teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

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.

CORPORATE RISK REGISTER.

Summary Corporate Risk Register.

Ambition.	Workstream.		True North Metric.	Risk Appetite.	Level of Risk to Achieve Metric – Linked to Risk Appetite							
					1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Best Quality, Safest Care	Ever Safer Care		Moderate & Above Harm	**Clinical: Minimal**								
	Excellent Outcomes			**Clinical:**								
	A positive experience		Patient Experience	**Clinical: Minimal**								
Person Centred, Integrated Care, Strong Partnerships	The best place for person centred integrated care		4-hour ED standard	**Operational: Cautious**								
	An exemplar system for the care of the elderly		Length of Stay – Patients with Frailty	**Operational: Cautious**								
	Equitable, Timely Access to Best Quality Planned Care		Elective Recovery RTT – 18 Weeks	**Operational: Cautious**								
			Cancer 62 Day Standard – 62 Days Treatment	**Operational: Cautious**								
Great Start in Life	National Leader for Children & Young People's Public Health Services		Children at Risk of Vulnerability	**Clinical: Minimal**								
	Hopes for Healthcare		Children's Patient Experience	**Clinical: Minimal**								
At Our Best – Making HDFT the Best Place to Work	Looking After our people		Staff Engagement	**Workforce: Cautious**								
	Belonging											
	Growing for the future		Staff Availability	**Workforce: Cautious**								
	New ways of working											
Finance	Financial Sustainability		Annual Breakeven	**Financial: Cautious**								
			System Oversight Framework Rating	**Financial: Cautious**								
An Environment that promotes wellbeing	Wellbeing	All	Capital Programme Delivery (Spend vs Budget)	**Operational: Cautious**								
	Quality & Safety		PAM >moderate improvement	**Operational: Cautious**								
	Environmental Impact		Natural gas consumption	**Operational: Cautious**								
Digital Transformation	Well Led		Achieve a score of 5/5 across all seven What Good Looks like (WGLL) pillars.	**Operational: Cautious**								
	Ensuring Smart Foundations			**Operational: Cautious**								
	Safe Practice			**Operational: Cautious**								
	Support People			**Operational: Cautious**								

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

Risk Score.

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

February 2026.

As per the HDFT protocol on the 13th and 14th May 2026, Directorates, through their Performance Review Meetings (PRM) reviewed the risks rated 9 and above on their Directorate Risk Register. Discussions were held on any risks to escalate or de-escalate from the Corporate Risk Register.

As per the HDFT protocol on the 14th May 2026, Executive Risk Review Group was held, where Executives reviewed all risks currently on the Corporate Risk Register and any risks that had been escalated or de-escalated by Directorates. At the meeting, the following was confirmed:

- 79 - Stroke: Provision at HDFT for Stroke- This risk was reviewed at the Exec risk review group on Thursday 14th May, this risk was escalated and accepted onto the corporate risk register.
- No further risks were escalated from Directorates in month for inclusion on the Corporate Risk Register
- No further risks were de-escalated from the Corporate Risk Register for management on Directorate Risk Registers

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

Summary: This risk was reviewed at the Exec risk review group on Thursday 14th May; the scoring has remained the same. No further changes to note.

Previous Rating: March 2026 - 15

Escalated to Corporate Risk Register: December 2023

Date reviewed: April 2026

CQC Domain: Responsive

Executive Committee: Resources

Principle Risk: Autism Assessment

Risk Description:

Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition. There is a need to reduce the backlog of referrals back to the NICE standard of three months (reduce the waiting list to approximately 120)

Current Position

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

The Key risk indicators are:

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

Key Targets	Current controls	Gaps in control
Waiting list would have to be reduced to 120 and longest wait to 13 weeks. Baseline capacity would need to meet the referral rate. Numbers on the waiting list 1560 (target 120) Longest wait of CYP having commenced assessment, 82 weeks (target 13) Activity - 31 completed assessments in Aug against ICB plan of 50 (plus 2 military assessment), YTD 255 against plan of 250. To meet the monthly ICB target for number of assessments Meet the annual planned target for assessments	Clinical streaming by complexity at triage. Waiting well offer at this point - includes signposting to support organisations and a facilitated offer if appropriate.	Autism team have drafted an options paper which has been reviewed by PSC leadership team, financial modelling included. Option paper being reviewed by Exec team and awaiting response. Katy Marshall, Strategic lead for autism at HNY ICB, is writing a paper around the capacity issues for all providers and options going forwards. Draft paper delivered in Jan 2025 (following a face-to-face workshop in October 24) is clear that there is no further funding available but that this needs consideration to enable reduction in waiting lists alongside demand management. Further work under Mental Health and learning disability collaborative to agree ICB wide service spec (will not address backlogs).

CRR ID: CRR61 / ID 3	**Target Date:** March 2027		**Very Low Risk**			**Low Risk**			**Medium Risk**		**High Risk**		**Significant Risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
Strategic Ambition: Person-centered, integrated care, strong partnership **Type:** Clinical; Patient Safety	C = 4	**12**							Target Rating			Initial Rating				
	L = 3											Current Rating				

Summary: This risk was reviewed at the Exec risk review group on Thursday 14th May; the scoring has remained the same. No further changes to note.

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

Risk Description:

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

Previous Rating: April 2026 - 12

Escalated to Corporate Risk Register: December 2023

Date reviewed: April 2026

CQC Domain: Safe

Executive Committee: Resources

Previous Target Date: March 2026

Current Position

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

Key risk indicators
ECS 4-hour target to be met - 78%
October 2025 - 74.3%
YTD - 78.25%
12 Hour Breaches target to be met - 0
October 2025 - 27 (consistently top quartile)
6-hour breach removed due to 12 hour and 4-hour performance. Data still captured on PowerBi.
November 2025 - rating remains unchanged.
January 2026 - temporary mitigations in place with pilots for USDEC / RIAT doctor. Final Trust position - 71.4%
February 2026 - extended RIAT pilot to end of March.
March 2026 - EEMAC trialed for March. Positive impact seen.
April 2026 - 78% in April so far as of 21/04/26.

Key Targets	Current controls	Gaps in control
4-hour performance A&E 4-hour target to be met, 6-hour breaches <102 per month 0 x 12-hour breaches	• Improved streaming pathways to HDFT specialties, with focused engagement from medicine; surgery; frailty & Paediatrics. This aligns with GIRFT clinical operation standards and part of Corporate Clinical Services Strategy. • Nurse staffing to SNCT levels. • Introduction and use of non-headed beds and use of rapid decompression plans. Shared risk site wide. • Point of care testing in ED to support swift decision making re. patient placement • Adoption of OPEL escalation • x4 daily bed meetings; manager of the day model embedded across PSC and LTUCC.	• Significant delays to medical bed. Plan to move medical admission ward in December 2025 to gain 6 medical beds. • Winter plan enacted to open escalation ward as of 29 December 2025. • Pilot of winter RAT doctor in ED. Pilot of urgent SDEC proposed.

CRR ID: ID 6

Strategic Ambition: Provide person-centered, integrated services through strong partnerships

Type: Clinical; Patient Safety

Target Date: June 2026		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
		1	2	3	4	5	6	8	9	10	12	15	16	20	25
C = 3	12						Target Rating				Initial Rating				
L = 4											Current Rating				

Summary: This risk was reviewed at the Exec risk review group on Thursday 14th May, the scoring has remained the same. No further changes to note.

Principle Risk: Community Dental Wait Times.

Risk Description:

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

The service is in the process of moving to a new provider and the risk with transfer with the service.

Previous Rating: March 2026 - 12

Escalated to Corporate Risk Register: December 2023

Date reviewed: March 2026

CQC Domain: Responsive

Executive Committee: Resources

Previous Target Date: March 2026

Current Position

As of April 2026
0 over 52wk RTT waiters
1646 over 52wk non-RTT waiters
694 overdue (assuming recall was set to 12 months) surveillance patients.
following audit, additional waiting patients identified not being tracked. 3 patients waiting since 2023, 373 since 2024.
maternity gaps remain and unsuccessful recruitment. no paediatric specialist in east locality at present
24 patients need expediting due to reporting pain and service cannot accommodate within six weeks - next soonest "soon" slot is eight and ten weeks depending on location (if require paed or adult specialist)

Key Targets	Current controls	Gaps in control
Numbers on the patients waiting to start treatment over 52weeks, 65weeks and 78weeks Current position for RTT waiters - 0 patients between 52-64 weeks. Current position for Non RTT waiters – 1187 patients over 52 weeks, no of overdue continuing care patients. Overdue surveillance patients -1666 (longest overdue by 3 years).	Implementation of business case agreed additional capacity - equipment and additional dentist/dental nurse capacity. Clinical prioritisation of patients at triage - currently meeting urgent P2 turnaround times for GA patients and 2 working day target for trauma patients. Pts advised to recontact service if deterioration - pain/repeated courses of antibiotics.	Lack of contract and delivery plan beyond 31st March 26 as procurement exercise for long term contract still not concluded (1yr extension offered in interim). Current extension has additional requirement of delivering Epidemiology survey for public health, which will reduce core service capacity - unfortunately base budget also not fully re-provided which has reduced capacity in the service. Current focus on key areas: 1) Continuing recruitment focus on posts and hard-to-recruit areas - paediatric specialist/consultant capacity. Paused recruitment due to unsuccessfully filling vacancies. Have recruited 3 new dentists, although not specifically paediatric specialists. 2) Patient IT system procurement to replace SOEL Health which is no longer supported (Procurement exercise in evaluation phase, implementation date for Oct25). Business case not progressed during Summertime, AM to submit for Dec BCRG. 3) If patients ring to report pain as advised, we aim to appoint within 6 weeks. 4) Focus on GA pathways to try to replicate productivity at York exodontia lists at Harrogate/Northallerton - implemented increase from 4 per list at Northallerton to 5 - further opportunity identified to work with South Tees in September25. Harrogate sessions have increased pts per list with a continued focus on theatre utilisation.

CRR ID: CRR96 / ID 79 **Strategic Ambition:** Person centred, integrated care, strong partnership **Type:** Clinical; Patient Safety	Target Date: March 2026		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	C = 4 L = 3	12				Target Rating						Current Rating		Initial Rating		

Summary: This risk was reviewed at the Exec risk review group on Thursday 14th May, Following the risk being discussed at corporate PRM. The risk was escalated and accepted onto the corporate risk register.

Principle Risk: **Provision at HDFT for Stroke.**

Risk Description:
Risk to patient care and safety due to delayed treatment caused by: - Lack of HASU Capacity at LTHT and YTHFT and aspects of the regional stroke pathway not being followed.

Previous Rating: August 2025 - 16

Date added to CRR: May 2026

Date reviewed: May 2026

CQC Domain: Safe

Executive Committee: Quality

Previous Target Date: October 2025

Current Position
Potential delays in assessment of patients self-presenting with stroke at HDFT ED. Variation of access to HASU for patients suffering an inpatient stroke at HDFT. 2023/4 SSNAP data: 41.5% of all confirmed strokes were directly admitted to HDFT and missed HASU care and assessment.

Key Targets	Current controls	Gaps in control
All eligible patients receiving HASU Care No patients requiring HASU are directly admitted to Harrogate for Emergency Care.	1. All eligible patients receive HASU care. 2. No patients requiring HASU are directly admitted to Harrogate from Emergency Care. 3. Pilot underway with YDH, LTHT and YAS, pathway review with stakeholder end of April 25. Teething problems identified but generally working well. Target date extended to end of October as a more realistic timeframe for fully embedded pathway.	1. Limited control and mitigations possible as ongoing negotiations with WY and NY are not yet concluded. Proposed pilot with York for inpatients and walk-ins to be referred to York remains under negotiation. 2. Continue to monitor SSNAP data and datix's raised re direct admissions to Harrogate. Ensure datix reports submitted for all delays and non-transfer is robust to understand root causes. Planned Audit with HDFT and YAS for last 12 weeks data to understand why these patients were directly admitted. This will commence 30/09/24.

CRR ID: ID 117 **Strategic Ambition:** An Environment that promotes wellbeing **Type:** Operational; Health & Safety	Target Date: March 2027		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	C = 4 L = 3	12							Target Rating			Current Rating		Initial Rating		

Summary: End of year data confirmed for 2025/26: 571 incidents reported on Datix, compared to 333 reported for the year 24/25.
Physical Assault - 153 (93), Inappropriate Behaviour 348 (171), Threatening and/or Verbal Abuse 70 (69)

Principle Risk: Managing the risk of violence and Aggression

Risk Description:

Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality or permanent disability to employees due to the failure to manage the risk of staff being subjected to acts of violence and aggression whilst carrying out normal duties, due to lack of suitable control measures and appropriate training.

Previous rating: March - 12

Escalated to Corporate Risk Register: February 2024

Date reviewed: March 2026

CQC Domain: Safe

Executive Committee: People & Culture

Previous Target date: ~~July 2025~~

March 2026

Current Position

End of year data confirmed for 2025/26: 571 incidents reported on Datix, compared to 333 reported for the year 24/25.
Physical Assault - 153 (93)
Inappropriate Behaviour 348 (171)
Threatening and/or Verbal Abuse 70 (69)

New V&A Policy is currently under consultation and first stage of approval expected at June H&S Committee. Work has also started on the supporting series of SOPs (clinically led), including 'Yellow/Red' card escalation process, security escalation process, this will support the creation of a Physical Restraint / Clinical Holding Policy / SOPs, the combination of these will replace the Managing and Identifying Patients with Challenging Behaviours. Work has also started on production of a new Absconding Patients Policy which will support potential V&A scenarios (being led by the CSM lead).

Violence and Aggression Risk Assessments continue to be progressed for HDH areas, multiple draft assessments now being finalised with ward managers.
Ligature Environmental Assessments completed for all inpatient areas / ED.

Current training compliance levels
Conflict Resolution Level 1 - 97.7% Trust, 97.9% HIF
Conflict Resolution Breakaway Skills - 65.9% (Trust), 67.6% (HIF)
Conflict Resolution Physical Restraint - 76.3% (Trust), N/A (HIF)
Lone Working - 99.5% (Trust, 1477), N/A at this time (HIF)
Increase in CPD funding will ensure additional training is provided through the first half of 26/27. V&A also being included in work-related stress sessions, and as part of new risk assessments.
New security provision at HDH will go live in June 2026 (2-person presence 24/7) in addition Mon-Fri supervisor on site who will liaise with clinical areas to identify improvements.

- Due to the time required to carry out changes to the above, as well as incorporate V&A as part of new 3-year Trust H&S Strategy currently being finalised the target score date is being extended to March 2027.

Key Targets	Current controls	Gaps in control

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

CRR ID: CRR98 / ID 264

Strategic Ambition: An Environment that promotes wellbeing

Type: Operational; Health & Safety

Target Date: June 2026

C = 3	15
L = 5	

Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
		Target Rating							Initial Rating	Current Rating			

Summary: Enabling work is underway, room has been stripped out, reception area reconfiguration work is complete. Some minor delay due to electrical work required. Likely completion date end of May 2026.

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

Risk Description:
The unavailability of the onsite Containment Level 3 (CL3) laboratory at HDFT, deemed unfit for purpose in November 2022, has led to the outsourcing of Hazard Group 3 microbiology work to external providers. Initially outsourced to NHS Trusts within WYAAT and, since June 2024, to a private laboratory in London, this situation poses risks to quality, safety, and financial sustainability, including potential delays in clinical diagnosis, risk of inappropriate treatment, and significant ongoing cost pressures.

Previous Rating: March 2026 – 15

Escalated to Corporate Risk Register: July 2024

Date reviewed: March 2026

CQC Domain: Effective

Executive Committee: TBC

Previous target date April 2025

Current Position

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

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

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

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

Key Targets	Current controls	Gaps in control
1. Minimise delay to patient treatment 2. Zero staff harms resulting from exposure to unexpected hazard group 3 pathogens 3. Zero lost samples 4. Cessation of outsourcing & transport cost pressure	Selected work being sent off site with results entered manually when returned. This is having a huge financial impact - approx. £53K for 12 months (this would have cost approx. £27K to do in house) Daily list of specimens packed provided.	Delay to results due to referral to Leeds and time taken to input results until issue resolved. No secure electronic transfer of results available.

CRR ID: ID 292

Strategic Ambition: Person-centered, integrated care, strong partnership
Type: Clinical; Patient Safety

Target Date: September 2028		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
		1	2	3	4	5	6	8	9	10	12	15	16	20	25
C = 4 L = 3	12				Target Rating			Initial Rating			Current Rating				

Summary: This risk was reviewed at the Exec risk review group on Thursday 14th May, the scoring has remained the same. No further changes to note.

Previous Rating: March 2026 - 12

Escalated to Corporate Risk Register: May 2025

Date reviewed: March 2026

CQC Domain: Safe

Executive Committee: Resources

Previous target date September 2025

Principle Risk: Automated medicines supply services

Risk Description:

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

Current Position

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

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

- 15/11/23 Robot training completed for all staff.
- 01/05/24 Weekly robot reboot including log of when this has occurred.
- 01/05/24 First recovery planning meeting held. Risk score increased due to increase in frequency of failure.
- 21/5/24 No failure requiring significant downtime for 4 weeks. Recovery plan in progress with completeness by mid-June. Service due 22nd May.
- 13/05/25 Failure around once a month. Escalated back to capital planning for replacement as this has dropped off the radar. To update the business case and resubmit to BCRG with the addition of a competitor in the robot market.
- 25/03/26 BCP reviewed and in place. 20/04/2026 No change
- 21/4/26 BD engineer on site twice since the last review. Had service review with BD. Optimising capacity in the robot.

Key Targets	Current controls	Gaps in control
	• Robot malfunctions monitored via Stores and Distribution and escalated where increasing frequency gives cause for concern. • Robot listed on the capital assets register. • Staff re-training in progress to ensure correct use. • More detailed reports now obtained from BD when issues logged with BD.	• Business case to support capital replacement of the robot. • Meeting with BD to discuss new robot options planned for 27th June. • 1.5.24 Business continuity plan for robot failure

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

Summary: Target date extended to reflect implementation of Security team and allow new Security Policy to be produced to reflect these changes and the impact of Martyn's Law

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

Risk Description:
Organisational risk to compliance with legislative requirements, and the risk of major injuries, fatality or permanent disability to employees, patients, visitors or others due lack of suitable policies and procedures, and the subsequent lack of suitable and sufficient control measures, including physical security provision, training, resources to support implementation.

Previous rating: March 2026 – 16

Escalated to Corporate Risk Register: August 2024

Date reviewed: March 2026

CQC Domain: Effective

Executive Committee: Health and Safety

Previous target date: April 2026

Current Position

Major development in implementation of HDH security provision, expected go live date of June 8th, 2026. Currently recruited x8 security officers and x1 team leader to allow 2-person 24/7 presence. Team leader will be Mon-Fri role and allow routine interaction with clinical teams to embed new service and liaise on required improvements.

Home Office has now published guidance in relation to Martyn's Law (still awaiting SIA enforcement guidance), Security Manager reviewing detailed guidance and preparing report on current HDFT position.

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

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

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

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

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

Key Targets	Current controls	Gaps in control
Building Security Assessments completed for all premises used by Trust staff (this will not include patient homes which will be	Suitable and sufficient assessments of risk have been carried out for all Trust / HIF activities.	• Limited assurance audit has been received in relation to Security, which links to the work on V&A. Discussed at H&S Committee that security should be separated from this risk entry and

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

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

Summary: This risk was reviewed at the Exec risk review group on Thursday 14th May, the scoring has remained the same. No further changes to note.

Previous Rating: March 2026 – 15

Escalated to Corporate Risk Register: November 2025

Date reviewed: March 2026.

CQC Domain:

Executive Committee:

Previous target date: December 2025

Principle Risk: Histopathology space and safety concern

Risk Description:

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

Current Position

As of April 2026, the department is still very tight on space and is currently in contingency with the down draft benches so working in less space around the one bench (this is a separate risk on the Histology register) this is still the same status as last month’s review. This is a risk that UKAS will want to see we have tried to reduce when they come to access currently set for September.

Key Targets	Current controls	Gaps in control
	Risk of specimen loss - controlled by specimen disposal performed by x2 staff members with quality control checks in place Risk of spillage due to specimens being stacked and at height - Disposal carried out weekly in order to try and create space and reduce specimens being stacked at height. Wax deliveries (20kg) each are having to be stored under benches in the lab - this poses a health and safety risk to staff having to move the bulk boxes from under benches. Blocks are required to be stored for a minimum of 30 years. Blocks are kept on site for a minimum of 2 years due to additional tests that may be required. They are then transferred to an offsite secure facility to store for the remaining 30 years. The capacity for storage has been reached and there are limited options for further storage due to the requirement for a reinforced floor. A significant amount of flammable reagent (alcohol, xylene and formalin) are used daily and more frequently due to additional strainers being required to keep up with the increased demand. Due to limited space majority of this is being stored in the outside flammable store. This results in staff having to make frequent trips to the store and poses a manual handling issue. When receiving a breast mastectomy specimen national standards state that the specimen should be opened within 4 hours. This is not always possible due to a downdraft bench being unavailable. This may lead to degradation of the specimen	Specimens being stacked at height - we ensure that disposal is regular, but this is not always sufficient to ensure that specimens are not stacked at height. Risk assessment complete and staff trained in spill procedure, spill kits available if required. Datix completed if a spill occurs Breast mastectomy specimens - in order to meet national standards, the team try to reorganise workload to enable a downdraft bench to be freed up. If this is not possible a different bench is used but this requires the movement of all reagents to an area where there is no downdraft ventilation. This poses a health and safety risk Inability to expand the service to support additional workload i.e. - expansion of specific services, TIF2 project. Discussion underway with cancer alliance regarding funding opportunity and if this can be used for expansion either additional equipment or capital work. Paper submitted to environment board to highlight space issues

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

Summary: This risk was reviewed at the Exec risk review group on Thursday 14th May, the scoring has remained the same. No further changes to note.

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

Risk Description:

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

Previous Rating: March 2026 - 12

Escalated to Corporate Risk Register: November 2024.

Date reviewed: March 2026.

CQC Domain: Safe

Executive Committee: Quality

Previous target date – December 2025

Current Position

- Inadequate staffing 12.5 PAs down at consultant level currently filled with locum cover,
- lack of continuity of Registrar/middle grade ward cover,
- reliance on locum consultant and associated team and quality risks

Risk of burnout of current medical and ACP team due to workload pressures.
Other consequences to these factors include outpatient RTT, angio and echo waiting time breeches.
Cardiology Strategy Planning meeting scheduled for November 24. Current position managed through HDFT IMPACT and regular updates provided to LTUC Tri-Team for escalation to the executive team.
October 2025 - Locum consultant no longer in post.
December 2025 - recruitment processes underway re-previous long-term locum.
Development of workforce planning document underway.

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

CRR ID: ID 721 **Strategic Ambition:** Overarching Finance **Type:** Financial	**Target Date:** March 2027		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	C = 5 L = 5	25							Target Rating					Initial Rating		Current Rating

Summary: This risk was reviewed at the Exec risk review group on Thursday 14th May, the scoring has remained the same. No further changes to note.

Previous Rating: February 2026 - 20

Escalated to Corporate Risk Register: May 2025

Date reviewed: February 2026

CQC Domain: Well-Led

Executive Committee: Resources

Previous Target Date: March 2026

Principle Risk: Group Cash Position.

Risk Description:

The cash position for 26/27 will require support throughout the financial year due to the planned £15.3m deficit. The Trust is managing cash flow on a week-by-week basis there is currently £10m+ payments outstanding with Suppliers at the end of April.

Current Position

PDC is being chased for capital schemes that have been approved in the prior year.
£14.4m cash support received in 25/26, year-end deficit £23.75m.
Cash support requested in April, May and June. April received 1/2 of the £9.2m application, May outcome unknown and June requires submitting 11th May.
Despite Supplier relationships being maintained to date, relationships are becoming strained despite the payment team's best efforts. Fines/penalties, threat of accounts being put on hold escalate. WRAP delivery is key in reducing the run rate for 26/27 which will relieve some of the cash pressures being faced.

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

CRR ID: ID 884 Strategic Ambition: Type: Clinical; Patient Safety	Target Date: July 2026		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	C = 4 L = 4	16			Target Rating									Initial Rating Current Rating		

Summary: This risk was reviewed at the Exec risk review group on Thursday 14th May, the scoring has remained the same. No further changes to note.

Previous Rating: April 2026 - 16

Date added to CRR: August 2025

Date reviewed: April 2026

CQC Domain: Responsive

Executive Committee: Resources

Previous target date March 2026

Principle Risk: Risk to Patient Safety & Experience due to non-compliance with National KPI's for waiting times and reporting in Imaging Services

Risk Description:

Due to the delays in routine diagnostic imaging, there is an unknown risk of patients waiting up to 5.5 months for diagnostics which should be delivered within 6 weeks. This is causing delays in treatment, diagnosis and decision making for care plans for patients. It impacts on RTT performance, organisational reputation and patient experience. There is also a risk due to our non-compliance with National KPI's for waiting times and reporting.

Current Position

Internal CT scanner (acute scanner) replaced with new scanner (was the TIF2 scanner in storage) is now operational as of 09/03/26. Last instance of unplanned downtime with CT scanners in mobile village was in February. Score downgraded - risk for this issue now back on departmental register.
Lifespan of CT scanners now approx. 8years.
Chillers need replacing on the CT scanner in the mobile village due to take place 15/04/26.
InHealth CT booked until 30/04/26
SOPs in place to divert patients to alternative providers.
x3 CT scanners now running in parallel with plan to continue until end of April. Aim by end of April to have CT scan within 6 weeks.
Still out of target for KPIs
Please note these are dependent on resource availability and exam requested.

Appointment Waiting Times

CT	DEXA	MRI	US
863	378	1067	1453

Average Reporting Wait Times in Days

CT	DEXA	MRI	PLAIN FILM
33.7 days	26 weeks	24 days	36 days

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

	They are then transferred to an offsite secure facility to store for the remaining 30 years. The capacity for storage has been reached and there are limited options for further storage due to the requirement for a reinforced floor. A significant amount of flammable reagent (alcohol, xylene and formalin) are used daily and more frequently due to additional strainers being required to keep up with the increased demand. Due to limited space majority of this is being stored in the outside flammable store. This results in staff having to make frequent trips to the store and poses a manual handling issue. When receiving a breast mastectomy specimen national standards state that the specimen should be opened within 4 hours. This is not always possible due to a downdraft bench being unavailable. This may lead to degradation of the specimen	of specific services, TIF2 project. Discussion underway with cancer alliance regarding funding opportunity and if this can be used for expansion either additional equipment or capital work. Paper submitted to environment board to highlight space issues

CRR ID: ID 959 **Strategic Ambition:** **Type:** Operational	**Target Date:** **September 2027**		**Very Low Risk**			**Low Risk**			**Medium Risk**		**High Risk**		**Significant Risk**			
			1	**2**	**3**	**4**	**5**	**6**	**8**	**9**	**10**	**12**	**15**	**16**	**20**	**25**
	C = 3 **L = 5**	**15**				**Target Rating**		**Initial Rating**					**Current Rating**			

Summary: This risk was reviewed at the Exec risk review group on Thursday 14th May, the scoring has remained the same. No further changes to note.

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

Risk Description:

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

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

Previous Rating: April 2026 - 15

Escalated to Corporate Risk Register: February 2026

Date reviewed: April 2026.

CQC Domain: Responsive

Executive Committee: Resources

Previous target date: ~~March 2026~~

~~September 2026~~

September 2027

Current Position

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

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

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

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

CRR ID: ID 1241 Strategic Ambition: Overarching Finance Type: Financial	Target Date: March 2027		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	C = 3 L = 4	12							Target Rating			Current Rating		Initial Rating		

Summary: This risk was reviewed at the Exec risk review group on Thursday 14th May, the scoring has remained the same. No further changes to note.	**Previous Rating:** April 2026 - 12
Principle Risk: Recurrent delivery of Efficiency programme (WRAP) **Risk Description:** £20.8m WRAP target 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.	**Escalated to Corporate Risk Register:** April 2026 **Date reviewed:** April 2026 **CQC Domain:** Well-Led **Executive Committee:** Resources

Current Position
Following review 14/02/2026: The Trust has a £14.4m WRAP programme to deliver in 25/26. As of January, 93% has been actioned and £6.2m cost reduction schemes have also been identified. Risk adjusted plans have improved but still leave a gap to full delivery. Governance structure has been developed and PRMs will pick up progress each month. There is also the £6m risk share to consider how this will be addressed (part of the contract agreement 50/50 risk share) Internal audit provided significant assurance on the WRAP process due to current delivery and the benchmarking information which supports the targets.

Key Targets	Current controls	Gaps in control
	• Weekly meeting with Fm's in place to review progress. • Monthly reporting Directorate to Board level. • Exec leads in place for central schemes. • Key focus on run rate reduction schemes. • Start review that costs are being managed within contractual envelopes (similar to CYPH)	• Lack of transformational schemes • High level unidentified • Directorate ownership

CRR ID: ID 1242

Strategic Ambition: Overarching Finance

Type: Financial

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

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

Principle Risk: Delivery of Financial Plan 26/27

Risk Description:

The trust has submitted a breakeven plan for 26/27 however there are a number of risks still to be mitigated including full delivery of WRAP programme, mitigating unfunded cost pressures and how the risk share with the ICB will be managed.

Previous Rating: April 2026 - 20

Escalated to Corporate Risk Register: April 2026

Date reviewed: April 2026

CQC Domain: Well-Led

Executive Committee: Resources

Current Position

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

The Trust has a planned Deficit £19m for 26/27.

The Trust came under scrutiny for not delivering 25/26 plan (Breakeven versus £20m deficit).

HDFT Impact measure - Number of cost centres overspent, based on 25/26 315 cost centres were overspent.
WRAP Delivery key to delivering plan (Separate risk for this) £28m.

Key Targets	Current controls	Gaps in control
• Financial Variance to plan • WRAP delivery • Cash position	Finance Governance structure HDFT Impact - key measure in place for all Directorates All the below were shared with all budget holders in March that will continue into 26/27. • Discretionary spend controls will continue. • Trust wide vacancy panel will remain in place for all non-clinical roles. • Agency requests that are off framework or exceed NHS cap rates must be approved by an Executive Director. (Please ensure the agency request form is fully completed for all agency bookings.) Agency Form for all requests outside of NHSP (Medical/AHP/Nursing/Admin/Support Services) – Fill in form • All requisitions over £25k will continue to be reviewed. • Invoices without valid purchase orders will be returned to the supplier. • The Finance Delivery Oversight Group (FDOG) will continue to meet monthly.	• HNY Contract • Delivery of activity plans

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NHS Harrogate and District NHS Foundation Trust

BOARD OF DIRECTORS
27th May 2026

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

<table>
<tr><td>Purpose of the report and summary of key issues:</td><td colspan="2">The report provides Quality Committee with:
Assurance on nursing and midwifery quality indicators triangulated with nurse and midwifery staffing data,
Assurance that daily monitoring of patient safety and quality risks in relation to the workforce are in place.</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></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">Report reviewed at the Quality Committee</td></tr>
<tr><td>Recommendation:</td><td colspan="2">The Board is asked to note the content of the report.</td></tr>
</table>

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

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NHS Harrogate and District NHS Foundation Trust

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

Quality Committee

Nursing and Midwifery Quality and Safe Staffing Report

1.0 Introduction

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

Data in this report is provided for February and March 2026.

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

As per the Safer Staffing Policy, the threshold for enhanced monitoring of performance is where nursing establishment levels have fallen below the 80% threshold in month.

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

2.0 Hard Truths Data

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

HDFT have set a threshold of 80% with regards to achieving its planned nursing numbers by shift. Any ward / in patient area, that falls below 80% will be reviewed in line with several quality metrics to see if patient care and outcomes has been affected due to planned establishment not being fully met. It has been identified that the only area where Registered Nurse (RN) planned hours fell below 80% in February and March was Woodlands and the Acute Medical Unit. These reduced staffing percentages were aligned with bed occupancy levels and actual staffing requirements. This is reflected in the CHPPD score of 8.6 across both areas. 'Actual' Care Support Worker (CSW) staffing levels showed that many inpatient areas were operating below 80% fill. In line with the Safer Staffing Policy and associated Safe Staffing SOP, all areas were reviewed to ensure continued safe staffing assurance. Available staff were redeployed to the most appropriate areas according to patient acuity, dependency, and bed occupancy.
The table below shows all wards and the percentage fill rate for days and nights, split by registered and unregistered staff.

March							
	Day		Night		CHPPD		
	RN	CSW	RN	CSW	RN	CSW	Overall
Ward	Fill (%)	Fill (%)	Fill (%)	Fill (%)			
Acute Frailty Unit	92.5%	76.3%	103.1%	107.9%	5.1	3.7	8.9
Acute Medical Unit	79.9%	83.9%	82.3%	97.7%	5.3	3.3	8.6
Bolton	99.8%	81.4%	100.9%	104.8%	4.3	3.1	7.3
Byland	94.7%	75.8%	97.6%	96.0%	3.5	3.0	6.5
ITU/HDU	91.8%	23.8%	106.0%	25.8%	32.8	1.5	34.3
Fountains	92.2%	74.6%	98.3%	99.7%	4.1	2.9	7.0
Granby	90.1%	79.5%	97.8%	92.9%	3.8	3.7	7.5
Jervaulx	97.7%	80.3%	99.9%	95.1%	3.6	3.1	6.7
Lascelles	97.8%	61.5%	99.9%	96.8%	4.5	2.7	7.2
Maternity	115.0%	117.4%	96.6%	91.6%	9.4	2.8	12.3
Nidderdale	94.4%	88.4%	97.5%	100.0%	4.1	2.9	7.0
Oakdale	96.6%	91.1%	101.7%	127.8%	3.6	3.1	6.8
Trinity	100.0%	85.1%	100.0%	98.4%	3.9	3.1	7.0
Rowan	101.4%	59.6%	98.2%	55.2%	8.1	2.5	10.6
Special Care Baby Unit	83.8%	-	103.6%	-	19.0	-	19.0
Wensleydale	92.4%	76.3%	105.2%	90.2%	5.9	2.6	8.5
Woodlands	79.1%	64.7%	104.9%	73.9%	6.8	1.8	8.6
Total	**94.6%**	**79.4%**	**99.0%**	**95.9%**	**5.2**	**3.0**	**8.2**

February							
	Day		Night		CHPPD		
	RN	CSW	RN	CSW	RN	CSW	Overall
	Fill (%)	Fill (%)	Fill (%)	Fill (%)			
Acute Frailty Unit	94%	81%	123%	107%	4.8	3.3	8.1
Acute Medical Unit	82%	87%	84%	99%	4.7	2.9	7.6
Bolton	97%	82%	104%	105%	4.2	3.1	7.3
Byland	94%	78%	103%	94%	3.6	2.9	6.5
ITU/HDU	92%	25%	79%	35%	26.8	1.4	28.2
Fountains	86%	84%	94%	93%	4.0	3.2	7.2
Granby	92%	74%	99%	95%	3.3	3.0	6.3
Jervaulx	92%	85%	99%	98%	3.4	3.1	6.5
Lascelles	100%	70%	100%	96%	4.2	2.7	6.9
Maternity	114%	136%	92%	87%	8.7	2.9	11.6
Nidderdale	97%	100%	100%	123%	3.8	3.1	6.9
Oakdale	97%	93%	101%	112%	3.6	3.0	6.6
Trinity	97%	90%	100%	100%	3.4	2.8	6.2
Rowan	98%	58%	99%	24%	11.7	2.8	14.5
Special Care Baby Unit	82%	0	95%	0	11.6	0.0	11.6
Wensleydale	93%	52%	148%	89%	5.7	2.4	8.1
Woodlands	81%	55%	102%	63%	7.0	1.6	8.6
Total	**94%**	**78%**	**103%**	**95%**	**5.0**	**2.9**	**7.8**

3.0 February and March 2026 Results

During February and March 2026, 17 eligible inpatient areas were reviewed.

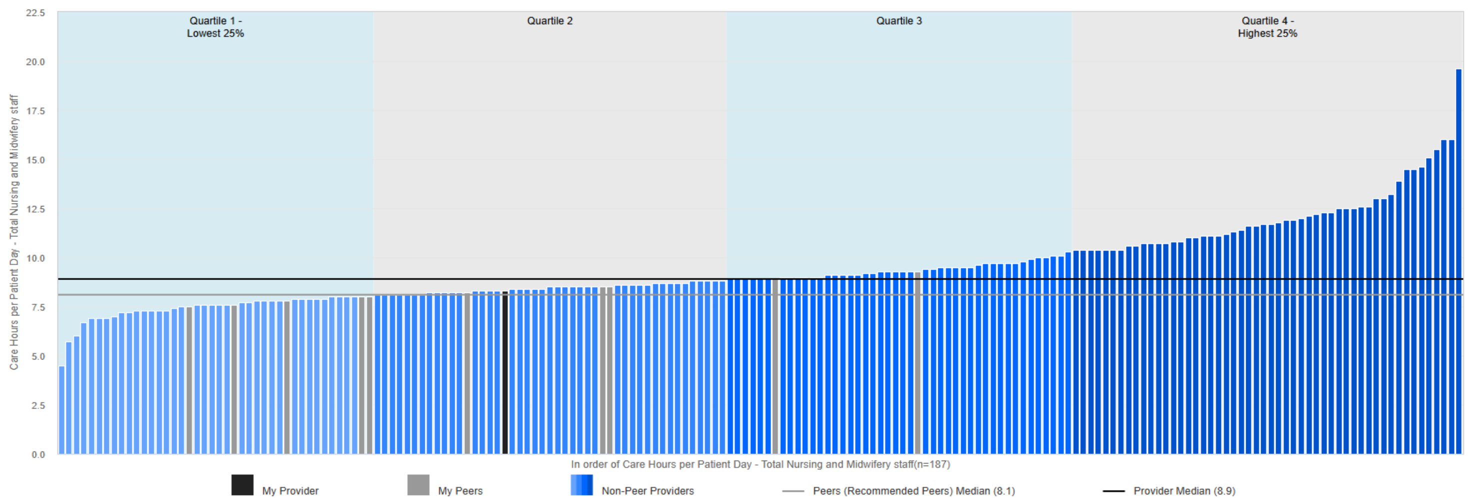
Planned versus actual fill rate data varied across inpatient wards for both registered and unregistered staff, with some areas operating below threshold and others above. This variation demonstrates the effective and responsive deployment of the available workforce, ensuring staffing levels were aligned to patient acuity and dependency in accordance with safer staffing processes.

Care Hours Per Patient Day, is a metric used in healthcare to measure the amount of direct care provided to patients by registered nurses, midwives, and healthcare support workers over a 24-hour period. Care Hours Per Patient Day (CHPPD) remain above the national 'peer' hospital median, placing the organisation in national quartile 2. This position demonstrates staffing levels that are comparable with, and in some areas exceed, peer performance.

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

Maternity services had 1.8 WTE midwifery vacancy position in February, which had reduced to 1 WTE in March. Midwifery sickness has continued to steadily increase over the winter period with February sickness being 8.82% however March has seen a slight decrease to 8.43%. Shifts were released to NHSP however fill rates remain just above 50%. The staffing template has been increased in March further to the agreed increase in establishment being fulfilled.

The table below demonstrates that HDFT CHPPD is in the second quartile (8.3), which places us above our peers (8.1) and lower than the national median (8.9). This data is taken from Model Health System on 27th April 2026.



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

Care Hours Per Patient Day	Data period	Provider value	Peer average	National value	National value method	Chart
Care Hours per Patient Day - Total Nursing and Midwifery staff	Dec 2025	8.3	8.1	8.9	Provider median	
Care Hours per Patient Day - Registered Nurses and Midwives	Dec 2025	5.3	4.8	4.9	Provider median	
Care Hours per Patient Day - Healthcare Support Workers	Dec 2025	3.0	3.4	3.5	Provider median	

4.0 Temporary Workforce Usage

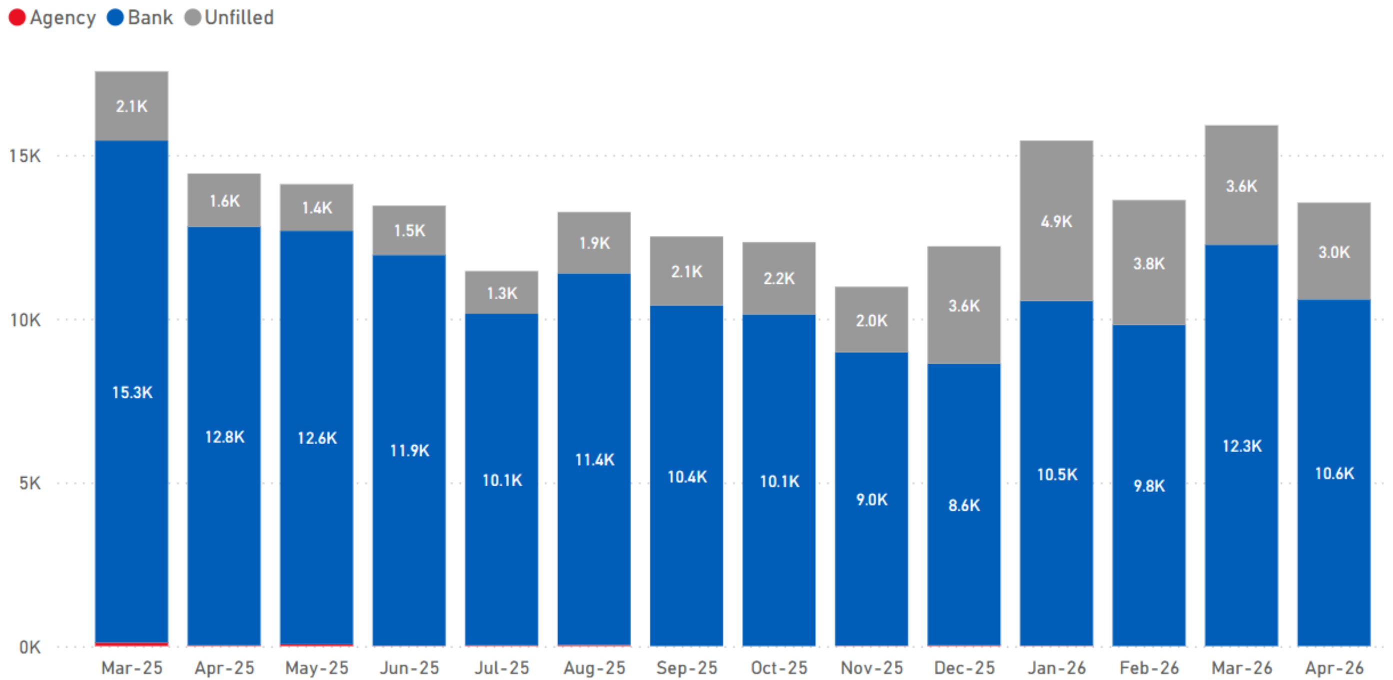
Temporary workforce usage remained elevated in February and March to support the safe staffing of escalation wards and additional beds. There was no agency usage across the 17 inpatient areas.

Within Adult Inpatient wards, the introduction of strengthened assessment processes for Enhanced Therapeutic Observational Care has significantly reduced the requirement for temporary staffing. Combined with the successful recruitment to RN vacancies, these measures continue to deliver a sustained reduction in temporary workforce reliance and improved workforce stability.

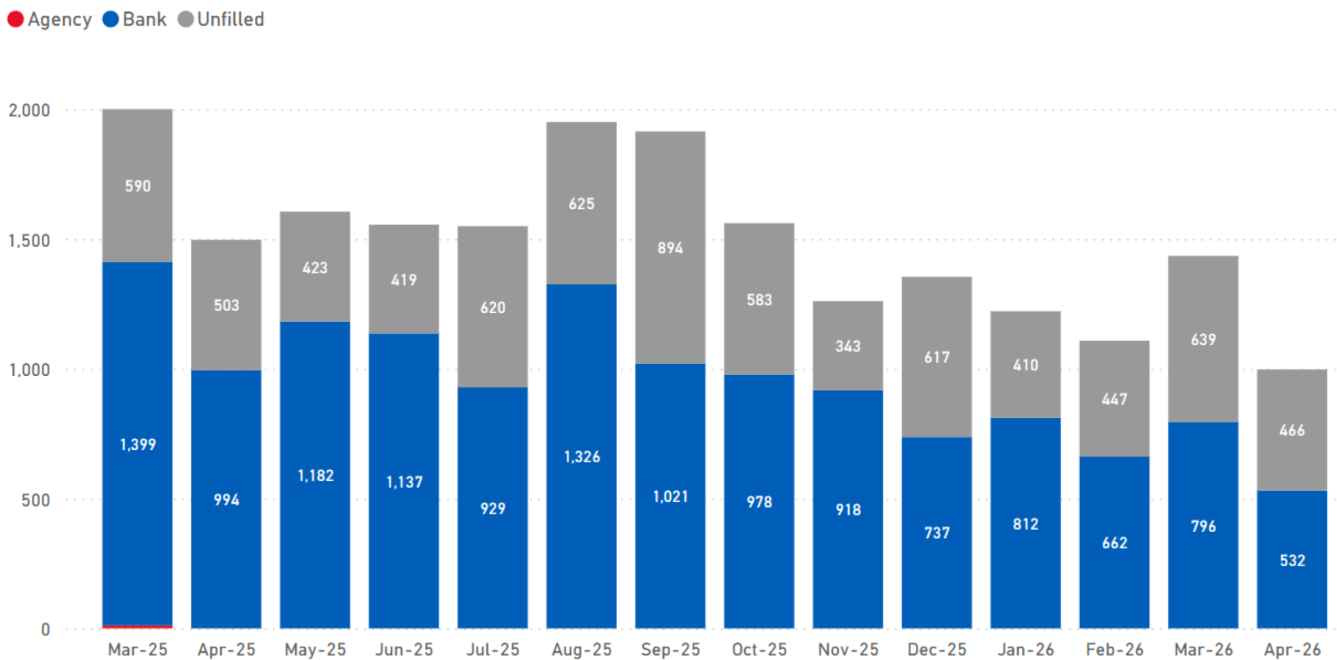
Recruitment to CSW vacancies is progressing, with posts now being recruited at Band 3 following the conclusion of the Band 2 role review. In the interim, vacancies are being safely managed through NHSP, ensuring continuity of care while substantive appointments are finalised. In addition, a 'New to Care' programme has been launched to attract and retain CSWs who are new to the sector and do not yet hold the qualifications required to apply directly for a Band 3 role. This 12-month development programme will enable individuals to commence employment at Band 2 and progress to Band 3 once the required knowledge and skills have been consistently demonstrated.

Overall, temporary workforce utilisation continues to reduce year on year. This reflects effective recruitment, strengthened workforce controls, and increased assurance that services are staffed with the right people, with the right skills, in the right place, at the right time.

Registered and Unregistered Nursing Temporary Workforce



Midwifery Temporary Workforce



5.0 Key Performance Indicators

5

Between February and March 2026, 20 moderate and above events were reported (note: some of these events are still awaiting verification).

The events occurred across nine categories: Diagnosis, Tests & Imaging; Obstetrics & Maternity; Procedure & Surgery; Pressure Ulcers & Skin Damage; Fundamentals of Care; Appointments, Bookings Transfer & Discharge; Health & Safety; Bereavement; Workload & Staffing.

Falls:

In February there were no falls with moderate or above harm.

In March there were four falls with moderate harm reported and one medical collapse with severe harm. When investigated at Quality Oversight panel one moderate harm fall had omissions in care identified. Learning has been shared. No omissions in care were identified for the other incidents.

Pressure ulcers:

In February, two moderate harm pressure ulcers were identified. Investigation into these is ongoing and reports will be reviewed at Quality Oversight panel once finalised.

In March, three moderate harm pressure ulcers were identified. Investigation into these is ongoing and reports will be reviewed at Quality Oversight panel once finalised.

6.0 Assurance Report

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

- no areas have fallen below the 80% threshold for three consecutive months for staffing
- no areas have fallen below the expected range for key quality indicators for three consecutive months

The Trust has recently updated the Safe Staffing Policy and introduced Standard Operating Procedurs (SOPs) for Safe Staffing and Temporary Workforce, to ensure safe staffing escalation and a monitoring process. A bespoke dashboard is also in development to support the monitoring of this and will incorporate key quality metrics.

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

7.0 Escalation and Reporting Nurse and Midwifery staffing concerns

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

and dependency to staffing levels to support the management of workforce requirements on a shift-by-shift basis.

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

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

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

After discussion with the nurse in charge/unit manager, the matron will add professional judgement to SafeCare, documenting any mitigation they have made. Once any moves, mitigations and professional judgement have been added, all matrons or deputies join the 10.30 safe staffing meeting. During this meeting, the lead matron will complete a systematic review of each area, asking for any concerns or safety risks to be raised. Each matron or deputy will highlight any areas where there is still a staffing risk or other concerns, and where they have been unable to mitigate this risk from within their own care group.

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

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

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

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

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

8.0 February - March 2026 SafeCare Red Shifts

There were no red shifts escalated to the Director of Nursing Midwifery and AHP's during the months of February and March.

Recommendations

The Quality Committee is asked to:

- Note the safety, quality and staffing information detailed for February and March 2026.
- Note assurance of the daily process for monitoring and managing nurse and midwifery staffing levels at inpatient level through the SafeCare system.
- Note that actions are ongoing to monitor the standards of nursing care given within the Trust and support any identified areas with reduced performance.

Jenny Nolan, Deputy Director of Nursing, Midwifery and AHPs
Brenda Mckenzie, Workforce Assurance Lead

18 May 2026

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Finance Report Month 1 March – 2026/27

Author
Director of Finance – Jordan Mckie
Deputy Director of Finance – Karen Scarth

26/27 Finance summary as at April

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26/27 ACTUAL YTD	CASH POSITION	CAPITAL SPEND	RISKS 12+
£-4.9M	£4.3M	£1M	25 - Cash Position 16 - Delivery of Financial Plan 12 – Recurrent WRAP Delivery
PLAN £-1.5M DEFICIT	MINIMUM BALANCE £2M	PLAN £2M	

26/27 FORECAST	PAY GROWTH	WASTE REDUCTION AND PRODUCTIVITY ACTIONED (WRAP)	BANK AND AGENCY USE
£-19.3M	0.01% 24.66WTE	3%	Agency on target Bank forecast £5M off track
LIKELY CASE	*49.98 WTE SOUTH TYNESIDE NEW CONTRACT	7% PLAN M1	

YTD Summary

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£-4.9M ACTUAL

£-1.5M PLAN

£-3.4M VARIANCE

Key drivers in month

Type	£000's	Narrative	Future Mitigation
Income	£600k	• Further work to do in understanding activity delivery	• Review activity monitoring and gain assurance around reporting and impact on £'s. **Performance/Finance Team** - **May-26**
Pay	£307k	• Industrial Action	• No external funding to support costs need to absorb costs in year. **OD's**
N Pay	£1.8m	• WRAP delivery	• Prioritise focus on WRAP delivery in all meetings to close gap. All Directorates to establish WRAP program for the year by **May -26**.
Qtr 4 Activity Delivery	£0.7m	• CT Scanner hire £0.1m • NHSP/Tempre £0.3m • LLP £0.2m	• Additional stretch target to mitigate across year
Total	**£3.4m**		

Key Items in Month

- Pay Award processed for all A4C staff £1.3m impact in month, ICB supported funding the gap 2.10%-3.30%. Estimate for the DDRB also included with an assumption for the income top up 2.1%-3.5%.
- South Tyneside 0-19 new contract commenced April 26.
- Cash support requirement continues June application to submit and May outcome unknown.
- Capital spend on track, letter of support still outstanding to support CDC business case being submitted, £12.5m.
- Agency and bank spend within NHSE targets (further 10% and 30% reduction).

YTD Summary & Forecast

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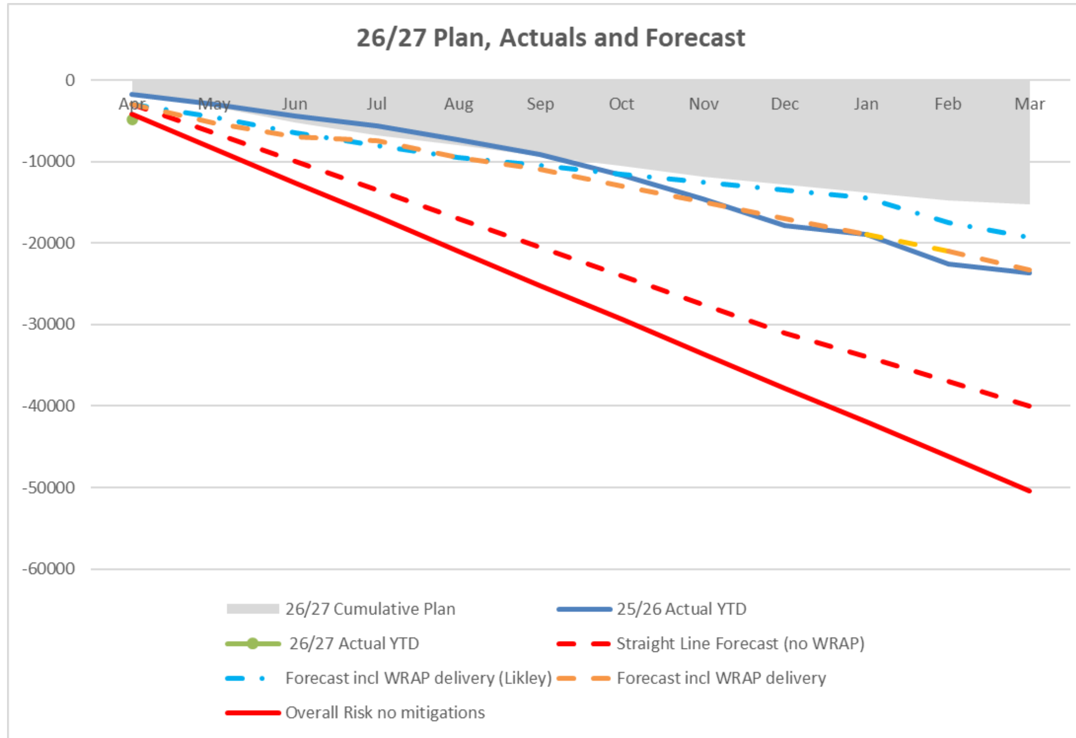
£-4.9M
ACTUAL

£-15.3M
BEST
£-19.3M
LIKELY
£-40M
WORSE (RUN RATE)



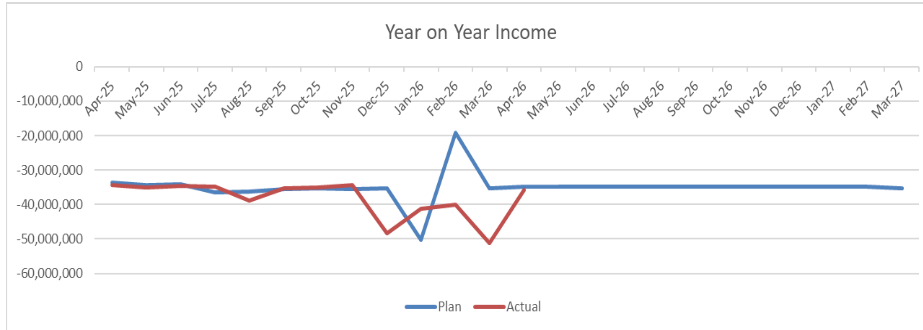
Areas of concern for 26/27

- Delivery of activity plans
- Utilisation of core time (M-F)
- Current run rate
- WRAP delivery
- Y/End risks moving into 26/27
- Limited provisions on B/Sheet
- No opportunities for developments in year unless significant cash releasing benefits identified
- Industrial Action

Mitigations to be agreed.

PFR reported forecast £15.3M

Year on Year

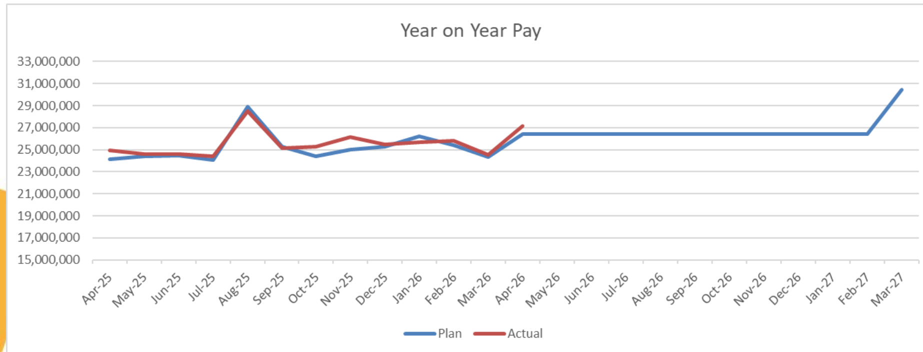


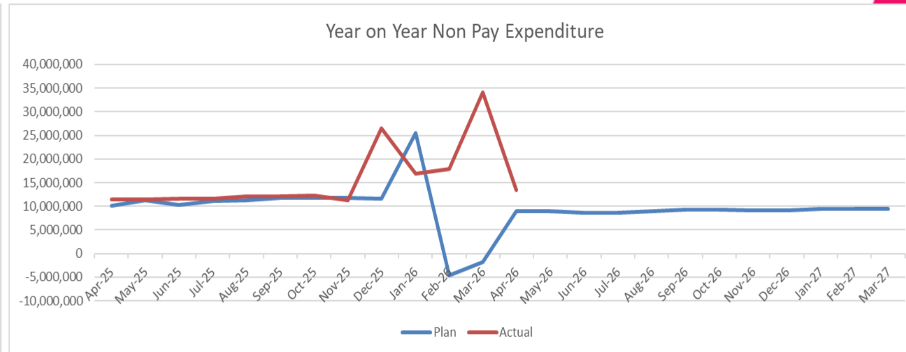
25/26 Plan went through a forecast protocol change, Qtr 4 plan amended.

Pension impact in March 25/26 has been removed £18.5m(I&E).

Non Pay budget plans include WRAP targets.

25% of Income and Expenditure is from Local Authorities (0-19 Contracts).



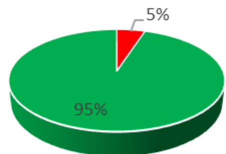


Waste Reduction and Productivity (WRAP)

MONTH
£0.9M ACTUAL
£2.7M PLAN

YEAR
£32M TARGET

ACTIONED YTD RECURRENT
95%



WRAP delivery is behind plan by £1.8m (plan phased in twelfths) as of month 1 due to delayed implementation and a £9m gap in plans.

WRAP Progress

3,500,000
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 Budget Phasing

£9m gap in plans

Recovery actions in place, including weekly WRAP delivery meetings. Numerous schemes remain dependent on PID completion and EQIA/Board approval, delaying cash release.

26/27 Grip and Control

Grip and Control Section	Action	Rag Rating Delivery	Rag Rating Impact	Further Action needed
1) Rapid actions	•Pace in delivery of financial improvement;			Focus on specific actions
	•Improve financial culture;			Internal special measures/recovery plans for loss making specialties/directorates. Weekly reporting.
	•Rapid develop and deliver CIPs;			No Finance PMO. Ownership and plans limited.
	•Central procurement controls;			
	•Reduce discretionary spend;			
	•Reduce pay spend;			Employee incentives (Mileage/Living Wage/subsidised catering) Ban on agency.
	•Estates benefit;			
	•Business cases and Capex review;			Projects that can be cancelled or delayed.
	•Income generation.			Private Patients needs a decision/Review R&D

Recovery Plans – 26/27

	Recovery Mthly Value	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Risk	Decsion to be agreed at Board
Plan		-1,480	-1,842	-1,842	-1,602	-1,269	-1,271	-1,272	-1,272	-1,033	-940	-939	-523	**-15,279**		
Actual YTD		-4,866												**-4,866**		
Run Rate forecast			**-3,666**	**-3,666**	**-3,666**	**-3,666**	**-3,666**	**-3,666**	**-3,666**	**-3,666**	**-3,666**	**-3,666**	**-3,666**	**-40,326**		
Forecast without recovery actions or risks														**0**		
RECOVERY ACTIONS																
Mileage uplift (7p top up)	22				22	22	22	22	22	22	22	22	22	**198**		
Remove Real living Wage	172							172	172	172	172	172	172	**1,032**		
Remove subsidy of catering	8				8	8	8	8	8	8	8	8	8	**72**		
Stop non clinical agency	33				33	33	33	33	33	33	33	33	33	**297**		
Suspend training	78				78	78	78	78	78	78	78	78	78	**702**		
Stop loss making WLIs	91		91	91	91	91	91	91	91	91	91	91	91	**1,001**		
Reduce NHSP Mid point	58				58	58	58	58	58	58	58	58	58	**522**		
Reduce NHSP bottom point	25				25	25	25	25	25	25	25	25	25	**225**		
Delivery activity plan	200		200	200	200	200	200	200	200	200	200	200	200	**2,200**		
WRAP Delivery - Central schemes	1,500							1,700	1,700	1,700	1,700	1,700	1,700	**10,200**		
WRAP Delivery - Directorates			500	500	500	500	500	750	750	750	750	750	750	**7,000**		
TIF2	67							67	67	67	67	67	67	**402**		
Ward staffing levels	350							350	350	350	350	350	350	**2,100**		
Total Recovery Actions		**0**	**791**	**791**	**1,015**	**1,015**	**1,015**	**3,554**	**3,554**	**3,554**	**3,554**	**3,554**	**3,554**	**25,951**		
Industrial Action														**0**		
Total Risks		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		
Recovery/Risks Net + Run rate		**0**	**-2,875**	**-2,875**	**-2,651**	**-2,651**	**-2,651**	**-112**	**-112**	**-112**	**-112**	**-112**	**-112**	**-14,375**		
Updated forecast position including recovery actions and risks		**-4,866**	**-2,875**	**-2,875**	**-2,651**	**-2,651**	**-2,651**	**-112**	**-112**	**-112**	**-112**	**-112**	**-112**	**-19,241**		
Actual Position		**-4,866**														

Balance Sheet

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Row Labels	Plan	AP01
Capital and Reserves	**-207,963**	**-204,893**
Income and Expenditure Reserve	24,900	22,953
Public Dividend Capital	-217,696	-217,698
Revaluation Reserve	-15,167	-10,148
Current Assets	**44,865**	**36,838**
Cash and Cash Equivalents: Commercial / In Hand / Other	1,000	2,389
Cash and Cash Equivalents: GBS/NLF	4,413	738
Credit Loss Allowances	-380	-378
Inventories	3,747	2,565
Trade and Other Receivables: NHS Receivables	11,300	8,413
Trade and Other Receivables: Non-NHS Receivables	24,785	23,112
Current Liabilities	**-52,937**	**-48,081**
Borrowings	-2,352	-6,965
Other Liabilities: Deferred Income	-1,400	-207
Provisions	-448	-557
Trade and Other Payables: Capital	-3,513	-3,240
Trade and Other Payables: Non-Capital	-45,224	-37,113
Non-Current Assets	**226,636**	**221,979**
Credit Loss Allowances		-97
Intangible Assets	18,900	18,740
Property, Plant and Equipment: Other	197,423	196,418
Right of Use Asset	9,147	6,218
Trade and Other Receivables: NHS Receivables	361	361
Trade and Other Receivables: Non-NHS Receivables	805	340
Non-Current Liabilities	**-10,601**	**-5,843**
Borrowings	-10,601	-5,843

Cash continues to be a concern (separate slide details position). No other concerns to flag.

Cash

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£4.3M (APRIL 2026)

£6.3M (MARCH 2026)

MINIMUM CASH BALANCE £2M

BPPC

Paid within 30 days

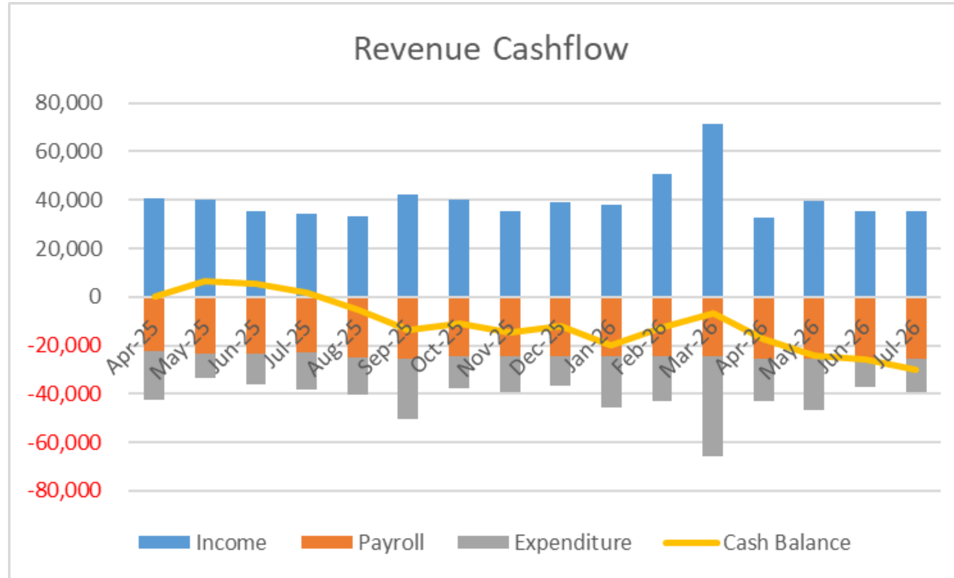
23%

No of Invoices

59%

Value of Invoices

TARGET 95%



Mth	Cash Support request	Cash Support Approved
April	£9.5m	£4m
May	£4m	£2m
June to August	£4.7m	

Cash support total £14.6m received 25/26.

Cash support applications will continue each month into 26/27.

Cash remains a challenge into next financial year, the impact with no cash support is highlighted in the chart.

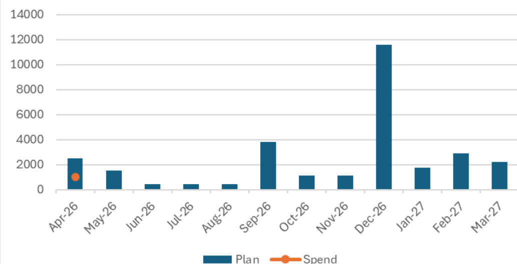
£10m+ approved Supplier payments on hold as cash is being managed within set weekly thresholds. Supplier relationships are becoming more strained and accounts have been put on hold.

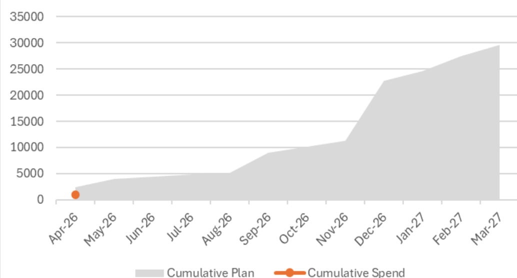
Key Areas of priority focus
1.Aged Debt
2. WRAP delivery
3. Recovery Actions

Capital

£1M

SPEND YTD INCL IFRS16





CDEL Assumption	Description	Scheme ID	Plan	Actual	Forecast
CDEL Schemes					
	IT	IT	210	20	210
	RAAC/TIF2	RA/T2	2,200	350	2,200
	EPR	EPR	2,500	342	2,500
	Carry Forward Schemes from 25.26	PRIOR YEAR		297	0
	Staff Survey		250	0	250
	MRI Scanners		2,000	0	2,000
	HIF Management Fee		500	0	500
	IFRS16			0	0
	Balance		-2,113		0
Total Plans against CDEL			**5,547**	**1,009**	**7,660**
PDC Schemes (Non CDEL)					0
Confirmed	Estates RAAC	RAAC - OTHER	4,167	21	4,167
TBC	Constitutional Standards - Imaging CT Scanner		660	0	660
TBC	Constitutional Standards - CDC		12,250	0	12,250
Confirmed	RTT Target Delivered 25/26	RTT26	2,000	0	2,000
TBC	Estate Safety - Fair Share		1,800	0	1,800
Total Non CDEL Schemes			**20,877**	**21**	**20,877**
Grants					0
	Research 3T MRI Scanner	3TMRI	1,225	0	1,225
	Salix Phase 4	SALIX4	1,950	1	1,950
Total Grants			**3,175**	**1**	**3,175**
					0
Total Capital Programme			**29,599**	**1,031**	**31,712**

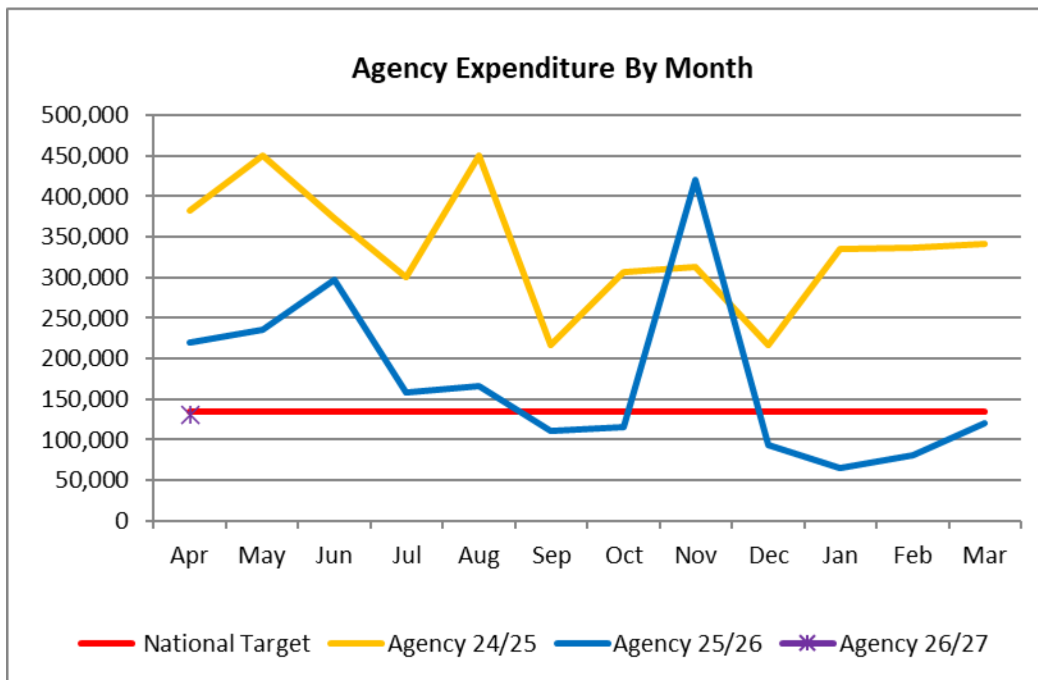
- 26/27 capital position limited due to CDEL allocation and payback to Hull/NLAG (£3.5m 26/27 and £2m 27/28).
- 3 main schemes 26/27 EPR and completion of RAAC Block C and all other eradication.
- A CDC case is being pursued but is subject to NHSE approval, £12.5m.
- Current risk £2m overspend

Agency

£131K
IN MTH

£1.5M
FORECAST

£1.6M
NHSE TARGET



Agency spend on track to deliver within the NHSE target based on M1 spend.

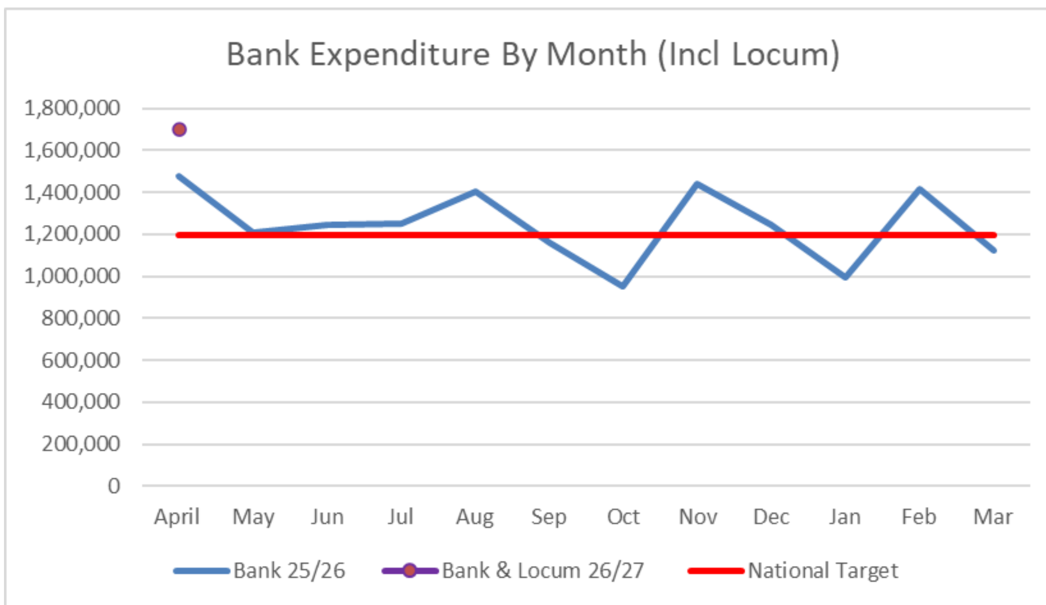
Consultant spend is the biggest driver of agency spend due to sickness and vacancies.

Bank & Locum

£783K
IN MTH
£9.3M
FORECAST

LOCUMS
£1M
IN MTH
£10M
FORECAST

£14.3M
NHSE TARGET



Although there has been good progress on reducing bank spend based on M1 we would not meet the NHSE target.

NHSP rates are now at top of band versus mid point at the same point last year, £3m impact in 25/26.

The majority of bank spend is around nursing.

Need to consider reporting of locums as some are paid via payroll on either bank or fixed term contracts.

21% of Locum spend is linked to GP OOH service.

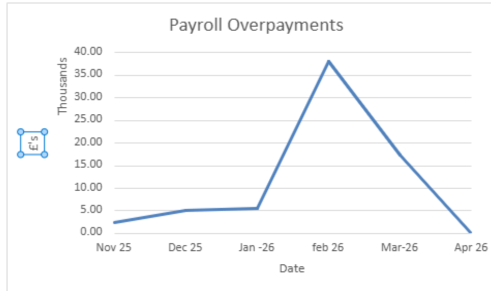
Watch Metrics

teamHDFT
At our best

RETROSPECTIVE PO's

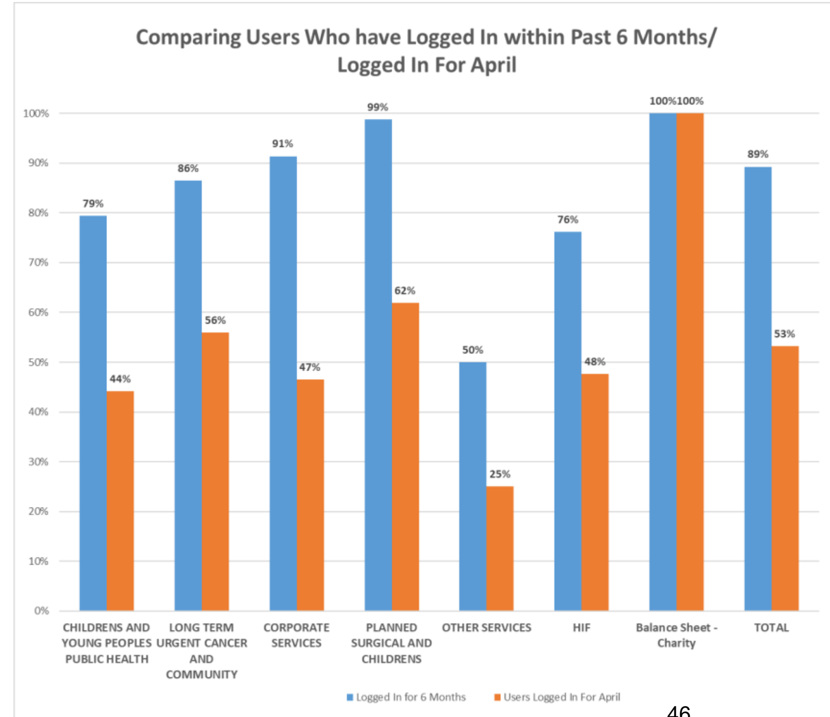
	March	April
Retospective PO's	106	100
% PO's raised	25%	18%

PAYROLL OVERPAYMENTS



REACH ACCESS

ACCESS BUDGET REPORTS



COST CENTRES NOT IN BALANCE

- 313 OUT OF 783 £7.7M O/SPENT
- 65 CC OVER £20K O/SPENT
- 307 OUT OF 783 U/SPENT £3.5M

OVERTIME