Board of Directors Meeting Held in Public

To be held on Wednesday, 25th March 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 (Audio)**	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 28th January 2026**	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	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	Learning from Deaths Quarterly Q3 Report	Medical Director	Note	Supp. Pack Attached
2.3	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

Item No.	Item	Lead	Action	Paper
3.2	**Strengthening Maternity and Neo-Natal Safety Report**	Director of Nursing, Midwifery and AHPs / Associate Director of Midwifery	Note	Attached
SECTION 4: Ambition: Person Centred; Integrated Care; Strong Partnerships				
4.1	**Board Assurance Framework:** Person Centred; Integrated Care; Strong Partnerships	Chief Operating Officer & Deputy Chief Executive/ Resource Committee Chair	**Approve**	Attached
4.2	**Board Assurance Framework:** Finance	Finance Director / Resource Committee Chair	**Approve**	Attached
SECTION 5: Ambition: At Our Best: Making HDFT the Best Place to Work				
5.1	**Board Assurance Framework:** At Our Best: Making HDFT the Best Place to Work	Director of People & Culture / People & Culture Committee Chair	**Approve**	Attached
5.2 5.2.1 5.2.2	**Gender and Ethnicity Pay Gap Slides** **Gender Pay Gap Report** **Ethnicity Pay Gap Report**	Director of People & Culture	Note	Attached Attached Attached
5.3	**National Staff Survey**	Director of People & Culture	Note	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
7.2	**Audit Committee Chairs Report**	Director of Finance/Audit Committee Chair	Note	Verbal
SECTION 8: Governance Arrangements				

Item No.	Item	Lead	Action	Paper
8.1	Trust Plan 2026/27 • Annual Plan • Strategic Planning Framework	Director of Finance Director of Strategy	**Approve** **Approve**	Attached Attached
9.0	**Any Other Business** *By permission of the Chair*	Chair	Discuss/ Note/ Approve	Verbal
10.0	**Board Evaluation**	Chair	Discuss	Verbal
11.0	**Date and Time of next Board Meeting to be held in public:** Wednesday 27th May 2026 at 1.00 – 3.45pm Venue: Boardroom, Trust Headquarters, Harrogate District Hospital			

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

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

CORPORATE

RISK REGISTER.

Summary Corporate Risk Register.

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**	
Person Centred, Integrated Care, Strong Partnerships	The best place for person centred integrated care		4-hour ED standard	**Operational: Cautious**	
	An exemplar system for the care of the elderly		Length of Stay – Patients with Frailty	**Operational: Cautious**	
	Equitable, Timely Access to Best Quality Planned Care		Elective Recovery RTT – 18 Weeks	**Operational: Cautious**	
			Cancer 62 Day Standard – 62 Days Treatment	**Operational: Cautious**	
Great Start in Life	National Leader for Children & Young People's Public Health Services		Children at Risk of Vulnerability	**Clinical: Minimal**	
	Hopes for Healthcare		Children's Patient Experience	**Clinical: Minimal**	
At Our Best – Making HDFT the Best Place to Work	Looking After our people		Staff Engagement	**Workforce: Cautious**	
	Belonging				
	Growing for the future		Staff Availability	**Workforce: Cautious**	
	New ways of working				
Finance	Financial Sustainability		Annual Breakeven	**Financial: Cautious**	
			System Oversight Framework Rating	**Financial: Cautious**	
An Environment that promotes wellbeing	Wellbeing	All	Capital Programme Delivery (Spend vs Budget)	**Operational: Cautious**	
	Quality & Safety		PAM >moderate improvement	**Operational: Cautious**	
	Environmental Impact		Natural gas consumption	**Operational: Cautious**	
Digital Transformation	Well Led		Achieve a score of 5/5 across all seven What Good Looks like (WGLL) pillars.	**Operational: Cautious**	
	Ensuring Smart Foundations			**Operational: Cautious**	
	Safe Practice			**Operational: Cautious**	
	Support People			**Operational: Cautious**	

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
	Empower Citizens			**Operational: Cautious**	
	Improving Care			**Operational: Cautious**	
	Healthy Populations			**Operational: Cautious**	
Healthcare Innovation	Healthcare Innovation	All	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**	

Risk Score.

Initial Score	The score before any controls (mitigating actions) are put in place.
Current Score	The score after the risk has been mitigated (by controls) but with gaps in controls (things we are not able to do) identified.
Target Score	The score at which the risk management committee would be comfortable in removing the risk from the corporate risk register (CSU or corporate function).

February 2026.

As per the HDFT protocol on the 11th and 12th February 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 12th February 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:

- 959 - Risk to Theatre utilisation and scheduling due to aged condition of estates - This risk was reviewed at the Exec risk review group on Thursday 12th February, Following the risk being reviewed by Care group. The risk was accepted onto the corporate risk register.
- 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

CRR ID: ID 117	Target Date: March 2026		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
Strategic Ambition: An Environment that promotes wellbeing	C = 4	12							Target Rating			Current Rating		Initial Rating		
Type: Operational; Health & Safety	L = 3															

Summary:

This risk was reviewed at the Exec risk review group on Thursday 12th February, the scoring has remained the same. No further changes to note.

Previous rating: February - 12

Escalated to Corporate Risk Register: February 2024

Date reviewed: March 2026.

CQC Domain: Safe

Executive Committee: People & Culture

Previous Target date: July 2025

Principle Risk: Managing the risk of violence and Aggression

Risk Description:

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.

Current Position

Following review on 05/03/2026: The final quarter of 25/26 has seen an increase in the number of incidents involving high-risk mental health patients. In response, there has been increased interaction with / support for the Right Care Right Person Group, along with support from the police to take action in relation to incidents of assaults on staff. The new V&A Policy will begin the governance process in April 2026, and this is now being supported by a series of SOPs (clinically led), including: 'Yellow/Red' card escalation process and security escalation process, which will support the creation of a Physical Restraint / Clinical Holding Policy / SOPs. The combination of these will replace the Managing and Identifying Patients with Challenging Behaviours.

2025/26 data as of 27/02/2026: 530 incidents reported on Datix, compared to 304 reported for the same period in 24/25.
Physical Assault - 138
Inappropriate Behaviour 323
Threatening and/or Verbal Abuse 69
Final quarter of 25/26 has seen an increased number of incidents involving high-risk mental health patients. IN response there has been an increased interaction / support for the Right Care Right Person Group and support from the police to take action in relation to incidents of assault on staff.
New V&A Policy will start governance process in April, and this is now being supported with a series of SOPs (clinically led), including 'Yellow/Red' card escalation process, security escalation process, this will support the creation of a Physical Restraint / Clinical Holding Policy / SOPs, the combination of these will replace the Managing and Identifying Patients with Challenging Behaviours.
Group also established to implement NHSE ETOC implementation. EOI completed access to NHSE funding for Trauma Risk Management (TRiM) training, this would allow the Trust to provide TRiM practitioners who will be able to support staff in high-risk areas.
Violence and Aggression Risk Assessments continue to be progressed for HDH areas, multiple draft assessments now being finalised with ward managers.
Ligature Environmental Assessments completed for all inpatient areas / ED.

Current training compliance levels

- Conflict Resolution Level 1 - 97.7% Trust, 97.9% HIF
- Conflict Resolution Breakaway Skills - 65.9% (Trust), 67.6% (HIF)
- Conflict Resolution Physical Restraint - 76.3% (Trust), N/A (HIF)
- Lone Working - 99.5% (Trust, 1477), N/A at this time (HIF)

- Delay in transfer of CPD funds, additional sessions CR Breakaway Skills booked for end of February and March, further will continue into 26/27. CPD funding has been increased (another 120 places) which will be provided during 2026/27.
- Continued challenges to provide security support whilst HIF develops / recruits in house team.

Key Targets	Current controls	Gaps in control
Suitable and sufficient assessments of risk Trust / HIF activities. Supported by up-to-date policies that reflect the activities carried out by the Trust and the geographical differences created. Risk assessments, policies and control measures actively monitored and reviewed. Use of available data sources, such Datix, sickness absence as part of the monitoring and review process. Provision of appropriate training and information to all Trust staff clinical and non-clinical.	**Task and Finish Group**: A Task and Finish group, led by the Head of H&S, has been established to review and improve all existing policies and procedures, aligning them with NHSE's Public Health Approach. Executive led task and finish group met in September and August and has since been stood down. Issues will be taken through health and safety committee moving forwards. **Mental Health Triage and Policy Update**: Changes to mental health triage in the Emergency Department are ongoing and will be incorporated into a new policy for managing patients who may self-harm or have mental health issues. This policy is in the approval process as of April 2024. **Ligature Assessments**: Ligature risk assessments are under review due to ward and therapy area changes. Training provision for ligature risks is also being addressed after delays caused by staffing changes. **Conflict Resolution Training**: A new Conflict Resolution training program is being developed with three levels tailored to staff risk levels. The content will align with the CQC-supported Restraint Reduction Network, with ongoing discussions to ensure appropriate training needs assessments (TNA) across the Trust. A business case is being prepared to expand training provision. **Community Security and Lone Working**: Visits to all community teams and locations are underway to assess current security and lone working procedures. **Domestic Abuse and Sexual Violence**: Meetings are being held to integrate issues of domestic abuse, sexual violence, and workplace sexual safety into the Violence Prevention and Reduction Strategy. A new policy and training package for line managers is in development, with plans for a team talk session by September/October. **Policy Reviews**: New policy and procedure are under development for staff safety. The Lockdown Policy and Bomb Alert Policies are under review to ensure they are up-to-date and effective. **New Risk Assessment Process**: A Trust-wide risk assessment has been developed and is now being used to inform team and department-level assessments. This is part of an ongoing effort to implement a new risk assessment process across the Trust.	

CRR ID: CRR102 / ID 577 **Strategic Ambition:** An Environment that promotes wellbeing **Type:** Operational; Health & Safety	Target Date: April 2026 C = 4 L = 4 16	Very Low Risk: 1, 2, 3	Low Risk: 4, 5, 6	Medium Risk: 8, 9	High Risk: 10, 12	Significant Risk: 15, 16, 20, 25
				Target Rating		Initial Rating / Current Rating: 16

Summary:

This risk was reviewed at the Exec risk review group on Thursday 12th February, the scoring has remained the same. No further changes to note.
Inhouse security team (provided through HIF) is being progressed with recruitment currently being carried out - target date for implementation of a 24/7 2-person team at the HDH site is April 2026. Single security guard (Gough & Kelly sub-contractor) currently at HDH site 24/7 Fri-Mon and 7pm-7am Tues-Thurs.

Previous rating: February 2026 – 16

Escalated to Corporate Risk Register: August 2024

Date reviewed: March 2026.

CQC Domain: Effective

Executive Committee: Health and Safety

Principle Risk: Governance of security (Physical security provisions, training and support resources)

Risk Description:
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.

Current Position

Following review on 09/03/2026: Inhouse security team (provided through HIF) is being progressed with recruitment currently being carried out - target date for implementation of a 24/7 2-person team at the HDH site is April 2026. Single security guard (Gough & Kelly sub-contractor) currently at HDH site 24/7 Fri-Mon and 7pm-7am Tues-Thurs.

HIF are progressing the establishment of an onsite security team with a target date of April 2026; this will provide a basic level of security presence at the HDH site (2-person team 24/7 presence). Limited presence continues to be provided by contractor Gough & Kelly.
Weaknesses around CCTV at HDH site have been partially addressed regarding Information Governance - x3 HIF staff now completed SIA CCTV training to allow ongoing monitoring arrangements to be completed by HIF.
Ad hoc support continues to be provided by single HIF LSMS to community teams, this resource remains very stretched in being able to support entire community footprint.

There has been a steep increase in V&A related incidents in 2025/26 in comparison to the same period 2024/25 (detailed in CRR 117 V&A risk register entry), in part it is believed that this is down to improved reporting by staff.
Continue to develop improved working relationship / communication between HIF / H&S / Safeguarding to support single instances of risk to staff and patients, including honour-based threats, and mental health incidents, this has seen a number of significant incidents requiring significant staff resource due to lack of dedicated security team.

Achieving target score, which is primarily based on establishment of Security team, is now highly unlikely by previously stated date, as such it is advised that target date should be in line with security team establishment, which will also allow implementation of governance structure to support this implementation.

Executive led Task and Finish Group now established for V&A and the importance of Security will be included in this work. Met in August and September but has now been stood down to allow for this to be managed through the H&S Committee led by Jordan McKie.

Key Targets	Current controls	Gaps in control
Building Security Assessments completed for all premises used by Trust staff (this will not include patient homes which will be referenced in any relevant patient plan) Supported by up-to-date policies that reflect the activities carried out	Suitable and sufficient assessments of risk have been carried out for all Trust / HIF activities. Building Security Assessments completed for all premises used by Trust staff (this will not include patient homes which will be referenced in any	• Limited assurance audit has been received in relation to Security, which links to the work on V&A. Discussed at H&S Committee that security should be separated from this risk entry and have its own created to reflect the areas security covers including: • Policies for Security and other associated policies including Lockdown / Bomb Alert / Theft and Damage of Trust assets or person property / CCTV are out of date and do not reflect the

by the Trust and the geographical differences created. Risk assessments, policies and control measures actively monitored and reviewed. Reported via Security Forum Use of available data sources, such Datix, sickness absence as part of the monitoring and review process. Security incidents investigated and remedial action taken were identified. Effective communications to all staff. Provision of appropriate training and information to all Trust staff clinical and non-clinical.	relevant patient plan) Supported by up-to-date policies that reflect the activities carried out by the Trust and the geographical differences created. Risk assessments, policies and control measures actively monitored and reviewed. Reported via Security Forum Use of available data sources, such Datix, sickness absence as part of the monitoring and review process. Security incidents investigated and remedial action taken were identified. Effective communications to all staff. Provision of appropriate training and information to all Trust staff clinical and non-clinical.	Trust, in particular the geographical footprint covered. • Risk assessments, where available, are generic and do not provide clear identification of hazard or control measures. • No Building Security Assessments have been completed. • Security presence in the Acute setting is limited - Security guard in place on site every night 6pm-6am, Mondays & Fridays 7am-5.30pm, Saturdays and Sundays 6am-6pm. Ripon Community Hospital does not benefit from a security presence. • Currently single LSMS supporting entire Community footprint. • Training is limited and is not currently provided to staff on a risk-based approach. • Escalation procedures for staff in response to incidents and the procedures to follow when dealing with patients is limited and not consistently applied. • Lack of dedicated 24/7 security provision at HDH site limit's ability to support clinical staff – clinical resources redirected to find absconded patients or deal with V&A incidents. • CCTV provision is limited, does not provide cover for entire HDH site, currently managed by HIF (potential IG issues). • Site access control – existing swipe card access system is no longer supported and requires replacement. In addition, control of keys / combination lock codes is poor, control of keys has previously not been suitably managed both with Trust staff and contractors. • It should also be noted that Martyn's Law, Terrorism (Protection of Premises) Bill, is expected to come into law this year, and this will generate significant work to ensure the Trust is compliant. • Management of Security, as specified in the HIF contract, is unclear as to where responsibility for the above sits, in particular the provision of security presence at the HDH site. • Recent high-risk incidents has further highlighted difficulties faced both in acute and community settings – lack of resource to support all areas, i.e. ONE security team member and ONE dedicated H&S team member to support the entire community footprint. • County Lines gang warnings from NY Police also highlighted no formal communication between Safeguarding Team and Trust Security management, this was primarily due to lack of clear security structure. • Trust Security Forum in place – now reports directly to the Trust H&S Committee – current review of membership and TOR • Policies for Security and other related, being carried out by HIF and H&S Team • Replacement of door access system has been costed, current plans are to replace area by area as part of wider Backlog Maintenance work • HIF obtaining legal advice relating to provision of Security Guards at HDH site, licensing implications. This will be reflected in HIF business case for funding Security Guards at HDH site. • Training is being reviewed and amended as part of the V&A Risk entry response. • H&S team are currently carrying out building checklists within our community footprint which includes security – this will inform Building Security assessments.

CRR ID: CRR98 / ID 264	Target Date: April 2026	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: An Environment that promotes wellbeing		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Operational; Health & Safety	C = 3 / L = 5 = 15			Target Rating							Initial Rating	Current Rating			

Summary:

This risk was reviewed at the Exec risk review group on Thursday 12th February, the scoring has remained the same. No further changes to note.

Previous Rating: February 2026 – 15

Escalated to Corporate Risk Register: July 2024.

Date reviewed: March 2026.

CQC Domain: Effective

Executive Committee: TBC

Previous target date April 2025

Principle Risk: Outsourcing of Hazard Group 3 Microbiology Work Due to CL3 Facility Unavailability

Risk Description:
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.

Current Position

Following review on 05/03/2026: enabling **work is underway, room has been stripped out, reception area reconfiguration work is complete. Some minor delays due to electrical work required. Likely completion date end of April 2026. Target date moved to June 2026.**

Since the unavailability of the CL3 lab at HDFT and the outsourcing of Hazard Group 3 microbiology work to a private laboratory in London, significant risks have emerged related to the logistics provider (DX).
These include:

- **Sample Delays:** Routine delays of one day compared to in-house testing, with an additional four-day delay for Friday samples due to weekend non-delivery.
- **Lost Samples**: In June 2024, a box of 12 samples was lost for nine days without an audit trail, raising concerns about sample integrity, data breaches, and mishandling of potentially hazardous materials.
- **Patient Safety**: Delays in sample processing may lead to inappropriate antibiotic use, missed opportunities for treatment adjustments, and patients needing to repeat invasive procedures.
- **Mitigation Efforts**: Attempts to source alternative NHS suppliers within the region have been unsuccessful, as many facilities are at capacity or under refurbishment, leaving limited options to reduce current risks.

These issues present quality, safety, and financial implications that remain unresolved while awaiting further mitigation strategies.

November 2025 - The assigned contractor Bassaire have performed an onsite assessment to then work up the quote for the required capital works. Once the trust are in receipt and have agreed the quote a plan of works can then be agreed. In order for the refurbishment of the Cat3 lab to start there is some enabling work required which HIF will coordinate alongside the Microbiology team. The capital team have confirmed we are still on track to complete this financial year.

Key Targets	Current controls	Gaps in control
1. Minimise delay to patient treatment 2. Zero staff harms resulting from exposure to unexpected hazard group 3 pathogens 3. Zero lost samples 4. Cessation of outsourcing & transport cost pressure	A series of plans and actions are being developed to address the risks associated with the outsourcing of Hazard Group 3 microbiology work, including delays, lost samples, and logistical challenges. These include: • **Recommissioning of Onsite CL3 Facility:** An outline business case to recommission an onsite CL3 facility was presented to the BCRG on 2 July 2024. A full business case will proceed. This business case will detail the lab specification, costs, and implementation timescale, aiming to restore onsite testing capabilities and reduce reliance on external providers. • **DX Transport Investigation:** DX, the transport provider, is conducting an internal investigation to identify potential errors and establish mitigations to prevent future occurrences of lost or delayed samples. The results of the	Jan 25- Design plans in the final stages of agreement - required enabling work to move doors approved by Health & Safety and Fire.

	investigation are awaited, with the aim of improving sample tracking, delivery times, and overall reliability. • **Sourcing Alternative NHS Suppliers:** Despite ongoing efforts to find an alternative NHS supplier for Hazard Group 3 work, no viable options have been found due to capacity and facility issues at other trusts within the region. Attempts to identify a suitable alternative will continue alongside the progression of the onsite CL3 facility business case. These actions are critical to mitigating current risks and ensuring patient safety, sample integrity, and operational continuity.	

CRR ID: CRR34 / ID 1	Target Date: March 2026	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Great Start in Life		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical; Patient Safety	C = 3 / L = 5 = 15								Target Rating		Initial Rating	Current Rating			

Summary:

Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within three months of referral.
Risk that children may not get access to the right level of support without a formal diagnosis and that this would lead to deterioration in condition and patient harm.
This risk was reviewed at the Exec risk review group on Thursday 12th February, the scoring has remained the same. No further changes to note.

Previous Rating: February 2026 - 15

Escalated to Corporate Risk Register: December 2023.

Date reviewed: February 2026.

CQC Domain: Responsive

Executive Committee: Resources

Principle Risk: Autism Assessment

Risk Description:

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)

Current Position

Following review on 23/02/2026:
Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within three months of referral.
Risk that children may not get access to the right level of support without a formal diagnosis and that this would lead to deterioration in condition and patient harm.

The Key risk indicators are:

- **Numbers on the waiting list: 1479 (target 120)**
- **Longest wait for completed assessment: 129 weeks (target 13 weeks)**
- **Activity - Financial Year end position 546 completed assessments against ICB plan of 530 (plus 14 military assessments completed in addition).**

Our commission capacity is now lower at 40 assessments per month which means the waiting list will grow more steeply.
Non-recurrent funding challenges service management due to lead times for capacity acquisition and staff training, exacerbated by national shortages. Loss of a key clinical team member impacts medium-term assessment capacity.
Support provided to the team; commissioners informed. ICB-wide autism and ADHD group supersedes previous locality-based group, aiming to standardize referral criteria. No extra funding is available for capacity gaps. Stabilizing waiting lists requires increased capacity, costing £490k annually. Modelling shared at CC Resources Review and escalated to place ICB meeting for executive consideration. No agreed plan for long-term resource provision is currently agreed and in place.
The ongoing risk has been escalated to HNY ICB executive team. A meeting between HDFT and HNY ICB executives is planned for September to discuss the ongoing capacity and demand challenges and future commissioning intentions.
The Key risk indicators are:

- Numbers on the waiting list: 1560 (target 120)
- Longest wait for completed assessment: 98 weeks (target 13 weeks)
- Activity - Financial Year end position 546 completed assessments against ICB plan of 530 (plus 14 military assessments completed in addition).

Key Targets	Current controls	Gaps in control
Waiting list would have to be reduced to 120 and longest wait to 13 weeks. Baseline capacity would need to meet the referral rate.	The progress with PLACE based work. Mobilisation of WLI and new pathways	Autism team have drafted an options paper which has been reviewed by PSC leadership team, financial modelling included. Option paper being reviewed by Exec

Numbers on the waiting list 1560 (target 120) Longest wait of CYP having commenced assessment, 82 weeks (target 13) Activity - 31 completed assessments in Aug against ICB plan of 50 (plus 2 military assessment), YTD 255 against plan of 250. To meet the monthly ICB target for number of assessments Meet the annual planned target for assessments	In order to stabilise the waiting list, we would need to increase the service capacity to approx. 90 assessments per month with the additional staffing costing £490k full-year effect. The modelling has been shared at the CC Resources Review Meeting and has been escalated to the place ICB meeting with Execs as it was felt HDFT could no longer carry all the risk of these waits and there is currently no agreed plan to provide the resources required to address this longer term.	team and awaiting response. Katy Marshall, Strategic lead for autism at HNY ICB, is writing a paper around the capacity issues for all providers and options going forwards. Draft paper delivered in Jan 2025 (following a face-to-face workshop in October 24) is clear that there is no further funding available but that this needs consideration to enable reduction in waiting lists alongside demand management. Further work under Mental Health and learning disability collaborative to agree ICB wide service spec (will not address backlogs).

CRR ID: CRR61 / ID 3	Target Date:	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Person-centered, integrated care, strong partnership	March 2026	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical; Patient Safety	C = 4 / L = 3 = **12**							Target Rating			Initial Rating / Current Rating				

Summary:

EEMAC trialed for March. Positive impact seen. Risk reviewed by risk owner and current position updated.

Previous Rating: February 2026 - 12

Escalated to Corporate Risk Register: December 2023

Date reviewed: March 2026.

CQC Domain: Safe

Executive Committee: Resources

Principle Risk: **ED** 4-hour Standard

Risk Description:

Risk of patient harm and increased morbidity / mortality for patients due to failure to meet the Emergency Care Standard Performance (National Standard 78%).

Current Position

Following review on 11/03/2026: EEMAC trialled for March. Positive impact seen.

Risk of patient harm and increased morbidity / mortality for patients due to failure to meet the Emergency Care Standard Performance (National Standard 78%).

Key risk indicators
ECS 4-hour target to be met - 78%
October 2025 - 74.3%
YTD - 78.25%

12 Hour Breaches target to be met - 0
October 2025 - 27 (consistently top quartile)

6-hour breach removed due to 12 hour and 4-hour performance. Data still captured on PowerBi.

26/11/2025: rating remains unchanged.
January 2026 - temporary mitigations in place with pilots for USDEC / RIAT doctor. Final Trust position - 71.4%
February 2026 - extended RIAT pilot to end of March.

Key Targets	Current controls	Gaps in control
4-hour performance A&E 4-hour target to be met, 6-hour breaches <102 per month 0 x 12-hour breaches	Introduction and use of non-headed beds and use of rapid decompression plans. Shared risk site wide. Point of care testing in ED to support swift decision making re. patient placement Adoption of OPEL escalation 4 daily bed meetings; manager of the day model embedded across PSC and LTUCC.	Significant delays to medical bed. Plan to move medical admission ward in December 2025 to gain 6 medical beds. Winter plan enacted to open escalation ward as of 29 December 2025. Pilot of winter RAT doctor in ED. Pilot of urgent SDEC proposed.

CRR ID: ID 642	Target Date: December 2026	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Person-centered, integrated care, strong partnership		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical; Patient Safety	C = 3 / L = 4 = **12**			Target Rating							Initial Rating / Current Rating				

Summary:

This risk was reviewed by risk owner – no changes to the position and scoring has remained the same. No further changes to note.

Previous Rating: February 2026 - 12

Escalated to Corporate Risk Register: November 2024.

Date reviewed: March 2026.

CQC Domain: Safe

Executive Committee: Quality

Previous target date – December 2025.

Principle Risk: Risk to providing DGH urgent and emergency care services due to lack of 24/7 cover (cardiology)

Risk Description:

Risk to HDFT being able to deliver acute DGH services due to the fragility of the cardiology service. Significant control and reduction in likelihood.

Current Position

Following review on 04/03/2026: no change to current position.

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.
October 2025 - Locum consultant no longer in post.
December 2025 - recruitment processes underway re-previous long-term locum.
Development of workforce planning document underway.

Key Targets	Current controls	Gaps in control
Staffing and Workforce KRIs: • Consultant Staffing Levels: Percentage of Consultant PAs filled with substantive staff versus locums. Number of unfilled Consultant posts after each recruitment round. Quality and Outcomes KRIs: • Clinical Outcomes: Mortality rates for acute cardiology patients on CCU. Readmission rates for cardiology patients within 30 days of discharge.	• Safety risk for acute patients on CCU • Staffing - Substantive post for consultant back out to advert with R&R premia • Current medical workforce do not have the skillset for temporary pacing wires and pericardiocentesis – excellent links with LGI • Long waits for outpatient angios (30% waiting over 6 weeks) – using locum to reduce was 50% over 6 weeks – also review use of Cath lab • ECHO service reliant on outsourcing workload (12 months ago 70% patients waiting over 6 weeks – now 22% waiting over 6 weeks – Sanus cor delivered activity and bank) – now recruited to a vacant post (starting Jan 25) and plans to grow our own No weekend Consultant ward round or ECHO provision • Increasing demand on pacemaker service due to increasing aging patient profile • Not meeting GIRFT requirements with 7-day service and weekend cover/ on call - Cardiology strategy planning meeting scheduled for 7 November 24. Consultant of the week in place to cover in hours, Monday-Friday.	Linking in with Clinical Lead at LTHT for specialty support. - working progress Seeking a fellow for Cardiology for service continuity and ward cover. Locum reg in place. Consultant recruitment processes underway

CRR ID: ID 292 **Strategic Ambition:** Person-centered, integrated care, strong partnership **Type:** Clinical; Patient Safety	Target Date: September 2028		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	C = 4 L = 3	12				Target Rating			Initial Rating			Current Rating				

Summary:

This risk was reviewed at the Exec risk review group on Thursday 12th February, the scoring has remained the same. No further changes to note.

Previous Rating: February 2026 - 12

Escalated to Corporate Risk Register: May 2025.

Date reviewed: February 2026.

CQC Domain: Safe

Executive Committee: Resources

Previous target date September 2025.

Principle Risk: Automated medicines supply services

Risk Description:

There is a risk of failure of the inpatient-dispensing robot caused by wear and tear over a number of years and the robot exceeding it predicting lifespan. The impact of this is inability to provide a lean and efficient medicines supply service for top-up, inpatient dispensing and discharge dispensing. The effect on patients would be delays in supplies of medicines for inpatient/discharge and potential delays to discharge as processes would revert to time-consuming manual processes.

Current Position

Following review on 24/02/2026: Monitor broke on the robot 17/2/26. Interim fix done that day. Awaiting parts. No other change.

July 25- Business Case Developed, however waiting for detail from capital planning before submission to business case review group. Aim for re-submission at September's review group, pending outstanding information from capital planning team.
Staff re-training in progress to ensure correct use.
6 monthly service due 5th July 2023.
Detailed reports now obtained from supplier when issues logged.

- 15/11/23 Robot training completed for all staff.
- 01/05/24 Weekly robot reboot including log of when this has occurred.
- 01/05/24 First recovery planning meeting held. Risk score increased due to increase in frequency of failure.
- 21/5/24 No failure requiring significant downtime for 4 weeks. Recovery plan in progress with completeness by mid-June. Service due 22nd May.
- 13/05/25 Failure around once a month. Escalated back to capital planning for replacement. To update the business case and resubmit it to Business Case Review Group.

Key Targets	Current controls	Gaps in control
	Robot malfunctions monitored via Stores and Distribution and escalated where increasing frequency gives cause for concern. Robot listed on the capital assets register.	• Business case to support capital replacement of the robot. • 1.5.24 Business continuity plan for robot failure • Meeting with supplier to discuss new robot options planned for 27th June.

CRR ID: ID 721	Target Date:	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Overarching Finance	March 2026	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Financial	C = 5							Target Rating					Initial Rating		Current Rating
	L = 5	25													

Summary:

This risk was reviewed at the Exec risk review group on Thursday 12th February, the scoring has remained the same. No further changes to note.

Previous Rating: February 2026 - 20

Escalated to Corporate Risk Register: May 2025

Date reviewed: February 2026.

CQC Domain: Well-Led

Executive Committee: Resources

Principle Risk: Group Cash Position 2025-26

Risk Description:

The Trust is managing cash flow on a week-by-week basis there is currently £14m payments outstanding with Suppliers at the end of December. The finance team are prioritising the payroll and then any urgent payments. (The bank was overdrawn in May, £2m for the afternoon until payments were received from HNY). ICB provided an early payment for ERF in December 1.9m, which allowed some suppliers to be paid.

Current Position

Following review on 14/02/2026: Cash position at the end of January 0.3m, this is £1.7m less than the minimum cash balance. The Trust is managing cash flow on a week-by-week basis there is currently £12m payments outstanding with Suppliers at the end of January. The finance team are prioritising the payroll and then any urgent payments. (The bank was overdrawn in May, £2m for the afternoon until payments were received from HNY). ICB provided an early payment for ERF in December of 1.9m which allowed some suppliers to be paid. PDC is still being drawn down for capital cases. Cash support request has been submitted for March £9m required for March, to date £1m received in Jan and £9m in Feb. Despite Supplier relationships being maintained to date, relationships are becoming strained despite the payment teams best efforts. Fines/penalties, threat of accounts being put on hold escalate.

Cash position at the end of December £3.5m.

The Trust is managing cash flow on a week-by-week basis there is currently £14m payments outstanding with Suppliers at the end of December. The finance team are prioritising the payroll and then any urgent payments. (The bank was overdrawn in May, £2m for the afternoon until payments were received from HNY). ICB provided an early payment for ERF in December 1.9m which allowed some suppliers to be paid.

PDC still to be drawn down for new schemes recently agreed and Littondale (awaiting case approval)

Local Authorities have confirmed they will pass on the pay award uplift (bar 2 contracts).

Cash support request has been submitted £19.6m required for quarter 4, NHSE have confirmed receipt and queries have been responded to.

Key Targets	Current controls	Gaps in control
Cash position maintained	• Emergency Case Protocol to be developed to prioritise cash payments, which factors in cash support not being offered. • Regular monitoring of cash position and forecast. • Review of Council payment terms. • Cash support requests being submitted in NHSE timeframes.	• Aged Debt - Although more focused is still needed, due to supplier payments being delayed it is impacting payments from other Trusts. • Balanced financial plan - Financial Plan for 25/26 remains challenging • NHSE timeframes for review of capital cases and issuing MOU's.

CRR ID: ID 816	Target Date: March 2026	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Overarching Finance		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Financial	C = 4 / L =5 = 20							Target Rating				Initial Rating		Current Rating	

Summary:

Forecast protocol £20m. £30m likely outcome, with mitigating actions in M12 which would be £10m away from the forecast protocol change. Scoring remains the same

Principle Risk: Delivery of Financial Plan 25/26

Risk Description:

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.

Previous Rating: February 2026 - 20

Escalated to Corporate Risk Register: June 2025

Date reviewed: March 2026.

CQC Domain: Well-Led

Executive Committee: Resources

Current Position

Following review 06/03/2026: Forecast protocol £20m, £30m likely outcome with mitigating actions in M12 which would be £10m away from the forecast protocol change.

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.

As at the end of December, the Trust reported a £17.8m deficit this is £15m away from plan. The plan includes a risk share arrangement of £12m, the £6m HDFT need to identify has been phased into the second half of the year (M12). Deficit funding, £5.2m is at risk if the financial plan is not delivered across the system (secured for Qtr1 and Qtr2) pay back of Qtr 3 and Qtr 4 begin withheld is now likely. Key drivers impacting the position include

WRAP (Non-Pay Variance)
Prior year £1.3m
Wards £1.2m but does include 0.2m 1:1 247 care (Pay Variance)
Medical Staffing £0.8m A3 being developed to explore drivers
Forecast deficit £20-28m without any mitigating actions.

Key Targets	Current controls	Gaps in control
Financial Variance to plan WRAP delivery Cash position	Vacancy Panels to review all TRACS following finance review. Further Exec review each week implemented. Requisitions are in place before any spend is committed. No PO no Pay. Need to monitor compliance. Discretionary spend controls remain in place, moved onto an online form for secondary approvals and panel available to pick up any themes/queries. All exemptions to be removed. NHS Supply Chain restrictions in place. All spend over £10k is authorised by the Finance Director. EASY expenses is restricted for specific spend requests including Travel/Eye Test/Course Fees/Vaccination/Blue Light Card/Telephone Calls. Nonclinical overtime being monitored and escalated to managers to review arrangements and approval. Off Framework agency monitoring. Agency requests to be recorded via the online form, confirming Exec sign off if over cap or off framework. All minor works requests approved by Trust prior to HIF undertaking. Finance governance escalation – FDOG commenced from June 2025. Weekly recovery meetings in place with Directorates significant overspends. WRAP Principles, A3 documentation and governance arrangements in place (Internal audit provided significant assurance on process) Double Lock has been implemented with ICB.	Recurrent delivery of WRAP Contracts agreed (ICB) - Now finalised Managing spend within budgeted allocations Testing controls - to ensure they are doing as needed Wharfedale - opportunity to earn additional income ERF performance - fixed contract for HNY

CRR ID: ID 73	Target Date:	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Overarching Finance	March 2026	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Financial	C = 3 / L = 4 = 12							Target Rating			Current Rating		Initial Rating		

Summary:

This risk was reviewed at the Exec risk review group on Thursday 12th February, the scoring has remained the same. No further changes to note.

Previous Rating: February 2026 - 12

Escalated to Corporate Risk Register: June 2025

Date reviewed: February 2026.

CQC Domain: Well-Led

Executive Committee: Resources

Principle Risk: Recurrent delivery of Efficiency programme (WRAP)

Risk Description:

The Trust has a £14.4m WRAP programme to deliver in 25/26.
As at December £9m has been actioned, £12m forecast. £6.2m cost reduction schemes have also been identified. Risk adjusted plans have improved but still leave a gap to full delivery.

Current Position

Following review 14/02/2026: The Trust has a £14.4m WRAP programme to deliver in 25/26. As of January, 93% has been actioned and £6.2m cost reduction schemes have also been identified. Risk adjusted plans have improved but still leave a gap to full delivery.

There are a number of high-risk schemes that are being worked through via the A3 HDFT impact methodology.
Top 5 unactioned schemes
Theatres Utilisation £500k
Procurement non pay £300k
CYP Non pay saving £264k
Drug savings £263k
LTUC Model Health £208k
Total £1.5m 11% of the target

Governance structure has been developed and PRMs will pick up progress each month.
There is also the £6m risk share to consider how this will be addressed (part of the contract agreement 50/50 risk share)
Internal audit provided significant assurance on the WRAP process due to current delivery and the benchmarking information which supports the targets.

Key Targets	Current controls	Gaps in control
	Monthly Directorate and Trust reporting. Directorate performance panels. Regional engagement/shared learning.	25/26 plans were underpinned by the opportunity to attract Elective Recovery Funding, HNY have now confirmed a fixed contract, WY is a variable contract but confirming if there is a ceiling in place. Recurrent schemes versus non recurrent schemes.

CRR ID: ID 6	Target Date: March 2026	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition: Provide person-centered, integrated services through strong partnerships		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical; Patient Safety	C = 3 / L = 4 → **12**						Target Rating				Initial Rating / Current Rating				

Summary:

This risk was reviewed at the Exec risk review group on Thursday 12th February, the scoring has remained the same. No further changes to note.

Previous Rating: February 2026 - 12

Escalated to Corporate Risk Register: December 2023.

Date reviewed: February 2026.

CQC Domain: Responsive

Executive Committee: Resources

Principle Risk: Community Dental

Risk Description:

Risk to Trust performance standards by failing to meet NHS annual planning target of no RTT waiters beyond 52wks by end March 2025. Risk to patient safety due to correlation of long waiting times and increased risk of pain and infection which may impact on quality of life and treatment required, particularly for surveillance patients due to lower capacity than required to meet review timescales.

Current Position

02/02/26 - Current position - 0 over 52wk RTT waiters, 1513 over 52wk non-RTT waiters, 509 overdue (assuming recall was set to 12 months) surveillance patients - longest overdue 2 years. Currently have gaps due to maternity leave in the West and fixed term contract come to an end with no further recruitment to date. One candidate going through the recruitment process and all other recruitment now on hold due to contract but is leaving the service in a deficit.

08/12/2025 Current Position - 0 over 52wk RTT waiters, 1945 over 52wk non-RTT waiters, 619 overdue surveillance patients - longest overdue 2 years.
When reported: 0 over 52wk RTT waiters; 1187 over 52wk non-RTT waiters and 1666 overdue surveillance patients, longest overdue by 3yrs

The ICB has agreed to invest an additional £1.5 million into the CDS service at HDFT, extending the contract by 18 months until March 31, 2025.
Regional discussions suggest a potential agreement on a 7+3 contract and amended service specification, with a possible increase in the funding envelope, though formal confirmation is pending post-general election.
The current funding does not fully align with the submitted business case, so the operational team and service manager have developed a plan to optimize the use of this investment, focusing on managing waiting times for both RTT and non-RTT patients. Key actions for July include recruiting a new clinical lead, continuing IT procurement, and addressing low staff engagement, which has been identified as a significant risk to service delivery.
The CDS team is also being encouraged to participate in the HDFT Impact work as part of phase 4 to further support service improvements.
Procurement tender process has been complete, awaiting assessments and contract sign off. No change to risk scoring until system is implemented.

Key Targets	Current controls	Gaps in control
Numbers on the patients waiting to start treatment over 52weeks, 65weeks and 78weeks Current position for RTT waiters - 0 patients between 52-64 weeks. Current position for Non RTT waiters – 1187 patients over 52 weeks, no of overdue continuing care patients. Overdue surveillance patients -1666 (longest overdue by 3 years).	Implementation of business case agreed additional capacity - equipment and additional dentist/dental nurse capacity. Clinical prioritisation of patients at triage - currently meeting urgent P2 turnaround times for GA patients and 2 working day target for trauma patients. Pts advised to recontact service if deterioration - pain/repeated courses of antibiotics.	Lack of contract and delivery plan beyond 31st March 26 as procurement exercise for long term contract still not concluded (1yr extension offered in interim). Current extension has additional requirement of delivering Epidemiology survey for public health, which will reduce core service capacity - unfortunately base budget also not fully re-provided which has reduced capacity in the service. Current focus on key areas: 1) Continuing recruitment focus on posts and hard-to-recruit areas - paediatric specialist/consultant capacity. Paused recruitment due to unsuccessfully filling vacancies. Have recruited 3 new dentists, although not specifically paediatric specialists. 2) Patient IT system procurement to replace SOEL Health which is no longer supported (Procurement exercise in evaluation phase, implementation date for Oct25). Business case not progressed during Summertime, AM to submit for Dec BCRG. 3) If patients ring to report pain as advised, we aim to appoint within 6 weeks.

		4) Focus on GA pathways to try to replicate productivity at York exodontia lists at Harrogate/Northallerton - implemented increase from 4 per list at Northallerton to 5 - further opportunity identified to work with South Tees in September25. Harrogate sessions have increased pts per list with a continued focus on theatre utilisation.

CRR ID: ID 597	Target Date:	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition:	December 2026	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Clinical; Patient Safety	C = 3														
	L = 5	15			Target Rating				Initial Rating			Current Rating			

Summary:

This risk was reviewed at the Exec risk review group on Thursday 12th February, the scoring has remained the same. No further changes to note.

Previous Rating: February 2026 – 15.

Escalated to Corporate Risk Register: November 2025.

Date reviewed: February 2026.

CQC Domain:

Executive Committee:

Previous target date: December 2025.

Principle Risk: Histopathology space and safety concern

Risk Description:

The Histopathology laboratory area has limited space due to expansion over the last 10 years. Expansion has been essential to ensure that the service provided to the trust is appropriate to the requirements aligned to cancer pathways. Additional analysers and essential equipment have been installed, which has now resulted in the area being extremely cramped. Due to increase in specimen numbers the storage capacity of the laboratory is now critical and imposing a safety concern to both staff and patient specimens. It is a regulatory requirement to store specimens for 42 days post authorisation. This is now resulting in specimens being stacked on top of each other including at height as there are no other options currently. This increases the risk of specimen formalin spillages and higher risk of incorrect disposal or loss of specimens. Increased risk of slips and trips to staff. This has now been raised as a finding by UKAS, who we are accredited with. UKAS need to be provided with evidence of how this will be rectified to ensure the safety of both staff and specimens. Due to increased demand from the trust further expansion is required but due to the space constraints this is not currently possible. This will impact the ability to support any further workload increase e.g. TIF2, proposal for women's unit expansion, dermatology expansion. It has also hindered the ability to take on further clinical trials which may have improved the patient pathway and clinical outcome. The inability to expand will also hinder support of cancer targets i.e. ensuring 62-day referral to a cancer pathway, and RTT targets are met.

Current Position

Following review 11/03/2026: no change regarding space. The capital team are supporting the upgrade of 2 of the downdraft benches which are out of action, this has been raised as a separate risk.

24.07.25 No funding opportunity from cancer alliance. Working through impact plan to approach capital team

31.10.25 Flagged to Jordan McKie as an issue and will prevent us from taking on any additional work in histopathology e.g. TIF2. Discussions took place around drawing up proposal for expansion.

Key Targets	Current controls	Gaps in control
	Risk of specimen loss - controlled by specimen disposal performed by x2 staff members with quality control checks in place Risk of spillage due to specimens being stacked and at height - Disposal carried out weekly in order to try and create space and reduce specimens being stacked at height. Wax deliveries (20kg) each are having to be stored under benches in the lab - this poses a health and safety risk to staff having to move the bulk boxes from under benches. Blocks are required to be stored for a minimum of 30 years. Blocks are kept on site for a minimum of 2 years due to additional tests that may be required. They are then transferred to an offsite secure facility to store for the remaining 30 years. The capacity for storage has been reached and there are	Specimens being stacked at height - we ensure that disposal is regular, but this is not always sufficient to ensure that specimens are not stacked at height. Risk assessment complete and staff trained in spill procedure, spill kits available if required. Datix completed if a spill occurs Breast mastectomy specimens - in order to meet national standards, the team try to reorganise workload to enable a downdraft bench to be freed up. If this is not possible a different bench is used but this requires the movement of all reagents to an area where there is no downdraft ventilation. This poses a health and safety risk Inability to expand the service to support additional workload i.e. - expansion of specific services, TIF2 project. Discussion underway with cancer alliance regarding funding opportunity and if this can be used for

	limited options for further storage due to the requirement for a reinforced floor. A significant amount of flammable reagent (alcohol, xylene and formalin) are used daily and more frequently due to additional strainers being required to keep up with the increased demand. Due to limited space majority of this is being stored in the outside flammable store. This results in staff having to make frequent trips to the store and poses a manual handling issue. When receiving a breast mastectomy specimen national standards state that the specimen should be opened within 4 hours. This is not always possible due to a downdraft bench being unavailable. This may lead to degradation of the specimen	expansion either additional equipment or capital work. Paper submitted to environment board to highlight space issues

CRR ID: ID 959	Target Date: March 2026		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
Strategic Ambition:			1	2	3	4	5	6	8	9	10	12	15	16	20	25
Type: Operational	C = 3	15						Initial Rating					Current Rating			
	L = 5															

Summary:

This risk was reviewed at the Exec risk review group on Thursday 12th February, when the risk was accepted onto the Corporate Risk Register.

Previous Rating: February 2026 - 15

Escalated to Corporate Risk Register: February 2026

Date reviewed: February 2026.

CQC Domain: Responsive

Executive Committee: Resources

Principle Risk: Risk to Theatre utilisation and scheduling due to aged condition of estates.

Risk Description:

Risk to Theatre utilisation and scheduling due to aged condition of estates.

- Air handling system needs renewing
- General theatre area need refurbishment.
- New doors that meet current standard
- Theatre panels need renewing
- Inbuilt IT equipment.
- Cancellation of theatre lists
- Short notice cancellation of patients
- Increased risk of infection
- Impact on acute services

Current Position

28/01/2026 Agreed risk remains same and to be escalated to CRR.

11/12/25 theatre 5 issues causing cancellations of multiple patients (4)

14/12/25 Theatre issues with Laminar flow (2)

Key Targets	Current controls	Gaps in control
	• Regular Audits • Maintenance Checks • Servicing	• unexpected failure of systems • leaks

Harrogate and District NHS Foundation Trust

Board Meeting Held in Public

Title:	Learning from Deaths Quarterly Report Q3: October-December 2025
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

Purpose of the report and summary of key issues:	The board is asked to note the surveillance of mortality indices across the trust.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	N/A	
Report History:	Paper also submitted to End of Life Group, Patient Safety Forum, Quality Governance Management Group and Quality Committee	
Recommendation:	The board is asked to note the contents of the report, including the metrics and methodology used.	

Harrogate and District NHS Foundation Trust

Board Meeting Held in Public

Learning from Deaths Quarter 3 Report

Executive Medical Director

1.0 Executive Summary

Crude mortality rates for the trust continue to oscillate around national levels.

SHMI has remained stable this quarter, within the expected range.

21 cases have undergone a structured judgement review since the last report. Two case was identified of poor overall care but that was not felt to have significantly affected the outcome. One case was the subject of an After Action Review as part of our PSIRF process, and the second was discussed at a departmental Governance meeting for learning.

We are continuing to use “watch metrics” in keeping with HDFT Impact methodology to identify areas for increased scrutiny.

Harrogate and District NHS Foundation Trust

2.0 Introduction

Although mortality represents a very small percentage of all trust activity, it is important that it is monitored and examined appropriately. This report aims to triangulate mortality indices with other markers of quality of care, in particular that provided by structured judgemental reviews (SJRs) of medical records.

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality. In total, 167 deaths were recorded in Q3, up from 143 in the preceding Q2 but down from Q3 in 24/25 which had 199 deaths. This data is not risk-adjusted so takes no account of the unique characteristics of individual admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years. Note that the rise in mortality in HDFT seen in December 2024 is mirrored by a similar rise in national numbers.

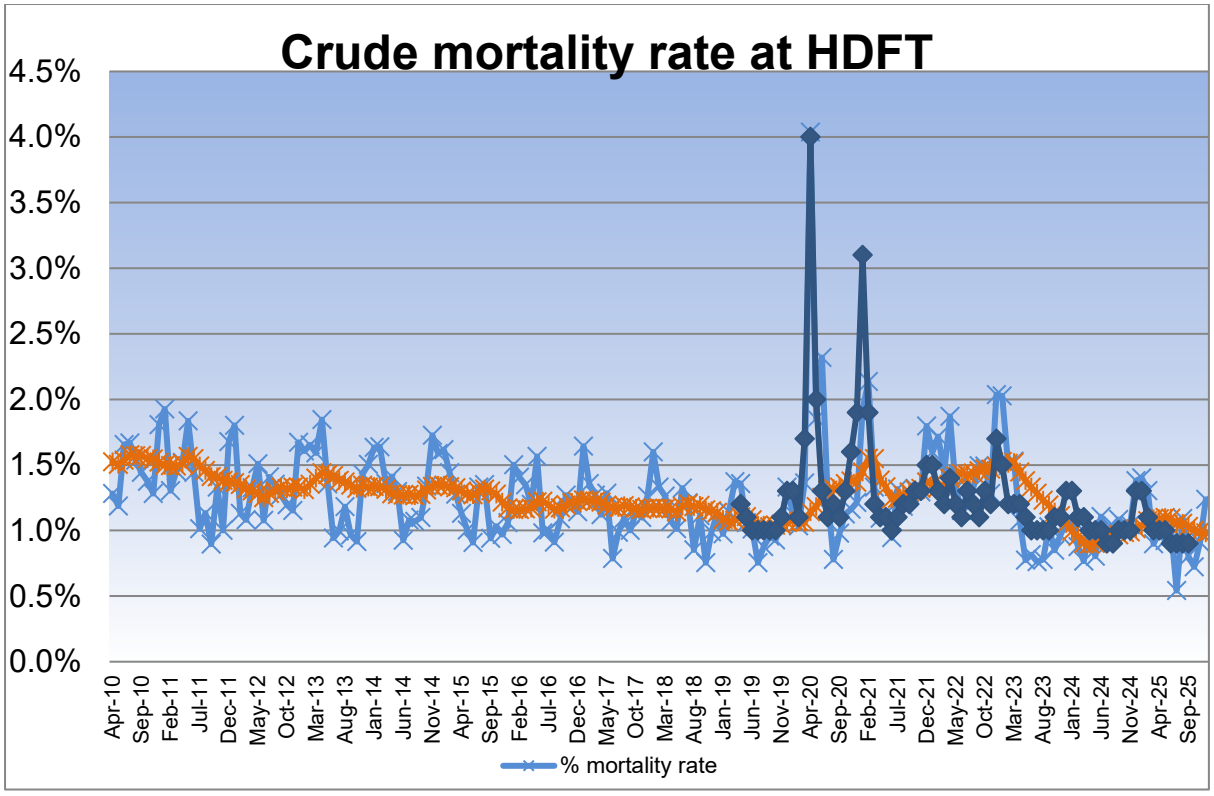


Figure 1: Crude mortality rates over the last 15 years (%deaths per hospital episode)

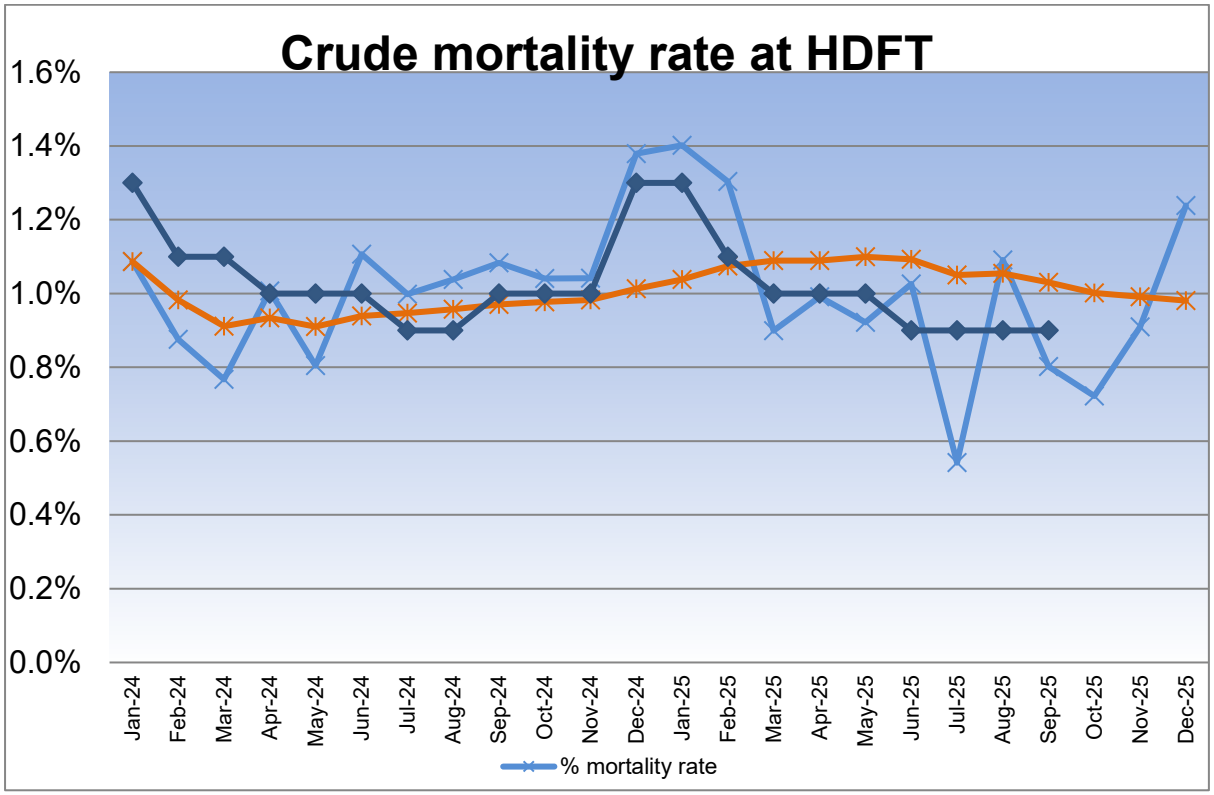


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

3.2 Standardised Hospital Mortality Index (SHMI)

Figure 3 shows our 12 month rolling SHMI compared to regional peer organisations, with Figure 4 comparing HDFT to national peers:

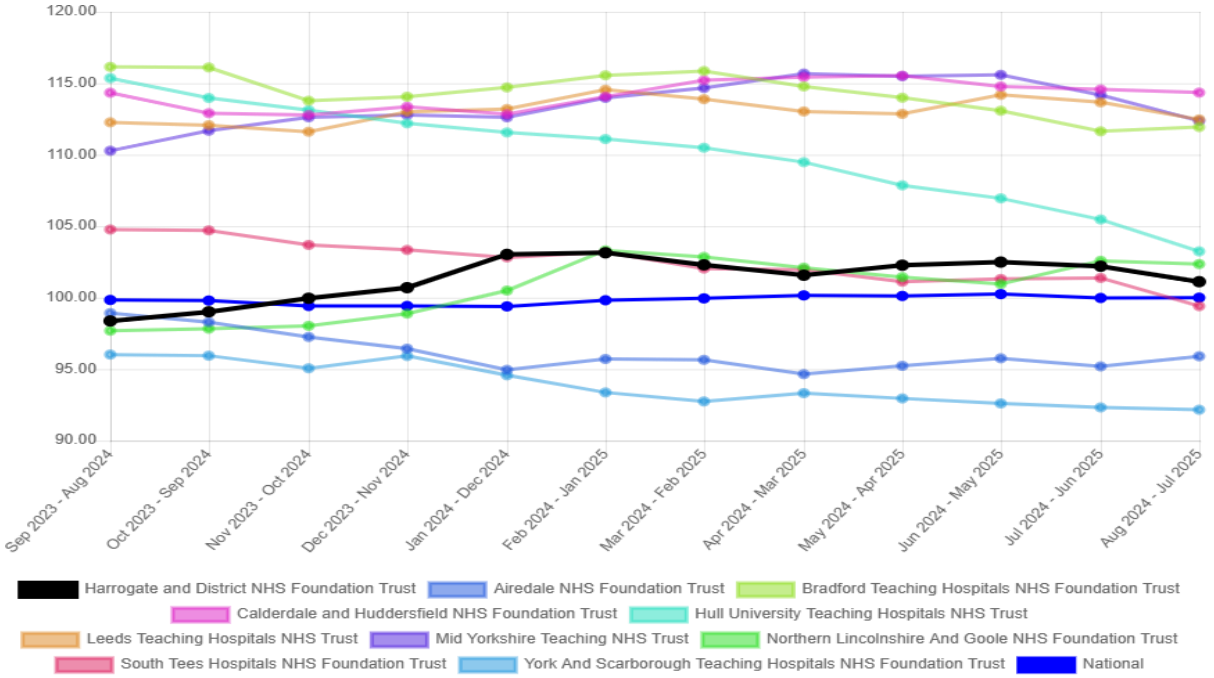


Figure 3: HDFT SHMI since Sept 2023 versus regional peers

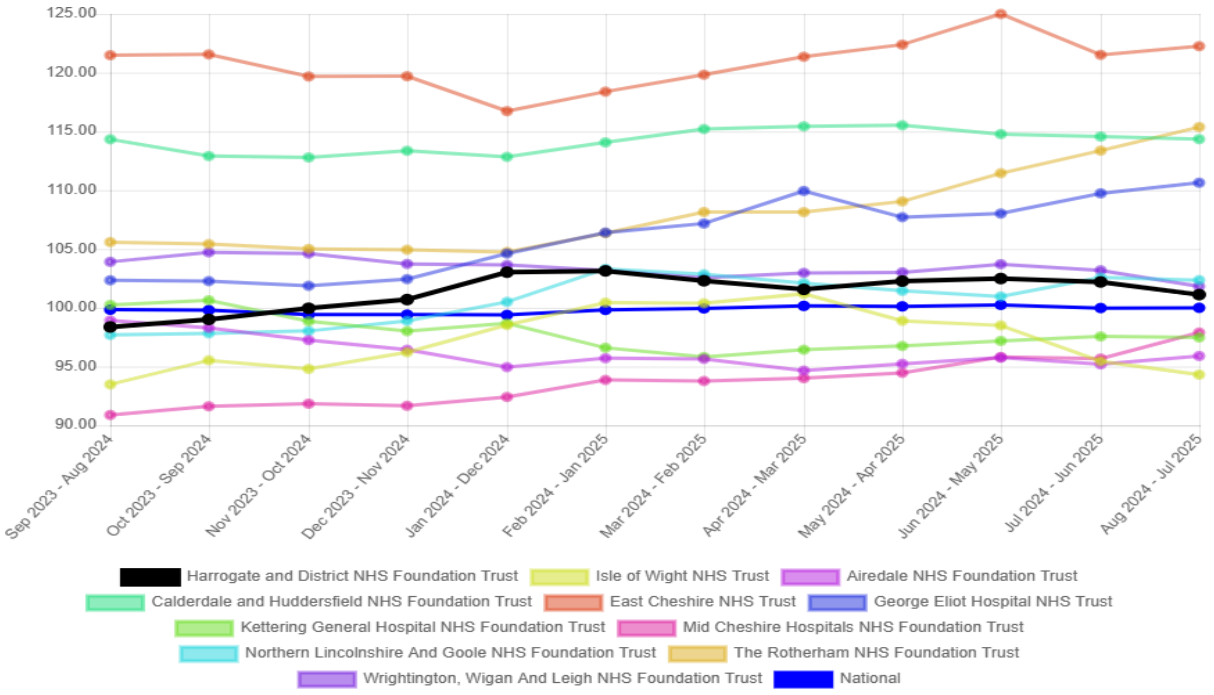


Figure 4: HDFT SHMI since Sept 2023 versus national peers

As can be seen, our SHMI peaked in the period Feb 2024-Jan 2025 having slowly climbed previously. This rise was primarily driven by a precipitous fall of expected deaths, as shown in figure 5:

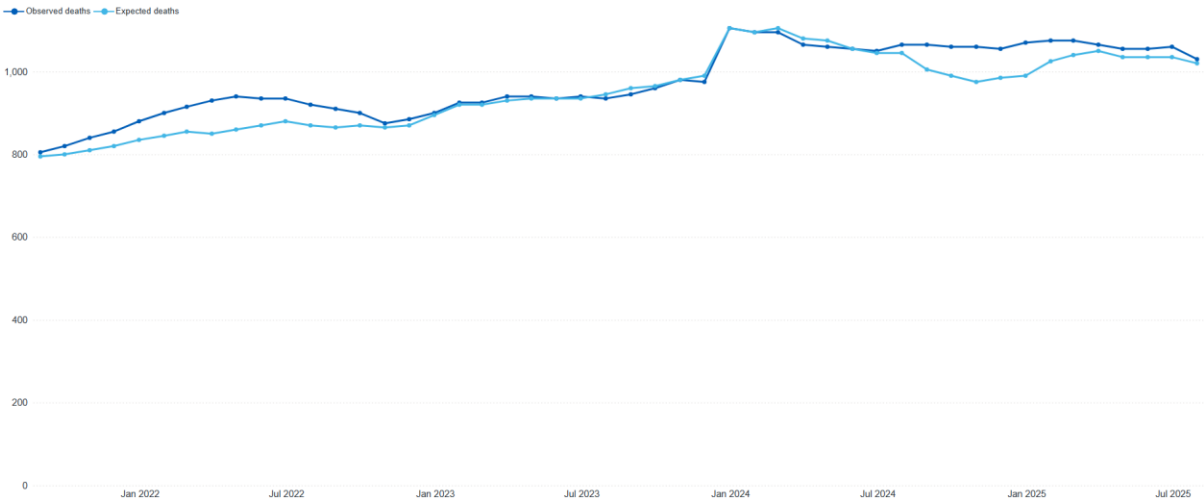


Figure 5: Observed (dark blue) and expected (light blue) number of deaths (in hospital or within 30 days of discharge – rolling 12 months)

A sudden fall in expected death numbers, as seen from July to December 2024, raises concerns of a data quality issue. We identified an increase in patients' diagnostic code in the category "Invalid primary diagnosis". We normally have very few spells in this category, but it sharply rose in 24/25 year. The reason behind the rise of this category is likely due to incomplete clinical coding by the time of SHMI generation. The number of cases with "invalid primary diagnosis" has now fallen significantly but still remains at around 10%. There remains some challenging issues affecting coding team capacity currently, but actions are being taken to support the team during this difficult period.

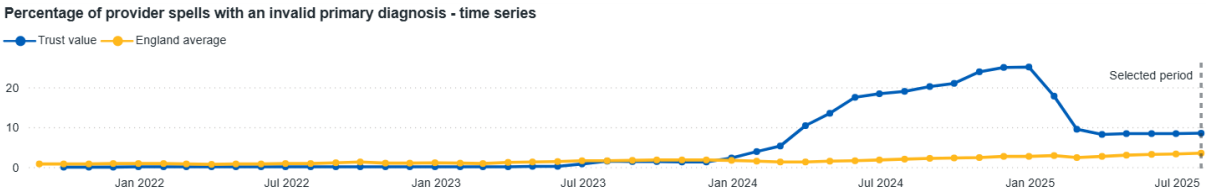


Figure 6: Spells with an "Invalid primary diagnosis" coding. Note how the number has fallen but not fully returned to baseline

3.3 Structured judgement reviews (SJR)

21 cases have been reviewed in this quarter with 10 relating to deaths in this period, 9 from the preceding Q2 and 2 from Q1.

No triggers were reached in our agreed mortality "watch metrics" and therefore targeted selection of specific diagnoses was not undertaken this quarter (see Appendix 1). Note we have modified these triggers following our pilot period.

Table 1 shows how the cases in this financial year have been selected for review, together with the overall quality of care. Note those cases selected at random have a high proportion of excellent and good care, with no cases of poor care identified.

	Poor care	Adequate care	Good care	Excellent care	Total
Death within 30 days of elective surgery	1	0	0	0	1
Diagnostic category	0	1	9	0	10
Learning Disability/Mental Health	0	1	7	4	12
Medical Examiner	1	1	1	0	3
Quality Team/Trust concern	0	0	2	0	2
Random selection	0	8	13	10	31
Specialty concern	1	4	2	0	7
Other	0	1	0	0	1
Total	3	16	34	14	67

Table 1: Breakdown of Overall Care rating by reason for case selection

4 cases were in patients with a learning disability who will receive a second external review as part of the LeDeR process.

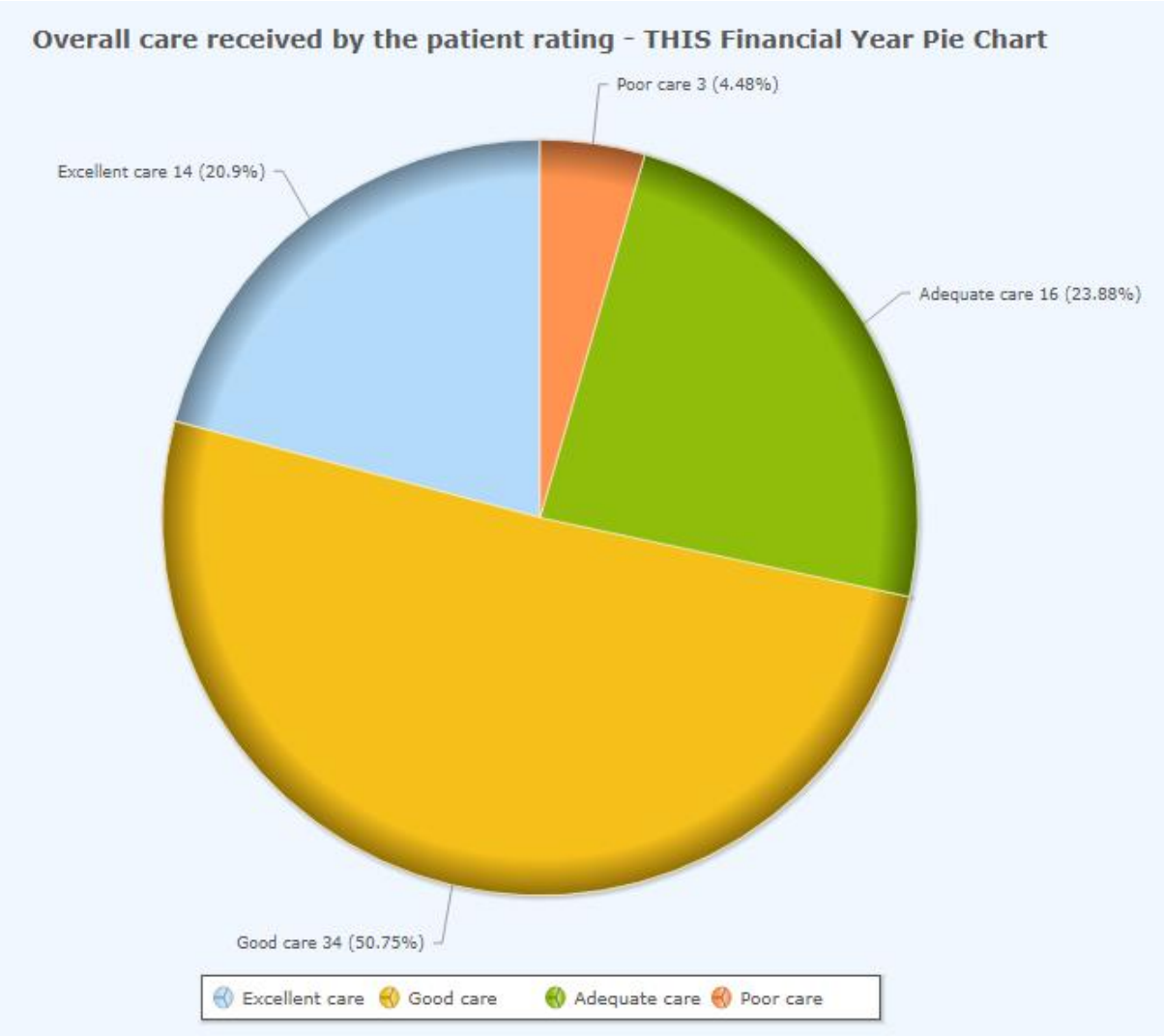


Figure 7: Breakdown of Overall Care rating in all cases reviewed this financial year

Figure 7 shows the overall care rating for all cases reviewed this financial year. 2 cases in Q3 were recorded as receiving poor overall care. The first related to a patient who died within 30 days of elective surgery where a number of aspects of poor medical and nursing care were identified in the days following surgery. This case was investigated as per our PSIRF process, with a rapid review (RRose) and a more in-depth after-action review (AAR) being undertaken. It was felt that although there were lapses in care, they did not have a significant bearing on the sad outcome.

The second case was a patient with sepsis following chemotherapy. Delays were noted in moving the patient from the Sir Robert Ogden Macmillan Centre to the Emergency Department, where there were further delays in administrating timely antibiotics and appropriate fluids. This case was reviewed independently by 2 reviewers from different specialties and both concluded that the death was “possibly avoidable but not very likely (less than 50:50)” - if this were deemed to be higher than 50:50 then the process to commence a Patient Safety Incident Investigation (PSII) would be triggered. Learning from this incident fits closely with the newly completed thematic review into deteriorating patients and sepsis.

The overall assessment of the standard of care for each case of is shown in Table 2:

Date of admission	Care in First 24 hours	Ongoing Care	Avoidability of Death	Clinical/Organisational score (NCEPOD)	Overall Care
08/04/2025	Poor care	Excellent care	Possibly avoidable but not very likely (less than 50:50)	Room for improvement in clinical and organisational care	Poor care
03/05/2025	Adequate care	Adequate care	Slight evidence of avoidability	Room for improvement in clinical care	Adequate care
10/07/2025	Good care	Not Applicable	Definitely not avoidable	Good practice	Excellent care
23/07/2025	Good care	Not Applicable	Definitely not avoidable	Good practice	Excellent care
05/08/2025	Adequate care	Not Applicable	Slight evidence of avoidability	Room for improvement in clinical and organisational care	Adequate care
23/08/2025	Good care	Not Applicable	Definitely not avoidable	Good practice	Good care
18/09/2025	Excellent care		Definitely not avoidable	Good practice	Good care
22/09/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
28/09/2025	Adequate care	Not Applicable	Slight evidence of avoidability	Room for improvement in clinical and organisational care	Adequate care
28/09/2025	Excellent care	Excellent care	Definitely not avoidable	Good practice	Excellent care
30/09/2025	Good care	Poor care	Possibly avoidable but not very likely (less than 50:50)	Room for improvement in clinical care	Poor care

08/10/2025	Excellent care	Good care	Definitely not avoidable	Good practice	Excellent care
17/10/2025	Good care	Good care	Definitely not avoidable	Good practice	Good care
17/10/2025	Excellent care	Good care	Definitely not avoidable	Good practice	Excellent care
22/10/2025	Good care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
23/10/2025	Good care	Adequate care	Definitely not avoidable	Room for improvement in clinical care	Good care
31/10/2025	Good care	Good care	Probably avoidable (more than 50:50)	Room for improvement in organisational care	Good care
31/10/2025	Good care	Adequate care	Definitely not avoidable	Good practice	Adequate care
22/11/2025	Excellent care	Good care	Definitely not avoidable	Good practice	Excellent care
23/11/2025	Adequate care	Good care	Definitely not avoidable	Room for improvement in clinical care	Good care
27/11/2025	Good care	Adequate care	Definitely not avoidable	Room for improvement in clinical care	Adequate care

Table 2: Details of the cases reviewed this quarter

Table 3 shows the quality of end-of-life care received. Note this is recorded as “not applicable” in the case of a sudden death.

Care received by the patient during end of life care rating - THIS Financial Year by Quarter				
	25/26 Q1	25/26 Q2	25/26 Q3	Total
Not Applicable	7	7	6	20
Poor care	2	1	0	3
Adequate care	3	5	3	11
Good care	11	4	8	23
Excellent care	2	4	4	10
Total	25	21	21	67

Table 3: End of Life Care provided

Reviewers are able to highlight any positive or negative learning from cases. These are shared with the clinicians via the regular Medical Directorate newsletter. Positive lessons this quarter related to the quality of care from ambulance, ED, Admission Ward through to Specialty Wards and clinicians remaining curious and exploring other diagnoses over time. Negative themes included poor record keeping during busy periods or events (e.g. during a cardiac arrest) and timely actions triggered by abnormal investigation results.

The Medical Examiner team have not identified any emerging concerns in the last quarter.

4.0 Recommendation

The Board is asked to note the contents of this report and the processes for ensuring learning from deaths.

Harrogate and District
NHS Foundation Trust

Appendix 1

“Watch Metrics”

Month HED Alert Received	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
SHMI (monthly SHMI - use last month in period)												
111:205-Spondylosis												
58:101-Coronary atherosclerosis			X									
110:204 Other nontraumatic joint disorders												
75:127 COPD and bronchiectasis												

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 December 2025 and January 2026.

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 80% 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 80% with regards to achieving its planned nursing numbers by shift. Any ward / in patient area, that falls below 80% 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 the only area where planned hours fell below 80% in December and January was Woodlands ward. This currently remains within the business rules but will be closely reviewed.

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.

As part of our winter plan an additional ward was opened from 29th December to 16th February. This was staffed by substantive staff moved on a temporary basis from our in-patient wards and bank cover used to backfill these staff.

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

Ward	January Day RN Fill (%)	January Day CSW Fill (%)	January Night RN Fill (%)	January Night CSW Fill (%)	January CHPPD RN	January CHPPD CSW	January CHPPD Overall	December Day RN Fill (%)	December Day CSW Fill (%)	December Night RN Fill (%)	December Night CSW Fill (%)	December CHPPD RN	December CHPPD CSW	December CHPPD Overall
Acute Frailty Unit	93%	80%	125%	113%	4.1	2.9	7.0	93%	85%	127%	109%	4.9	3.5	8.4
Acute Medical Unit	99%	86%	103%	101%	4.3	2.6	6.9	102%	87%	108%	102%	8.1	4.9	13.0
Bolton	106%	78%	121%	142%	4.3	3.0	7.3	115%	87%	128%	135%	4.7	3.2	7.9
Byland	92%	78%	99%	90%	3.4	2.9	6.3	96%	79%	101%	94%	3.6	3.0	6.5
ITU/HDU	110%	52%	92%	61%	25.6	2.1	27.7	97%	32%	82%	39%	30.4	1.8	32.1
Fountains	86%	81%	92%	99%	3.7	2.9	6.6	91%	94%	93%	113%	3.7	3.4	7.1
Granby	92%	75%	99%	96%	3.3	3.1	6.3	91%	71%	99%	93%	3.5	3.1	6.6
Jervaulx	88%	80%	99%	86%	3.4	2.9	6.2	94%	83%	100%	87%	3.5	3.0	6.5
Lascelles	99%	78%	99%	103%	4.1	3.0	7.1	103%	77%	98%	103%	4.5	3.2	7.7
Maternity	114%	137%	90%	86%	8.3	2.8	11.1	89%	107%	101%	98%	8.4	2.8	11.2
Nidderdale	90%	92%	95%	103%	3.9	3.0	6.9	94%	94%	99%	94%	4.2	3.0	7.2
Oakdale	94%	94%	99%	102%	3.5	2.9	6.4	99%	95%	99%	104%	3.6	2.9	6.5
Trinity	95%	93%	100%	105%	3.2	2.8	6.0	98%	70%	100%	98%	3.7	2.7	6.3
Rowan	100%	65%	94%	26%	10.7	2.8	13.5	89%	64%	81%	35%	9.8	3.2	13.0
Special Care Baby Unit	85%	29%	105%	0	12.7	0.6	13.3	85%	0	105%	0	32.4	1.4	33.8
Wensleydale	91%	72%	108%	99%	5.7	2.5	8.2	94%	81%	112%	86%	6.2	2.6	8.8
Woodlands	79%	48%	105%	84%	8.7	2.3	11.0	79%	44%	104%	111%	6.3	1.9	8.1
Total	**96%**	**81%**	**100%**	**97%**	**4.9**	**2.8**	**7.7**	**94%**	**90%**	**96%**	**93%**	**5.3**	**3.0**	**8.3**

3.0 December 2025 and January 2026 Results

During December 2025 and January 2026, 17 eligible inpatient areas were reviewed.

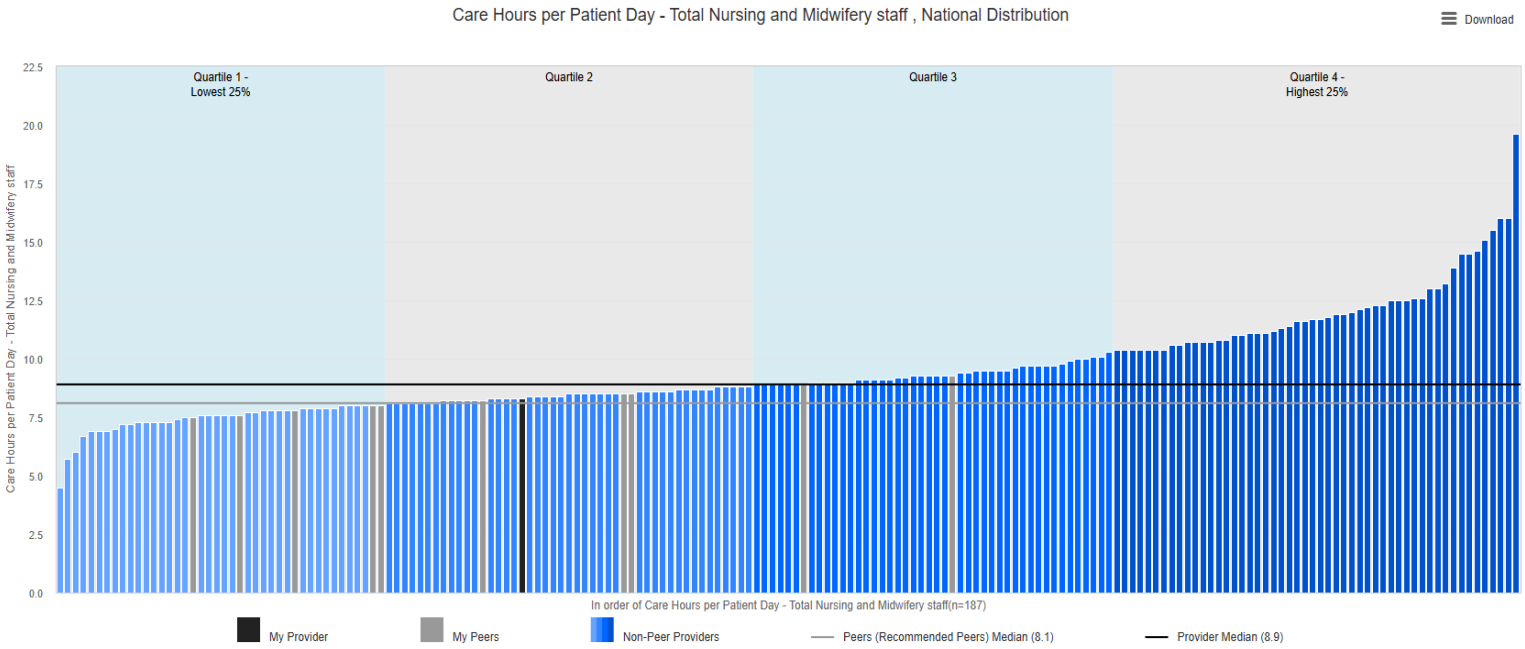
Planned vs actual fill rate data shows that one department fell below the 80% threshold for Registered Nurses. Care Support Worker fill rates varied across wards, with some areas below and others above threshold. This variation reflects the effective and responsive deployment of the unregistered workforce 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 2. 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 3.8 WTE midwifery vacancy position in December, 2.2 WTE of which were fixed term vacancies. In January all these vacancies had been filled, and 2.6 WTE midwives were in the recruitment process. Sickness has steadily increased over the winter period with January sickness being 7.33%. Shifts were released to NHSP however fill rates were only just above 50%.

The table below demonstrates that HDFT CHPPD is in the second quartile (8.3), which places us above our peers (8.1) and lower than the national median (8.9). This data is taken from Model Health System on 10th March 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	Dec 2025	8.3	8.1	8.9	Provider median	
Care Hours per Patient Day - Registered Nurses and Midwives	Dec 2025	5.3	4.8	4.9	Provider median	
Care Hours per Patient Day - Healthcare Support Workers	Dec 2025	3.0	3.4	3.5	Provider median	

4.0 Temporary Workforce Usage

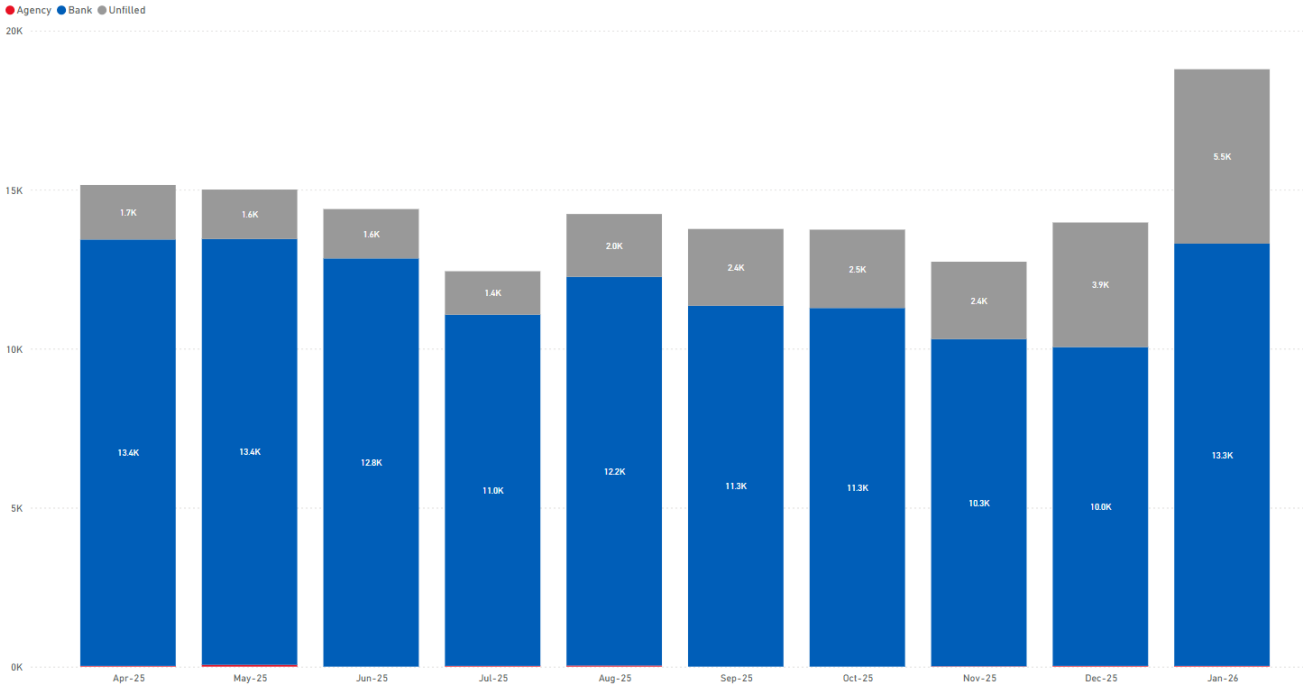
Temporary workforce usage increased in December and January to assist with safe staffing of the planned winter escalation ward/beds. There has been minimal agency use to cover service critical shifts (24 hours in December and 23 hours in January) across the adult Inpatient wards. Limited agency use has 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.

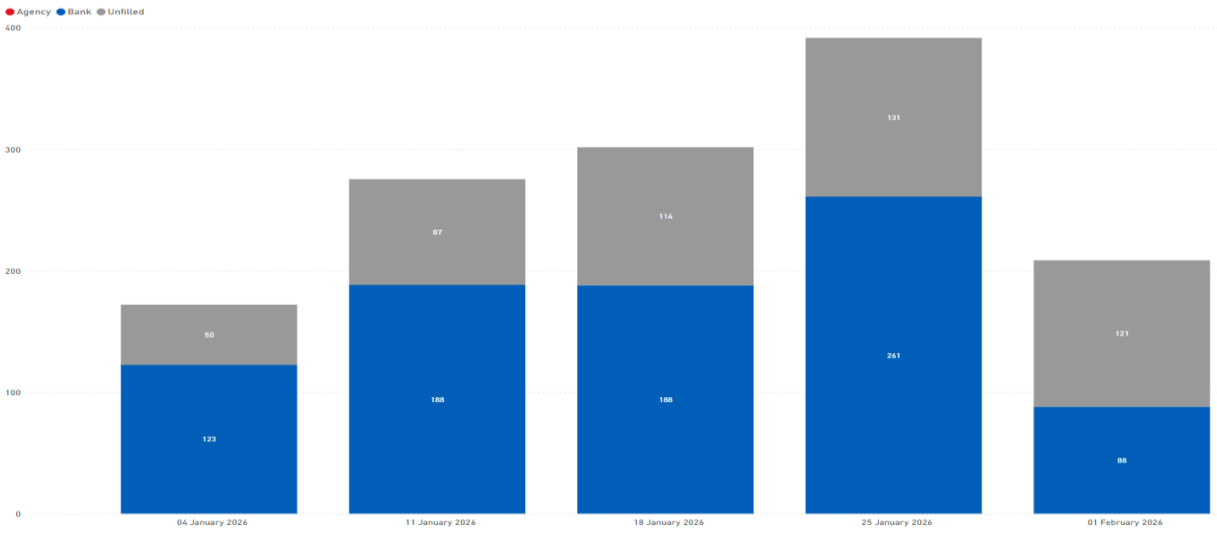
Recruitment to Clinical Support Worker (CSW) vacancies is progressing, with posts now being recruited to Band 3 following the conclusion of the Band 2 role review. In the interim, these vacancies are being safely managed using NHSP, ensuring continuity of care while substantive appointments are finalised.

Overall, temporary workforce utilisation is reducing 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 2025 – January 2026)



Midwifery Temporary Workforce (April 2025 - January 2026)



5.0 Key Performance Indicators

Between December 2025 and January 2026, 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 December there were two falls with severe harm, both were identified as no omissions in care following investigation at Quality Oversight panel. Learning has been identified and shared.

In January there were two falls with moderate harm reported. Both are awaiting investigation at Quality Oversight panel. Learning will be identified and shared.

Pressure ulcers:

In December, four moderate harm pressure ulcers were identified. Following investigation, two had omissions in care identified and two identified all preventative measures were in place and HDFT policy followed.

In January, one moderate harm pressure ulcer was reported, investigation identified omissions in care.

6.0 Assurance Report

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

- no areas have fallen below the 80% 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 and will incorporate key quality metrics.

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.

As part of the normal quality oversight processes Woodlands underwent their local Accreditation review in January and following the findings they were accredited 2 Kites which is sub optimal and requires full directorate oversight. An immediate action plan has been put in place, with corporate support, this will be followed up by a repeat Accreditation in April.

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 or 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 remain.

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 December 2025 – January 2026 SafeCare Red Shifts

There were no red shifts escalated to the Director of Nursing, Midwifery and AHP's during the months of December and January.

Recommendations

The Quality Committee is asked to:

- Note the safety, quality and staffing information detailed for December 2025 and January 2026.
- 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

March 2026