How NHS England supports</th><th>How NHS England drives improvement</th><th>How NHS England intervenes</th></tr><tr><td>3</td><td>NHS England agrees the support needs of the organisation involving the provider's relevant ICB in the decision. To do this we take account of segmentation and capability. Support is delivered through local support offers, defined national support programmes and bespoke regional interventions.</td><td>The organisation receives increased scrutiny targeted at delivering improvement in challenged performance areas.</td><td>NHS England may apply interventions and/or require the organisation to take action in specific areas of low performance. This may involve use of our enforcement powers, particularly where performance concerns persist.</td></tr></table> The Trust are pursuing the forecast protocol changes following board approval in the prior month.			

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 M9 89% of WRAP schemes have been actioned, £12.8m along with cash reduction schemes £7m 54% of current actioned schemes are non recurrent which will impact 26/27. 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 • All non recurrent schemes are being reviewed to identify what can be moved to recurrent. • Internal audit has recently reviewed the WRAP process and have provided significant assurance, the team are working through a number of recommendations following the audit.		

Directorate	Target £000	Actioned %	Actioned £000	Total Plans £000	Identified %	Risk Adjusted Plans £000	Risk adjusted shortfall £000	Risk Adjusted Identified %	Cost Reduction £000
Central	2,342	104%	2,442	2,442	104%	2,442	-100	104%	422
Corporate	1,287	101%	1,299	1,299	101%	1,299	-12	101%	863
CYPPH	1,475	100%	1,475	1,475	100%	1,475	-0	100%	470
HIF	1,019	100%	1,022	1,022	100%	1,022	-4	100%	0
LTUCC	4,579	43%	1,970	2,525	55%	2,332	2,246	51%	4,245
PSCC	4,785	97%	4,628	5,283	110%	4,994	-209	104%	1,029
Total	15,486	83%	12,836	14,046	91%	13,565	1,922	88%	7,030
Reporting Total*	14,468	89%	12,836	14,046	97%	13,565	903	94%	7,030
Last Month	14,468	83%	12,000	13,660	94%	13,049	1,419	90%	7,035

Strategic Project:

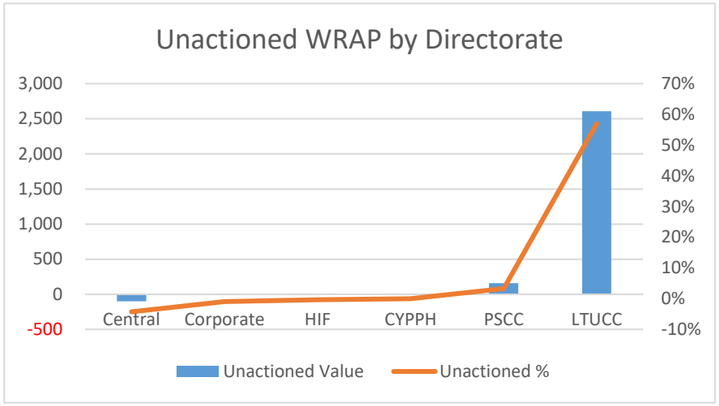
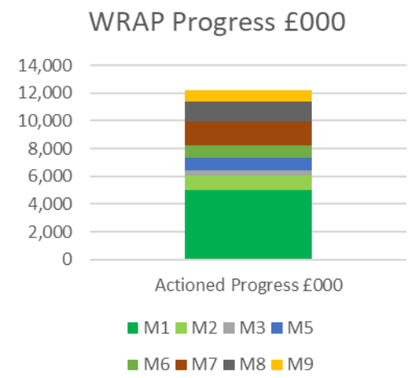
True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal	Level of Risk for progressing actions
None relevant at present						

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 (currently over delivering). As at M9 the Trust reported £18.2m deficit, £15m away from plan. It is important to note the plan is now phased to improve by £971k each month. 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, Qtr2 & Qtr 3) Qtr 4 allocation has been confirmed that this will not be received. Added to	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
		this there is ongoing discussions around clawbacks relating to depreciation and CDC prior year, £2.8m which have now been excluded in the forecast and will continue to be disputed. There is an opportunity to over delivery on outpatients with procedures and first appointments but guidance around this has not been clarified. Underlying issues have been described above. Forecast Protocol being followed following board approval last month.				
ID 721	Group Cash Position	Cash support will be required through the year as per the cash flow forecast. 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. NR funding for the LA NI contributions has been received but leaves a £400k cost pressure. As at December £14m supplier payments remain outstanding and the BPPC has dropped to 27.9%(No of invoices)/67.7% (Value of invoices) target is 95%. A cash support request has been submitted for the additional CDEL allocation in year and a revenue cash support request was submitted in December for Qtr 4. There is also a MOU outstanding for £5m in relation to works on Littondale. The cash forecast aims to clear all outstanding supplier payments by the end of March 26. Unfortunately no cash support confirmation has been received to date.	5 x 5 = 25	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
		Trust Name | **Harrogate and District NHS Foundation Trust** **Trust Code** | **RCD** £000 | £000 | £000 | £000 | £000 **December** | **January** | **February** | **March** | **April** Opening Balance | **1,438** | **6,030** | **8,437** | **2,742** | **3,898** ***Monthly Income*** **Revenue** *NHS Receipts - ICB* | 21,725 | 21,292 | 21,292 | 17,391 | 21,725 *NHS Receipts - NHSE/WT&E* | 1,303 | 1,303 | 4,369 | 1,303 | 1,303 *NHS Receipts - Other* | - | - | - | - | - *NHS Receipts - Moved to Capital Depreciation* | (992) | (992) | (992) | (992) | (992) *NHS Receipts - NHS Funding* | 2,695 | 2,680 | 2,680 | 2,680 | 3,350 *Non NHS Receipts* | 12,465 | 6,531 | 5,345 | 10,411 | 6,742 **Revenue Total** | **37,196** | **30,814** | **32,694** | **30,793** | **32,128** **Capital** *Receipts for Capital* | 4,782 | 1,680 | 1,680 | 1,855 | 992 **Capital Total** | **4,782** | **1,680** | **1,680** | **1,855** | **992** **TOTAL RECEIPTS** | **41,978** | **32,494** | **34,374** | **32,648** | **33,120** ***Monthly Payments*** **Revenue** *Payroll Payments* | (24,559) | (25,459) | (24,559) | (24,559) | (24,559) *NHS Payments* | (3,542) | (4,669) | (3,051) | (3,044) | (4,057) *Non NHS Payments* | (4,527) | (6,442) | (5,195) | (5,182) | (6,905) *Loan Payments* | (210) | - | (442) | - | - *PDC Dividend Payments* | - | - | - | (3,765) | - *Other Payments* | (3) | (2) | (2) | (3) | (3) **Revenue Total** | **(32,841)** | **(36,572)** | **(33,249)** | **(36,553)** | **(35,524)** **Capital** *Capital Payments* | (4,545) | (5,228) | (6,947) | (2,729) | (992) **Capital Total** | **(4,545)** | **(5,228)** | **(6,947)** | **(2,729)** | **(992)** **TOTAL PAYMENTS** | **(37,386)** | **(41,800)** | **(40,196)** | **(39,282)** | **(36,516)** **Balance** | **6,030** | **(3,276)** | **2,615** | **(3,892)** | **502** *Revenue Support PDC Receipts* | **-** | **11,713** | **127** | **7,790** | **-** **Adjusted Balance** | **6,030** | **8,437** | **2,742** | **3,898** | **502**				
ID73	Recurrent Delivery of the Efficiency programme (WRAP)	Recurrent delivery of the WRAP is crucial to the long term financial standing of the Trust. 83% of the WRAP programme has been delivered however 54% of this is NR. PSC and LTUCC have £3.6m 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 £7m.	4 x 3 = 12	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
		 				

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. Despite the good intentions of a risk share arrangement it has not worked in practice. Drugs, Boundary Changes, Direct Access all continue to be a provider pressure. Unfortunately Wharfedale, TIF1 scheme has also not delivered as per the business case which has left an income gap.	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**

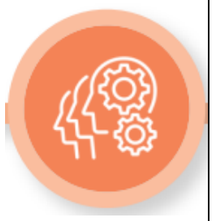
Breakthrough Objective:	Involvement
Corporate Project:	Medical and Dental Workforce Scheduling and Payment Transformation Project
Overarching Risk Appetite:	Workforce - Cautious

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. 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.	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. • The National Staff Survey for 25/26 closed on 28 November and HDFT response rate was 62% which is the highest response rate achieved. All Directorates qualified for funding under the newly introduced incentive scheme and a total of £240K will be distributed to support patient/colleague wellbeing initiatives. • A communication plan has been developed, and the Board of Directors are due to receive a presentation on the IQVIA data in February 2026. Embedding Equality paper presented to August Board Workshop and gained full support. Good progress is being made on this programme of work: 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. 2. 17 Independent Panel Members have been recruited. 3. EDI Data was included in the October 2025 Clinical Directorate Workforce Information Packs. 4. 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		

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		up to the programme, and the initial sessions were hugely impactful. 5. A listening event for colleagues with a disability or long-term condition has been scheduled for spring 2026 to give the opportunity for further learning about the lived experience. Colleague Wellbeing The Staff Flu Vaccination Campaign is running very successfully, with HDFT being the top performing Trust in NHS England for 6 consecutive weeks. The percentage of colleague vaccinated is 69% with 22.8% colleagues declining to have the vaccine. The remaining 450 colleagues who have not responded either way are being actively followed up.		

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 – undertaken and audit recommendations being implemented. Contract with an EAP with improved mental health and wellbeing provision – implemented and impact being monitored New 2026 countermeasures being developed.	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 747.58wte in December 2025. Unavailability has increased by 39.43wte this month, when compared to November. Sickness is the predominant reason for the rise in unavailability this month, accounting for just over half (54%) of the 39.43wte increase. All clinical Directorates have seen an increase in sickness in December, with LTUCC and PSC seeing the greatest increase of 10.33wte and 8.76wte, respectively. CYPPH Directorate continues to see an increasing trend in sickness rates and has seen a further increase from 8.85% in November to 9.23% this month. An increase of vacancies in December has also impacted unavailability by 12.25wte. This is due to an increase in the budgeted establishment by 18.25wte, which has been partially offset by growth in the substantive workforce by 6.00wte. Unavailability due to maternity leave has increased this month by 6.64wte. LTUCC saw the greatest increase, by 6.53wte when compared to November. The Trust vacancy rate is 6.22% at the end of December 2025, which is below the Trust target of 7% (this is above the A3 threshold of 6%). Trust turnover is 9.38%		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
					Sickness is 6.24% Staff leaving within 1st year is 16.52% (this remains at a similar position to last month, which saw a rate of 16.53%.) The Trust undertook a baseline assessment for each of the ten areas of the Resident Doctors Ten Point Plan (TPP) and submitted this to NHS England. The detail of this was reported through the People and Culture Committee in November 2025. An updated assessment of the Trust's TPP position was also submitted on 8 December 2025. A comparison of this return will be reported in the Trust January 2026 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 have been 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 • For all additional payments to be digitised for payment and removing all paper/spreadsheet submissions	Local Medical A/L processes will not enable it to work in the roster system as they are not calculated in hours. Review of bank staff module and payroll processes/interface with Optima system. To put all medical and dental staff on the electronic rostering system. Job plans have not been reviewed regularly. Work with the General Managers to help fix any problems that arise and move us away from spreadsheet double running.	28 services out of 40 remain 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 as it also underpins project delivery. Job planning compliance is at 87% in early January 2026 with an increased number of job plans in the dispute process. Further rollout across specialties continues to be paused whilst this job planning work is undertaken and the rostering team is re-focused on post-implementation optimisation of resident doctors' rotas and digital locum payments. Bankstaff+ was turned on by the E-Rostering Team in December 2026 as scheduled. The job plan review work will cause some further review of rosters where the system is already live. The Project governance structures are being reviewed as part of developing the road map for delivery next year and the scoping work around roster re-build is being undertaken. This governance re-modelling will be completed by the end of January 2026.		

Strategic Project.

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

Related Corporate Risks.

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

Related External Risks.

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

ENABLING AMBITION: DIGITAL TRANSFORMATION 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

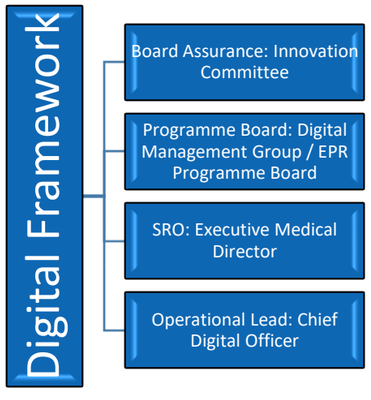
Information

Timely, Accurate Information to enable continuous improvement

Electronic Health Record

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

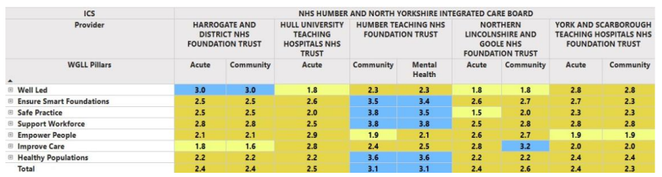
Ambition Metrics (Executive Lead: 10-15 Year deliverable)



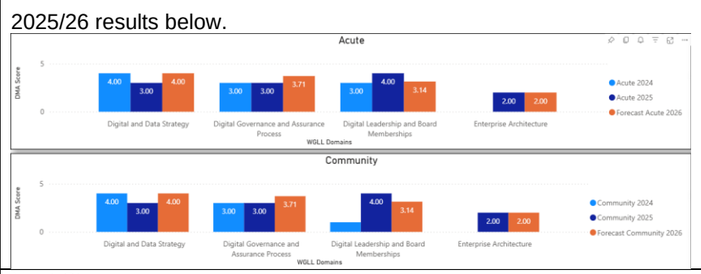
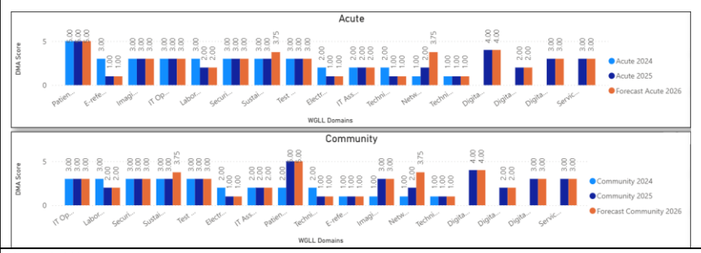
True North Metrics Summary:

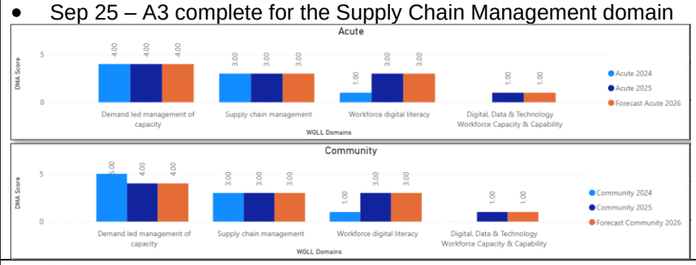
Breakthrough Objective:	None
Corporate Project:	None
Overarching Risk Appetite:	Operational - Cautious

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

True North 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: 		

ICS	NHS HUMBER AND NORTH YORKSHIRE INTEGRATED CARE BOARD								
Provider	HARROGATE AND DISTRICT NHS FOUNDATION TRUST		HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	HUMBER TEACHING NHS FOUNDATION TRUST		NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST		YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST	
WGLL Pillars	Acute	Community	Acute	Community	Mental Health	Acute	Community	Acute	Community
Well Led	3.0	3.0	1.8	2.3	2.3	1.8	1.8	2.8	2.8
Ensure Smart Foundations	2.5	2.5	2.6	3.5	3.4	2.6	2.7	2.7	2.3
Safe Practice	2.5	2.5	2.0	3.8	3.5	1.5	2.0	2.3	2.3
Support Workforce	2.8	2.8	2.5	3.8	3.8	2.5	2.8	2.8	2.8
Empower People	2.1	2.1	2.9	1.9	2.1	2.6	2.7	1.9	1.9
Improve Care	1.8	1.6	2.8	2.4	2.5	2.8	3.2	2.0	2.0
Healthy Populations	2.2	2.2	2.2	3.6	3.6	2.2	2.2	2.4	2.4
Total	2.4	2.4	2.5	3.1	3.1	2.4	2.6	2.4	2.3

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 25 Onwards – A3 and countermeasures to be developed • July 25 – 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 25 Onwards – A3 and countermeasures to be developed • July 25 – 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 25 Onwards – A3 and countermeasures to be developed • July 25 – 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 25 Onwards – A3 and countermeasures to be developed • July 25 – 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 25 Onwards – A3 and countermeasures to be developed • July 25 – 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 25 Onwards – A3 and countermeasures to be developed • July 25 – National Digital Maturity Assessment results published		

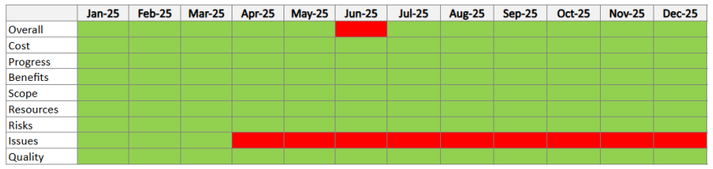
Breakthrough Objective:

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 • Awaiting funding to be confirmed		
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 needs 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 • Jan 26 - Project Initiation • Funding confirmed		
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 merging the Meal Ordering Project with Portering and Domestics as they will use the same system • Business case to BCRG Dec and SDR Jan		
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 • Interim solution being progressed by the service due to urgency		
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 table below	See 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. T1a Go Live for Observations completed successfully on Wednesday 19th November. T1a Go Live for Investigations completed successfully on Tuesday 2nd December. Focus now turning to T1b delivery. 		

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

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Overall												
Cost												
Progress												
Benefits												
Scope												
Resources												
Risks												
Issues												
Quality												

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

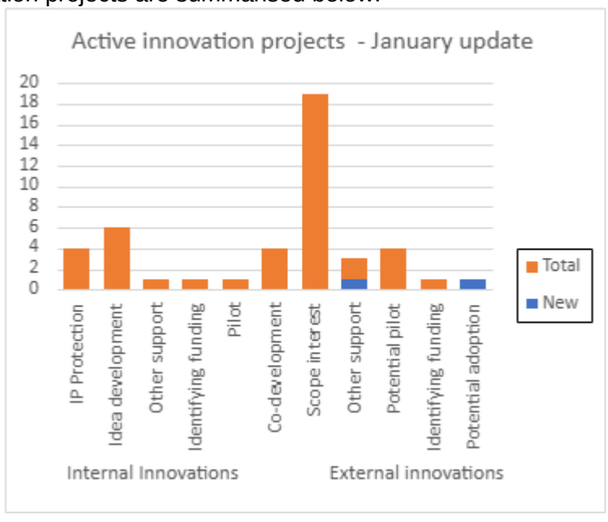
GOVERNANCE:

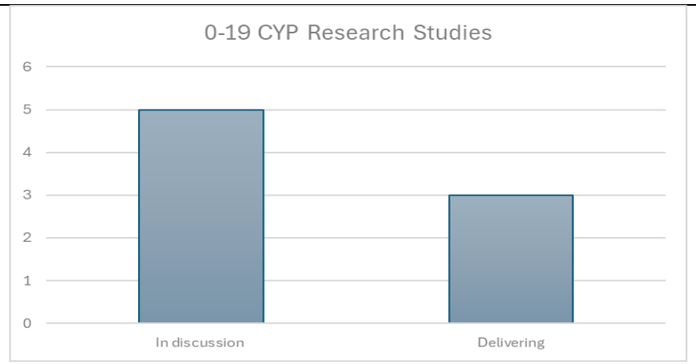
Ambition Metrics
(Executive Lead: 10-15 Year deliverable)

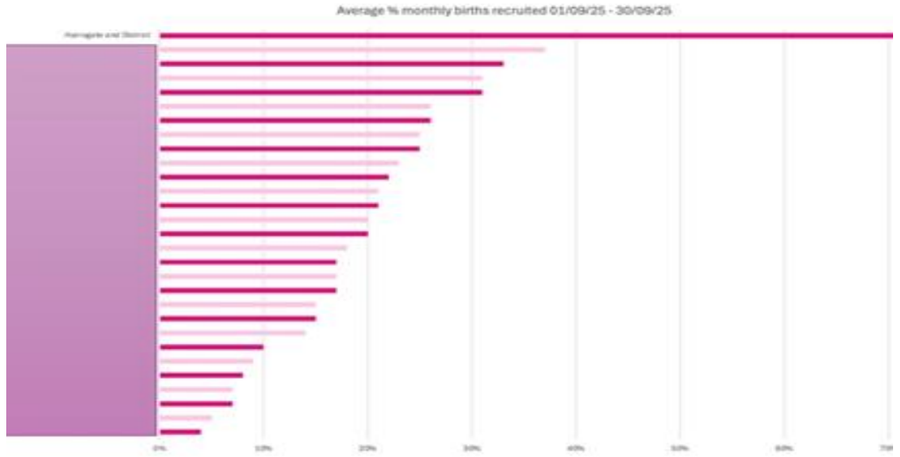
1. **Healthcare Innovation- support of external and internal innovations and strategic partnership with industry**
2. **Children's Public Health**
3. **Clinical Trials - increased recruitment of patients into reseach studies. All studies to be delivered to time and target.**

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 created to support companies developing innovations and to generate income for HDFT ○ Soft launched and received 2 applications • 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 ○ 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; in-depth sessions to start in Mar 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	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.*	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*		

		Deliver at least 1 0-19 showcase events .	 **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 (PIC site currently 0 recruited, 32 sites nationally recruitment total 15) **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** / **November** / **December** **BaBI**: 44 / 43 / 26 / 44 / 25 **Generation** (monthly target 42): 89 / 100 / 76 / 47 / 62 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. 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.	*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. Further opportunities identified through the centre of excellence DAIM (Data Science, AI and Modelling) University of Hull.		



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 - November			Wider dissemination Develop short staff survey	
December				Next steps meeting completed

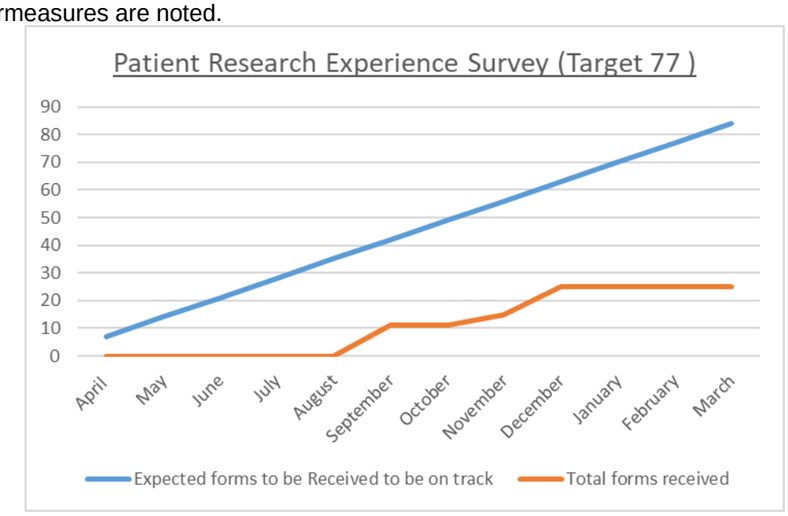
Countermeasures are noted.

Watch Metrics:

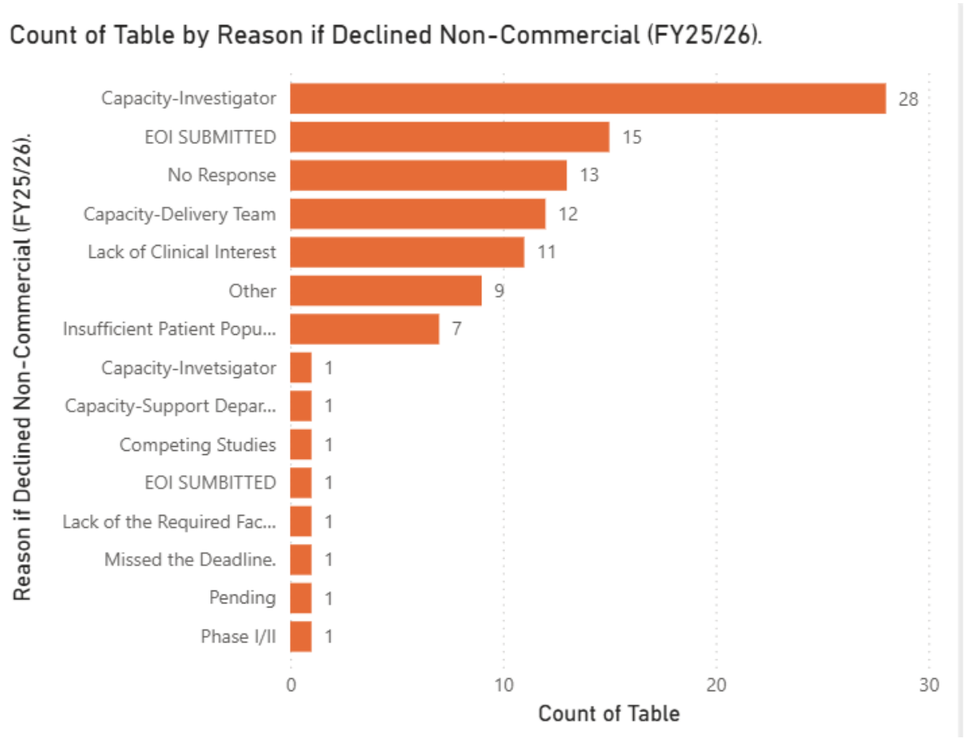
To ensure SOPS for department in relation to 0-19 research are updated by end of 2025 and system in place to review regularly n = 17, *Gantt chart developed, allocated & in development*

GCP training numbers increase Year on Year for 0-19 trust staff. *Working with Education Team to integrate GCP access onto the learning lab platform – drafted*

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

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		

Detailed Decline Commercial FY25/26.	Count of Table
HDFT cannot facilitate Phase II trials.	104
Capacity-Investigator.	68
Treatment not performed at HDFT; only LTH.	19
HDFT cannot facilitate Phase I trials.	17
Lack of Clinical Interest.	17
Capacity-Delivery Team.	15
Insufficient Patient Population.	14
No Response.	12
EOI SUBMITTED.	11
Capacity-Support Departments.	3
Deadline missed due to annual leave;timeframe too narrow to assess feasibility.	1
Divates from Local Care Pathway.	1
Lack of required facilities/equipment.	1
Lack of required facilities/equiptment.	1
The study has pre-selected sites, however they require a back-up site to be open and recruiting quickly.	1
Trial is for Primary Care.	1



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.

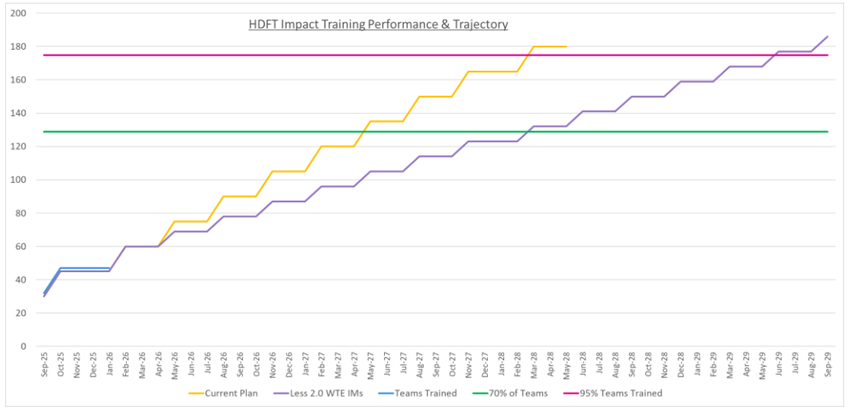
Breakthrough Objective

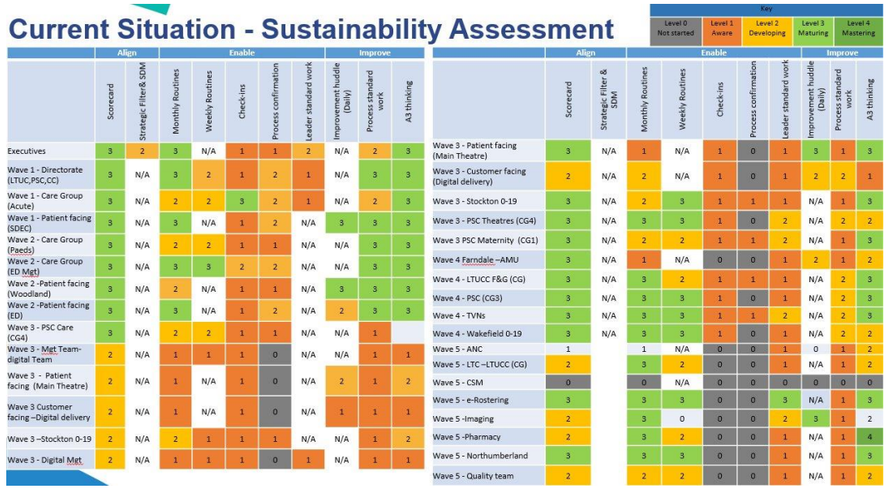
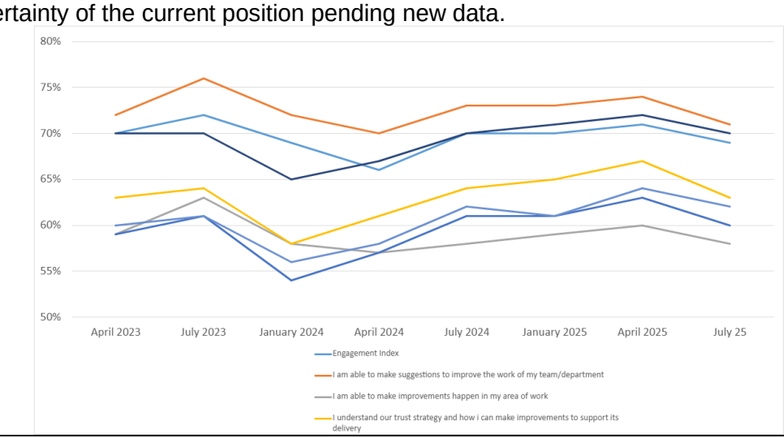
True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
None						

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. • Wave 7 training started in November 2025 with 15 teams involved. The total number of teams in or who have completed training remains 44 which is unchanged since the last report. • The chart below now includes an increased baseline require reflecting the expansion of the Children & Young People's Public Health (CYPPH) service areas. • The total is now estimated as 184 teams which results in a modified training completion of 26% across the Trust. • The adjusted trajectory is charted below and demonstrates the initial 70% target will be achieved by Aug 2027 (9-months beyond original plan). • The risk to achieving the training target due to an anticipated 40% reduction in the capacity of the Improvement Academy from April 2026 is the primary driver of the amber rating. Chart 1: HDFT Impact training performance & trajectory 	Testing continues for a revised delivery model for frontline training developed with CYPPH. CYPPH colleagues remain on track to move to independent delivery of Impact training within 2-months. Wave 8 is now scheduled with team selection confirmed by with directorate leadership teams via the Impact programme board. This will commence in Feb'26 and use a rationalised 12-week delivery model. The review of existing 'Silver' training offers was postponed in Dec'25 and the outcomes are now expected this month. A team workshop day on 14/Jan/26 will focus on producing a revised training offer. The ambition is to meet the original delivery targets without losing the fidelity of the model. External collaboration continues with scheduled sessions on 21/Jan/26 and 06/Feb/26. A robust benefits analysis will be added to the business case requesting 2 years further funding for the Improvement Managers which will be submitted this month.		
		Sustainability: 90% of those who have completed training will have embedded the routines and	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.	HDFT Impact strategic programme board has agreed on the principles and format for a revised sustainability metric. With this endorsement, a new data collection process is being		

		processes of the Improvement Operating Model after 4 months.	The overall sustainability score is 36%. This is unchanged from the last report in the absence of new data which is expected in month but not available at time of reporting. 	designed. Implementation is planned prior to performance review meetings (PRM) in February 2026. From March 2026, sustainability scores from all teams who have completed Impact training will be reported into PRMs monthly. This will provide accurate and regular data to monitor performance and respond to variation. Action on the countermeasure to improve understanding of the root cause barriers to sustainability are insufficiently understood was delayed in December and will resume as priority this month. The re-start of executive and senior leader Gemba (go, see) visits as a core element of leader standard work has been scheduled for 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 January. The next data set is expected from the January Inpulse survey which will be available in February 2026. Consequently, most recent performance for this metric remains the July 2025 data which showed: • a dip in performance for this metric to 63% (-4% from Apr'25) • A modest decline of 2-3% for other questions in the survey related to strategy The amber goal rating is cautious and driven by the previous dip in performance and uncertainty of the current position pending new data. 	New activities in this work stream remain limited since the last report due to capacity challenges and competing priorities. Their programme board remains supportive of more local and regular content to feed directorate and organisation-wide communications. The template and process to enable this change are due this month. The quarterly strategy progress update will be circulated this month ahead of the next Inpulse staff survey.		

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 2025-26

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

GOALS:

Wellbeing

A patient and staff environment that promotes wellbeing

Quality & Safety

An environment and equipment that promotes best quality, safest care

Environmental Impact

Minimise our impact on the environment

GOVERNANCE:

Environment Framework

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

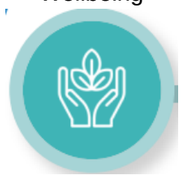
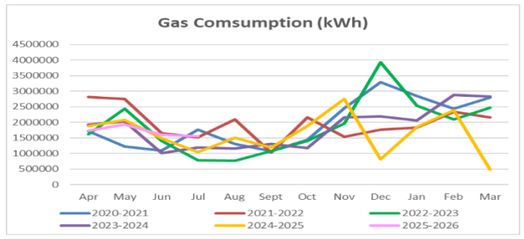
Enabling Ambition Metrics (Executive Lead: 10-15 Year deliverable)

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

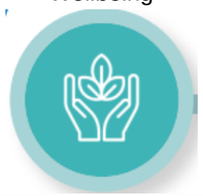
Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
An Environment that promotes wellbeing	**Wellbeing**	**Capital Programme Delivery (Spend vs Budget)**	**Operational: Cautious**	
	Quality & 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 £42,962m. • Spend YTD is 40% • Predicted spend forecast is 101% • 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 25/26 submission • Critical infrastructure risk funding from HNY ICB confirmed. • Business case for additional RAAC funding outside of Block C - Approved. Tight timescales for delivery by 31 March 2026 due to asbestos work in 50 LPR. Awaiting programme from specialist contractor.		
Environmental Impact 	Minimise our impact on the environment HDFT to be carbon net zero by 2040	Reduce Scope 1 and 2 CO2 emissions by 1,700t by 2028 	• Refreshed Green Plan developed and approved • Carbon accounting process implemented • PLOI 25/26 agreed with HIF – 31 Jan 26 • PLOI 26/27 agreed with HIF – 28 Feb 26 • Waste to Energy ○ Complete preparation for trial by 31 Mar ○ System trial – Q1/2 26/27 • Energy sub-metering – 31 Mar • PSDS 4 Grant ○ Preparation complete – 31 Mar ○ Delivery – 26/27 • Sustainable Travel Plan – Q3/4 26/27 • Geothermal	• Complete • On Track • On Track • On Track • On Track • On Track • On Track • On Track • On Track • To be started • On hold – awaiting national direction		

Enabling Ambition Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
			• Medicines - End use of piped Nitrous Oxide by replacing with local canisters.	• Complete – Local nitrous oxide canisters in place, piped system drained.		

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 – October 2026 • On Track – December 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 2 = 10	5 x 2 = 10 Nov 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 April 26	Operational: Health & Safety	Minimal

Related External Risks

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