Board of Directors Meeting Held in Public

To be held on Wednesday, 27th May 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**	Deputy Director 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 25th March 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
1.8	**Board Assurance Framework 2025-26 Close Down**	Chief Executive	**Approve**	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	Statement – Delivering Same Sex Accommodation	Deputy Director of Nursing, Midwifery and AHPs	Note	Attached
2.3	Nursing and Midwifery Quality and Safe Staffing Report	Director of Nursing and Midwifery and AHPs	Note	Supp. Pack Attached
2.4	EPRR Update	Acting Chief Operating Officer	Note	Attached

Item No.	Item	Lead	Action	Paper
SECTION 3: Ambition: Great Start in Life				
3.1	**Board Assurance Framework:** Great Start in Life	Director of Nursing, Midwifery and AHPs & Quality Committee Chair	**Approve**	Attached
3.2	**Strengthening Maternity and Neo-Natal Safety 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	Acting Chief Operating Officer / Resource Committee Chair	**Approve**	Attached
4.2	**Board Assurance Framework:** Finance	Finance Director / Resource Committee Chair	**Approve**	Attached
SECTION 5: Ambition: At Our Best: Making HDFT the Best Place to Work				
5.1	**Board Assurance Framework:** At Our Best: Making HDFT the Best Place to Work	Acting Chief People Officer/ People & Culture Committee Chair	**Approve**	Attached
5.2	Public Sector Equality Duty	Acting Chief People Officer	Note	Attached
5.3	Modern Slavery Annual Report	Acting Chief People Officer	**Approve**	Attached
SECTION 6: Ambition: Enabling Ambitions				
6.1	**Board Assurance Framework:** Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience	Medical Director & Innovation Committee Chair	**Approve**	Attached
6.2	**Board Assurance Framework:** Healthcare Innovation to Improve Quality and Safety	Medical Director & Innovation Committee Chair	**Approve**	Attached
6.3	**Board Assurance Framework:** An Environment that Promotes Wellbeing	Director of Finance / Resources Committee Chair	**Approve**	Attached
SECTION 7: BAF Summary and Escalation from Committees				
7.1	**Escalation from Sub-Committees of the Board**	All Executive and Non-Executive Directors	Discuss	Verbal

Item No.	Item	Lead	Action	Paper
SECTION 8: Governance Arrangements				
8.1	Going Concern Report	Director of Finance	**Approve**	Attached
8.2	NHS Provider Licence Annual Self-Assessment	Chief Executive	**Approve**	Attached
8.3	Fit and Proper Person Test Annual Report	Acting Chief People Officer	**Approve**	Attached
9.0	**Any Other Business** *By permission of the Chair*	Chair	Discuss/ Note/ Approve	Verbal
10.0	**Board Evaluation**	Chair	Discuss	Verbal
11.0	**Date and Time of next Board Meeting to be held in public:** Wednesday 29th July 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.

Board of Directors – Register of Interests

As at 20th May 2026

Board Member	Position	Relevant Dates From	To	Declaration Details
Andrew Alldred	Non-executive Director	April 2026	Current	1. Familial relationship with Professor of Medicines Use and Safety: Faculty of Medicines and Health, School of Healthcare Studies, University of Leeds. 2. Familial relationship with Senior Practice Pharmacist – Colton Mill Medical Practice, Leeds
Jacqueline Andrews	Executive Medical Director, Deputy Chief Executive	June 2020 June 2020 December 2023 April 2024 May 2024 August 2025	April 2024 January 2026 Current Current August 2025 Current	3. Familial relationship with managing partner of Priory Medical Group, York 4. Lead for Research, Innovation and Improvement for Humber and North Yorkshire Integrated Care Board 5. Member, Leeds Hospitals Charity Scientific Advisory Board 6. Familial relationship with Director of GPMx Ltd (healthcare consultancy) 7. Member, Independent Advisory Group for the National Medical and Surgical Clinical Outcomes Review Programme (hosted by HQIP on behalf of NHSE) 8. Trustee, Healthcare Quality Improvement Partnership (Charity number 1127049)
Sarah Armstrong	Non-executive Director until 31 March 2022 Chair from 1 April 2022	October 2018 September 2024	Current Current	1. Company director for the flat management company of current residence 2. Chief Executive, The Ewing Foundation, Ovingdean Hall Foundation and Burwood Park Foundation 3. Director of Coffee Porter (family business) 4. Member of West Yorkshire Chairs & Leaders Forum 5. Member HNY Provider Chairs 6. Member HNY CAP Board 7. Member Trustee – NHS Charities Together
Denise Chong	Associate Non-executive Director from 1/4/26 (previously Interim non-executive Director from	March 2025	Current	1. Trustee, Learning Partnerships Leeds (Feb 2023) 2. Member, Kaleidoscope Learning Trust (KLT) (Dec 2023)

Board Member	Position	Relevant Dates From	To	Declaration Details
	March 2025 to March 2026)			
Breeda Columb	Executive Director of Nursing, Midwifery & AHPs	June 2025	Current	1. Familial relationship with a Leeds Teaching Hospitals NHS Trust employee
Jonathan Coulter	Finance Director Chief Executive from March 2022	March 2022	Current	No interests declared
Jeremy Cross	Non-executive Director	January 2020	Current	1. Chairman, Tipton Building Society 3. Director and Shareholder, Cross Consulting Ltd (dormant) 4. Chairman, Forget Me Not Children's hospice, Huddersfield 5. Governor, Grammar School at Leeds 6. Director, GSAL Transport Ltd 7. Member, Kirby Overblow Parish Council 8. Stakeholder Non-executive Director, Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Chiara De Biase	Non-executive Director	May 2024 February 2026	Current Current	1. Director of Health Services, Equity & Improvement, Prostate Cancer UK 2. Interim Fundraising and Health Strategy Director, Prostate Cancer UK
Jordan McKie	Director of Finance (from July 2023)	August 2022	Current	1. Chair, Internal Audit Provider Audit Yorkshire
Colin Melville	Non-Executive Director	September 2025	Current	1. Trustee, Faculty of Medical Leadership and Management 2. Fellow, Royal College of Physicians, London 3. Fellow, Royal College of Anaesthetists 4. Fellow, faculty of Intensive Care Medicine 5. Honorary Fellow, Academy of Medical Educators 6. Senior Fellow, Faculty of Medical Leadership and Management 7. Honorary Professor, University of Manchester

Board Member	Position	Relevant Dates From	To	Declaration Details
				8. Visiting Professor, Anglia Ruskin University 9. Nephew is an employee of HDFT (non-decision maker)
Andrew Papworth	Non-executive Director	March 2020	Current	1. Chief Finance Officer, Insight222 2. Ambassador for Action for Sport
Laura Robson	Non-executive Director	September 2017	Current	No interests declared
Wallace Sampson OBE	Non-executive Director	March 2020 July 2023 August 2023 September 2023 October 2023 August 2024	Current Current Current March 2025 Current Current	1. Member of Society of Local Authority Chief Executives 2. Advisory Board Consultant – Commercial Service Kent Ltd. 3. Commissioner – Local Government Boundary Commission for England 4. Chair – Middlesbrough Independent Improvement Advisory Board. 5. Director and Shareholder – Sampson Management Services Ltd. 6. Member – Council of Governors, Leeds University
Julia Weldon	Non-executive Director	May 2024 September 2025	Current Current	1. Fellow of the Faculty of Public Health (FPH) FPH Assessor and Advisor 2. Associate of Local Government Association (LGA) 3. Director of Julia Weldon Executive Leadership Ltd

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

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

Name	Position	Declaration Details
Dr Matthew Shepherd	Deputy Director of Business Intelligence, Planning, Performance and Productivity	1. Director of Shepherd Property – company lease flat.
Dr Sarah Sherliker	Deputy Medical Director	1. Clinical Private Practice providing anaesthesia services (ad hoc very occasional) 2. Shareholder TheSmartTHING Ltd (49%)
Shirley Silvester	Deputy Director of People & Culture	No interests declared
Kate Southgate	Associate Director, Quality & Corporate Affairs	1. Familial relationship with Director in NHS England
Rachael Stray	Operational Director (Long term, Urgent, Cancer and Community)	No interests declared
Julie Walker	Associate Director of Nursing (Planned, Surgical and Children's Care)	No interests declared
Andy Williams	Chief Interim Digital Officer	1. Shareholder (50%) in The Human Digital Collaborative Ltd 2. Shareholder (25%) in One Clinical Ltd. 3. Shareholder (100%) in AHLC Solutions Ltd.

Directors and Attendees
Previously recorded Interests – For the 12 months period pre May 2026

Board Member	Position	Relevant Dates From	To	Declaration Details
Matt Graham	Director of Strategy	September 2021 April 2022 November 2025	December 2025 April 2026	1. Member: Local Governing Body, Malton School (part of Pathfinder Multi-Academy Trust) 2. Stakeholder Non-executive Director, Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust) 3. Trustee of Harrogate & District Community Action
Russell Nightingale	Chief Operating Officer & Deputy Chief Executive	April 2021	April 2026	1. Director of ILS and IPS Pathology Joint Venture
Alison Smith	Interim Director of Nursing, Midwifery & AHPs	24 March 2025	June 2025	1. No interests declared
Julia Weldon	Non-Executive Director	November 2022	September 2025	1. Director of Public Health / Deputy Chief Executive, Hull City Council 2. Co-chair of the Population Health Committee, Humber & North Yorkshire Integrated Care Board
Angela Wilkinson	Director of People & Culture	October 2019	May 2026	3. Director of ILS and IPS Pathology Joint Venture

BOARD OF DIRECTORS MEETING – PUBLIC (DRAFT)

Wednesday, 25th March 2026

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

Present:	
Sarah Armstrong	Trust Chair
Jonathan Coulter	Chief Executive
Russell Nightingale	Deputy Chief Executive and Chief Operating Officer
Jeremy Cross (JCr)	Non-Executive Director, Chair of Resource Committee
Colin Melville (CM)	Non-Executive Director
Andy Papworth (AP)	Non-Executive Director, Chair of People & Culture Committee
Laura Robson (LR)	Non-Executive Director, Chair of Quality Committee
Julia Weldon (JW)	Non-Executive Director
Denise Chong (DC)	Interim Non-Executive Director
Jacqueline Andrews	Executive Medical Director
Breeda Columb	Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs)
Matthew Graham	Director of Strategy
Jordan McKie	Director of Finance
Angela Wilkinson	Director of People and Culture

In Attendance:	
Kate Southgate	Associate Director of Quality and Corporate Affairs
Rachel Hewson	Company Secretary
Paula Chyzy	Corporate Governance Officer
Andrew Alldred (AA)	Non-Executive Director (Shadowing – in post 1st April 2026)
Rob Armstrong	Deputy Chief Operating Officer
Rob Eames	Deputy Director of People & Culture
Jenny Nolan	Deputy Director of Nursing, Midwifery and Allied Health Professionals (AHPs) *for the Patient Story*
Leanne Likaj	Associate Director of Midwifery and Children's Services for the *Strengthening Maternity and Neonatal Safety report*

Apologies:	
Chiara DeBiase (CdB)	Non-Executive Director, Chair of Audit Committee
Wallace Sampson OBE (WS)	Non-Executive Director, Chair of Innovation Committee

Observers:	
Governors	Richard Farrar, David Haynes
Member of the public / press	2
Colleagues	
External Partners	

Item No.	**Item**
BD/03/25/1.1 **1.1.1**	**Welcome and Apologies for Absence** The Chair welcomed everyone to the meeting. The Chair thanked all observers for attending the public meeting of the Trust Board, noting Andrew Alldred was in attendance in a shadowing capacity prior to commencing as a Non-Executive Director on 1st April 2026.
1.1.2	Apologies for absence were noted as above.

Item No.	Item
BD/03/25/1.2 **1.2.1**	**Patient Story** The Chair introduced the patient story noting that the story was of a former colleague at the Trust. The Executive Director of Nursing, Midwifery and AHPs noted that the feedback on the patient story video had been provided approximately 3 months ago and captured the key points that the patient wished to feed back on.
1.2.2	The story was of Kath, a deeply respected and much-loved nurse at HDFT who had spent over 30 days being cared for at Harrogate District Hospital and her appreciation of the many and varied teams that had cared for her during her time there including the Oncology, Respiratory Nursing, Medical Enhanced Care Unit (MECU), Emergency Department, Physiotherapy and Palliative Care teams.
1.2.3	The Executive Director of Nursing, Midwifery and AHPs noted that Kath's husband was aware that the video was being shared at Trust Board and that it was felt that this was a fitting tribute to her. The Executive Director of Nursing, Midwifery and AHPs shared the news that Kath had sadly passed away on 9th March after being readmitted to Wensleydale Ward.
1.2.4	The Non-Executive Director (LR) queried whether the feedback had been shared with the teams mentioned and it was confirmed that this was the case. The Non-Executive Director (AP) noted the excellent feedback regarding the teams involved in her care and remarked on how rewarding it had been to work with her.
1.2.5	The Non-Executive Director (LR) noted that Kath had been a great advocate for nursing and hoped that the level of care she received was reflective of the care provided to all patients.
1.2.6	The Non-Executive Director (JW) reflected on her own personal experience of providing feedback noting that it had occurred several months after her care episode. She highlighted the value of capturing patient perspectives in a timely manner and suggested there may be learning in how the Trust gathers such feedback.
1.2.7	The Non-Executive Director (CM) noted that although he had not personally known Kath, it was extraordinary that, at a time when she was aware of her declining health, she chose to record her reflections and described the recording as an extraordinary commendation and expression of gratitude for the care she had received. He observed that this reflected the compassionate and high-quality care delivered by staff.
1.2.8	The Chair expressed sincere thanks for the patient story, noting that it was a deeply moving account.
1.2.9	**Resolved:** The patient story was noted.
BD/03/25/1.3 **1.3.1**	**Declarations of Conflicts of Interest and Register of Interests** There were no new Declarations of Interest declared.
1.3.2	**Resolved:** The register of interests was received and noted.
BD/03/25/1.4 **1.4.1**	**Minutes of the Previous Board of Directors meeting held on 28th January 2026** The following amendments were noted: • 3.2.17 The Non-Executive Director (AP) queried whether the detail regarding West Yorkshire's non-compliance with the Maternity Voices

DRAFT

Item No.	Item
	Partnership (MVP) was correct and the Associate Director of Quality & Corporate Affairs confirmed that she would check this information. • 4.1.3 – removal of extra "YTD". • 6.1.4 – addition of the word "Digital" to the sentence "there are 50 projects currently live and all on track" to clarify that these are not AI projects.
1.4.2	**Resolved:** The minutes of the meeting on the 28th January 2026 were approved as an accurate record of the meeting noting the amendments.
BD/03/25/1.5 **1.5.1**	**Matters Arising and Action Log** There was one item on the action log - BD/11/26/5.1.10 for The Director of People and Culture, and the Chief Executive to discuss a mechanism to make Executive Director's Equality, Diversity and Inclusion (EDI) objectives more visible and it was confirmed that this had been deferred to the next People and Culture Committee meeting.
1.5.2	No further matters arising were raised which were not already noted on the agenda.
1.5.3	**Resolved:** All actions were agreed as above.
BD/03/25/1.6 **1.6.1**	**Overview by the Chair** The Chair noted a range of activities that had taken place since the last meeting of the Board.
1.6.2	The Chair highlighted the following points:
1.6.3	• The financial year is almost at a close and planning continues. Significant progress has been made but acknowledgment was made that this had not been easy and thanks were expressed to colleagues, particularly Executive colleagues for their commitment, time and energy.
1.6.4	• The staff survey results for HDFT had been excellent with a 62% response rate. It was noted that national headlines were not positive this year, with many Trusts experiencing difficulties. The median response rate across the benchmarking groups was just under 40%.
1.6.5	• The February Board workshop was held in Morpeth and included time spent with colleagues delivering 0-19 services. This was an excellent opportunity to meet staff who were visibly proud of the work they are delivering.
1.6.6	• The KITE (Kindness, Integrity, Teamwork, Equality) awards event was praised as an outstanding event.
1.6.7	• Forthcoming changes within the Executive team were noted, acknowledging the contributions that had been made by The Chief Operating Officer, Deputy Chief Executive; the Director of People and Culture and the Director of Strategy. It was noted that there had been a significant period of stability which had supported strong working relationships.
1.6.8	• Thanks were also expressed to Sarah Shaw, who joined through the Insight Programme; her involvement was of great value to the organisation.
1.6.9	• Thanks were expressed to Denise Chong who had undertaken numerous roles over the past 18 months, including stepping into the Non-Executive Director role.
1.6.10	• Andrew Alldred was welcomed as a returning colleague to the Trust in his new capacity as a Non-Executive Director. Andy will officially begin in April but was welcomed to March Board in a shadowing capacity.
1.6.11	• The Chair had attended a session in London with NHS Providers—soon to become NHS Alliance—and reflected on a key reminder shared during

DRAFT

Item No.	Item
	discussions on quality improvement. The most resonant message was the importance of being "curious and not judgmental." The Chair encouraged the Board to consider this principle during the afternoon's discussions.
1.6.12	**Resolved:** The Chair's report was noted.
BD/03/25/1.7 **1.7.1**	**Chief Executive Report** The Chief Executive presented his report as read, noting the Chair's reflection on remaining curious encapsulates how the Board should conduct its business collectively.
1.7.2	The following points were highlighted:
1.7.3	• The British Social Attitudes survey had indicated early signs of improving public satisfaction with the NHS. It was observed that over the last 12 months the Trust can demonstrate improvements in access, care environment and increased staff engagement.
1.7.4	• Looking ahead to the new financial year, the key requirements are to improve access standards, operate within available resources, and ensure plans align with the longer-term direction set out in the 10-year plan. A final plan submitted in February met all performance standards but showed a financial deficit. Initial financial plans were not aligned with the Integrated Care Board (ICB); however, alignment has now been achieved without changes to the Trust's internal plans, resulting in a deficit position of £19 million. The Humber and North Yorkshire (HNY) system has an overall deficit of approximately £130 million. The system is currently subject to national escalation processes. It was also noted that the ICB remains underfunded by around £45 million, with similar levels of financial pressure held within other providers across the system. The Trust will continue to deliver its internal plan and will review the implementation model for community services, where underfunding is most acute.
1.7.5	• The Trust recently hosted the Chair and Chief Executive of the ICB to support their understanding of the Trust's ambitions. The visit was described as positive. The publication of the neighbourhood health guidance was noted, which will be picked up through future discussions. The work undertaken by the Director of Finance on navigating difficult financial discussions was highlighted.
1.7.6	• Work continues with Leeds Teaching Hospitals Trust including the improvement of the stroke pathway and the use of Wharfedale Hospital.
1.7.7	• Significant effort had gone into the recent elective sprint and thanks were expressed to all colleagues involved. The improvement seen within the new 0–19 services since their mobilisation last April was commended as exceptional.
1.7.8	• Challenges relating to cash management remain and it was noted that securing agreement from the ICB on cash support was essential.
1.7.9	• The Diagnostic position remains challenging due to capacity gaps.
1.7.10	• There are ongoing conversations with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and the ICB on autism assessment pathways regarding the potential repatriation of individuals currently accessing independent sector provision back into the NHS.
1.7.11	There was reflection on the national staff survey feedback endorsing earlier comments made by the Chair. The principle of remaining curious and non-judgemental was reiterated as the appropriate approach for the organisation.

DRAFT

Item No.	Item
1.7.12 1.7.13 1.7.14 1.7.15 1.7.16	• Thanks were expressed to The Chief Operating Officer, Deputy Chief Executive; the Director of People and Culture and the Director of Strategy for their contribution to HDFT and the support they have provided. The Non-Executive Director (LR) asked whether there is any mechanism by which the under-funded HNY system could secure additional resources and whether other local ICBs are fully funded. The Chief Executive explained that the shortfall arises from the national funding formula and that the funding will vary across the country. The Non-Executive Director (AP) raised a question regarding community dental services and the Chief Executive confirmed that a request had been made to continue the service for a further two months to the end of May. It was also confirmed that this was funded with inflationary uplift. The Non-Executive Director (LR) asked whether York is included in the meetings referenced in the report. The Chief Executive explained that an agreement is in place to work with Leeds Teaching Hospitals on several issues, including the use of Wharfedale facilities and support for fragile services. A specific matter relates to the stroke pathway, where Medical Directors from Leeds and York have met to strengthen resilience. The Chief Executive clarified that the reference in the report was primarily to work taking place with Leeds. **Resolved:** The Chief Executive's Report was noted.
BD/03/25/2.1 2.1.1 2.1.2 2.1.3 2.1.4 2.1.5 2.1.6 2.1.7 2.1.8	**Board Assurance Framework – Best Quality, Safest Care** The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Best Quality, Safest Care. This Strategic Ambition had two True North metrics for 2025-26. The first metric was eliminating moderate and above harm, and the goal is to have 20% reduction year on year. This metric is in the second year having achieved year one. The metric is on track to achieve with 72 events against a threshold of 80. There are no risks associated with this metric. Two never events have been declared this year, and the level of low and no harm reporting continues to be strong. On the staff survey on the question of "Would I feel secure in raising concerns about unsafe clinical practices" HDFT was the highest reported in the country. The second metric on patient experience and engagement is on track for delivery. On the Friends and Family Test (FFT) 100% of Outpatients reported their care as good or very good and for Inpatients this was 97.9% for February. There has been a small increase in complaints in January and a dip in response times but this is now improving. There are no corporate risks associated with this metric. There is a plan for the first year of the engagement strategy and this will continue to be developed. The Non-Executive Director (CM) queried whether there is a sense of what proportion of patients responded and the Executive Director of Nursing, Midwifery and AHPs noted that there would be data available and this would be picked up outside the meeting.

DRAFT

Item No.	Item
2.1.9	The Non-Executive Director (Shadowing) (AA) noted the excellent results and asked whether issues identified through the Quality Committee are triangulated with the FFT. The Non-Executive Director (LR) confirmed that Quality Committee has extensive discussions on this matter and that the FFT is not always a sufficiently strong tool for meaningful insight.
2.1.10	The Chief Executive added that the organisation does not yet have a sufficiently resilient or robust alternative mechanism, which is why ongoing work in this area remains a priority. The Executive Director of Nursing, Midwifery and AHPs noted that response numbers remain low to surveys, reinforcing the need for a clear engagement strategy.
2.1.11	The Non-Executive Director (LR) commented that it would be useful to understand how satisfied individuals are with the responses they received and whether this is addressed in the strategy.
2.1.12	The Chief Executive acknowledged the point raised and agreed that this should be considered.
2.1.13	**Resolved:** The Board Assurance Framework: Best Quality, Safest Care was noted and approved.
BD/03/25/2.2 **2.2.1**	**Learning from Deaths Quarterly Report Q3** **Resolved:** Following review at the Quality Committee, The Learning from Deaths Quarterly Report was noted.
BD/03/25/2.3 **2.3.1**	**Nursing and Midwifery Quality and Safe Staffing Report** **Resolved:** Following review at the Quality Committee, The Nursing and Midwifery Quality and Safe Staffing Report was noted.
BD/03/25/3.1 **3.1.1**	**Board Assurance Framework – Great Start in Life** The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Great Start in Life.
3.1.2	This Strategic Ambition had two True North metrics for 2025-26:
3.1.3	Early intervention and prevention - in 11 Local Authority commissioned 0-19 Services, the target is to have 90% delivery of contacts within national timeframes.
3.1.4	For February 2026 the data demonstrates this is achieving over 90% - 51 of 55 areas. Two contact areas where this breached are Cumberland and Westmorland and Furness – these are the two newest services and metrics are improving month on month.
3.1.5	Child patient experience – the goal is to engage with Children and Young People and achieve a return rate to surveys of 10% of children seen. In February the return rate was 11% and the first time the target has been achieved. Teams are working hard to see how to increase rates.
3.1.6	The related corporate risk is autism assessment.
3.1.7	**Resolved:** The Board Assurance Framework: Great Start in Life was noted and approved.
BD/03/25/3.2	**Strengthening Maternity and Neonatal Safety**

DRAFT

Item No.	Item
3.2.1	The Associate Director of Midwifery and Children's Services was welcomed to the meeting and took the report as read noting that the risk regarding parking had been resolved.
3.2.2	All Obstetricians and Gynaecologists now have agreed job plans in place, and compliance with Delivery Suite Co-ordinator supernumerary status was maintained throughout February.
3.2.3	Access to Birmingham Symptom-specific Obstetric Triage System (BSOTS) module on Badgernet is now in place to enable roll out of BSOTS in the Maternity Assessment Centre.
3.2.4	Areas of concern include remaining above national average for third- and fourth-degree tears and postpartum haemorrhage; a detailed review of the data has been completed and a number of actions are now underway; and an increasing incidence of issues with antenatal clinic appointments breaching Key Performance Indicators (KPIs).
3.2.5	Work is underway on a review of the Maternity Care Bundle and Postnatal Toolkit and a benchmarking tool is expected by the end of the month.
3.2.6	Improvements have been made with home birth provision. Benchmarking has confirmed the service is safe, although some areas for further enhancement have been identified.
3.2.7	Patient Flow Midwives have been introduced, and increased staffing levels were implemented from 14th March.
3.2.8	Two appendices were submitted with the report: the first Avoiding Term Admissions into Neonatal units – no concerns were identified and the second Perinatal Mortality Review Tool – no concerns were identified.
3.2.9	The Non-Executive Director (AP) reported very positive feedback from a recent walkaround, noting that students, midwives, and other staff said they felt safe and confident to raise concerns.
3.2.10	The Board was informed that the Maternity and Neonatal Voices Partnership (MVP) Lead Ruth has resigned due to uncertainty regarding future funding. Ruth was commended for her contribution; this represents the second loss of an individual in this role due to ICB funding constraints. The Associate Director of Midwifery and Children's Services confirmed that interim arrangements are in place, with oversight to be provided by the HNY MNVP Lead from a strategic perspective. In addition, a Neonatal Service User Voice Lead has agreed to expand their service user engagement role to include maternity and will provide support until a long-term decision is made.
3.2.11	**Action: The Chief Executive to seek clarity from the ICB regarding future MVP funding.**
3.2.12	The Non-Executive Director (Shadowing) (AA) noted that, given the current national scrutiny of maternity services, it was reassuring to hear positive feedback regarding culture. The Non-Executive Director (AP) recalled that five years ago a facilitated session resulted in a long queue of staff wishing to raise concerns; the improvement since then is a credit to the current management team.

DRAFT

Item No.	Item
3.2.13	**Resolved:** The Strengthening Maternity and Neonatal Safety report and the Maternity incentive Scheme report were approved.
BD/03/25/4.1 4.1.1 4.1.2 4.1.3 4.1.4 4.1.5 4.1.6 4.1.7 4.1.8 4.1.9 4.1.10	**Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships** The Chief Operating Officer provided the Board with an update on the Strategic Ambition: Person Centred, Integrated Care, Strong Partnerships. The Strategic Ambition for 2025-2026 had four True North metrics. **Metric 1: 4-Hour Emergency Department (ED) standards:**– the aim was for 78% of patients having their care completed within four hours by March 2026. In February the rate achieved was 77.04% and month to date approximately 79%. Extended Emergency Medicine Ambulatory Care (EEMAC) trial began on 9th March which was recommended by the Getting It Right First Time (GIRFT) team. The Acute Medical Unit (AMU) opened providing 7 medical beds. Ripon Urgent Treatment Centre (UTC) opened and saw 60 patients yesterday. **Metric 2: Frailty:-** Length of Stay the aim was to hit the top quartile nationally by March 2027 – this has been achieved in March 2026. The work on the discharge programme has helped with this and this metric is being reviewed at present. **Metric 3: Elective Recovery Standard – Referral To Treatment (RTT):**– By March 2026, we will achieve 18-week performance at 70.49% (as per national mandate). At the end of February this was 73.61%, outturn for March is 76.4% and hope to be 77% at end March. The last time 77% was achieved was March 2020. **Metric 4: Cancer 62-day treatment standard:**– 85% of our patients will commence treatment within 62 days of referral (the national ask is 82.5%). In February this was 83.4% but unvalidated. The Non-Executive Director (JW) welcomed the improvement reported and emphasised that the progress achieved was very positive. The Non-Executive Director (JCr) added that the strength of the performance numbers should not be underestimated. The Non-Executive Director (CM) asked whether the Trust is, in practice, treating more patients. The Chief Operating Officer and Deputy Chief Executive confirmed that the organisation is treating 8% more patients than last year and 27% more than in 2019. The Non-Executive Director (Shadowing) (AA) noted it would be useful to have further information regarding pressures within diagnostics. The Chief Operating Officer and Deputy Chief Executive advised that progressing the Community Diagnostic Centre (CDC) remains a key priority. Demand continues to exceed available capacity. **Resolved:** The Board Assurance Framework: Person Centred, Integrated Care, Strong Partnerships was noted and approved.
BD/03/25/4.2 4.2.1 4.2.2	**Board Assurance Framework – Finance** The Director of Finance provided the Board with an update on the Strategic Ambition: Overarching Finance 2025-26. The Director of Finance highlighted a minor correction on the BAF noting the position reported as at month 10 should read month 11 showing a deficit of £22.6

DRAFT

Item No.	Item
	million, behind where predicted to be in the forecast protocol. The key drivers of this position are set out within the report. Recovery actions include the benefits arising from the elective sprints, improved operational performance at Wharfedale, and a review of income streams. Waste Reduction and Productivity (WRAP) performance has reached 91% against a £14 million target. A number of review exercises are ongoing; however, it was noted that achieving a £20 million position will be challenging.
4.2.3	The Director of Finance advised that cash continues to be a significant challenge. This was discussed at the Resources Committee, where cash risk is recorded at 25 on the risk register. Supplier payment times currently average 60 days, and this issue is expected to continue into the new financial year.
4.2.4	The Non-Executive Director (JCr) emphasised that cash remains a critical issue and noted the risks have been well highlighted.
4.2.5	The Non-Executive Director (LR) queried the status of the KPMG work and the Director of Finance confirmed that the work is currently in week five of a 12-week programme, with a midpoint report expected shortly. KPMG is adopting a continuous improvement methodology, which is expected to align effectively with the Trust's existing improvement work
4.2.6	**Resolved:** The Board Assurance Framework: Finance was noted and approved.
BD/03/25/5.1	**Board Assurance Framework – At Our Best: Making HDFT the Best Place to Work**
5.1.1	The Director of People and Culture provided the Board with an update on the Strategic Ambition: At Our Best: Making HDFT the Best Place to Work.
5.1.2	This Strategic Ambition for 2025-2026 had two True North metrics:
5.1.3	**Metric 1: Staff Engagement Index and to continually improve the Employee Engagement Score** – this is achieving well against ambitions. While the Trust is not "best in class" within its benchmarking group, progress remains positive. Based on a 62% response rate, the Trust would require a response rate of approximately 70% and an engagement score above 7.0 to reach the highest benchmark.
5.1.4	**Metric 2: Staff Availability** – challenges remain sickness absence and vacancies. Sickness absence currently stands at 5.54%, with a vacancy rate of 6.3% against a target of 7%. Sickness continues to present the greatest risk. Recruitment has been slowed due to the ICB's "double/triple lock" approval process, though this largely affects non-clinical roles.
5.1.5	The Non-Executive Director (AP) highlighted the chart showing the People Promise chart on the BAF.
5.1.6	The Non-Executive Director (CM) asked what measures are needed to sustain momentum and prevent performance from declining, noting that improvement becomes progressively harder to maintain. The Director of People and Culture advised that a paper considered at the People and Culture Committee sets out the focus areas for next year. She confirmed that directorates have access to detailed data sets and are required to monitor areas with low or no engagement responses closely.
5.1.7	The Chief Executive reported that free-text comments from the survey have only just been received and represent a rich source of information. A workshop is

DRAFT

Item No.	Item
	planned for the end of April with the Senior Management Team, and Gemba visits will be arranged in areas where engagement levels remain low. He also highlighted that two new services in Cumbria are currently showing lower engagement.
5.1.8	The Non-Executive Director (AP) welcomed the progress, noting that the Trust's response rate has increased significantly—from 31% in 2020 to 62% this year.
5.1.9	The Non-Executive Director (Shadowing) (AA) asked whether vacancy levels had resulted in any clinical risks being escalated. The Director of People and Culture confirmed that clinical roles are exempt from the ICB approval lock, reducing the risk of delays. The Chief Executive added that early themes from the free-text comments emphasised working in a positive environment and feeling valued.
5.1.10	The Non-Executive Director (JCr) reflected that improvements in workforce planning—ensuring the right people are in the right place at the right time—have contributed to reduced agency expenditure and strengthened stability in recent years and the Non-Executive Director (LR) noted the importance of ensuring Gemba visits strike the right balance between engaging with teams who are less engaged and recognising those who are performing strongly.
5.1.11	There were no Corporate Risks associated with this ambition.
5.1.12	**Resolved:** The Board Assurance Framework: At Our Best: Making HDFT the Best Place to Work was noted and approved.
BD/03/25/5.2 **5.2.1**	**Gender Pay Gap Report** It was noted that this had been discussed at People and Culture Committee. The Deputy Director of People and Culture noted that the gender pay gap has reduced significantly, largely due to changes in Clinical Excellence Award arrangements. He noted that a summary has been prepared; however, this is not in the format intended for publication. The report has been signed off by the Committee, subject to Board approval, for publication and submission.
5.2.2	**Resolved: The Gender Pay Gap Report was approved.**
BD/03/25/5.3 **5.3.1**	**Ethnicity Pay Gap Report** It was noted that this had been discussed at People and Culture Committee. The report has been signed off by the Committee, subject to Board approval, for publication and submission.
5.3.2	**Resolved: The Ethnicity Pay Gap Report was approved.**
BD/03/25/5.4	**National Staff Survey**
5.4.1	It was noted that the National Staff Survey had already been discussed and the Non-Executive Director (AP) clarified a number of items discussed at the People and Culture Committee.
5.4.2	The Freedom to Speak Up (FTSU) guardian could not attend the Committee but there are changes to the national FTSU framework and a paper had been presented demonstrating the current reach and identifying the risks that the change in framework creates.
5.4.3	Equality Delivery System (EDS) 22 report had been presented – the workshop this year had been well attended with both Non-Executive and Governor representation.

DRAFT

Item No.	Item
5.4.4	Flu vaccinations – HDFT was at the top nationally for eight weeks and thanks were recorded.
5.4.5	Resident Doctor Matthew Rabin-Smith joined the Committee and will give assurance on the 10-point resident doctor plan at HDFT.
5.4.6	**Resolved:The update was noted.**
BD/03/25/6.1	**Board Assurance Framework – Enabling Ambition: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience**
6.1.1	The Executive Medical Director provided the Board with an update on the Enabling Ambition: Digital Transformation for 2025-26: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience.
6.1.2	The Enabling Ambition had one true north metric: Achieve a score of 5/5 across all seven What Good Looks Like (WGLL) pillars with the goal to achieve 3 out of 5 this year. Significant work is underway to ensure that an A3 plan is in place for every area, with current progress flagged amber due to the forthcoming go-live of the EPR at the end of April. A digital strategy road map has been developed to support this work.
6.1.3	WGLL framework for digital maturity has been delayed due to resource constraints at NHSE.
6.1.4	All major digital projects are currently reporting green, alongside approximately 50 other live projects.
6.1.5	The Strategic Electronic Patient Record (EPR) Programme remains on track. The first go-live was scheduled for November, with the second planned for 28 April, by which point approximately 80% of modules affecting inpatient and outpatient areas will be implemented. The programme has undergone the NHSE Digital Gateway Review and received approval to proceed. As experienced previously, final approval will again be required from the Chief Executive of NHSE.
6.1.6	The Non-Executive Director (CM) acknowledged that delivering A3 plans by May is a challenging objective but was assured that progress to date indicates reasonable achievement.
6.1.7	Concern was noted around the external risks associated with the EPR, particularly given the wider uncertainty in the national environment and the potential financial implications, with some implementations being delayed. It was suggested that the Trust should consider writing to NHSE Chief Executive outlining the risks and associated costs of delay, alongside our risk assessment and confidence in respect of the implementation. This will be considered by the Chief Executive if it was thought to be helpful and/or necessary in April.
6.1.8	The Non-Executive Director (LR) queried why approval from the NHSE Chief Executive is required. The Executive Medical Director confirmed that during the previous phase, a formal letter signed by both the Chief Executive and herself had been mandated.
6.1.9	In response to a question from the Non-Executive Director (AP) regarding oversight of Artificial Intelligence (AI), the Executive Medical Director confirmed that governance is in place. This includes Innovation Committee, AI-related

DRAFT

Item No.	Item
	documentation (with recent papers reviewed via the blue box / supplementary items), and an established governance structure comprising a Strategy Group, Governance Group, and Operations Group to ensure safe and appropriate deployment of AI technologies.
6.1.10	**Resolved:** Board Assurance Framework: Digital Transformation and Maturity to Integrate Care and Improve Patient, Child and Staff Experience 2025-26 was noted and approved.
BD/03/25/6.2	**Board Assurance Framework – Enabling Ambition: Healthcare Innovation to Improve Quality & Safety**
6.2.1	The Executive Medical Director provided the Board with an update on the Enabling Ambition: Healthcare Research and Innovation to Improve Quality and Safety 2025-26 which had three True North metrics: Healthcare Innovation, Children's Public Health, and Clinical Trials.
6.2.2	All innovation programmes are currently reporting green. The Executive Medical Director highlighted the continuing development and strengthening of key partnerships. Work is progressing with the University of York Medical School and with Local Authorities across North Yorkshire and York. A recent event involved presenting to Hull York Medical School (HYMS) to support development of a strategic alliance, and a Senate delegation will be visiting the Innovation Hub next week.
6.2.3	In relation to Research, the National Institute for Health and Care Research (NIHR) has issued several funding calls. The Trust has submitted multiple grant applications, including proposals relating to 0–19 research, primary care, and non-surgical oncology. All research policies are up to date, with the next phase focusing on the development of detailed Standard Operating Procedures (SOPs). The Clinical Research Facility (CRF) opened four weeks ago, currently operating from a temporary base in Farndale. On its first day some patients took part in a Parkinsons study.
6.2.4	Progress continues within Children and Young People's (CYP) Research, with new partnerships being formed and increasing numbers of CYP engaging in studies. Work continues to support breakthrough objectives to grow the number of CYP-related research projects.
6.2.5	The Non-Executive Director (CM) commended the positive progress and made two observations. First, there is strong evidence that the presence of active research improves outcomes for patients and the wider community. Second, research should not be viewed as limited to medical staff, and there are opportunities to involve a broader range of professional groups.
6.2.6	**Resolved:** Board Assurance Framework: Healthcare Innovation to Improve Quality & Safety was noted and approved.
BD/03/25/6.3	**Board Assurance Framework – Enabling Ambitions: An Environment that Promotes Wellbeing**
6.3.1	The Director of Finance provided the Board with an update on the Enabling Ambition: An Environment that Promotes Wellbeing. The True North metrics for the 2025-26 Ambition were:
6.3.2	**Wellbeing (capital programme delivery)** – spend continues to reflect the Trust's commitment to addressing historic under-investment in the estate. Total capital expenditure for the year is £49.5 million compared with approximately one-tenth of

DRAFT

Item No.	Item
	that level prior to the COVID-19 period. Looking ahead to next year, Block C is expected to open, alongside the new Imaging facilities and the Targeted Investment Fund 2 (TIF2) development. The Acute Medical Unit (AMU) has now opened, and new leases have been secured for several community sites.
6.3.3	**Impact on the Environment** Work continues with colleagues in Harrogate Integrated Facilities (HIF) to reduce emissions across the estate, with progress ongoing. The refurbishment of the Category 3 laboratory remains a key operational risk while works continue. Violence and aggression toward staff, and the associated security risks, remain high-priority concerns. The Trust's move to bring security in-house in the new financial year is expected to reduce these risks over the coming months.
6.3.4	The Non-Executive Director (AP) observed that violence and aggression had also been raised within the recent staff survey results. The Interim Non-Executive Director (DC) noted that similar concerns were reflected in the HIF survey feedback.
6.3.5	The Director of Strategy reported on HDFT Impact - training delivery remains on track, with the number of teams trained meeting expectations. However, the metric is currently rated red due to continued organisational growth, and the baseline will be reset for the next Board report.
6.3.6	In relation to Sustainability, the Trust is rolling out a new assessment approach, with the first full data set expected to be available in May.
6.3.7	Awareness of Impact continues to trend upwards, and plans are in place to strengthen communications to further reinforce this progress.
6.3.8	**Resolved:** Board Assurance Framework: An Environment that Promotes Wellbeing was noted and approved.
BD/03/25/7.1 **7.1.1**	**Escalations from Sub-Committees of the Board** The Chair welcomed the Committee Chairs to raise any areas that they wished to escalate from the Committees that had taken place earlier in the day.
7.1.2	The Non-Executive Director (LR) noted that the Learning from Deaths report had been included within the blue-box supplementary papers. She advised that the Quality Committee had held a detailed discussion on the report and confirmed that further reflection would take place during the private session, particularly in relation to the Patient Safety Incident Response Framework (PSIRF).
7.1.3	**Resolved**: The Committee Chairs noted that all areas of escalation had been discussed earlier in the meeting.
BD/03/25/7.2 **7.2.1**	**Audit Committee Chair's Report** The Director of Finance provided an update on the Audit Committee Chair's behalf.
7.2.2	Updates from NHSE Audit and Risk Assurance Committee had been received. It was noted that internal audit activity has intensified in recent weeks. Attendance at the Healthcare Financial Management Association (HFMA) conference was highlighted, with several useful topics identified for further consideration. An update from Audit Yorkshire on Counter Fraud had been circulated. At the March Audit Committee, the Committee received a helpful update from HIF regarding violence and aggression, along with a useful report from Procurement. The external audit

DRAFT

Item No.	Item
7.2.3	(EA) process was reported to be progressing well. Work continues on the change to asset ownership between HIF and the Trust.
7.2.4	The Non-Executive Director (LR) commended the Chair of the Audit Committee, noting the excellent leadership provided.
	Resolved: The Audit Committee Chair's report was noted.
BD/03/25/8.1	**Trust Plan 2026/27**
8.1.1	The Director of Strategy presented the planning framework for 2026/27, noting that the improvement priorities had been discussed at the February workshop and the plan reflected the outputs from that session. While the strategic areas established in 2022 remain broadly appropriate, some refinement is now required.
8.1.2	In relation to Clinical Effectiveness, is has been difficult previously to identify a suitable metric in this domain and therefore focused on harm and patient experience. This now needs to be revisited to ensure the metric accurately reflects clinical outcomes.
8.1.3	For Patient Experience, work was highlighted to strengthen the engagement strategy and consider the value and limitations of FFT in determining whether the current metric remains appropriate.
8.1.4	Reference was made to the 4-hour ED standard, with a proposal to reflect this more accurately as an Emergency Care Standard. Frailty needs to be fully incorporated into the Board Assurance Framework (BAF) and associated metrics. It was queried how maternity would be factored into the Great Start in Life metric.
8.1.5	On Trust wide projects – scheduling is due to be completed in the next few months, with the Imaging project already up and running.
8.1.6	The Estates Plan has been updated, noting that the Trust continues to operate on a highly constrained hospital site
8.1.7	Under Productivity and Sustainability, in addition to WRAP targets, there is a substantial programme of work required to meet efficiency and sustainability goals.
8.1.8	The Plan also incorporates four breakthrough objectives, including:
8.1.9	• The need to address never events, where a core underlying cause has been incomplete checklist use. To prevent recurrence, 100% checklist completion is required.
8.1.10	• Time to inpatient bed, improving patient flow and the time to next destination.
8.1.11	• Children and Young Peoples (CYP) research, strengthening research activity and outcomes.
8.1.12	• Achieving budgets in balance.
8.1.13	The next step is to develop A3s detailing what each project will look like in practice, with work scheduled for completion in May.
8.1.14	The Non-Executive Director (JCr) commented on the Great Start in Life (GSIL) terminology, noting that clarity was needed under the term "non-CYPPH Children's Services".

DRAFT

Item No.	Item
8.1.15	The Non-Executive Director (AP) sought reassurance on whether WRAP was captured under productivity and it was confirmed that WRAP sits within both productivity and the requirement to deliver balanced budgets. He also welcomed the inclusion of checklists as a specific objective.
8.1.16	The Non-Executive Director (AP) noted that there were a number of numerical elements that would require final alignment once the planning round was complete.
8.1.17	The Non-Executive Director (CM) observed that never events had broader causes than checklist completion alone and highlighted documentation issues. The Executive Medical Director responded that the thematic review identified the failure to follow checklists as the primary cause. The Director of Strategy added that the metric is intended to be framed as a clear action requirement: "do this in order to achieve the goal."
8.1.18	The Non-Executive Director (JW) reflected that checklist usage had been the subject of discussions earlier that morning and welcomed its inclusion. She also expressed support for separating Public Health and CYP as distinct areas of focus.
8.1.19	The Non-Executive Director (JCr) asked whether, looking five years ahead, the Trust's structure for CYP services would remain the same. He suggested that the plan should explicitly acknowledge that the future model may evolve.
8.1.20	**Resolved**: The Trust Plan 26/27 was approved.
BD/03/25/9.0 **9.1**	**Any Other Business** No further business was received.
BD/03/25/10.0 **10.1.1**	**Board Evaluation** The Non-Executive Director (Shadowing) (AA) thanked the Board for the opportunity to contribute, noting that it had been a very open and transparent meeting with constructive dialogue and strong assurance-focused questioning. He commented that the papers were clear and easy to follow, enabling him to understand how the various elements of the agenda aligned. He also highlighted the value of beginning the meeting with a patient story, observing that it grounds the Board in its core purpose.
10.1.2	The Non-Executive Director (AP) observed that a significant proportion of the discussion had focused on finance and noted that this level of scrutiny is not always fully reflected in the formal minutes, although much of the detailed financial oversight takes place within the Resources Committee.
10.1.3	It was noted that a wide range of business had been discussed. The Trust Chair thanked everyone for their attendance.
BD/03/25/11.0 **11.1**	**Date and Time of the Next Meeting** The next meeting would be held on Wednesday 27th May 2026.
BD/01/28/12.0 **12.1**	**Confidential Motion** **Resolved:** to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7, Section 18 (E), (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

Signed:

Dated:

DRAFT

Item No.	Item

Board of Directors (held in Public) Action Log
for March 2026 Board Meeting

Minute Number	Date of Meeting	Subject	Action Description	Responsible Officer	Due Date	Comments	Status - completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action
BD/11/26/5.1.10	26-Nov-25	EDI Objectives	The Director of People & Culture confirmed that all Executives have individual objectives but would discuss with the Chief Executive a mechanism to make this more visible.	Director of People and Culture	May-26	Deferred in March to May P&C meeting - added to forward plan	
BD/03/25/3.2.11	25-Mar-26	MVP Funding	Chief Executive to seek clarity from ICB on future of MVP funding	Chief Executive	May-26		

BOARD OF DIRECTORS (PUBLIC)
27th May 2026

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

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

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
MAY 2026

CHIEF EXECUTIVE'S REPORT

National and system issues

1. We begin the new financial year with the news that we have a new Secretary of State and with the NHS Modernisation Bill published to begin its passage through parliament. Whilst these are significant changes, these should not distract us from the priorities that the NHS has established through the ten year plan for health, namely the focus on delivering more care outside hospital, a greater emphasis on prevention rather than treatment, and the need to digitise the NHS in a way that improves safety, productivity and access to services for people.

2. In terms of the priorities for 2026/27, these are also well established, namely, to improve the urgent care pathway, to reduce waiting times, and to live within our means. There is also an emphasis on rethinking the model of providing outpatient services, as a means to the end of improving access and productivity.

3. A key national message is also that whilst we have priorities for 2026/27, we need to collectively invest our time developing neighbourhood health, and moving from the theory – which is probably universally accepted – to the practical implementation, which is often hamstrung by important but sometimes circular discussions about resources, risk, and the dynamics of power between various parties.

4. As we have discussed, we are well-placed to lead the delivery of neighbourhood health in the Harrogate and District area given the services we provide and the relationships we have across our local system. In recent weeks I have attended a North Yorkshire workshop in respect of this, an ICB workshop regarding this, and been part of a session with the national NHSE lead. The message is clearly to get on and develop the models to pilot, and we are in the process of engaging with partners to determine what that could look like for our population and geography.

5. In terms of our plan for 2026/27, this has not yet been signed off by NHSE. We have agreed to reduce our deficit plan of £19.3m by £4m, to £15.3m, which is a part of the HNY deficit position of c£100m. As we have discussed, this financial plan will be a significant challenge for the Trust this year. The HNY system is part of the national escalation process, and to this end there is a meeting with the national team being planned for early June. We did receive a further letter this week, requesting information at an organisational level rather than HNY-wide, with particular reference to the drivers of the deficit, ie which services do we make a loss on and what are our plans to resolve this.

6. Our key area of concern in this respect is our Harrogate and District community services, where the costs significantly exceed the income received. This was discussed as part of the planning process in February and agreed with the ICB that we would review the funding and services provided. Other specialties that are relatively expensive include specialties that require a network model of care to improve both clinical resilience and financial

resilience. We know, having reviewed all contracts, that our 0-19 services are self-sufficient financially.

7. Our strategy of leading the way in respect of 0-19 services, of developing the out of hospital service as part of neighbourhood health, and working with WYAAT and LTHT in particular to improve the resilience of services and also the productivity of our already efficient elective services, are the right responses to the short term planning issues and the longer term sustainability challenge. The Board will also be aware that these reflect the findings from the Carnall Farrar review undertaken a number of years ago, which recommended modernising community services, utilising our productive elective services across WYAAT, and developing networks for services that were needed within HDFT but required a partnership to ensure resilience and best value. We are therefore clear about the direction we need to take, we need to ensure we are organised in a way that delivers this strategic intent.

8. As part of our response to the challenging financial position across the system, ourselves and York and Scarborough FT jointly commissioned a piece of work from KPMG to identify areas where we could deliver greater productivity and efficiency. We will receive a report this week which we will consider as part of our financial plan delivery options for this year.

9. In relation to the HNY ICB, outside of the planning process that is still ongoing, we have now received support to progress our business case in respect of developing a community diagnostic centre in Harrogate. This is positive and we are now engaging the Regional team within NHSE to progress this much-needed proposal.

10. As the Board is aware, we are in the process of decommissioning and transferring the community dental service to a new provider. This transfer is effective from 1st June. There are a number of issues still outstanding, and the operational and corporate teams in particular are providing support to ensure that the service transfers safely and effectively.

11. In relation to the West Yorkshire system and WYAAT in particular, we continue to focus on delivering the priorities identified in the Case for Change. There is a WYAAT clinical board now in place that will oversee the services where we work together, to ensure that we maintain oversight and delivery of services when they move beyond a specific change project. A key discussion currently relates to the pathology programme and the feasibility assessment in respect of further consolidation of microbiology.

12. In respect of our partnership with LTHT, we had a further joint executive team meeting with LTHT at the end of April. There is still some work to do to progress the proposal in respect of the future use of Wharfedale Hospital, which is an ongoing dialogue. The stroke pathway challenges is also high up on our agenda, and there is a recognition that the current arrangement with LTHT and York – whilst beneficial for Harrogate patients – is not resilient and remains a risk. Senior colleagues across organisations, including both ICBs, are involved in working through the service concerns both in the short term and in the longer term.

13. As referenced earlier, we continue to work across our local care partnership and the wider North Yorkshire place to further our thinking in respect of integrated care and neighbourhood health. We have strong relationships across the Place, we are an active member of the NY health collaborative, and I am a member of the Health and Wellbeing Board, as we discuss the role of the H&WB in agreeing neighbourhood health plans.

14. We continue to work in partnership with Local Authority colleagues across twelve areas in relation to the provision of our 0-19 services. These relationships continue to be positive with all Local Authorities, as we work with them to deliver services to children and young people. The mobilisation of the South Tyneside service has gone very well, and we are building a positive relationship with the Council in this area.

15. As ever, there are a lot of moving parts that we are managing at the moment across a number of issues and systems. These all contribute to our coherent strategic approach as we seek to deliver the best care and outcomes for our population.

HDFT issues

Introduction

16. As is appropriate, the first part of this report has focused significantly on the important national and regional issues that impact upon HDFT, whilst also outlining the appropriate engagement we have with partners across a number of systems to deliver high quality care. We will continue to focus on maintaining the appropriate balance that engages externally for the benefit of patients across our systems whilst recognising the absolute importance of supporting colleagues within the organisation, which is where the improvements to services will actually be delivered.

17. As part of this balance, we have developed our priorities for the year, and these have been agreed across the organisation and cascaded through Directorates as part of the governance cycle. The focus now is to ensure that we deliver our priorities, whilst recognising the external and national context within which we work. A paper later on the agenda closes down the previous year's BAF, and we now move onto our new BAF that reflects our priorities for the year.

Our people

18. Since the last Board meeting, we have had a further period of industrial action by our Resident Doctors. The strike period was managed very effectively in terms of ensuring that services were safe and activity continued to be delivered as planned, but the work undertaken by clinical and operational teams to plan and deliver services in this period should be recognised. There will also be a cost to ensuring services were covered appropriately.

19. At the time of writing this report, the ballot is open for potential industrial action by Consultants. We await the outcome of this national ballot.

20. Internally, there are some concerns being raised by medical colleagues in respect of our policy to manage annual leave. I mention this in the context of staff engagement and the current climate nationally in respect of how people are feeling and the influence that this can have on local relationships. We are engaging with colleagues about this specific issue raised, but I will also reflect on how we engage well with our wide range of colleagues to ensure that we reinforce and maintain our values-based culture, and prioritise staff engagement as the route to delivering the best and most productive care.

21. We are still awaiting further details about the review of bandings for nurses within the Agenda for Change framework. We will engage with our Trade Union colleagues once we have the necessary guidance.

22. On a positive note, we are currently at a very strong place in relation to our staff availability indicator that we focus on through our Impact methodology.

Our Quality

23. As part of our priorities for 2026/27, we have identified the need to assess our services against the relevant standards as part of our focus on clinical effectiveness. This work is underway and will give us very helpful insight into areas where we might need to focus our improvement over the coming years.

24. Our complaints response times remain inconsistent from month to month. This has been discussed through our SDR, and we will be working through countermeasures to assist us to improve how we respond in a timely way to patients who have raised concerns about their care or experience of our services.

25. As referenced earlier, there are concerns about the robustness of the stroke pathway between ourselves and local partners. There is a national concern about stroke services, but we need to ensure that the service for our patients is good and reliable. There are workforce challenges that we recognise, and which are affecting the resilience of the service at present.

26. In respect of our maternity services, there are no risks escalated to the corporate risk register, and staffing levels, including our QIS staffing compliance, remain strong. We have seen a reduction in the number of diverts over the last two months. This is positive for women in our service and reflects the impact of the business case we approved last year in respect of maternity staffing.

Our Services

27. Our 0-19 services continue to deliver strong performance across the majority of our geographic footprint and across the vast majority of the KPIs that we measure ourselves against. We are delivering against 52 of 55 indicators, with the only areas where we don't quite meet the Healthy Child Programme metrics being in Cumberland and Westmoreland & Furness, where there has been a huge improvement over the last twelve months. We will be incorporating the South Tyneside service into this reporting from July, following a successful transfer in April.

28. Our urgent care pathway performance delivered a four hour emergency care standard of just over 79% in April, in line with expectations. The plan next year is to achieve 85% against this standard, and it is important that we do so, as the experience and outcome for some of our patients is not what we should be delivering. It remains a key priority and breakthrough objective for 2026/27. The position for May has been more challenging, and we are working through the information to ensure that our validation processes are back to where they were following the implementation of the EPR, which understandably has

delayed some of this process. This is not to distract ourselves from the fact that our performance hasn't been to the level we are seeking to achieve and will continue to be a focus for us.

29. In relation to cancer, our performance remains a positive one, with significant improvement achieved over the last twelve months which has continued into 2026/27.

30. We continue to deliver our elective recovery plan, and our RTT position is over 76% (national average 65%). We have an ambition to return to the constitutional standard by 2028/29, which we are continuing to target for the benefit of our patients.

31. We continue to struggle to meet our diagnostic waiting times standards due to the ongoing mismatch between capacity and demand for our CT/MRI services. As discussed previously, discussions are ongoing in respect of creating additional permanent capacity through a Harrogate based Community Diagnostic Centre. Whilst the facility itself will not be up and running in 2026/27, as part of the proposal we will have access to revenue funding to make some necessary improvements this year in advance of the CDC being fully operational. Along with the new Imaging department on the Harrogate site, and our Trust-wide project to improve our Imaging services, we should expect to be in a much better place later in the year.

32. The provision of autism assessments in a timely way continues to be a significant risk to HDFT. Discussions with the Commissioner are wrapped up in our overall planning discussions, which are challenging. This remains a risk and we continue to keep this high on the agenda with our partners as we seek a sustainable solution.

Our money

33. As the Board will know through many discussions over the last few months, we have a challenging financial plan to deliver this year. The overall WRAP programme is £32m, including the additional stretch that we have agreed to as part of improved plan position signed off in early May. We have prioritised this delivery through our PRMs and at SDR, and we have set up a Strategic Programme (HDFT Futures) to address the medium-term productivity and sustainability challenge. This programme will be led by Jackie, our Medical Director.

34. As referenced earlier, we will receive the draft report this week from KPMG in respect of further opportunities for financial improvement. This follows a number of weeks work which culminated in a workshop on 14th May. There are definitely areas for us to focus on as we get on with delivering the financial plan we have set out.

35. As discussed previously, we are also working through a series of potential revenue saving schemes, that will necessarily require robust EQIA being undertaken. This process is in train and will report through the Quality Committee. I fully anticipate that there will be potential proposals that don't pass the EQIA test, which should be the case as we look to take all of the action that we can without compromising the quality and safety of the services we provide.

36. We have a significant cash risk as a result of the financial position. We received cash support during 2025/26, but until we have our financial plan for 2026/27 agreed, we will by necessity be trying to manage this position on a daily basis. Payments continue to be being delayed, with a cost to the suppliers, our team, and also directly in terms of late payment fines. We continue to work with partners to support our requirements.

37. The route to financial balance and sustainability lies in the strategic solutions that I have outlined earlier, alongside a clear agreement with our Commissioners in respect of the services we deliver. Our HDFT Futures strategic programme will be the framework within which we will organise ourselves to plan and deliver the transformational change that will result in higher quality, more efficient services for our patients for the years ahead.

38. We continue to be a very productive Trust when comparing ourselves with others. This is positive and we need to maintain our level of performance as we work through service and financial issues for this year and beyond.

Corporate Risk Register

39. As per the HDFT protocol, Performance Review Meetings (PRM) were held with all Directorates and Harrogate Integrated Facilities in April and May 2026. At the PRMs risks rated 9 and above on Directorate Risk Register were reviewed. Discussions were held on any risks to be escalated or de-escalated to/from the Corporate Risk Register.

40. As per the HDFT protocol the Executive have reviewed all risks currently on the Corporate Risk Register. Since the last meeting of the Board, I can confirm the following changes have been made:

- 79 - Risk to Stroke Provision at HDFT has been re-escalated back to the Corporate Risk Register due to an increase in likelihood. Discussions remain ongoing with system partners to review risk mitigation

41. No further risks were escalated from Directorates in month for inclusion on the Corporate Risk Register and no further risks were de-escalated from the Corporate Risk Register for management on directorate risk registers.

Other

42. Our EPR implementation at the end of April was very successfully implemented. The many people involved did a great job over a period of time to implement and support colleagues with the new system. There are a few issues to work through as always happens, but overall, this has been a really well-delivered programme of work to date. The EPR will bring lasting benefits to the Trust, and this will be the focus of our work now. I would like to record my thanks to everyone involved in getting us to this point in the programme.

43. I had the pleasure of attending the Great Start in Life conference in Durham earlier this month. This was a brilliantly organised and brilliantly delivered day, with many areas of improvement and best practice on show. It reinforced the strength of our 0-19 services

and the impact that they make for the many children and families across the North of England.

44. As part of the Harrogate Healthcare 200 celebrations, I was pleased to attend both the launch of the event and to engage with colleagues who participated in our Open Days at the Harrogate Hospital site in May. The programme of events will culminate in a conference on 1st July.

45. We have now completed our recruitment processes for the executive director team. I am delighted with the outcome and look forward to welcoming our new Board members over the coming months.

46. I am also delighted to mention in this report the fact the Jackie has been appointed as an Honorary Professor with the Hull York Medical School. This is richly deserved and a great reflection on Jackie's significant contribution to the NHS over her career to date.

47. Finally, it is important to always remind ourselves that despite some of the challenges that we and the NHS are facing at the moment, that we maintain our focus on our values and the engagement with colleagues. We have great staff across the Trust who are committed to improvement and delivering the best for our patients. Our role is to harness this talent and provide an environment within which it can shine. I am confident that we have the people to continue to strengthen the outcomes for our patients and population, provided that we continue to focus on doing the right things in the right way.

Jonathan Coulter
Chief Executive
May 2026

BOARD OF DIRECTORS (PUBLIC)
27th May 2026

Title:	Board Assurance Framework 2025-26 Close Down
Responsible Director:	Kate Southgate, Director of Governance and Improvement
Author:	*Kate Southgate, Director of Governance and Improvement*

<table>
<tr><td>Purpose of the report and summary of key issues:</td><td colspan="2">This report presents a summary of the Trust's Board Assurance Framework for 2025–26, outlining how strategic risks have been identified, managed and assured, and providing the Board with confidence to formally close down the BAF for the year.</td></tr>
<tr><td rowspan="8">Trust Strategy and Strategic Ambitions</td><td colspan="2">The Patient and Child First
Improving the health and wellbeing of our patients, children and communities</td></tr>
<tr><td>Best Quality, Safest Care</td><td>x</td></tr>
<tr><td>Person Centred, Integrated Care; Strong Partnerships</td><td>x</td></tr>
<tr><td>Great Start in Life</td><td>x</td></tr>
<tr><td>At Our Best: Making HDFT the best place to work</td><td>x</td></tr>
<tr><td>An environment that promotes wellbeing</td><td>x</td></tr>
<tr><td>Digital transformation to integrate care and improve patient, child and staff experience</td><td>x</td></tr>
<tr><td>Healthcare innovation to improve quality</td><td>x</td></tr>
<tr><td>Corporate Risks</td><td colspan="2"></td></tr>
<tr><td>Report History:</td><td colspan="2">April SDR</td></tr>
<tr><td>Recommendation:</td><td colspan="2">Review the content of this report, and confirm sufficient assurance has been received to close down the 2025-26 Board Assurance Framework</td></tr>
</table>

TRUST BOARD (HELD IN PUBLIC)
BOARD ASSURANCE FRAMEWORK 2025-26 CLOSE DOWN REPORT

May 2026

1.0 INTRODUCTION

The Board Assurance Framework (BAF) is our key governance tool used by the Board to systematically identify, assess, and gain assurance over the risks to achieving our Trust Strategy.

The BAF exists to:

1. Link strategy to risk - It translates the Trust's strategic objectives (our True North) into a clear view of what could prevent success and where delivery may fail. This ensures the Board focuses on the most important risks to our strategy, not just operational issues.

2. Provide structured assurance - The BAF brings together our key risks, controls in place (countermeasures), sources of assurance and gaps in assurance or control. This enables the Board to understand how well risks are being managed and where further action is needed.

3. Support effective Board oversight - It gives the Board visibility of high-level strategic risks, performance against key objectives and whether mitigations are working. This supports informed decision-making and prioritisation.

4. Highlight gaps and areas of concern - a core purpose is not just to show assurance, but to identify where assurance is weak or missing and where controls are insufficient. This allows the Board to focus on actions to strengthen governance and risk management.

5. Align risk, performance and governance - The BAF integrates risk management, performance monitoring and strategic delivery. This ensures the Board has a single, coherent view of organisational resilience and delivery.

6. Support accountability and regulatory assurance - It provides evidence that the organisation understands its risks, is actively managing them and has appropriate oversight and control. This is particularly important for regulators, auditors, and external stakeholders.

The Board Assurance Framework is a strategic tool that helps us answer a fundamental question: *"Can we be confident that we will achieve our ambitions, and if not, what are we doing about it?"* It enables the Board to move beyond reporting to true assurance, insight, and proactive risk management.

2.0 DELIVERY OF THE BAF IN 2025-26

During 2025-26, the Trust continued to deliver against its True North ambitions of:

- Best Quality, Safest Care;
- Best Place to Work;
- Person-Centred Care, and
- Great Start in Life.

Supported by Enabling Ambitions of:

- Financial Sustainability;
- Digital Transformation;

- Research and Innovation, and
- Environmental Sustainability.

On a bi-monthly basis, each element of the BAF was reported and reviewed by the designated Sub-Committee of the Board and by the Trust Board itself.

2.1 Best Quality, Safest Care

Significant progress was achieved in patient safety and quality outcomes. The Trust exceeded its target for reducing moderate and above harm incidents, reporting 82 events against a target of 88, continuing progress in a three-year improvement programme.

This was supported by targeted work on pressure ulcers, falls, and deteriorating patients, alongside strengthened system learning through the Patient Safety Incident Response Framework (PSIRF) and thematic reviews.

Patient experience remained positive, with over 96% of patients rating care as good or very good. While complaint response times fluctuated due to workforce pressures, improvements to processes were implemented and will continue into 2026-27.

Strategically, the Trust progressed its Clinical Services Strategy, focusing on community based care (HDFT@Home), frailty pathways, and partnership working, aligning with national priorities to shift care closer to home and towards prevention.

2.2 Person Centred Care

The Trust delivered improvements across key operational performance standards impacting patient experience and flow.

- Emergency Care (4-hour standard): Achieved 78.84% in March 2026, meeting the national target, with performance improved year-on-year.
- Elective Recovery (RTT): Delivered 76.2% against a 72% trajectory, with elimination of 65-week waits and progress toward the 92% standard.
- Cancer 62-day standard: Achieved 85%, meeting the national target, with more consistent performance than the previous year.
- Frailty length of stay: Reduced to 10.7 days, significantly better than the national median (12.31 days), reflecting improved care pathways .

Major improvement programmes contributed to these outcomes. The Bed Capacity and Patient Discharge programmes delivered significant gains in patient flow, including:

- Faster diagnostics and pharmacy turnaround times
- Increased same-day and weekend discharges
- Improved use of discharge lounges and community pathways

Partnership working, particularly through WYAAT and Leeds Teaching Hospitals, continued to enhance access to specialist services and collaborative pathways.

2.3 Best Place to Work

Staff engagement continued to improve, with improved NHS Staff Survey response rates (62%) and strong benchmark performance across peer organisations. Although not yet consistently top-ranked, trends show sustained year-on-year improvement and a narrowing gap to the best performers.

Workforce stability remained strong, with:

- Vacancy rate: 5.75% (below target)
- Turnover: 10.06% (below target)

However, sickness absence (5.32%) and early attrition (15.97%) exceeded targets, highlighting areas for ongoing focus.

The Medical and Dental Workforce Payment Transformation Programme delivered major improvements, including increased compliant job planning (from 50.4% to 87.7%) and rollout of the BankStaff+ system, enabling more accurate and efficient workforce management.

Efforts to enhance staff involvement showed measurable progress, with improved survey scores and targeted interventions in lower-scoring areas supporting better engagement.

2.4 Great Start in Life

The Trust continued to make strong progress in improving outcomes for children and young people. Delivery of the Healthy Child Programme reached 52 out of 55 mandated contacts at ≥90% compliance, approaching full delivery across services.

The Great Start in Life (GSIL) pathway was successfully launched, with 95% of eligible children recruited, and an evaluation of outcomes due in 2026.

In relation to children's patient experience:

- Parent/carer survey response rates exceeded target at 11%.
- Development of a dedicated CYP engagement approach is ongoing, including digital and paper tools to improve participation and representativeness .

A key risk remains in autism assessment waiting times, with:

- 1,479 children on the waiting list (target 120).
- Longest wait of 129 weeks (target 13 weeks).

This continues to present a significant operational and quality challenge, with ongoing mitigation in place.

2.5 Financial Sustainability

The Trust faced a challenging financial environment and reported a £23.6m deficit against a planned breakeven position. This was driven by a combination of factors including failure to deliver activity plans, cost pressures above inflation, workforce costs, and winter pressures.

The Trust delivered £13.4m (92%) of the WRAP programme against a target of £14.5m. This increases to £20.4m when non-cash releasing schemes are included. Although 92% of efficiency plans were achieved, 59% of those plans were non-recurrent. Strengthened governance and methodology are now in place to support more recurrent savings delivery.

The financial position also impacted cash flow and supplier payments performance and resulted in the Trust remaining in System Oversight Framework Segment 3, despite good performance in other operational metrics.

Relationships with system partners, including the ICB, were an additional challenge, particularly in relation to risk-sharing arrangements.

2.6 Digital Transformation

The Trust made substantial progress in advancing digital maturity aligned to the national "What Good Looks Like" framework. Key achievements included:

- Establishment of a Digital and Data Strategy
- Appointment of a Chief Digital Officer

- Expansion of patient-facing digital services
- Adoption of AI capabilities, including Copilot and governance frameworks
- Increased use of virtual consultations

A major milestone has been the Electronic Patient Record (EPR) programme, with a Trust-wide go-live completed in April 2026. This programme will enable more integrated, paper-lite care, improved patient experience, and better data-driven decision-making

2.7 Research and Innovation

The Trust made good progress towards its ambition to be a leading organisation for healthcare innovation and research.

Key achievements include:

- Launch of a Clinical Advice Service (CAS) for Innovation, supporting both internal and external innovation and establishing a future income-generating model.
- Engagement with over 20 companies and support for multiple start-ups and internal projects.
- Development and support of six internal innovation initiatives and multiple external partnerships.

While income generation fell short of the £50k target, funding was secured through grants and partnerships, with stronger foundations now in place for growth.
In research, the Trust strengthened its position as a 0–19 research provider, with:

- Multiple new studies in development.
- Delivery of national portfolio research (e.g. Generation study).
- Successful showcase and collaboration activity across research networks.

Progress was also made towards a self-sustaining clinical trials function, maintaining core funding and expanding partnerships, although growth in commercial research was constrained by infrastructure delays.

The HDFT Impact strategic programme continues to embed improvement capability:

- Awareness of strategy improved to 67% (+4% in year).
- Training and implementation progressed despite capacity challenges.

2.8 Environmental Sustainability

The Trust successfully delivered its £45.9m capital programme in full (100% utilisation), ensuring continued investment in modern infrastructure and high-quality care environments. Key developments included new theatres, imaging facilities, ward upgrades, and critical infrastructure improvements.

Progress against the Premises Assurance Model (PAM) shows improvement, with moderate improvement findings reducing from 37 to 28 over two years, reflecting continued focus on infrastructure quality and risk reduction.

Strong progress was also made against the Trust’s Green Plan ambitions with the Trust moving forward with our ambition to reach carbon net zero by 2040. Progress to date includes:

- 51.5% reduction in direct carbon emissions (Scope 1 & 2).
- 75% reduction in electricity-related emissions.
- Completion of major decarbonisation projects worth £14.1m.
- 80% reduction in anaesthetic gas emissions, delivering significant carbon savings.

Major redevelopment schemes, including the Block C Theatres and Imaging project, remain on track to deliver new state-of-the-art facilities from late 2026.

3.0 SUMMARY

In 2025-26, the Trust delivered strong improvements in quality, access, workforce engagement, digital capability, estates, and sustainability, alongside growing innovation and research activity.

These achievements were delivered despite significant financial, operational, and system pressures, including demand increases and workforce challenges.

The Trust enters 2026-27 with:

- A strong platform for digital transformation and service redesign.
- Improved patient outcomes and operational performance.
- Clear priorities for financial recovery and workforce wellbeing.

Overall, the organisation is well positioned to continue delivering high-quality, person-centred care while pursuing long-term transformation and sustainability.

4.0 RECOMMENDATIONS

The Board is recommended to:

1. Review the content of this report, and
2. Confirm sufficient assurance has been received to close down the 2025-26 Board Assurance Framework

Kate Southgate
Director of Governance and Improvement

May 2026

STRATEGIC AMBITION: BEST QUALITY, SAFEST CARE 2026-2027

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

GOALS:

Safety

Ever safer care through continuous learning and improvement

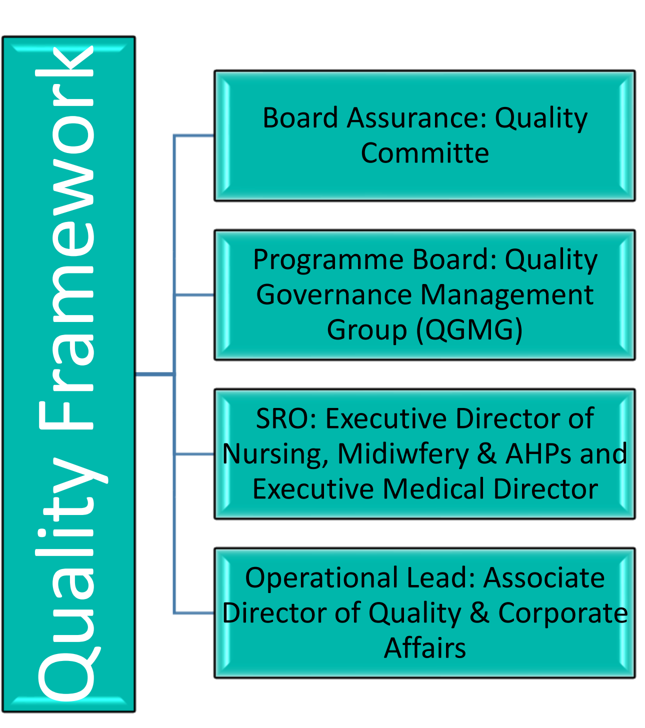
Effectiveness

Excellent outcomes through effective, best practice care

Patient Experience

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

GOVERNANCE:



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

Strategic Programme	Clinical Services Strategy
Breakthrough Objectives	Checklist Completion
Overarching Risk Appetite:	Clinical - Minimal

Overarching Risk Summary:

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

True North Summary:

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in year goal	Level of Risk for progressing actions
Ever Safer Care	Eliminate Moderate & Above Harm	Decrease the total number of moderate & above harm incidents while increasing reporting of low or no harm	Long term: Eliminate moderate & above harm Short term: 20% reduction each year for 3 years Baseline: 140 per annum Year 1: 110 (achieved) Year 2: 88 (achieved) **Year 3: 71 (approx.. 6 per month)**	The True North Metric of eliminating moderate and above harm continues into its third year (2026-27). The target of a 20% reduction in harm was achieved in 2024-25 and in 2025-26. 2026-27 sees a step change of a further 20% reduction. This is a target of less than 71 moderate and above incidents for the year, which equates to approximately 6 per month. The previous two years have seen a focus on Pressure Ulcers and Deteriorating Patients. This work continues as business as usual into 2026-27. In addition, due to a number of Never Events linked to checklist being declared in recent years, a focus for 2026-27 will be a Breakthrough Objective: Checklist Completion. Details of which are in the section below. Watch Metrics: • Number of Never Events – **0** declared in year • Number of PSIIs – **0** declared in year • Level of low and no harm events reported – ratio maintaining at **99%** with numbers maintaining approximately **1,166**	Breakthrough Objective: Checklist Completion – programme for 2026-27 Pressure Ulcers Improvement Plan Deteriorating Patient Thematic Review – Implementation Plan Trauma Pathway Thematic Review – Implementation Plan Falls Improvement Plan Core Service Review Programme Directorate Countermeasures		
Excellent Outcomes	Clinical Effectiveness – Clinical Standards Review (CSR) Award Distribution	Increase the proportion of services that are compliant with evidence based clinical standards	Long term: All services to be compliant with evidence based clinical standards. Goal 1: Short term: increase the number of services that have completed a CSR. Baseline: 25 services Goal 2: Medium term: increase the proportion of services moving from Bronze to Silver	This is a new True North metric focusing on the delivery of effective care by developing professional curiosity into patient outcomes and achieving sustained compliance with evidence-based clinical standards. The focus for Quarter 1 will be to increase the number of services (108 in scope) that have completed the Clinical Standards Review. Currently this standards as a baseline of 25 services. When a CSR has been completed, an award of Gold, Sliver and Bronze will be awarded depending on the level of compliance. The focus will then move towards moving Bronze status services to Silver status. Watch Metrics: • % Guidelines in date – **94%** • % SOPs in date - **89%**	Establish a Trust-level Clinical Effectiveness True North Metric Implement a Bronze / Silver / Gold Standards Maturity Model Complete and Maintain a Trust wide baseline of standards compliance Create an explicit escalation and prioritisation route for system-level gaps Embed clinical effectives into business as usual governance Shift culture from compliance judgement to improvement and learning		

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in year goal	Level of Risk for progressing actions
A Positive Experience	Patient Experience Response Rates	For every patient to recommend our services	Long term: Development of a bespoke Engagement Strategy Short term: Increase the response to FFT by 10% over the next 12 months for inpatient: 413 (baseline 375)	Despite ongoing efforts to improve patient experience across HDFT, the current systems for collecting and acting on patient feedback are often delayed fragmented and inconsistently used. Traditional methods such as surveys (e.g., Friends and Family Test) and complaints processes typically capture feedback retrospectively, meaning opportunities to respond to patient concerns in real time are missed. As a result, staff may lack timely insight into patient needs and experiences during care delivery, limiting their ability to make immediate improvements. Over the last 12 months, the Trust has used the FFT as the primary Trust-wide measure of patient experience, with an average of 375 responses per month. Over the last 12 months, the percentage of patients reporting a “Very Good” or “Good” experience has remained consistently high, with an average of approximately 93.7%, showing stable and sustained positive patient experience across the year. The focus for 2026-27 is to increase FFT responses by 10% in Year 1. This will run alongside the development of an Engagement Strategy once further guidance is received on the 10 year delivery plan. Watch Metrics: • 34 complaints submitted in April 2026 • Response rate of complaints due in April with 60%	Development of a real time engagement tool Development of a 12 month engagement plan Development of an Engagement Strategy Develop a bank of patient stories		

Strategic Programme:

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
Clinical Services Strategy	Best Quality, Safest Care	A coherent, clinically led model of care where services are standardised where appropriate, redesigned to meet changing demand, and delivered through the right setting with the right workforce, improving outcomes for patients while maintaining system sustainability.	To progress delivery of priority Clinical Services Strategy projects, notably Clinical Services Review (CSR), Single Point of Contact (SPOC) for UEC, and Neighbourhood Health, embedding agreed clinical standards and service models that support quality, workforce resilience and operational sustainability.	CSS remains an active strategic programme for 2026–27, with delivery primarily progressed through three major transformation programmes: • Clinical Services Review (CSR): progressing achievement of a clear, consolidated picture of clinical effectiveness using service compliance against national standards, enabling prioritised trust wide transformation (for cross cutting issues) and local QI (for service level issues), aligned to Green Plan, health inequalities, and EDI improvements. • Single Point of Contact (SPOC) for UEC: developing more coordinated access and referral pathways to improve flow, reduce duplication and support timely clinical decision making. A central coordination hub for HDFT@Home, providing seamless and consistent management of integrated urgent care pathways across acute and community settings. Led by experienced, trusted assessors with access to live system capacity, the SPOC will utilise structured pathways to ensure service user needs are met in a timely, clinically safe, and financially sustainable manner, optimising resource utilisation across the system. • Neighbourhood Health: advancing place-based models of care to support population health management, integration and care closer to home. To deliver Neighbourhood Health across Harrogate and Rural District to enable the shifts from treatment to prevention and from hospital to community by implementing the six components of neighbourhood health Programme governance is in place through SDR, quarterly CSS Strategic Programme Board and a monthly CSS Operational Board which focusses on delivery and oversight of individual schemes at varying stages of maturity. Delivery is dependent on workforce capacity, financial headroom and system-wide interdependencies.	• Programme-level oversight via SDR with regular assurance against agreed CSS priorities • Translation of CSS priorities into defined workstreams with accountable clinical and executive leads • Alignment with Clinical Standards framework to support consistent quality and safety expectations • Use of A3s to articulate problem definition, benefits, risks and countermeasures for priority areas • Active management of interdependencies (workforce, finance, digital and estates) via CSS Operational Board to support delivery		

Breakthrough Objective:

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
Checklist completion	Best Quality, Safest Care	To significantly reduce safety-critical variation by embedding the reliable use of safety-critical checklists and checks as a routine part of delivery across clinical, corporate and enabling services, thereby strengthening patient safety and organisational assurance.	Reduction in safety events linked to checklists Baseline: TBC	The current state is characterised by significant variation and lack of clarity across the organisation: • It is not consistently clear which services should have checklists, and which do not. • Where checklists exist, completion is variable and often not meaningfully embedded into workflow • .Assurance processes identify gaps but do not reliably explain why checklist completion fails. • Never Events have occurred across both traditional and non-traditional environments, demonstrating that safety risk is not confined to theatres. The thematic review identified checklist-related issues in 6 of the 12 Never Events, alongside failures in accountable item checks, visual prompts, SOPs, and safety processes, indicating systemic rather than individual failure. A key early challenge is that it is not consistently clear across the organisation which services require safety-critical checklists or equivalent controls, particularly outside traditional clinical pathways. While clinical never events provide clear examples, it is recognised that corporate and enabling teams also operate safety-critical processes where failure could result in significant harm. At present, these processes and controls are not always explicitly identified, monitored or assured in a consistent way.	Establish services requiring safety-critical checklists Review and rationalise checklist content to ensure safety-critical steps are included Embed checklist completion into routine workflow, including stop moments Strengthen human-factors reliability, including speaking up culture and role clarity Standardise and strengthens training for safety critical checklist Improve visual and digital support, including use of electronic systems where possible Share learning from Never Events		

Related Corporate Risks

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

Related External Risks

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

Board of Directors

May 2026

Title:	**Delivering Same Sex Accommodation – Annual Statement**
Responsible Director:	Breeda Columb, Executive Director of Nursing, Midwifery and AHPs
Author:	Jenny Nolan, Deputy Director of NMAHP's

Purpose of the report and summary of key issues:	The report provides the Trust Board with the annual declaration on Delivering Same Sex Accommodation. The declaration confirms that there has been 1 breach in 2025 - 2026	
Trust Strategy and Strategic Ambitions:	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	x
	Person Centred, Integrated Care; Strong Partnerships	x
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	
	An environment that promotes wellbeing	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks:	No Corporate Risk associated with this paper	
Report History:	The Board reviews and receives this annual declaration each May. The report was also received at: • SDR on 20th May 2026 • Quality Committee on 27th May 2026.	
Recommendation:	The Board is asked to approve the annual declaration.	

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

TRUST BOARD (in Public)
Delivering Same Sex Accommodation – Annual Statement
May 2026

1.0 INTRODUCTION

The Operating Framework 2011-12 made it clear that NHS organisations are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, or reflects their personal choice. During 2025 – 26 there has been one reported breach at the organisation, this breach impacted 5 other patients and was reported in line with our incident reporting framework and current process.
The incident happened at Trinity Ward at Ripon community hospital, following a patient allocation to the area by colleagues who were unfamiliar with the layout of the ward which meant that the patient placement caused a mixed sex breach, impacting five other patients. The learning from this incident was that not all site and senior nursing teams were aware of the geography of remote locations to enable them to make patient transfer decisions appropriately. This has been addressed and all colleagues involved in patient transfers are aware of the ward layout.

2.0 ANNUAL DECLERATION

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

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

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

3.0 RECOMNNMENDATIONS

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

Breeda Columb
Executive Director of Nursing, Midwifery and AHPs

Jenny Nolan
Deputy Director of Nursing Midwifery and AHP's
May 2026

Trust Board

27th May 2026

Title:	Emergency Preparedness, Resilience & Response Report 2025-26, 6-month update
Responsible Director:	Robert Armstrong Accountable Emergency Officer
Author:	*Alexander Chatten, EPRR & Site Support Officer*

<table>
<tr><td>Purpose of the report and summary of key issues:</td><td colspan="2"> The Civil Contingencies Act 2004 identifies NHS Acute Trusts as Category 1 responders, giving them legal responsibility to plan for and respond to emergencies, working in co-operation with other responders and communicating with the public. The NHS EPRR Framework identifies that NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. It also provides a set of core standards for all NHS funded organisations in England to help with meeting the legislative requirements. Last year's report advised that the EPRR team would bring a second report, in 6 months' time, in order to give assurance that the action plan put in place is delivering the ability to improve the Trust's Core Standards performance in time for the next assurance process in October 2026. This report details the result of 2025/26 assurance outcome and subsequently updates the Board on the range of actions undertaken this year as part of the Emergency Preparedness, Resilience and Response ("EPRR") agenda by the Trust. </td></tr>
<tr><td rowspan="8">Trust Strategy and Strategic Ambitions</td><td colspan="2">The Patient and Child First
Improving the health and wellbeing of our patients, children and communities</td></tr>
<tr><td>Best Quality, Safest Care</td><td>X</td></tr>
<tr><td>Person Centred, Integrated Care; Strong Partnerships</td><td>X</td></tr>
<tr><td>Great Start in Life</td><td></td></tr>
<tr><td>At Our Best: Making HDFT the best place to work</td><td>X</td></tr>
<tr><td>An environment that promotes wellbeing</td><td></td></tr>
<tr><td>Digital transformation to integrate care and improve patient, child and staff experience</td><td></td></tr>
<tr><td>Healthcare innovation to improve quality</td><td></td></tr>
<tr><td>Corporate Risks</td><td colspan="2"></td></tr>
<tr><td>Report History:</td><td colspan="2">HDFT's previous EPRR Core Standards Assurance ratings:

2023 10% Non-compliant
2024 45% Non-compliant</td></tr>
</table>

	2025 53% Non-compliant
Recommendation:	*Updates to the action plan following the Core Standards Assurance Process in 2025-26 is detailed in Appendix A – Core Standards Action Plan.* *The Board is asked to:* • Note the self-assessed improvement against the Core Standards and delay further decisions on resource investment following the formal submission and outcome of the Core Standards in October 2026

1. INTRODUCTION

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

The report outlines key activities undertaken since the last report in November 2025 by the Trusts’ EPRR Team and the wider health emergency planning community in Humber and North Yorkshire.

2. BACKGROUND

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

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

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

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

3. RISK ASSESSMENT

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

- Denial of Access to Systems
- Adverse Weather
- Infectious Diseases & Pandemics

- Loss of Utilities (including energy & telecommunications)
- COMAH Site Release, Explosion or Malicious Attack (contaminated bodies)

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

The Trusts' EPRR Risk Register is reviewed regularly at the Emergency Planning Steering Group (EPSG) and risks managed in line with the EPRR Strategy.

4. RESPONSE TO INCIDENTS

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

- IT/ Systems Outages
- CT Scanner Failure
- Health Care Industrial Action (BMA Resident Doctors)

5. TRAINING

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

The On-call Managers and Directors Portfolio Team was expanded to include the training needs analysis and training log. Work is still ongoing to incorporate reporting compliance onto LearningLab records. Commanders have their own portfolios to log training attendance but also complete reflective practice on their experiences. Portfolios need to be reviewed once in a 3-year cycle, and the EPRR team are working through the practicalities and governance surrounding this.

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

Overall Compliance Against the Portfolio

Number of Strategic Health Commanders	17
Number of Tactical Health Commanders	19
Number of EPRR specialists/advisors	3

30.70%

Compliance against the relevant portfolio	0-24%	25-49%	50-74%	75-99%	100%
Strategic compliance against Health Commander Portfolios	1	7	4	2	0
Tactical compliance against Health Commander Portfolios	12	6	0	1	0
EPRR compliance against Health Commander Portfolios	1	0	2	0	0

Due to ongoing uncertainty as to if the NHS England EPRR team will be continuing to host the majority of the training sessions, alongside a high turnover of commanders, compliance has fallen from 32.46% to 30.70%.

6. EXERCISING

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

Name	Type	Domain	Date
Exercise Flanders	Live	CBRN	Nov 2025
Inpatient Ward BCP	Tabletop	BCP	Nov 2025
Communications Exercise	Comms	Comms	Dec 2025
Exercise Wren - DHSC	Live	Cyber	Feb 2026
SROMC BCP	Tabletop	BCP	Mar 2026
Exercise Kaus Australis - NHSE	Workshop	Power	Apr 2026
SDEC BCP	Tabletop	BCP	Apr 2026

Future Exercises Planned:-

Name	Type	Domain	Date
Communications Exercise	Comms	Comms	May 2026
CBRN (Multi-Agency)	Live	CBRN	TBC

7. LESSONS IDENTIFIED

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

Exercise or Incident	Lessons Identified	Resulting Actions
Exercise Flanders (Nov 2025)	• Report from YAS detailed resulting actions and recommendations	• 23 resulting actions from this live CBRN exercise.
Inpatient Ward BCP (Nov 2025)	• Unsure what is stored in cupboard outside Wensleydale • Unsure of the EWS escalation process	• Review of BCP cupboard outside Wensleydale • Checking if ward ASCOMS contain SIMs
Communications Exercise (Dec 2025)	• Switchboard struggled to conduct exercise • Only 1 loggist responded	• Training required for switchboard operators • Switchboard to consider calling loggists separately if no response received.
CT Scanner	• Increase resilience with agreed pathway including LTHT • Embedding imaging pathways and awareness • Difficult to communicate to everyone in incidents	• Consider allowing a 24hr service to send all-user email out of hours • Ensure porters are aware to contact CSM if there are transfer difficulties • Ensure that replacement of aging equipment is included in capital plan
Industrial Action (April 2026)	• TBC	• TBC

8. BUSINESS CONTINUITY

The Trust has a Business Continuity Management Strategy which outlines our Business Continuity Management System (BCSM). The key performance indicators

have been developed for inclusion in the board report every year to provide assurance to the board on effectiveness of the BCMS.

All directorates to have completed a BIA	Included in each service Business Continuity Plan
Strategic BIA has been reviewed	Completed Sep 2024 (next review Sep 2026).
Exercise(s) have been completed to test all aspects of business continuity arrangements.	Exercises for Service Level BCPs are in progress for all directorates. It is estimated that this will be completed by the end of this financial year.
Any business continuity incidents have been entered onto the EPRR Team Incident Log	Completed - work ongoing to ensure staff are aware this needs to be communicated to EPRR staff.
Any business continuity exercises have been entered onto the EPRR Team Exercise Log	Completed – work ongoing to ensure staff are aware this needs to be communicated to EPRR staff.
Any lessons identified from incidents and exercises, and their resultant actions have been captured on the Master Action Tracker	Complete
Business continuity plans have been reviewed, incorporating any changes to BIAs and/or changes due to lessons identified through incidents or exercising	In progress once exercise(s) have been completed. It is estimated that this will be completed by the end of this financial year.

The Business Continuity Working Group (BCWG) established in 2025 meets every 6 weeks, to better coordinate the Business Continuity requirement of the organisation. The group continues to work through conducted and planned exercises and reviews of service level business continuity plans and has provided a welcome platform for plan owners to share lessons identified and continuous improvement.

9. POLICIES AND PLANNING

In February 2026, the Trust moved from a Major Incident Plan to an Incident Response Plan. This change aimed to expand on the different incident categories, clarify the activation and escalation processes and simplify command and control.

This change resulted in the EPRR team conducting an increased training programme for staff involved in the initial stages of the new Incident Response Plan, such as Health Commanders, Switchboard and Matrons.

Ongoing work with the Yorkshire Ambulance Service Special Operations team has resulted in an extensive update to the Chemical, Biological, Radiological and Nuclear (CBRN) Plan, which is due to be approved in May. This update aims to dramatically increase compliance against domain 10 of the EPRR Core Standards Assessment. More information can be found in Appendix A.

10. NHSE EPRR CORE STANDARDS ASSURANCE PROCESS

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

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

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

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

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

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

Assurance Rating Thresholds

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

Calculated using the number of FULLY COMPLIANT EPRR Core Standards.

REMINDER OF CURRENT POSITION

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

The overall position was determined as non-compliant. Our total percentage of compliance for 2025 was 53%, being fully compliant with 33 of the 62 core standards.

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

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

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

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

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

A breakdown of the 10 domains can be seen below:

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

10.1.1. Deep Dive

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

10.1.2. Overall position

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

11. CONCLUSION

Actions identified from the 2025 Core Standards Assurance process were transferred into the EPRR Action Tracker that is reviewed regularly at Emergency Planning Steering Group (EPSG) or the relevant sub-groups.

In Appendix A, the EPRR team has provided an update on the resulting actions, of which there were a total of 29, alongside a predicted position for each of the standards that were partially or non-compliant last year.

The results have been compiled below and compared to the 2025 position.

	Core Standards		
	Fully Compliant	**Partially Compliant**	**Non-Compliant**
2025	33	27	2
2026 (expected)	51	10	1
Difference	**+18**	**-17**	**-1**

2025 compliance	53.22%
2026 expected compliance	82.25%
Difference	**+29.03%**

The final assessed position against the Core Standards for the 2026 deadline remains subject to change due to several influencing factors, including ongoing validation processes and potential updates to evidence or requirements. However, based on the current trajectory, it is not anticipated that the Trust's level of compliance will increase significantly beyond the position outlined above.

Notwithstanding this, the Trust is expected to achieve partial compliance with the Core Standards this year, representing a marked and positive improvement compared to the previous year's performance. This progress reflects the diligent work carried out by the EPRR team, continued organisational focus, strengthened governance, and targeted actions to address areas of non-compliance, although further work will be required to reach full compliance in future reporting periods.

The implementation and expansion of the new Action Tracker and Business Continuity Working Group continue to facilitate further enhancements and sustain continued progress in compliance.

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

The Core Standards evidence portal for the forthcoming assurance process opened in May 2026. The EPRR team will prioritise the early submission of evidence to enable timely feedback from the ICB. This proactive approach will help identify any gaps or areas requiring further development, allowing sufficient time for refinement and completion ahead of the October deadline.

12. RECCOMENDATIONS

The Trust Board are asked to:

- Note the self-assessed improvement against the Core Standards and delay further decisions on resource investment following the formal submission and outcome of the Core Standards in October 2026.

13. APPENDICES

Appendix A – Core Standards Action Plan with Updates

Appendix A – Core Standards Action Plan

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	2025 RAG	Action to be taken	Lead	Timescale	Comments	Expected RAG 2026
Domain 1 - Governance										
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	Partially compliant	EPRR Board Reports to go every 2 months on BC/ Training & Exercising/ Incidents/ Assurance. Include linking in with ICB EPRR team and provide feedback from them regularly and resource struggles. To include Comms test/ texting system.	Roseanne Kirkham	30/11/2025	The board reports now contain the relevant information that is expected to be reported to the Trust Board	Fully Compliant
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Partially compliant	EPRR Board Report to include recommendations on this.	Alex Chatten	30/11/2025	Board to approve	Partially Compliant
Domain 2 - Duty to risk assess										

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

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14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Partially compliant	EPRR Plans to go to consultation then back to EPSG if significant changes. Draft countermeasures plan included in this		30/01/2026	Draft plan to be expanded and reviewed by ICB as to what it needs to contain and what the current gaps are. Plan is heavily centred around CBRN countermeasures but needs to include mass vaccination and countermeasure deployment	Partially Compliant
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Partially compliant	EPRR Plans to go to consultation then back to EPSG if significant changes. Mass Casualty plan included in this	Alex Chatten	31/01/2026	Draft plan to be reviewed by EPRR Clinical Lead and ICB team	Fully Compliant

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NHS Foundation Trust

17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially Compliant	Plan should consider an alternative location for the ICC in case of restricted access	Matt Johnson	30/01/2026	Plan in place but requires updating and exercising from a full-site lockdown response	Partially Compliant
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Consideration needs to be added for those under police protection/ high profile prisoners, including decontamination	Giles Latham	30/01/2025	HPP Policy to be updated to include consideration for those under police protection or prisoners and if they required decontamination	Fully Compliant
Domain 5 - Training and exercising										
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Partially compliant	PDPs to be made mandatory on LearningLab to affect compliance. Sessions to be held to cover off certain elements of PDPs	Alex Chatten	31/01/2026	PDP compliance remains low. Work ongoing with L&D team to make individuals' compliance visible on Learning Lab	Partially Compliant
25	Training and	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Non compliant	e-learning mandatory on LearningLab for all staff	Alex Chatten	26/12/2025	Work ongoing with L&D team to request an e-learning package for all staff to complete	Partially Compliant
Domain 6 – Response										

Harrogate and District
NHS Foundation Trust

29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Partially compliant	Loggists due refresher training. Response to Communications Tests (comms test requires update). To be included in Board Report in November.	Alex Chatten	30/11/2025	Response from loggists should increase when Switchboard move over to new Communications Test Process in line with new Incident Response Plan	Fully Compliant
Domain 9 - Business Continuity										

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

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

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

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55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	New CBRN plan in consultation and expected to be active May 2026	Fully Compliant
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Non compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	No current Risk Assessments for CBRN capability. E.g. safe working in CDU, wearing PPE, manual handling & lifting. These will be progressing in the next 6 months	Partially Compliant
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	New CBRN plan in consultation and expected to be active May 2026	Fully Compliant

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58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: • command and control structures • Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability • Procedures to manage and coordinate communications with other key stakeholders and other responders • Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) • Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control • Distinction between dry and wet decontamination and the decision making process for the appropriate deployment • Identification of lockdown/isolation procedures for patients waiting for decontamination • Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • Arrangements for staff decontamination and access to staff welfare • Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes • Plans for the management of hazardous waste • Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities • Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	New CBRN plan in consultation and expected to be active May 2026	Fully Compliant

59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	Investment required in training people outside of ED as currently cannot maintain safe systems of work alongside ED BAU.	Partially Compliant

60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/ https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	New CBRN plan in consultation and expected to be active May 2026. New CBRN Tent procured with funding from NHS England. PRPS Suits in date and on radar for replacement – awaiting potential funding from NHS England or advice from YAS SME	Fully Compliant

Harrogate and District NHS Foundation Trust

Ref	Domain	Standard name	Standard detail	Supporting information	Self-assessment	Action	Lead	Timescale	Update	Status
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	New CBRN plan in consultation and expected to be active May 2026. New CBRN Tent procured with funding from NHS England – 10 year PPM. PPMs in place for all other CBRN equipment (RamGene, PRPS etc.)	Fully Compliant

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62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	New CBRN plan in consultation and expected to be active May 2026.	Fully Compliant
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	Staff require training on new CDU tent. Until Trust reaches 80% compliance we need to keep previous tent.	Partially Compliant

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64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	YAS SME to confirm if current plans and procedures are sufficient. May include establishing IOR training for reception staff across Trust.	Partially Compliant
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	YAS SME to confirm if current procedures are sufficient.	Fully Compliant

66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Partially compliant	Chase YAS to find out what actions/ recommendations are required for this standard.	Alex Chatten	31/06/2025	Live CBRN exercise took place in November 2025 and a multi-agency exercise is being planned for 2026.	Fully Compliant

STRATEGIC AMBITION: GREAT START IN LIFE 2026-2027

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

GOALS:

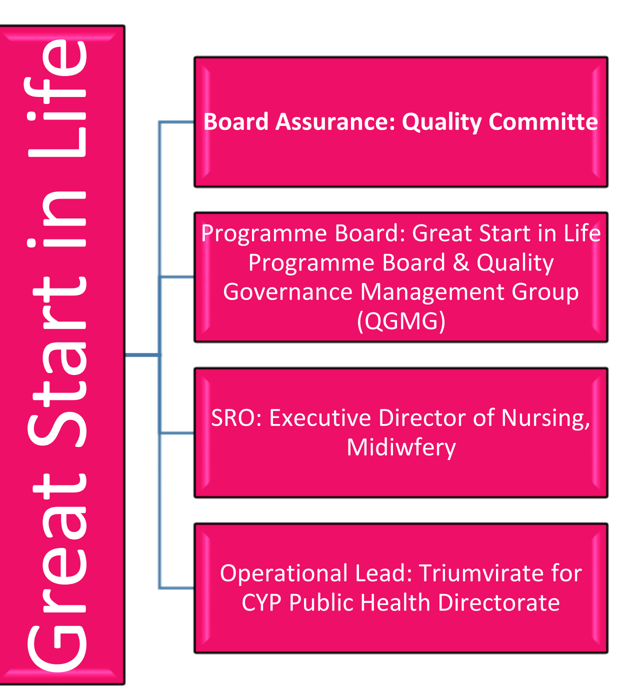
Public Health

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

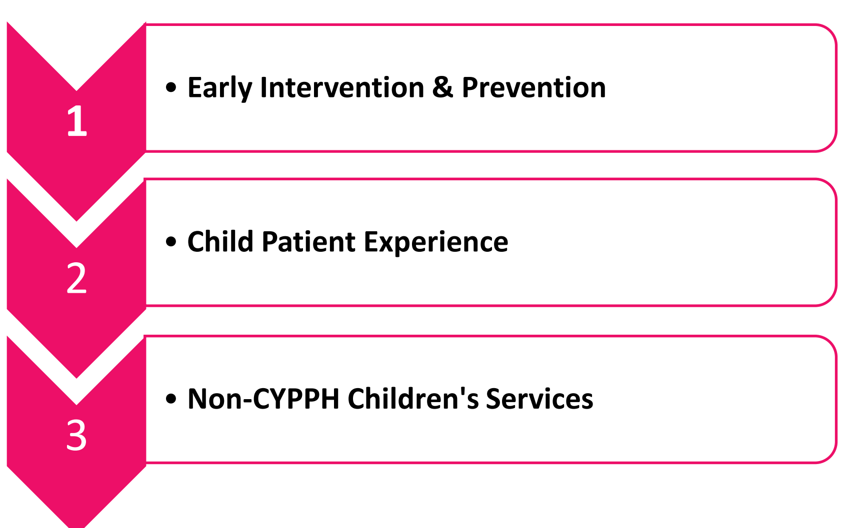
Hopes for Healthcare

Services which meet the needs of children & young people

GOVERNANCE:



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



Trustwide Project:	
Strategic Programme	CYP Strategy
Breakthrough Objective:	Children's PH Research
Overarching Risk Appetite:	Clinical - Minimal

Overarching Risk Summary:

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

True North Metrics Summary:

<table>
<tr><th>Workstreams</th><th>True North Metric</th><th>Vision</th><th>Goal</th><th>Current State</th><th>Countermeasures</th><th>Level of Risk to Achieving Goal (CxL)</th><th>Level of Risk for progressing actions</th></tr>
<tr>
<td>Public Health</td>
<td>Great Start in Life: Early intervention & prevention – Children at Risk of Vulnerability</td>
<td>‘As an organisation we aim to reduce the number of children who are vulnerable to poor health and wellbeing and to take action to mitigate risks of poor outcomes’.</td>
<td>Goal 1: To achieve 90% delivery of mandated Healthy Child Program Contacts within national timescales.

Goal 2: To deliver the HDFT Great Start in Life pathway launching April 25 to all eligible children in Darlington and report outcomes linked to Public Health high impact areas.</td>
<td>The Trust North Metric of Early Intervention and Prevention continue into its second year (2025-26). Metrics remain as per revision of year end 24/25 with the addition of QPMS Compliance reporting. This report is now live in ESR and has been launched with all teams. This will provide assurance that individual practitioners are being performance managed & supported to deliver the HCP in timescales and that supportive measure / actions are in place.
Quality and Performance Management Supervision compliance for Dec 25: Performance was 74% (inclusive of Westmorland and Furness and Cumberland).

We have 11 LA Commissioned 0-19 Services. There are five mandated contacts in each service making 55 contacts. Target is to have 55 at 90% (delivering with HCP Timescales) April 26 data 52/55 and continues to increase month on month with only 2 contacts breaching business rules.

<table>
<tr><td rowspan="2">Great start in Life Improve outcomes by identifying children by ensuring we achieve >90% for all mandated contracts</td><td>Zero mandated contacts in all our contract areas breaching business rules</td><td></td><td></td><td></td><td></td><td>11</td><td>8</td><td>7</td><td>6</td><td>5</td><td>4</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>All mandated contacts at 90% or above (55 contracts)</td><td>41</td><td>43</td><td>43</td><td>43</td><td>42</td><td>46</td><td>48</td><td>48</td><td>50</td><td>51</td><td>51</td><td>52</td><td>52</td></tr>
</table>

CYPH Directorate Driver to focus on HCP Mandated Contacts not delivered within timescales over three consecutive months with associated countermeasures.

Watch Metrics:
Goal 2: Watch Metrics will report and include the outcomes of the GSIL Pathway linked to High Impact Areas; this will be an annual impact report on the cohort of children recruited and will be available June 26.
April data- 95% of eligible children recruited to the GSIL Pathway.
38% recruited to the pathway in April 25 were identified as ‘Specialist / Universal Partnership Plus and as of April 26 this cohort has reduced down to 8% with 30% now achieving Universal level of intervention.</td>
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Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Hope for Healthcare	Children's Patient Experience	Improve experience of care by considering elements that matter most to children & young people so we can measure their experience of care and shape services according to their specific needs	Goal 1: Engage with children and young people with lived experience across HDFT geography to consult with on our CYP Strategy which will for part of the Clinical Strategy Goal 2: CYP Patient Experience Tool Developed- Return rate significantly low - distribution, engagement, and accesses to the tool to be developed with CYP and approach embedded with teams and professionals working with CYP.	The Trust North Metric of improving Children's Patient Experience continues into its second year (2025-26). Target return rate 10%. **April 26 9% return** Active Countermeasures are noted. • Darlington, Tees Valley CIC & Wakefield are developing Countermeasures using HDFT Impact methodology to increase return rate. We will review each of these approaches at the Learning & Best Practice Group and evaluate approach and impact. We will use this to determine a standard work. • New learning best practice workstream established footprint-wide to drive increase in CYP survey returns using best practice examples from every contract area. • Working with CYPD Digital team to explore how best to get themes from paper CYP survey returns. • Data will be reported as a percentage for each Contract area and monitored via Governance Huddle with each HoN. Total number of surveys returned Jan-25: 11; Feb-25: 8; Mar-25: 75; Apr-25: 40; May-25: 182; Jun-25: 83; Jul-25: 78; Aug-25: 37; Sep-25: 47; Oct-25: 57; Nov-25: 55; Dec-25: 63; Jan-26: 83; Feb-26: 59; Mar-26: 66; Apr-26: 64	CYP Patient Experience Tool 'engagement methods' to increase uptake and return being developed with involvement of CYP representatives. • Focus Groups held with GSIL Young Advisor Committees and individual advisors. • Poster design to be finalised, digitised and circulated to school's W/C 7th April 25. • Standardise paper version of survey for use. • Hopes for Health presentation to increase staff awareness and importance of gathering feedback (at all team huddles) • Assurance Survey for completion by staff to review awareness - this will inform future promotion and target support. • Meeting with S1 & IG scheduled 13th March to explore use of S1 to send survey link and push notification. • Application to charity for adaptable devises to support completion of survey by CYP All above completed.		

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
				Contact age range 20: 1 5 - 8: 4 9 - 12: 5 16 - 19: 12 20+: 16 13 - 15: 28 Overall how was your experience? Very poor 3% Don't know 6% Neither good or poor 3% Good 17% Very good 71% Very good, Good, Don't know, Neither good or poor, Very poor Watch Metrics: Directorate CYP Patient Experience Champions produces a monthly report with themes, trends and areas for improvement. This will be shared with the central patient experience team and reported into MEC Forum.			

Trustwide Project:

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

Strategic Programme: CYP Strategy

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
	Not yet approved, unable to provide an update this month						

Breakthrough Objective: CYP in Research

<table>
<tr><th>Workstreams</th><th>True North Metric</th><th>Vision</th><th>Goal</th><th>Current State</th><th>Countermeasures</th><th>Level of Risk to Achieving Goal (CxL)</th><th>Level of Risk for progressing actions</th></tr>
<tr>
<td></td>
<td></td>
<td>The overarching ambition is to provide services that meet the needs of young children, young people and their families and care givers informed by good quality research to ensure a great start in life.
We need to demonstrate safe practice to provide assurance that our services have evidence of impact on children and young people's health and wellbeing</td>
<td>• Create a research active culture, where staff have the opportunity to be research active, engaged with critical thinking practice, completed Good Clinical Practice (GCP).
• NHS Elect Critical Thinking training
• Complete literature reviews - library
• GCP - as needed
• Disseminate in Learning & Best Practice quarterly
• Conference findings disseminated</td>
<td>Over the past two years there have been 15 approaches within the research and innovation team that focused upon Children & Young People of which 14 have been Children's Public Health related.
• We have had 2071 participants engage across 3 currently active research projects. These are:
  ◦ Generation: 637 screened; 636 recruited
  ◦ BABI Harrogate: 1991 recruited

• To note: whilst these research projects have Public Health impacts, these have now been categorised as research delivered by Children's Services.
• There are three research projects under discussion and two research projects that have advanced to set up phase.
• Established research working group that has met three times on a monthly basis.

A briefing paper from September 2025 outlines the elements to increase engagement with research that focuses on:
• people: staff training
• organisation: creating governance systems
• participants: patient and public participation
• National influence: continue to build trust and reputation

The Working group contributed to the Trust Research Strategy and Implementation Plan to</td>
<td><table>
<tr><th>Concern</th><th>Cause</th><th>Countermeasure</th><th>Owner</th><th>Due Date</th></tr>
<tr><td>We don't currently understand the barriers to engaging in research activity</td><td>No process or pathway for review of research offers</td><td>Create a process and pathway all research offers across the children and young people's environment</td><td>ZA & CS</td><td>Sept 2026</td></tr>
<tr><td>Current environment does not support research activity</td><td>• No process or pathway for review of research offers.
• Lack of clarity on skill sets, resources and capacity</td><td>Establish working group across the 12 teams within the directorate and R&I team to understand:
• Capacity
• Skill sets
• Resources
• Governance

Benchmark directorate for research readiness using NHS England's SORT tool</td><td>ZA & CS</td><td>July 2026</td></tr>
<tr><td>We don't know what research is currently underway</td><td>Research offers occur across the directorate and there is no specific group looking at the these systematically.</td><td>Establish a research working group with representation from teams across the directorate, research lead in the trust and representative from R&I Team</td><td>ZA/CS</td><td>May 2026</td></tr>
<tr><td>We do not know the training needs and current research skills our team have</td><td>We do not review research interest and skills</td><td>Complete a research training audit for staff across the directorate.
• Review themes from appraisal discussions
• Create a monitoring dashboard for completion of
- Good Clinical Practice
- NHS Select Critical Thinking Training
- Principal Investigator Training</td><td>ZA/CS</td><td>June 2026</td></tr>
<tr><td>We do not have a way of monitoring completion of training in research and critical thinking</td><td>It is not currently available on Learning Labs therefore difficult to monitor</td><td>Work with R&I Team to add to Learning Labs</td><td>R&I Team</td><td>June 2026</td></tr>
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Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
				ensure a strong focus on Children's Public Health research. Secured funding via a NIHR strategic bid funding for a 0.6 Band 6 0-19 Research Practitioner Teams are approached reactively to be involved in research. These research approaches can happen anywhere across the twelve local authority areas we serve There is no clear process to review these offers to ensure staffing, resources and governance needs have been addressed. There are Great Start in Life young advisers and local parent/carer panels and external youth boards but this needs to be more consistently engaged with across the directorate Are our existing groups set up appropriately to fulfil PPI groups requirements to access national funding • Funding secured £31,810 for 0.6 B6 0-19 / Paediatrics Research Practitioner			

Related Corporate Risks:

Datix ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR34/ID1	Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition. There is a need to reduce the backlog of referrals back to the NICE standard of three months (reduce the waiting list to approximately 120)	3 x 5 = 15	3 x 3 = 9 ~~March 2025~~ March 2026	Clinical: Patient Safety	Minimal

Related External Risks:

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

Strengthening Maternity and Neonatal Safety Report

April 2026

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

Purpose of the report and summary of key issues:	The purpose of this report is to provide a summary and update on the board level safety measures for the month of April as set out in the Perinatal Quality Oversight Model (2025).	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	√
	Person Centred, Integrated Care; Strong Partnerships	√
	Great Start in Life	√
	At Our Best: Making HDFT the best place to work	√
	An environment that promotes wellbeing	√
	Digital transformation to integrate care and improve patient, child and staff experience	√
	Healthcare innovation to improve quality	√
Corporate Risks	No new corporate risks	
Report History:	Maternity Risk Management Group Maternity Quality Assurance Meeting Maternity Safety Champions	
Recommendation:	Board is asked to note the updated information provided in the report and for further discussion.	
Appendices attached for oversight	Appendix A - Explanatory notes Appendix B – Bi-annual Midwifery Staffing report Appendix C – Perinatal Mortality Review Tool Quarterly Report Appendix D – Neonatal Readmissions Appendix E – Avoiding Term Admissions into the Neonatal unit (ATAIN)	

Strengthening Maternity and Neonatal Safety Report

1) Summary
This paper provides a summary and update of the detail on the board level measures for the month of April 2026 as set out in the Perinatal Quality Oversight Model (2025).

2) Introduction
The Perinatal Quality Oversight Model seeks to provide consistent and methodical oversight of all services, including maternity. Strengthening trust-level oversight for quality and safety includes a focus on leadership, strong governance processes and pathways for information and escalation from floor to Board. The model includes five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. There are local, regional and national elements of this model. At local level, the model includes a monthly review of maternity and neonatal safety and quality reported to the Trust board.

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

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

5) Equality Analysis
Not applicable.

6) Risks and Mitigating Actions
Sixteen ongoing risks. See below Section 4 for details.

7) Recommendations

a) Positive news
- Diverts have reduced over last two months.
- Heatmap score reduced to lowest concern category following update to CQC rating
- Discretionary funding from Maternity Incentive Scheme agreed

b) Areas of concern
- Continue to demonstrate above average rates for third degree tears on National dashboard
- Pannal acuity continues to report below 50% staffing (mitigations in place, see point 5b.)
- Funding for Maternity and Neonatal Voices Partnership

c) Work underway
- On-going work to review Maternity Care Bundle and Postnatal Toolkit.
- Maternity incentive requirements under review
- Work ongoing in Maternity Assessment centre regarding activity and implementation of BSOTS

d) Decisions required of Board/Board oversight
- Appendix B – Bi-annual Midwifery Staffing report
- Appendix C – Perinatal Mortality Review Tool Quarterly Report
- Appendix D – Neonatal Readmissions
- Appendix E – Avoiding Term Admissions into the Neonatal unit (ATAIN)

Narrative in support of the Provider Board Level Measures

April 2026 data

1. Introduction

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

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

i. Proportion of midwives responding 'agree' or 'strongly agree' to whether they would recommend their trust as a place to work or receive treatment (reported annually)
j. Proportion of specialty trainees in obstetrics and gynaecology rating the quality of clinical supervision out of hours as 'excellent' or 'good' (reported annually)

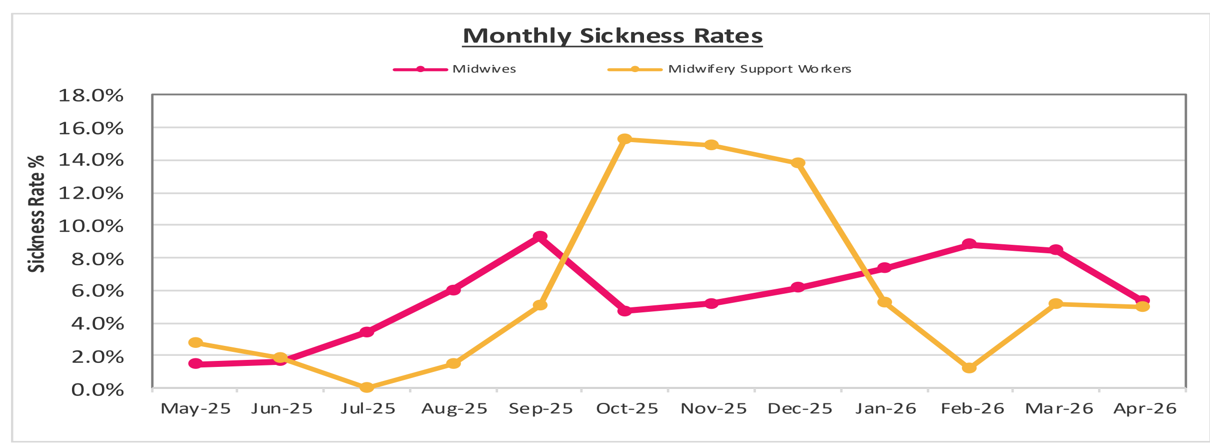
2. Obstetric cover on Delivery Suite, gaps in rota

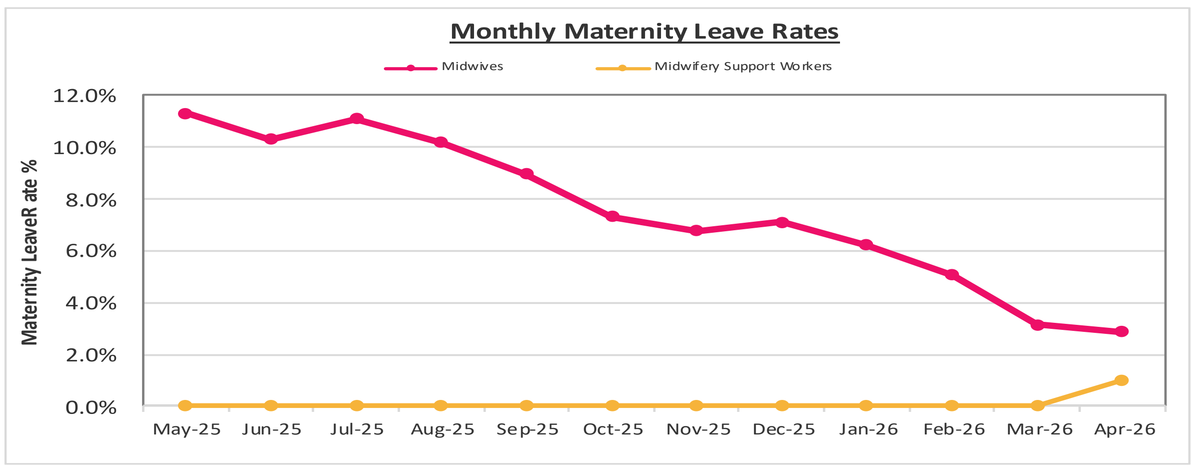
Safe levels of cover on Delivery Suite have been maintained with any gaps filled by locum shifts, extra sessions from the substantive team, and a small number of external bank doctors. A clinical teaching fellow and a locally employed doctor (LED) have been recruited. Recruitment is ongoing for the one remaining LED post.

3. Midwifery safe staffing, vacancies and recruitment update

a. Bi-Annual Midwifery Staffing Report
The bi-annual midwifery staffing report is included at Appendix B

b. Absence position
Total sickness absence in April has decreased for midwifery to 4.87 WTE, from 8.64 WTE last month, and maternity support workers absence has remained stable at 1.13 WTE. The main causes of absence relate to stress (2.73 WTE). 2.25 WTE midwives and 0.6 WTE support workers are on maternity leave at present. The monthly sickness and maternity leave percentages and trend can be seen below.

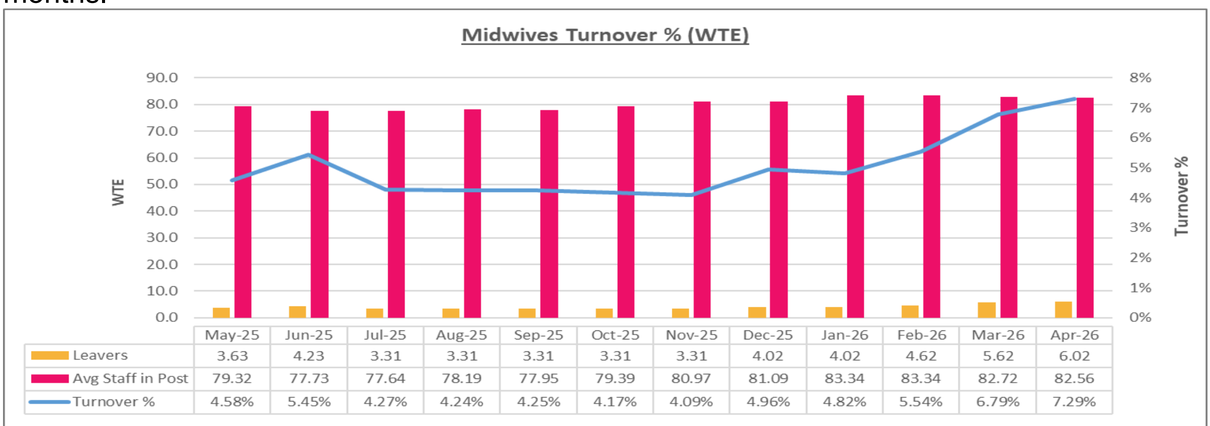




c. Vacancy position

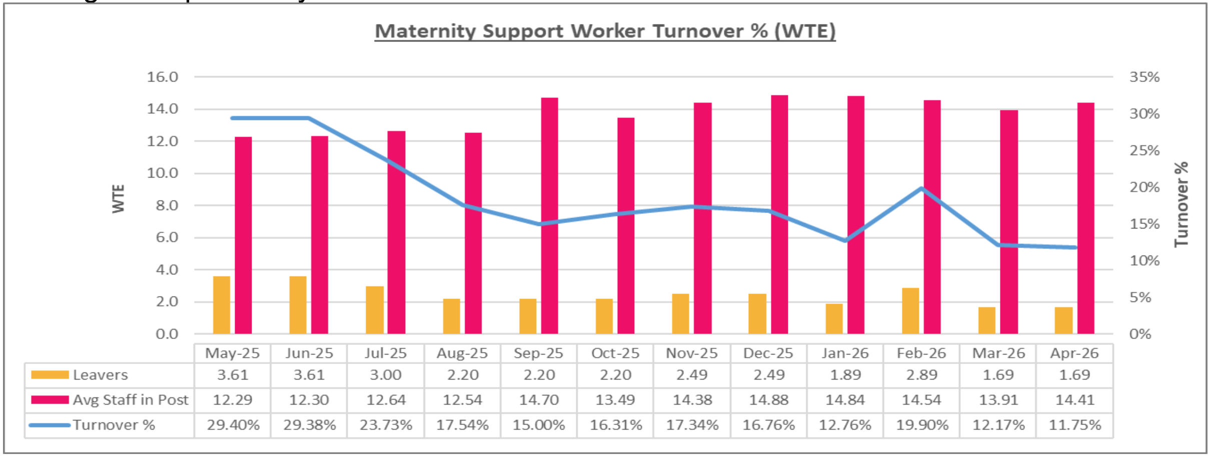
There is 1 WTE midwifery vacancy at present with recruitment underway and 1 WTE midwife in the recruitment process. There is 3 WTE maternity support workers in recruitment and 1.2 WTE maternity support workers in the recruitment process.

The last three month has seen an increase in midwifery turnover however this continues to be below Trust target at 6.02% for April with one person leaving each month over the last three months.



	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Leavers	3.63	4.23	3.31	3.31	3.31	3.31	3.31	4.02	4.02	4.62	5.62	6.02
Avg Staff in Post	79.32	77.73	77.64	78.19	77.95	79.39	80.97	81.09	83.34	83.34	82.72	82.56
Turnover %	4.58%	5.45%	4.27%	4.24%	4.25%	4.17%	4.09%	4.96%	4.82%	5.54%	6.79%	7.29%

The maternity support worker turnover has significantly improved over the last twelve months although is impacted by small numbers. March MSW turnover is 11.75%.

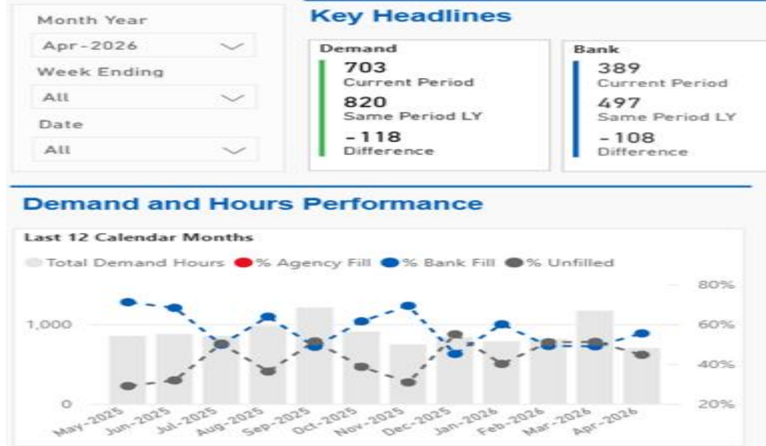


	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Leavers	3.61	3.61	3.00	2.20	2.20	2.20	2.49	2.49	1.89	2.89	1.69	1.69
Avg Staff in Post	12.29	12.30	12.64	12.54	14.70	13.49	14.38	14.88	14.84	14.54	13.91	14.41
Turnover %	29.40%	29.38%	23.73%	17.54%	15.00%	16.31%	17.34%	16.76%	12.76%	19.90%	12.17%	11.75%

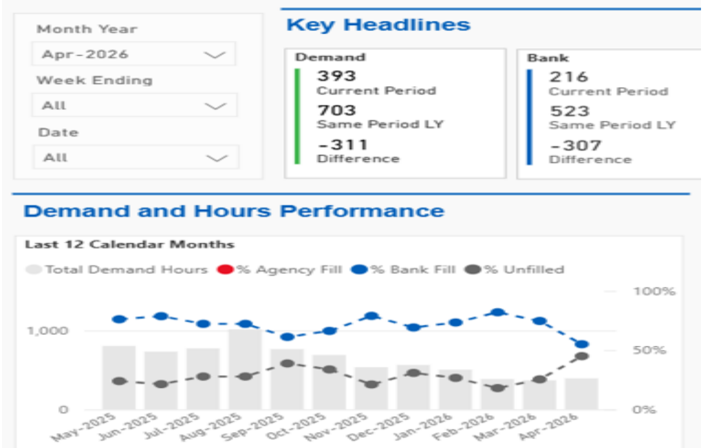
d. NHSP provision

Both graphs below demonstrate a significant reduction in demand for bank staff in comparison with the previous year.

Midwives – demand has significantly reduced this month given that the staff sickness rate has also reduced. There has been no agency use since March 2025.



Maternity Support workers – Demand has shown a consistent reduction following increasing the maternity support worker establishment. Fill of NHSP shifts appears to have dropped this month.



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

b. Neonatal absence position

There was 0.79 WTE nurse sickness absence during April 2026. 2 WTE QIS nurses and 0.79 WTE Clinical support worker are currently on maternity leave.

c. Neonatal Vacancy

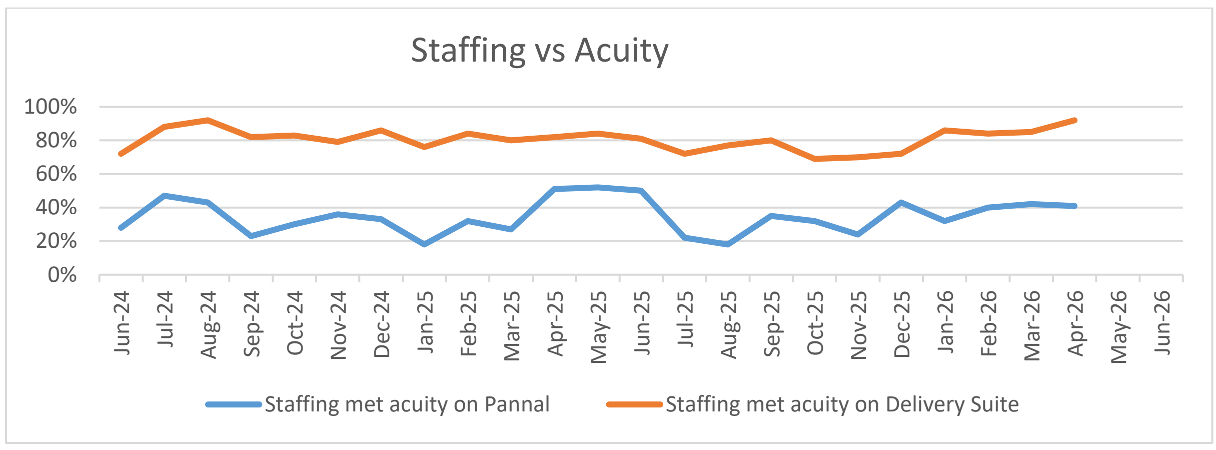
Special Care Baby unit is fully recruited however 1.84WTE nurses are in the recruitment process.

d. Qualified in Speciality (QIS) Nurses

To meet British Association Perinatal Medicine (BAPM) standards 70% of the budget establishment is required to be QIS nurses. The Operational Delivery Network (ODN) state that the QIS compliance is based on staff in post excluding any vacancy. Three nurses are on a pathway to complete their QIS qualification. QIS compliance for April was 75%.

5. Birthrate Plus Acuity Staffing Data

The trend in Birthrate Plus staffing versus acuity, on both Delivery Suite and Pannal, can be seen in the below graph.



a. Delivery Suite Staffing and impact on clinical workload

A supernumerary delivery suite co-ordinator was rostered and available at the start of every shift in April. 100% compliance with one-to-one care in labour was maintained throughout the month. According to the data captured in Birthrate Plus acuity tool staffing met the acuity requirements 92% of the time, was up 1.5 midwives short 8% of the time and never was the service was over 1.5 midwives short. Compliance with data capture was 92.22%.

b. Pannal Ward Staffing and impact on clinical workload

According to the data capture in the Birthrate plus acuity tool, 41% of the time staffing has met acuity on Pannal with an 83.33% compliance with data capture. In order to manage workload during times of high activity and acuity inductions of labour were delayed and staff were redeployed from other areas of maternity services, including Pannal, Community and Specialist midwives. Clinical risk was mitigated and delays were kept as minimal as possible. In April there were 31 hours recorded as having been worked clinically ad hoc on Pannal Ward to cover acuity by specialist midwives. Thirty-five staffing factors were recorded as shown below. Staff were redeployed and inductions were delayed managing the situations.

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	8	23%
SF2	MW redeployed to other area	7	20%
SF3	Unexpected support staff absence/sickness	3	9%
SF4	Unable to fill vacant MW shifts	9	26%
SF5	Unable to fill vacant support staff shifts	6	17%
SF6	Staff on transfer duties	0	0%
SF7	Support staff redeployed to other area	1	3%
SF8	Admin staff less than rostered numbers	1	3%
TOTAL		**35**	

6. Homebirth provision

Home birth provision is covered by community midwives working clinically in the day and a first and second on-call midwife every night between 17:00 – 08:00. There are currently 17 midwives working in community. Two midwives are currently unable to do on calls due to occupational health restrictions, and one midwife can only be the second person on call due

to level of experience. Two midwives on call are required every night to cover the service equating to approximately 62 on call shifts requiring cover each month. Each midwife is therefore allocated three or four on calls per month depending on their WTE.

In April 2026 the home birth on call provision was unavailable on two occasions at night due to no volunteers to cover short term sickness absence. No homebirths were affected. Work is ongoing to review the working pattern and improve the resilience of the homebirth service.

Two homebirths were booked for the month of April. One had a successful homebirth whilst the other woman's baby was born before arrival (BBA) of the midwife following a rapid labour.

7. Red Flag Events Recorded on Birthrate Plus

a. Delivery Suite Red Flags

There was two Red Flag noted on Birthrate plus in April on Delivery Suite regarding delayed or cancelled time critical activity. The following management actions were taken to mitigate the risks over the course of the month;

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff from Pannal	13	62%
MA2	Staff unable to take breaks	6	29%
MA3	Review of staff management time	0	0%
MA4	Use of Specialist Midwife	0	0%
MA5	Use of staff on training days	0	0%
MA6	Use of ward/department managers	0	0%
MA7	Staff sourced from wider Trust (theatre & CSW's)	0	0%
MA8	Use of hospital MW on call	1	5%
MA9	Use of community MW	0	0%
MA10	Unit on Divert	1	5%
MA11	Patient diverted	0	0%
TOTAL		**21**	

b. Pannal Ward Red Flags

There were four Red Flags recorded on Birthrate Plus on Pannal during April all of which were due to 'Delay between admission for induction and beginning of process'.

The following management actions were taken to mitigate the risks;

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	5	56%
MA2	Staff unable to take allocated breaks	1	11%
MA3	Redeploy staff from training	0	0%
MA4	Specialist MW working clinically	1	11%
MA5	Manager/Matron working clinically	1	11%
MA6	Utilise on call MW	0	0%
MA7	Redeployment from community	0	0%
MA8	Maternity Unit on Divert	0	0%
MA9	Staff sourced from bank/agency	0	0%
MA10	Staff stayed beyond rostered hours	0	0%
MA11	Escalate to manager on call	1	11%
TOTAL		**9**	

c. Elective Caesarean Sections (LSCS)

There were 12 elective caesarean section lists, with 24 caesareans performed. There were four elective LSCS on Delivery Suite during April.

d. Delayed Induction of Labour (IOL)

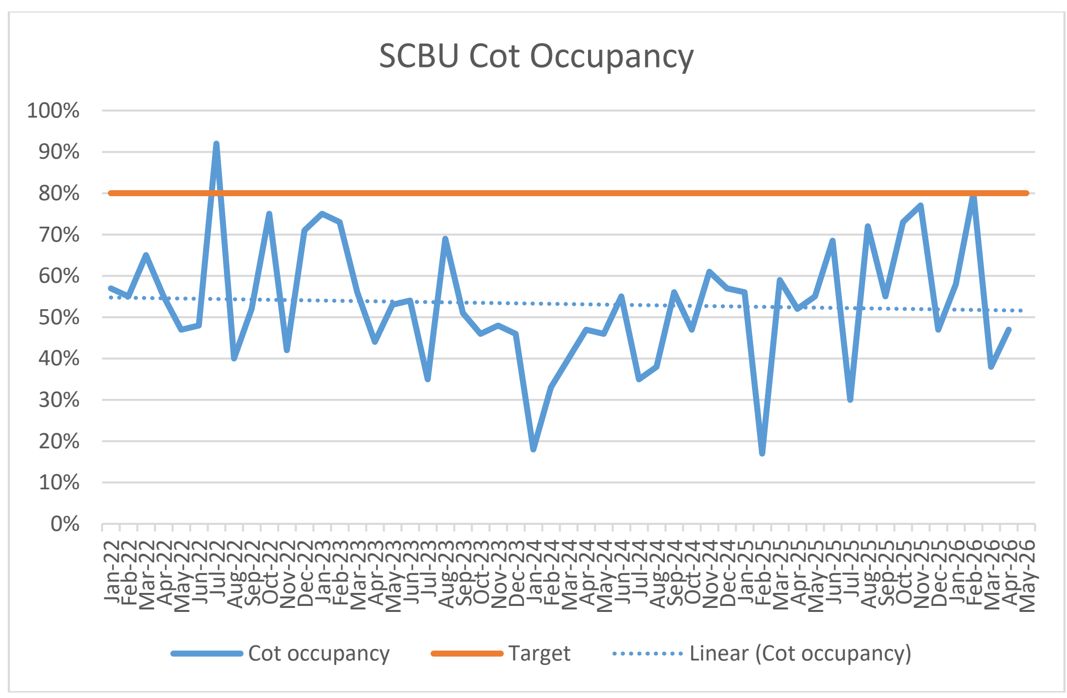
During April there were five episodes of delayed induction of labour over 24 hours:

- three were delays greater than 24 hours in admission to commence IOL,
- two were delays greater than 24 hours in transferring to labour ward for artificial rupture of membranes (ARM) without the administration of prostaglandins or cervical ripening balloon (CRB).

This is a significant reduction since last month.

8. SCBU Cot Occupancy

SCBU cot occupancy appears to be returning to a trend just below 60% (as seen in 2022) over the last twelve months, up from 50% occupancy in the previous twelve months, and a 40% occupancy Oct 2023 to October 2024. Looking at SCBU over a longer period gives an average trend of 50% occupancy.



Two babies were transferred out to a tertiary unit for clinical reasons. Thirteen babies received transitional care on Pannal Ward.

9. Appraisals

Department	Assignments Appraised	Assignment Count	Percentage Compliant
Obs & Gynae - Medical Staffing	15	16	94%
Ante Natal Clinic	12	15	80%
Community Midwifery	19	21	90%
Maternity Staffing	48	55	87%
Pannal Ward	26	27	96%
Early Pregnancy Assessment Unit	4	5	80%
Total	**124**	**139**	**89.2%**

10. Training Compliance for All Staff Groups in Maternity Related to Core Competency Framework and Wider Job Essential Training

a. Mandatory training (as at 01/05/26)

Department	Assignment Count	Percentage Compliant
421 Level 4 Obs & Gynae - Medical Staffing	29	72%
421 Level 4 Ante Natal Clinic	13	80%
421 Level 4 Community Midwifery	20	85%
421 Level 4 Pannal Ward	30	85%
421 Level 4 Maternity Staffing	60	90%
421 Level 4 Early Pregnancy Assessment Unit	5	93%

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

The below table demonstrates the service compliance with attendance at the following training

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

which is required for Maternity Incentive Scheme requirements.

Course Name	Midwives	Obs& Gynae Consultants	Obs& Gynae (Other Staff)	Anaesthetics Consultants	Anaesthetics (Other Staff)	Paediatric Consultants	Paediatric Medical (Other Staff)	Maternity Support Worker	SCBU
Resuscitation Courses									
Resuscitation - Level 2 - Adult Basic Life Support (CSTF)	79%	56%	72%			89%	76%	95%	73%
Resuscitation Level 3 - Newborn Intermediate Life Support (HNILS)	96%						67%		
RCUK Newborn Life Support	95%					100%	67%		91%
Resuscitation - Level 3 - Adult Immediate Life Support (RCUK eILS) - (CSTF)	65%								
Maternity Specific Courses									
Fetal Wellbeing Competency Assessment	97%	100%	100%						
MAT - Birthing Pool Hoist	85%							80%	
MAT - Growth Assessment Protocol (GAP)	98%	67%	88%						
MAT – Maternity Training Day 2	98%	89%	91%						
MAT - Saving Babies Lives	71%	89%	73%						
MAT 3 - Personalised Care & Care in Labour	90%								
MAT-PROMPT - Emergency Skills Facilitator Led	89%	78%	61%	73%	78%			95%	
Mandatory Training - Safeguarding									
Safeguarding Adults	92%	67%	78%	95%	71%	89%	76%	89%	93%
Safeguarding Children	94%	56%	28%	85%	76%	100%	35%	95%	40%

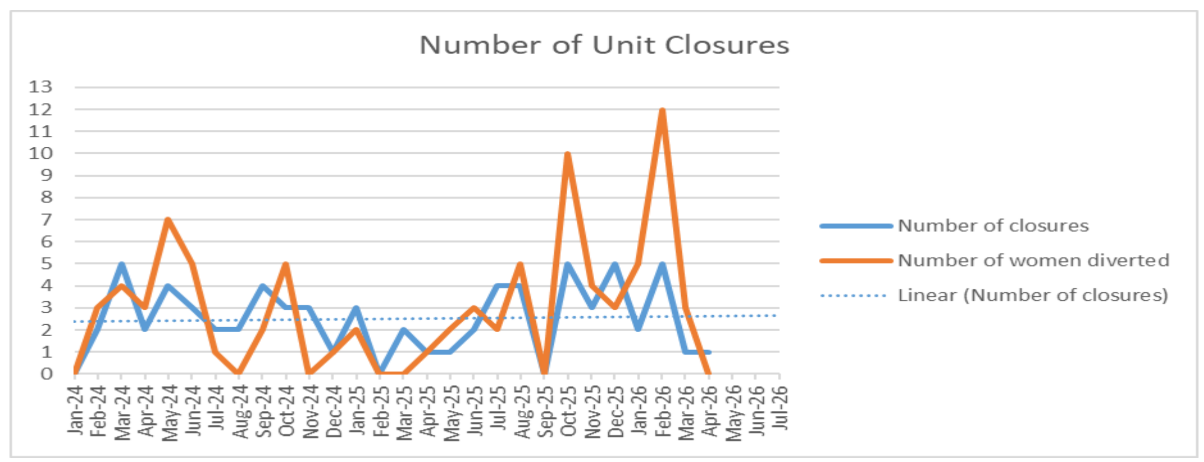
Saving babies lives training compliance has been affected by new starters and people returning from maternity leave. Plans are in place for all to attend training.

Work is ongoing for rotational medical staff to ensure compliance with Safeguarding Children training is transferred into the Trust on rotation in line with the Intercollegiate guidance. Safeguarding training compliance requirement is three yearly and there have been issues with Learning Lab reporting in relation to this. SCBU nurses have all been booked on to Safeguarding training and therefore compliance will improve over the coming two months.

11. Risk and Safety

a. Maternity Unit Divert

There has been one event of divert of the unit in April 2026. No women were diverted.



b. Maternity Accepted Diverts

A daily (Monday – Friday) regional meeting is in place, supported by the Local Maternity and Neonatal Systems, to review staffing, activity and the number of women awaiting induction of labour across the regions. During the month of April five women were transferred to Harrogate maternity service from elsewhere in the region for artificial rupture of membranes, on-going induction process or labour care.

c. SCBU Incidents

No moderate harm incidents.

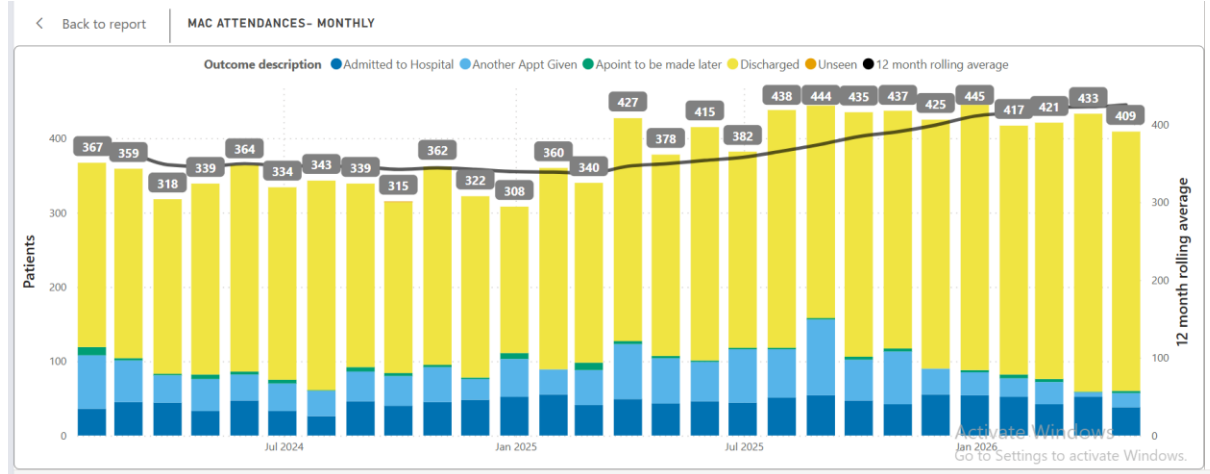
d. SCBU Risk Register

No new risks have been added to the risk register.

e. Maternity Risk Register Summary

The risk register was last formally reviewed in February 2026 and is next due for formal review in May. There are sixteen current active risks;

- **Risk to patient experience and breach of triage timescales due to insufficient midwifery staffing in Maternity Assessment Centre (Score 10)**. Launch of ANDU not had desired improvement on MAC attendances at present. Additional midwife staffing on MAC from next roster and dedicated Obstetric cover where possible. Risk score to remain the same at present.



- **Risk to Information Governance and breach of confidentiality resulting from lack of training in redaction of patient record requests (Score 9)**
  Risk remains and limited progress to date. Exploration of use of AI and external company to complete redaction for local sign-off. Current risk score to remain the same at present.
- **Risk to delivery of safe and quality care due to inability to share records electronically between healthcare providers when patients being transferred or receiving shared care between Trusts (Score 9).** Risk requested to be added by WY&H LMNS. Work ongoing at LMNS level. Score to remain the same at present
- **Risk to patient safety and experience and staff burnout due to Obstetric staffing pressures (Score 8).** Current situation remains the same but improving consultant cover. Anticipate full consultant staffing from 1st April. Score to currently remain the same.
- **Risk to patient satisfaction and safety, resulting from delays in facilitating ultrasound growth scans (USS)(Score 8).** Recent issues meeting increased demand. Sustained pressures and difficulty covering additional lists. Planned meeting to discuss ongoing service management. Score upgraded due to frequency and risk of breaching of screening timeframes.
- **Risk to safe monitoring and management of Perinatal Mental Health due to insufficient clinic capacity for PNMH appointments (Score 8).** Work still ongoing to review Perinatal Mental Health service requirements, and TEWV service launch. No current change to score.
- **Risk to patient satisfaction and safety, resulting from delays in facilitating induction of labour (IOL) (Score 8).** Patient flow coordinator role now in place. Some recent delays but anticipate improvement. No change to score at present.
- **Risk to operational running and governance surrounding safety and quality of homebirth service (Score 6).** Action plan in progress. No significant changes to cover of service, but additional community staff training and specific community scenarios. Risk score currently to remain the same.
- **Risk to patient safety and experience associated with need to divert patients to other units in times of escalation (Score 6).** Ongoing necessary diversions and recognise impact on patient experience. Risk score to remain the same at present.
- **Risk to patient experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 6)**. Informed consent remains a factor in some complaints. Work progressing and to monitor situation.
- **Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 6)**. Issues remain with clerical staffing incidents from breaches in screening timeframes for ultrasound scanning and consultant appointments. Antenatal Assurance Group monitoring. No change

- **Risk due to inability to meet gold standard requirements for clinical documentation (Score 5)**. Some improvement noted in personalisation and updating of management plans and risk assessments. Records audit planned and for further assessment of risk score after findings. No change in score at present.
- **Risk to reputation and patient satisfaction for failing to meet national target and provide evidence-based care in relation to Continuity of Carer (Score 4).** Continuity and vulnerabilities midwife now in place. Still not providing full Continuity of Carer principles. Score to remain unchanged.
- **Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 4).** Improvement in midwifery staffing. Score downgraded.
- **Clinical risk related to inconsistent access to Maternity medical records related to Mediviewer (Score 4)**. Staff now have appropriate access. Risk score to remain the same for present.

A new risk is under review to be added to the risk register at the next review related to the on-going funding of the Maternity and Neonatal Voices Partnership following the changes to the ICB and NHS England.

12. Maternity Incidents

In April 2026 there were 66 total incidents reported through DCIQ (including 3 incidents occurring in SCBU). There were no incidents reported as Moderate Harm or above.

Incidents of note include:

- 10 incidents reported for Instrument Trays returned to SSD with no patient details. Process changes and staff reminders have been put in place to try to resolve the issue.
- 7 incidents of PPH≥1500ml
- 5 incidents of Third Degree Tears
- 4 incidents of Appointment issues

13. Perinatal Mortality Review Tool (PMRT)

PMRT for stillbirth in March 2026 has been reviewed. Stillbirth occurring in Leeds in April 2026, PMRT request received for review of antenatal care at HDFT and has been completed.

Issues identified: Some lack of guidance and clarity about requirement for oxygen when patient controlled analgesia (PCA) is administered and not documented correctly. Bereavement midwife in discussion with Anaesthetic Lead to clarify, and video production about PCA protocols. Please see Appendix C for the Quarter 4 report.

14. Feedback

a. SCBU Feedback

"In March 2025 I had an emergency caesarean at Harrogate hospital, my son was born 5 weeks early, after an initial couple of days on Pannal ward he needed admitting to SCBU due to weight loss and jaundice. The whole team were angels and were wonderful in what was a scary time for me and my family. Having the family room and a camp bed in our son's room meant we never had to leave him which I know isn't the case in all hospitals. But the best part was the support, encouragement and education all the staff gave me with breastfeeding. So much so that 12 months later I am able to still breastfeed. They are all true superstars, but Amy, Sally, Gail, Princess and both Becky's were pivotal in our stay.

Also, a special shoutout to our community midwife Sophie McDonnell who was wonderful both during my pregnancy and afterwards."

b. Maternity and Neonatal Voice Partnership Feedback

Due to changes in the MNVP Leadership and the Easter holidays there is no feedback via the MNVP received this month at the time of writing.

Service user feedback has been received via alternative sources and a couple of snippets of such feedback can be seen below-

I would like to share my heartfelt thanks for the care I received from the maternity team back in July 2025. Apologies in advance for the lengthy message, however words never seem enough.

Although it has taken me some time to write this now that my baby is 9 months old I wanted to make sure my appreciation was formally recognised.

Firstly thank you to **Ellie Tempest**, my community midwife, supported me throughout my whole pregnancy and was truly amazing. She cared for me with such kindness, consistency, and reassurance, and always made me feel listened to and supported every step of the way and always so smiley and caring. Even our post birth home visits never felt rushed and Ellie didn't discharge us until we both felt comfortable.

Secondly thank you to **Rachel Clark**, who looked after me during labour, was incredible. She is one of a kind. She cared not only for me but also for my partner and my baby with such compassion and professionalism. I felt so well looked after during my very quick pool birth, along with her Student Midwife. Rachel's support continued in theatre afterwards, which meant so much to me during a very intense and vulnerable time, I felt like I had known her longer than a few hours and I truly can't thank her enough for being that shining light of support whilst holding my hand and using such words of encouragement.

Thank you also to the theatre team, especially Anaesthetist **Shenouda** and Registrar **Zoe** who were both great. Even the 5am music choice was of good taste!

Another special thanks to Maternity Support worker **Shannon**, who was so supportive in our stay on Pannal she really cared for me and baby with such kindness.

Thirdly thank you to **Anna Sebine**, the mental health midwife, whose support was so important to me. I had a difficult time after the birth, and her understanding, compassion, and guidance made a real difference to my recovery.

The care I received from all three midwives was exceptional, as well as the whole team, and I am so grateful for everything they did for me and my family. Their support has stayed with me long after those early weeks and months.

Thank you again for such outstanding care, that I will never forget.

We just wanted to say a huge thank you to the amazing Harrogate midwife team after welcoming our baby girl Erin on St Patrick's Day

After a really tough previous birth, we were quite anxious this time around, but the team completely changed that for us. They helped us feel positive and supported every step of the way, which made this experience so healing and special.

From pregnancy through to labour and postnatal care, the kindness and genuine support we received meant everything to us. A special thank you to our community midwife Ellie Tempest– you made me feel truly heard and understood, and that made such a difference

We're so grateful to the whole team – your care meant the world to our family

15. Complaints, concerns, compliments

One complaint from February has a meeting planned relating to concerns regarding urogynae follow up by HDFT. Four complaints/concerns received in March. One complaint response has been completed, one complaint response is in progress, and two complaints have a meeting planned.
One complaint was received in Apri relating to a long wait in ANC which is being reviewed.

16. Coroner Regulation 28 made directly to trust

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

The homebirth services have been reviewed, and an action plan has been created. The action plan is being monitored via Maternity Quality and Assurance Meeting and Maternity Safety Champions.

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

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

18. Maternity and Newborn Safety Investigation (MNSI)

No new MNSI incidents reported.

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

Women and families remain at the heart of NHS Resolution's systemwide commitment to improving the safety and quality of maternity and neonatal services. The Maternity (Perinatal) Incentive Scheme (MIS) is a system convener, which incentivises and supports a core set of standards that underpin safe care. The ambition is for every family to receive the high-quality care they deserve.

MIS Year 8 reflects learning from previous years of the scheme, the evaluation findings, national reviews, and feedback from perinatal services, clinicians and families.

From Year 8 onwards:

- the scheme focuses on six revised safety actions
- requirements are less prescriptive than in previous years, supporting organisations by sharing examples of 'what good looks like'
- Trusts are expected to use professional judgement and local governance to demonstrate assurance that align more closely with local priorities and needs
- there is greater emphasis on outcomes, learning and impact, rather than the volume of evidence

This approach recognises that maternity and neonatal services operate in different contexts and that effective safety assurance should build on existing effective governance arrangements. The six core safety actions are:

A. Workforce and capacity
B. Training
C. Learning from reviews and investigations
D. Service-user voice and equity
E. Care bundles
F. Board oversight, governance, culture and leadership

Further information about each safety action can be found in Appendix A. The changes reflect insights gained through evaluation, respond to known system priorities, and prepare for future responses to the National Maternity and Neonatal Investigation and Taskforce.

Key findings include that MIS, since launching in 2018, has strengthened Board engagement and prioritisation, improved compliance with essential safety practices, supported local improvements and enhanced assurance processes.

Work is ongoing locally at HDFT to ensure the Trust is compliant with the requirements. Updates on this compliance will be provided in future reports. Discretionary funding has been received from Maternity Incentive Scheme to enable compliance with workforce requirements for Year 8 of the scheme.

20. National priorities

a. Maternity Care Bundle (MCB)

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

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

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

- benchmarking current compliance and developing an improvement plan with trajectories for sign off by the trust board
- providing regular reports to the trust board on implementation against this plan and trajectories, so that the board can oversee, support and challenge local delivery. Trust boards should also ensure the involvement of all relevant services in the planning and delivery of interventions. This will include relevant medical and surgical specialties, gynaecology and urgent and emergency care, as appropriate
- ensuring that where local plans do not meet nationally recommended pathways, timescales or performance, or where local delivery subsequently deviates from these plans, this is escalated to the regional NHS England team
- engaging with maternal medicine networks. This means co-producing and complying with the local network’s protocol for the management and referral of medical problems in pregnancy, across all relevant medical specialties and settings
- local reporting of routine care data relating to key process and outcome measures for each element as defined in the national implementation tool which will be made available to trusts on the FutureNHS platform in quarter 4 2025/26.

Work is underway to benchmark our services against the MCB and develop an action plan to improve services as required to meet the recommendations. The National benchmarking tool/action plan template was expected to be release in April but has not yet been shared.

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

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

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

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

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

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

NHS England wrote to all Trusts in October 2025 to advise on next steps to improve care for women, babies and families. The following elements were detailed;

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

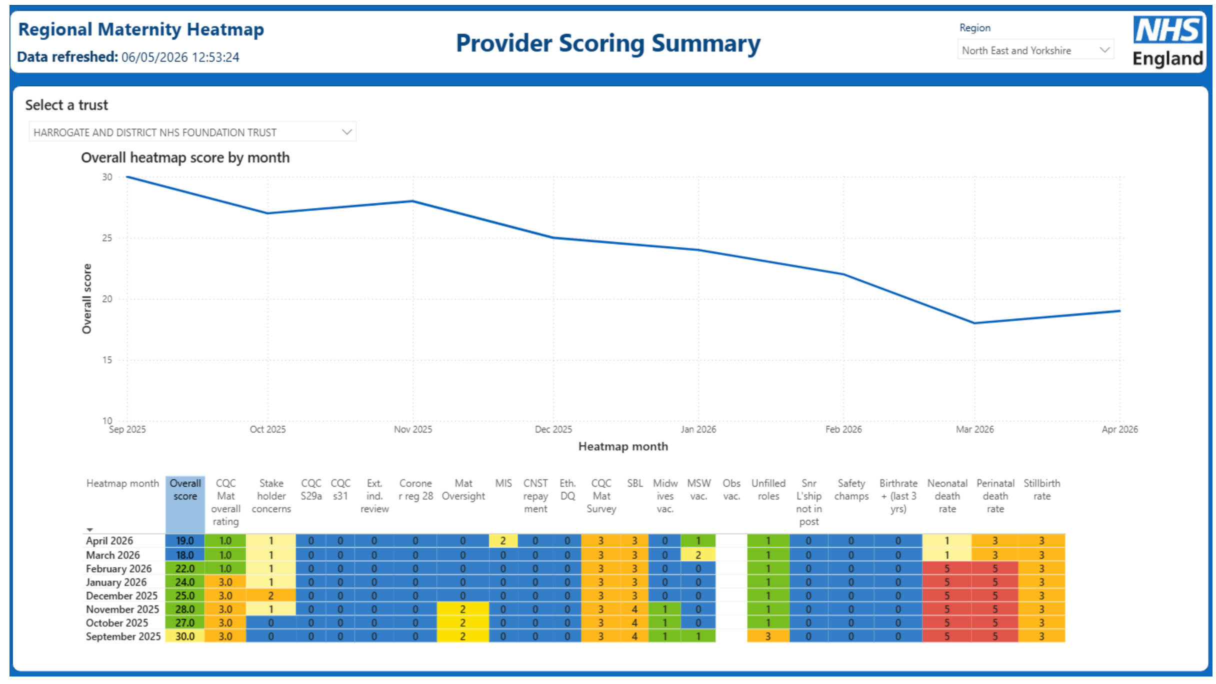
ii) **Submit a Perinatal Event Notification (SPEN) service:** this portal streamlines the administrative time required by frontline staff to notify perinatal safety events to MBRRACE-UK, Maternity and Newborn Safety Investigations; and NHS Resolution Early Notification Scheme. SPEN has been implemented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

iii) Maternity and Neonatal Performance Dashboard: This set of metrics is used to monitor performance in maternity and neonatal services in all parts of the system, supporting trusts and integrated care boards to monitor and have insight into their own progress. The dashboard represents a balanced scorecard of operational, outcome and patient experience measures. These metrics, together with the broader Perinatal Quality Surveillance Model and the rollout of the Maternity Outcomes Signal System (MOSS), will enable trusts and integrated care boards to monitor their own progress, while supporting the collective work to drive improvements across all maternity and neonatal services and identifying trusts that may need additional support.

(1) Heatmap

The regional maternity heat map is an analytical tool that pulls information around trusts CQC status, regulatory notices and regulatory body/stakeholder concerns, progress towards national priorities, safe staffing, MBRRACE mortality, service user and staff feedback surveys. The heat map enables monthly oversight of the triangulated data and then scores each

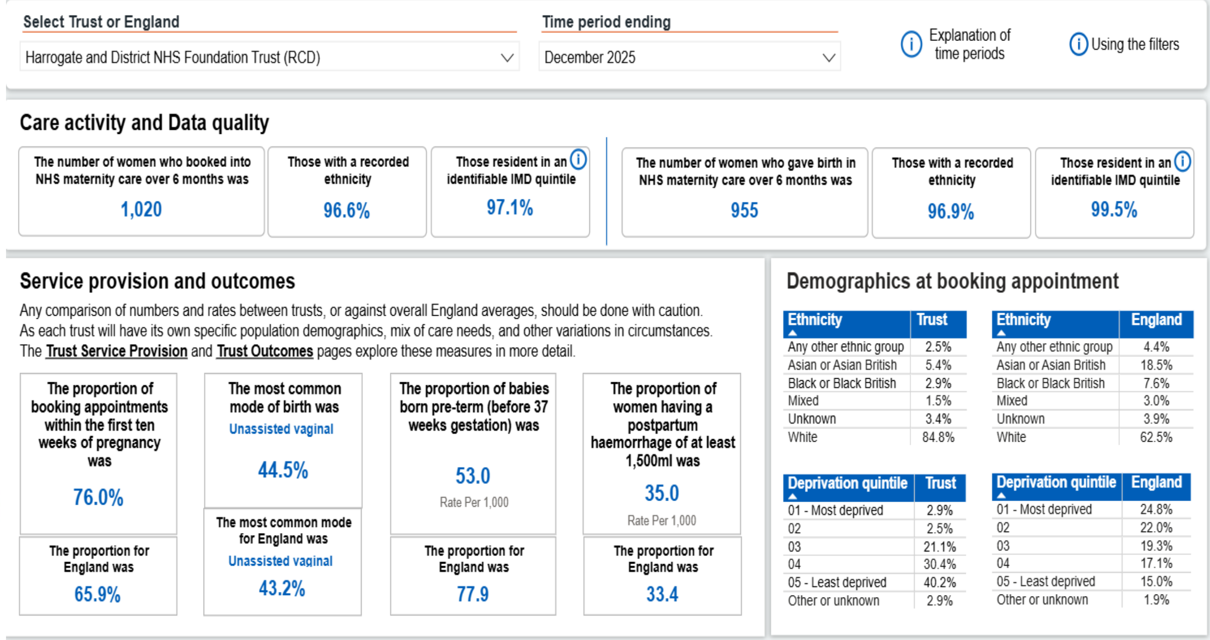
element to read the signals of trusts that require additional early intervention and support. The heat map is produced in a format for systems to use the information to direct work programmes to the right areas. The data is updated monthly and reports two months behind like the National Dashboard. The data for September is from the pilot month, with data completeness and accuracy work continuing throughout Q3 25/26. Please see below screenshot taken from the Regional Heatmap system. HDFT currently have a score of 19 which is in the least concerning category of the heatmap.



Heatmap month	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repayment	Eth. DQ	CQC Mat Survey	SBL	Midwives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
April 2026	19.0	1.0	1	0	0	0	0	0	2	0	0	3	3	0	1		1	0	0	0	1	3	3
March 2026	18.0	1.0	1	0	0	0	0	0	0	0	0	3	3	0	2		1	0	0	0	1	3	3
February 2026	22.0	1.0	1	0	0	0	0	0	0	0	0	3	3	0	0		1	0	0	0	5	5	3
January 2026	24.0	3.0	1	0	0	0	0	0	0	0	0	3	3	0	0		1	0	0	0	5	5	3
December 2025	25.0	3.0	2	0	0	0	0	0	0	0	0	3	3	0	0		1	0	0	0	5	5	3
November 2025	28.0	3.0	1	0	0	0	0	2	0	0	0	3	4	1	0		1	0	0	0	5	5	3
October 2025	27.0	3.0	0	0	0	0	0	2	0	0	0	3	4	1	0		1	0	0	0	5	5	3
September 2025	30.0	3.0	0	0	0	0	0	2	0	0	0	3	4	1	1		3	0	0	0	5	5	3

(2) Maternity and Neonatal Equalities Dashboard

A Maternity and Neonatal Equalities Dashboard can be accessed here link. The dashboard shows data from December 2025. There are interesting comparisons able to be made regarding outcome and service provision broken down by ethnicity and deprivation. Below are a couple of screen shots taken from that dashboard.



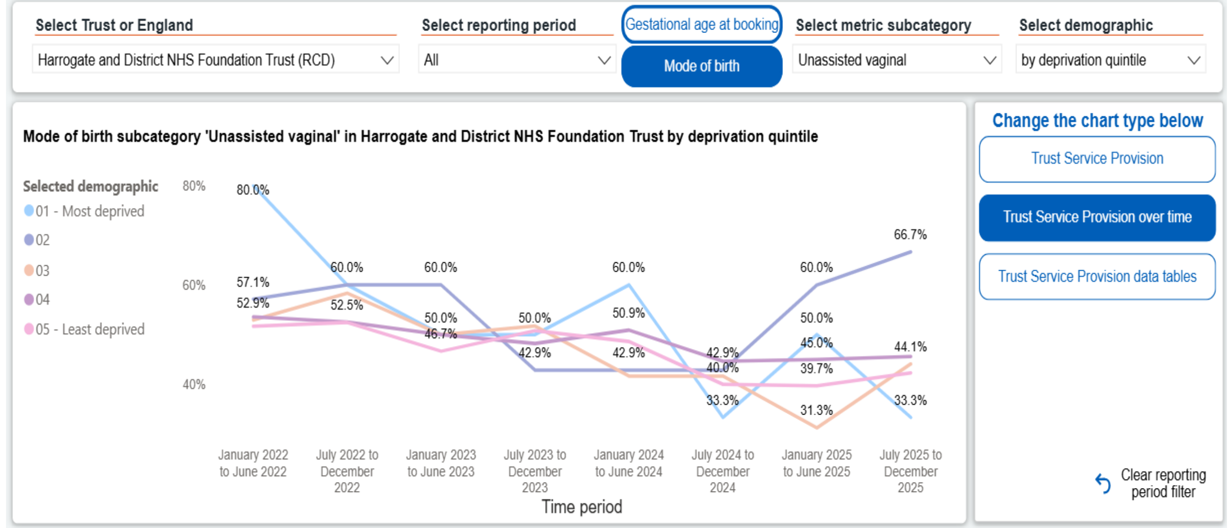
Ethnicity	Trust
Any other ethnic group	2.5%
Asian or Asian British	5.4%
Black or Black British	2.9%
Mixed	1.5%
Unknown	3.4%
White	84.8%

Ethnicity	England
Any other ethnic group	4.4%
Asian or Asian British	18.5%
Black or Black British	7.6%
Mixed	3.0%
Unknown	3.9%
White	62.5%

Deprivation quintile	Trust
01 - Most deprived	2.9%
02	2.5%
03	21.1%
04	30.4%
05 - Least deprived	40.2%
Other or unknown	2.9%

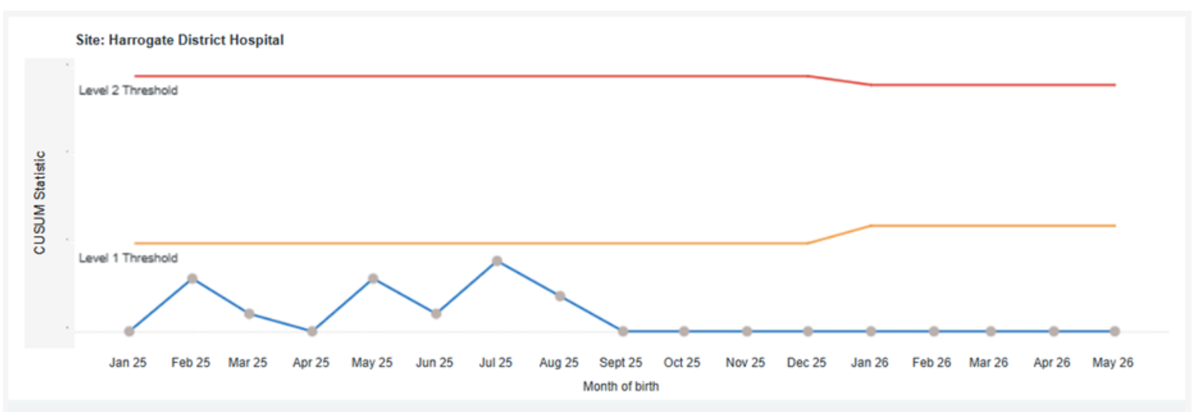
Deprivation quintile	England
01 - Most deprived	24.8%
02	22.0%
03	19.3%
04	17.1%
05 - Least deprived	15.0%
Other or unknown	1.9%

The below graph is interesting showing the reduction in unassisted vaginal births over time with significant variation for the most deprived population over the three years and an increase for the second most deprived quintile over the same time period. The above small numbers shown above need to be taken into consideration when reviewing the dashboard as small numbers give significant swings in the percentages.



(3) Maternity Outcomes Signal System (MOSS)

Trust maternity teams are required to check MOSS (and the MBRRACE-UK Real Time Data Monitoring Tool) at least monthly for discussion at perinatal quality meetings. No MOSS signal has been triggered over last 6 months or last 12 months. See below screen shot from the MOSS signal system.



d. Vaccinations during pregnancy and the postnatal period

Of the 419 eligible patients in Q1, 357 were offered the RSV vaccination (85%). 239 were vaccinated before birth (57%). 41 patients declined the vaccination (9.8%).

e. Three Year Delivery Plan for Maternity and Neonatal Services

An action plan is in place that documents the steps required and completed to meet the requirements of the Three-Year Delivery Plan. The remaining action relates to the full implementation of saving babies lives.

21. Local HDFT Maternity Services Dashboard

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

[Maternity Dashboard]

Work continues to ensure accuracy of data and benchmarking is included in all data fields captured in the dashboard.

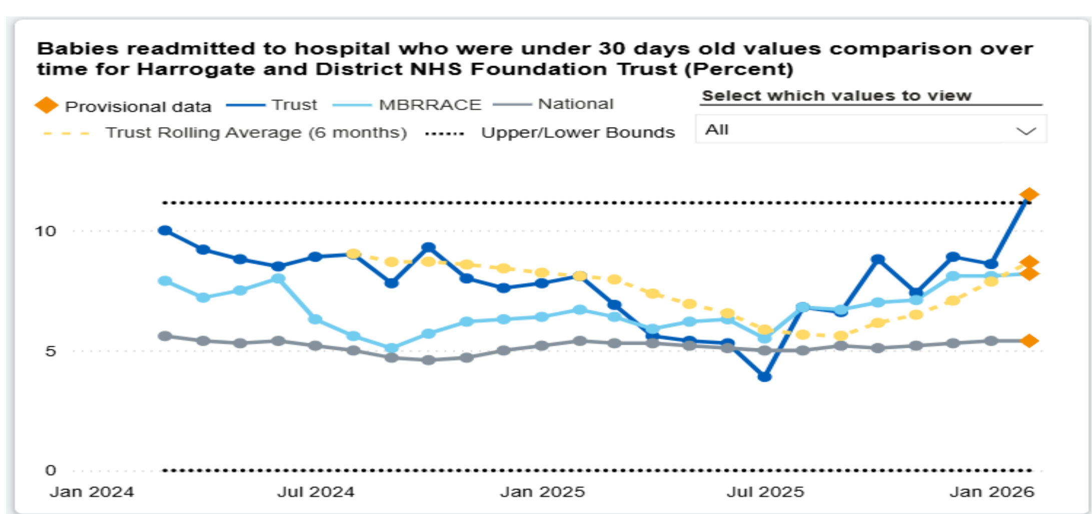
The National Maternity dashboard is available at the following link- [National Maternity Dashboard]. The data available in the National dashboard is up to February 2026. The Clinical Quality Improvement Metric comparison (CQIM+) tabs gives the opportunity to compare HDFT Maternity services against National services, Regional Peers, the Local Maternity and Neonatal System (HNY LMNS) peers and MBRRACE peers (other maternity services with under 2000 births per year at 24 weeks or later).

It has been identified that Harrogate & District NHS Foundation Trust Maternity Unit is currently negatively showing on the National Maternity Dashboard and/or Local Dashboard Power BI for several indicators. As a result, further investigation has been undertaken to try to understand the underlying cause for this and to consider possible remedial actions.

In particular, the following areas have been identified as area of concern:

- Neonatal Readmissions
- Apgar score at five minutes 0 - 6
- 3rd and 4th degree tear

a. Neonatal Readmissions



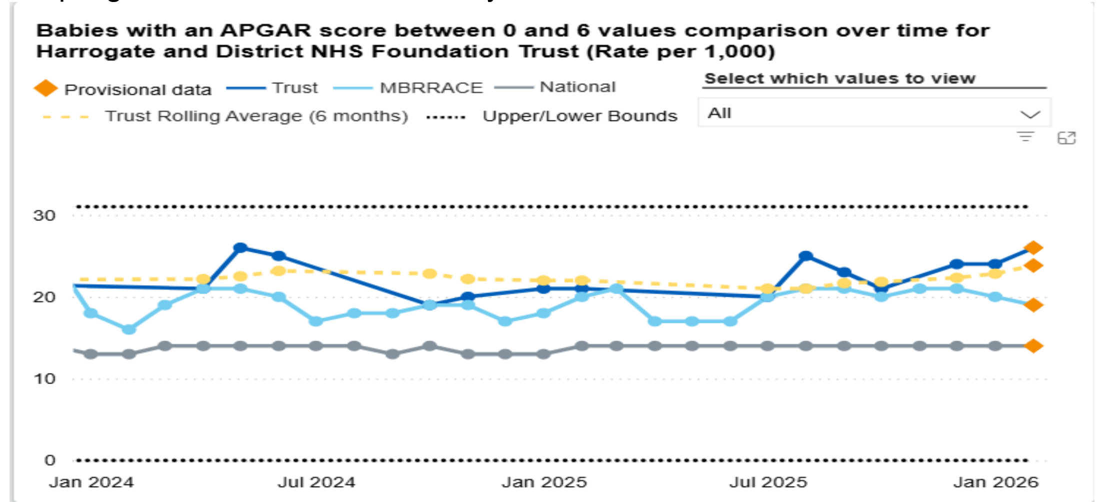
Admission criteria does differ across the UK making benchmarking across Trusts difficult. Although lower readmissions are often measured as a positive marker this may be at the detriment of exclusive breastfeeding. Breastfeeding initiation in Harrogate is currently 91% and supplementation rates continue to be within World Health Organisation and UNICEF UK parameters (2024/25).

The Infant Feeding Coordinator provides a quarterly readmission report, analysing all of the neonatal readmissions. As part of this report, it is evident that readmissions to Maternity are most commonly for reasons of weight loss and/or jaundice. Further work

is ongoing to understand the readmissions to the children's ward, Woodlands. The quarterly report Is attached as Appendix D.

b. Apgar score at five minutes 0 - 6

The Apgar score is a rapid assessment of a newborn's health at 1 and 5 minutes after birth, evaluating five criteria: Appearance (colour), Pulse (heart rate), Grimace (reflex), Activity (muscle tone), and Respiration (breathing). Each factor scores 0–2, with a maximum total of 10. Scores of 7–10 are typically normal, indicating the baby is adapting well, while lower scores may indicate a need for immediate intervention.

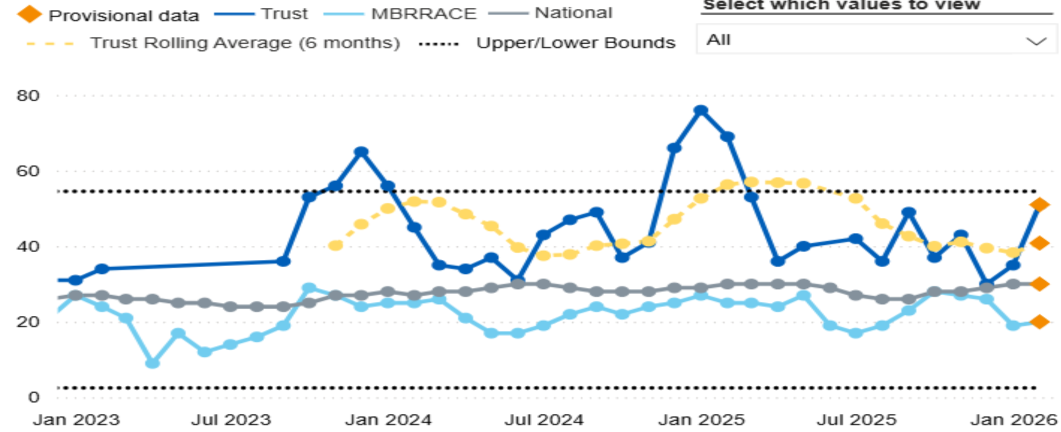


The figure above shows the national Maternity Dashboard CQIM+ data since January 2024 for Apgar score below 7 at 5 minutes of age. The latest Trust data (dark blue line) shows a rate of 26.0 per 1,000 against a national rate of 14.0 per 1,000 for December 2025 (the latest datapoint) and MBRRACE comparators rate of 19 per 1000. Whilst the HDFT rate is not an outlier above the statistical upper limits, this is above the national average rate.

After a deep dive into the data no specific modifiable factors have been identified, and appropriate action appears to have been taken.

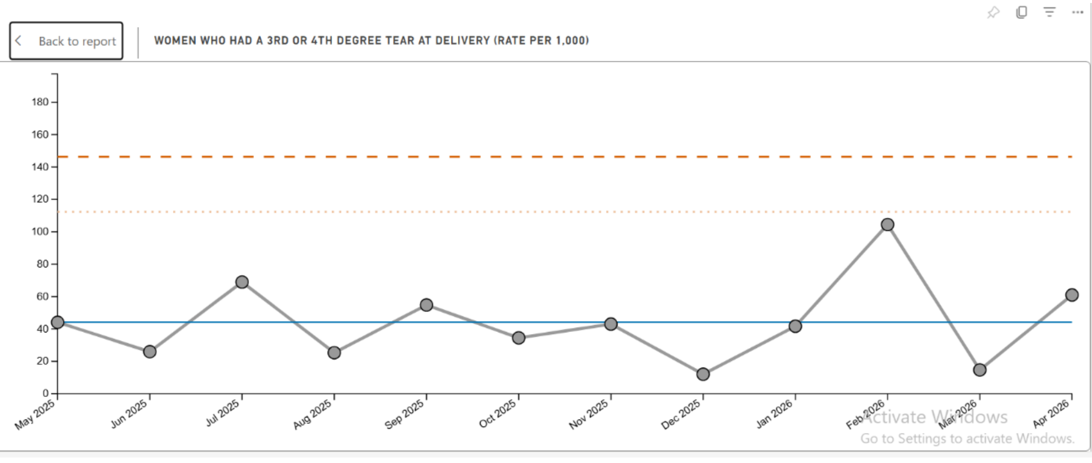
c. Third- and fourth-degree tears (local dashboard demonstrates a significant increase this month)

Third- and fourth-degree perineal tears are significant perineal trauma involving the anal sphincter and represent a class of trauma classified as Obstetric Anal Sphincter Injury (OASI).



The figure above shows the national Maternity Dashboard CQIM+ data since January 2023 for 3rd or 4th degree perineal tears. The latest Trust data (dark blue line) shows a rate of 51 per 1,000 against a national rate of 30 per 1,000 for February 2026 (the latest datapoint).

Local dashboard (PowerBI) data has also identified areas of increase, with seven incidences of OASI tears in February (106 per 1,000) however this has reduced in March with just one case.



Actions are being taken to improve this outcome which includes the following;

- Feedback and learning to the Obstetric Team
- Quality Improvement work to increase awareness of correct hands-on technique and supporting of the posterior shoulder at delivery, including at instrumental deliveries.
- Reinforcement about the correct angle of episiotomy
- Reinforcement of the RCOG OASI care bundle
- Additional training through the Pelvic Health midwife
- Awareness of increased birthweight as a risk factor, together with forceps risk factors

22. Avoiding Term Admissions in Neonatal Units (ATAIN)

Please see the Quarterly report for January to March 2026 at Appendix E.

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

An action plan is in place, work is on-going, and compliance is reassessed by the LMNS quarterly. Harrogate maternity services have demonstrated progress in achieving compliance with all six elements Saving Babies Lives Care Bundle version three. The most recent compliance review meeting occurred in February 2026 and the Trust's overall compliance had increased from 93% (Q2 25-26) to 94% (Q3 25-26). The Trust demonstrates being fully compliant with Elements 2, 3, 4 and 6 and there was evidence of improvements with meeting ambitions for Element 1 (Reducing Smoking in Pregnancy) and Element 5 (Reducing Pre-Term Birth).

Small-for-gestational age detection rate [AN detection of SGA user reported or EFW <10th: Proportion of babies SGA (<10th) at birth that were reported by users to be suspected antenatally as SGA <10th or detected by EFW <10th] Fetal growth restriction detection rate [AN detection of SGA <3rd by EFW <3rd: Proportion of babies with birthweight<3rd centile who were detected as <3rd centile from one or more AN EFW]	SGA – Q1 (calendar): **55.3%** detection (<10th centile; 26 cases)(National average 48.9%) FGR – Q1 (calendar): **42.9%** detection (<3rd centile; 6 cases) (National average 37.0%)	
	Jan-March 2026	April 2026
Percentage of babies <3rd centile >37+6 weeks' gestation	1.39% (6/431)	0% (0/142) as % of all babies born
Percentage of babies <10th centile >39+6 weeks' gestation	3.48% (15/431)	1.4% (2/142) as % of all babies born
SBLv3 Element 2 report (2d): Percentage of babies <3rd centile who were born >37+6 weeks	35.3% (6/17) i.e. babies <3rd centile AND >37+6 as proportion of all babies <3rd centile	0% (0/2) i.e. babies <3rd centile AND >37+6 as proportion of all babies <3rd centile
Percentage of babies <10th centile who were born >39+6 weeks (% of all babies <10th centile)	27.3% (15/55) i.e. babies <10th centile AND >39+6 as proportion of all babies <10th centile	20.0% (2/10) i.e. babies <10th centile AND >39+6 as proportion of all babies <10th centile
Percentage of babies ≥3rd birthweight centile born <39+0 weeks	23.9% (99/415) i.e. babies ≥3rd centile AND <39+0 as proportion of all babies ≥3rd centile	20.0% (28/140) i.e. babies ≥3rd centile AND <39+0 as proportion of all babies ≥3rd centile
Incidence of women with singleton pregnancy (as % of all singleton births) giving birth (liveborn and stillborn):		
• In late second trimester (16+0-23+6 weeks)	0.96% (3 fetal loss, 1 NND; 4/417)	0% (0 births 16+0-23+6 weeks)
• Preterm (24+0-36+6 weeks)	5.5% (23/417)[2 stillbirth, 21 livebirth]	3.7% (5/135)[5 livebirth]

24. Maternity Safety Champions

Bi-monthly Safety Champion executive and non-executive director walk around and meetings continue. The most recent walkaround and meeting occurred on 16th March 2026. The Exec and Non-exec Safety Champions completed the walkabout. Feedback was positive and new starters reported being made to feel welcome and were not afraid to ask for help or support. Some negative feedback was received regarding the food on SCBU, and this has been fed back to catering. The next meeting is scheduled for 18th May 2026.

25. Conclusion and Recommendations

a) Positive news

- Diverts have reduced over last two months.
- Heatmap score reduced to lowest concern category following update to CQC rating
- Discretionary funding from Maternity Incentive Scheme agreed

b) Areas of concern

- Continue to demonstrate above average rates for third degree tears on National dashboard
- Pannal acuity continues to report below 50% staffing (mitigations in place, see point 5b.)
- Funding for Maternity and Neonatal Voices Partnership

c) Work underway

- On-going work to review Maternity Care Bundle and Postnatal Toolkit.
- Maternity incentive requirements under review
- Work ongoing in Maternity Assessment centre regarding activity and implementation of BSOTS

d) Decisions required of Board/Board oversight

- Appendix B – Bi-annual Midwifery Staffing report
- Appendix C – Perinatal Mortality Review Tool Quarterly Report
- Appendix D – Neonatal Readmissions
- Appendix E – Avoiding Term Admissions into the Neonatal unit (ATAIN)

Appendix A - Explanatory notes

1. Birthrate Plus Establishment

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

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

2. Birthrate Plus Acuity Staffing Data

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

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

3. Red Flag Events Recorded on Birthrate Plus

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

4. Perinatal Mortality Review Tool (PMRT)

Principles for the conduct of local perinatal mortality reviews:

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

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

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

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

Which perinatal deaths can we review using the PMRT?

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

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

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

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

From MIS Year 8, the scheme focuses on six core safety actions. These reflect the essential foundations of safe maternity and neonatal care and are intended to support consistent, high-quality services across England.

Each safety action brings together national expectations, professional standards, learning from reviews and investigations, and lived experience.

1. Workforce and capacity

- This safety action focuses on ensuring that maternity and neonatal services are safely staffed and sustainably resourced.
    - Trusts are expected to have effective systems in place to plan, monitor and manage workforce and capacity across maternity and neonatal services, identify and escalate staffing risks, and ensure appropriate senior clinical presence.
    - Strong workforce planning supports safe care, timely escalation and effective decision-making for women and babies.

2. Training
    - This safety action focuses on ensuring that staff have the skills, confidence and support needed to provide safe maternity and neonatal care.
    - Trusts are expected to provide regular, multidisciplinary training that reflects local and national learning, and to maintain oversight of training participation through established governance routes.
    - High-quality training supports teamwork, communication and effective responses in both routine and emergency situations.

3. Learning from reviews and investigations
    - This safety action focuses on how services learn when things go wrong, including reviews and investigations, and listening to families' experiences.
    - Trusts are expected to have systems in place to identify and review qualifying events, involve parents and families meaningfully, and use learning to drive improvement and reduce the risk of harm.
    - The emphasis is on learning, improvement and compassion, rather than blame.

4. Service-user voice and equity
    - This safety action focuses on ensuring that the voices of women, families and carers are heard, valued and acted upon, and that care is equitable.
    - Trusts are expected to capture and use feedback from women and families, understand the needs of their local population, and address barriers to safe, accessible and inclusive care.
    - This includes recognising and responding to differences in experience and outcomes across different groups.

5. Care bundles
    - This safety action focuses on the implementation of national maternity and neonatal care bundles, which bring together evidence-based practices to improve outcomes.
    - Trusts are expected to prioritise implementation based on local safety intelligence, monitor progress through established governance routes, and ensure Board-level oversight of care bundle delivery.
    - Care bundles support consistent, evidence-based care across services.

6. Board oversight, governance, culture and leadership
    - This safety action emphasises the role of Trust Boards in leading and overseeing maternity and neonatal safety. They are ultimately accountable for ensuring safe perinatal services in their organisation.
    - Trusts are expected to demonstrate that Boards receive clear, regular information on safety and quality, that risks are identified and escalated appropriately, and that leadership supports a positive safety culture.

- Effective Board oversight is crucial to ensure that learning leads to sustained improvement, and to facilitate appropriate Trust resource allocation.

NHS Trusts in England that deliver perinatal services and are members of the Clinical Negligence Scheme for Trusts (CNST) contribute to the MIS as part of their CNST premium.

During the MIS year, Trusts are expected to:

- monitor progress against the six safety actions
- use local governance systems to review risks, learning and improvement
- provide robust assurance to their Trust Board that the safety actions are being met

At the end of the MIS year, Trust CEOs make a Board-level declaration confirming whether they meet the MIS requirements.

The scheme is not based on routine submission of detailed evidence to NHS Resolution. Instead, Trust Boards are responsible for assuring themselves that the standards are met and that appropriate evidence is retained locally.

Evidence should demonstrate how risks are identified and managed, how learning leads to improvement, and how Boards maintain oversight of maternity and neonatal safety.

Additional external assurance models and support will be introduced in year 8 to ensure these processes are happening effectively.

Further information can be found at https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

6. Avoiding Term Admissions in Neonatal Units (ATAIN)

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

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

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

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

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

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

This means there are now 6 elements of care:

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

In addition to the provision of safe and personalised care, achieving equity and reducing health inequalities is a key aim for all maternity and neonatal services and is essential to achieving the national maternity safety ambition. In developing each element in SBLCBv3, actions to improve equity have been considered, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas, in accordance with the NHS equity and equality guidance.

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

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

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

Appendix B

Bi-Annual Midwifery Staffing Report

Bi Annual Staffing Report	
	Time Period of Data **1st October 2025 – 31st March 2026**
Name & designation of person completing the summary	**Emma Barker, Matron for Maternity Service and EPAU** **Dawn Edmundson, Head of Midwifery** **Leanne Likaj, Associate Director of Midwifery and Children's Services**
Clinical area/s covered by summary:	Delivery Suite Maternity Assessment Centre (MAC) Pannal Ward Community Midwifery Antenatal Clinic
Sources of data collection	Information obtained from E-Roster, Birthrate Plus acuity tool, NHS professionals.

Executive Summary

1. The aim of this bi-annual report (1st October 2025 – 31st March 2026) is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels in the maternity department. This is a requirement of the NHS Resolution Maternity Incentive Scheme, Safety Action A.

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

- A systematic evidence-based process that has been used to calculate midwifery staffing establishment within the last three years
- A midwifery staffing budget that reflects the establishment calculated above.
- A process is in place to manage daily workload activity and to address any shortfall in planned versus actual midwifery staffing levels.
- A calculated midwife to birth ratio.
- An appropriate percentage of specialist midwives employed and mitigation to cover any inconsistencies.
- 100% compliance with a midwifery coordinator in charge of labour ward who has supernumerary status; (defined as having a rostered planned supernumerary coordinator and an actual supernumerary coordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service.

- An escalation plan which includes the process of providing a substitute coordinator in situations where there is no coordinator available at the start of a shift.
- One-to-one midwifery care for all women in active labour
- Monitoring of red flag incidents associated with midwifery staffing

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

Midwifery Establishment

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

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

A BR+ establishment review was last completed in August 2024 utilising three months data for December 2023, January and March 2024 and annual birth activity from 2023/24 (see Appendix A). The total number of births in 2023/24 review period was 1714. The Birthrate Plus establishment staffing is based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care. The 2024 BR+ establishment review recommended a total Clinical, Specialist and Management whole time equivalent (WTE) of 77.86 midwives, 10.45WTE of which are specialist and management. This was an overall increase of 1.65 WTE midwives from the previous BR+ report in 2021 and was based on a 20.78% headroom/uplift for absence. Given the increased training requirements for midwives, it was proposed to move to an uplift of 24%, which is more in line with other maternity departments across the UK. BR+ therefore proposed that 80.56 WTE midwives are required. Two business cases were written to uplift the midwifery and maternity support worker staffing in line with the Birthrate Plus report and professional judgment. The first business case was agreed to increase the establishment of midwifery staffing by 5.48WTE Band 7 midwives giving a funded establishment of 82.67WTE. The intention was that this staffing increase would enable improved senior support available outside of working hours, increase staffing at night, reduce diverts, increase patient safety and improve staff wellbeing. As part of this review the headroom uplift applied to midwifery was reviewed,

given the increased training requirements for midwives following the Core Competency Framework release and Maternity Incentive Scheme requirements. The headroom uplift applied to all midwives working in maternity services has now been increased to 24% as recommended by Birthrate Plus.

Birthrate plus recommendations don't include calculations for support staffing required in the clinical areas and this requires professional judgement. Previously there was a funded establishment for support staff of 13.6 WTE. An additional business case was approved at Business Case Review Group in April 2025 to increase the establishment by 5.58WTE Band 3 maternity support workers, giving us a total of 19.18. During this period, additional funding to support the vaccination programme was received giving an extra 0.6wte, having a total of 19.80 WTE.

The HDFT funding for midwives currently is 83.43 WTE and there is currently 90.02 WTE in post (including 5.94 WTE midwives on Maternity Leave) as at the end of March 2026. See below month on month breakdown of WTE midwives in post.

Midwives (Band 5-8A)	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	March 26
Budgeted Establishment	83.43	83.43	83.43	83.43	83.43	83.43 (+0.8WTE LMNS funded post for Enhanced Continuity)
Staff in Post (including maternity leave)	82.00	82.40	82.54	89.46	86.28	90.02

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

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

Establishment Deficits

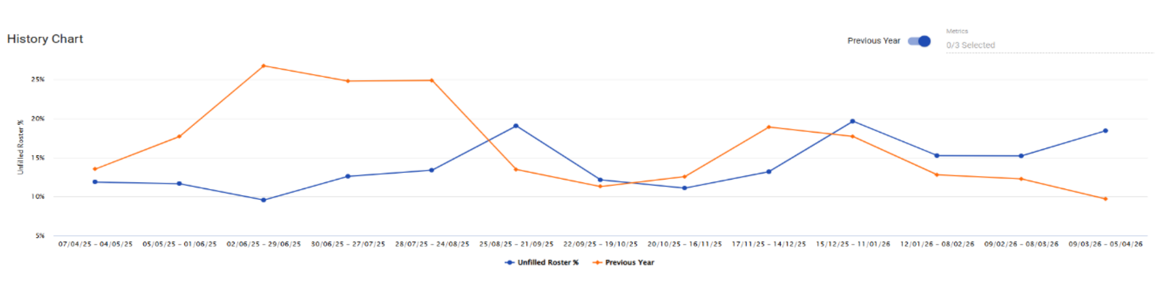
Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.

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

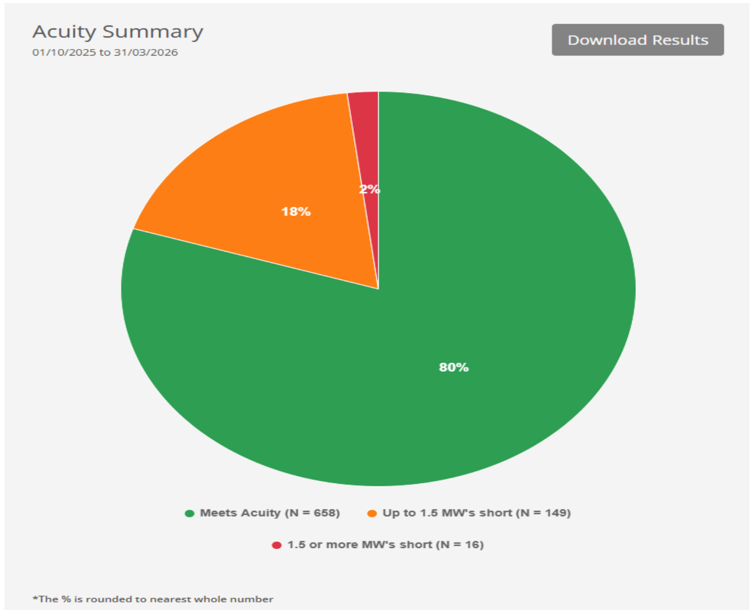
The maternity department continues to actively recruit new staff as required. The table below shows the number of starters (in WTE) balanced against the numbers of leavers between October 2025 and the end of March 2026.

	Midwives	Maternity Support Workers (MSW's)
New Starters	9.06	4.76
Leavers	4.42	1.69
Career break	1.0	0
Maternity Leave	2.8	0
Secondment	1.4	0

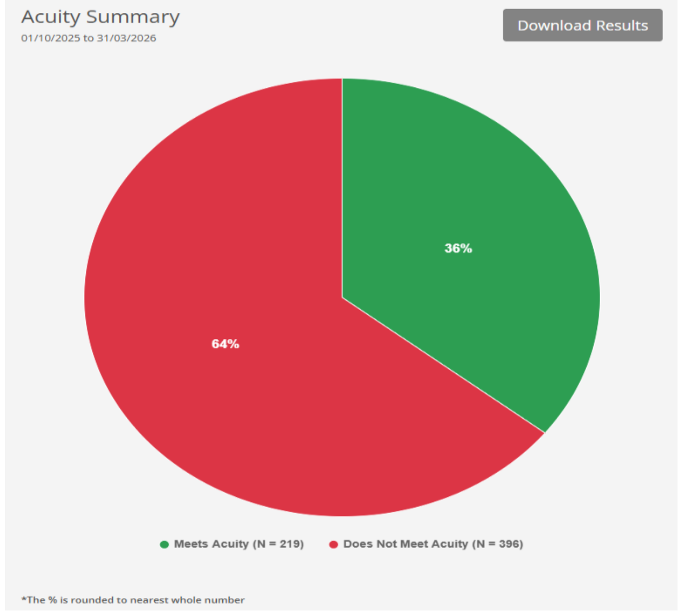
The graph below demonstrates the unfilled roster percentage March 2025 to March 2026 as shown by the purple line. The orange line provides a reference point against the previous calendar year.



From the data submitted on BR+ over the six month period, staffing met the acuity on Delivery Suite 80% of the time, 18% of the time staffing was up to 1.5 midwives short and 2% of the time more than 1.5 midwives short (this is equal to 16 occasions). Compliance with completing the tool was 75.37%.

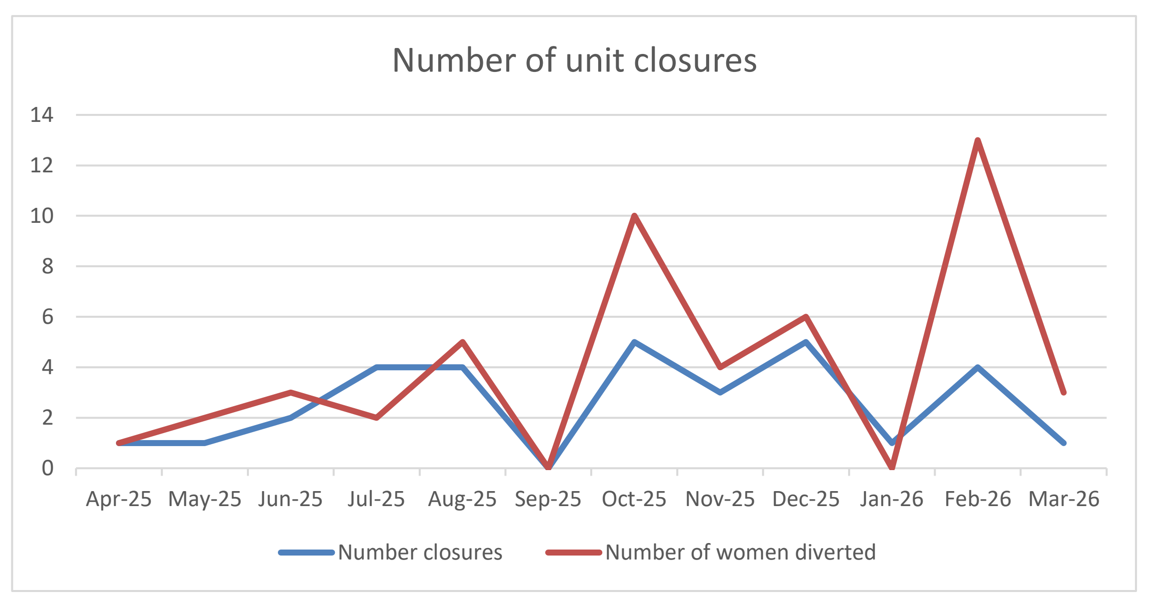


BR+ have developed the acuity app for Pannal ward for antenatal and postnatal care. The tool demonstrates that staffing does not meet acuity on Pannal 64% of the time, this is an increase of 2% on the last 6 months. The ward manager is monitoring the compliance of the submission of this data.



The maternity unit has the ability to move staff around the unit and between inpatient and outpatient areas dependent on activity and acuity as and when required. Mitigation to cover shortfalls is incorporated in the maternity escalation guideline and achieved in the short term by implementing clinical and management actions, collected in the BR+ acuity tool. Due to the nature of maternity services, there will be periods of high and low activity and the unit has the ability to move staff accordingly or temporarily close to further admissions. During this period the maternity unit was on divert on 19 occasions with 30 women diverted to other hospitals. The graph below demonstrates a steady increase in the number of women being diverted in the last six months.

Harrogate and District NHS Foundation Trust



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

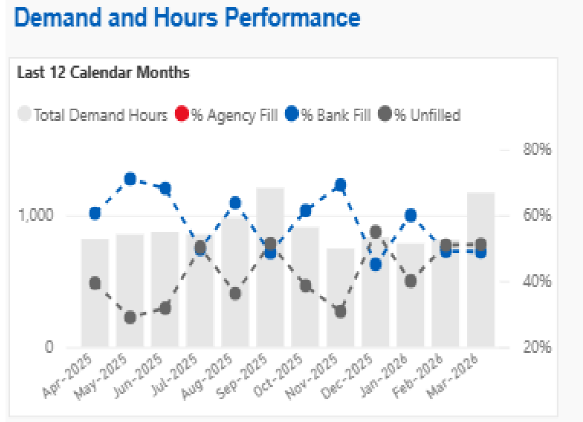
Planned Versus Actual Midwifery Staffing Levels

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

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

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

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



Midwife: Birth Ratio

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

HDFT midwife to birth ratio

Midwife to Birth ratio	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	March 2026
Ratio	1:28.8	1:27.7	1:28.2	1:22.9	1:22.6	1:24.4
Number of births	163	158	161	144	136	148
Midwives in post (excluding specialist midwives)	67.86	68.26	68.40	75.32	72.14	72.60

Specialist Midwives

BR+ suggests 15.5% (12.82WTE) of the midwifery establishment is not included in clinical numbers. This includes those in management positions and specialist midwives

The current percentage of specialist midwives employed is 13.7%. All midwives within this staff group support the maternity unit by working clinically if required at times high activity or acute sickness within office hours. A significant number of them also provide clinical care as part of their specialist role.

The specialist roles support national recommendations to ensure the service has the correct specialist posts for the demographic served and are in line with current national initiatives.
The service has a wide range of specialist midwifery posts at Band 6, Band 7 and 8A as detailed below totalling 11.48 WTE;

- Bereavement Specialist Midwife 0.96 WTE
- Infant feeding Specialist Midwife 0.8 WTE
- Quality and Safety & Governance Lead 1.00 WTE
- Named Midwife for Safeguarding 1.0 WTE
- Antenatal and New-born Screening Specialist Midwife 1.0 WTE
- Digital Midwife 0.8 WTE
- Midwife Sonographer 0.80 WTE
- Recruitment and Retention Midwife 0.72 WTE
- Perinatal Pelvic Health Midwife 0.4 WTE
- 2 x Professional Development Midwives 1.3 WTE (Inc. Fetal Monitoring Lead role)
- Clinical Educator Midwife 0.4 WTE
- Perinatal Mental Health Midwife 0.8 WTE
- Audit Midwife 0.7 WTE
- Diabetes Specialist Midwife 0.6 WTE
- Pre-term Birth Midwife 0.2 WTE
- Professional Midwifery Advocate Lead Midwife 0.6 WTE (Corporate funding)
- Research Midwives (research funded)

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

Data extracted from Birthrate plus during the six months shows there was a completion rate of 75.37% on the Delivery Suite and 84.48% for Pannal. A higher compliance completion rate provides more assurance that the interpretation of the results is accurate.

The labour ward coordinator has supernumerary status, defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift (NHS Resolution, Maternity Incentive Scheme, 2024) to enable oversight of all the birth activity within the service. MIS year 8 (2026), no longer requires this information to be submitted, however this is gold standard, and it will be continuously monitored at HDFT.

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

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

All information was collated using the Birthrate Plus acuity tool. During this six-month time period there were 45 occasions when during the shift the Delivery Suite coordinator became not supernumerary out of 1092 opportunities to record (823 recorded occasions) which equates to 96% supernumerary status. Each completion refers to a four-hour period and the occasions of none supernumerary status may only occur for a small amount of time during each four-hour period. Predominantly these occasions were during the night and at weekends when there are no additional staff available to support the service (ward managers and specialist midwives). There is a clear escalation process in place when the

coordinator cannot be supernumerary which includes contacting the community teams at a weekend and the hospital midwife on call at night.

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

- 910 women birthed
- 3 women experienced a baby being born before the arrival (BBA) of the midwife,
- 8 women had a homebirth

Red Flags

Red flag events have been agreed locally (including guidance from NICE) and are captured on the BR+ acuity tool on Delivery Suite. During the 6-month period between 1st October and 31st March the following red flag events were identified on Delivery Suite;

Number of Red Flags recorded

01/10/2025 to 31/03/2026

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	4	40%
RF2	Missed or delayed care	0	0%
RF3	Missed or delayed mediation > 30 mins	0	0%
RF4	Delay in providing pain relief > 30 mins	0	0%
RF5	Delay between presentation and triage >30 mins	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	4	40%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	10%
RF10	Midwife unable to provide 1:1 high dependency care for AN or PN patient	1	10%
TOTAL		10	

*The % is rounded to nearest whole number

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

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

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

Summary

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

We are now fully recruited to the BR+ recommended establishment; however, the nature and complexity of Maternity services is increasing therefore diverts are sometimes still necessary. Close monitoring of all diverts continues.

Recommendations

1. Pannal ward manager and Patient flow coordinators to work with Pannal midwives to ensure correct and objective data is submitted
2. Review and evaluate the role of the patient flow coordinator after 6 months

Appendix C

Compliance of completion of Perinatal Mortality Review Tool

Quarter 4, January-March 2026

This document provides a summary of current compliance against Safety Action 1 of the Maternity Incentive Scheme (MIS) for the second quarter, January-March 2026.

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

Requirements of the Maternity Incentive Scheme Safety Action 1:

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

MBRRACE-UK Case ID	Reported to MBRRACE (within 7 working days)	Review started (within 2 months)	Report published (within 6 months)	Parents informed of review and questions/concerns sought
101529	Yes	Yes	In progress	Yes
102998	Yes	Yes	In progress	Yes
Overall Compliance against targets of Safety Action 1	100% - Compliant (Target 100%)	100% - Compliant (Target 100%)	100% - Compliant (Target 100%)	100% - Compliant (Target 100%)

Table 1: Eligible perinatal death against MIS requirements

Compliance of eligible perinatal deaths with MIS requirements

During quarter 4, there was one perinatal death eligible to be reported to MBRRACE-UK. A notification to MBRRACE-UK was completed as per requirements and a PMRT is in progress.

There is one PMRT that is in the final writing stages of the report, and due be published shortly.

Ongoing Action Plan following PMRT review

Root Cause/Contributory Factor	Action/s	Responsible Lead	Target Date	ID no.	Risk at review (H/M/L or complete)
Management and escalation of pathology results	For clearer definition of roles and responsibilities, and pathway for checking and managing pathology results in all clinical areas.	Team leaders	28/02/2026	98640	Complete Trust policy shared
The baby was small for gestational age at birth scans were indicated and performed but the baby was not identified as IUGR.	Continue auditing cases of fetal growth restriction and reporting to the LMNS and Trust Board in line with SBLCB. There is an ongoing audit on the accuracy of growth scans compared with birth weight, to confirm accuracy and offer learning points.	Andy Brown and Rachel Tabram	01/01/2026	98640	Complete
Fundal height measurements performed alongside serial scanning pathway.	Reinforcement on mandatory training day and case study learning.	Charlotte O'Donovan Kathy McClune Alex Bedford	01/01/2026	98640	Completed
Delay in attendance with RFM's.	Learning to be shared with MDT and MNVP as part of case study. MNVP to share information about early attendance to hospital with any episode of RFM's.	Alex Bedford MNVP	30/11/2026	98640	Completed
Difference in perspectives on communication content and ongoing plan of care in relation to reduced fetal movements attendance.	Additional training for obstetric and midwifery staff regarding communication and discussions of recommendations for ongoing planning of care.	Charlotte O'Donovan Kathy McClune Emily Wilkinson	01/08/2026	99258	Medium
Missed opportunity for earlier antenatal clinic appointment with obstetric team to review low ferritin level.	Continuous improvement plans ongoing. Individual feedback to staff member. Case study to be shared with MDT.	Susan Wallace Alex Bedford	31/03/2026	99258	Completed
Challenges in contacting community midwifery team with non-urgent queries.	Reinforcement of SPOC contact details to service users and communications from MNVP team.	MNVP	31/03/2026	99258	Completed

Appendix D

Hospital readmissions of babies within 30 days of life
Quarter 4 January – March 2026

1) Report Overview

Potentially preventable readmissions, such as for jaundice or feeding problems, make up the majority of early neonatal readmissions across the UK. Theoretically, such admissions could be reduced either through additional support during the newborn hospital stay, or increased levels of follow-up after discharge. Evidence on safe early discharge is conflicting as most of the evidence comes from the United States where postnatal care in the community is very different. UK studies have demonstrated that decreasing the length of postpartum stay does not increase readmission rates, given adequate postnatal care outside of hospital.
There should be cautious interpretation of data between Trusts across the UK due to differing admission criteria, breastfeeding rates and levels of supplementation of breastfed babies in the community. Although lower readmissions are often measured as a positive marker this may be at the detriment of exclusive breastfeeding. Breastfeeding initiation in Harrogate is currently 91.7% and supplementation rates continue to be within World Health Organisation and UNICEF UK parameters (2024/25).

2) Process for data collection

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

3) External reporting

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

4) National guidance

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

5) Local guidance and preventative measures

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

6) Individual readmission data of babies with jaundice issues in the first month of life

Jaundice	Age when readmitted	Gestation at birth	Treatment	Feeding	Length of stay
Baby 1	4 days	39+1	Phototherapy	Mixed	2 days
Baby 2	2 days	35+6	Phototherapy	Breast	2 days
Baby 3*	6 days	39+1	Phototherapy	Breast	2 days
Baby 4*	5 days	37+4	Intensive phototherapy	Breast	2 days
Baby 5	2 days	40	Phototherapy	Breast	2 days
Baby 6	2 days	39+6	Phototherapy	Breast	24 hours
Baby 7*	8 days	38+6	Phototherapy	Breast	3 days

***Comments**

- **Baby 3** serum bilirubin monitored for several days before rising above treatment threshold on day 6. Feeding well throughout with minimal weight loss.
- **Baby 4** transferred home less than 24 hours of age. Admitted on day 5. Serum bilirubin 20 micromol/litre below exchange transfusion threshold. Baby transferred to Special Care Baby Unit for continuous intensive phototherapy.
- **Baby 7** monitored for jaundice from day 3 with biliflash and serum bilirubin on alternate days till treatment required on day 8. Care appears appropriate. Direct Coombs Test positive.

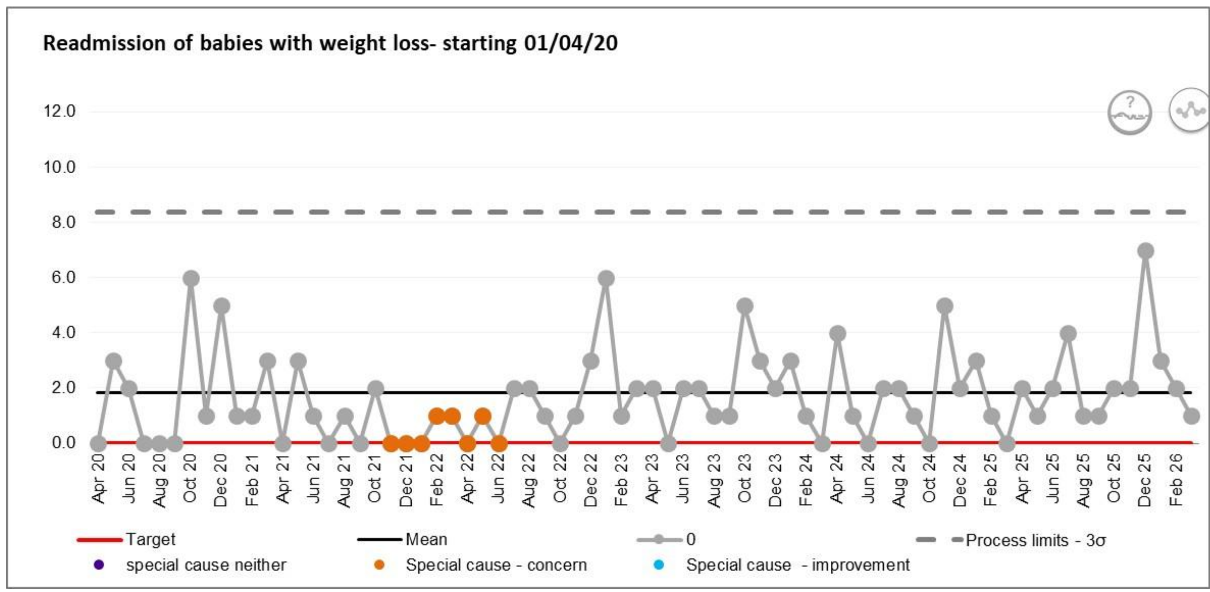
7) Individual readmission data of babies with feeding issues in the first month of life

Feeding issues	Age when readmitted	Gestation At birth	Weight loss	Treatment	Feeding	Length of stay
Baby 1	3 days	39	13.6%	Feeding plan	Breast	1 day
Baby 2	3 days	37+2	12.9%	Feeding plan	Breast	2 days
Baby 3*	3 days	38+5	10.4%	Feeding plan	Breast	2 days
Baby 4	4 days	37+4	13.4%	Feeding plan	Breast	24 hours
Baby 5*	3 days	41+1	15.4%	Feeding plan	Breast	24 hours
Baby 6	5 days	40+2	12.2%	Feeding plan	Breast	24 hours

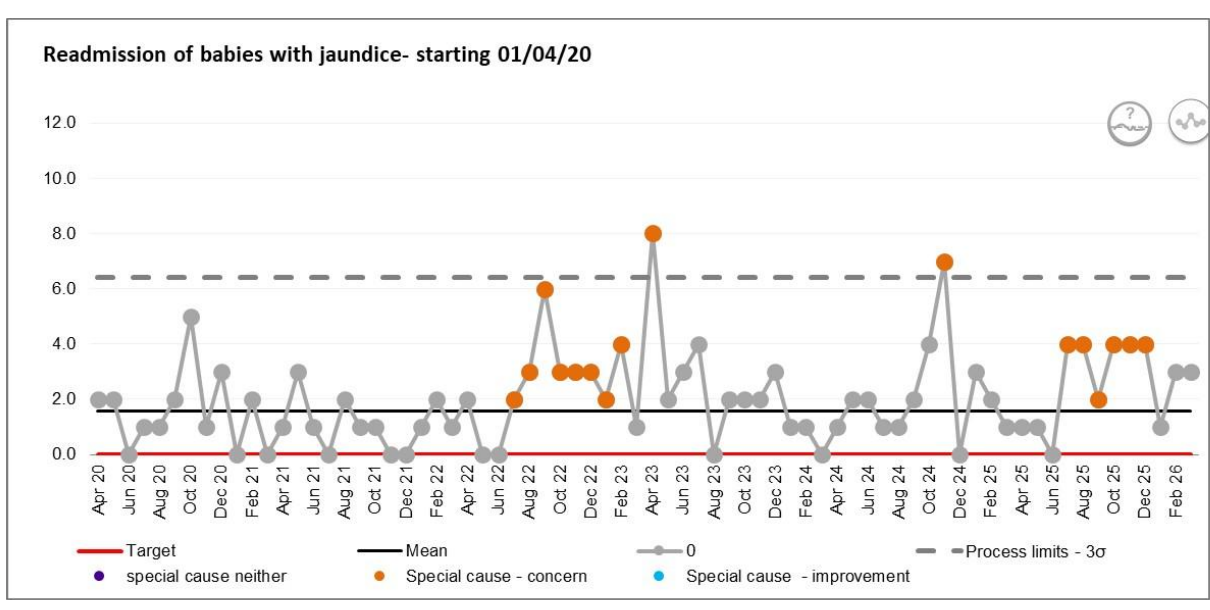
*Comments

- **Baby 3** admitted with lethargy and poor feeding via community midwife. Further weight loss in hospital. No cause for lethargy found.
- **Baby 5** significant weight loss however sodium level 133mmol/L within normal range.
- **Baby 6** weight loss 9.6% prior to home on day 3, appropriate feeding plan in place. Transferred out of area. No documentation for day 4, readmitted day 5 via community midwife with increased weight loss and raised sodium however good milk supply and no supplements required.

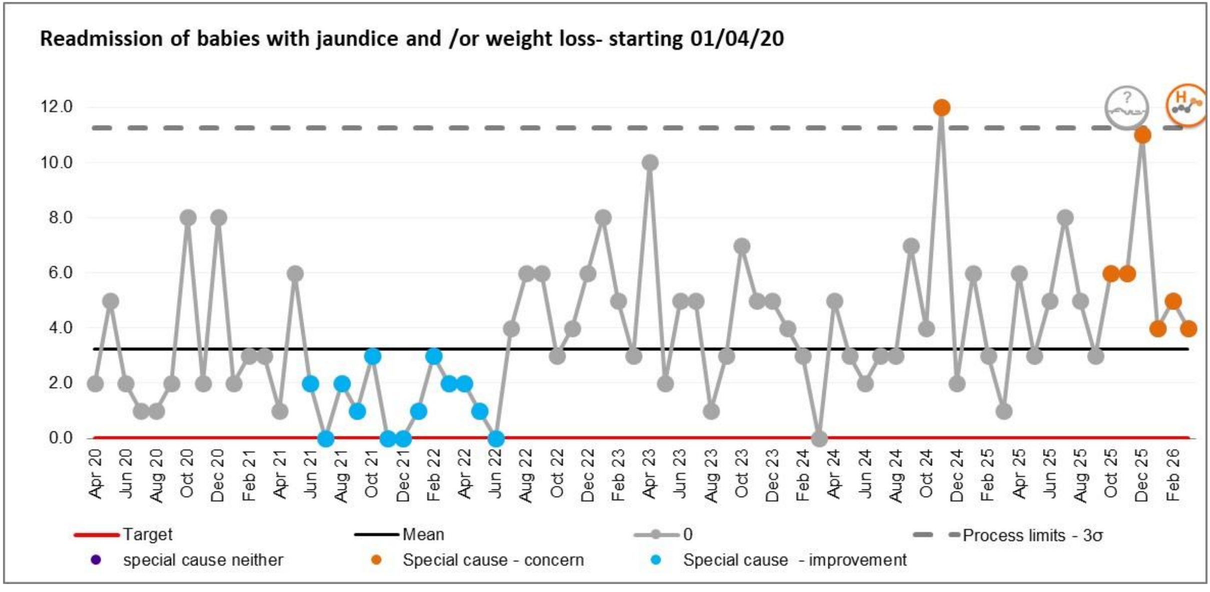
8) Chart 1 Statistical process control chart (SPC) for readmissions with feeding issues /weight loss



9) Chart 2 SPC chart for readmissions with jaundice



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



11) Findings Summary

During Quarter 4, seven babies were readmitted due to jaundice and six due to feeding issues. The trend above the mean for the total number of readmissions persisted this quarter and work continues to ensure preventable measures are identified and best practice implemented (see action plan 1.8). All cases continue to be reviewed on an individual basis.

12) Recommendations

Action plan

Recommendations from datix review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date	Comments
Review readmissions to paediatrics in more depth	Babies readmitted to paediatrics for causes other than jaundice or weight loss will be reviewed in more depth in future reports ,with the aim of identifying any potentially preventable factors.	Infant Feeding Co-ordinator	**June 2026**	
Review current practice to ensure all preventable measures to reduce readmissions of babies with jaundice have been identified and implemented	Review a cohort of babies previously admitted, and all new admissions over the next two quarters • Agree the data set to be collected, including a more comprehensive review of maternal history, and adapt the current proforma accordingly • Utilise previously collected data, alongside data from ongoing readmissions, to inform the analysis • Submit a report of findings to MRMG for review and discussion	Infant Feeding Co-ordinator Lead Midwife for Safety, Quality & Clinical Governance	**Dec 2026**	Jan 2026 Proforma adapted – Data set to be agreed at neonatal obstetric meeting

NHS
Harrogate and District
NHS Foundation Trust

Ensure NICE guidance and local policies on newborn jaundice are followed	Refresher for midwives, neonatal nurses and paediatricians • NICE guidance on when to commence phototherapy including risks • Not relying on visual assessment to assess level of jaundice • Daily weight when being treated with phototherapy	Infant Feeding Co-ordinator	**Completed**	Care of babies with Jaundice included in yearly updates for midwives. Individual feedback given to paediatricians regarding commencing phototherapy below treatment thresholds.
Ensure weight loss guidance is followed	• Write a newsletter for staff to support weight loss guidance • Write supporting guidance for babies with further weight loss following day 3 • Ensure out of area Trusts have HDFT guidance • Discuss admissions that may not be required and length of stays at neonatal obstetric meeting • Individual feedback to be continued	Infant Feeding Co-ordinator	**June 2026**	
Ensure accurate weighing and recording of babies' weights in hospital and community	Ensure staff: • Check weight with another person, except where not possible in exceptional circumstances • Take a photograph for evidence. • Enter the weight on Badger Net immediately. • Take care not to transpose digits. • Make sure equipment is set to zero prior to placing baby on the surface. • Baby to be weighed naked.	Lead Midwife for Safety, Quality & Clinical Governance	**Completed**	'Learning from incidents' newsletter sent to all staff
Avoid overnight stays for babies with weight loss that have normal blood test results	• Explore cost of purchasing a hospital grade double breast pump to loan to parents overnight to help with feeding plan. • Remind staff to give parents an individual plan of care, which where appropriate, includes a plan to re weigh baby on	Infant Feeding Co-ordinator	**Completed**	October 2024: Bereavement support group contacted but no available funding at present. Jan 2025: Application submitted to HDFT Charities

	the postnatal ward in 24 hours.			July 2025: No further response from Charities. Other funding to be considered. Oct 2025: Consideration to be given to using small loan pumps on a trial basis, to be discussed at neonatal obstetric meeting. March 2026: HDFT Charities have supported the purchase of a new breast pump.
Ensure feeding plans are consistent for babies readmitted with weight loss.	• Arrange meeting with the Paediatric clinical lead for postnatal and the infant feeding co-ordinator to discuss more formal feeding plans for larger weight loss in babies. Include when to supplement and when to repeat weight and bloods. • Update guideline to reflect outcomes of decisions made at meeting. • Communicate updated guideline to staff. • Ensure training includes updated guidance.	Neonatal Clinical Lead Infant Feeding Co-ordinator	**Completed**	October 2024: Draft SOP completed. Requires discussion with paediatric clinical lead and then agreement at Paediatric governance. Jan 2025: Meeting arranged with paediatric consultant. March 2025: 1. Draft plans agreed 2. Readmission guideline updated 3. Feeding plans added to Mat 3 update for 2026/7. Will be added to next infant feeding newsletter for staff 4. Readmissions and feeding plans included in full infant feeding training
Ensure moderately preterm babies on the postnatal ward receive the same level of care as babies on SCBU	• Work with neonatal nurses to develop a plan of care for moderate/late preterm babies on the postnatal ward. Include feeding, thermoregulation, increased risk of jaundice and neurodevelopmental care. • Train all midwives in care of late preterm babies • Develop an information package for parents. • Ensure any changes to care are included in appropriate guidelines	Infant Feeding Co-ordinator Neonatal Educator and Governance Lead	**Completed**	March2025: 1. Plan of care developed and agreed 2. Care of late preterm babies is the theme for Mat 3 infant feeding update 2025/6. 3.Parent package in draft, nearly complete 4.Guidleines to be reviewed July 2025: 3) Parent package completed, to be agreed at MQAM. 4) Guideline updated
Share learning with the community team to improve care and consistency	• Arrange dates to meet with community midwives • Share good practice and discuss individual cases where care could possibly be improved • Develop plans of care for static weight / weight loss following introduction of a feeding plan	Infant Feeding Co-ordinator Community Team Leader	**Completed**	

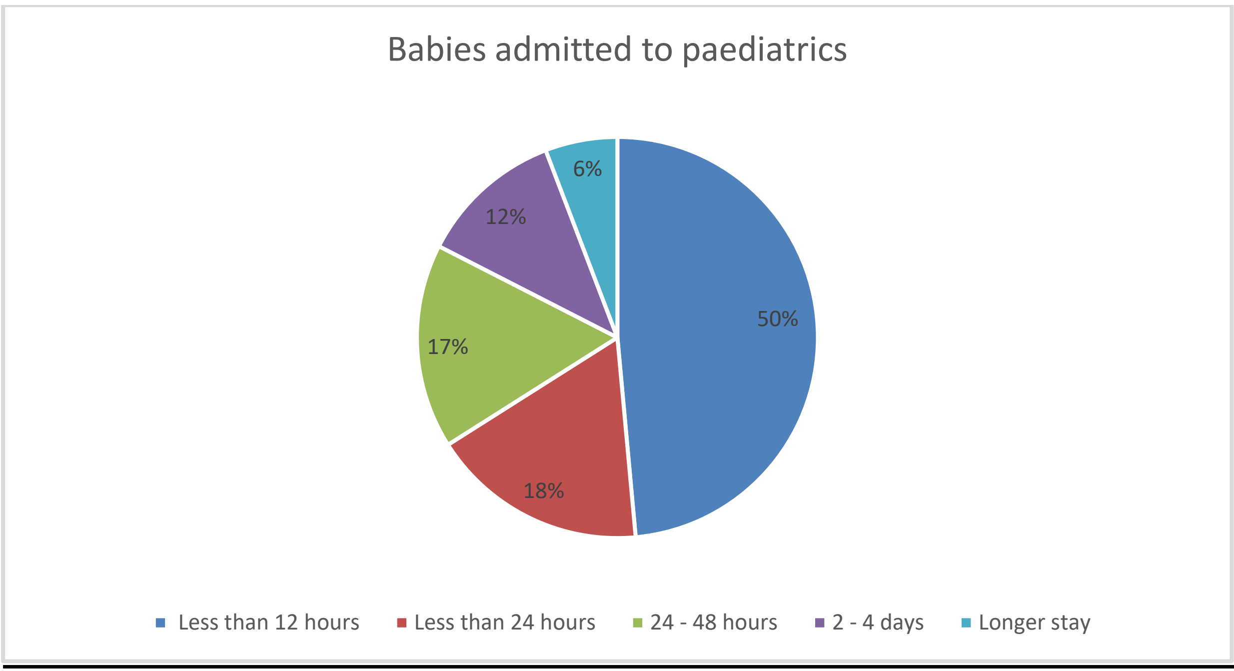
13) Readmissions to paediatrics

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

14) Paediatric readmission data

A total of 60 babies, with an age range between 2 and 25 days, were admitted for a variety of reasons during this quarter. 30 babies were discharged within 12 hours following arrival. Work is ongoing to ensure babies that are reviewed and discharged within 12 hours are not recorded as admissions.

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



16) Conclusion

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

We continue to assess individual cases and learn from each event to prevent recurrence. We also aim to find modifiable predictors and develop interventions to reduce risk in certain categories. Presently the highest reason for readmission to maternity is jaundice with prematurity being a significant risk factor. All actions will be implemented (see action plan 1.8) and evaluated. Progress will be monitored via Maternity Quality Assurance Meeting.

Appendix E

ATAIN and Transitional Care provision report

Quarter 4 (1st January 2026 - 31st March 2026)

1. Report Overview

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

2. The National Ambition

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

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

3. Why is it important?

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

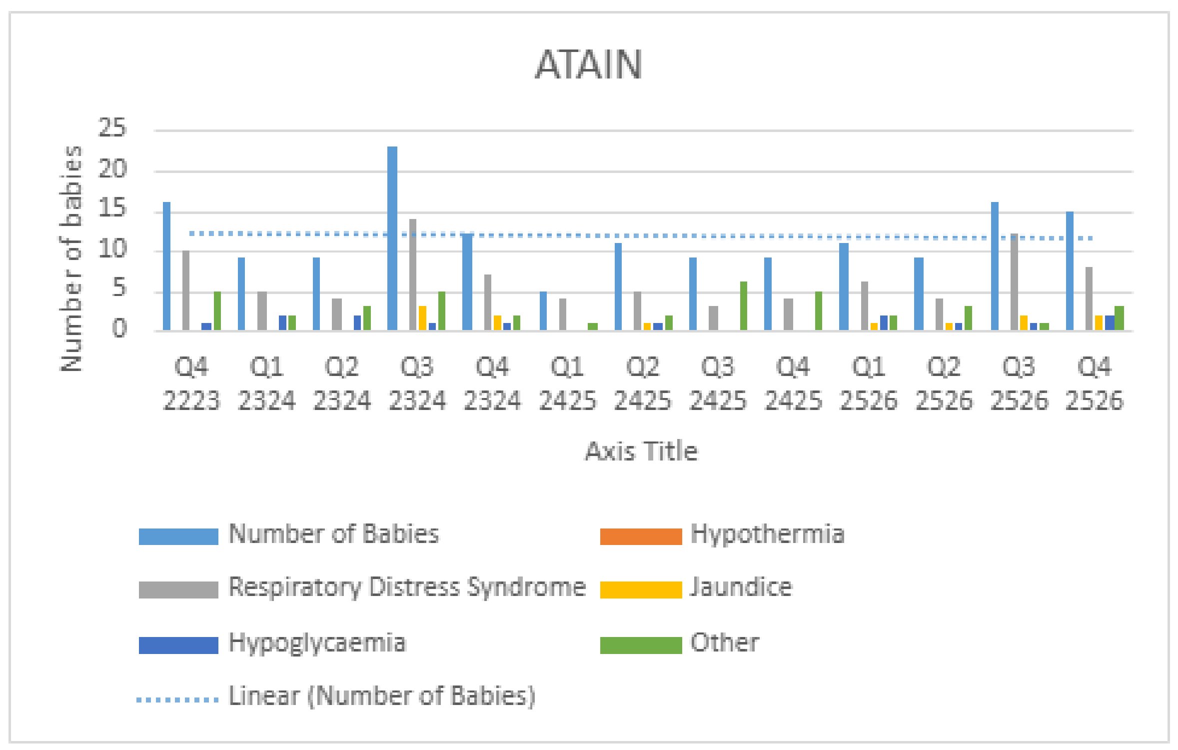
The maternity and neonatal teams review the babies born at or over 37 weeks (term) who were admitted to Special Care Baby Unit (SCBU) at designated monthly ATAIN meetings and the joint maternity and neonatal meeting. The monthly term admission rate for HDFT is reviewed and tracked on the dashboard and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

4. ATAIN data: Quarter 4 2025/2026

During Quarter four there were a total of 427 registerable babies of all gestations born at HDFT. 392 of these were born at term and therefore admissible for ATAIN audit. Of the 392, 15 babies were admitted to SCBU giving a rate of 3.8%. Reasons for admissions to SCBU for this quarter are displayed in the table below:

Reason for admission to SCBU	Respiratory distress syndrome (RDS)	Hypoglycaemia	Jaundice	Should have gone to TCU	Other	Total
Number of babies	8	2	2	1	2	15

5. **ATAIN data trend**



6. **ATAIN action plan**

- ATAIN teaching sessions being delivered monthly by Neonatal Education and Governance Lead and Pannal Team Leaders on MAT 3 study days which commenced in January 2026. Case reviews are included for discussion and enables disseminating learning from cases effectively.
- Neonatal Herpes guideline identified as a requirement following identification of a case whereby only a partial herpes screen was completed – work commenced towards this by Paediatric Consultant and Neonatal Education and Governance Lead.
- Neonatal Polycythaemia guideline identified as a requirement - work commenced towards this by Paediatric Consultant and Neonatal Education and Governance Lead.

7. **Transitional Care Provision and Standards**

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

One of the key advantages of TC is offering early intervention makes it less likely the neonate's condition will deteriorate. Therefore, reducing the risk of maternal and neonatal separation, increases the chance that neonates remain well. This also ensures that care is cost effective. It is important that the staff working on SCBU and the postnatal ward understand the difference between 'normal' postnatal care and TC. It is also vital that maternity and neonatal staff can

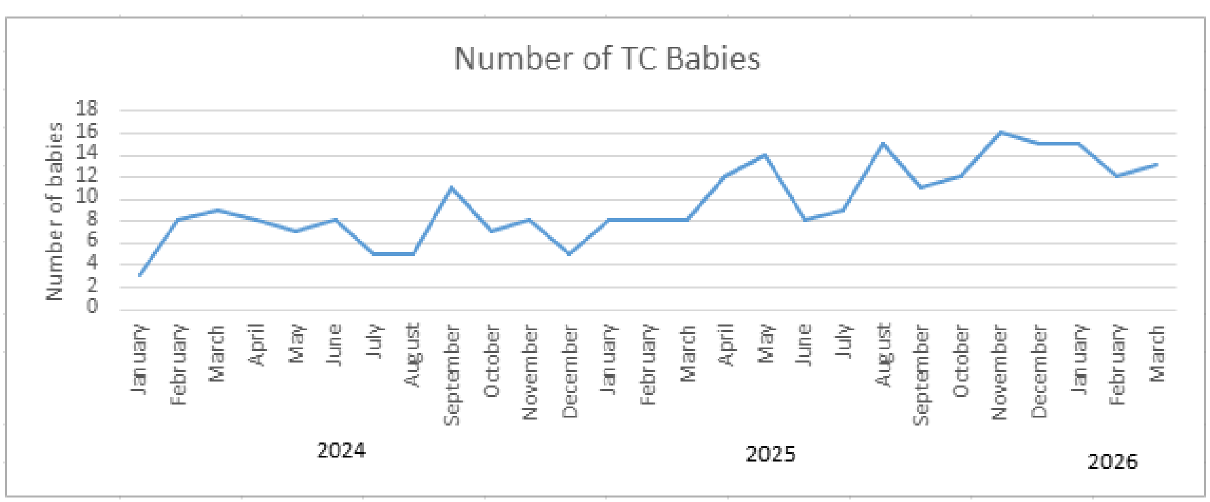
evaluate and respond to the maternal and neonatal needs whilst being able to detect signs of deterioration as early as possible, therefore multidisciplinary collaboration is essential.

At HDFT, a review of TC babies occurs daily during dedicated ward rounds, where assessment takes place and plans of care are made. This review takes place using the 'Transitional care' tab on Badgernet, enabling completion of the 'Daily summary' on each ward round. There is an escalation policy for any babies who are unwell, which is well known by the team and followed should the need arise. We are continuing, within our MDT, to ensure these occur at a set time every day and increase representation from both services.

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

Month	January	February	March	Total TCU
Number of babies	15	12	13	40

9. Transitional Care provision January 2024 – March 2026



10. Quarter 4 Transitional Care Data

During this quarter we have had 40 babies on TCU on Pannal, rationale for TCU as below:

Reason for TCU	IV Antibiotics	Jaundice	Babies stepped down from SCBU	Gestation 35-35+6	Total
Number of babies	21	10	6	3	40

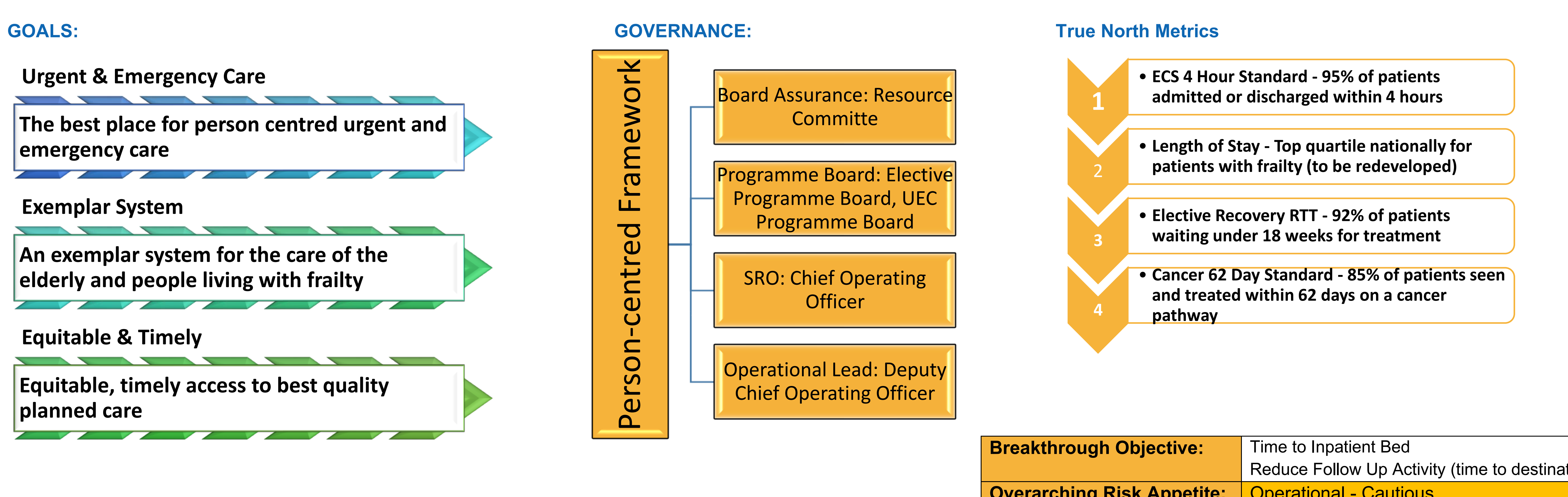
11. TCU action log

Transitional care reconfigured on postnatal ward 1st August 2025 with all babies and parents receiving a door label, cot card and bedside booklet with reason for Transitional care included. Some inconsistences were identified in families receiving bedside booklets, door labels and cot cards – so these elements are now being provided by SCBU, on the initial TCU ward round to improve consistency.

- Feedback is ongoing from service users in collaboration with MNVP following the reconfiguration of TC on Pannal ward – QR code and paper surveys in circulation. Further support sought from the MNVP in obtaining feedback, following only 1 paper survey returned and follow up telephone calls now commenced with TCU families, with the aim to increase feedback obtained and identify further areas for improvement.
- Micro-dot heel lancets trial completed for newborn blood spot sampling and significant reduction in insufficient/haemolysed samples observed – further supply ordered and to be changed indefinitely for future regular stock top-ups.
- RAG rating tool for determining SBR samples for consideration of being run on SCBU blood gas analyser now paused in view of significant improvement in samples and reduction in repeat samples required.
- SOP approved for 'Transitional care on Central Labour Ward Suite, for babies born 34-34+6 weeks gestation.' Pilot commenced in February 2026.
- Quotes obtained from capital planning for widening of SCBU doors, to facilitate transfer of postnatal beds to SCBU, for further minimising separation of birthing parents and neonates – works expected to commence in next financial year.
- Communications ongoing with the resuscitation department ahead of the estates work planning for transfer of postnatal beds to SCBU – in terms of assessing maternal/adult emergency equipment that would be required in order to safely proceed with relocation of women/birthing people to SCBU but under the care of Pannal midwifery team.

STRATEGIC AMBITION: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS 2026-27

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



Breakthrough Objective:	Time to Inpatient Bed Reduce Follow Up Activity (time to destination)
Overarching Risk Appetite:	Operational - Cautious

Overarching Risk Summary:

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Person Centred, Integrated Care, Strong Partnerships	**The best place for person centred urgent and emergency care**	**ECS 4-hour Standard**	**Operational: Cautious**								
	An exemplar system for the care of the elderly	**Length of Stay - Patients with Frailty (being redeveloped)**	**Operational: Cautious**								
	Equitable, timely Access to Best Quality Planned Care	**Elective Recovery RTT – 18 Weeks**	**Operational: Optimistic**								

		Cancer 62 Day Standard – 62 Days Treatment	Operational: Optimistic					

Strategic Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care	ECS 4 Hour Standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated and discharged with 4 hours. 95% of admitted patients to be moved to required department within 60 minutes of medical decision.	By March 2026, we want to be at 78% of patients having their care completed within 4 hours. By March 2027, we want to be at 85% of patients having their care completed within 4 hours. By March 2028, we want to be at 95% of patients having their care completed within 4 hours.	Emergency 4 Hour Standard Last Full Month Whole Trust 79.10% Last Full Month Type 1 Only 73.19% Delivered 79.1% in April , lower than April 2025. Target of 80% each month and delivery of 85% by March 2027. Countermeasures are noted. Breakthrough Objective: Time to Inpatient Bed (see below) Associated/Linked Watch Metrics: (all below threshold unless indicated) • 12-hour breach numbers • ED 'Harms' • Sepsis screening in ED • Ambulance Handovers • ED Attendances vs Plan	ED pathways work. COS now live with monthly review of feedback on issues delivering COS standards Review of EEMAC impact New Group Clinical Lead for ED commenced Nervecentre implemented which will improve data quality and operational flow See further countermeasures in BO.		
An exemplar system for the care of the elderly and people living with frailty.	Length of Stay with Frailty	Top quartile Length of Stay nationally for patients with Frailty by March 2027.	By March 2026, we will achieve top half Length of Stay for Frailty nationally. By March 2027, we will achieve top quartile Length of Stay for Frailty nationally.	HDFT vs National Upper Quartile LOS – **last full month validated: 11.24 (Goal 11.33)** HDFT Emergency Elderly LOS Average (6 month rolling) vs national benchmarked quartiles Length of Stay with Frailty HDFT vs National Upper quartile LOS - last full month 11.24 Better than Upper quartile LOS for last 3 months.	Development of Data for stratification with advent of new EPR. Frailty Team Driver Metric now: meeting discharge targets. Acute Medicine Matron now covering AFU with a focus on discharge. Proposed restructure to support closer working with Frailty/Community. Recruitment to consultant (0.8wte) - incl. covering Fridays. Pathway review from UCR -> Hospital@Home now complete and new service launched 11th May		

					See Corporate Project updates: Bed Capacity and Patient Discharge. Full review of A3 for this project underway with wider frailty team.		
Equitable & Timely	Elective Recovery (RTT) Standard	Sustained achievement of the 92% of patients being treated within 18 weeks.	By March 2026, we will achieve 18-week performance at 70.49% (as per national mandate). By March 2027, we will achieve 18-week performance at 92%.	Current 18-week performance data: Trust RTT metrics - RTT waiting list and trajectories from LUNA - Power BI Validation focus on under 18 weeks has led to increase in overall PTL. 18 weeks remains well above last year end target. End of April **75.25**%. A slight deterioration from the previous month Watch metrics – theatre utilisation below target at 78%.	HDH Additional Theatres (TIF2) build on track for 2026 delivery. Outpatient Transformation, rollout of further faster programme and track key metrics: • New: Follow Up ratios • Absolute reduction in follow ups • DNA rates • Clinic cancellation rates • Patient Initiated Follow Up Rate TPAM meetings. Occurring fortnightly to review RTT performance. Ops colleagues signed up to NHSE led Impact training for RTT performance. Dedicated HVLC lists in Ophthalmology from June Gynae and Ophthalmology have dedicated lists in WDH from June Elective SPOA group developed. Patient not Present process in deployment across the Trust		
	62 Day Cancer standard	85% of our patients will commence treatment within 62 days of referral.	By March 2026, 85% of patients will have commenced definitive treatment within 62 days of referral for suspected cancer. By March 2027, 85% of patients will have commenced definitive treatment within 62 days of referral for suspected cancer.	Cancer Performance Report - Power BI	Developing workforce capability and expertise to better guide analyst time in creation of stratified data dashboard for cancer waiting times. Ensure capacity to deliver first appointments within 19 days. Accelerator funding increased CT capacity in Q1 Development of 6-4-2 in endoscopy to improve list utilisation and use of bowel cancer screening capacity. Stratify impact of complex imaging waits on cancer performance - data now available (August 2024):		

				85% for March, current position 78.11% April (unvalidated). Colorectal largest contributor to breaches of 62 days.	Imaging - Power BI. RCAs to be completed on all 104-day cancer breaches to understand themes and opportunities. See Corporate Project updates: Bed Capacity and Patient Discharge. Outpatient transformation, Theatre productivity board alongside PSCC PRM's will set and edit countermeasures: • Calling patients 48-hours pre-theatre to reduce on the day cancellations. • New theatre scheduling process gone live 1st Sept. • Theatre management team reaching out to individuals where performance <80%. Cancer Fast Track team transferred to PSC Appointment centre to increase resilience.		

Trustwide Project:

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

Strategic Programme:

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

Breakthrough Objective: Time to Destination

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Time to move to medical bed from decision to admit in Emergency Department	ECS 4 Hour Standard	95% of admitted patients to be moved to required department within	By March 2026, 60% of patients will move to an inpatient bed within 60mins of the decision to admit.		Continuous flow embedded. Clinical Services strategy – now supported by GIRFT COS.		

Workstreams	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
		60 minutes of medical decision.	By March 2027, 75% of patients will move to an inpatient bed within 60mins of the decision to admit.	Median time from DTA to arrival at next destination (Ward/SDEC/SAU) at 133mins in April against target of under 120mins. Improvement on March (151mins) Current data for the new measure below: **ED performance breaches and LOS - Power BI**	Escalated as corporate risk - new ED Clinical lead for interface with imaging, sharing of data RE imaging delays. Ward discharge targets established for base wards and Driver Metric within Care Groups to improve delivery. Deployment of Nervecentre will improve data quality and consistency of clinically ready to proceed		
Reduce Follow Up Activity	Elective Recovery (RTT) standard	Patients will avoid unnecessary follow up appointments using technology and patient initiated follow up enabling an increased in new patient capacity and reduced waiting times.	By March 2026, reduce the number of follow up appointments by 10% from outturn 2024/5. By March 2027, further reduce the number of follow ups to a 15% reduction from outturn 2024/5.	Follow ups remain high – due to delays in coding this is likely to reduce as more procedures are coded – current data is not yet reliable.	Outpatient transformation project countermeasures: • Increased Patient Initiated Follow Up (PIFU) (also monitored through TPAM). • Develop performance data pack on outpatients for individual clinicians including benchmarking. • Use performance data of teams (Model Hospital) and individuals to challenge. • Influence change in practice through effective clinical leadership/ coaching. • Introduce demand led, data driven job planning to optimise clinic configuration and reduce unnecessary follow ups. • Fortnightly TPAM with focus on FU activity.		

Related Corporate Risks:

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR61/ID3	ECS 4 Hour Standard	Risk of increased morbidity/ mortality for patients due to a failure to meet the 4-hour standard. See the A3 & Breakthrough Objectives pertaining to this.	4 x 3 = 12	4 x 2 = 8 March 27	Clinical: Patient Safety	Minimal
CRR87/ID6	Community Dental	Risk to patient safety due to correlation of long waiting times and increased risk of pain and infection, which may affect quality of life and treatment required. Secondary risk to Trust performance standards by failing to meet NHS annual planning target of no RTT waiters beyond 78weeks currently, 65 weeks by end March 2024 and 52wks by end March 2025.	3 x 4 = 12	3 x 2 = 6 March 26	Clinical: Patient Safety	Minimal

ID642	Cardiology: Risk to providing DGH urgent and emergency care services due to lack of 24/7 cover	Risk to HDFT being able to deliver acute DGH services due to the fragility of the cardiology service. Current Position/Issues: • Inadequate staffing 12.5 PAs down at consultant level currently filled with locum cover, • Lack of continuity of Registrar/middle grade ward cover, • Reliance on locum consultant and associated team and quality risks • Risk of burnout of current medical and ACP team due to workload pressures. • Other consequences to these factors include outpatient RTT, Angio and echo waiting time breeches. Cardiology Strategy Planning meeting scheduled for November 24. Current position managed through HDFT IMPACT and regular updates provided to LTUC Tri-Team for escalation to the executive team.	3 x 4 = 12	3 x 1 = 3 Dec 26	Operational: Business Continuity	Cautious

Related External Risks:

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

STRATEGIC AMBITION: OVERARCHING FINANCE 2025-2026

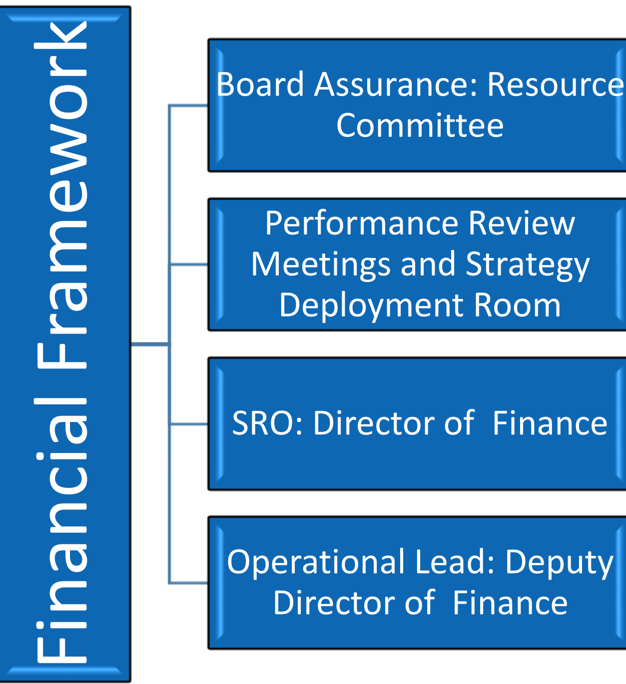
Our ambition is to provide the best quality, safest care whilst being a financially sustainable organisation.

GOALS:

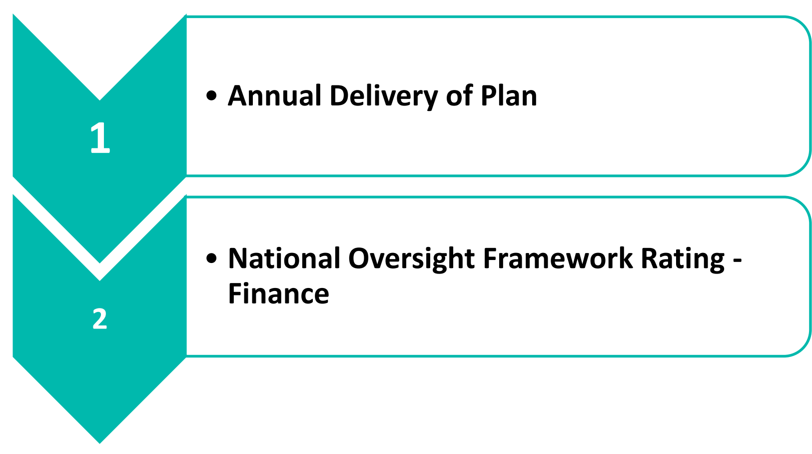
Financial Sustainability

HDFT To be a financial sustainably organisation

GOVERNANCE:



True North Metrics (Executive Lead: 10-15 Year deliverable)
Finance and Delivery Oversight Group (FDOG)



Trustwide Project:	
Strategic Programme:	Productivity & Sustainability
Breakthrough Objective:	% Budgets in Balance
Overarching Risk Appetite:	Financial - Cautious

Overarching Risk Summary:

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

True North Metrics Summary:

True North Metric	Vision	Goal	Current State	Countermeasure	Owner	Date	Status	Level of Risk to Achieving Goal	Level of Risk for progressing actions
Financial Sustainability	HDFT to be a financially sustainable organisation	In 2026/27 the Trust, and therefore directorates, aim to live within the financial resources available to us.	Currently HDFT does not have an agreed plan with NHS England. 26/27 Plan, Actuals and Forecast (26/27 Cumulative Plan; 25/26 Actual YTD; 26/27 Actual YTD; Straight Line Forecast (no WRAP); Forecast incl WRAP delivery (Likley); Forecast incl WRAP delivery; Overall Risk no mitigations) The month one position for HDFT is a deficit of £4.9m, £3.4m adverse to plan. The key drivers are the adverse Waste Reduction and Productivity (WRAP) position of £1.8m, £1.1m of quarter 4 activity delivery costs, £0.3m of strike action and a small income variance. The proposed plan includes a number of challenges. The WRAP target is split into three areas - Core Delivery of initial planning requirement - £20m Delivery of activity plan in line with previous years outturn - £8m Further ask to improve and reduce deficit on journey to returning to break even - £4m Planning against this £32m target is outlined in the graphic below.	The Trust is aiming to agree a plan with NHS England by the end of May.	Director of Finance	Original - March 2026 Updated – May 2026	In Progress	4 x 4 = 16	3 x 3 = 9
				Directorate led programme of work in relation to core WRAP requirement	Directorate Snr Tri/Quad	March 2027	In Progress		
				Delivery of 2026/27 Activity Plan	Chief Operating Officer	March 2027	In Progress		
				KPMG Review Stage 1 output	Director of Finance	May 2026	In Progress		
				Trustwide actions to be developed	Executive Team	May 2026	In Progress		
				EQIA process to have more regular cadence given challenges which may emerge	Medical Director, Director of Nursing, Midwifery and AHPs, Director of Governance and Improvement	May 2026	Planned		
				Explore Workforce Controls	Chief People Officer	TBC	Under Development		
				Strengthen Non Pay Expenditure Step up procurement review group to oversee current controls. Remove all exemptions to process Stronger approach to no PO no Pay requirements	Director of Finance	May 2026	Under Development		
				Establish strategic programme	Deputy Chief Executive/Medical Director	May 2026	Under Development		

True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal	Level of Risk for progressing actions
			WRAP Progress 3,000,000 / 2,500,000 / 2,000,000 / 1,500,000 / 1,000,000 / 500,000 / 0 Apr-26 May-26 Jun-26 Jul-26 Aug-26 Sep-26 Oct-26 Nov-26 Dec-26 Jan-27 Feb-27 Mar-27 High Low Medium Actioned Plan In addition the Trust is working with KPMG, alongside York and Scarborough Teaching Hospitals NHS Foundation Trust on further opportunities to improve the position. Given plans are not in place for the full target and the year is already progressing, a number of additional actions are under review. The scale of these actions currently equates to £700k per month, however, the list is developing further and will be subject to EQIA. There is a need to establish a more sustainable programme of work in future years which is transformational, engages colleagues and harnesses innovation from all areas of the organisation. Current approach focuses on cost control due to the void in this space. As well as the large scale change, there is a need to ensure resources are being well utilised at cost centre level. The current position is uneven across the Trust as evidenced by material numbers of cost centre overspends and variable access of reach reporting.	Establish Breakthrough Objective | Director of Finance | May 2026 | Complete		
		The Trust will move out of segment 3	Currently the National Oversight Framework has an override based on financial plans or performance being breakeven or worse. The Trust has established there is the ability to breakeven in 2027/28, however this would be dependent on the outputs of a community services review in conjunction with Humber and North Yorkshire ICB, the delivery of the Waste Reduction and Productivity Programme recurrently, and appropriate financial risk sharing mechanisms in place.	**Countermeasure** | **Owner** | **Date** | **Status** Agreement with ICB to establish community services review scheduled for mid 2026/27. | Chief Executive | May 2026 | Agreement in principle – plans to be developed.		

<table>
<tr><th>True North Metric</th><th>Vision</th><th>Goal</th><th>Current State</th><th colspan="4">Countermeasures</th><th>Level of Risk to Achieving Goal</th><th>Level of Risk for progressing actions</th></tr>
<tr><td rowspan="4"></td><td rowspan="4"></td><td rowspan="4"></td><td rowspan="4">Within the oversight framework there are three finance measures which are outlined below
<table><tr><td>Metric</td><td>Q3 2025/26 Position</td><td>Q3 2025/26 scoring</td></tr><tr><td>Planned Surplus/Deficit</td><td>-1.39%</td><td>3</td></tr><tr><td>Year to date variance to plan</td><td>-£11.6m</td><td>4</td></tr><tr><td>Implied Productivity v previous year</td><td>-3.3%</td><td>4</td></tr></table>
The data which supports the community element of the productivity metric is being challenging to reconcile.

The productivity metric also appears to be influenced by coding position of activity which is currently behind plan. This will also influence income position.</td><td>Agreement of contract in line with national payment scheme to ensure risk is appropriately shared.</td><td>Director of Finance</td><td>March 2026</td><td>Complete</td><td rowspan="4"></td><td rowspan="4"></td></tr>
<tr><td>Work with local commissioners to establish updated local pricing following change since covid.</td><td>Director of Finance</td><td>September 2026</td><td>In progress</td></tr>
<tr><td>Work with NHS England Informatics team to better understand and inform approach to costing of 0-19 services as part of implied productivity metric</td><td>Director of Finance</td><td>June 2026</td><td>In Progress</td></tr>
<tr><td>Address coding backlog through recovery plan</td><td>???</td><td>???</td><td>Being implemented</td></tr>
</table>

Trustwide Project: Productivity & Sustainability

<table>
<tr><th>Workstream</th><th>True North Metric</th><th>Vision</th><th>Goal</th><th>Current State</th><th>Countermeasures</th><th>Level of Risk to Achieving in Year Goal</th><th>Level of Risk for progressing actions</th></tr>
<tr><td colspan="6">Agreed move to strategic programme with tactical year one response</td><td></td><td></td></tr>
</table>

Strategic Project: Productivity & Sustainability

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal	Level of Risk for progressing actions
Productivity and Sustainability	Financial Sustainability	Short Term Deliver a 12 month WRAP / financial recovery project that stabilises the Trust's finances and cash position while protecting safe, high-quality care—by coordinating and assuring directorate-led schemes (existing and new), tightening key controls, improving contract and income recovery, and delivering practical productivity improvements that makes savings recurrent where possible. Long Term Build a Trust-wide 3–5-year Programme that leverages IMPACT methodology to free up time and capacity for care and strengthen financial sustainability through digital/AI, safe workforce change, service redesign / decommissioning and income growth.	**Short Term** Month 2: One Trust-wide WRAP delivery plan agreed. Month 3: Every directorate has a clear plan to deliver its schemes and has identified further opportunities to close the gap (with the main risks and gaps clearly shown). Delivery underway. Month 4: Core controls in place so overspends are visible and acted on quickly (workforce controls, approval gates, and benefit tracking). Month 11: High-impact directorate-led and Trust-wide schemes delivered Month 11: Pipeline for the following year identified **Long Term** Month 6: A small number of Trust-wide "big moves" agreed, with named leads and clear measures. Year 1: Clear, up to date strategies defined for digital/workforce/estates/finance and a joined-up roadmap established. Year 1 - Deliver a tactical WRAP/Financial Recovery Project under this Strategic Programme Year 2: Digital/automation wave 1 delivered, with evidence it reduces manual work and frees up capacity. Year 2: First tranche of 'service redesign/stop-doing' delivered safely (quality, safety and equality checked). Years 3–5: Safe workforce change and income growth delivered and scaled; expanding what works.	In terms of short term, £32m target to deliver 26/27 and longer term ambition to return back to breakeven position. M1 - £807k actioned, 4% recurrent. £12.5m unidentified £1m High Risk £7.6m Medium Risk	Following Exec review a further countermeasure is the consideration on how the longer-term requirement will be resourced.	4 x 3 = 12	3 x 3 = 9

Breakthrough Objective: % Budgets in Balance

<table>
<tr><th>Workstream</th><th>True North Metric</th><th>Vision</th><th>Goal</th><th>Current State</th><th>Countermeasures</th><th>Level of Risk to Achieving Goal</th><th>Level of Risk for progressing actions</th></tr>
<tr>
<td>% Budgets in Balance</td>
<td>Annual Breakeven</td>
<td>For HDFT to deliver the financial annual plan as agreed with NHSE and return to a breakeven position by the end of 27/28. Monitoring through monthly financial reporting in year, recovery plans identified to ensure finances remain on track.</td>
<td>Every budget holder managing budgets to plan, which in turn will support the delivery of the annual plan, a reduced need for cash support and an improved reputational position in relation to managing taxpayer resources.</td>
<td>
In 2025/26 313 cost centres were overspent across the organisation out of 783 cost centres. Month 1 over £50k is summarised in the table below –
The first one incorporates the planned deficit and central WRAP targets.
<table>
<tr><th>Row Labels</th><th>Sum of YTD Variance</th></tr>
<tr><td>Trust Held Income & Reserves</td><td>-2,294,772</td></tr>
<tr><td>Management Team - Long Term And Unscheduled Care</td><td>-474,474</td></tr>
<tr><td>South Tyneside Management Team</td><td>-260,433</td></tr>
<tr><td>Gen Surgery - Medical Staffing</td><td>-189,700</td></tr>
<tr><td>Pathology JV Charges - Staffing Recharges (IPS)</td><td>-175,443</td></tr>
<tr><td>Final Accounts Adjustments</td><td>-129,359</td></tr>
<tr><td>Critical Care & Theatres - WRAP</td><td>-119,750</td></tr>
<tr><td>Acute Medicine - Medical Staffing</td><td>-112,571</td></tr>
<tr><td>Cumberland 0-19 Whitehaven</td><td>-109,475</td></tr>
<tr><td>Pathology JV Charges - Direct Access</td><td>-108,683</td></tr>
<tr><td>Non Contract Ccg Income - Acute</td><td>-108,500</td></tr>
<tr><td>Cumberland 0-19 Carlisle</td><td>-108,355</td></tr>
<tr><td>Doctors in Training - Medical Staffing LTUC</td><td>-99,383</td></tr>
<tr><td>WLI Claims - Nurse Endoscopists</td><td>-94,661</td></tr>
<tr><td>Capital Charges Misc Capital Charges-Hdh Site</td><td>-93,153</td></tr>
<tr><td>Emergency Medicine - Medical Staffing</td><td>-81,798</td></tr>
<tr><td>Elderly Medicine - Medical Staffing</td><td>-80,071</td></tr>
<tr><td>Middlesbrough Central</td><td>-77,585</td></tr>
<tr><td>Head & Neck - WRAP</td><td>-75,842</td></tr>
<tr><td>Westmorland and Furness Dalton</td><td>-68,543</td></tr>
<tr><td>Radiology Department</td><td>-67,208</td></tr>
<tr><td>Northumberland Mgmt team</td><td>-64,283</td></tr>
<tr><td>Nhse Specialised Services - 13v - Acute</td><td>-61,901</td></tr>
<tr><td>Occupational Health</td><td>-60,919</td></tr>
<tr><td>Medical Directorate - WRAP</td><td>-60,742</td></tr>
<tr><td>Day Surgery Unit - Pay</td><td>-56,727</td></tr>
<tr><td>MSK & Imaging - WRAP</td><td>-55,217</td></tr>
<tr><td>Wakefield Council (CCCW)</td><td>-55,060</td></tr>
<tr><td>Cardio-Respiratory Unit</td><td>-54,946</td></tr>
<tr><td>WLI Claims - Gastroenterology - Medical Staffing</td><td>-50,298</td></tr>
</table>
Key causes for the current position include

Budget holders outlined a lack of clarity around roles and responsibilities in relation to budget management, as well as an understanding of the information.
Reach reporting shows that access to budget report information is mixed for those responsible for overseeing budgets at a local level.
There is a cluster of overspends within Pathology which required a specific review.

</td>
<td>
<table>
<tr><th>Concern</th><th>Cause</th><th>Countermeasure</th></tr>
<tr><td>Financial management</td><td>CC's not in budget</td><td>Monitor No of CC's not in budget balance/agreed escalation process</td></tr>
<tr><td></td><td>Financial understanding</td><td>Refresh of Finance training offer.
Monitor uptake/link with mandatory training.</td></tr>
<tr><td>Pathology</td><td>JV arrangements</td><td>External review, take forward recommendations</td></tr>
</table>
</td>
<td></td>
<td></td>
</tr>
</table>

Related Corporate Risks -

<table>
<tr><th>ID</th><th>Title</th><th>Description</th><th>Current Rating (CxL)</th><th>Target Rating (CxL) & Date</th><th>Risk Type</th><th>Risk Appetite</th></tr>
<tr><td>ID 721</td><td>Group Cash Position</td><td>Cash support will be required throughout the year in line with the deficit plan, added to this there is the gap in cash awarded in 25/26 versus the deficit position (£14.4m awarded v's £23.75m deficit). There was £10m+ outstanding to Suppliers and the BPPC has declined below 60%.
The impact of not meeting the BPPC 95% target will affect future business development opportunities including 0-19 contract.
Cash support requests submitted for April £9.5 awarded £4m, May £4 still awaiting outcome, June £1.8m, July £1.6m and August £1.3m (total for last 3 months £4.7m).
<table>
<tr><th>Mth</th><th>Cash Support request</th><th>Cash Support Approved</th></tr>
<tr><td>April</td><td>£9.5m</td><td>£4m</td></tr>
<tr><td>May</td><td>£4m</td><td>£2m</td></tr>
<tr><td>June to August</td><td>£4.7m</td><td></td></tr>
</table>
Key actions being prioritised
1. Aged Debt
2. WRAP delivery
3. Recovery Actions</td><td>5 x 5 = 25</td><td>4 x 2 = 8
~~March 2026~~
March 2027</td><td>Financial: revenue, funding and liquidity</td><td>Cautious</td></tr>
<tr><td>ID1241</td><td>26/27 Waste Reduction and Productivity</td><td>£30.2m WRAP target in totality.
Central Schemes (EPR, Estate, Bed Base, Outpatients) and Directorate targets.
Added to this £7.4m WRAP income target, this will be delivered if the activity plans submitted is delivered.
Directorates are still working on schemes however there is a significant gap.</td><td>4 x 4 = 16</td><td>3 x 3 = 9
March 2027</td><td>Financial: Financial Management</td><td>Minimal</td></tr>
<tr><td>ID1242</td><td>Financial Plan Delivery 26/27</td><td>The Trust has a planned deficit £15.3M for 26/27. The Trust has faced significant scrutiny for not delivering the 25/26 plan (Breakeven versus £23.75m reported deficit). WRAP delivery and managing costs within allocated budgets is key in delivering the financial plan for 26/27.</td><td>4 x 4 = 16</td><td>3 x 3 = 9
March 2027</td><td>Financial: revenue, funding and liquidity</td><td>Cautious</td></tr>
</table>

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	Local Authority Contract Changes for the Pay Award & NI Contributions	Pay Award and NI contributions for Local Authority organisations £1.6m still to be agreed. (To note £1.6m agreed). NHSE confirmed ICB should continue to provide the funding for NI changes, but this is still being reviewed by the ICB.	3 x 3 = 9	4 x 1 = 4 May 2025	Financial: revenue, funding and liquidity	Cautious

STRATEGIC AMBITION: MAKING HDFT THE BEST PLACE TO WORK 2026-2027

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

GOALS:

Looking after our people

Physical and emotional support to be "At Our Best"

Belonging

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

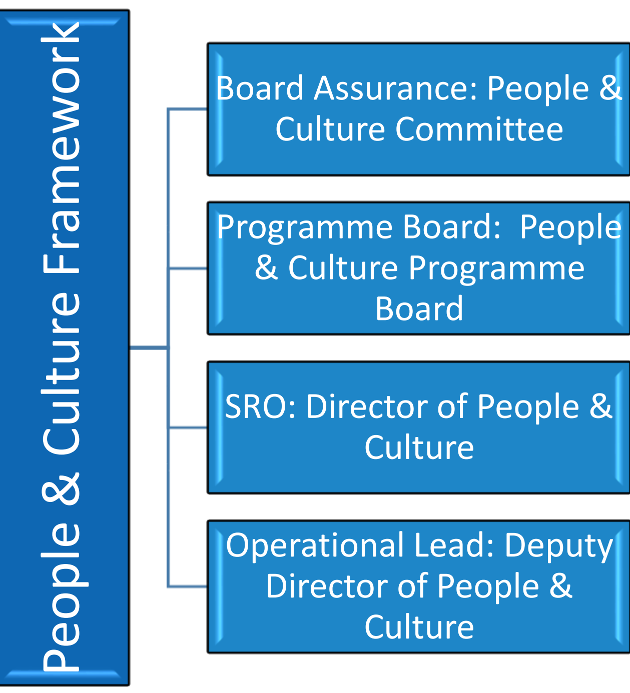
New ways of working

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

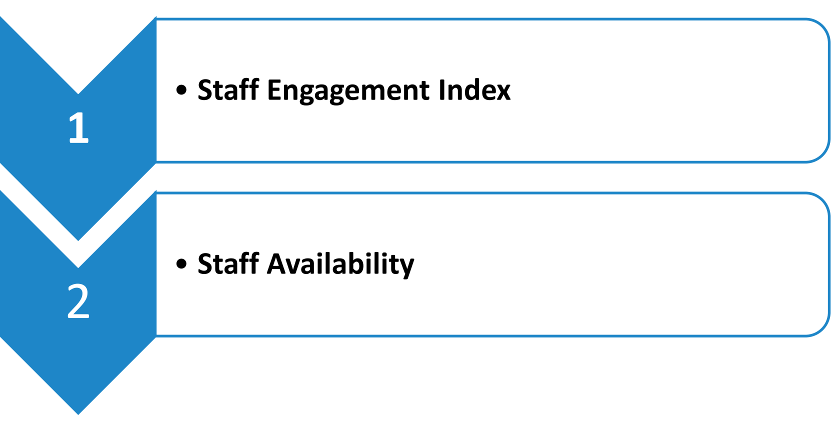
Growing for the future

Education, training and career development for everyone

GOVERNANCE:



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



Trustwide Project:	Medical and Dental Workforce Scheduling and Payment Transformation Project
Strategic Programme	N/A
Breakthrough Objective:	N/A
Overarching Risk Appetite:	Workforce - Cautious

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

Strategic Metrics Summary:

Workstream	True North Metric	Vision (People Plan)	Goal (True North Metric Target)	Countermeasures	Current Status	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
Looking after our people	Staff Engagement Index	We will develop our leaders to deliver appreciative, compassionate, inclusive and improvement focused leadership that is aligned to our KITE behaviours and our IMPACT continuous improvement programme.			National Management & Leadership Framework implementation planning underway. National launch date tbc.		
Looking after our people	Staff Engagement Index	We will have a clearly communicated and positive focus on all aspects of health and wellbeing with the aim that every colleague feels supported. We will ensure that we give thanks and recognise the invaluable contributions from our colleagues through the recognition schemes.			Staff Flu Vaccination programme now closed. Final percentage of staff vaccinated was 68.2% putting us at the highest level within NHS England. Programme close down paper sent to March 2026 Board of Directors. Kite Awards Celebration event took place on Friday 6 March, including colleagues entitled to Long Service Awards		
Looking after our people	Staff Engagement Index	We will create and maintain multiple channels for our colleagues to have a voice, be heard and feel empowered to speak up.	Maintain Inpulse survey response rate. Continuously tracking above our benchmark group engagement score. Validate the Improvement by seeing an improvement in the National Staff Survey Overall Engagement Score in the 2025 survey results. Maintain a continuously improving trend on both NQPS (Inpulse) and the NHS Staff Survey response rates and aspire to be best within our benchmark group. Achieve and maintain the best engagement score within our benchmark group.		The response rate achieved in the February 2026 Inpulse Survey was 25%. The National Staff Survey for 25/26 closed on 28 November and HDFT response rate was 62% which is the highest response rate achieved. All Directorates qualified for funding under the newly introduced incentive scheme and a total of £240K will be distributed to support patient/colleague wellbeing initiatives. The national embargo on results was lifted on 12 March, and the results have been shared and celebrated across the organisation. A Staff Survey Showcase Event was held at the SMT Workshop on 22 April to hear a high-level summary of results from each Directorate. Three organisational priority areas of focus have been identified for FY 2026-27. National Education and Training Survey (NETS 2025): Total response rate 97 learners. Highest scoring acute Trust for overall experience in the region, 5th highest against all 22 regional Trusts – 81.26%.One red flag in Obs&Gynae, pink flag themes in Obs&Gynae and Sexual Safety, action plans in place to improve placement experience.		

Workstream	True North Metric	Vision (People Plan)	Goal (True North Metric Target)	Countermeasures	Current Status	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
Belonging	Staff Engagement Index	We will promote equality and diversity, so everyone feels valued and recognised through the embedding of Equality Impact Assessments as expected practice, the continued development of our Staff Support Networks, leadership development and training of all colleagues. Our work on Equality, Diversity and Inclusion will be nationally aligned to the NHS Equality, Diversity and Inclusion Improvement Plan.	Embedding Equality by focussed work based around the 6 EDI High Impact Actions (HIA). Progress to be made on: HIA1: Chief Executives, Chairs and Board Members should put EDI objectives in place that they are personally responsible for. The goal is: • Each Director to have an EDI objective HIA 2: Employ & Develop Staff in a fair and inclusive way and target groups that are under-represented in the organisation. The goal is: •Improve the reported lived experience of colleagues who are BME or have a disability or long-term condition		Embedding Equality paper presented to August Board Workshop and gained full support. Good progress is being made on this programme of work: EDI Data was included in the October 2025 Clinical Directorate Workforce Information Packs. The Reciprocal Mentoring Programme for colleagues with a disability or long-term condition started in September 2025. 12 pairs of aspiring and established leaders are signed up to the programme, and the initial sessions were hugely impactful. A listening event for colleagues with a disability or long-term condition has been scheduled for spring 2026 to give the opportunity for further learning about the lived experience. Recruitment is underway for our Equality & Diversity Champions - with 7 excellent colleagues signed up to the role.		
Belonging	Staff Engagement Index	We will seek to increase diversity in our leaders and decision makers and have a representative pool of leaders.	Improve WRES metric regarding relative likelihood of appointment from shortlisting and increase diversity within senior leadership roles.		17 Independent Panel Members (IPM) have been recruited – and are actively taking part in recruitment activity – currently across 8 recruitment campaigns, which is a great start. It has been agreed to include Band 7 clinical roles in the initial pilot of this role. IPMs are involved in the current Trust Executive Recruitment processes.		
Growing for the future	Staff Availability	To ensure HDFT is the 'best place to work' there must be the right number of staffing available each day for deployment to ensure quality of care and to enable those staff to have a good experience and do their best.	Sickness levels throughout HDFT to not exceed 4.1% A vacancy rate that does not exceed 6% Staff leaving within their first year of employment to not exceed 15% A Turnover rate that does not exceed 12% (HNY is 12%)		The Trust vacancy rate is 3.30% at the end of April 2026, which is below the Trust target of 7% (this is below the A3 threshold of 6%). • Trust turnover is 9.13% • Sickness is 4.85% • Staff leaving within 1st year is 15.52% (thi s is an increase from 14.90% last month.) Staff unavailability decreased by 167.70wte in April, reducing from 724.05wte in March to 556.36wte		

Workstream	True North Metric	Vision (People Plan)	Goal (True North Metric Target)	Countermeasures	Current Status	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
					The main contributor to this reduction was a decrease in vacancies of 143.08wte. This is predominantly due to the removal of the budgeted establishment for bank staff from the 2026/27 budget (60.52WTE). Sickness also saw a reduction in April, decreasing from 5.33% in March to 4.85%, equating to a 20.79wte reduction in unavailability.		
New Ways of Working	Staff Availability	We will continue with the implementation of e-rostering and the safe care staffing tool, to ensure that safe staffing levels can be allocated and managed with maximum efficiency.	100% of rosters signed off and issued 8 weeks before		Roster sign off at 80.7% (excluding HIF, non-medical only)		

Trustwide Project. Medical and Dental Workforce Scheduling and Payment Transformation Project.

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving in year Goal	Level of Risk for progressing actions
Medical and Dental Workforce Scheduling and Payment Transformation Project	Staff Availability	To have all Medical Staff on the rostering system and managers really engaged in using it as a tool to help improve patient care delivery. This will help enable us to fully align the workforce with service requirements/improvements	• To ensure medical and dental staff are deployed to maximum effect • To enable workforce gaps to be planned and managed • For the locum bank to be managed via the e-Rostering system achieving visibility and accountability • To ensure best practice roster rollout • To have full visibility of having the right people in the right place at the right time • To have all unavailability's of staff reported • For all additional payments to be digitised for payment and removing all paper/spreadsheet submissions		As we have moved to 1st April sign off, so any job plans that were due between Jan and Mar weren't renewed but were changed to reflect a 1st April start date. Job planning compliance is now at 71.8% at the end of April. Go live for SAS and consultant Optima roll out on tack, with Bank staff Plus go live due May 1st and Staff Direct June 1st. 8 rosters currently being rebuilt and 3 built in last period.		

Strategic Project.

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

Breakthrough Objective: Staff Involvement.

Workstream	True North Metric	Vision	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
Making HDFT the best place to work	Staff Engagement Breakthrough Objective - Involvement	To create an environment within HDFT where staff feel genuinely involved in decisions that affect their work and their team, and where they are able to contribute to and influence improvements to their work. This corresponds with the True North Ambition of improving Staff Engagement. **Goals** 1. The Trust score for Involvement in the NHS Staff Survey matches the best result for the benchmark group (2024 HDFT scored 6.85 vs best in benchmark of 7.27). 2. To achieve, at Trust level, a score on question 3f, "I am able to make improvements happen in my area of work," matching the best result in benchmark (2024 HDFT 55.37% vs 63.91%).	Hold Focus Groups with the 9 teams scoring the lowest for Involvement in the 2024 National Staff Survey to understand reasons for score and what would improve.	Work occurred to identify teams with low survey response rates/low engagement scores and advocacy and the top performing teams as well. 14 focus groups have been held across 9 care groups/services, with a total of 107 people being involved in these. The outputs from the focus groups have been used to inform the development of an Involvement Toolkit, which was launched in September 2025. Directorate level feedback on the output from the focus groups was provided to Directorate Triumvirate Teams and Composite Summary Feedback provided to SDR, People & Culture Programme Board and People & Culture Committee.		

Related Corporate Risks.

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

Related External Risks.

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

Public Sector Equality Duty Report
April 2025–March 2026

People and Culture Committee

Board of Directors

27 May 2026.

Title:	Public Sector Equality Duty Report 2025–2026
Responsible Director:	Acting Chief People Officer
Author:	Equality, Diversity, and Inclusion Manager

Purpose of the report and summary of key issues:	The purpose of this report is to provide assurance of compliance with the Public Sector Equality Duty (PSED). The report meets its workforce obligations for the period of April 2025–March 2026. The Trust is required to comply with both the general duties and the specific duties of the PSED. It is mandated to publish the results of activities in relation to the Equality Delivery System (EDS) 22 for the period 2025, Workforce Race Equality Standard 2025, Workforce Disability Standard 2025, Gender Pay Gap (GPG) Report 2025, and Ethnicity Pay Gap (EPG) Report 2025. This report is an aggregation of all Equality, Diversity, and Inclusion (EDI) work to provide assurance that Harrogate District NHS Foundation Trust (HDFT) is compliant with PSED. Key themes include: Staff engagement. Targeted initiatives for disability and long-term conditions. Reductions in bullying and harassment for some protected characteristics, but not all. The Trust maintained its 'Achieving' rating under EDS22, indicating compliance with national standards, with scope for further improvement.

<table>
<tr><td></td><td colspan="2">The report is for noting prior to its publication.</td></tr>
<tr><td rowspan="8">Trust Strategy and Strategic Ambitions:</td><td colspan="2">The Patient and Child First
Improving the health and wellbeing of our patients, children, and communities</td></tr>
<tr><td>Best Quality, Safest Care</td><td></td></tr>
<tr><td>Person Centred, Integrated Care; Strong Partnerships</td><td></td></tr>
<tr><td>Great Start in Life</td><td></td></tr>
<tr><td>At Our Best: Making HDFT the best place to work</td><td>√</td></tr>
<tr><td>An environment that promotes wellbeing</td><td>√</td></tr>
<tr><td>Digital transformation to integrate care and improve patient, child, and staff experience</td><td></td></tr>
<tr><td>Healthcare innovation to improve quality</td><td></td></tr>
<tr><td>Corporate Risks:</td><td colspan="2">None</td></tr>
<tr><td>Report History:</td><td colspan="2">Belonging sub-group – 09/06/26
People & Culture Programme Board – 05/05/26
SDR – 20/05/26
People & Culture Committee – 27/05/26</td></tr>
<tr><td>Recommendation:</td><td colspan="2">It is recommended that this report is noted prior to publication on the Trust’s external website.</td></tr>
</table>

Contents

Purpose 5

1.0: Background 5

To Advance Equality of Opportunity 7

Staff Survey Results 7

2.0: Percentage of Black and Minority Ethnic (BME) Staff 9

Seniority and Ethnicity 10

Workforce Race Equality Standard (WRES) Data 13

3.0: Gender 16

Gender Pay Gap 17

4.0: Age 17

5.0: Disability 18

Reasonable Adjustments 20

Workforce Disability Equality Standard 2025 (WDES) Data 20

6.0: Sexual Orientation 22

Gender Reassignment and Transgender 23

7.0: Religion 23

8.0: Pregnancy & Maternity and Part-Time Working 24

9.0: Fostering good relations between those who share protected characteristics and those who do not 25

10. To eliminate unlawful discrimination, harassment, and victimisation 26

National Staff Survey Results 2025 26

11.0: Equality Delivery System 22 29

12.0: Conclusions 30

13.0: Recommendations 31

Appendices 32

Appendix 1: Workforce Race Equality Standard 2025 32

Appendix 2: Workforce Disability Equality Standard 2025 34

Appendix 3: EDS22 Action Plan 36

Purpose

The Trust has a statutory duty under the Equality Act 2010 to eliminate discrimination, advance equality of opportunity, and foster good relations. This report provides assurance that these duties have been met across the workforce by the following:

- Advancing equality of opportunity between individuals who share a relevant protected characteristic and those who do not.
- Fostering good relations between individuals who share a relevant protected characteristic and those who do not.
- Eliminating unlawful discrimination, harassment, victimisation, and any other conduct prohibited under the Act.

This report provides assurance that Harrogate District NHS Foundation Trust (HDFT) has met its statutory obligations under the Public Sector Equality Duty (PSED) for the period April 2025 to March 2026. It brings together key workforce equality metrics, including the Equality Delivery System (EDS22), Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and pay gap reporting.

1.0: Background

The first two aims of the PSED (advancing equality of opportunity and fostering good relations) apply to eight of the nine protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. While marriage and civil partnership is recognised as a protected characteristic under the Equality Act 2010, it is not relevant to these two aims. It is, however, applicable to the third aim – eliminating unlawful discrimination, harassment, victimisation, and other prohibited conduct – which applies to all nine protected characteristics.

HDFT strives to create a culture of inclusivity through the People Plan 2025 and beyond. This is delivered through a governance structure that includes:

- The Belonging Subgroup – “where everyone is valued and recognised, where diversity is celebrated and where they are proud to work”.
- Looking After Our People – “physical and emotional support to be At Our Best”.

- Growing For The Future – “education, training and career development for everyone”.
- New Ways Of Working – “the right people with the right skills in the right roles”.

This group facilitates the organisation’s EDI ambitions:

- Everyone will demonstrate HDFT KITE (Kindness, Integrity, Teamwork, and Equality) behaviours to care for our patients, children, and communities.
- HDFT will build strong teams that support each other.
- HDFT will promote equality and diversity.
- HDFT will increase diversity in leaders and decision makers.

Alongside the use of the PSED, HDFT also works in line with the NHS’s first National EDI improvement plan, published on 8 June 2023. This improvement plan sets out targeted actions to address prejudice and discrimination. This discrimination maybe direct and indirect that exist through behaviour, policies, practices, and cultures against certain groups and individuals across the NHS workforce.

The NHS EDI improvement plan includes six high-impact actions (HIAs):

1. Ensure chief executives, chairs, and board members have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2. Embed fair and inclusive recruitment processes and talent management strategies that target underrepresentation and lack of diversity.
3. Develop and implement an improvement plan to eliminate pay gaps.
4. Develop and implement an improvement plan to address health inequalities within the workforce.
5. Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment, and physical violence at work occur.

Success metrics for the National Improvement Plan include NSS results, WRES and WDES, the National Education and Training Survey (NETS), and the Board Assurance Framework. The implementation of the National EDI improvement plan will strengthen the

progress of the PSED within HDFT. In turn, this will lead to better outcomes for patients and a more inclusive work environment for staff. The success metrics for the NHS Improvement Plan are largely encompassed within this PSED.

This report also supports the Trust's legal duty under the Equality Act 2010 to have due regard to equality in the design and delivery of its services. The Trust evidences due regard by addressing disadvantage linked to protected characteristics within its workforce, mitigating the risk of indirect discrimination, in line with the Equality Act 2010.

The report will now set out HDFT data under the three key areas of the PSED for the period of April 2025 to March 2026. Please be aware that there may be variations in headcount figures between the 2025 and 2026 periods throughout the report, as the data is sourced from multiple channels at different points in time.

To Advance Equality of Opportunity

Staff Survey Results

Response rates to the National Staff Survey increased to 61.9% (3,341 respondents), up 13.2% from the previous year.

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Between September and November 2025, the National Staff Survey was undertaken by IQVIA for 128 organisations, including HDFT. Seventy-one of these organisations are Acute and Acute & Community Trusts, which make up the comparator group displayed across the HDFT NSS results.

Some of the seven NHS People Promises and themes of Engagement and Morale have changed significantly from 2024.

Metric	2024; 2025	Absolute change	% change (vs 2024)	Rank
PP5 We are always learning	5.75; 5.89	**+0.14**	$+2.43\%$	**1**
PP6 We work flexibly	6.52; 6.63	**+0.11**	$+1.69\%$	**2**
PP7 We are a team	7.06; 7.15	**+0.09**	$+1.28\%$	**3**
PP3 We each have a voice that counts	6.88; 6.96	**+0.08**	$+1.16\%$	**4**
PP1 We are compassionate and inclusive	7.54; 7.61	**+0.07**	$+0.93\%$	**5**
PP2 We are recognised and rewarded	6.28; 6.34	**+0.06**	$+0.96\%$	**6**
PP4 We are safe and healthy	6.26; 6.29	**+0.03**	$+0.48\%$	**7**

Two questions from the NSS can demonstrate improvements in the advancement of opportunity.

1. Staff who agree or strongly agree that the organisation respects individual differences (e.g., cultures, working styles, backgrounds, ideas).

There is a 1.1% improvement in respondents agreeing that the organisation respects individual difference, as illustrated below.

HDFT 2025	HDFT 2024	Difference	Comparator
75.1%	74%	1.1%	69.0%

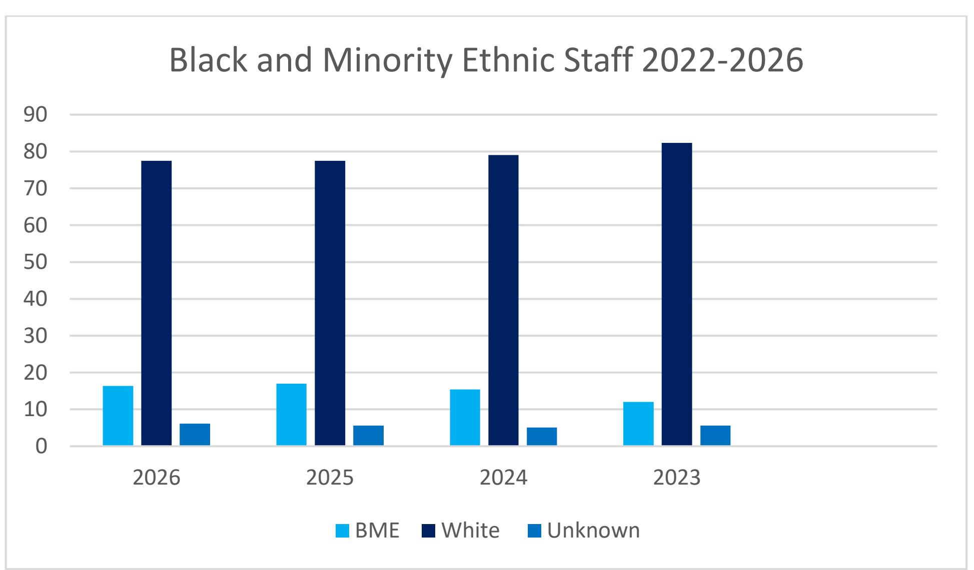
2. Staff who agree that the organisation acts fairly concerning career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age.

As illustrated below, there is a 0.4% improvement in respondents agreeing that the organisation acts fairly concerning career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age.

HDFT 2025	HDFT 2024	Difference	Comparator
59.1%	58.7%	0.4%	53.1%

2.0: Percentage of Black and Minority Ethnic (BME) Staff

The graph below shows the proportion of Black and Minority Ethnic (BME) staff from 2023 to 2026 with percentage values - exhibiting a slight decrease in from 17.0% to 16.4% in 2026.



Of the 5,484 employees who declared their racial identity on ESR, 899 disclosed their ethnicity under the umbrella category of 'BME'; however, their proportion of the workforce decreased slightly due to the overall workforce growth.

The table below shows the total number of BME staff on 31 March 2026.

BME Ethnic Origin	Headcount
D Mixed – White & Black Caribbean	9
E Mixed – White & Black African	15
F Mixed – White & Asian	20

G Mixed – Any other mixed background	14
GA Mixed – Black & Asian	1
GD Mixed – Chinese & White	2
GE Mixed – Asian & Chinese	2
GF Mixed – Other/Z Not Stated	3
H Asian or Asian British – Indian	293
J Asian or Asian British – Pakistani	82
K Asian or Asian British – Bangladeshi	11
L Asian or Asian British – Any other Asian background	37
LA Asian Mixed	1
LB Asian Punjabi	2
LE Asian Sri Lankan	9
LG Asian Sinhalese	1
LH Asian British	6
LK Asian Z Not Stated	7
M Black or Black British – Caribbean	11
N Black or Black British – African	205
P Black or Black British – Any other Black background	7
PB Black Mixed	1
PC Black Nigerian	39
PD Black British	3
PE Black Z Not Stated	1
R Chinese	23
S Any Other Ethnic Group	43
SC Filipino	43
SD Malaysian	3
SE Other Specified	5
TOTAL	**899**

Seniority and Ethnicity

Using three broad pay bandings across all staff groups, it is evident that there is an increase in the number of staff disclosing their ethnicity from 2025 to 2026. The overall growth is driven by the increase in BME staff and reduction in White staff within Medical and Dental.

HDFT remains committed to taking positive action to address underrepresentation or disadvantage faced by certain groups. Over this reporting cycle, the organisation has:

- Encouraged the disclosure of protected characteristics on employment records.
- Implemented cohort three of a Reciprocal Mentoring programme for colleagues with a disability or long-term condition.
- Maintained the REACH network (previously known as the BAME and Ally Staff Network).
- Commenced delivery of the Embedding Equality framework, including four catalysts.
- Recruited Independent Panel Members for interviews at clinical band 7–VSM; the first cohort was recruited and trained in January 2026. They are successfully being integrated into senior manager and leader interviews, with evaluation and feedback being collated as part of the process.
- Data-driven EDI reports (Employee Experience Performance Pack) are being rolled out from May 2026, the content of which will be examined and discussed at each Directorate board.
- Directorate-level EDI Champions are being recruited for and will be launched shortly after training in June 2026.
- Career-ready training toolkits for BME staff at band 6 and 7 are being curated using a variety of platforms and providers to enable flexibility and accessibility for employees.

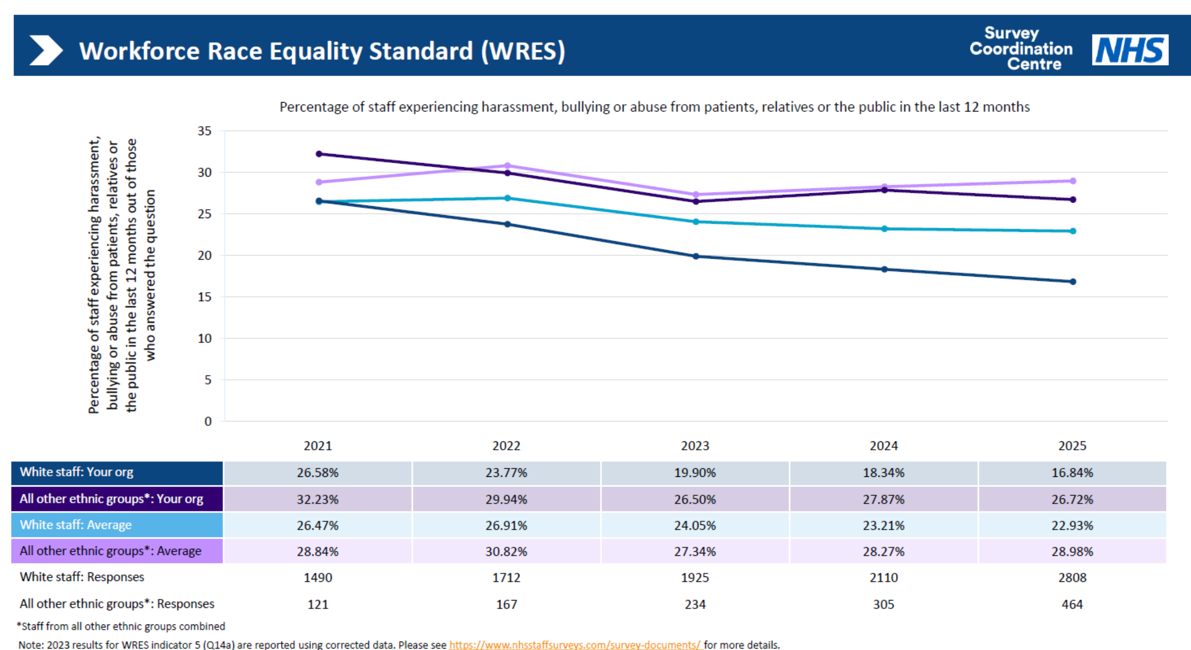
A comparison table showing the pay bandings of BME staff, including categories for White and Not Stated, is shown below.

31 March 2026				
Banding	**BME**	**White**	**Not Stated**	**TOTAL**
Bands 2–7	681	3637	251	**4569**
Band 8–VSM	24	292	9	**325**
Medical and Dental	194	304	66	**564**
Other (North House Surgery – currently on local payscale)	0	15	11	**26**
TOTAL	**899**	**4248**	**337**	**5484**
Total %	**16.0%**	**77.0%**	**6.0%**	
31 March 2025				
Banding	**BME**	**White**	**Not Stated**	**Total**
Bands 2–7	661	3513	248	4422
Bands 8–VSM	15	277	8	300
Medical and Dental	188	312	41	541
TOTAL	864	4102	297	**5263**
Total %	**16.0%**	**78.0%**	**6.0%**	

Workforce Race Equality Standard (WRES) Data

HDFT can demonstrate improvements in the advancement of equality of opportunity through WRES data (reporting period to 31 March 2025):

- Metric 1: The total percentage of BME employees in HDFT (excluding Board members) has increased since 2023.
- Metric 5: There has been a 1.5% improvement in staff experiencing harassment, bullying, or abuse from patients, relatives, or the public in the last 12 months. This is 2.26% better than the benchmarked average.



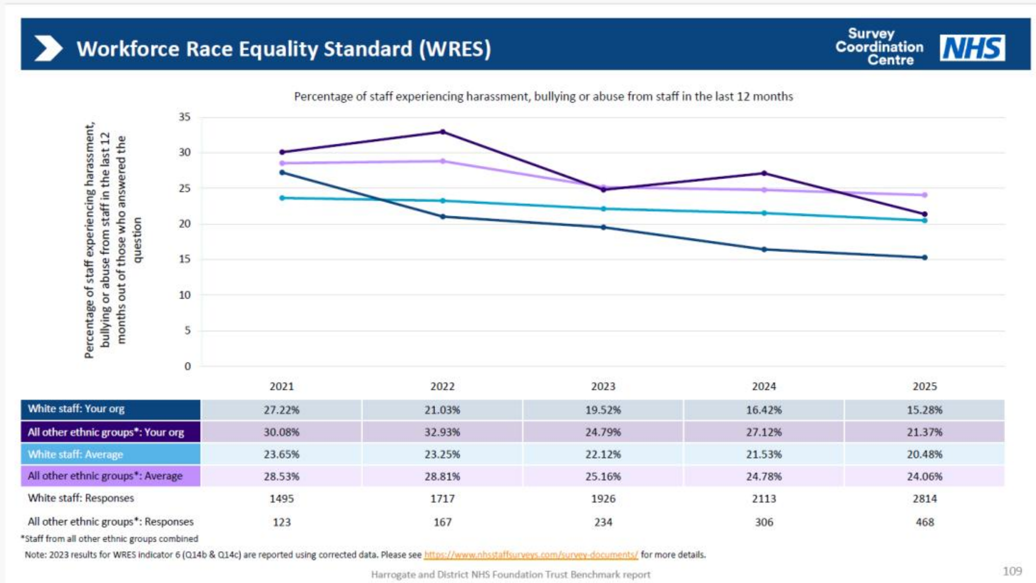
	2021	2022	2023	2024	2025
White staff: Your org	26.58%	23.77%	19.90%	18.34%	16.84%
All other ethnic groups*: Your org	32.23%	29.94%	26.50%	27.87%	26.72%
White staff: Average	26.47%	26.91%	24.05%	23.21%	22.93%
All other ethnic groups*: Average	28.84%	30.82%	27.34%	28.27%	28.98%
White staff: Responses	1490	1712	1925	2110	2808
All other ethnic groups*: Responses	121	167	234	305	464

*Staff from all other ethnic groups combined

Note: 2023 results for WRES indicator 5 (Q14a) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Harrogate and District NHS Foundation Trust Benchmark report 108

- Metric 6: There has been a 5.75% reduction (an improvement) in staff experiencing harassment, bullying or abuse from staff in the last 12 months, which is also 2.69% better than the benchmarked average of 24.06%.



	2021	2022	2023	2024	2025
White staff: Your org	27.22%	21.03%	19.52%	16.42%	15.28%
All other ethnic groups*: Your org	30.08%	32.93%	24.79%	27.12%	21.37%
White staff: Average	23.65%	23.25%	22.12%	21.53%	20.48%
All other ethnic groups*: Average	28.53%	28.81%	25.16%	24.78%	24.06%
White staff: Responses	1495	1717	1926	2113	2814
All other ethnic groups*: Responses	123	167	234	306	468

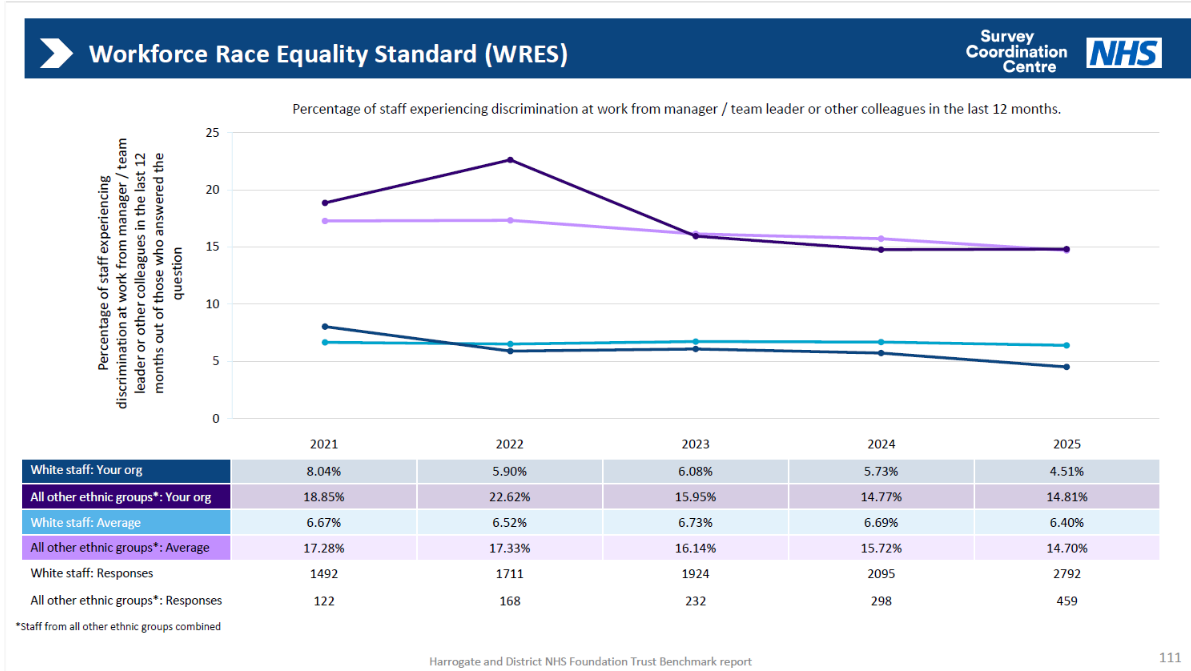
*Staff from all other ethnic groups combined

Note: 2023 results for WRES indicator 6 (Q14b & Q14c) are reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Harrogate and District NHS Foundation Trust Benchmark report

109

- Metric 8: 2025 showed a 0.04% worse position compared to 2024 for staff experiencing harassment, bullying or abuse from their manager, team leader, or other colleague in the last 12 months. The 2025 percentage figure of 14.8% is below the benchmarked average of 14.7%.



	2021	2022	2023	2024	2025
White staff: Your org	8.04%	5.90%	6.08%	5.73%	4.51%
All other ethnic groups*: Your org	18.85%	22.62%	15.95%	14.77%	14.81%
White staff: Average	6.67%	6.52%	6.73%	6.69%	6.40%
All other ethnic groups*: Average	17.28%	17.33%	16.14%	15.72%	14.70%
White staff: Responses	1492	1711	1924	2095	2792
All other ethnic groups*: Responses	122	168	232	298	459

*Staff from all other ethnic groups combined

Harrogate and District NHS Foundation Trust Benchmark report

111

- Metric 9: There has been an overall 6.84 reduction in Board of Directors representation compared to the overall workforce, from 18.6% in 2024 to 11.8% in 2025.

During 2025, the Trust relaunched all their staff support networks including REACH (Race, Ethnicity, and Cultural Heritage). Senior BME leaders supported the event to help address issues around membership and focus on actions for 2026. This is a well-established network with around 111 members, and the relaunch helped to improve visibility, attendance, and engagement. Since then, the network has acquired several new members. Despite attendance at meetings being low, there are events throughout the year for this group of staff.

Activities delivered during this reporting period include:

- **Workforce celebrations and awareness raising**, including ethnicity and religious festivals such as Ramadan, Eid, and the Festival of Light, as well as health inequalities and Black History Month.
- **Sharing information via the colleague Facebook and Team Talk**. Team Talk is the Trust-wide weekly live MS Teams session led by our Chief Executive, featuring invited speakers to raise awareness of EDI, health, long-term conditions, and a range of other topics.
- **Senior leadership support**, with the Executive Sponsor, and Non-Executive Director/EDI Champion, attending a number of network meetings to demonstrate commitment and provide high-level support to members.

For further information, please see the Workforce Race Equality Standard report for 2025: Equality and diversity - Harrogate and District NHS Foundation Trust

3.0: Gender

The workforce remains predominantly female, with little movement in percentage terms (86% in March 2022, 85% in March 2023, 83% in March 2024, and 84% in 2025 and in 2026). The Trust demonstrates a steady increase in female staff at higher bands and in Medical and Dental as shown below.

	31 March 2026			31 March 2025			31 March 2024			31 Mar 2023		
	Employees	Female	Male	Employees	Female	Male	Employees	Female	Male	Employees	Female	Male
Bands 2–7	4569	4035	534	4422	3901	521	4,408	3,887	521	3,983	3,545	438
Band 8 to VSM	325	248	77	300	231	69	282	219	63	242	190	52
Medical and Dental	564	306	258	541	296	245	562	277	285	470	244	226
Other	26	26	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total	5484	4615	869	5263	4428	835	5252	4383	869	4695	3979	716

Key insights from the data include:

- There are more women in roles in bands 2–7: 88.0% female, 12.0% male, with no change from 2025.
- There are more women in roles in band 8–VSM: 76.0% female, 24.0% male. In 2025, the figures were 77.0% female, 23.0% male.
- Representation of men and women within Medical and Dental: 54.0% female, 46.0% male. In 2025, the figures were 55.0% female, 45.0% male.

Across the whole of the NHS, 87.0% women make up the NHS workforce – a 10.0% increase from 2025 (NHS workforce statistics - NHS England Digital).

Gender Pay Gap

In 2018, it became mandatory for all public sector employers with more than 250 employees to measure and publish their gender pay gap (GPG) information. The GPG shows the percentage difference in pay between all male and female employees. However, closing the gender pay gap is about more than the figures – it is also about strengthening support for women in the workplace.

At HDFT, the 2025 Gender Pay Gap report shows that females earn on average £20.99 hour compared to £28.12 for males. This means that females earn £7.13 less per hour, which equates to a £7.13 (25.35%) gender pay difference or 'gap'. Last year, this was 24.4%, which means that the gap has worsened by 0.95%. However, the pay gap is driven by the Medical and Dental workforce, and if this data is removed from the calculations, the median for females becomes £19.23 compared to £19.55 for men, resulting in a pay gap of £0.32 or 1.65%. A further factor potentially impacting is that North House Surgery (female workforce) are currently on a local pay scale, which will have had some impact on the gap. They are being moved onto Agenda for Change, and this will be reflected in our next pay gap report.

4.0: Age

The majority of Trust staff continue to be aged between 31 and 60. The biggest rise has been in the age group of 31–40. There are 32.5% of colleagues aged 50–70+, which highlights the organisation's ageing staff population.

This table shows the headcounts and percentage of workforce by age band groupings.

	2025/2026		2024/2025		2023/2024	
Age Band	**Headcount**	**% of Workforce**	**Headcount**	**% of Workforce**	**Headcount**	**% of Workforce**
16–20 Years	19	0.3%	17	0.3%	17	0.3%
21–30 Years	835	15.2%	847	16.1%	757	15.0%
31–40 Years	1483	27.0%	1392	26.5%	1,312	26.0%
41–50 Years	1362	24.8%	1310	24.9%	1,286	25.5%
51–60 Years	1311	23.9%	1283	24.4%	1,290	25.6%
61+ Years	474	8.6%	410	7.8%	377	7.5%
TOTAL	**5,484**		**5,259**		**5,039**	

5.0: Disability

The number of staff who have disclosed their disability on the Electronic Staff Record (ESR) has risen by 60 employees and is 8.0% of the workforce. There has been a 0.8% increase in colleagues choosing to declare their disability or long-term condition.

The ability to report on who has, or has not, verified their information has only been available from March 2024. Most ESR data is provided at the start of employment. However, it should be considered that disabilities can be acquired during employment and therefore may not be disclosed.

The National Staff Survey for 2025 shows 902 (27.0%) employees disclosing their disability or long-term condition compared to 665 (27.0%) employees in the previous year, which equates to 8.0% of the workforce. Data collection on ESR continues to be improved in several ways, including by regular communications in our all-staff weekly bulletin, promoting step-by-step guides to complete ESR and highlighting what the data is used for on SharePoint.

The dataset in the table below shows the headcount of people who have disclosed their disability of long-term condition on ESR.

Disability Status	Headcount 31 March 2026	Headcount 31 March 2025	Headcount 31 March 2024
Yes	437	377	315
No	4,522	4,396	4,402
Not Declared	510	473	525
Prefer not to answer	15	11	10
TOTAL	**5,484**	**5,257**	**5,252**

Significant work has continued to support colleagues with disabilities and long-term conditions.

- **Disability and Long-Term Condition Staff Network**
    - Membership is over 80 colleagues.

    - Discussion topics include WDES data, staff policies, and awareness raising.
    - Practical support themes include managing a condition through nutrition and physiotherapy.
    - Executive sponsor engagement is strong: the Director of Strategy and a Non-Executive Director both attend network meetings to offer support.

- **Neurodiversity Staff Network**
    - Membership has grown to over 90 colleagues.
    - Discussions are shaped by members lived experiences.
    - The network supports both neurodivergent colleagues and parents/carers of neurodivergent children, helping people build understanding and learn from one another.
    - Communications include regular e-updates and intranet articles.
    - There is an active Teams chat forum providing ongoing peer support.
    - The network has hosted guest speakers, including:
        - Professor Rachael Charlton (Goldsmiths, University of London) on neurodiversity and menopause.
        - Professor Megan Freeth (University of Sheffield) on autism in the workplace.
        - Sadie Dingfelder, neurodivergent science journalist, speaking about living with face blindness.
    - The Trust is recognised under the Disability Confident Scheme (Level 2). This best-practice standard supports fair recruitment by offering an interview to candidates who identify as disabled or as having a long-term condition, where they meet the minimum requirements for the role. Work continues to embed this approach into recruitment and selection, with an annual review to help ensure candidates are not disadvantaged.
    - The Trust has several initiatives and points of contact to help prevent the development of long-term mental health conditions, including burnout:
        - Mental Health First Aiders.

- Colleague Wellbeing Manager.
- Referral pathways between the Employee Assistance Programme and Occupational Health.
- Annual health and wellbeing events.
- Health promotions, such as the Blue Light Card.
- Staff rest areas within the hospital.

Reasonable Adjustments

Significant work has been carried out to enable colleagues to feel more empowered to request reasonable adjustments from their manager. The annual National Staff Survey asks the question, ‘Has your employer made adequate adjustment(s) to enable you to carry out your work?’.

A total of 75.8% of colleagues received their reasonable adjustment compared to 78.1% in 2024. This shows a 2.3% decrease in staff accessing required reasonable adjustments.

Improved communications via multiple platforms have since taken place with additional signposting for colleagues and managers to inform them on reasonable adjustments and the Access to Work process.

Workforce Disability Equality Standard 2025 (WDES) Data

Harrogate District Hospital Foundation Trust can demonstrate improvements in the advancement of equality of opportunity at the Trust, using WDES data (reporting period to 31 March 2025):

- Metric 1: There continues to be year-on-year increases in staff declaring their disability or long-term condition, from 6.3% in 2024 to 7.22% in 2025.
- Metric 3: 1.5 employees with a disability or long-term condition entered the capability process in 2024–2025 (figures are taken over a two-year rolling period).
- Metric 4: This includes four separate metrics about staff experiencing bullying and harassment or abuse:

- Metric 4a: Harassment, bullying, or abuse from patients, relatives, or the public in the last 12 months reduced from 26.7% in 2024 to 21.7% in 2025.
- Metric 4b: Harassment, bullying, or abuse from line managers in the last 12 months worsened slightly from 11.0% in 2024 to 11.7% in 2025.
- Metric 4c: Harassment, bullying, or abuse from other colleagues in the last 12 months reduced from 22.1% in 2024 to 20.6% in 2025.
- Metric 4d: The reporting of incidents of harassment, bullying, or abuse increased from 56.1% in 2024 to 57.5% in 2025.

Please see the following link for further information: Equality and diversity - Harrogate and District NHS Foundation Trust

6.0: Sexual Orientation

The table below shows the number of LGBTQ+ people who have disclosed their sexuality on ESR.

Sexual Orientation	2026		2025		2024	
	Headcount	%	Headcount	%	Headcount	%
Bisexual person	67	1.2%	52	0.99%	43	0.8%
Gay or Lesbian	71	1.3%	74	1.41%	71	1.4%
Heterosexual or straight	4,487	81.8%	4,265	81.07%	4,107	78.2%
Not stated (person asked but declined to respond)	845	15.4%	789	15.0%	1,024	19.5%
Other sexual orientation not listed	7	0.1%	2	0.04%	4	0.1%
Undecided	7	0.1%	8	0.15%	3	0.1%
TOTAL	**5,484**		**5,190**		**5,252**	

The number of staff who have disclosed their sexual orientation has increased by 0.19%. The number of people on ESR who identify within the umbrella of 'LGBTQ+' (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning; the plus stands for all other identities not captured within the acronym) has increased from 136 employees to 152 employees. This figure only includes sexual orientation within LGBTQ+, as gender is referred to in other sections of the report.

The number of people who have 'not stated' their sexual orientation remains high, at 15.4%; however, this is 0.4% lower than the previous year and 4.1% lower than in 2024.

The network membership stands at almost 60 colleagues and is active with its awareness and inclusion events throughout the year; however, participation remains low.

Gender Reassignment and Transgender

Records relating to non-binary colleagues are limited, as the ESR system is currently configured to record only ‘male’ or ‘female’. However, colleagues may disclose that they are non-binary or transgender and may choose to use ‘Mx’ (a gender-neutral title) where a title is recorded.

Staff are encouraged to update their ID badge, share their pronouns, and include them alongside their name in their email signature. Examples include ‘he/him/his’, ‘she/her/hers’, and ‘they/them/theirs’.

7.0: Religion

Compared to 2025, the proportional split of religious groups is similar to 2026 in that 50.0% of employees disclose Christianity as their religious belief. People who choose not to disclose their religion or belief is 20.6% on ESR.

The table shows the headcount of the workforce mapped against different religions or beliefs.

Religious Belief	2026		2025		2024	
	Headcount	%	Headcount	%	Headcount	%
Atheism	1,013	18.5%	913	17.35%	828	15.8%
Buddhism	39	0.7%	32	0.61%	30	0.6%
Christianity	2,744	50.0%	2685	51.04%	2,674	50.9%
Hinduism	97	1.8%	98	1.86%	84	1.6%
I do not wish to disclose my religion/belief	1,128	20.6%	1,033	19.64%	1,220	23.2%
Islam	147	2.7%	140	2.66%	130	2.5%
Jainism	0	0.0%	1	0.02%	1	0.0%
Judaism	6	0.1%	7	0.13%	13	0.2%
Other	295	5.4%	258	4.90%	258	4.9%
Sikhism	15	0.3%	16	0.30%	14	0.3%
Unspecified	0	0.0%	78	1.48%	-	-
Total	**5,484**					

The Trust's Multi-faith Centre offers emotional, spiritual, and religious support to people of all faiths, beliefs, and religions. The Centre is also open to those who do not observe any belief system. Chaplains provide a confidential listening ear for staff and patients at ward level. They are also available to offer prayer, communion, and confession for patients and employees.

The Chaplaincy Service works closely with the Colleague Wellbeing Manager, Freedom to Speak Up Guardians, and the Equality, Diversity, and Inclusion Manager to share approaches and identify where the workforce would benefit from greater awareness of their combined pastoral support.

8.0: Pregnancy & Maternity and Part-Time Working

The number of pregnant employees totalled 150 in the period to 31 March 2025. This figure excludes employees who TUPE-transferred during their Maternity Leave. The Trust does not have the ability to collate data on TUPE staff transfers.

The table below shows the number of people who took maternity leave and compares them with the last three years.

	2025/26 Head count	2024/25 Head count	2023/24 Head count
Number of staff who went off on maternity leave between Apr 25 and Mar 26 *	153	150	235
Number of staff who went off on maternity leave between Apr 25 and Mar 26 **	276		
How many returned during this period	139	137	107
How many left the Trust during this period ***	17	15	17
How many left the Trust during this period ****	5		
How many returned part-time	102	107	76
How many returned full-time	32	30	31

* This number is based on how many employees commenced maternity leave in the financial year **(i.e. maternity start date of 1 April 2025 or later).**

** This number is based on how many employees had a period of maternity leave in the financial year **(i.e. maternity start date may be earlier than 1 April 2025).**

*** This is how many employees left the Trust within the period 1 April 2025 to 31 March 2026 **(this includes 5 who left on their Maternity Leave end date).**

**** This is how many employees left the Trust on the date their maternity leave ended. This is of the total 17 employees who left in the period.

All pregnant staff are offered a maternity risk assessment to support their physical and mental wellbeing throughout their pregnancy, with Occupational Health referral where required.

During 2025/26, 153 colleagues commenced maternity leave (compared to 150 in 2024/25). The Trust does not currently track those who TUPE-transfer during leave.

A total of 139 colleagues returned from maternity leave during the year, including those who commenced leave in previous periods. Of these:

- 73.0% (102 colleagues) returned part-time.
- 23.0% (32 colleagues) returned full-time.

This continues a strong pattern of part-time returners, though the changes in the figures year on year are marginal.

Turnover among colleagues on maternity leave rose slightly to 14.0% (22 leavers), up from 10.0% in 2024/25. While this reflects an upward trend, the figure remains above the Trust's overall turnover threshold of 12.0%.

This data continues to support the Trust's approach to flexible working and family-friendly policies, but suggests ongoing monitoring is needed to ensure we support increased flexibility for returners seeking full-time roles.

9.0: Fostering good relations between those who share protected characteristics and those who do not

There are regular events run by the staff networks to improve colleagues' understanding of underrepresented groups. The Trust uses staff networks to help inform which inclusion calendar days should be recognised across the Trust, aligning with the NHS Employers' calendar of inclusion events. This includes Lunar New Year, Ramadan, Eid, Christmas, Transgender Awareness Week, and Black History Month. Examples of initiatives to recognise these events include Trust-wide communications, social media posts, guest speakers, charity-funded snack bags, face-to-face meetings, and social events.

Education and training to support the fostering of good relations includes the commencement of Cohort 3 in 2025, for Reciprocal Mentoring targeted at colleagues with a disability or long-term condition. Colleagues are paired with senior leaders in the organisation, helping to influence policy change, improve opportunities for career progression, strengthen inclusion, and increase understanding among non-disabled colleagues of the day-to-day 'lived experience' of being a person with a disability or long-term condition.

10. To eliminate unlawful discrimination, harassment, and victimisation

National Staff Survey Results 2025

The following tables show benchmarked data from the National Staff Survey 2025, measured against other 121 Acute and Acute & Community Trusts. The area of interest is the data provided regarding discrimination shown across different protected characteristics. The results from these tables are used to help formulate our programme of work for the following year. Ethnicity and colleagues with disabilities and long-term conditions will be the focus of equality, diversity, and inclusion action plans for 2026.

Race

	2025
Your org	42.80%
Best result	27.76%
Average result	52.00%
Worst result	70.56%
Responses	310

Sex

Your org	12.60%
Best result	8.47%
Average result	15.75%
Worst result	20.93%
Responses	310

Religion

Your org	4.69%
Best result	2.29%
Average result	6.87%
Worst result	21.49%
Responses	310

Sexual Orientation

Your org	1.86%
Best result	1.25%
Average result	3.12%
Worst result	5.67%
Responses	310

Disability

Your org	14.11%
Best result	4.23%
Average result	10.47%
Worst result	24.69%
Responses	310

Age

Your org	20.91%
Best result	11.08%
Average result	17.46%
Worst result	26.25%
Responses	310

Other

Your org	26.32%
Best result	16.16%
Average result	21.87%
Worst result	29.43%
Responses	310

The work carried out by the Trust to eliminate unlawful discrimination, harassment, and victimisation includes the development of appropriate policies, processes, and networks to support staff.

- Further work has been carried out to support colleagues with disabilities and long-term conditions, including regular staff network meetings for peer support, and the first cohort for Reciprocal Mentoring commenced in 2025 for this group of staff.
- During 2025, presentations were made by network groups, raising awareness among the workforce via TeamTalk.
- The Disability Confident Employer accreditation was renewed again at the start of 2026, which supports people with a disability, neurodivergence, or long-term conditions with their reasonable adjustments.
- Guest speakers were invited to present their research or lived experiences for the Trust as part of our ‘lunch and learn’ programme of work.

11.0: Equality Delivery System 22

The Equality Delivery System (EDS) aims to help NHS organisations improve service quality for their communities and create discrimination-free workplaces for NHS employees, in line with the Equality Act 2010. The implementation of EDS22 is a mandatory assessment of NHS services.

The 2025 review was delivered with three separate stakeholder groups, with Domain 1 led by the Director of Strategy, and the Clinical Director for Children and Young People's Public Health Directorate. Domains 2 and 3 were led by the Equality, Diversity, and Inclusion Manager.

The overall EDS22 assessment was 'Achieving' and remains the same as the previous year.

Outcome	Description	Rating (Score)	
1. A	*Patients (service users) have the required levels of access to the service.*	●●	**Excelling (3)**
1. B	*Individual patients (service users) health needs are met.*	●●	**Excelling (3)**
1. C	*When patients (service users) use the service, they are free from harm.*	●●	**Excelling (3)**
1.D	*Patients (service users) report positive experiences of the service.*	●●	**Excelling (3)**
2. A	*When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions.*	●	**Achieving (2)**
2. B	*When at work, staff are free from abuse, harassment, bullying, and physical violence from any source.*	●	**Achieving (2)**
2. C	*Staff have access to independent support/advice when suffering from stress, abuse, bullying, harassment, and physical violence from any source.*	●●	**Excelling (3)**
2. D	*Staff recommend the organisation as a place to work and receive treatment.*	●	**Achieving (2)**
3. A	*Board members, system leaders (Band 9 and VSM), and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.*	●	**Achieving (2)**
3. B	*Board/Committee papers (including minutes) identify equality- and health inequality-related impacts/risks and how they will be mitigated and managed.*	●	**Achieving (2)**

3. C	*Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.*	●	**Achieving (2)**

12.0: Conclusions

This report provides a comprehensive overview of how HDFT meets its Public Sector Equality Duty (PSED) and discharges its workforce obligations.

Below are the key conclusions, with both highlights and areas for further attention, based on the data provided.

- **Staff engagement.** The National Staff Survey response rate rose to 3,341 respondents (61.86 % of the workforce), a 13.16% increase over the previous year. There are indications that more staff agree that the organisation respects individual differences (up 1.1%) and acts fairly on career progression (up 0.4%).
- **Increasing diversity declarations.** HDFT has encouraged staff to disclose protected characteristics and offered reciprocal mentoring and staff network support. This has led to more colleagues disclosing their disability and sexual orientation. The Neurodiversity network has grown to over 90 members, offering peer support and awareness-raising activities, and the Menopause network now attracts over 200 members and achieves many of its own successes.
- **Race equality.** The total number of BME staff grew to 899, reflecting continued recruitment of minority ethnic colleagues. HDFT's WRES data shows fewer BME staff reporting harassment from patients and the public (a 1.5% improvement, outperforming the national average by 2.26%) and less abuse from other staff (a 5.75% improvement, 2.69% better than average). However, the proportion of BME staff decreased slightly, and representation at board level fell from 18.6% to 11.76%, with only two BME directors. A slight increase in harassment from managers (0.04%) also points to further necessary work to be carried out in that regard.
- **Ageing workforce.** The largest proportion of staff remains in the 31–60 age bracket, but 32.5% of employees are aged 50–70+, indicating an ageing

workforce and highlighting the need for succession planning and support for older workers.

- **Disability discrimination.** While more colleagues are declaring a disability and the WDES data shows a fall in harassment from service users, only 75.8% of disabled staff reported receiving reasonable adjustments – a drop from 78.1%. Harassment from line managers increased slightly from 11.0% to 11.7%, and 1.5 staff entered capability processes, suggesting that more work is needed to create a supportive environment.
- **Disclosure and inclusion for LGBTQ+ colleagues.** Even with a slight increase in disclosures, 15.4% of staff still do not state their sexual orientation, and active membership of the LGBTQ+ network is low. Greater visibility of role models and allyship training could help reduce this 'prefer not to say' group and create a more inclusive culture.
- **Maternity and part-time working raise retention issues.** During the reporting period, 153 staff took maternity leave and 139 returned. Turnover rose from 10.0% to 14.0% and the Trust saw 73.0% of colleagues return on a part-time basis.
- **Overall judgement and future direction.** The Trust's EDS22 assessment remains 'Achieving', indicating compliance with the Equality Act 2010 but leaving room for further progress. Positive trends in survey results and network engagement show that efforts to improve equality are working. Continuing to embed fair recruitment, strengthen accountability for senior leaders, and prioritise health inequality reduction will be key for HDFT to fully realise its PSED obligations and build a truly inclusive workforce.

13.0: Recommendations

The Board of Directors are asked to:

- Review the enclosed paper. The Trust meets the requirements of the Equality Act 2010 in discharging its workforce obligations for the Public Sector Equality Duty.
- Approve the report for publication on the Trust's website.

Appendices

Appendix 1: Workforce Race Equality Standard 2025

Points to note:

- **Point 2** – A figure below 1.00 indicates that BME staff are more likely than White staff to be appointed from shortlisting.
- **Point 3** – In 2025, 1.01 BME colleagues entered the formal disciplinary process. The figure is taken from a two-year rolling period.
- **Point 4** – A figure below 1.00 indicates that BME staff are more likely than White staff to access non-mandatory training and CPD.

	Metric		**March 2025**	**March 2024**
1	Percentage of BME staff	Overall	16.47%	15.4%
2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to BME applicants		2.97	2.44
3	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff		1.01	0.49
4	Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		0.83	0.71
5	Percentage of staff experiencing harassment, bullying, or abuse from patients, relatives, or the public in the last 12 months	BME	27.9%	26.5%
		White	18.3%	19.9%
6	Percentage of staff experiencing harassment, bullying, or abuse from staff in the last 12 months	BME	24.3%	24.8%
		White	13.2%	19.5%
7	Percentage of staff believing that their Trust provides equal opportunities for career progression or promotion	BME	49.2%	53.9%

8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	9.8%	15.6%
		White	7.3%	6.1%
9	BME Board membership	BME	11.78%	18.7%
		White	82.35%	81.3%
	Difference (Total Board – Overall Workforce)	BME	−5.0%	3.0%
		White	4.0%	2.0%

Appendix 2: Workforce Disability Equality Standard 2025

		March 2025	March 2024
1	Percentage of staff in AfC pay bands or Medical and Dental subgroups and Very Senior Managers (including Executive Board members, but excluding Non-Executive Board members) compared with the percentage of staff in the overall workforce		
	Cluster 1 (up to Band 4)	7.14%	6.9%
	Cluster 2 (Bands 5–7)	9.25%	6.5%
	Cluster 3 (Bands 8a–8b)	9.7%	8.5%
	Cluster 4 (Bands 8c–9 and VSM)	9.05%	0.0%
	Cluster 5 (Medical/Dental consultants)	0.0%	2.4%
	Cluster 6 (Medical/Dental, non-consultants)	1.41%	0.7%
	Cluster 7 (Medical/Dental, trainees)	4.57%	4.67%
		7.22%	6.3%
2	Relative likelihood of Non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts	1.01	1.15
3	Relative likelihood of Disabled staff compared to Non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	4.34	3.33
4a	Percentage of Disabled staff compared to Non-Disabled staff experiencing harassment, bullying, or abuse from Patients or other members of the public	21.7%	26.7%
4b	Percentage of Disabled staff compared to Non-Disabled staff experiencing harassment, bullying, or abuse from managers	11.7%	11.0%
4c	Percentage of Disabled staff compared to Non-Disabled staff experiencing harassment, bullying, or abuse from other colleagues	20.6%	22.1%

		March 2025	March 2024
4d	Percentage of Disabled staff compared to Non-Disabled staff saying that the last time they experienced harassment, bullying, or abuse at work, they or a colleague reported it	57.5%	56.1%
5	Percentage of Disabled staff compared to Non-Disabled staff believing that the Trust provides equal opportunities for career progression or promotion	55.0%	57.9%
6	Percentage of Disabled staff compared to Non-Disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	20.3%	18.4%
7	Percentage of Disabled staff compared to Non-Disabled staff saying that they are satisfied with the extent to which their organisation values their work	39.7%	42.9%
8	Percentage of Disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work	78.0%	75.9%
9a	The staff engagement score for Disabled staff, compared to Non-Disabled staff (0–10)	6.63	6.8
9b	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	Y	Y
10a	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce (voting membership of the Board)	−7.0%	−6.0%
10b	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce (Executive membership of the Board)	−7.0%	−6.0%

Appendix 3: EDS22 Action Plan

February 2026 EDS Action Plan	
EDS Lead	**Year(s) active**
Dr Zakyeya Atcha, Clinical Director and Consultant in Public Health Dr Richard Dunston Brady, Equality, Diversity, and Inclusion Manager	2026 2025 and 2026
EDS Sponsor	**Authorisation date**
Mr Mathew Graham, Director of Strategy Ms Angela Wilkinson, Director of People and Culture	26 February 2026

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services.	1A: Patients (service users) have required levels of access to the service	Continue to consider the needs and barriers to accessing services to identify solutions to minimise their impact to obtaining services needed.	Work with partners to ensure that our information leaflets and letters are translated into the recipient's first language.	December 2026
	1B: Individual patients (service users) health needs are met	Ensure that we continue to understand the changing needs of our service users and their caregivers, so that we can provide the best support possible.	Review themes arising from a range of feedback methods, including staff feedback, to ensure that services are responsive to service users' needs.	December 2026
	1C: When patients (service users) use the service, they are free from harm	Explore specific training in respect to those with protected characteristics and at risk of experiencing inequalities in health and access to services.	Each directorate and service area to complete staff training and development needs reviews as part clinical and reflective supervision session and at annual appraisals.	December 2026
	1D: Patients (service users) report positive experiences of the service	Seek feedback from service users with protected characteristics and those at risk of experiencing inequalities to better serve them and the needs of their caregivers.	Actively develop and use a range of survey methods to receive feedback from service users and their caregivers.	December 2026

	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions	To develop EDI data available to managers and directorates to inform them of trends.	Workforce Pack including survey results and EDI data to be shared with directorates.	End Q1 2026
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Year-on-year improvements of WRES and WDES data. Continue to deliver Cultural Competency Training to staff. Recording and analysis of themes from the Freedom to Speak Up Guardian.	Equality, Diversity, and Inclusion Manager to report on these metrics annually. In place. Freedom to Speak Up Guardian to collate date where available and report on analysis.	Ongoing
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Deliver an anonymous reporting process for staff to call out incidences of bullying and harassment from any source.	Work with FtSu Guardians to deliver this.	Q1 2026
	2D: Staff recommend the organisation as a place to work and receive treatment	Year-on-year improvements of National Staff Survey.	Equality, Diversity, and Inclusion Manager to report on these metrics annually.	Review Jan 2027

	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Health inequalities are to be a standing item on the agenda at all board meetings. Improved attendance at staff networks by Exec Sponsors Board to hold services to account and demonstrate their commitment to health inequalities.	All directorates to action this and include the EDI Manager in quarterly meetings for updates.	Ongoing
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Directorate business plans should shape the needs of their population in terms of health inequalities.	All directorates to work with planning teams as per 1A.	Ongoing
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Year-on-year improvements of WRES, WDES, Gender Pay Gap and Impulse survey.	Equality, Diversity, and Inclusion Manager to report on these metrics annually.	Ongoing

Board of Directors

27th May 2026

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

<table>
<tr><td>Purpose of the report and summary of key issues:</td><td colspan="2">The aim of this statement is to demonstrate that the Trust follows best practice and that all reasonable steps are taken to prevent slavery and human trafficking.</td></tr>
<tr><td rowspan="8">Trust Strategy and Strategic Ambitions</td><td colspan="2">The Patient and Child First
Improving the health and wellbeing of our patients, children and communities</td></tr>
<tr><td>Best Quality, Safest Care</td><td></td></tr>
<tr><td>Person Centred, Integrated Care; Strong Partnerships</td><td></td></tr>
<tr><td>Great Start in Life</td><td></td></tr>
<tr><td>At Our Best: Making HDFT the best place to work</td><td>√</td></tr>
<tr><td>An environment that promotes wellbeing</td><td>√</td></tr>
<tr><td>Digital transformation to integrate care and improve patient, child and staff experience</td><td></td></tr>
<tr><td>Healthcare innovation to improve quality</td><td></td></tr>
<tr><td>Corporate Risks</td><td colspan="2">N/A</td></tr>
<tr><td>Report History:</td><td colspan="2">Approved at May SDR meeting.</td></tr>
<tr><td>Recommendation:</td><td colspan="2">The Committee is asked to support final approval.</td></tr>
</table>

Modern Slavery and Human Trafficking Annual Statement

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

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

Policies relating to Modern Slavery

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

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

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

Our People

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

Our Supply Chain

Members of the Procurement Team are professionally qualified through the Chartered Institute of Procurement & Supply (CIPS) and operate in accordance with the CIPS Code of Professional Conduct. The Procurement team follow all relevant Procurement laws regarding the Modern Slavery Act 2015 including the Crown Commercial Service standards.

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

Our Performance

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

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

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

Approval for this statement
This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes the Harrogate and District NHS Foundation Trust slavery and human trafficking statement for the financial year ending 31 March 2026.

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

Jonathan Coulter
Chief Executive

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

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

GOALS:

Quality & Safety

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

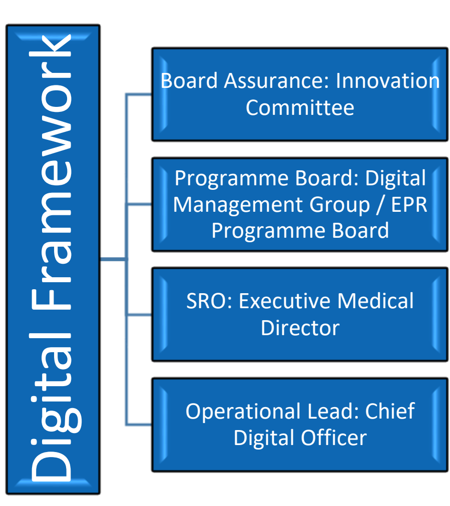
Information

Timely, Accurate Information to enable continuous improvement

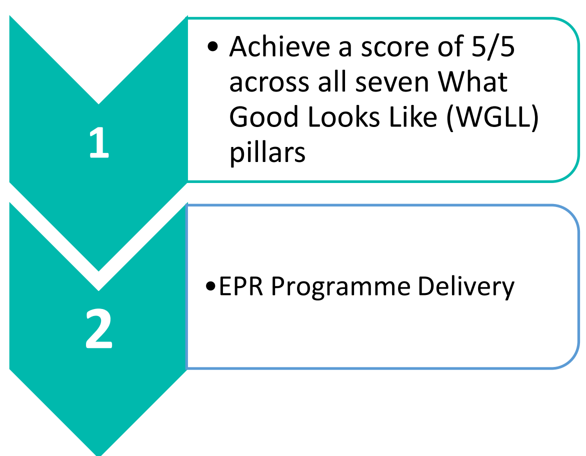
Electronic Health Record

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

Governance:



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



Trustwide Project:	
Strategic Programme:	**EPR**
Breakthrough Objective:	
Overarching Risk Appetite:	Operational - Cautious

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

True North Metrics Summary:

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality & Safest Care Person Centred, Integrated Care Great Start in Life Making HDFT The Best Place to Work	***Overarching Vision:*** To improve our Digital Maturity in keeping with the "What Good Looks Like" national programme for Digital Services in the NHS, so that our colleagues will have improved leadership skills, more advanced solutions, safe and secure digital foundations and practices, improved support and services, and will be better empowered to perform their roles. In turn, this will lead to better and more informative data and improvements in patient care and clinical services.	We aspire to achieve a score of 5/5 across all seven What Good Looks Like (WGLL) pillars. For our Q1 26/27 submission, we aim to achieve an average score of 3/5 across the seven pillars.	Our ambition is to improve the organisations digital maturity that promotes best quality, safest care and now continues into its third year (2026-27). The delivery of the new EPR is well underway with a significant amount of functionality already live. We are focussing on how we can improve our overall digital maturity against WGLL. We assess ourselves annually using the National Digital Maturity Assessment (DMA) tool for both Acute and Community. The charts below describe the results of the DMA reported in Q2 25/26. The scores below for all seven pillars cover Acute and Community and there are separate DMA submissions for Acute and Community. The 2026 scores will be added to the tables below when the results are published in summer 2026.	• A3's are being produced for the pillars and domains (May 26) • These will then be run through the strategic filter (Jul 26) • They will then be prioritised and planned for delivery		

HNY DMA Scores 2025

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

Acute

DMA Score	Acute 2024	Acute 2025
Well Led	3.33	3.00
Ensuring Smart...	2.92	2.47
Safe Practice	2.50	2.50
Healthy Popula...	2.20	2.20
Empower Citize...	2.00	2.14
Improving Care	1.40	1.80

Total Score 2024: 0.00 – 2.43 – 5.00

Total Score 2025: 0.00 – 2.41 – 5.00

Community

DMA Score	Community 2024	Community 2025
Well Led	2.67	3.00
Safe Practice	2.50	2.50
Ensuring Smar...	2.43	2.47
Healthy Popul...	2.20	2.20
Empower Citiz...	2.17	2.14
Improving Care	1.40	1.60

Total Score 2024: 0.00 – 2.34 – 5.00

Total Score 2025: 0.00 – 2.38 – 5.00

The plan for the National Digital Maturity Survey is as follows as at 18th February 2026:

"The programme has now taken the decision to delay this year's DMA by around 2 - 3 months. This is due to approval delays and internal resource uncertainty. We are

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
			still planning to give Provider trusts and regional teams plenty of preparation time for the assessment. Therefore, from early April we will require your support to validate our respondent list. We will shortly confirm the new launch date; in the meantime, we would appreciate your patience and support in managing any respondent enquiries about the delay to assure Trusts that we still intend to launch the DMA this year."			
	Seven Pillars of WGLL: ***1. Well Led*** – A clear strategy for digital transformation & collaboration. Our leaders collectively own & drive the digital transformation journey, placing citizens & frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe, high-quality care	As above	Completed A3's • Digital & Data Strategy, Digital Leadership & Board Membership, Digital Governance & Assurance Processes, Enterprise Architecture	• A3's are being produced for the pillars and domains (May 26) • These will then be run through the strategic filter (Jul 26) • They will then be prioritised and planned for delivery		
	Ensuring Smart Foundations - Digital, data & infrastructure operating environments are reliable, modern, secure, sustainable & resilient. We have well-resourced teams who are competent to deliver modern digital & data services		Completed A3's • Sustainability Agenda, Networking, Technical and Legacy Debt, Technical Infrastructure, Security and Privacy of Hardware Devices, IT and Infrastructure Asset Management, Public Switched Telephone Network (PSTN), IT Operations & Service Management, Service Quality Assurance, EPR Coverage, Digital Medicines – Interoperability, Digital Medicines – Prescribing & Administration, Digital Medicines – Dispensing & Suppliers, Imaging Systems, Test Management (Diagnostics), Imaging Systems, Laboratory & Pathology Specimen Management & Automation Systems, A3's to Complete (May 26) • EPR Digital Capabilities, Patient Administration System, NHS E-Referral System, Blood Management	• A3's are being produced for the pillars and domains (May 26) • These will then be run through the strategic filter (Jul 26) • They will then be prioritised and planned for delivery		
	Safe Practice - We maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health & social care (DTAC) & routinely review system-wide security, sustainability & resilience		Completed A3's • Cyber & Network Security, Identity & Access Management • Data Governance A3's to Complete (End March 26) • Clinical Safety & Assurance	• A3's are being produced for the pillars and domains (May 26) • These will then be run through the strategic filter (Jul 26) • They will then be prioritised and planned for delivery		
	Support Workforce- Our workforce is digitally literate & able to work optimally with data & technology. Digital & data tools & systems are fit for purpose & support staff to do their jobs well		Completed A3's • Digital Data & Technology Workforce Capacity & Capability, Demand Led Management of Capacity, Supply Chain Management A3's to Complete (End March 26 • Workforce Digital & Data Literacy	• A3's are being produced for the pillars and domains (May 26) • These will then be run through the strategic filter (Jul 26) • They will then be prioritised and planned for delivery.		
	Empower Citizens - Citizens are at the centre of service design & have access to a standard set of digital services that suit all literacy & digital inclusion needs. Citizens		A3's to Complete (End March 26 • Digital Consultations, Citizen Accessible Health Records, Public Engagement & Communication, Appointment Booking & Check in, Self-Triage & Self-Referral Capabilities, Digital Front Door & Patient Portals, Condition Specific Care Apps & Portal	• A3's are being produced for the pillars and domains (May 26) • These will then be run through the strategic filter (Jul 26)		

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
	can access & contribute to their healthcare information, taking an active role in their health & well-being			• They will then be prioritised and planned for delivery		
	Improve Care - We embed digital & data within our improvement capability to transform care pathways, reduce unwarranted variation & improve health & wellbeing. Digital solutions enhance services for patients & ensure that they get the right care when they need it & in the right place		Completed A3's • Monitoring & Operational Performance, Artificial Intelligence A3's to Complete (End March 26 • Shared Care Records, Care Co-Ordination, Virtual Wards & Hospital At Home, Standards & Interoperability	• A3's are being produced for the pillars and domains (May 26) • These will then be run through the strategic filter (Jul 26) • They will then be prioritised and planned for delivery		
	Healthy Populations - We use data to design & deliver improvements to population health & wellbeing, making best use of collective resources. Insights from data are used to improve outcomes & address health inequalities		A3's to Complete (End March 26 • Central Data Repository & Data Lakes, Design of Interventions, Predictive Analytics for Population Health, Innovation & Research A3's to Complete (End March 26) • Metadata Management	• A3's are being produced for the pillars and domains (May 26) • These will then be run through the strategic filter (Jul 26) • They will then be prioritised and planned for delivery		

Major Digital Projects (Equivalent toTrustwide Projects):

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving in Year Goal	Level of Risk for progressing actions
	Best Quality & Safest Care	Upgrade to the cloud version of Chemocare in readiness for a possible future regional cloud solution	Chemotherapy Prescribing System Upgrade	• Discovery in progress • Awaiting funding to be confirmed	• Engage with supplier/service • Complete discovery • Plan & deliver solution		
	Best Quality & Safest Care	Radiology booking office with ability for patients to book direct into appointments	Radiology Electronic Booking Office	• Feb 26 - Business case approved by BCRG • Mar 26 – Solution procured • PM resource allocated • Delivery underway	• Develop business case and secure funding • Complete procurement • Complete discovery • Plan & deliver solution		
	Best Quality & Safest Care	Replace the current Cardiology system	Cardiology System Replacement	• Feb 26 – Solution procured • Feb 26 - Project Initiated • Delivery being planned	• Engage with supplier/service • Complete discovery • Plan & deliver solution		
	Best Quality & Safest Care	Electronic meal ordering system so patient can order their own meals and provide efficiencies to the catering team/Trust	Meal Ordering, Portering & Domestics System	• Synbiotix supplier confirmed for Meal Ordering, Portering and Domestics • Business case approved by BCRG and SDR • 3 Projects being initiated and planned	• Piggyback off LTHT procurement • Complete business case and secure funding • Engage with supplier/service • Complete discovery • Plan & deliver solution		
	Best Quality & Safest Care	Delivery of a regional integrated PACS and RIS solution	Regional PACS & RIS Replacement	• Awaiting procurement to be completed, business case to be developed and funding to be secured • Procurement plan shared • Procurement evaluation being planned	• Regional procurement and business case to be developed and funding secured • Work with supplier/service - regional programme to plan delivery • Deliver solution		
	Best Quality & Safest Care	Job planning solution for AHP's	Job Planning for AHP's	• Market testing underway with supplier demos planned • Project Manager allocated	• Developing requirement before testing the market • Complete discovery • Plan & deliver solution		
	Best Quality & Safest Care	SystmOne Adult Optimisation	To optimise the use of SystmOne in Adult Community	• Progressing through the digital approval process • If approved and prioritised, then Project Manager to be allocated to compete discovery	• Complete discovery • Plan & deliver optimisation work		

Strategic Programme: Electronic Patient Record

Workstream	True North Metric	Vision	Goal	Current State	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
	Best Quality & Safest Care		*Goals – Date* *EPR Live* – *Apr 26* *New processes to realise benefits* – *Apr 26* *Paper-Lite* – *Apr 26* *HIMSS Level 5* – *Apr 26* *Reduction in patient record systems* – *Apr 26* *EPR DCF 90% Achieved* – *Apr 26* *Optimised System Yr1* – *Mar27* *ePMA* – *Mar28*	This Strategic Programme for the delivery of the Nervecentre EPR continues into its third year (2026-27). T1a Go Live for Observations completed successfully on Wednesday 19th November 25 and Tuesday 2nd December 25 and included: • eObservations • Assessments for eObs (Sepsis, VTE, Stool Chart, Fluid Balance, Weight Chart) • Clinical Photography • Investigations Read Only • Integrations (PCS, MedChart, Winpath, AegisPOC, CRIS, Endovault) • User Acceptance Testing for all T1 scope (Except IP/OP paperless) • Electronic Document Management System (EDMS) – Start scanning Case Notes for live clinics and admissions (9m roll out) T1b Go Live completed successfully on Tuesday 28th April 26 and included • Urgent & Emergency Care • Bed Management & Patient Flow • Remainder of Patient Safety Bundle • Inpatient / Outpatient Paperless & Case Noting • Data Reporting • Pathways & Protocols • Integrations (PACS, YHCR) • EDMS - Users use EDMS to access other systems patient data The following are planned for delivery: • Optimisation (Apr 26 – Mar 27) • Medical Device Integration (Jun 26 – Mar 27) • Ambient Voice Technology Trial (Jun 26 – Aug 26) – Roll Out TBC • eConsent (Sep 26 – Mar 27) • ePMA (Dec 26 – Jul 28) • HIMSS Assessment – Jul 26	• Design, build & test the EPR • Train end users & prepare for go live • Go live with the new EPR, new ways of working & support • Optimise the solution & realise benefits • Enhance with additional modules and functionality • Perform HIMSS Assessment		

Breakthrough Objective:

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

Related Corporate Risks

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

Related External Risks

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

ENABLING AMBTION: HEALTHCARE RESEARCH AND INNOVATION TO IMPROVE QUALITY AND SAFETY 2026-2027

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

GOALS:

Healthcare Innovation

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

Children's Public Health Research

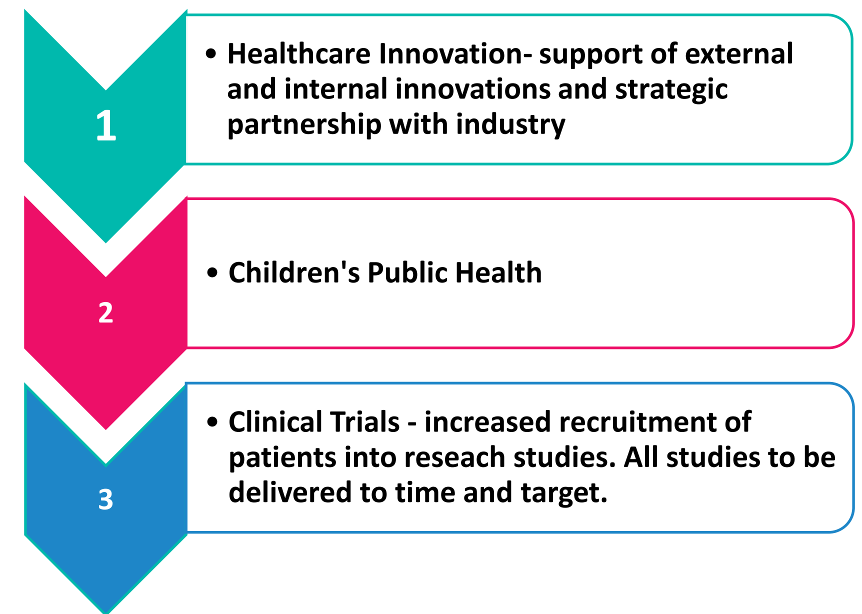
To be a leading trust for the Children's Public Health Services Research

Research studies

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

GOVERNANCE:

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



Trustwide Project:	3T MRI and CRF
Strategic Programme:	HDFT Impact
Breakthrough Objective:	-
Overarching Risk Appetite:	Operational - Cautious

Overarching Risk Summary:

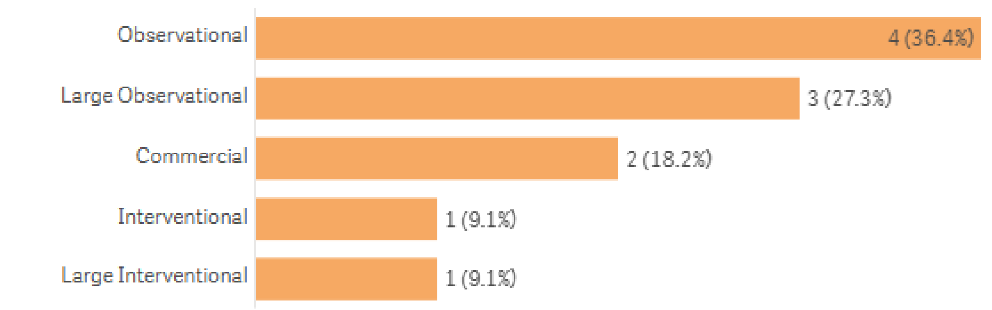
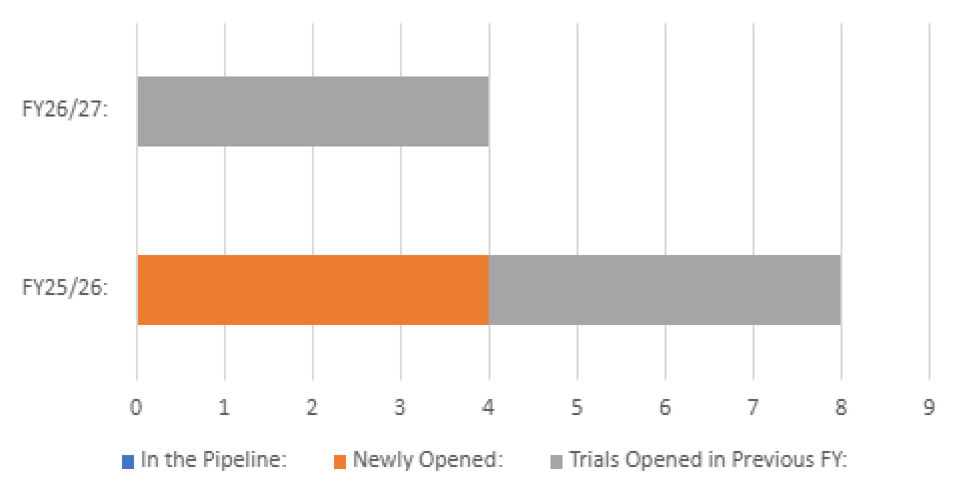
Ambition	True North Metric	Workstream	Ambition Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
					1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Healthcare Research and Innovation	All	Healthcare Innovation	Adopt / develop health innovations that improve the health and care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

True North Summary:

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk to Achieving Goal (C x L)	Level of Risk for progressing actions
Healthcare Innovation	To be a leading trust for the testing, adoption and spread of Healthcare Innovation and to facilitate and accelerate the growth of innovative healthcare solutions in HDFT	Generate, or create cost/time saving benefits equivalent to, >£100,000 to cover staffing costs of innovation team Assess **all** internally generated innovation ideas and support if deemed worth progressing Adopt at least 1 innovation that supports Trust priorities. Help create culture of innovation and develop relevant competencies in all staff by: Delivering a further 3 x Clinical Entrepreneur Fellows; Delivering at least 2 innovation training events per year. Develop strategic partnership with at least one organisation - academia, industry, charity, innovation support organisation	• Clinical Advice Service o Continue to work with paediatric physiotherapy to develop payment mechanism and be first test case by providing support to a North Yorkshire based company who have developed a device to aid in children's physiotherapy o Presented to North Yorkshire Council business advisors to advertise service • Second cohort of Clinical Entrepreneur Fellows (3 x FY2s Aug 25 – Jul 26) continue entrepreneurial work o 1 fellow supporting new project evaluating potential economic benefit of introducing DVT ultrasound in SDEC o Discussions with Blood Cancer UK to explore partnering a fellow to explore improving their referral pathway • Third cohort of CEFs planned to commence in Aug 26 • Working with Medipex to create Service Level Agreement between HDFT, University of York and Hull York Medical School to formalise collaboration. • Delivered 'Introduction to AI in Healthcare' session with Health Innovation – attended by 56 people from across WYAAT Trusts. • 2 x new internal innovation ideas received - currently assessing • Active innovation projects are summarised below: Active innovation projects - April update 0 2 4 6 8 10 12 14 16 18 20 IP Protection, Idea development, Other support, Identifying funding, Pilot, Co-development, Scope interest, Other support, Potential pilot, Identifying funding, Potential adoption, Clinical Advice Service Internal Innovations, External innovations Total, New	Develop benefit-realisation tool Continue to deliver Clinical Advice Service to generate income, support innovation developments and create partnerships Continue and develop new partnerships with industry to create sponsorship opportunities Continue development of innovation governance processes and pathway and communicate to all staff. Utilise project management tools to streamline innovation workflows and tracking. Develop innovation scorecard to aid project prioritisation. Continue to deliver Clinical Advice Service to generate income, support innovation developments and create partnerships. Work with WYAAT innovation partners, Medipex and Health innovation to develop innovation training offerings.		

Children Young People Public Health (CYPPH)	To be a leading trust for CYPPH research, delivering services that are underpinned by evidence of impact on health and wellbeing whilst informing national policy and best practice.	Continue to build workforce confidence, capability and research literacy. Increase portfolio research activity and engagement that aligns to Trust priorities. Strengthen national research engagement, visibility and impact of CYPPH research contributions. Develop strategic partnership with at least one organisation - academia, industry, charity, innovation support organisation. Analyse and utilise CYPPH datasets to shape service provision.	**Build workforce confidence, capability and research literacy.** ○ Embed research learning opportunities on eLearning - Launched Good Clinical Practice (GCP) initial / refresher training completion will be an output metric - Launching What is Health Research ○ Disseminating training opportunities ○ Mentorship & coaching x2 NIHR research applicants ○ CYPPH inclusion within R&I Strategy 2026-2030 **Increase portfolio research activity** • NIHR bid Jan 26 for 0-19 delivery resource funding ○ Feb 26 partial funding secured (0.6WTE B6) ○ May 26 post advertised • Study activity Studies in discussion: Represent Study NIHR302504 Studies in delivery: Circle by the Sea NIHR 162162 Escalator (ELIM -1) NIHR 207059 • CYPPH Research concepts ○ Top to Toe assessment ○ 10-14 Day assessment partnering with Teesside University ○ Housing project (service evaluation stage) ○ Inclusion SCPHN research seeking partnership with Teesside University • **National engagement, visibility & impact** ○ Participation in the Great Start in Life (GSIL) conference May 12th ○ Participation with Yorkshire & Humber (Y&H) 0-19 Research Network ○ Presented at Y&H ARC ○ NIHR Children's Specialty Group – paediatric research involvement in regional collaborations • **Data analysis / use** ○ University of York (UoY) MSc student taking forward; data extraction and analysis stage	Benchmark current research readiness via staff survey and completion / analysis of research SORT assessment. Continue to expand research learning and delivery opportunities and reporting. Develop a clear governance process to governance research activity; including intellectual properties recognition. Develop a standard process to record research activity and outputs. Establish a PPI group to support co-production, capture lived experience to shape research delivery. Develop at least 1 sponsored research concept to a deliverable NIHR approved study that aligns to Trust priorities. Participate in at least 1 showcase event. Develop processes to support data extraction and analysis to evaluate CYPPH datasets to inform service provision. Continue to develop research partnerships including further developing CAMHR at UoY, Y&H ARC, the Centre of excellence DAIM (Data Science, AI and Modelling) and the University of Hull.		
Clinical Trials	To excel in the governance and delivery of clinical research, expanding patient access to high-quality clinical trials through sustainable growth and collaborative partnerships. We aim to be a highly recognised and valued department within the trust, fostering a strong culture of	Generate income to match our research delivery costs.	**Generate income to ensure financial sustainability** Income is generated through two main funding streams, RRDN funding and income generating (including commercial) research: Income predicted from RRDN ~£710k Total forecasted staff costs including direct research delivery staff and support services including Pharmacy ~£1.14m. With expected non pay costs of £50k Income predicted from income generating research based on run rate: ~£86k Forecasted deficit ~£236k	Enhanced financial scrutiny through regular reporting and monitoring. Work through case for dedicated research finance support. Open permanent CRF. Which will attract and enable more income generating and commercial research. Open Research MRI scanner and establish studies to boost utilisation.		

	research and innovation that drives improvement, empowers our workforce, and enhances outcomes for all patients.	Sustain partnership and funding for department with Y&H Research Delivery Network. Deliver contractual agreement and high-level objectives:	Funds currently raised for 26/27: £47,000 **Sustain Partnership (RRDN) funding** The Trust will sustain funding by meeting the key objectives agreed with the RRDN. These are: • Accelerating timelines for research • Driving inclusivity for groups traditionally lacking access to research • Shifting care settings for research away from secondary care • Supporting the life sciences industry • Workforce development	Develop academic partnerships further via York, Bradford and Leeds. YHN community collaboration project will strengthen partnership with GPs and RRDN. Ensure the success of this project to maintain government and RRDN strategic directions are followed. Continue to develop a trial scorecard to ensure prioritisation of studies, which ensures that we open trials that deliver against our ambitions and align to establishment. Review and consider new workforce operational models and structures for the delivery of CYPPH studies. Develop Comms strategy and ensure research remains visible throughout trust and beyond to boost involvement in CYPPH research.		
		Increase the number of patients recruited year on year.	The Trust will deliver by: **To grow the numbers of recruited participants into clinical specialities including CYPPH. To harness the potential of CYPPH research in a community setting.** CYPPH= currently recruiting 0% of Trust patients involved in research (with 1x study due to open and 1x study recently opened to improve this position) **Study Managing Specialty** Reproductive Health and... 108 (67.1%) Public Health 29 (18.0%) Dermatology 10 (6.2%) Cancer 6 (3.7%) Musculoskeletal and Ort... 5 (3.1%) Critical Care 3 (1.9%)			
		Ensure studies open at least 80% are on time and target	**Ensure studies open at least 80% are on time and target:** 81.25% of all trials open are currently meeting their recruitment to Time and Target.			
		Ensure a balance of the different types of studies are opened	**Ensure a balance of the different types of studies are opened:**			

		Open all studies within 60 days of approval). Recruit to opened studies within 30 days of opening Increase the number commercial studies opened year on year	  **Open all hosted studies within 60 days of approval:** FY26/27: 100% of Hosted Trials opened this year have been Setup within 60 days. Note: This figure is impacted by being so early in the FY. **Recruit to opened studies within 30 days of opening** FY26/27: 0% of Trials Opened this year have recruited within 30 days. Note: This figure is impacted by being so early in the FY. **Increase the number commercial studies opened year on year:**  **Facilitate the safe opening and running of a permanent Clinical research facility.** Report; Pop up CRF opened and 70 research patients utilised centre. Patients and team feel resource is starting to show visible presence of research.	Identify and plan for permanent CRF space, building on delivery and lessons learned from pop up CRF space. New project manager (CRF/MRI) post established (temporary) and in recruitment.		

		Successfully apply for at least one external research financial funding bid per year to create fundi ng for staffing . Continue to develop new partnerships to progress research via WYATT, NSO , YHN and academic and commercial alliances. To sustain and develop a patient partnership group and increase the feedback we receive year on year from our patients, sponsors and Pi's Increase the number of trust staff who have completed a recognised research course or qualification. Create a workforce culture where research is part of everyday practice.	Possible move of pop up CRF out of existing space threatens newly established positive outcomes and ongoing need for development of more commercial studies. **External research financial funding bid** Generate more income for the department through external funding bids applications/ and manage the KPIS associated with these funding bids . Two bids successful in 2026 to start April 2026 – associated KPIS to be monitored via RRDN 3 monthly. (see community collaboration project YHN & HDFT) **Develop new and existing partnerships to progress research** Feedback on progress of each partnership alliance through key achievable. Community Collaboration Project YHN and HDFT: May 26 - 2 posts currently in recruitment process. Objectives and short-term plan in place with YHN. WYATT Oncology Y&H partnership - May 26 - Funding arrangements and contractual elements currently being sorted Academic partnerships: York University partnership in various departments established. **Develop patient partnership group and increase the feedback we receive year on year** Monitored via PRES target 25/26 and numbers received each quarter from RRDN **PRES Target FY25/26/27: 77** **PRES Total Achieved FY25/26: 25/77** **PRES Total Achieved FY26/27: 1/77** Development of patient partner group in progress. Feedback on activity and impact 3 monthly. May 26 - 3 new patient partners currently in process of trust induction and local induction. Group objectives in development and regional collaborations being considered. **Create a workforce culture where research is part of everyday practice.** Number of successful applicants to NIHR funding for research-related courses, clinical academic pathways, or development routes.to be collated and published. Completion of the National SORT tool (Used to assess and strengthen research readiness and capability.) Promote the GCP on learning lab and developing other research related materials.	Continue to hold regular patient partner evenings, feedback research results and develop further interest with patients and public . Develop social media platform further with volunteers contributing. Continue to work with national and regional research workforce groups to ensure up to date learning of best practice ad sharing of models. Develop electronic survey to regularly gather feedback from research sponsors and professional investigators within trust to understand their viewpoints when delivering research. Develop monitoring tool with workforce lead at RRDN regarding monitoring of research course activity from trust staff.		

			Feedback report 6 monthly from sponsors and Professional investigators through development of survey. **Separately to the RRDN targets, the Trust aims to increase the number of patients recruited year on year:** 25/26 total recruitment: 2802 Current recruitment 26/27: 156 Target 26/27: 3000 HD FT Cumulative Recruitment 3,500 3,000 2,500 2,000 1,500 1,000 500 0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar FY2526 265 547 802 1,130 1,914 2,228 2,368 2,509 2,637 2,734 2,839 2,962 FY2627	Continue to learn from trials at HDFT that are delivering above the national average for recruitment. Selecting trials via the scorecard process that have potential to give varied access to Clinical Trials at HDFT. Review and consider new workforce operational models and structures for the delivery of studies. Develop Comms strategy and ensure research remains visible throughout trust and beyond to boost involvement in research.		

Trustwide Project: 3T MRI and CRF

True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Best Quality Safest Care: Healthcare Innovation	To have outstanding MRI technology and associated facilities that enable the delivery of our research and innovation ambitions	Procure and install a new 3T MRI scanner.	• Scoping phase behind original trajectory although not affecting overall plan at present. TIF2 timeline ahead of trajectory and therefore not a risk to this project at present. • Mechanical and Engineering Feasibility report received. • Pre market engagement completed. • Full market engagement requested through NHS Procurement route. • Business Case review to be carried out in next few weeks to ensure Research requirements fully included.	• Capital Planning looking at essential versus nice to have within the feasibility study. Business case review to include Research requirements in full along with MRI staffing requirements.		

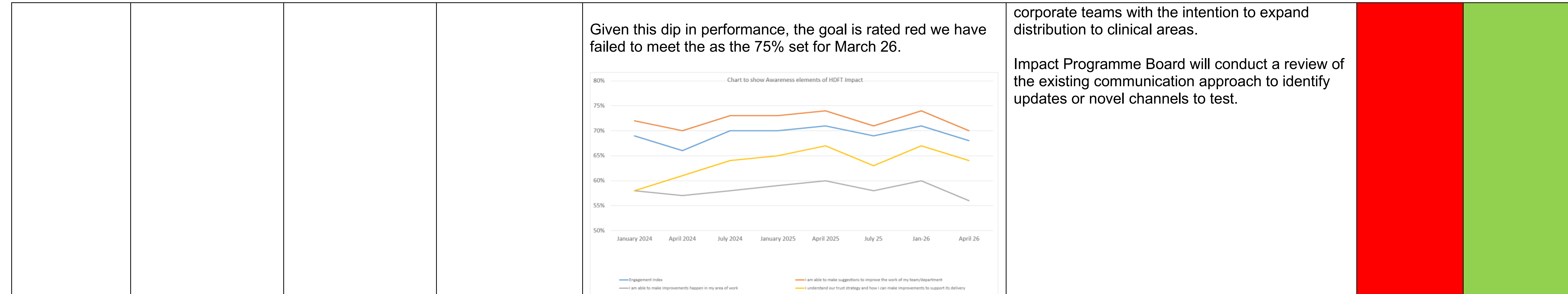
			• Costs to be reviewed in full with a “Must have” and “Nice to have” approach, with costs currently exceeding funding.			

Strategic Programme: HDFT Impact

Workstream	True North Metric	Vision	Goal	Current Status	Countermeasures	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
	All	To develop our capacity and capability and to embed the culture for continuous improvement through the Implementation of the Impact Improvement Operating Model.	Training: **50%** (92/184) of Teams will be trained to use HDFT Impact by Nov 2026 **70%** of teams trained (138/184) by Sept 27.	This Strategic Programme for HDFT Impact continues into its third year (2026-27). In year two we continued the development of HDFT Impact, refining our training offer to meet the needs of operational teams, re-designing our sustainability assessment to understand where the model was robust and where gaps exist that require attention, and exploring different approaches to increase engagement and awareness. Training, Sustainability, and Awareness are now established as our 3 key workstreams for this programme. Performance in these key elements is monitored with three driver metrics. The first is the percentage of teams trained across HDFT. As we have grown our CYPPH services, the number of teams that require training has increased. This accounts for occasional decreases in this performance metric as the denominator grows despite training being delivered at or ahead of trajectory. • In March ‘26 Innovation Committee approved a revised training target which remains ambitious but is more realistic in the current context. • 55 of 184 (30%) of teams have now completed their Impact training. • There are 18 teams in Wave 8 (new model) who complete next month. Waves 9 & 10 will have a further 14 teams each. • Approval of the Improvement Manager business case provides a more positive outlook with regards to delivery of the training targets. • Recent testing of a digital ‘huddle’ board has been well received as has the prospect of a frontline ‘rapid’ PRM that can be completed at the huddle board for teams with 2 or fewer driver metrics. • Delivery of the new training model has proven more challenging for management teams Chart 1: HDFT Impact training delivery performance & trajectory	Early confirmation of Wave 9 & 10 teams via operational leaders at programme board is supporting effective onboarding which is important as the lead time in the new training process is now under 10 weeks per wave. The prospective implementation of a team ‘readiness’ filter will further refine team selection and build confidence that conditions for successful implementation and sustainability of the Impact model exist at the outset. Further Impact for Leaders one-day training sessions are planned for Q2 and Q3 to support those joining HDFT in leadership roles. Returning to full team establishment in the next month will provide vital capacity to continue development of the training offer in response to colleague feedback. Key areas include modification of the new model for management teams and provision of ‘refresher’ training around core concepts for established and senior leaders. Continue to expand testing, development, and implementation of the digital huddle board and ‘rapid’ PRM concept.		

				Forecast for HDFT Impact based on Actual Teams Cum. Number of Teams: 0, 50, 100, 150, 200, 250, 300, 350 Months: Jan-26, Feb-26, Mar-26, Apr-26, May-26, Jun-26, Jul-26, Aug-26, Sep-26, Oct-26, Nov-26, Dec-26, Jan-27, Feb-27, Mar-27, Apr-27, May-27, Jun-27, Jul-27, Aug-27, Sep-27, Oct-27, Nov-27, Dec-27 Labels: 42, 57, 72, 87, 102, 117, 132, 147, 162, 177, 192 Cum. Actual Teams; 90% Upper Confidence Bound(Cum. Actual); 95% Upper Confidence Bound(Cum. Actual)			
			Sustainability: 65% of those who have completed training will have embedded the routines and processes of the Improvement Operating Model after 4 months.	Teams who have completed the HDFT Impact training will reach level 3 maturity (sustainable independence with routines & processes). The new self-assessment process for this metric was launched via the Impact programme board last month. The intention was to have an indicative data set available to report to SDR and Innovation committee in May. Response rates have been very low limiting analysis. At time of writing (8/May/26) the Improvement Academy have received 14 responses as follows: • LTUCC: 9 / PSCC: 3 / CYPPH: 1 / Corporate: 1 • The average score for planned huddles happening was 68% (4.5/5.25) with a quality score of 2.29/3. • One gemba visit was planned and occurred with a quality score of 3/3. • 4 PRMS and 2 Weekly Driver Meetings took place and were assessed with an average score of 2.33/3. • The average response time was 2 mins18 secs. Of those responding, the average scores are suggestive that routines are of good quality and sustained. However, the low response rate means these values should be interpreted with caution rather than taken to be representative. At the request of the Directorate leaders, the data from the ABC survey tool designed to understand the barriers to effective sustainability of Impact processes has been re-issued to with the primary breakdown by directorate rather than professional group.	Impact coaches will recontact their Teams from earlier waves by attending at least one of each relevant routines to further introduce, practice and troubleshoot the data return. This can be carried out as part of the Improvement Academy's own gemba visits. The Dep. Dir Strategy & Improvement is linking with the Directorate leadership teams to explore and mitigate barriers to the self-assessment process. The Head of Improvement is taking this approach with leaders of care group teams who have completed training. Directorates will be able to use the insight from the ABC tool to target interventions more effectively to remove barriers to compliance with Impact routines. The data collection form will be adapted to enable free text comments and requests for help. Modifications are also planned to help analysis.		
			75% of HDFT staff will answer positively to the question: 'I understand our trust strategy and how I can make improvements to support its delivery' by Mar 2026.	The April Inpulse survey provides new data to inform our strategic awareness performance which is presented in the chart below. In summary scores in all domains dipped 1-4% despite the additional training delivered and countermeasures deployed since the last data point in January. Key scores include: • Engagement index: 68% (-3%) • "I understand our trust strategy and how i can make improvements to support its delivery": 64% (-3%) • "I am able to make improvements happen in my area": 56% (-4%)	Two videos to showcase the use and success of HDFT Impact for frontline teams will be finalised and released this month. Production of a third video is planned for early June. These will be available and promoted through internal and external channels. The strategic progress infographic is now loaded into the screensaver function for computers in		

				Given this dip in performance, the goal is rated red we have failed to meet the as the 75% set for March 26.	corporate teams with the intention to expand distribution to clinical areas. Impact Programme Board will conduct a review of the existing communication approach to identify updates or novel channels to test.		



Breakthrough Objective:

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

Related Corporate Risks

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

Related External Risks

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

ENABLING AMBTION: AN ENVIRONMENT THAT PROMOTES WELLBEING 2026-27

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

GOALS:

Wellbeing

A patient and staff environment that promotes wellbeing

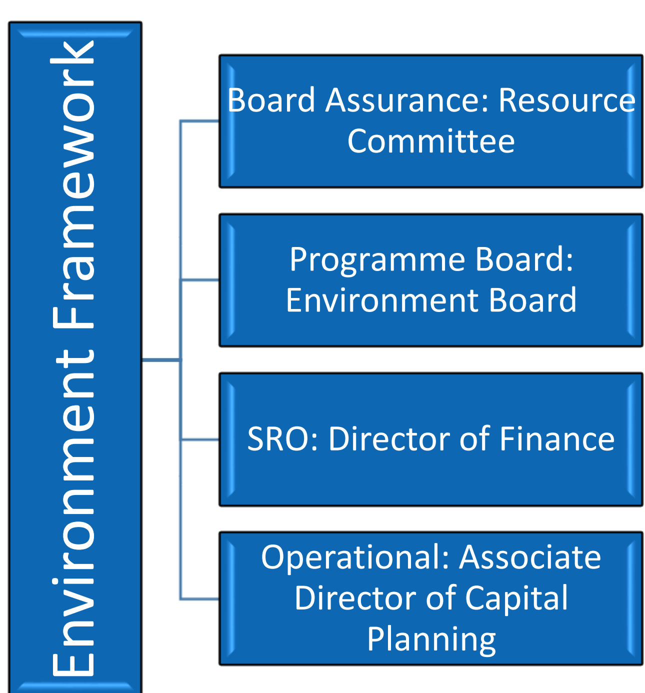
Quality & Safety

An environment and equipment that promotes best quality, safest care

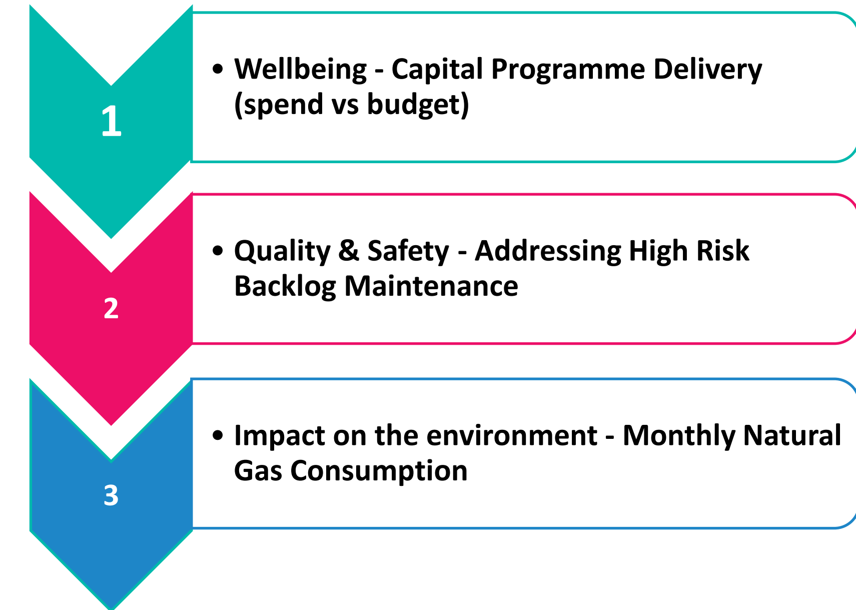
Environmental Impact

Minimise our impact on the environment

GOVERNANCE:



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



Trustwide Project:	- Imaging Project (included in other BAF) - Harrogate Estates Plan
Strategic Programme	N/A
Breakthrough Objective:	N/A
Overarching Risk Appetite:	Operational - Cautious

Overarching Risk Summary:

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

Enabling Ambitions Metrics Summary:

Enabling Ambition Metric	Vision	Goal	Countermeasures	Current State	Level of Risk to Achieving Goal	Level of Risk for progressing actions
Wellbeing	A patient and staff environment that promotes wellbeing	To improve the environment for patients and staff Capital spends vs budget – to ensure delivery against allocated budget.	• Deliver 2026/27 Capital Programme • Develop Capital Priorities for future years • Deliver Block C Theatres & Imaging build • Develop plans for Imaging Corporate Project • Deliver Harrogate Estates Plan	2026/27 Capital Programme - £30.4m Predicted spend forecast – 100% • Block C build – On track • Community Diagnostic Centre – Programme timescales to be confirmed, awaiting letter of support from commissioner and confirmation of funding from NHS England before being able to schedule updated case for Board of Directors. • Harrogate Estates Plan – A3 developed		

Quality & Safety	An environment and equipment that promotes best quality, safest care	To reduce high risk backlog maintenance risks and improve the Trust's premises infrastructure.
		
		2023/24 PAM
		• 37 Moderate Improvement SAQs
		2024/25 PAM
		• 28 Moderate Improvement SAQs
			• Premises Assurance Model
			  ○ Deliver 25/26 PAM action plan
			  ○ Assess Trust against 26/27 standards
			
			• Deliver £1.8m Estates Safety Fund monies
			• Deliver £4.2m RAAC Eradication programme for Estates department
			
			• Develop business case for remaining Estates RAAC Eradication (circa £11m)
			
			• Develop business case for Fire Alarm upgrade (circa £9m)
				• Premises Assurance Model 26/27 submission – On track
				
				• Estates Safety Fund (Fire & Main Theatres design) – On track
				• RAAC Eradication – On track
				
				• Commissioned scoping exercise for the works across RAAC footprint in preparation for business case which will seek approval for funding to eradicate. Case anticipated for Board Q2 2026/27. No funding or timescale agreed.
				
				• Design and Quote from supplier to undertake upgrade received, business case under development. Case anticipated for Board Q2 2026/27. No funding or timescale agreed.		

Environmental Impact	Minimise our impact on the environment	HDFT to be carbon net zero by 2040
		
		Achieve 1,700 tCO2e reduction in Scope 1 and 2 emissions by 2028
			• Refreshed Green Plan developed and approved
			• Carbon accounting process implemented
			• Estates & Facilities
			  ○ Replacement of CHP with more modern, efficient system
			  ○ Investigate geothermal energy
			  ○ Investigate onsite waste to energy system
			  ○ PSDS 4 Works
			
			Medicines- Complete nitrous oxide removal and develop Entonox reduction plan.
				• Complete
				• On Track
				• TBC depending on funding
				
				PLOI agreed between HIF and Trust – will update next month.
				
				External funding received for trolleys to house localised canisters. Piped network will be capped off. Entonox project to be initiated.		

Enabling Ambition Metric	Vision	Goal	Countermeasures	Current State	Level of Risk to Achieving Goal	Level of Risk for progressing actions
				Gas Comsumption (kWh) Apr May Jun Jul Aug Sept Oct Nov Dec Jan Feb Mar 2020-2021, 2021-2022, 2022-2023, 2023-2024, 2024-2025, 2025-2026		

Trustwide Project: Harrogate Estates Plan

Enabling Ambition Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal	Level of Risk for progressing actions
Wellbeing	An Estates Plan for Harrogate District Hospital acute site to improve longer-term Capital Programme Planning to support the Clinical Strategy.	To agree principles of department locations, adjacencies and priority workstreams for the Capital Programme and a more coherent site plan.	• Stakeholder events for involvement • Clinical, Workforce, Digital, Financial, ICS strategy alignment work. • Adjacencies mapping exercise • Links to High Risk Backlog Maintenance & Green Plan goals	A3 has been developed and project approved		

Strategic Programme:

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

Breakthrough Objective:

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

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ID 117	Violence and aggression against staff	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality or permanent disability to employees due to the failure to manage the risk of staff being subjected to acts of violence and aggression whilst carrying out normal duties, due to lack of suitable control measures and appropriate training.	4 x 3 = 12	4 x 2 = 8 ~~March 2026~~ March 2027		
CRR98 / ID 264	Containment Level 3 Laboratory	The unavailability of the onsite Containment Level 3 (CL3) laboratory at HDFT, deemed unfit for purpose in November 2022, has led to the outsourcing of Hazard Group 3 microbiology work to external providers. Initially outsourced to NHS Trusts within WYAAT and, since June 2024, to a private laboratory in London, this situation poses risks to quality, safety, and financial sustainability, including potential delays in clinical diagnosis, risk of inappropriate treatment, and significant ongoing cost pressures.	3 x 5 = 15	3 x 1 = 3 June 2026	Operational: Health & Safety	Minimal
CRR102 / ID 577	Physical security provisions, training and support resources	Organisational risk to compliance with legislative requirements, and the risk of major injuries, fatality or permanent disability to employees, patients, visitors or others due lack of suitable policies and procedures, and the subsequent lack of suitable and sufficient control measures, including physical security provision, training, resources to support implementation.	4 x 4 = 16	4 X 2 = 8 ~~April 2026~~ October 2026	Operational: Health & Safety	Minimal
ID 959	Risk to Theatre utilisation and scheduling due to aged condition of estates	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	3 x 5 = 15	2 x 2 = 4 ~~March 2026~~ ~~Sept 2026~~ Sept 2027		

Related External Risks

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

Author: Kim Zamiteas, Financial Controller

To: Board of Directors

Date: 27th May 2026

CONSIDERATION OF THE GOING CONCERN PRINCIPLE

Harrogate and District NHS Foundation Trust

The Audit Committee considered the Going Concern principle at the March Audit Committee. The following paper outlines the key background to the discussion.

The 2025-26 Department of Health and Social Care Group Accounting Manual (DHSC GAM) refers to paragraphs 4.18 to 4.28 regarding the adoption of the going concern basis extract below:

Going concern

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

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

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

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

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

statements.

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

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

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

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

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

4.28 Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report, but is a separate matter from the going concern assessment.

**HM Treasury – The Government Financial Reporting Manual 2025/26 (FReM).*

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

Actions Requested:

- The Board is asked to approve the Audit Committee recommendation to prepare the 2025/26 Accounts on a Going Concern basis.

BOARD OF DIRECTORS

27th May 2026

Title:	Self-certification with regard to the Provider Licence and Review of Compliance with the NHS Foundation Trust Code of Governance
Responsible Director:	Kate Southgate, Director of Governance & Improvement
Author:	Kate Southgate, Director of Governance & Improvement Paula Chyzy, Corporate Governance Officer

Purpose of the report and summary of key issues:	This report provides the proposed content of the Provider Licence and the review of compliance with the NHS Foundation Trust Code of Governance for approval.	
Trust Strategy and Strategic Ambitions:	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	x
	Person Centred, Integrated Care; Strong Partnerships	x
	Great Start in Life	x
	At Our Best: Making HDFT the best place to work	x
	An environment that promotes wellbeing	x
	Digital transformation to integrate care and improve patient, child and staff experience	x
	Healthcare innovation to improve quality	x
Corporate Risks:	None noted	
Report History:	Approved at Audit Committee 6th May 2026	
Recommendation:	The Board is recommended to approve the Compliance declaration.	

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

BOARD OF DIRECTORS

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

27th May 2026

1.0 INTRODUCTION

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

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

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

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

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

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

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

As reported to the Audit Committee and Board of Directors in 2023, the Guidance on Good Governance and Collaboration was enacted by NHSE in October 2022. Therefore the Trust is also required to review its compliance in relation to this guidance for 2025-26.

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

The Executive Lead is identified as the Chief Executive Officer, supported by his Executive Directors.

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

These documents are presented as follows:

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

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

The Annual Report will be presented to the Executive Management Team for sign-off prior to final submission to the Board for approval in June 2026.

2.0 SELF-CERTIFICATION

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

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

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

Conditions to support continuity of service (CoS7)

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

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

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

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

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

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

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

3.0 RECOMMENDATIONS

The Board of Directors is recommended to:

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

Kate Southgate

Director of Governance and Improvement

May 2026

Appendix 1 – Self Certification

Condition GS6(3) Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution			
The Trust is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.			
	Statement	**Response** **(and supporting information/ assurance)**	**Risks and Mitigations**
	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution	**Confirmed** Audit Committee received the draft annual accounts and the draft charitable accounts in late April 2026 The Trust's Internal Audit progress report highlighted that they believe that the Head of Internal Audit Opinion would confirm that "there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently". The Head of Internal Assurance Report is planned to be presented to the Audit Committee. This is a key piece of evidence to support compliance against this condition of the provider licence. Further evidence to support this condition includes the Board Workshops and Board meeting discussions on the Annual Plan 2025-26. This includes all known risks to compliance, risk reports presented to each Audit Committee and Board meetings, the development of the Board Assurance Framework supported by the Annual Assurance Framework Opinion from Internal Audit, Resource Committee reports, Quality Committee reports, the Integrated Board Reporting arrangements, the quality governance review and the development of the Corporate Governance Framework. The Trust's information processes provide the opportunity to review performance data across multiple domains, to improve the availability and accuracy of data and the flow of information and assurance through the governance structure.	No risks identified

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

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

The Trust is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.

	Statement	Response (and supporting information/ assurance)	Risks and Mitigations
	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed** During the year a wide range of activities have taken place to ensure that Governors have required training. This has included: • Training, learning and development opportunities are available to Governors throughout the year and a comprehensive Governor induction programme is in place for new Governors. • All Governors have access to the external courses programme delivered by Governwell (the National Training Programme for Governors) which is routinely publicised amongst Governors • Communications from a range of sources, including the Kings Fund, NHS Providers, NHS England, CQC, WYAAT, ICB and the local Healthwatch are shared with Governors as appropriate to inform and support the development of their knowledge base with regard to the national and local health economy. • 4 x a year Public and Private Council of Governor meetings • 6 weekly informal governor sessions where the Chair, Chief Executives and rotating executive directors meet with governors to brief them on key areas of business as well as respond to a wide range of questions • 2 x governors observe each sub-committee of the Board	No risk identified

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

	(c) Clear reporting lines and accountabilities throughout its organisation.	• Resource Committee • Remuneration Committee • Audit Committee • People and Culture Committee • Innovation Committee The Trust's governance structure ensures the appropriate flow and review of information at service level and up through the Directorates to Strategy Deployment Room (SDR) formally Senior Management Team (SMT) and supporting groups, providing assurance to the Board and its Committees. The monthly SDR meeting provides scrutiny and monitoring of operational performance, which supports the working of the Board's Committees. An internal audit review of governance through the working of the Board Assurance Framework was carried out during 2025-26, the report provided High Assurance.	
	The Board is satisfied that the Licensee effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	**Confirmed** The Board's infrastructure includes Board scrutiny/assurance Committees and various operational groups, to ensure that the Board of Directors can be assured that the organisation's decisions and business are monitored effectively and efficiently. There are clear escalation routes up to the Board of Directors (as described above). b) SDR and supporting groups scrutinise key areas of performance including quality, workforce, finance, operational and contractual. The Committees review performance and risk by exception (and in accordance with ToR) at each meeting and subsequently provide assurance to the Board of Directors through the Chair's reports highlighting any key recommendations or key risks identified.	No risks identified

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

		review and refresh required to ensure the information provided to the Board is timely and up to date.	
	(f) To identify and manage (*including but not restricted to manage through forward plans*) material risks to compliance with the Conditions of its Licence;	f) The Trust has an approved Risk Policy in place, the Board Assurance Framework (BAF) and Corporate Risk Register provide the framework through which risks are considered, reviewed and managed. The Board receives a summary of the Corporate Risk Register. The Board Assurance Framework forms the basis of the structure to Trust Board in Public and each section is reviewed at each Sub-Committee of the Board. The Audit Committee retains overall review of the process for the development of the BAF. This is the principle tool used to oversee the progress of delivery against the Trust Strategy	
	(g) To generate and monitor NHS Improvement delivery of business plans *(including any changes to such plans*) and to receive internal and where appropriate external assurance on such plans and their delivery; and	g) The Trust has an Annual Planning process that ensures future business plans are developed and supported by appropriate engagement across the organisation. The Annual Plan is discussed in detail at the Resource Committee and by the Board before this is approved.	
	(h) To ensure compliance with all applicable legal requirements.	h) The governance, risk and control processes in place ensures that any risks to legal requirements are considered to ensure the Trust remains compliant.	
5.	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective	**Confirmed** a) There are appraisal processes in place to support Board members individually and collectively. The outcome of appraisals are reported to the Remuneration Nomination and Conduct Committee for Non-	No risks identified

	organisational leadership on the quality of care provided;	Executive Directors, including the Chair and to the Remuneration Committee for the Executive Directors including the Chief Executive.	
	(b) That the Board's planning and decision making processes take timely and appropriate account of quality of care considerations;	b) There are EQIA processes in place to support decision making processes for any service development or changes and any impact on the quality of care is carefully considered.	
	(c) There is collection of accurate, comprehensive, timely and up to date information on quality of care;	c) The Quality Committee supports the monitoring of information on the quality of care; the monthly SDR receive a performance report on the key quality metrics via the BAF reporting framework. The Quality Committee Chair reports any key decisions, risks and escalations to the Board.	
	(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	d) As above - the Board receives a report from the Quality Committee Chair and receives approved minutes of the Committee at the Board meeting held in private. The Board also receives the Quality Account.	
	(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account, as appropriate, views and information from these sources; and	e) The Board, both Executive and Non-Executive Directors play an active part in the organisation, and the visibility of this was highlighted in the NHS Staff Survey. This has been further enhanced in year with a programme of "Meet the Executives" and Gembas (Walk-arounds) in place. Freedom to Speak Up arrangements were strengthened with the support of associate FTSUGs and champions, the "At Our Best" programme to support the cultural agenda, the health and well-being offer was particular strengthened, which was all overseen by People and Culture Committee. In addition, further resource was allocated to the role with a full time Guardian now in post. One of the Non-Executive Directors (NED) is nominated as a NED lead to support 'Freedom to Speak Up' for the Trust and the Executive Director of Nursing, Midwifery and AHPs support the assurance	

		arrangements in place to provide advice and support to the Board as necessary. The members of the Board, meet with the Council of Governors formally 4 times a year with 6 weekly informal meetings being held. Ad hoc activities are also programmed in through out the year.	
	(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	f) There is clear accountability for quality of care through the governance structures in place across the Trust, which reported to the Executive Director of Nursing, Midwifery and AHPs and the Executive Medical Director supported by the Director of Governance & Improvement and Associate Director of Quality.	
6.	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed** All members of the Board, Clinical Directors, relevant Deputy Directors and those that carry out a role to provide advice to the Board comply with the requirements of the Fit and Proper Persons Regulation. All members of the Board and senior decision makers are required to comply with the declaration of interests including loyalty interest policy, which was refreshed and processes and systems strengthened during the year. The annual appraisal process supports effective succession planning through talent conversations and a number of senior managers are engaged in national programmes to support their development to Director level, as appropriate. The Board of Directors during the year had considered its development needs discussing through its Board Workshops. External facilitation was engaged to support the Board development agenda throughout the year.	No risks identified

Appendix 2 – Statements Required to be Confirmed by Board by May and June 2026

1. Statements required to be confirmed by Board by 31 May 2026

G6 Declaration

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

CoS7 Declarations

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

2. Statements required to be confirmed by Board by 30 June 2026

FT4 Declaration

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Board of Directors
27 May 2026

Title:	**Fit and Proper Persons Test Declarations/Annual Return**
Responsible Director:	Rob Eames, Acting Chief People Officer
Author:	Lee-anne Hutchison, Head of Resourcing and Workforce Information

Purpose of the report and summary of key issues:	Under the Fit and Proper Persons FPPT 2023 Framework for NHS Trusts, we are required to undertake a Fit and Proper Persons Test on relevant staff commencing employment and we are also required to undertake these tests annually as part of the 2023 Framework. HDFT and HIF colleagues within the following roles are included in these tests: • Executive directors - existing, interim or permanent • Non-executive directors To complete a FPPT review, the above mentioned colleagues are required to provide/undergo the following: • A completed and signed copy of the Self Attestation form • A completed and signed copy of the Social Media Declaration form • A completed and signed copy of the FPPT Declaration form • A copy of a recent proof of address document • A clear DBS check dated within the last 3 years **or** registered to the update service (this is the only check that requires updating every 3 years). • A Satisfactory Credit Check – This check enables employers to run a financial soundness check on an individual. It provides access to adverse public data in the form of County Court Judgments (CCJs), Bankruptcies (BAIs) and Individual Voluntary Arrangements (IVAs). It also provides up to 5 years of address history and address links which enable Trusts to identify any bad debt at previous addresses. • A Companies House and Charities House Check – to check that they are not prohibited from holding the office in question. • A Social Media check – to check for any context that is offensive or controversial.

<table>
<tr><td></td><td colspan="2">The Trust is required to submit an annual NHS FPPT reporting template as part of the governance process to demonstrate compliance with this framework. This template provided in the extraordinary Board meeting for review and sign off by the Trust Chair before submission.</td></tr>
<tr><td rowspan="8">Trust Strategy and Strategic Ambitions</td><td colspan="2">The Patient and Child First
Improving the health and wellbeing of our patients, children and communities</td></tr>
<tr><td>Best Quality, Safest Care</td><td>x</td></tr>
<tr><td>Person Centred, Integrated Care; Strong Partnerships</td><td></td></tr>
<tr><td>Great Start in Life</td><td></td></tr>
<tr><td>At Our Best: Making HDFT the best place to work</td><td>x</td></tr>
<tr><td>An environment that promotes wellbeing</td><td></td></tr>
<tr><td>Digital transformation to integrate care and improve patient, child and staff experience</td><td></td></tr>
<tr><td>Healthcare innovation to improve quality</td><td></td></tr>
<tr><td>Corporate Risks</td><td colspan="2">N/A</td></tr>
<tr><td>Report History:</td><td colspan="2">N/A</td></tr>
<tr><td>Recommendation:</td><td colspan="2">The Board is asked to:
1) note the rationale/requirements of the FFPT and yearly re-test
2) review and approve the contents of the annual FFPT reporting template before it is submitted by the Trust</td></tr>
</table>

Appendix 5: NHS FPPT submission reporting template

This is a submission form. If anything changes during the year, submit a new form and notify an RD immediately. Do not alter the form.

NAME OF ORGANISATION	**TYPE OF ORGANISATION** ***Select organisation***		**NAME OF CHAIR**	**FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:**
Harrogate and District NHS Foundation Trust		Trust	Sarah Armstrong	11/05/2025
	X	Foundation Trust		
		ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	**Total Number Count**	**Confirmed as fit and proper?**			**Leavers only**	
		Yes	**No**	**How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? ***	**Number of leavers**	**Number of Board Member References completed and retained**
Chair/NED board members	11	11		None	3	2 - 1 leaver was a retirement
Executive board members	12	12		None	3	2 - 1 leaver was a retirement
Partner members (ICBs)						
Total	**23**	**23**			6	

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

***** Do not enter names of board members.***

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	**Yes**	No

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC		No inspection of the 2023 FPPT Framework to date		
Other, e.g., internal audit, review board, etc.		No audit of the 2023 FPPT Framework to date – *We have requested for FPPT to be in the 2026 Audit program*		

Add additional lines as needed

Part 3: Declarations

<table>
<tr><th colspan="5">DECLARATION FOR Harrogate and District NHS Foundation Trust 2026</th></tr>
<tr><td colspan="5">For the SID/deputy chair to complete:</td></tr>
<tr><td rowspan="2">FPPT for the chair (as board member)</td><td>Completed by (role)</td><td>Name</td><td>Date</td><td>Fit and proper? Yes/No</td></tr>
<tr><td>Director of Governance & Improvement</td><td>Kate Southgate</td><td>20/05/2026</td><td>Yes</td></tr>
<tr><td colspan="5">For the chair to complete:</td></tr>
<tr><td rowspan="2">Have all board members been tested and concluded as being fit and proper?</td><td>Yes/No</td><td colspan="3">If ‘no’, provide detail:</td></tr>
<tr><td>Yes</td><td colspan="3"></td></tr>
<tr><td rowspan="2">Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?</td><td>Yes/No</td><td colspan="3">If ‘yes’, provide detail:</td></tr>
<tr><td>No</td><td colspan="3"></td></tr>
<tr><td colspan="5">As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.</td></tr>
<tr><td>Chair signature:</td><td colspan="4"></td></tr>
<tr><td>Date signed:</td><td colspan="4">20/05/2026(Date of signature)</td></tr>
<tr><td colspan="5">For the regional director to complete:</td></tr>
<tr><td>Name:</td><td colspan="4"></td></tr>
<tr><td>Signature:</td><td colspan="4"></td></tr>
<tr><td>Date:</td><td colspan="4"></td></tr>
</table>